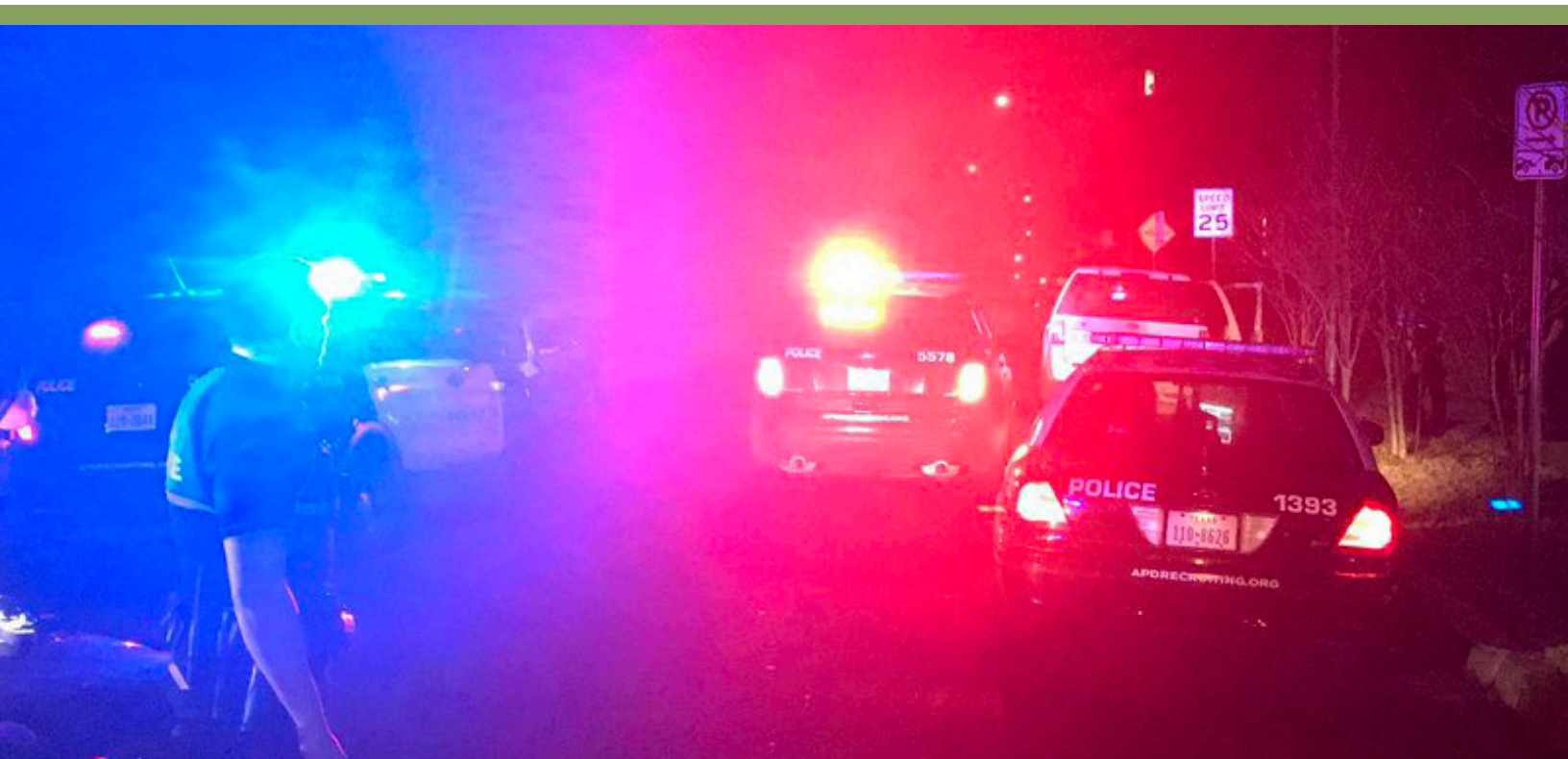


Audit Report

APD Response to Mental Health-Related Incidents

September 2018



The Austin Police Department (APD) and peer cities have organized their response to mental health-related calls for service under a best practice model. Some APD practices align with this model and with practices reported by peer cities, but we identified opportunities for improvement in the following areas:

- APD crisis intervention training meets state requirements, but not all of the best practice elements are included in their certified training;
- APD does not dispatch certified officers to lead the response to mental health-related calls and those officers are not always available when needed. In addition, officers may not have all relevant information when responding to these calls for service; and
- APD does not track and review crisis intervention incidents to improve outcomes. In addition, statistics on mental-health related calls are challenging to track.

As a result, people experiencing a mental health crisis in Austin may be at higher risk of having a negative police interaction than people in a city that more closely aligns with best practices.

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Cover: @Austin_Police Twitter, January 2018.

Objective

Our objective was to determine if the Austin Police Department is effectively receiving and responding to incidents involving people with mental health or other specialized needs.

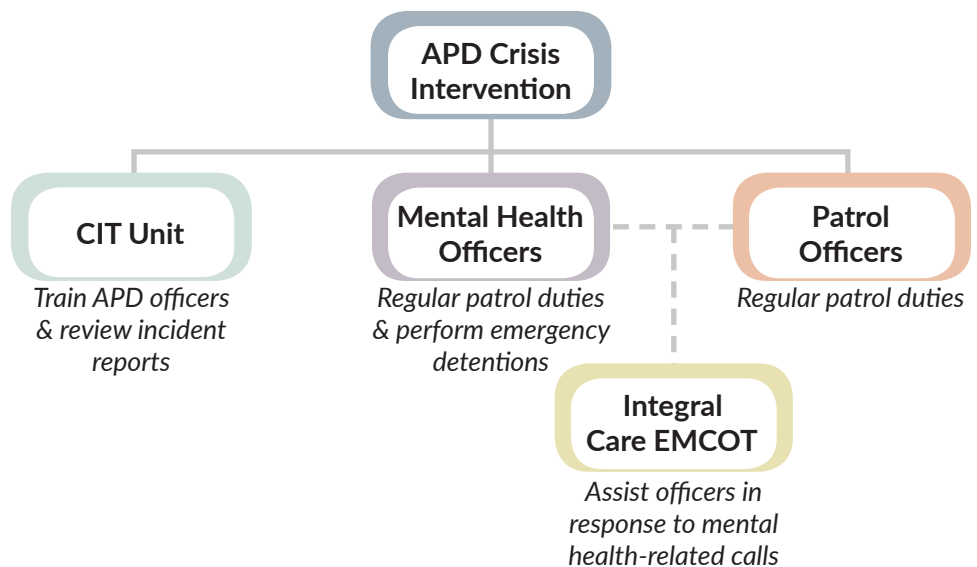
Background

The vision of the Austin Police Department (APD) is “to be respected and trusted by all segments of Austin’s diverse community,” including individuals with specialized needs. This term refers to people with intellectual and developmental disabilities, chronic and acute mental health illnesses, physical disabilities, intoxicated individuals, and others. For the purposes of this audit, we focused primarily on police responses to people experiencing mental health-related issues.

Since 2008, APD reported a 95% increase in mental health-related calls. From 2014 through 2017, these calls accounted for about 7% of all calls for service. To respond to these type of calls for assistance, police departments across the country have followed the example of the “Memphis Model” of crisis intervention, first established in Memphis, Tennessee. The elements of this model are discussed in more detail within the findings of this report.

The Austin Police Department has organized their response to people with mental health-related issues under this model, as shown in Exhibit 1.

Exhibit 1: APD Crisis Intervention Team Structure



SOURCE: OCA analysis of APD CIT structure, August 2018.

What We Found

Summary

Overall, we found that some, but not all, APD practices align with the “Memphis Model” and practices reported in peer cities for responding to mental health-related calls for service. As a result, people experiencing a mental health crisis in Austin may be at higher risk of having a negative police interaction than people in a city that more closely aligns with best practices.

Based on the “Memphis Model,” we used the Crisis Intervention Team Core Elements developed by CIT International¹ as the benchmark of our analysis. The Core Elements are recognized by law enforcement as a best practice for “police-based crisis intervention.” As shown in Appendix A, the Core Elements provide guidance for departments on all aspects of a successful crisis intervention program.



Crisis Intervention Team Core Elements

Basic Goals:

- Improve the safety of the person in crisis and the officer.
- Redirect the person with mental illness from the judicial system to the health care system.

Using the applicable Core Elements as a guide, we evaluated APD’s model for receiving and responding to mental health-related calls. We also contacted several peer cities to compare their crisis intervention program models against the Core Elements and to see how their practices may align or differ from APD’s practices. As shown in Exhibit 2, APD’s practices were not aligned and, in a few instances, were noticeably different from practices reported by other cities (see Appendix B for a more detailed comparison).

We have three findings related to APD’s response to mental health-related calls which are detailed below.

¹ CIT International is a non-profit organization focused on promoting community collaboration using the Crisis Intervention Team Program to assist people living with mental illness who are in crisis.

Exhibit 2: APD's CIT Practices are Not Consistently Aligned with the Core Elements or Reported Practices in Other Cities

	Austin	Dallas	Houston	San Antonio	Philadelphia	Phoenix	Seattle
Population (2016)	947,890	1,317,929	2,303,482	1,492,510	1,567,872	1,615,017	668,849
Number of CIT Calls (2017)	12,004	15,593 (2016)	37,000	15,903	N/A	15,863	10,000
Crisis Intervention Team International Core Elements							
CIT Officers receive a 40-hour specialized training	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CIT-Trained Officers receive regular refresher trainings on topics related to crisis intervention, de-escalation, and mental health	No	Yes	Yes	Yes	Yes	Yes	Yes
Call-Takers receive training on CIT crisis event call recognition	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dispatchers identify nearest CIT officer and dispatch officer to crisis event	No	Yes	Yes	Yes	Yes	Yes	Yes
Department partners with mental health professionals	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CIT Incidents are reviewed and evaluated for process improvements	No	No	No	Yes	No	Yes	Yes
Peer City Practice							
Self-registry or similar system (e.g., Smart 911)	No	No	No	No	Yes	No	Yes
Co-Response model (police paired with mental health professional)	No	Yes	Yes	No	No	No	Yes

SOURCE: OCA interviews with representatives of referenced cities, as well as OCA analysis of documentation from referenced cities. Interviews and analysis conducted March 2018 - July 2018.

Finding 1

APD meets state requirements for crisis intervention training for all officers. APD's certified training does not cover specialized de-escalation and mental health crisis topic areas, include direct interactions with the community served, or offer regular refreshers to update officer knowledge and skills. Peer city police departments appear to include more of these best practice elements in their certified trainings.

The best practice Core Elements recommend the type and frequency of training that should be offered to officers and dispatch personnel, and also contain guidance on establishing partnerships with mental health professionals.

APD meets Texas Commission on Law Enforcement (TCOLE) training requirements by providing basic training to officers in the Cadet Academy and a 40-hour comprehensive course to volunteer officers who want to become CIT-certified officers. However, APD's certified training does not include some best practice elements and differs from trainings reported by peer cities. Also, APD does not offer regular refresher trainings for CIT-trained officers.

APD call-takers are trained on crisis communications, but their call prompts do not include instructions on how to proactively identify and assist with a mental health-related call.

Finally, APD has a partnership with Integral Care to provide mental health treatment to individuals in mental health crisis as well as training to APD officers.



Officer Training

- All officers should receive mental health awareness and crisis intervention training in pre-service academy.
- CIT-certified officers should receive a 40-hour comprehensive training on topics related to crisis intervention and mental health response. This course should include lectures, visits to mental health facilities, engagement with individuals experiencing mental illness, and scenario based de-escalation skill training.
- Refresher trainings should be offered regularly for CIT-certified officers.
- 20-25% of patrol officers should be certified in crisis intervention.

According to CIT International, a successful crisis intervention program provides all patrol officers with training on identifying and responding to mental health-related calls for service. In addition, the department should develop a select group of experienced patrol officers as CIT-certified specialists for responding to these calls and connecting residents to community resources. APD refers to their CIT-certified officers as Mental Health Officers or MHOs.²

Pre-Service Academy Training

In accordance with TCOLE requirements, APD provides 40 hours of basic training in mental health awareness and crisis intervention to officers during the Cadet Academy.

Mental Health Officer Certification Training

APD provides the recommended 40-hour training to become a certified MHO. However, we found indications that MHO training does not fully align with the Core Elements. The curriculum of the MHO training is similar to the crisis training provided to all new officers in the Cadet Academy, but includes more information on the logistics and legality of

² In order to serve as an MHO, an officer must have served in the department for two years, have a clean record, and volunteer for the certification.

performing emergency detentions which, as discussed in Finding 2, is a task that is only performed by MHOs.

APD invites mental health clinicians from Integral Care to lead portions of the 40-hour MHO training and includes role-play exercises. The MHO training does not include visits to mental health facilities or direct interaction with people experiencing mental illness.

APD invites mental health clinicians from Integral Care to lead portions of the 40-hour MHO training and includes role-play exercises.

APD management asserted that these elements are offered during the Cadet Academy and through other trainings available to all officers. They also noted that officers visit mental health facilities during Cadet Academy and some classes interact with people experiencing mental illness through a partnership with the National Alliance on Mental Illness, but we did not see this in the curriculum. APD staff noted that these practices started around 2013. Staff also verified that the curriculum is created to document compliance with TCOLE requirements, and may not include specific methods taught in those classes. In addition, APD management cited other courses on topics such as veteran issues, interactions with people with intellectual or developmental disabilities, and substance abuse issues.

Not offering these elements during the MHO training does not align with the Core Elements and other guidance from CIT International, because “the tactics and techniques taught in the [MHO] course of instruction are advanced and require experienced learners who are motivated to engage with the material and take on the specialist CIT role. Many officers are not ready or interested or do not have the disposition to fully engage in this advanced specialist training and take on this role.”³

Peer Cities: Officer Training – Specialized Content and Interactions

All of the peer cities reported that role-playing and scenario-based exercises are included in their CIT-certified training. Seattle and the three Texas cities reported that their CIT-certified trainings emphasized de-escalation techniques.

Also, the Philadelphia Police Department reported that their CIT-certified training includes testimony from people with mental illness as well as conversations with their family members, veterans, and people in treatment for substance abuse. Staff also said their course provides in-depth training on recognizing the signs of mental illness, addressing the needs of specific populations such as veterans, and the use of de-escalation tactics.

Training May Not Fully Support APD’s Goal of De-escalation

Because APD’s approach to specialized training differed from the Core Elements and peer city practices, we also looked at relevant trainings available for all APD officers. According to APD policy, the goal of de-escalation is to gain a person’s cooperation without having to use force. De-escalation is particularly important for mental health-related calls because the person involved may not be able to understand or respond to an officer’s instructions.

³ CIT International Position Statement on CIT as a Specialist/Generalist Model - Not Mandated Training; CIT International Position Statement on Providing CIT Training in the Pre-Service Academy. Available on www.CITInternational.org.

APD management stated that de-escalation tactics are woven throughout all of APD's trainings. Based on our review of APD policy, training materials, and feedback gathered from patrol officers, we noted indications that APD may be providing inconsistent messages to officers regarding de-escalation. In addition, we identified a limited number of trainings dedicated to mental health and de-escalation topics. Specific to these mandatory trainings, we found that most officers attended, but 5% of officers, on average, did not attend.

We also noted that APD had received several recommendations from a previous citizen oversight body related to increasing training on mental health and de-escalation topics. APD's prior police chief replied to some of those recommendations noting that APD's existing training was sufficient and exceeded state requirements. Similarly, APD management and officers consistently described APD's current training model as following best practices.

APD's "response to resistance" policy is less specific than other cities with regard to expectations on when different levels of force should be used.

Additionally, we analyzed a report of fatal police encounters in the 15 most populated cities as well as Seattle. That data indicated that APD has the highest per capita rate of fatal police shootings involving persons believed to be experiencing a mental health crisis. APD management noted that Austin may have more people with mental health-related issues than other cities. We could not find data specific to the number of people with mental illness living in Austin as compared to other cities.

In January 2018, APD revised its "response to resistance" policy to address de-escalation issues. Also, APD reported that they are starting a new training course in late 2018 that includes 10 hours of de-escalation training. According to APD training staff, all officers will attend this training throughout the next year.

Regular Refresher Trainings

The Core Elements recommend that departments offer regular refresher training for CIT-certified officers. APD training staff confirmed that the department does not offer regular refresher trainings for MHOs. Mandatory refresher training topics for all officers are determined and issued by the Chief of Police. Without regular refresher trainings, an MHO's familiarity with crisis intervention topics may diminish. Additionally, officers may not have ready access to information on new techniques or clinical insights that may help them assist people experiencing a mental health-crisis. This is especially true for officers who were last trained 10, 15, or 20 years ago.

Peer Cities: Officer Training – Refreshers

All of the peer cities reported offering crisis intervention and de-escalation refresher trainings to their CIT-certified officers on a regular basis.⁴ Four of the six cities reported that they offer refresher trainings to CIT-certified officers every year and the other two cities reported offering these refresher trainings every two years.

⁴ See Appendix B for detailed training information in the Peer Cities Comparison Chart.

Percentage of Officers That Are CIT-Certified

More than 25% of APD patrol officers have taken CIT-certified training, but not all of those officers serve in a CIT role. At the time of our analysis, APD had 1,827 active patrol officers and 750 officers, 41%, had received the additional crisis intervention training. The most recent police labor agreement included 162 stipends, or extra pay, for these MHOs.⁵ According to officer assignment data, APD only deployed officers receiving the stipend to serve in the MHO role. At most, about 10% of APD patrol officers were actively serving as MHOs. Also, we saw indications that the volume of mental health-related calls for service may have exceeded the number of MHOs available, which is discussed in Finding 2.

Peer Cities: Officer Training – CIT Certification

Where data was available, we noted that peer city police departments also reported a high percentage of officers being CIT-certified.



Dispatch Training

- Call-takers should be trained to identify and assess a mental health crisis call.

APD does not ask if someone requires mental health assistance at the start of a 9-1-1 call.

APD call-takers receive a 24-hour crisis communications training that covers signs and symptoms of mental impairment or mental illness and how to communicate with callers in crisis. We also reviewed the APD call-taker instructions for responding to 9-1-1 calls. These instructions do not include prompts to help call-takers identify if someone is having a mental health crisis or ask if the caller needs mental health assistance or related resources. Proactively checking if mental health could be a factor in a call for service could provide notice to responding officers and identify the most appropriate resources for the caller's needs.

APD management said that call-takers do not collect this type of information at the start of a call because their priority is to gather basic information and send out the relevant services as fast as possible. In 2016, the City's citizen oversight body recommended that APD have call-takers automatically ask if callers need mental health assistance.⁶ APD did not respond to this recommendation.

Peer Cities: Dispatch Training

All of the peer cities reported providing training to call-takers on identifying mental health issues and crisis intervention tactics. Police call-takers in both Houston and Philadelphia reported having specific questions to ask the caller to help identify mental health issues. In addition, Phoenix reported that their call-takers receive training on crisis negotiation.

⁵ The labor agreement expired in December 2017. MHO stipends were reinstated outside of the labor agreement in February 2018.

⁶ Citizen Review Panel memo #2016-0115.



Mental Health Partnership

- Partnership should exist between police and mental health professionals to provide treatment to individuals with a mental illness and training to officers.

APD partners with Integral Care to teach aspects of the department's 40-hour crisis intervention course and to provide on-site mental health clinicians for certain types of calls through Integral Care's Expanded Mobile Crisis Outreach Team (EMCOT). The source of federal funding for EMCOT is not available for the coming fiscal year. The City Council approved one-time funding in the fiscal year 2019 budget.

Peer Cities: Mental Health Partnership

All of the peer cities reported partnerships with local mental health providers. In addition to these partnerships, San Antonio and Seattle police departments reported having mental health professionals on staff.

Finding 2

APD does not include all best practice elements related to responding to mental health crisis situations and specialized resources are not always available when needed. In addition, officers may not have all relevant information when responding to these calls for service.

The best practice Core Elements recommend that the nearest CIT-certified officer be identified and dispatched to lead the response to a crisis event. Also, mental health professionals should receive referrals from the police.

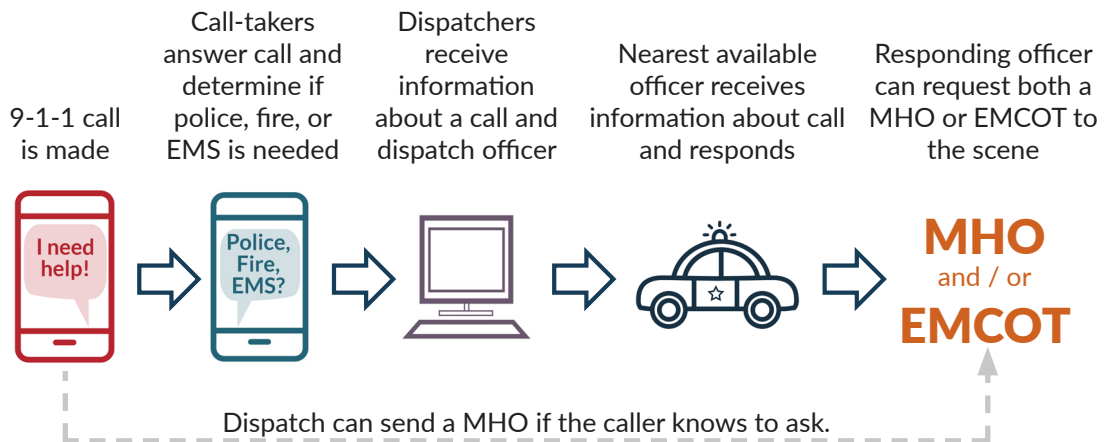
The APD approach to responding to calls for service does not consistently align with the Core Elements or practices in other cities. APD does not dispatch the nearest CIT-certified officers to a crisis event and they do not have officers with specialized training available to lead the response to mental health-related calls. Also, APD has a process to provide responding officers with needed information about calls for service, but that information may not consistently be available. APD partners with mental health professionals for certain types of calls, but they are not always available and their ability to respond to crisis situations in the field is limited.

★ Dispatch Action

- Nearest CIT-certified officer should be identified and dispatched to the crisis event.

9-1-1 calls for service received by APD go through the process shown in Exhibit 3.

Exhibit 3: Overview of 9-1-1 Call Process



SOURCE: OCA interviews with APD management and analysis of APD communications policies and instructions, March - July 2018.

As noted in Finding 1, APD call-takers do not proactively identify if a call for service involves a mental health issue. APD dispatchers assign all calls to patrol officers who respond to assess the situation. Dispatchers are not authorized to assign a CIT-certified officer to a call unless one is requested by the caller or the initial responding officer makes a request for an MHO. This means that certified resources may not be dispatched to a mental health-related call or may be delayed in responding to one. If dispatch were authorized to assign CIT-certified or other relevant resources to a call, it is more likely that the appropriate resources would arrive on scene to assess and handle the situation.

APD management stated that the goal of dispatch is to get an officer on-scene as quickly as possible. They explained that responding officers,

not dispatchers, are in the best position to determine if specialized help is needed at the scene. We participated in ride-outs with officers and observed that, in practice, APD officers select which calls they respond to in the field. Where a call appeared to clearly involve mental health issues, MHOs tried to respond if they were available.⁷

Peer Cities: Dispatch Action

All six of the peer cities reported allowing dispatch staff to route calls to the nearest CIT-certified officer when a call may involve a person experiencing mental illness and some cities require or prioritize such a response for certain critical calls.

APD Responding Officers May Not Receive Relevant Information Due to Information System Limitations

Since CIT-certified officers do not respond to all mental health-related calls, responding patrol officers need to have as much information as possible about a call to help them assess and handle the situation. APD has two major information systems that are relevant to officers responding to a call: computer-aided dispatch (also known as CAD) and the records management system. The dispatch system contains information about the call itself, such as the location and details provided by the caller. The records system contains incident reports and other information related to prior or on-going investigations.

APD responding officers do not readily have access to prior incident information because the dispatch and records systems do not interact. If these systems were linked, an officer would have more information that could result in a better outcome. For example, a call about a person expressing distress may be handled differently by a responding officer who has no context for the behavior than by a responding officer who has access to information about prior instances of similar behavior that may include contact information for the person's case worker.

Officers cannot easily look up key information about a person or location while responding to a call.

In order to address this lack of readily available information, APD staff have the ability to enter caution notes within the dispatch system. Dispatchers can read relevant notes over the radio or enter them into the dispatch display for responding officers to read. Caution notes often contain routine information such as gate codes, but can also contain key information about prior interactions that could be useful for a mental health-related call. For example, a caution note could advise officers that a person at the address had previously exhibited mental health issues, was hostile to police, and was known to have weapons in the house. This information could be critical in determining how the interaction will be handled in order to ensure the safety of the person involved and the responding officers.

One major limitation of the current caution notes system is that a note can only be associated with a physical location or phone number which makes it difficult to tie information to an individual. Additionally, we found that APD did not always have caution notes associated with individuals

⁷ For example, a Mental Health Officer might assign themselves to a call involving someone who is loudly arguing with themselves at a bus stop or a suicide attempt.

Relevant information about a person's mental health status may be deleted without review.

who had multiple mental health-related interactions with APD. Also, information included in some caution notes was not always helpful for preparing officers for a mental health-related incident.

In addition, caution notes are not subject to review. In an effort to minimize out of date information, caution notes automatically expire two years after they are entered, which may result in relevant information being deleted from the system.

APD management has considered integrating its two major information systems as well as establishing a self-registry system for people with mental illness. However, neither has been done. Until there is a solution to ensure that relevant, timely, and accurate information is available, officers responding to mental health-related calls may lack vital information that limits their ability to address the incident in a safe and effective manner.

Peer Cities: Dispatch Action – Relevant Information

Several of the peer cities reported similar difficulties in associating information about prior incidents with individuals rather than with physical locations or phone numbers. The Houston Police Department reported that their dispatch and records systems are linked, resulting in officers having easier access to information about prior incidents while responding to calls.

The Philadelphia and Seattle police departments reported having systems where individuals or their guardians can self-register information about mental health or other relevant conditions with the police. Both the Dallas and Houston police departments reported considering a self-registry system, but noted that no action had been taken to implement such a system.



Officer Action

- CIT-certified officer should respond to crisis event and lead the intervention.

As noted above, APD does not dispatch MHOs to lead the response to mental health-related calls. Patrol officers are generally the first to arrive on-scene and are responsible for assessing the situation. APD management and staff asserted that all patrol officers are trained to handle mental health-related calls. APD policy requires responding officers to request an MHO be dispatched if they believe a person's mental health is affecting their behavior, but APD management stated that officers may not call an MHO if they are able to handle the situation on their own. MHOs are requested when an emergency detention is needed or to help connect the person to community resources.⁸

However, MHOs may not be available to respond to calls when requested. APD staff stated that they seek to have one to three MHOs on duty in each patrol sector for each shift. We compared MHO staffing with mental

⁸ Under Texas state law, any peace officer is permitted to perform an emergency detention. The peace officer detains and transports the person to a location where they can receive medical treatment such as a hospital or behavioral health center.

MHOs were not fully staffed citywide for 22% of the time we tested. We also identified three instances where the mental health-related call volume was greater than the number of MHOs available to respond.

health-related calls over four days in May 2017 and March 2018. For 22% of that time, we found that MHOs were not fully staffed citywide. We also identified three instances where the mental health-related call volume was greater than the number of MHOs available to respond. If an MHO is not available in a patrol sector, APD officers can request assistance from an MHO in a nearby sector. However, the response time in those instances may be longer.

We participated in several ride-outs with APD patrol and MHO officers during this audit to observe how officers respond to mental health-related calls. The officers consistently reported that on-the-job experience is their best resource for learning how to effectively respond to calls. We observed officers using crisis intervention techniques to provide assistance to several people experiencing a mental health crisis.

Peer Cities: Officer Action

All six of the peer cities reported that CIT-certified officers are dispatched as first responders to mental health-related calls if they are available. Some cities reported prioritizing calls so that CIT-certified officers respond to the most critical calls. Other cities reported that they require CIT-certified officers to respond to certain types of critical calls.

Emergency detentions involve detaining and transporting a person to a location where they can receive medical treatment. In Austin, emergency detentions are only performed by a limited group of officers, the MHOs. APD management explained that this is because relevant laws, insurance practices, and bed availability changes frequently and it is easier to update a small group of officers than the entire patrol force. None of the Texas cities reported limiting which officers can perform an emergency detention.



Mental Health Professional Action

- Mental health professionals should receive referrals from police officers.

APD partners with Integral Care to provide on-site mental health clinicians for certain types of calls through Integral Care's Expanded Mobile Crisis Outreach Team (EMCOT). This partnership serves an important function and aligns with the best practice Core Element, but their ability to respond to crisis situations is limited. Both APD and Integral Care management noted that EMCOT team members, who are not police officers, should not be sent to calls that could place them in danger.

By policy, EMCOT does not respond in any situation that might be classified as a high-risk call, such as a call where a weapon is involved. This would include suicide attempts where the person is reported to have a weapon, even if their stated intention is to use it on themselves. According to APD and Integral Care, EMCOT is useful for mental health calls where an officer's presence is no longer required or where the officer's presence may be detrimental to the situation. These incidents are low-risk from a safety perspective, but may be complex from a diagnostic perspective.

APD and its partner agency does not allow mental health clinicians to be sent to high-risk calls, for fear of endangering the clinicians.

APD's partner agency for mental health crisis situations was not always staffed when incidents occurred.

Also, EMCOT is not staffed 24 hours a day and is not available to respond to all mental health-related calls. We compared EMCOT staffing with mental health-related calls over four weekdays in May 2017 and March 2018. We found that, on average, EMCOT was not available to cover 22% of the mental health-related calls during that period. This was largely due to EMCOT not staffing the overnight hours. As shown in Exhibit 4, the highest mental health-related call volume occurs in the evening hours when EMCOT staff are nearing the end of their shifts. EMCOT staff are not available again until the morning.

Exhibit 4: Mental Health-Related Call Volume, by Year and Time of Day

	2014	2015	2016	2017
12 AM	371	369	388	376
1 AM	311	319	322	349
2 AM	280	282	290	319
3 AM	225	261	238	259
4 AM	199	213	199	212
5 AM	170	197	163	164
6 AM	183	204	208	211
7 AM	223	216	249	214
8 AM	274	311	341	334
9 AM	336	384	385	411
10 AM	362	455	457	426
11 AM	448	462	512	468
12 PM	499	480	541	481
1 PM	494	456	559	514
2 PM	437	531	509	486
3 PM	467	537	526	525
4 PM	526	517	580	595
5 PM	478	605	578	603
6 PM	485	544	574	575
7 PM	556	564	647	625
8 PM	513	565	634	584
9 PM	515	550	587	594
10 PM	472	485	550	595
11 PM	422	428	475	462

SOURCE: OCA analysis of mental health-related calls reported by APD, July 2018.

Peer Cities: Mental Health Professional Action

Some of the peer cities reported operating limited “co-response models” of service where police officers and mental health professionals jointly respond to priority mental health-related calls. Seattle reported sending members of its Crisis Response Unit, made up of five sworn officers and one mental health professional, to SWAT calls and all calls involving active suicide attempts. Houston reported sending its Crisis Intervention Response Team, made up of a patrol officer and a mental health professional, to all SWAT calls. In Dallas, the police department’s RIGHT Care teams, made up of a patrol officer, a Dallas Fire Department paramedic, and a social worker are called to the scene by responding patrol officers. While the San Antonio Police Department employs two mental health professionals to interact with residents, staff said they do not respond to calls in the field.

Finding 3

APD does not follow best practice guidance to track and review crisis intervention incidents to improve outcomes. APD and other cities reported difficulties tracking and reviewing these incidents.

The best practice Core Elements recommend that the police department evaluate the CIT program to determine if goals are being met and whether there are any areas for improvement.

APD does not consistently track and review its response to interactions with people experiencing mental health issues in order to evaluate outcomes or make improvements to the CIT program. In addition, tracking mental health-related statistics can be challenging. Tracking and evaluating complete and accurate information could provide insight into what is or is not working and whether APD should adjust policies or training, reassign or reorganize resources, or take other appropriate action.



Evaluation

- Department should measure the impact and outcomes of the CIT program to determine if the program is meeting its objectives and to provide opportunities for improvement.

APD does not evaluate their response to mental health-related calls for service to identify areas for improvement. Also, APD executive management does not receive routine updates about these type of responses. APD's Crisis Intervention Unit is responsible for reviewing mental health-related incidents. At APD, calls for service as well as any resulting reports are labeled with specific titles, depending on the nature of the incident. All reports categorized with a mental health-related title are automatically reviewed by Crisis Intervention Unit staff. However, that review is focused on whether follow-up action is needed for the person involved. This review does not look at how the officer handled the situation or identify opportunities to improve the interaction to produce better outcomes in future cases.

When a critical incident occurs,⁹ the incident is reviewed by APD executive management and the Force Review Board. This Board is tasked with reviewing the incident for potential changes to tactics, training, and equipment.

Additionally, APD staff confirmed that data regarding mental health-related call responses is not regularly presented to executive management. Statistics regarding mental health-related calls, critical incidents involving a mental health component, or uses of force involving mental health factors do not appear in reports that are used to summarize and track key facts and trends for APD management. Without this type of information, APD management is unable to effectively evaluate the CIT program to ensure it is working as intended. Also, this type of information would be valuable for determining which training topics should be mandatory for APD refresher courses.

⁹ A critical incident is defined by APD as an officer-involved shooting, a death in custody, or a use of force by an APD officer that results in serious bodily injury or death.

Peer Cities: Evaluation

Half of the peer cities also reported not conducting evaluation of incidents. Only one of the three Texas cities, San Antonio, reported that they evaluate incidents for trends and improvement opportunities. In addition, San Antonio reported that their police department executive management reviews emergency detentions. Houston training staff review mental health-related incident reports to determine if the officer's actions complied with policy, but these reviews are not used for program improvements and do not appear to be reported to executive level command.

Following a settlement agreement with the U.S. Department of Justice, the Seattle Police Department reported developing a crisis intervention group made up of mental health professionals, service providers, judges, and other local stakeholders. Staff stated this group meets quarterly to re-evaluate Seattle's crisis intervention response model. Additionally, staff said the Crisis Response Unit reviews incident reports from mental health-related calls for procedure and training improvements.

APD and peer cities reported difficulty in tracking mental health-related incidents.

The Phoenix Police Department reported that their CIT Team reviews mental-health related incidents for trends and chronic issues. The Philadelphia Police Department reported not reviewing mental health-related incident reports, but they do review training on an annual basis and solicit training topic requests from patrol officers.

Statistics on Mental Health-Related Calls are Challenging to Track

As part of our work on this project, audit staff participated in several ride-outs with APD patrol officers and MHOs. Based on our observations and an analysis of the call data for those shifts, we noted that several potential mental health-related incidents were not coded as mental health calls in APD's system. This suggests that APD may not capture all mental health-related incidents in their data.

As noted earlier, officers label calls and reports with a specific title. The decision about which title to use is within the officer's discretion. It appeared that officers may either not recognize a call as involving a mental health issue or may decide that some other factor is more relevant to describe the incident. APD does have some processes in place to ensure appropriate titles are added, such as allowing detectives to review and add titles to incident reports based on their own investigation. However, a review may not occur if an incident does not require a detective.

Incidents that are not labeled as mental health-related will not be automatically forwarded to the Crisis Intervention Unit for review. This means that follow-up action for the person affected will not occur. It also means that the number of mental health-related incidents could be undercounted. Basing deployment decisions on undercounted data would result in fewer MHOs and other resources being assigned to meet the mental health needs of the community.

Peer Cities: Evaluation – Tracking Statistics

Four of the six peer city police departments, including all the Texas cities, reported tracking mental health-related calls and provided the number of incidents they responded to in 2017. For these cities, we noted that the numbers seemed to be based on coded incidents similar to Austin’s method. Also, Houston reported that they have expanded the number and specificity of their call type codes in an effort to better identify mental health-related incidents.

Seattle provided an estimate of their annual calls. Also, Philadelphia reported that they do not track the number of mental health-related calls because of the difficulty in defining what a mental health-related incident entails.

Additional Observation

Texas peer cities reported developing programs to identify and divert chronic mental health-related issues from police response to more appropriate health care-related resources.

During our peer city analysis, we noted that the Texas cities have instituted or just undertaken various 9-1-1 call diversion efforts. In general, these programs aim to identify the most frequent users of 9-1-1 calls for service and either divert those calls to more appropriate resources or proactively connect people in need to support services, which should reduce or prevent the need for police responses in the future. Reducing the number of calls for service means that these departments can use their law enforcement resources to focus on other priority issues.

Houston

The Houston Police Department, in collaboration with Harris County, reported having a Chronic Consumer Stabilization Initiative. This effort was designed to identify, engage, and provide services to people diagnosed with a chronic mental illness and a history of multiple interactions with the police. The goal of this program is to reduce the number of interactions between people with mental illness and the police, connect them with appropriate services, and reduce the number of admissions to emergency rooms. Houston reported a decrease in these interactions since the start of the program as well as 2,100 calls diverted from the 9-1-1 system since 2017.

San Antonio

The San Antonio Police Department reported setting up a program called the Chronic Crisis Stabilization Initiative. San Antonio works with partner organizations to identify frequent service users. The police work alongside licensed clinicians and proactively meet with people with specialized needs. The goal of this program is to provide assistance to people in need, such as ensuring they are taking prescribed medications, and prevent avoidable use of the 9-1-1 system.

Dallas

Dallas reported having over 6,000 people with mental health issues who are “super-utilizers” of emergency services. The Dallas Police Department and other regional partners started the RIGHT Care program to better assist this population and other residents. This grant-funded program pairs a paramedic and a behavioral health professional with a Dallas police officer to jointly respond to calls for service. The goal of this program is to reduce recidivism rates and provide more cost-effective and appropriate care for this segment of the population. It can also free up law enforcement and EMS personnel to respond to other high-priority calls. Also, we noted that Austin’s Homeless Outreach Street Team (HOST), while more narrowly focused, has a cross-functional membership that is similar to the Dallas RIGHT Care team.

Recommendations and Management Response

Because this audit identified multiple areas for improvement and we acknowledge that more information is needed to identify the right solutions for Austin, we have issued two recommendations that focus on (1) engaging the people who are the most informed and affected and (2) implementing workable solutions identified from that process.

1

The Chief of Police should engage with mental health stakeholders to identify solutions that have worked in other communities, evaluate the needs and available resources in our community, and review what solutions could work to benefit people with mental illness in the Austin area. This process should be documented and stakeholders should include, but not be limited to, members of the:

- law enforcement and criminal justice community;
- advocacy community including people and family members affected by mental illness; and
- mental health community including providers, practitioners, educators, and trainers.

Management Response: Agree

Proposed Implementation Plan: The Mental Health Stakeholder’s Group members will be identified, and the group will be formed.

Proposed Implementation Date: December 2018

2

The Chief of Police should use the results of the stakeholder process noted in recommendation 1 to implement changes to the City’s crisis intervention program. At a minimum, these changes should address the finding areas of this report, including:

- the format, frequency, and content of specialized training topics;
- dispatch practices for mental health-related calls for service;
- response practices for crisis intervention situations;
- access to relevant information;
- reporting and tracking to identify continuous improvements; and
- opportunities to re-engage this process on a periodic basis.

Management Response: Agree

Proposed Implementation Plan: The Austin Police Department (APD) will work with the Mental Health Stakeholder’s Group to develop improvements to its Crisis Intervention Program.

Proposed Implementation Date: The Mental Health Stakeholder’s Group will have regular meetings to make progress in the identified areas. Quarterly reports will be provided to the City Auditor’s office to report progress, beginning in the first quarter of 2019.

Management Response



MEMORANDUM

Austin Police Department Office of the Chief of Police

TO: Corrie Stokes, City Auditor, Office of the City Auditor
FROM: Brian Manley, Chief of Police, Austin Police Department
DATE: September 21, 2018
SUBJECT: Management Response to Audit of APD Response to Mental Health Incidents

Thank you for the opportunity to respond to the City Auditor's Audit Report on "APD Response to Mental Health-Related Incidents." Please find our responses to each of the recommendations below.

1. The Chief of Police should engage with mental health stakeholders to identify solutions that have worked in other communities, evaluate the needs and available resources in our community, and review what solutions could work to benefit people with mental illness in the Austin area. This process should be documented and stakeholders should include, but not be limited to, members of the:
 - Law enforcement and criminal justice community;
 - Advocacy community including people and family members affected by mental illness; and
 - Mental health community including providers, practitioners, educators, and trainers.

Management Response:

APD agrees with this recommendation.

Proposed Implementation Plan:

The Mental Health Stakeholder's Group members will be identified, and the group will be formed.

Proposed Implementation Date:

12/01/2018.

Management Response

2. The Chief of Police should use the results of the stakeholder process noted in recommendation 1 to implement changes to the City’s crisis intervention program. At a minimum, these changes should address the finding areas of this report, including:
 - The format, frequency, and content of specialized training topics;
 - Dispatch practices for mental health-related calls for service;
 - Response practices for crisis intervention situations;
 - Access to relevant information;
 - Reporting and tracking to identify continuous improvements; and
 - Opportunities to re-engage this process on a periodic basis.

Management Response:

APD agrees with this recommendation.

Proposed Implementation Plan:

APD will work with the Mental Health Stakeholder’s Group to develop improvements to its Crisis Intervention Program.

Proposed Implementation Date:

The Mental Health Stakeholder’s Group will have regular meetings to make progress in the identified areas. Quarterly reports will be provided to the City Auditor’s office to report progress, beginning in the first quarter of 2019.

BM:jc

Appendix A - Crisis Intervention Team Core Elements

Crisis Intervention Team Core Elements

The University of Memphis
School of Urban Affairs and Public Policy
Department of Criminology and Criminal Justice
CIT Center¹

September, 2007

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² Ms. Pillsbury is currently with the U.S. Department of Justice Federal Bureau of Investigation (FBI).

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SECTION 1

CIT Model Core Elements: Summary

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the “Memphis Model.” CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

Basic Goals:

- *Improve Officer and Consumer Safety*
- *Redirect Individuals with Mental Illness from the Judicial System to the Health Care System*

In order for a CIT program to be successful, several critical core elements should be present. These elements are central to the success of the program’s goals. The following outlines these core elements and details the necessary components underlying each element.

CORE ELEMENTS

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation & Networking
3. Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

Sustaining Elements

7. Evaluation and Research
8. In-Service Training
9. Recognition and Honors
10. Outreach: Developing CIT in Other Communities

SECTION 2
CIT Model
Core Elements: Outline

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
 - A. Law Enforcement Community
 - B. Advocacy Community
 - C. Mental Health Community
2. Community Ownership: Planning, Implementation & Networking
 - A. Planning Groups
 - B. Implementation
 - C. Networking
3. Policies and Procedures
 - A. CIT Training
 - B. Law Enforcement Policies and Procedures
 - C. Mental Health Emergency Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
 - A. CIT Officer
 - B. Dispatch
 - C. CIT Law Enforcement Coordinator
 - D. Mental Health Coordinator
 - E. Advocacy Coordinator
 - F. Program Coordinator (Multi-jurisdictional)
5. Curriculum: CIT Training
 - A. Patrol Officer: 40-Hour Comprehensive Training
 - B. Dispatch Training
6. Mental Health Receiving Facility: Emergency Services
 - A. Specialized Mental Health Emergency Care

Sustaining Elements

7. Evaluation and Research
 - A. Program Evaluation Issues
 - B. Development Research Issues
8. In-Service Training
 - A. Extended and Advanced Training
9. Recognition and Honors
 - A. Examples
10. Outreach: Developing CIT in Other Communities
 - A. Outreach Efforts

SECTION 3

CIT Model Core Elements: Detailed

3.1 Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health

A. Law Enforcement Community

Participation and Leadership within the Law Enforcement Community

Central to the formation and success of CIT is the role of the law enforcement community. Trained CIT Officers are able to interact with crisis situations using de-escalation techniques that improve the safety of the officer, consumer, and family members. In addition, the law enforcement community is able to provide care and help to consumers by transporting individuals in need of special treatment to appropriate facilities. It is also critical that all law enforcement participate in the formation of CIT and engage in all elements of the planning and implementation stages. Often those involved in the formation of the CIT program will become or help select the CIT coordinator for a particular law enforcement agency. The two main components within the law enforcement partnership are the operational Crisis Intervention Team within a law enforcement agency and general criminal justice system participants.

- 1) Law Enforcement: CIT Operational Component
 - Police Department
 - Sheriff's Department
- 2) Law Enforcement: Criminal Justice Partnership Component
 - Corrections
 - Judiciary
 - Public defender, State Attorney, Judges, Probation/Parole*
 - Crime Commission/Public Safety Commission
- 3) Law Enforcement: Policy Development Component
 - Law enforcement command staff
 - Training and Standards

1. Partnerships: Law Enforcement, Advocacy, Mental Health

B. Advocacy Community

Participation and Leadership within the Advocacy Community

Participation from the Advocacy Community is critical to the success of CIT. This partnership provides strong support from passionate and dedicated people whose goal is to improve the quality of life for individuals affected by a mental illness. Leadership roles should develop in the form of liaisons that help voice the support, ideas, and concerns of consumers and family members. This aspect of CIT brings the program to life by adding insight from those directly affected. This important partnership should be established early in the planning process and should continue as an ongoing operational element of CIT.

- 1) **Consumers/Individuals with a Mental Illness**
The personal accounts of individuals with a mental illness greatly enhance the planning process, officer training, and on-going support for CIT. Officers are able to gain an improved understanding and more realistic view of mental illness through these first-hand presentations. As a result, the involvement of individuals with a mental illness in the development, implementation, and ongoing sustainability of CIT is essential.
- 2) **Family Members**
Due to their first-hand knowledge and experience in dealing with mental illness, family members have a great deal to offer CIT. Family members also have much to gain from CIT, as the program encourages treatment instead of incarceration. In both the development and implementation phases of building a CIT program, this interdependency allows family members to provide direct guidance and assistance to the planning process, training and community education. Therefore, the involvement of family members is a critical hallmark of the CIT program.
- 3) **Advocacy Groups**
Advocacy groups may consist of family members, consumers, friends, and/or other individuals or groups that advocate for important issues surrounding mental illnesses and aim to improve the quality of life for those affected. Partnerships with advocacy groups, much like the partnerships with consumers and family members, are critical to the success of CIT. They provide strong support systems not only for members of the community, but also for law enforcement and mental health communities, as well as consumers. Advocacy groups may help by providing a voice for individuals with a mental illness; they also assist family members and consumers by providing services and guidance.

3) Advocacy Groups (continued)

Below is a list of some of the advocacy groups that have been critical to the initial development of CIT programs across the nation.

- National Alliance on Mental Illness (NAMI)
NAMI is a nonprofit, grassroots, advocacy organization whose mission is to eliminate mental illnesses and improve the quality of life for those who are affected. NAMI members consist of consumers, family members, and friends of individuals with a mental illness. www.nami.org
- National Mental Health Association (NMHA)
NMHA is a nonprofit organization that seeks to address all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans through advocacy, education, research, and service. www.nmha.org
- *Many other advocacy groups have participated in the initial development of CIT programs throughout the nation. These groups include those representing individuals with mental illness, as well as those representing local and state government, mental health agencies, and the judiciary.*

1. Partnerships: Advocacy, Law Enforcement, Mental Health

B. Mental Health Community

Participation and Leadership within the Mental Health Community

The mental health community plays an important role in the successful implementation, development, and ongoing sustainability of CIT. These professions provide treatment, education and training that result in a wide dissemination of knowledge and expertise to both individuals with a mental illness and patrol officers undergoing CIT training. This partnership is essential to maintaining access to the health care system and quality treatment.

1) Providers, Educators, Practitioners, and Trainers

- Professionals
Psychologists, Psychiatrists, Physicians, Social Workers, Counselors, Pastoral Counselors, Alcohol/Drug Counselors, Educators, Trainers, and Criminologists
- Public, Non profit & Private Agencies; Institutions; & Universities
Hospitals, Mental Health Centers, Emergency Intake Facilities, Universities, Colleges, and Medical Schools
- Trainers
Local professionals and agencies are encouraged to provide instruction during CIT training voluntarily as a service to the community. This is strongly suggested in an effort to minimize the training costs for local law enforcement agencies.

2. Community Ownership: Planning, Implementation & Networking

Communities both large and small are seeking solutions to crisis issues and situations. Community collaborations and partnerships are essential to this effort. Additionally, it is important to establish community ownership, which may be described as a dedicated investment that individuals within the community have in the CIT program. Individuals and organizations within the community must have a stake in the initial planning stages; the implementation of the CIT program and its training curriculum; and ongoing feedback in order to maintain, improve, and ensure the success of CIT. Also, local professionals and agencies, who dedicate their time without charge to assist in training the patrol officers, help to increase the sense of community ownership for CIT.

A. Planning

- 1) Advocates
- 2) Citizens
- 3) Consumers/Individuals with a Mental Illness
- 4) Family Members
- 5) Government
- 6) Judiciary
- 7) Law Enforcement Community
- 8) Mental Health Community

B. Implementation

- 1) Leadership from Law Enforcement, Mental Health, and Advocacy Community
- 2) Training Curriculum

C. Networking

- 1) Feedback
- 2) Problem Solving

3. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all those affected. Within the law enforcement community, policies exist in order to provide guidelines regarding how to properly transport consumers and how to develop an infrastructure through a system of partnerships and inter-agency agreements. These law enforcement policies address the actions of both emergency dispatchers and CIT patrol officers. The emergency dispatchers identifies the nearest available CIT Officer to respond to the crisis. The CIT Officer then responds to the crisis event and leads the intervention. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Within the mental health community, policies exist in order to provide guidelines regarding how to handle referrals from CIT Officers. The mental health community also plays a key role in training and feedback for the CIT program. The role of the advocacy community in policies and procedures are often more informal but involve the critical element of networking and feedback for the overall program.

A. CIT Training

- 1) Inter-Agency Agreements
- 2) Size and Scope

The number of trained CIT officers available to any shift should be adequate to meet the demand load of the local consumer community. Experience has shown that a successful CIT program will have trained 20-25% of the agency's patrol division. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. Ultimately, the goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times.

All dispatchers should be trained to appropriately elicit sufficient information to identify a mental health related crisis.

B. Law Enforcement Policies and Procedures

- 1) Dispatch Policies and Procedures

The nearest CIT Officer is identified and dispatched to the crisis event.

- 2) Patrol Policies and Procedures

Policies that maximize the officer's discretion are critical. In addition, a policy should address the issue of the lead CIT Officer, who guides the resolution of the crisis event.

3. Policies and Procedures (continued)

C. Mental Health Emergency Policies and Procedures

1) Law Enforcement Referral Policies

The policies in place should allow for a wide range of inpatient and outpatient referral sources in order to accommodate law enforcement agencies with a CIT program. Barriers that prevent officers from accessing immediate mental healthcare for an individual with mental illness should be eliminated. This should be a priority as important as any other in the CIT process. In addition, policies should be set to ensure minimal turnaround time for the CIT Officers, so that it is less than or equivalent to the turnaround time in jail.

3.2 Operational Elements

4. CIT: Officer, Dispatcher, Coordinator

Individuals within the law enforcement community primarily consist of CIT Officers, Dispatchers, and a CIT Coordinator. The following core element addresses the personnel required to effectively operate a CIT program.

A. CIT Officer

Officers within a patrol division should voluntarily apply for CIT positions. Each candidate then goes through a selection process, which is assessed according to the officer's application, recommendations, personal disciplinary police file, and an interview. Once selected, each of the CIT Officers maintains their role as a patrol officer and gains new duties and skills through the CIT training, serving as the designated responder and lead officer in mental health crisis events.

- 1) Voluntary
- 2) Selection Process
- 3) Patrol Role
- 4) CIT Role
- 5) CIT Training and CIT Skills
- 6) Safety Skills

B. Dispatch

Emergency dispatchers are a critical link in the CIT program and may include call takers, dispatchers, and 911 operators. The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer. Finally, dispatchers should know how to appropriately dispatch a CIT Officer. Dispatchers should receive training courses (a minimum of 8-16 hours) in CIT and additional advanced in-service training.

- 1) CIT Training
- 2) Familiarity with CIT
- 3) Recognize Call as CIT Crisis Event
- 4) Ask Caller Appropriate Questions
- 5) Dispatch Nearest CIT Officer
- 6) Additional/Advanced In-Service Training

4. CIT: Officer, Dispatcher, Coordinator

C. CIT Law Enforcement Coordinator

The CIT coordinator is part of the law enforcement community and acts as a liaison by maintaining partnerships with program stakeholders in order to ensure the success of CIT. The coordinator's involvement with CIT should start from the beginning and continue through the planning, implementation, and evaluation stages. The CIT coordinator provides support to CIT officers through training and feedback. The qualifications should include leadership ability and experience as a law enforcement officer. The job responsibilities include program development, training coordination, and maintenance of relationships with community partnership. The CIT coordinator also is a point of contact with the law enforcement agency for the community and brings stability to the program.

D. Mental Health Coordinator

The mental health coordinator is part of the mental health community who provides leadership and serves as a liaison with the advocacy and law enforcement communities. This position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important that each of them work with the overall community effort. This position has a significant operational component involving the training, curriculum and the function of the receiving facility or receiving facilities

E. Advocacy Coordinator

The advocacy coordinator is part of the advocacy community, which includes advocates, family members, and individuals with mental illness. As with the mental health coordinator, the position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important each of them work with the overall community effort. This position often involves the operational components such as training, curriculum and ongoing problem solving.

F. Program Coordinator

Multi-agency CIT programs may have a need for a Program Coordinator who is largely responsible for the day to day logistics of inter-departmental communication, data collection and management, records keeping and scheduling training. This person should be familiar with the roles of three primary components of the CIT program and comfortable and effective in communicating in all three environments. Much of the role of this person will be diplomatic in nature. They may have additional duties in identifying and securing sustaining programmatic resources.

5. Curriculum: CIT Training

The CIT program is an innovative national model of police-based crisis intervention with community mental health care and advocacy partnerships. Police officers receive intensive training to effectively respond to citizens experiencing a behavioral crisis. Patrol officers already have training and a basic understanding of the proper safety skills. Officers are encouraged to maintain these skills throughout the course, while incorporating new de-escalation techniques to more effectively approach a crisis situation. It is important that the individuals from the mental health, law enforcement, and advocacy communities play a critical role in the training curriculum in order to bring experience, ideas, information, and assistance to the CIT Officers in training. Additionally, all training faculty are encouraged to complete the 40-hour comprehensive course and participate in a ride-along in order to fully understand the complexities and differences that exist between mental health care and law enforcement.

A. Patrol Officer: 40-Hour Comprehensive Training

The 40-hour comprehensive training emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services. The format of a 40-hour course consists of didactics/lectures, on-site visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training. Experience has shown this is a minimum level of training hours. The material covered is complex. The desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioral changes learned as part of the training.

1) Didactics and Lectures/Specialized Knowledge

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post Traumatic Stress Disorders (PTSD)
- Legal Aspects of Officer Liability
- Community Resources

5. Curriculum: CIT Training

A. Patrol Officer: 40-Hour Comprehensive Training (Continued)

- 2) On-Site Visits and Exposure
 - On-Site Visits
- 3) Practical Skill Training/Scenario Based
 - Crisis De-Escalation Training Part I
Basic Strategies
 - Crisis De-Escalation Training Part II
Basic Verbal Skills
 - Crisis De-Escalation Training Part III
Stages/Cycle of a Crisis Escalation
 - Crisis De-Escalation Training Part IV
Advanced Verbal Skills
 - Crisis De-Escalation Training Part V
Advanced Strategies: Complex Scenarios
- 4) Questions and Answers
- 5) Commencement and Recognition

B. Dispatch Training

All dispatchers receive a specialized course detailing the structure of CIT. The training course also addresses how to properly receive and dispatch calls involving individuals with a mental illness and crisis situations. Additional and advanced in-service training courses should also be incorporated. Topics that are covered in the dispatcher's training course are listed below.

- 1) Recognition and Assessment of a CIT Crisis Event
- 2) Appropriate Questions to Ask Caller
- 3) Identify Nearest CIT Officer
- 4) Policies and Procedures

6. Mental Health Receiving Facility: Emergency Services

A designated Emergency Mental Health Receiving Facility is a critical aspect of the CIT Model. It provides a source of emergency entry for consumers into the mental health system. To ensure CIT's success, the Emergency Mental Health Receiving Facility must provide CIT Officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status. Additionally, the facility will need access to a wide range of emergency health care services and disposition options, as well as, alcohol and drug emergency services. Finally, the Emergency Mental Health Receiving Facility is part of the operational component of the CIT Model that provides feedback and engages in problem solving with the other community partners, such as Law Enforcement and Advocacy Communities.

A. Specialized Mental Health Emergency Care

- 1) Single Source of Entry (or well-coordinated multiple sources)
- 2) On Demand Access: Twenty-Four Hours/Seven Days A Week Availability
- 3) No Clinical Barriers to Care
- 4) Minimal Law Enforcement Turnaround Time
- 5) Access to Wide Range of Disposition Options
- 6) Community Interface (Feedback and Problem Solving Capacity)

3.3 Sustaining Elements

7. Evaluation and Research

Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT. Outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance abuse disorders. This was all accomplished while significantly decreasing police officer injury rates. The following components are being studied within CIT, some currently and others in the planning stages of evaluation.

A. Research and Evaluation Issues

- 1) Development of Community Consensus
- 2) Improved Law Enforcement Perception of Individuals with Mental Illness
- 3) Increased Confidence in Interacting with Individuals with Mental Illness
- 4) Decreased Crisis Response Times
- 5) Decreased Law Enforcement Injury Rates
- 6) Decreased Citizen Injury Rates
- 7) Improved Health Care Referrals
- 8) Decreased Arrest Rates
- 9) Jail Diversion Impact
- 10) Increased Treatment Continuity
- 11) Improved Treatment Outcomes
- 12) Decreased Psychiatric Symptomatology
- 13) Impact on Recidivism Rate
- 14) Improved Community Perception of Law Enforcement

8. In-Service Training

In-service training provides CIT Officers with additional knowledge and skills. In-service trainings should be offered regularly for current CIT Officers who have completed the 40-Hour Comprehensive Crisis De-Escalation Training course. The following is a list of several topics that have been used in previous In-service trainings:

A. Extended and Advanced Training

- 1) Extended/Advanced Suicide Crisis Intervention Training
- 2) Advanced Developmental Disabilities
- 3) New Developments in Psychiatric Medications
- 4) Advanced Verbal Skill Training (*Crisis Hotline*)
- 5) Advanced Scenario Training

9. Recognition and Honors

Recognizing and honoring CIT Officers provides a sense of accomplishment and ownership toward the program. It also gives officers an incentive to continue in their line of work. Recognition and honors can be awarded through local media, newsletters, program websites, or annual banquets. Such honors should be given to CIT Officers who have served the community in crisis situations with exceptional care and compassion, while ensuring the safety of themselves and others.

A. Examples

- 1) Awards
Departmental commendation for successfully de-escalating a crisis event
- 2) Certificate of Recognition
During monthly advocacy meetings, CIT Officers may be introduced to the community and given a Certificate of Recognition.
- 3) Annual Banquet
CIT Officers may be recognized and honored at an Annual CIT Banquet. The following are examples of the awards that can be given:
 - CIT Officer of the Year
 - Precinct CIT Officer of the Year
 - Five- or Ten-Year CIT Service Awards
 - New CIT Officer of the Year
 - Certificate of Appreciation/Recognition
For Individuals within the Mental Health Community
For Individuals within the Advocacy Community
For Other Individuals within the Community

10. Outreach: Developing CIT in Other Communities

Developing CIT programs in other communities, through partnerships and outreach efforts, will help to ensure that individuals who suffer from a mental illness receive the proper care needed, while increasing the safety of the community, patrol officers, family members, and consumers. Outreach efforts may include the involvement of other local communities in a 40-Hour CIT Comprehensive Training Course. The following are possible outreach efforts:

A. Outreach Efforts

- 1) Local Communities/Agency Development
Provide 40-Hour CIT Comprehensive Training Course for local communities and agencies.
- 2) Regional Community/Agency Development
Help other communities develop a CIT program and their own 40-Hour CIT Comprehensive Training Course.
- 3) Statewide CIT Development
Develop a statewide CIT effort to establish CIT programs in police and sheriff's departments.
- 4) Legislative Development
Develop a strong lobbying effort to educate policy makers and help secure adequate funding for program development

Appendix B - APD Practices are Not Consistently Aligned with Core Elements or Reported Practices in Other Cities

	Austin	Dallas	Houston	San Antonio	Philadelphia	Phoenix	Seattle
Population (2016)	947,890	1,317,929	2,303,482	1,492,510	1,567,872	1,615,017	668,849
Number of CIT Calls (2017)	12,004	15,593 (2016)	37,000	15,903	N/A	15,863	10,000
Crisis Intervention Team International Core Elements							
CIT Officers receive a 40-hour specialized training	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CIT-Trained Officers receive regular refresher trainings on topics of crisis intervention, de-escalation, and mental health	No	Yes; refresher training every 2 years	Yes; 8 hour advanced crisis intervention course each year	Yes; 4 to 8 hour crisis intervention course each year	Yes; 8 hour refresher training every 2 years	Yes; advanced crisis intervention courses each year	Yes; 8 hours of crisis intervention training every year
Call-Takers receive training on CIT crisis event call recognition	Yes; 24 hour crisis communication course	Yes; 8 hour training on identifying mental health issues	Yes; 2 to 4 hour training on identifying mental health issues	Yes; 16 hour crisis intervention training	Yes; training on questions to identify mental health issues	Yes; crisis intervention and negotiations training	Yes; crisis intervention training
Dispatchers identify nearest CIT officer and dispatch officer to crisis event	No; only upon request from caller or responding officer	Yes; forward call to Triage Specialist to dispatch appropriate unit	Yes; flag calls with CIT designation which triggers response by a CIT officer	Yes; ask if mental health resources are needed and code calls to CIT unit	Yes; flag calls as CIT and specifically route CIT officer	Yes; note calls with mental health issues and dispatch CIT team or CIT officer	Yes; dispatch CIT officer
Department partners with mental health professionals	Yes; Integral Care Expanded Mobile Crisis Outreach Team	Yes; Rapid Integrated Group Healthcare Team Care (RIGHT Care)	Yes; Harris County Center of Mental Health and IDD	Yes; two mental health professionals on CIT staff	Yes; JFK Behavioral Health Department of Philadelphia	Yes; Crisis Response Network	Yes; mental health professional on Crisis Response Unit staff
CIT Incidents are reviewed and evaluated for process improvements	No; incidents reviewed for follow up actions with individual, but not used for process improvements	No; no review of mental health-related police reports	No; training academy staff review incidents to determine if officer's actions complied with policy, but not used for process improvements	Yes; CIT Unit reviews mental health-related incidents for trends	No; training is reviewed annually for new topic areas, but no review of mental health-related calls	Yes; CIT team reviews mental health-related reports for trends or chronic issues	Yes; Crisis Response Unit reviews mental health-related incidents for trends and provides suggestions for improvement to command staff
Peer City Practice							
Self-registry or similar system (e.g., Smart 911)	No	No; briefly considered	No	No	Yes; individual or relatives can fill out form to register address for CIT response	No; system is in progress	Yes; individual or relatives can create SMART 911 profile that appears when calling 911
Co-Response model (police paired with mental health professional)	No	Yes; RIGHT Care unit with fire paramedic, police officer, and mental health professional	Yes; Crisis Intervention Response Team with police officer paired with master's level mental health clinician	No; two mental health professionals on CIT Unit staff, but do not respond to calls	No	No	Yes; Crisis Response Unit with police officers and one mental healthcare professional respond to crisis calls

Scope

The scope of this audit consisted of APD activities between October 1, 2013 and March 31, 2018.

Methodology

To accomplish our audit objectives, we performed the following steps:

- interviewed APD management and staff;
- participated in ride-outs with APD patrol officers;
- reviewed APD policies and standard operating procedures;
- analyzed APD call data and staffing patterns, to determine if coverage was sufficient to address average mental health-related call volume;
- compared APD call titles and report titles to determine if mental health-related calls were coded accurately in the associated reports;
- developed a random sample of mental health-related reports and evaluated APD's review of these incidents;
- selected a judgmental sample of people who had experienced a mental health-related issue and reviewed associated caution notes in APD's system;
- interviewed public safety and public health staff in other cities to review their approach to crisis intervention;
- analyzed APD training documents and curriculum, as well as training attendance records;
- reviewed internal APD reports for the presence of statistics regarding mental health-related calls or incidents;
- researched best practices related to law enforcement crisis intervention;
- analyzed fatal encounter data to determine per capita rates;
- evaluated IT controls related to APD information systems;
- evaluated the risk of fraud, waste, and abuse with regard to APD crisis intervention practices; and
- evaluated internal controls related to APD crisis intervention practices.

Audit Standards

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Office of the City Auditor was created by the Austin City Charter as an independent office reporting to City Council to help establish accountability and improve City services. We conduct performance audits to review aspects of a City service or program and provide recommendations for improvement.

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