



MEMORANDUM

TO: Mayor and Council Members

FROM: Rey Arellano, Assistant City Manager

DATE: May 22, 2019

SUBJECT: Response to Council FY 2019 Budget Direction Regarding First Response to Mental Health Incidents

This memorandum and the attached report serves as the response to Council direction regarding first response to mental health incidents. As part of the FY 2019 Budget, Council included \$75,000 to conduct a study regarding subject topic so that:

"System improvements will ensure that in an incident involving an individual in mental health crisis, Austin's first responders will ensure that individual receives clinical care as quickly as possible, thereby ensuring the safety and security of the individual and the community."

On January 31, 2019, Council approved staff's recommendation to negotiate and execute a contract with the Meadows Mental Health Policy Institute (MMHPI) to conduct the study. MMHPI developed recommendations estimated to cost \$3.2 million. Budget recommendations will be considered in light of fiscal constraints and other Council priorities as part of the City Manager's FY 2020 budget development process.

Following is a summary of the recommendations:

1. Create a program and response advisory function within the existing Travis County Behavioral Health and Criminal Justice Advisory Committee.
2. Create a mental health crisis call identification and management training for all call takers. Estimated cost: \$100,000.
3. Integrate mental health clinicians directly on the 911 dispatch floor to participate at an earlier triage point with call takers, divert calls to the most appropriate resources, and

provide support and appropriate information to officers or medics on scene. Estimated cost: \$300,000 per year.

4. Sustain the Expanded Mobile Crisis Outreach Team (EMCOT), including use of telehealth capabilities to expand immediate access to crisis screening. Estimated cost: \$2.8 million per year.
5. Coordinate Austin Police Department's Crisis Intervention Team activities with EMS' Community Health Paramedic program in order to shift from a reactive to proactive orientation.
6. Develop "what to do" educational materials in Spanish and Asian American languages so that constituents know what to tell first responders and what to do to ensure effective communication when first responders arrive on scene. Estimated cost: \$25,000.

cc: Spencer Cronk, City Manager
Executive Team
Brian Manley, Police Chief
Ernesto Rodriguez, EMS Chief
Pete Valdez, Downtown Austin Community Court Administrator
Stephanie Hayden, Austin Public Health Director
Ed Van Eenoo, Deputy Chief Financial Officer

Attachment:
Recommendations for First Responder Mental Health Calls for Service

Recommendations for First Responder Mental Health Calls for Service

Data Analysis, Review, and Program Recommendations

City of Austin

May 15, 2019



THE MEADOWS MENTAL HEALTH
POLICY INSTITUTE FOR TEXAS

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Attachment 1: Office of the City Auditor’s report, *Austin Police Department (APD) Response
to Mental Health-Related Incidents*

Executive Summary

The Austin Metro Area is one of the country's fastest growing metropolitan regions¹. With this growth comes a challenge to city leaders to ensure that public systems are effective, efficient, and well equipped to meet the needs of those who call Austin home.

In February 2019, the City of Austin invited the Meadows Mental Health Policy Institute (MMHPI) to conduct an analysis of its first responder system responses to mental health crisis calls for services. This analysis was guided by the Office of the City Auditor's report, *Austin Police Department (APD) Response to Mental Health-Related Incidents*² and informed by first responder best practices. The City requested this assessment to support its express goal of assuring that mental health crises are resolved quickly and safely and result in appropriate care.

In performing its analyses, MMHPI was guided by deliverables in the contract with the City. MMHPI reviewed multiple data sets, including crisis call for service data from the Austin Police Department and Austin Emergency Medical Services, and aggregate service utilization data from Integral Care's Helpline, Mobile Crisis Outreach Team, and Expanded Mobile Crisis Outreach Team. In addition to data analysis, MMHPI worked closely with a stakeholder committee to gather community feedback and to provide the committee with presentations highlighting best practices and emerging best practices from cities across Texas and the United States. The review revealed several strengths in Austin's programs as well as opportunities to bring programs to scale with innovation befitting the unique needs and nature of the City of Austin.

Our recommendations include:

- Establish an advisory role to the Chief of Police within the Behavioral Health Criminal Justice Advisory Committee.
- Develop mental health crisis call identification and management training for 911 call takers and dispatchers within Austin Police Department's call center.
- Integrate Integral Care crisis clinicians into the Austin Police Department's call center for mental health triage of 911 calls and support for officers tasked with answering crisis calls in the field.
- Fund the Extended Mobile Crisis Outreach Team including a telehealth expansion which emphasizes integrated care while working collaboratively with community stakeholders to create a long-term sustainability plan for the program.

¹ For more information, see: <https://www.census.gov/newsroom/press-releases/2019/estimates-county-metro.html>

² For more information, see:

http://www.austintexas.gov/sites/default/files/files/Auditor/Audit_Reports/APD_Response_to_Mental_Health_Related_Incidents__September_2018.pdf

- Integrate the Austin Police Department’s Crisis Intervention Team member’s follow-up functions into the Homeless Outreach Street Team, including use of telehealth.
- Creating Spanish language community education addressing how to effectively communicate crisis needs to first responders, in collaboration with National Alliance on Mental Illness Austin, for Latino communities identified as having high rates of response to resistance during a crisis call for service.

The recommendations included in this report are grounded in the principle that mental health care is best delivered as part of general health care and present an opportunity for the City of Austin to meet its goal of efficient and effective mental health crisis resolution and create a unique system addressing law enforcement and first responder system engagement with people in crisis.

Introduction

The City of Austin engaged the Meadows Mental Health Policy Institute (MMHPI) to identify improvements to the city's first response system. Our engagement, which was guided by the Office of the City Auditor's report, *Austin Police Department (APD) Response to Mental Health-Related Incidents*³, and informed by first responder best practices, included a data-driven analysis to support decisions and recommendations for policy and program developments.

The primary goal of this analysis is to develop recommendations to equip Austin's first responders with the tools and resources needed to connect a person in crisis to the appropriate clinical care as quickly as possible while resolving the crisis safely. Specifically, the City asked MMHPI to:

1. Review the Office of the City Auditor's report *APD Response to Mental Health-Related Incidents* and make responsive recommendations.
2. Analyze data related to mental health calls, including use of force, use of lethal force, number of arrests of people with mental health care needs, calls categorized as mental health calls coming into 911, and other calls determined to highlight trends relevant to potential system improvements.
3. Analyze 911 calls and dispatch data to identify potential opportunities within 911 for changes or enhancements to triage and dispatch services.
4. Review data and information collected in existing reports related to emerging best practices in response to mental health calls from other communities, and identify strategies that align with the project's defined goal.
5. Review local programs to identify what is currently in place and how to build on the community's strong foundation, including community health paramedics, Homeless Outreach Street Team (HOST), Mobile Crisis Outreach Team (MCOT), Expanded Mobile Crisis Outreach Team (EMCOT), and possibly others.
6. Identify emerging best practices from other community systems responding to individuals experiencing mental health crises – from 911 or other calls – through triage, dispatch, and response to identify strategies that address the project's identified goal. This includes a review of systems in Houston, San Antonio, and Dallas.
7. Identify enhancements/changes to existing programs and trainings and/or develop additional interventions with the input of key stakeholders that address the project's identified goal.
8. Identify any policy or procedural change across systems necessary or desirable to support project goals.
9. Bring together key stakeholders, including community-based organizations, to ensure the new first response strategies developed fulfill the stated purpose and goal of the planning process.

³ For the full report, see Attachment 1.

The City also requested a narrative report and final presentation by MMHPI to stakeholders with findings and recommendations.

Stakeholder Involvement and Planning

At the outset of this project, MMHPI first met with City leadership, Austin Police Department (APD), Integral Care, and Austin-Travis County Emergency Medical Services (EMS) leadership to establish data analysis priorities, a plan, and a schedule of regular meetings for the review of emerging best practices and first responder programs. Prior to our engagement, APD had established a stakeholder committee⁴ to review the Auditor’s report findings. It was determined during our initial meetings with City and agency leadership that the broader scope of working directly with the stakeholder committee could also address Recommendation 1, from the Audit:

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.

MMHPI then worked closely with the City to include the stakeholder committee in all program reviews and presentations while also engaging committee members in discussions regarding their perceptions of Austin’s needs, desires for system enhancements and/or changes, and their feedback on established and emerging best practices identified throughout our engagement.

After the full committee was convened, MMHPI coordinated program presentations on emerging best practices from other communities. The following agencies and departments were invited to present their programs to the stakeholder committee:

- Houston Police Department and The Harris Center for Mental Health and IDD’s Clinical Dispatch Program⁵,
- Harris County Sheriff Department and the Harris Center’s Tele-Health Crisis Intervention Program⁶,
- San Antonio Police Department Crisis Intervention Team⁷, and

⁴ For a full list of stakeholders, see Appendix 1.

⁵ For more information, see: <https://www.houstoncit.org/crisis-call-diversion-program/>

⁶ For more information, see: <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.1b17>

⁷ For more information, see: <https://www.sanantonio.gov/SAPD/SAPD-Outreach>

- Baltimore Police Department Law Enforcement Assisted Diversion (LEAD) program.⁸

In addition to these agency presentations, MMHPI provided the stakeholder committee with the following materials for review and discussion: peer reviewed journal articles and academic research; agency briefings; funder reports; and media articles regarding clinical partnerships in police dispatch, telehealth expansion of crisis outreach teams, Baltimore’s LEAD program, and co-responder units.

Following these external program presentations, MMHPI invited several Austin programs to provide the stakeholder committee with a comprehensive overview of specialized initiatives that address first responder management of crisis calls for service. Lastly, MMHPI hosted stakeholder roundtable discussions, led small group discussions at multiple locations across the city, and created an online survey to gather additional stakeholder feedback.⁹

Data Sources and Analysis

Guided by project goals and the stakeholder committee, we sent data requests to APD, Austin-Travis County EMS, and Integral Care in February 2019. The table below describes the type of data that were submitted for analysis. All data, including maps and tables, were from the years spanning 2016 through 2018. This set of data provides information on system utilization trends, including identifying areas of the city in which first responder crisis services are utilized at disproportionate rates.

Mental Health Encounters Involving Transport	
Entity	Data Received
Austin Police Department	2016–2018 crisis calls for service by location and time of day, crisis calls for service with response to resistance by location and time of day, additional information on Level 1 responses not originally submitted with first data set, training curriculum for CIT, number of patrol officers trained in CIT, training information for call takers, collaborations with external partners for CIT training, and program descriptions for CIT programs.
Austin-Travis County EMS	2016–2018 crisis emergency calls by location and time of day; program descriptions for C4 EMS Dispatch Program, Community Paramedics Program, HOST.

⁸ Because of an emergency, the Baltimore Police Department (BPD) cancelled its web conference presentation of its LEAD program. LEAD materials were provided to all of the stakeholders for their review. For more information see: <https://www.leadbureau.org>

⁹ See Appendix F.

Mental Health Encounters Involving Transport	
Entity	Data Received
Integral Care	2016–2018 MCOT dispatches by zip code of residence and time of day, EMCOT dispatches by zip code and time of day, crisis line calls by zip code of residence and time of day; program descriptions for ACT/FACT, MCOT, EMCOT, crisis line services

Data Summary

Total Crisis Calls for Service and Austin Police Department/Emergency Medical Service Shared Calls

Call for service data include incidents captured in an agency’s Computer-Aided Dispatch (CAD) system. MMHPI requested data on crisis calls for service¹⁰ to include an officer’s or paramedic’s response time, where the call took place, the call priority level, and the incident’s disposition (what happened when an officer arrived). We then utilized this data to determine trends related to crisis calls and associated outcomes. Trends analyzed in this report include the time of day and day of week the calls are most likely as well as areas of the city that generate crisis calls for service at rates higher than average. These trends allow us to see the strengths, gaps, and needs across multiple systems and inform recommendations intended to strengthen, sustain, and enhance crisis prevention, intervention, and response programs. We requested data sets for a three-year period, 2016–2018. This multi-year approach reduces the likelihood that a single interval of increased calls, a seasonal drop, or sudden shift in outcomes will be mistaken as a trend.

Often, crisis calls for service to law enforcement are consistent in utilization patterns with EMS crisis emergency calls¹¹. To determine if APD and EMS are responding to the same areas of the city while also sharing similar patterns across the time of day and day of the week for crisis calls, we compared their call service data. This analysis establishes a foundation for additional study to determine if certain areas of Austin could benefit from the development of intensive outreach programs to reduce the reliance on first responders for mental health crisis care. We first show data for APD crisis calls for service; after that, we show the number emergency crisis calls that resulted in a request for EMS for the same time period.

¹⁰ A crisis call for service is any call received by the 911 call center with information that would indicate a mental or behavioral health crisis is the primary reason for the call or associated with the final outcome of the call. This notation is not intended nor used as a diagnostic tool.

¹¹ A crisis emergency call is any call received by the 911 call center for EMS with information that would indicate a mental or behavioral health crisis is the primary reason for the call or associated with the final outcome of the call. This notation is not intended nor used as a diagnostic tool.

To begin our review of call data, we determined how frequently APD and EMS have been responding to crisis calls for services and crisis emergencies. This approach serves to establish a baseline that can be used to measure impact of future programs while also revealing the time each agency is currently spending managing mental health crises. Across the three-year data period, the APD averaged 10,675 calls for crisis calls for service each year, while Austin-Travis County Emergency Medical Service (EMS) averaged 4,362; both had little variation across the three years.¹² The following charts summarize the total number of crisis calls for service to APD, by year and police district. Chart 1 shows that 2018 had the highest number of calls to APD (11,124 calls), compared to the number of calls in 2016 (10,499) or 2017 (10,361 calls).

Chart 1: Crisis Calls for Service to APD, by Year

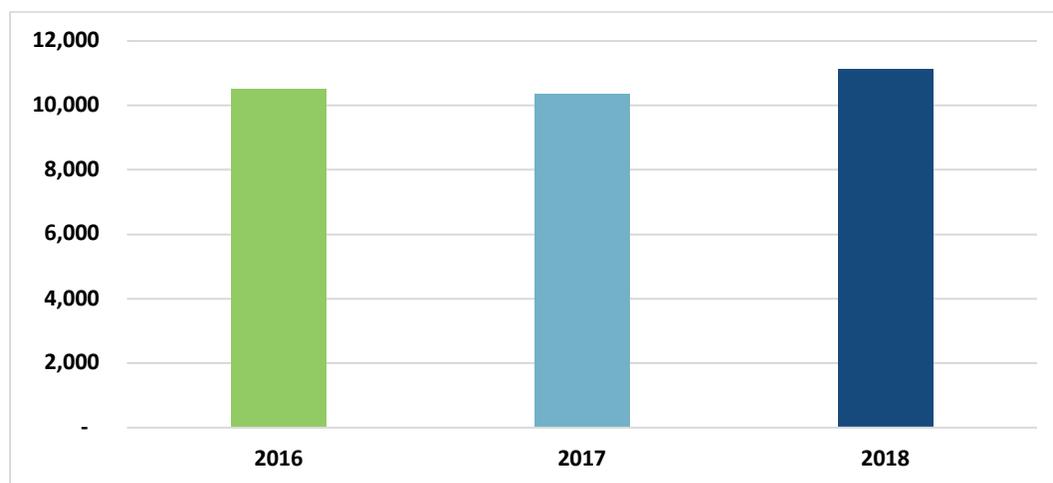
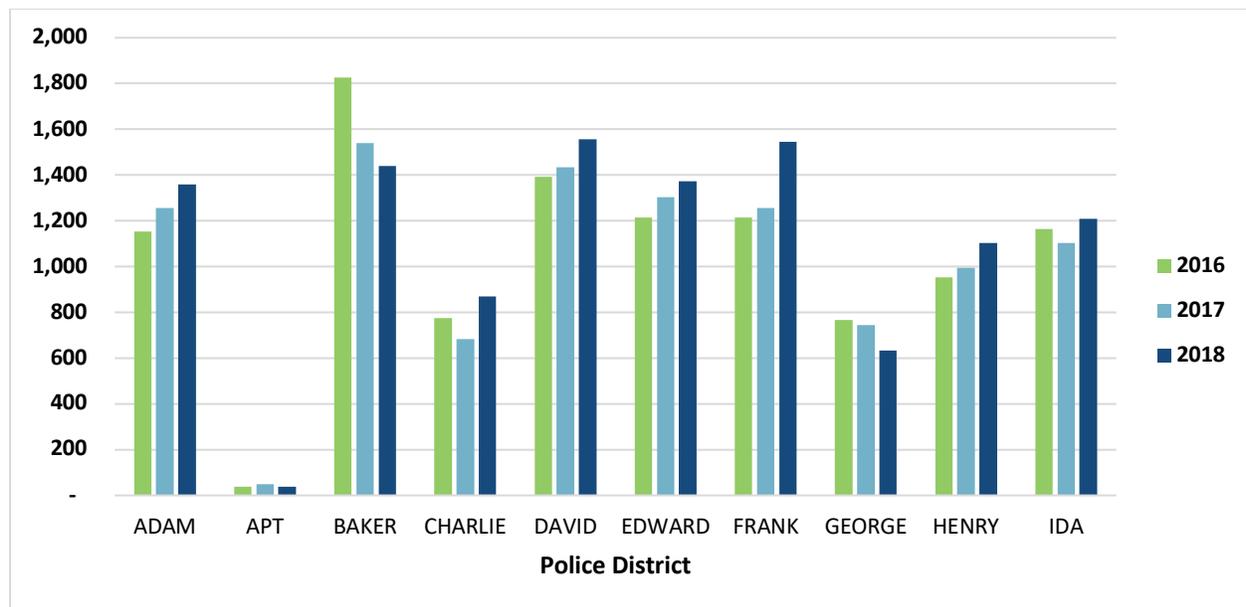


Chart 2 shows the total number of calls by police district and year. Most police districts had an increase in the number of crisis calls for service between 2016 and 2018. Increases in these calls occurred in police districts in East Austin (Charlie, Edward, Frank, Henry, and Ida), Northwest Austin (Adam), and Southwest Austin (David). The number of calls decreased over the time period in the Baker (Central and West Austin) and George (downtown) districts.

¹² For full data tables, see Appendix D.

Chart 2: Crisis Calls for Service Comparison, by APD District and Year



We also completed an analysis of crisis calls for service volume for day of the week, time of the day, and frequency across each year. Chart 3 shows these data points, which are critical in determining staffing needs or the sustainability of response programs. Data from 2016 through 2018 for both APD and EMS revealed that there is no particular day of the week when these crisis calls are more common. However, when we reviewed the 24-hour data, we found the highest volume of calls – 45% of crisis calls for service in each year to APD and EMS – takes place between 4:00 p.m. and 12:00 a.m.

Chart 3: Crisis Calls for Service, by Average for Day of Week – APD and EMS Combined

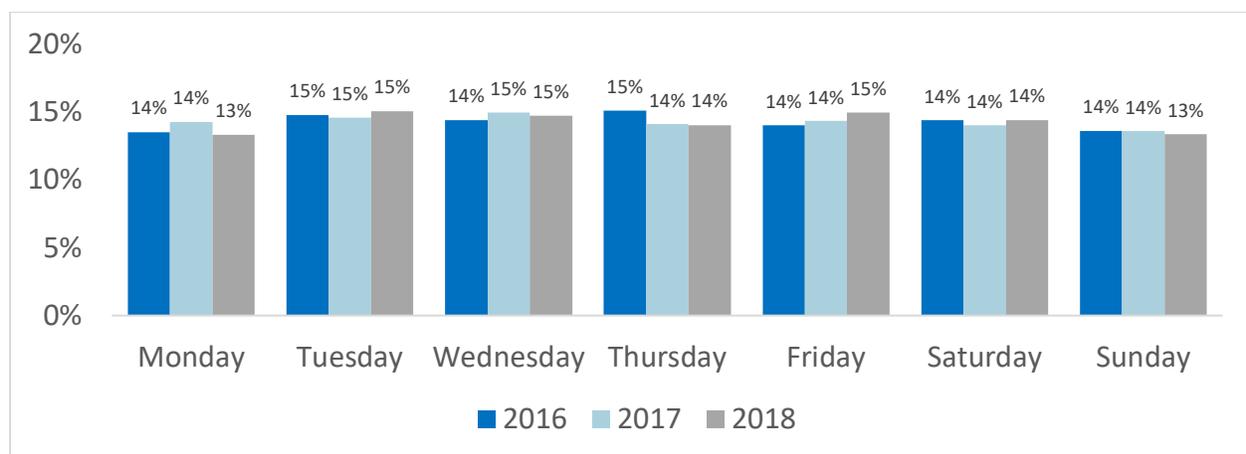


Table 1: Crisis Calls for Service, by Time of Day – APD and EMS Combined

Hour of Day	2016	2017	2018
	# of Calls	# of Calls	# of Calls
Midnight	518	502	558
1 AM	425	458	472
2 AM	378	412	363
3 AM	317	346	354
4 AM	263	271	283
5 AM	208	200	230
6 AM	266	283	302
7 AM	340	299	329
8 AM	417	413	384
9 AM	496	509	509
10 AM	534	529	576
11 AM	624	547	625
12 PM	640	627	619
1 PM	678	628	627
2 PM	605	560	549
3 PM	634	645	702
4 PM	736	741	800
5 PM	729	744	772
6 PM	734	706	718
7 PM	766	776	798
8 PM	789	727	741
9 PM	784	779	821
10 PM	685	796	741
11 PM	601	619	673

Geographic Information System Analysis

Our first step upon receiving data regarding the location of crisis calls for service was to clean and geo-locate all datasets and incident records with identifiable addresses to prepare these data for summative and geographic information system (GIS) analysis. We performed geolocation by using a Google Maps application programming interface (API) and the Texas A&M Geoservices.

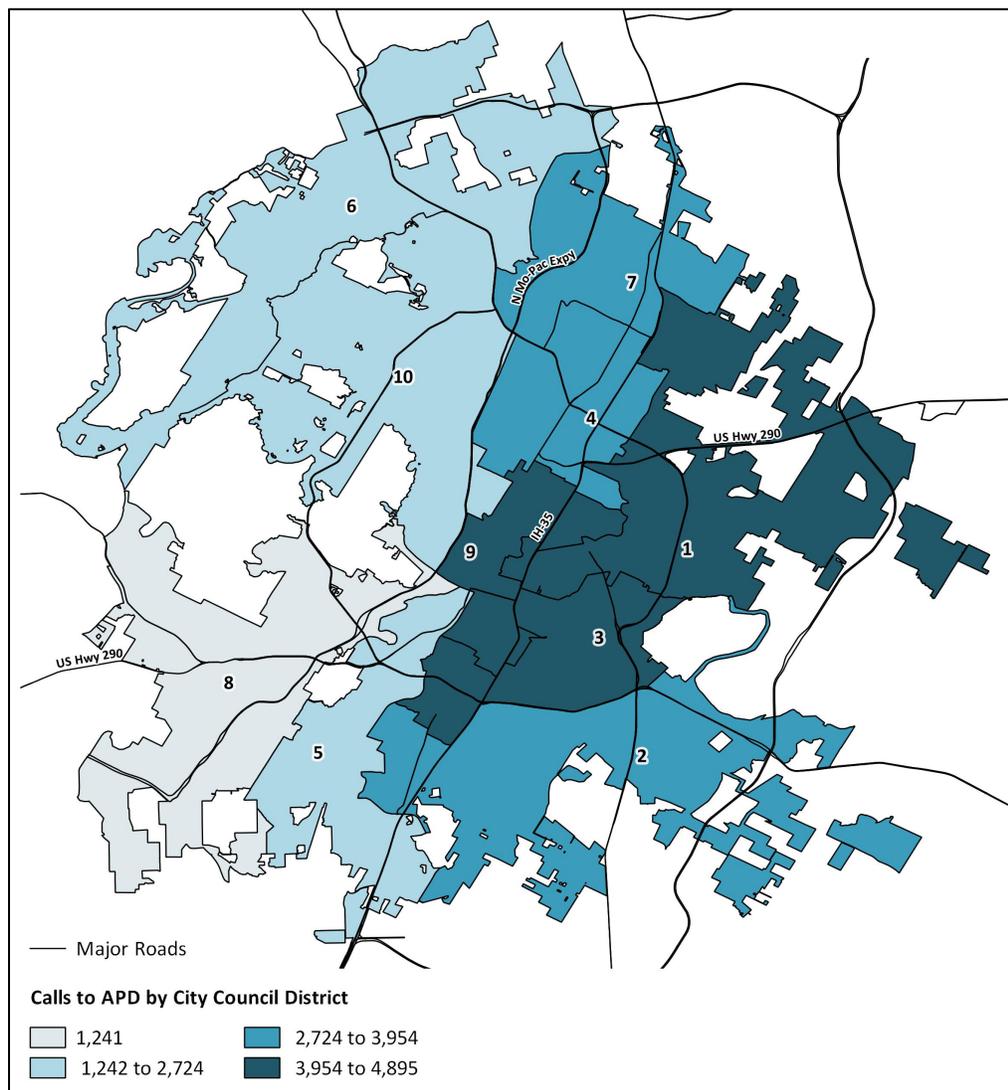
Areas of Austin with Highest Calls for Service

Crisis Calls for Service to 911 Resulting in APD Dispatch

The maps below show crisis calls for service that resulted in APD dispatches from January 1, 2016, through December 31, 2018.

Map 1 shows all calls aggregated by city council districts and reveals, overall, that city council districts 1, 3, and 9, which cover downtown, East, and Northeast Austin, had the highest volume of crisis calls for service to APD.

Map 1: Total Number of Crisis Calls for Service to APD, by City Council District (2016–2018)

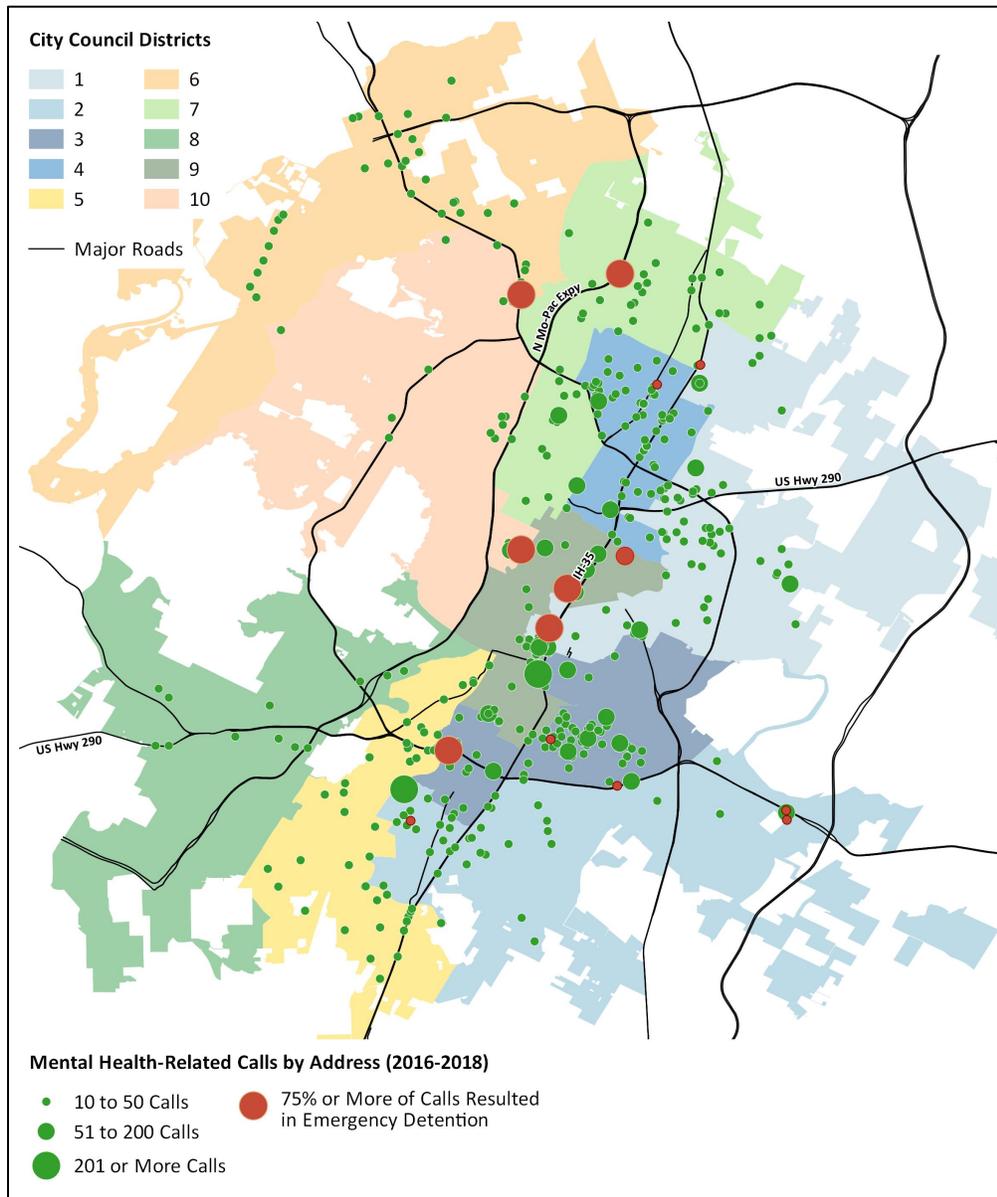


Maps 2 and 3¹³ reveal that the highest volumes of crisis calls for service from 2016 to 2018 that resulted in police dispatches occurred in the downtown area, North Austin around the Austin

¹³ Maps 2 and 3 show the exact locations of addresses with the highest volumes of crisis calls for service (10 or more calls) during the identified time period. Points are scaled to size to represent the volume of calls – larger symbols represent higher call volumes. Symbols marked in red reveal addresses that had the highest rates – more than 75% – of crisis calls for service that resulted in emergency detention.

State Hospital area, and South Austin just south of 290 West. We found that the addresses with the highest calls were primarily at or near hospitals and had a high percentage of calls that resulted in emergency detention (more than 75%). Other areas with pockets of high call rates that resulted in emergency detention included Northwest Austin near North Austin Medical Center and Seton Northwest Hospital, the Mueller area, and Southeast Austin near the airport.

Map 2: Addresses with 10 or More Crisis Calls for Service to APD, by City Council District (2016–2018)



Areas with high volumes of police crisis calls for service that did not result in emergency detention included North Austin near 183 and east of MoPac, North Austin off of IH-35, and Southeast Austin near Riverside.

Map 3: Addresses with 10 or More Crisis Calls for Service to APD, by Police District (2016-2018)

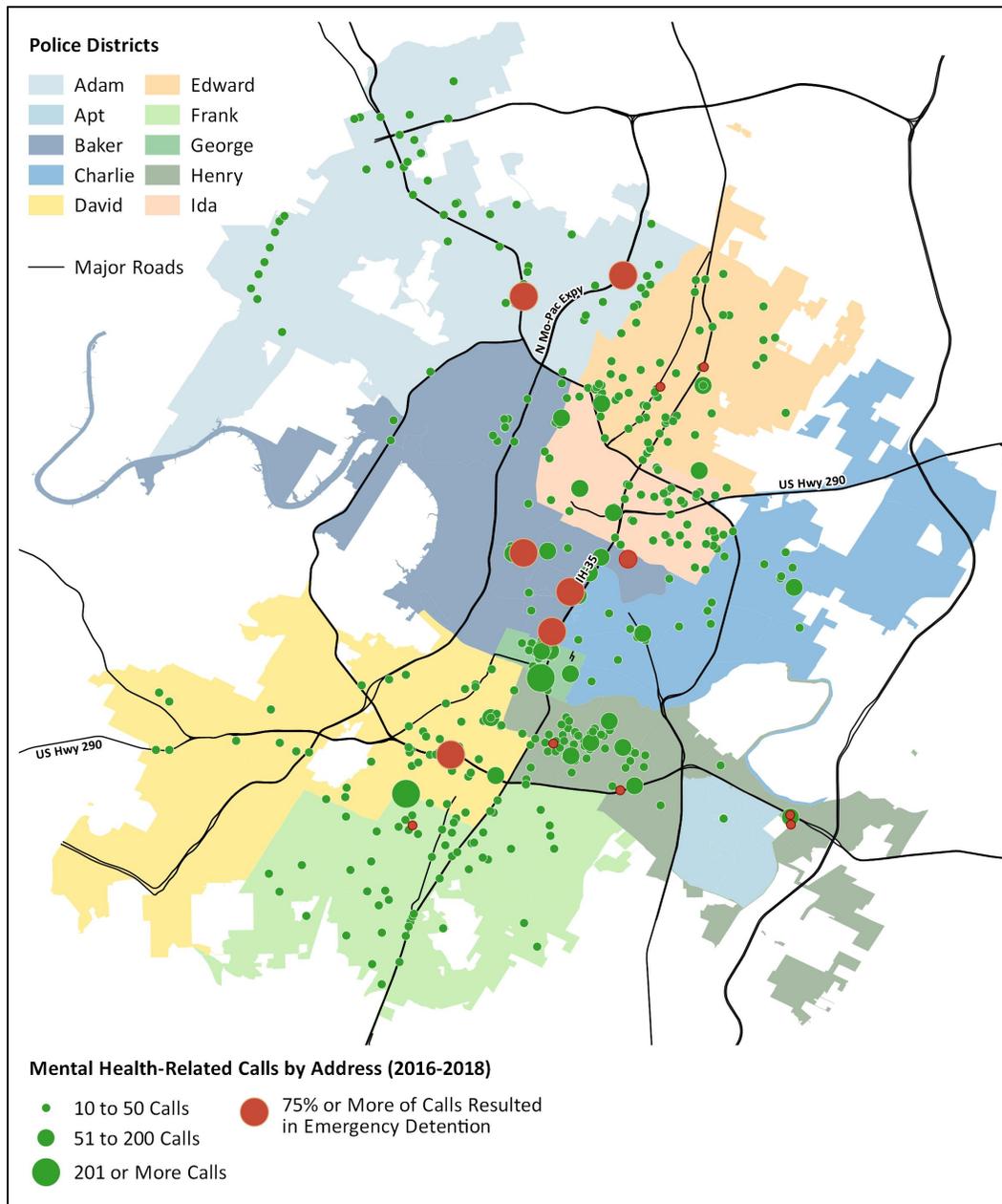


Table 2 below lists the top 10 addresses that resulted in a crisis call for service response from APD, including the total number of calls, the number of calls that resulted in emergency

detention, and the percentage of calls that resulted in emergency detention. Remarkably, all of the top 10 addresses were medical or mental health facilities.

Table 2: Addresses with the 1st to 10th Highest Volume of Crisis Call for Service to APD

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
Dell Seton Medical Center (15 th / Red River)	882	797	90%
St. David’s North Austin Medical Center	508	410	81%
Seton Medical Center	507	423	83%
St. David’s South Austin Medical Center	500	428	86%
Integral Care (56 East Avenue)	408	211	52%
Seton Northwest Hospital	305	238	78%
Austin Oaks Hospital	273	115	42%
St. David’s Medical Center (32 nd / Red River)	247	211	85%
CommUnity Care – Austin Resource Center for the Homeless (ARCH)	177	83	47%
Psychiatric Emergency Services (12 th / Airport)	166	94	57%

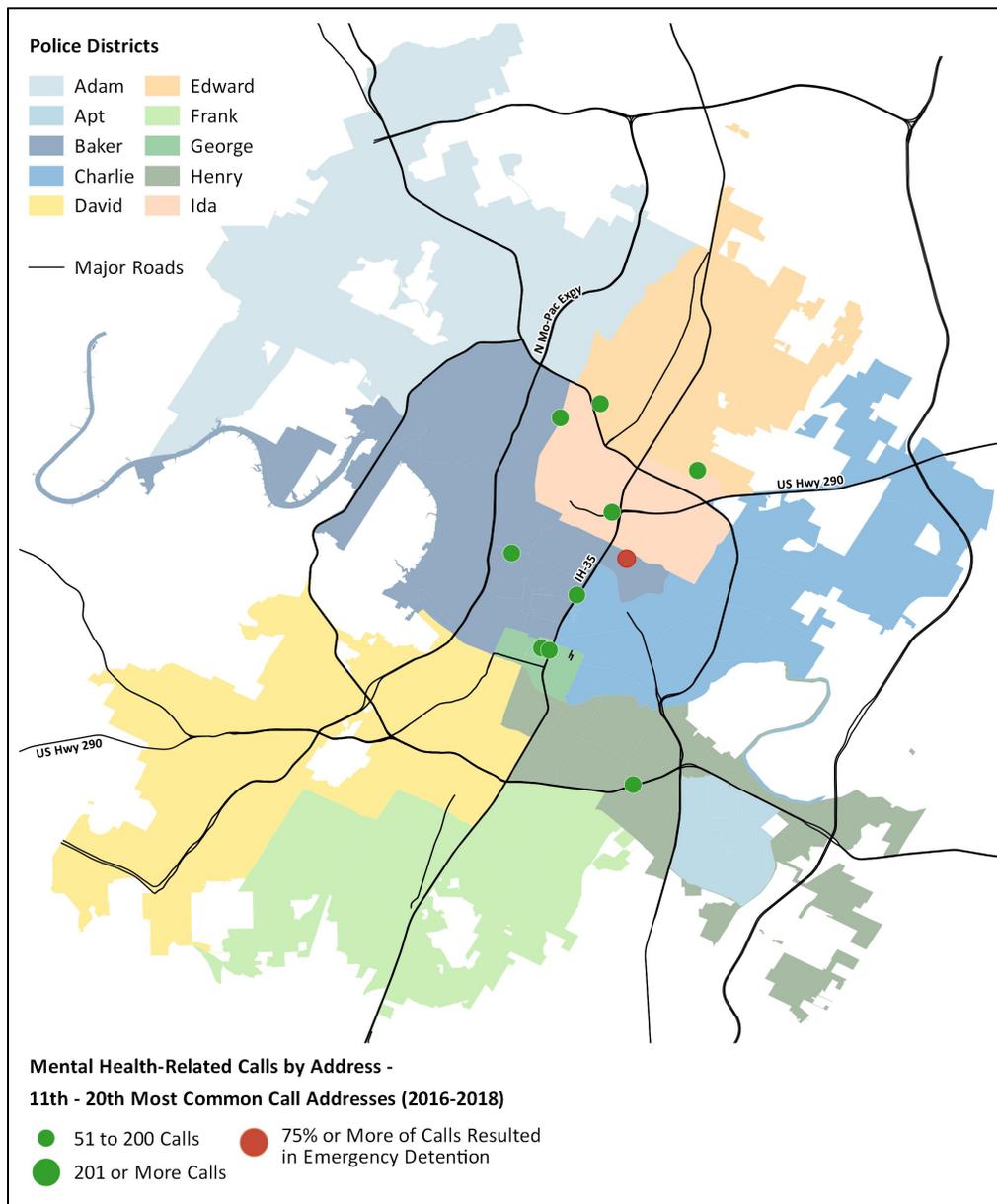
With the top 10 locations for crisis calls for service and emergency detentions all being medical or mental health facilities, we wanted to also look at the next 10 locations with the highest volume of crisis calls for service each to determine if locations other than hospitals would be revealed. Table 3 and Map 4 show the addresses with the 11th to 20th highest volume of calls to APD in the same time frame. Three percent (3%) of the calls to APD originated from these sites. The 11th to 20th most common call locations still included some hospitals (Seton Shoal Creek, Austin Lakes, and Cross Creek), but other areas, such as the Greyhound bus station, the Mueller area, and North Burnet, also had high numbers of calls.

Table 3: Addresses with the 11th to 20th Highest Volume of Crisis Calls for Service to APD

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
Burnet Road (Zoe’s Safe Place)	155	53	34%
CrossCreek Hospital	135	77	57%
Payton Gin Road (Settlement Home Residential Treatment)	131	93	71%

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
8 th and Neches (The Salvation Army)	125	50	40%
Austin Lakes Hospital	118	86	73%
35 th and Mills (Near Seton Shoal Creek Hospital)	102	76	75%
Mueller/Barbara Jordan Blvd (Dell Medical Center)	88	67	76%
East Ben White Boulevard (Near the Pointe at Ben White, Multi-Family)	86	21	24%
Greyhound Bus Station (Koenig Lane)	80	40	50%
8th and IH-35 Frontage Road South (Near APD)	79	16	20%

Map 4: Addresses With the 11th to 20th Highest Volume of Crisis Calls for Service to APD, by Police District (2016-2018)



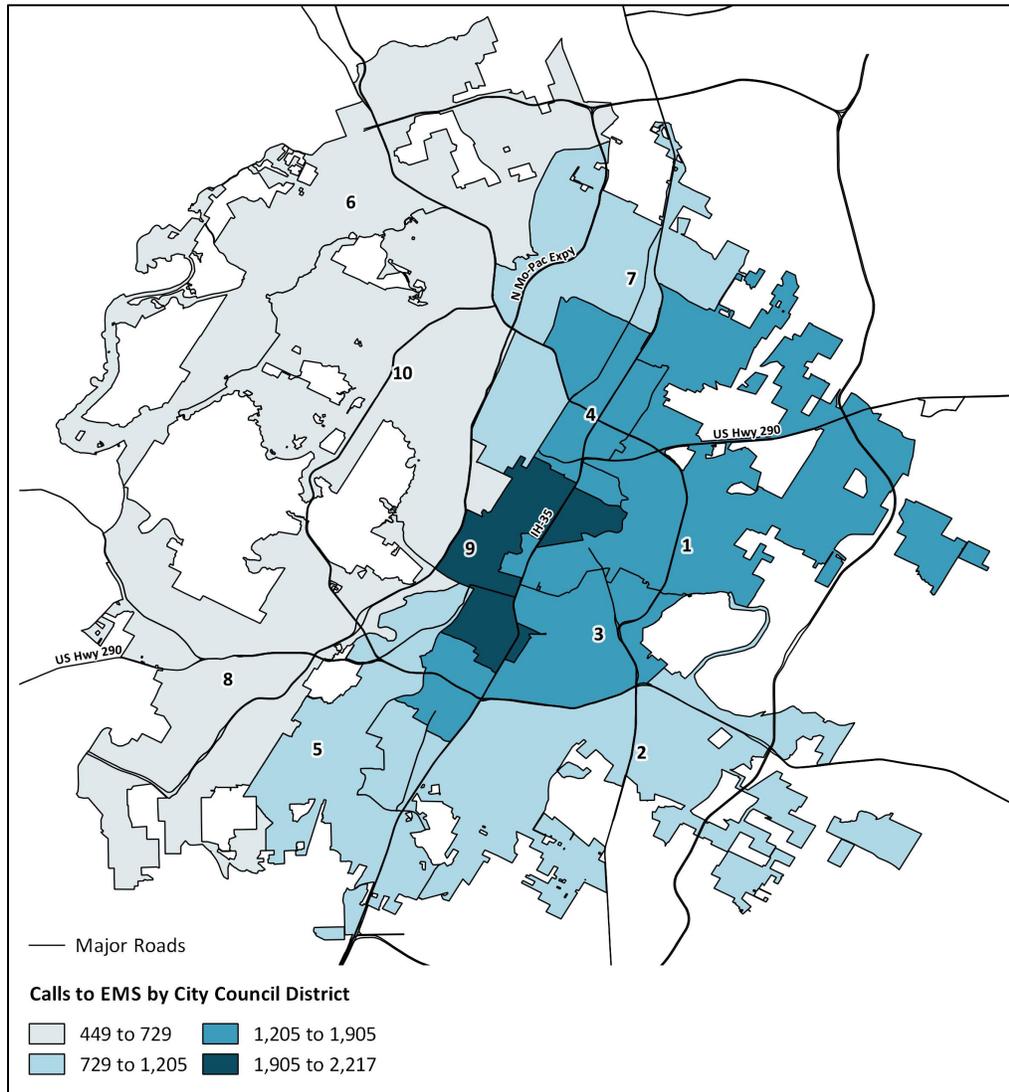
Crisis Emergency Calls Resulting in EMS Response

The next two maps show crisis emergency calls¹⁴ that resulted in EMS dispatches from January 1, 2016, through December 31, 2018. Similar to the previous maps, the first map (Map 5) shows the total number of EMS calls aggregated into the city council districts, while Map 6 shows the

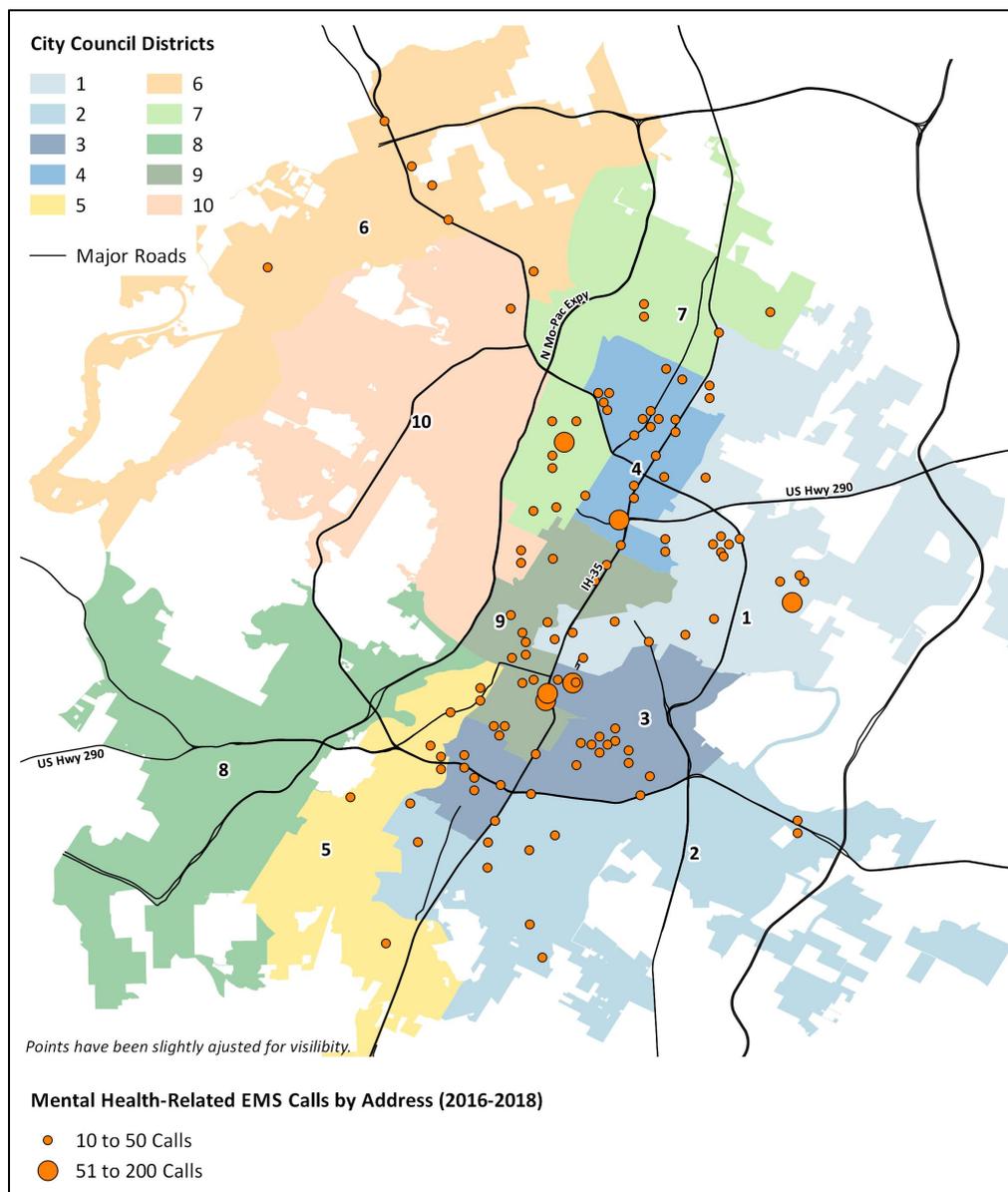
¹⁴ A crisis emergency call is any call received by the 911 call center for EMS with information that would indicate a mental or behavioral health crisis is the primary reason for the call or associated with the final outcome of the call. This notation is not intended nor used as a diagnostic tool; rather, it is an industry-standard term for EMS calls for service requiring or requesting a mental or behavioral health crisis response.

locations that had 10 or more calls – each point on these maps represents an address and is scaled to size to represent call volume. Of all crisis emergency calls to EMS, the majority of responses were to addresses in downtown Austin in the same area that also had a high number of police responses.

Map 5: Total Number of Crisis Emergency Calls to EMS, by City Council District (2016–2018)



Map 6: Addresses with 10 or More Crisis Emergency Calls to EMS, by City Council District (2016–2018)



In general, regions with the highest EMS call volumes generally matched the areas with the highest police call volumes, including East Austin just east of 183 off of Loyola Lane, North Austin just south of 183, South Austin off of 290, and in Southeast Austin near the airport.

However, singular addresses with the highest number of EMS calls, except for the addresses for Integral Care and the ARCH, did not match the addresses with the highest number of police

calls.¹⁵ The police calls were mostly to hospitals, while the top 10 EMS calls went to various locations, including two addresses that appeared to be residences, and intersections that were shared by the Salvation Army and the Heritage Park Nursing Home.

Impressions and Findings

- Crisis call for service volume is increasing in Austin.
- Crisis call for service volume is equally distributed across days of the week, Monday through Sunday.
- Crisis call for service volume is heaviest after 4:00 p.m. and declines again after midnight.
- The majority of crisis call for service resulting in an emergency detention originate from hospitals and clinics.
- Areas that experience the highest volume of crisis call for service include downtown, East Austin, and Northeast Austin.
- Regions with the highest EMS crisis call volumes generally matched the areas with the highest police crisis call volumes.

Response to Resistance

At the City’s request, we also analyzed the APD’s incidences of response to resistance across three years of crisis call for service encounters to help us make informed program recommendations, including policy approaches, that could address or perhaps reduce incidents requiring response to resistance. We then compared those findings to demographics in the areas of the city in which the greatest amount of force was deployed to address resistance. All demographic mapping relied on data from the American Community Survey 2017 5-Year Estimates.¹⁶

Law enforcement agencies generally define “use of force” as the means of overcoming resistance to an officer’s instructions in order to protect life, protect property, or to take a person into police custody. Given this definition, APD, along with many other police departments across the country, refer to the use of force as “response to resistance.” Although law enforcement departments may use the same broad definition to define the force continuum, there is neither a common continuum measurement nor reporting standard amongst police agencies. Without this common continuum measurement or reporting standard, we cannot effectively, and with any validity, compare response to resistance patterns in APD to other departments.

¹⁵ See Appendix D, Tables 4 and 5.

¹⁶ See Appendix E, Maps A1–A5.

APD's policy manual¹⁷ codes response to resistance in four levels as described in general terms below.

- Level 1: Any force resulting in death, a substantial risk of death, or serious injury.
- Level 2: A strike to the head, use of any impact weapons, deployment of a police canine, use of a Taser with neuromuscular incapacitation, or use of the Precision Immobilization Technique.
- Level 3: Use of pepper spray, use of an impact weapon without contact, use of a Taser without neuromuscular incapacitation, weaponless technics (such as kicks and elbow strikes).
- Level 4: A level of force utilizing empty hand control techniques that does not result in injury or continued complaint of pain and does not rise to a Level 3 response to resistance.

The APD responded to a total of 32,027 crisis calls for service from January 1, 2016, to December 31, 2018. Within those encounters, APD utilized response to resistance techniques in 644 encounters, or 2% of all crisis calls for service. These data were further broken down into the top two levels within the APD response to resistance policy definitions, indicating the greatest amount of force required to respond to resistance – Level 2 and Level 1.

From 2016–2018, APD used Level 2 response to resistance in 94 cases (0.3%) and Level 1 in four cases (0.012%) of encounters overall. During our stakeholder committee meetings, we identified six additional Level 1 cases from news media reports for this same time period; these cases were not included in the APD data submission. Including those additional six cases, APD used Level 1 response to resistance in 10 cases (0.030%) of behavioral health encounters across the three-year data period.

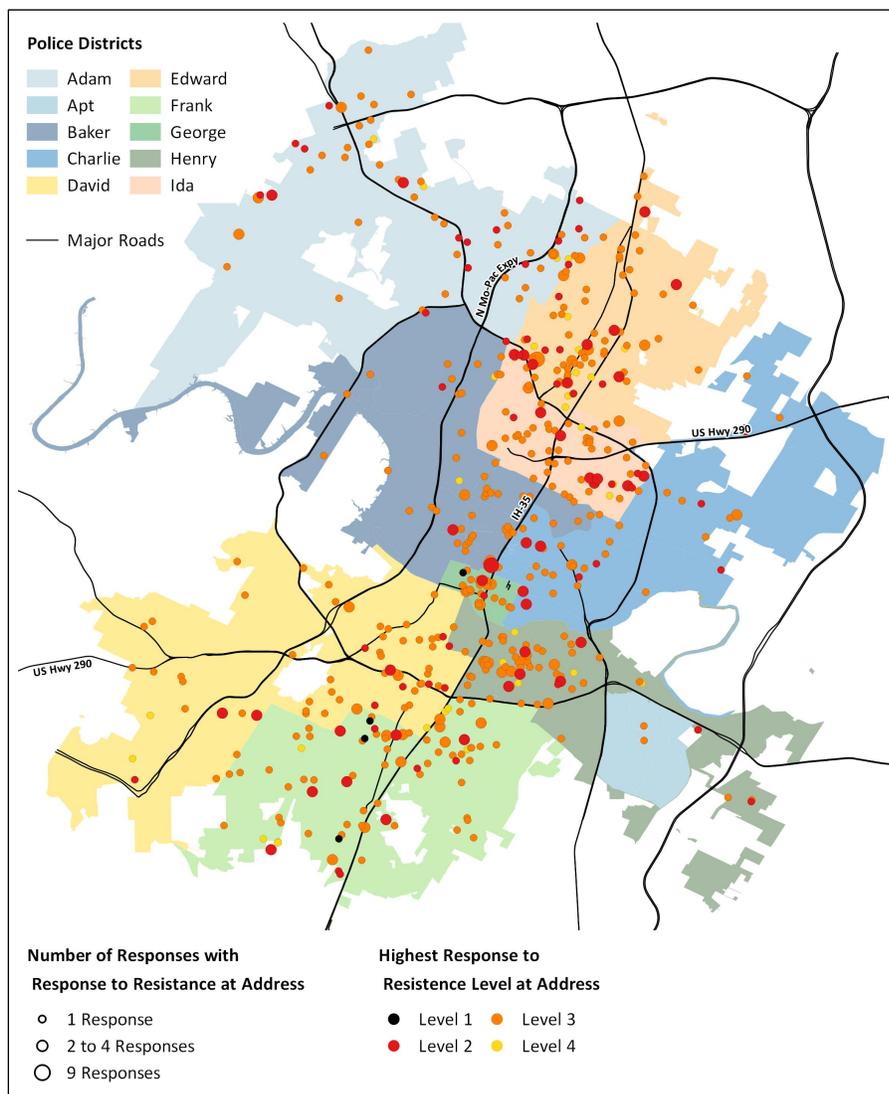
The common variant among the six cases not included in the data submission from APD was that these calls were not recognized or coded and dispatched as calls with a behavioral health or crisis element at the time they were received by 911. Although the calls all involved the presence or use of a weapon either against a third party or the responding officer, it appears the officers did not know at the time they were actively responding to the call that a behavioral health crisis was unfolding on scene. It is impossible, and unfair, to speculate if this knowledge would have changed or had an impact on the outcome of the call since police calls for service involving weapons are highly volatile and unpredictable. However, we recommend equipping the system, from call taker to responding officer, to be able to recognize, access, and transmit all relevant information concerning behavioral health crises.

¹⁷ Austin Police Department. (2017, July 20). *Austin Police Department policy manual 2017–1.5*. Retrieved from https://www.austintexas.gov/sites/default/files/files/Current_APD_Policy_Manual_2017-1.5_issued_7-20-2017.pdf

Given this low rate of response to resistance, we were able to conduct a more focused evaluation of the data to examine specific areas that could inform policy improvements. The following maps overlay response to resistance data on top of Austin demographic maps to highlight similarities in regions where people live and the number of calls that resulted in police response to resistance in those regions. In all maps, if a location made multiple crisis calls, and these calls resulted in different levels of force, then we used the highest level response to resistance at the location for color coding.

Map 7 shows all crisis call for service locations that involved police response to resistance, scaled to the number of incidents at that location that resulted in a response. This map reveals that fewer crisis incidents resulted in response to resistance in west Travis County compared to the number made in the regions in east, north, and south Travis County. Furthermore, when police response to resistance was reported in the western regions of Travis County, it was typically at lower levels (Levels 3 and 4).

Map 7: All Responses to Resistance by Address (2016–2018)



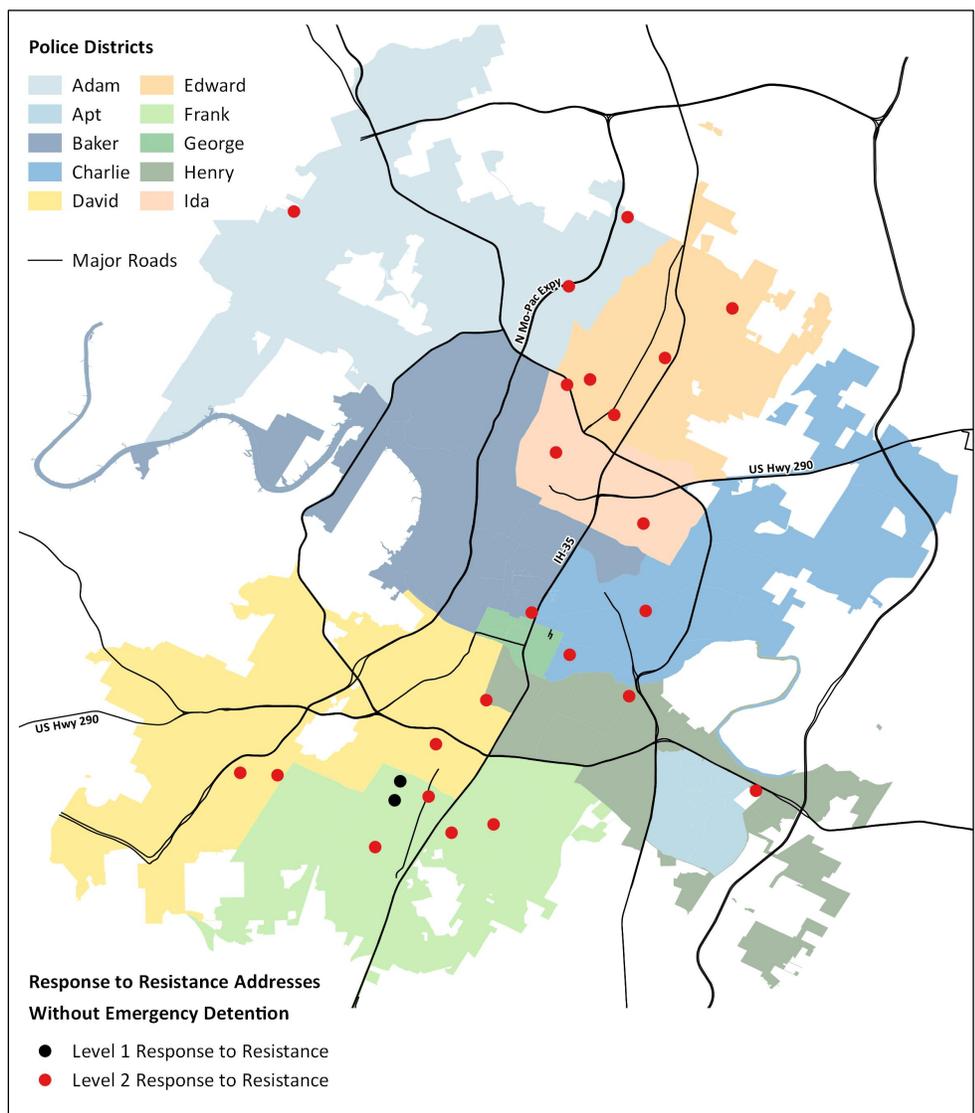
Areas that had the fewest number of calls that resulted in use of force were generally in the same regions where people living above 200% of the federal poverty level (FPL) reside. However, one notable exception was a region in northwest Travis County that had a high volume of calls that resulted in use of force, including several at Level 2. These included the Anderson Mill and Canyon Creek areas, which also have some of the areas with the highest number of people living above 200% FPL.¹⁸

The next two maps, Maps 8 and 9, provide a breakout of the locations where Levels 1 and 2 response to resistance were used, as well as breakouts of calls that resulted in emergency detention and calls that did not.

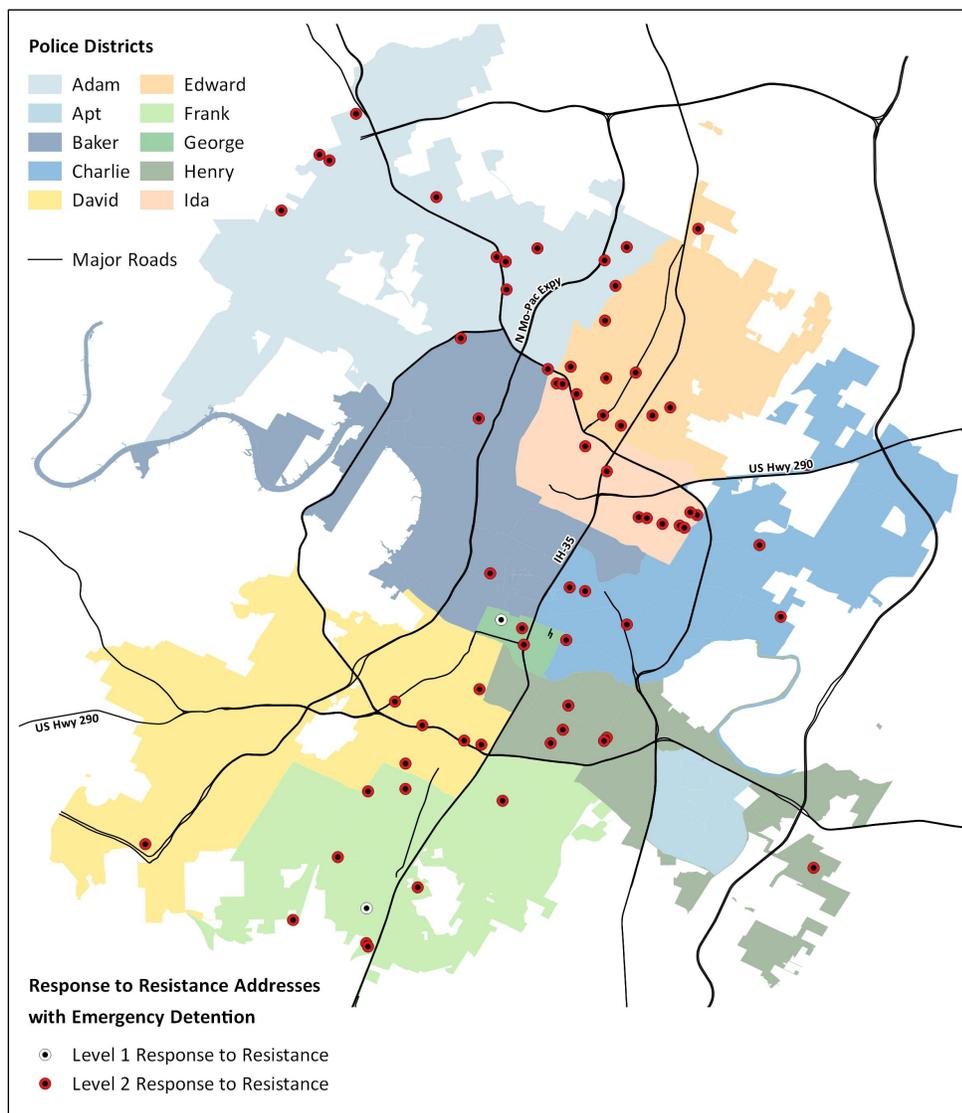
¹⁸ See Appendix E Map A6.

Map 8 shows the call locations that involved police response to resistance, but not emergency detention; Map 9 cross references response to resistance with emergency detention data. This map highlights the fact that among all calls that required response to resistance, most also resulted in emergency detention. Geographically, these calls appear to be located along IH-35 and in East Austin in densely populated areas that include people of color who are living in poverty.

Map 8: Level 1 and Level 2 Response to Resistance Without Emergency Detention (2016–2018)



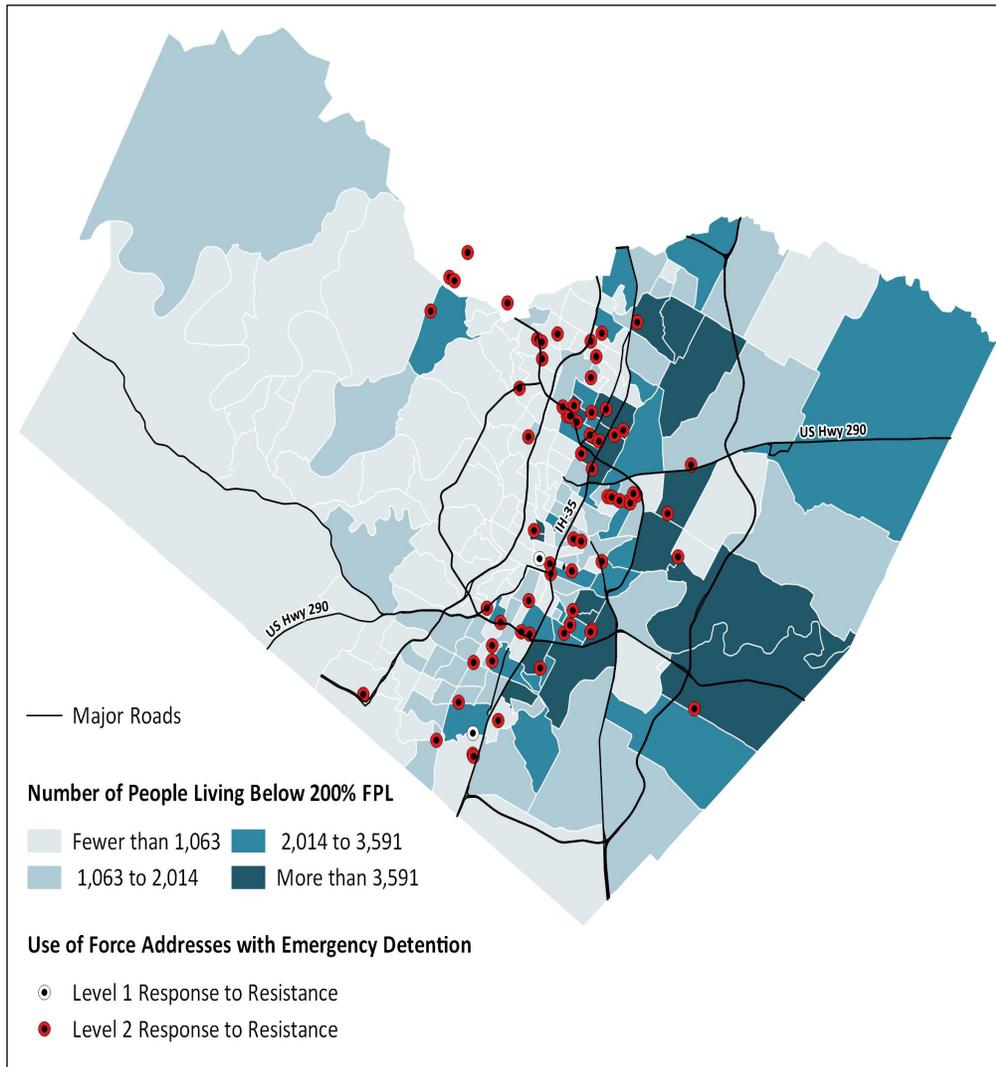
Map 9: Level 1 and Level 2 Response to Resistance with Emergency Detention (2016–2018)



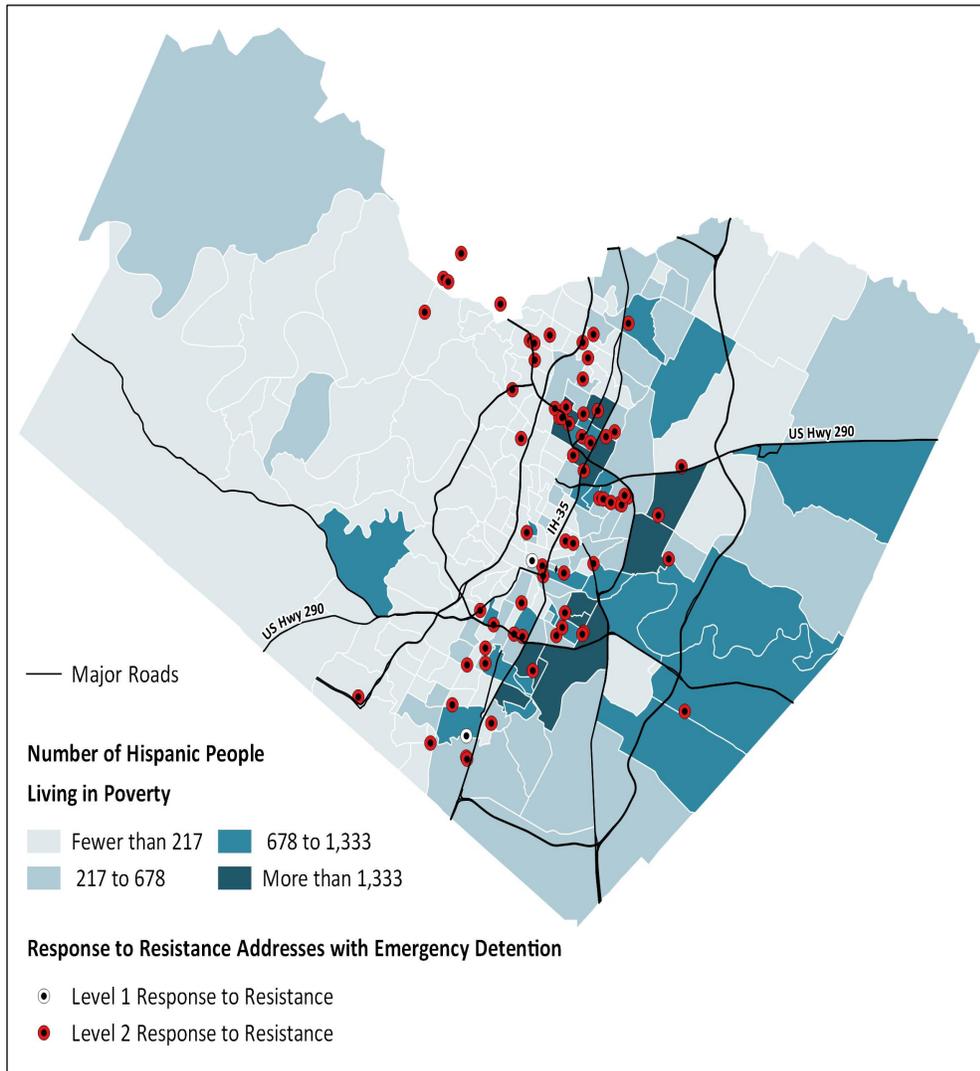
Map 10 shows that the calls that involved response to resistance at Levels 1 and 2 and resulted in emergency detentions also appear to be in the same areas where people in poverty live. To understand this pattern better, we overlaid this map with demographic data.

Maps 11, 12, and 13 compare response to resistance during calls for service to the areas where people of Hispanic, African American, and Asian descent who are living in poverty reside. It appears that the calls that resulted in the lowest number of response to resistance occurred in areas where people of Asian descent were living in poverty, while the highest level of response to resistance and emergency detention were in the same areas where people of Hispanic descent living in poverty reside.

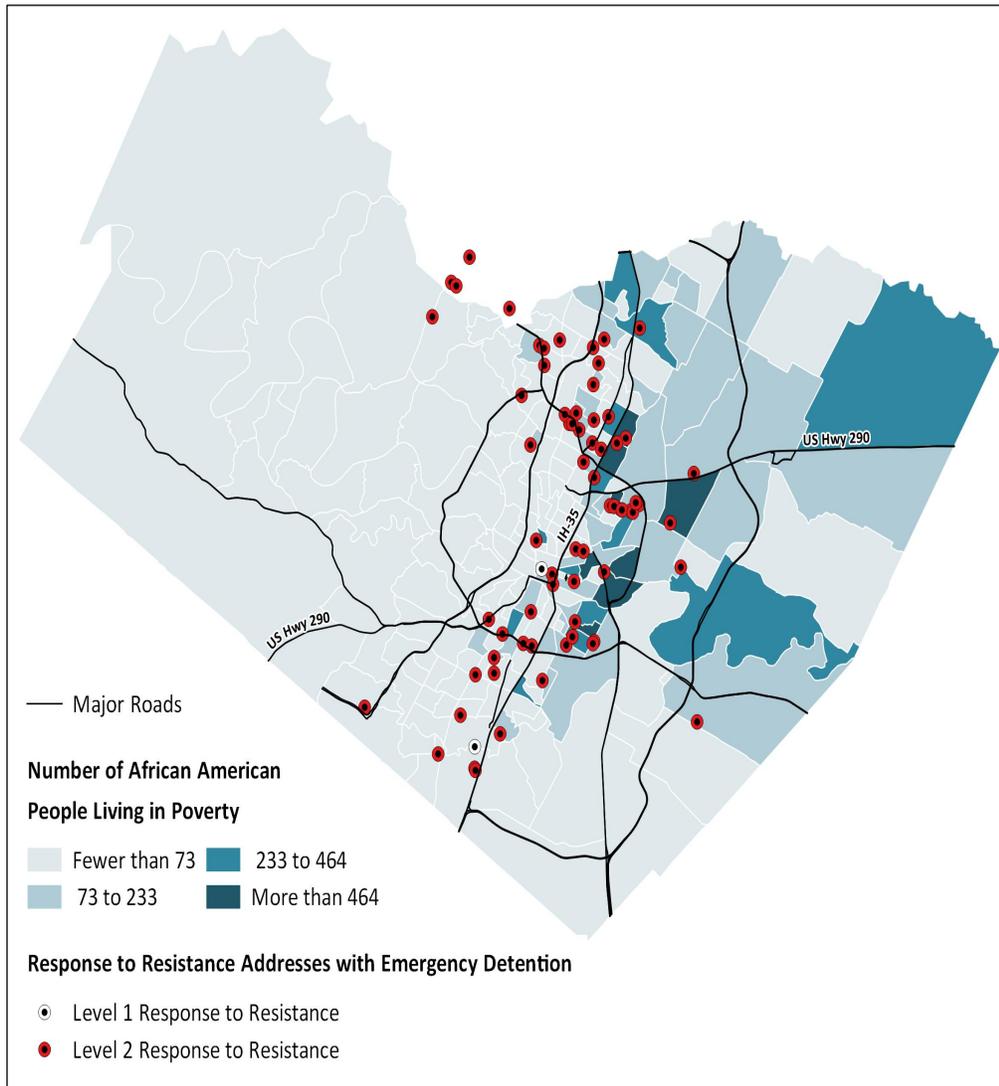
Map 10: Level 1 and Level 2 Response to Resistance with Emergency Detention (2016–2018) and People Living Below 200% FPL, by Census Tract



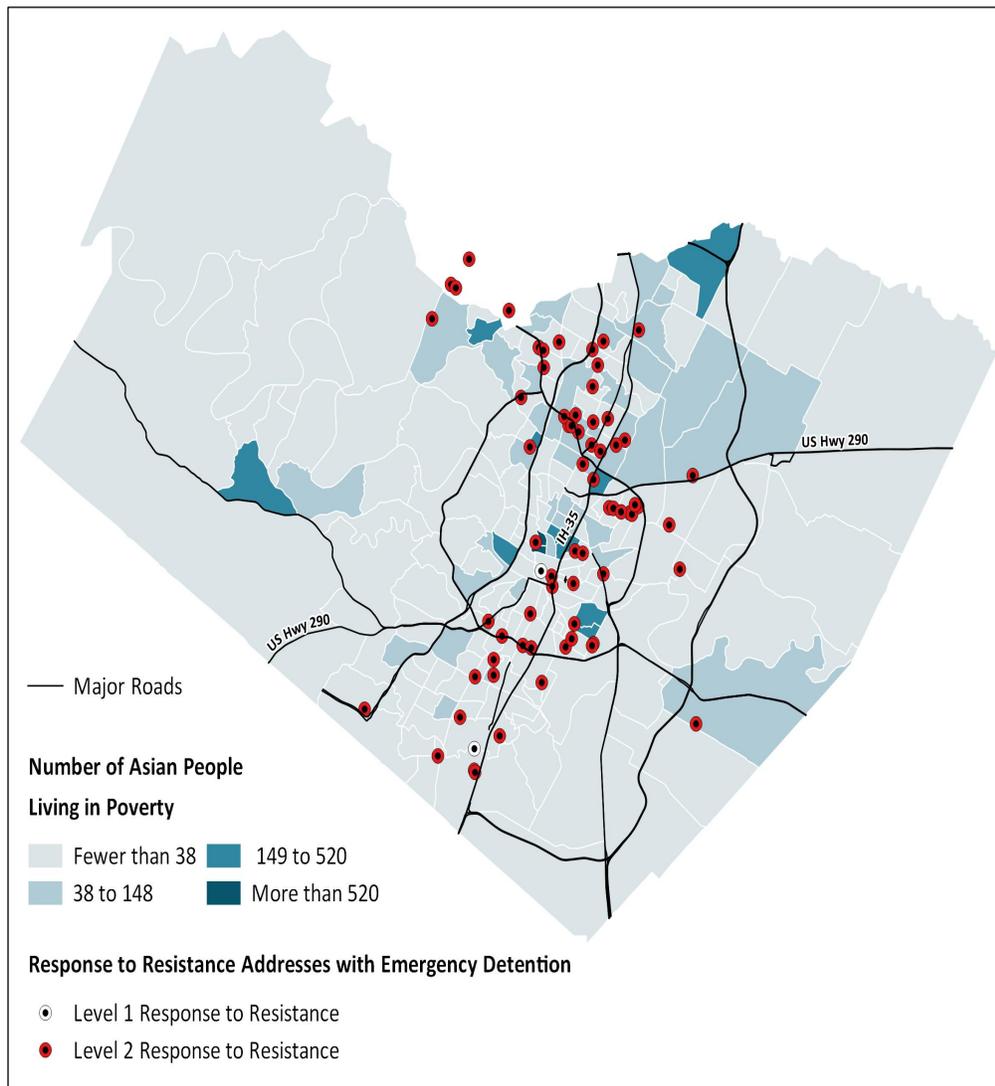
Map 11: Level 1 and Level 2 Response to Resistance with Emergency Detention (2016–2018) and Hispanic People Living in Poverty, by Census Tract



Map 12: Level 1 and Level 2 Response to Resistance with Emergency Detention (2016–2018) and African American People Living in Poverty, by Census Tract



Map 13: Level 1 and Level 2 Use of Force Responses with Emergency Detention (2016–2018), and Asian People Living in Poverty, by Census Tract



Impressions and Findings

- APD’s use of response to resistance techniques remained at a low rate from 2016 through 2018.
- Although response to resistance instances were low, it seems the most significant times that force was used were on calls not identified as having behavioral health or crisis elements at the time of dispatch, leaving officers unaware of vital call elements prior to arriving on scene.
- The majority of response to resistance incidents took place during emergency detentions.
- Areas of Austin where people of Hispanic descent living below the FPL resided were also areas with the highest rates of response to resistance during a crisis call for service.

Integral Care Mobile Crisis Outreach Team and Expanded Mobile Crisis Outreach Team Services

Integral Care provides an array of behavioral health services to people living with mental illness in the Austin area. Crisis related program descriptions, as provided by Integral Care, can be found in Appendix B. Below we discuss two of Integral Care’s mobile crisis programs. The mobile programs face the challenge of providing rapid community-based response services in one of Texas’ largest cities with over 300 square miles and a million residents within the city limits. The 11th largest city in the country, Austin continues to be ranked as one of the fastest growing major metropolitan areas in the United States.¹⁹

Mobile Crisis Outreach Teams (MCOTs)

MCOTs provide a combination of crisis services, including emergency care, urgent care, and crisis follow up and relapse prevention to people in need. MCOTs are clinically-staffed mobile treatment teams that provide rapid and prompt crisis response services through crisis assessments, crisis intervention services, crisis follow-up, and relapse prevention services for people in their homes, schools, or other community settings.

In Austin, an MCOT clinician is dispatched by Integral Care’s hotline when the staff member managing the call deems this service is necessary. Response time can range from one hour to 48 hours, depending on the needs expressed or identified during the call to the hotline. The Texas Health and Human Services Commission standards found in Texas Administrative Code Chapter 421, Division 3 allows the face-to-face requirements for MCOT response to be conducted through telehealth services as well as in person.

We conducted GIS mapping of MCOT calls to determine if MCOT services reflected similar patterns as APD and EMS crisis calls for service. To protect the privacy of people who contacted MCOT, the data were aggregated into zip codes (instead of using full street addresses); the zip codes reflect the residence of the individual in need of services, not necessarily the residence of the callers.

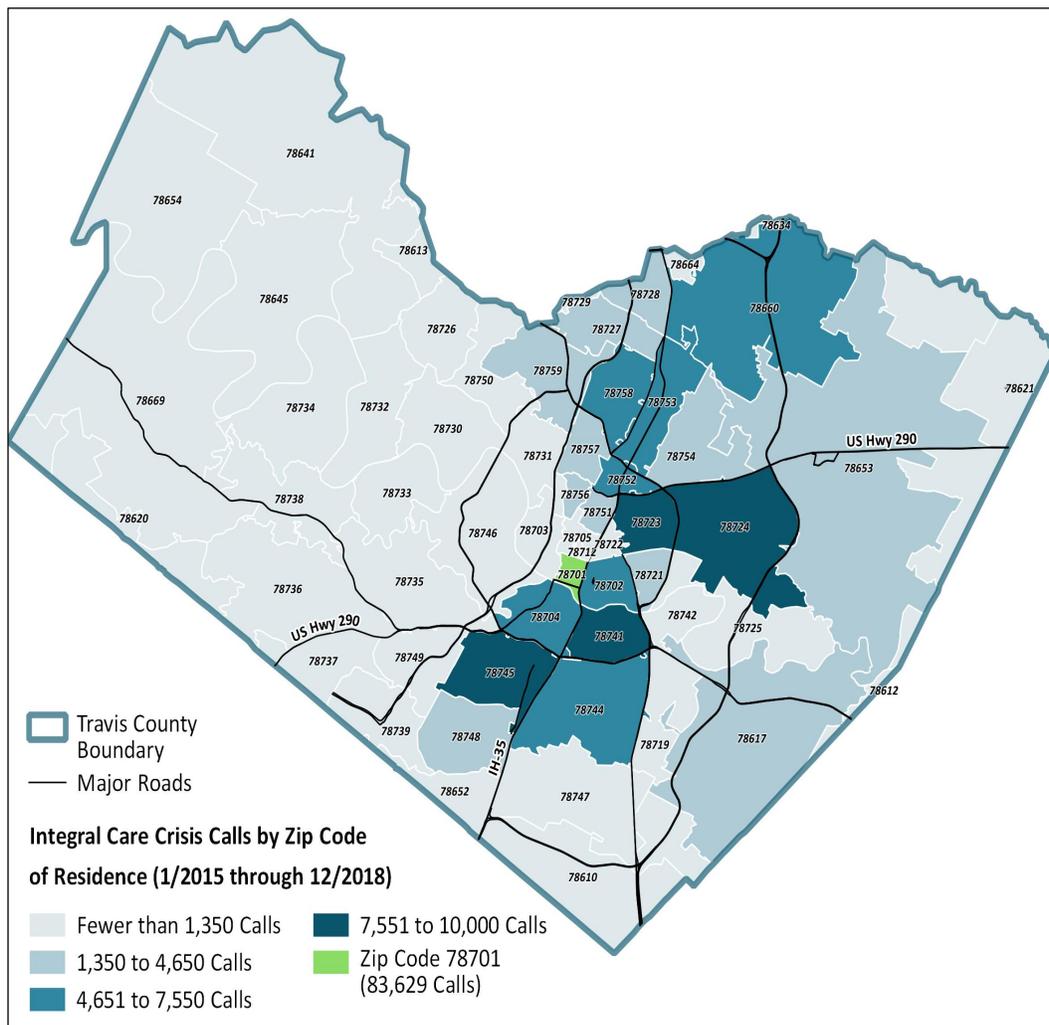
Map 14 shows the number of crisis calls made to Integral Care, by zip code, between 2015 and 2018. The map shows that the zip codes with the highest call volumes were located along Interstate Highway (IH)-35, including areas directly to the west and east of the highway, similar to patterns of first responder crisis calls for service.

Integral Care categorizes all encounters or calls with a person who is homeless – or unable to provide a zip code – into the 78701 zip code (which includes the downtown area), regardless of

¹⁹ For more information, see: <https://www.census.gov/newsroom/press-releases/2019/estimates-county-metro.html>

the zip code where the encounter took place. Therefore, zip code 78701, with 83,629 crisis calls, is marked in green to separate it from the rest of the zip codes. The zip codes with the next four highest counts of crisis calls include three in East Austin,²⁰ with the fourth zip code (78745) encompassing the area just south of Highway 290 and west of IH-35.

Map 14: Crisis Calls Made to Integral Care, by Zip Code of Call (2015–2018)



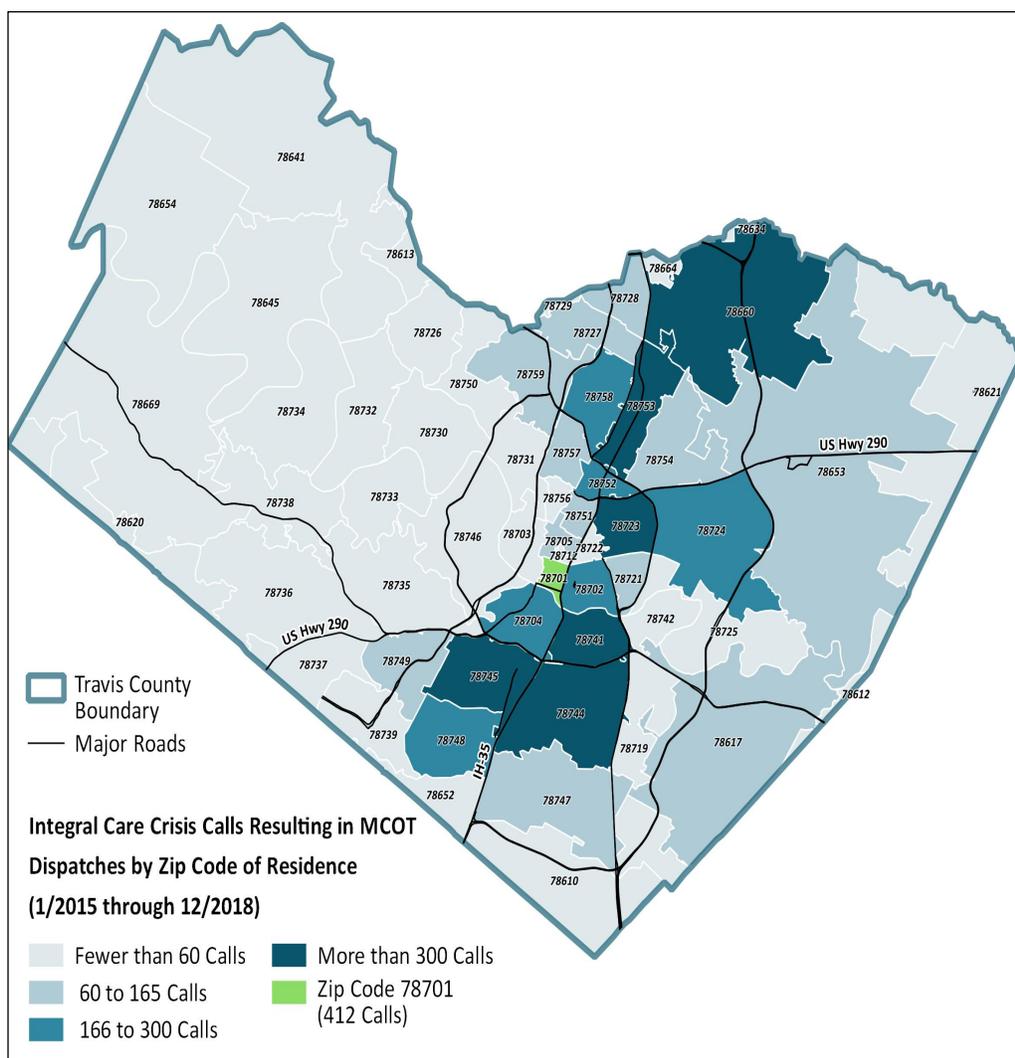
Similarly, Map 15 shows the number of crisis calls that resulted in an MCOT team member being dispatched for an in-person assessment. These are represented by the zip code of the location of the call, not necessarily the caller’s residence.

The areas with the highest concentrations of MCOT dispatches generally matched the areas with the highest number of crisis calls to Integral Care – areas along IH-35, including areas

²⁰ Three of the four zip codes with the highest call rates to MCOT include 78724 (9,784 calls), 78723 (8,065 calls), 78741 (8,781 calls).

directly east and west of the highway. However, Map 15 shows that zip codes 78660 (in Northeast Austin near Pflugerville) and 78744 (Southeast Austin) had high concentrations of MCOT dispatches compared to other zip codes, whereas Map 14 shows that these zip codes only had a moderate concentration of crisis line calls when compared to other zip codes. These are areas identified in Maps 1 through 3 as having disproportionately high rates of crisis calls for service to 911. This indicates that people in these geographic areas of the city may call 911 prior to engaging the Integral Care hotline, however; additional study is needed to confirm any causal relationship.

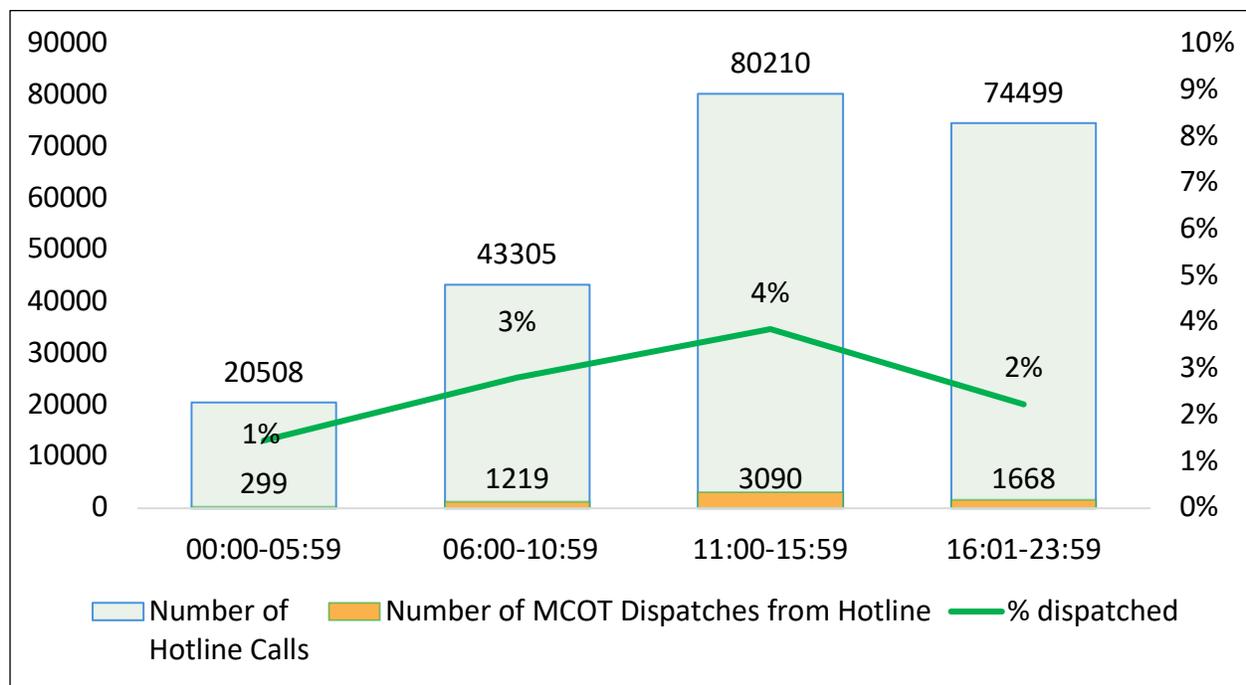
Map 15: Integral Care Hotline Crisis Calls Resulting in Mobile Crisis Outreach Team Dispatch, by Zip Code of Call (2015–2018)



MCOT can be requested by anyone calling Integral Care’s hotline service and is available Monday through Friday from 8:00 a.m. to 10:00 p.m. and on weekends and holidays from 10:00 a.m. to 8:00 p.m. with additional on call services available after business hours. Chart 4 on the

next page shows the time-of-day frequency for the number of hotline calls coming into Integral Care and the number of MCOT dispatches that resulted from those calls. Although the program is in operation until 10:00 p.m. (8:00 p.m. on weekends and holidays), we can see that MCOT dispatches begin to decrease from 4:00 p.m. to midnight, the same time in which crisis calls for service are at their peak for APD and EMS. We also learned through stakeholder small group meetings and roundtable discussions that the extended wait time for an MCOT worker to arrive (over an hour at times) is a barrier for many of those who rely on the program’s valuable services to reduce the risk of arrest or hospitalization. Factors contributing to the extended wait times included limited staffing, travel distance and traffic congestion, and the need to ensure a scene is safe prior to deploying a clinician.

Chart 4: Time-of-Day Frequency for MCOT Dispatch (2015-2018)



Expanded Mobile Crisis Outreach Team (EMCOT)

EMCOT is an innovative expansion of MCOT that was developed by Integral Care and is unique to Austin. EMCOT provides the same crisis services and crisis relapse prevention services array as MCOT; however, the team receives all of its dispatches and requests for services through first responders. This means a police officer or paramedic can directly request the dispatch of an EMCOT clinician by utilizing the agency’s dispatch control center or radio systems. Once an EMCOT request is made, the team will respond to the physical location and begin an assessment of the person in crisis. EMCOT is limited to responding to a low risk active police scenes. Response times vary depending on availability, traffic, length to travel, and scene safety.

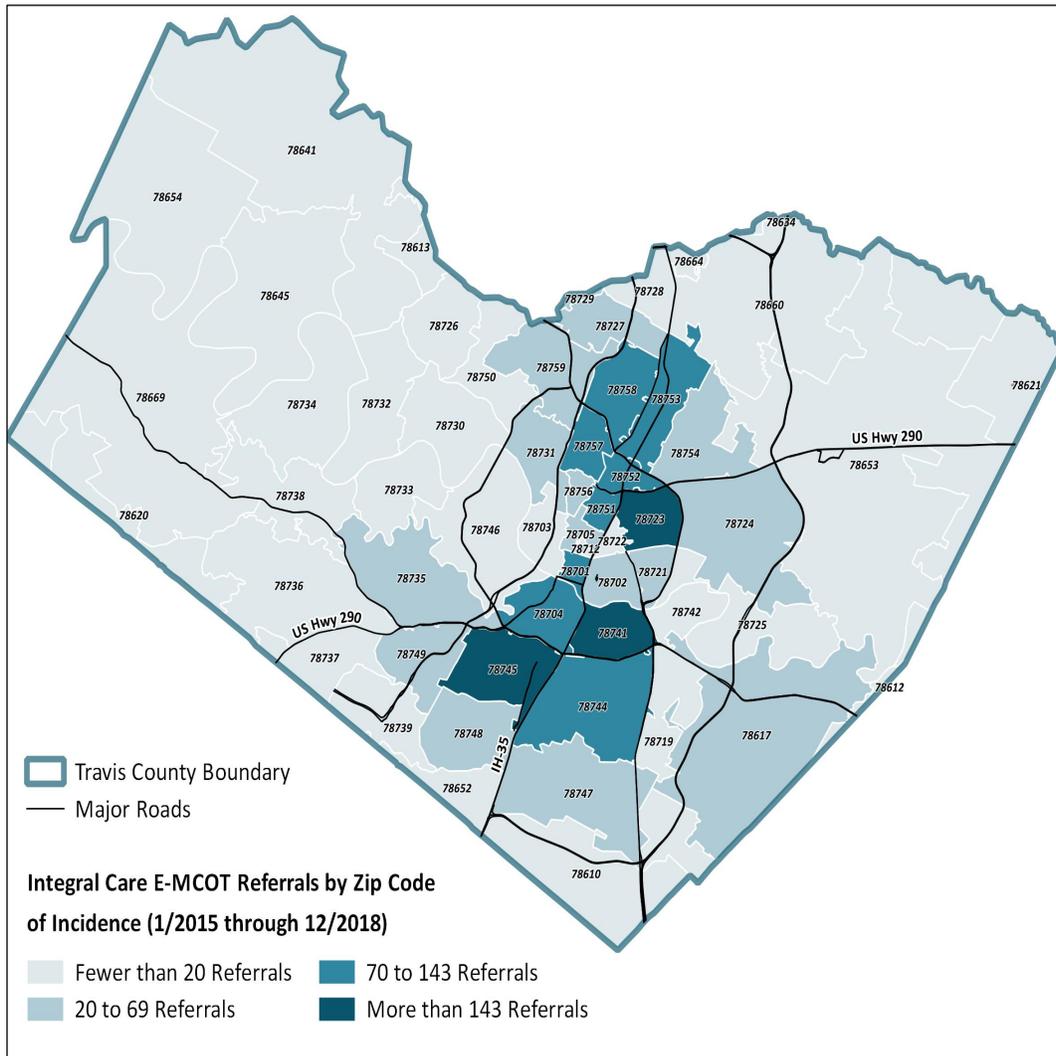
Once a person has engaged with EMCOT services, the EMCOT clinicians work to connect them, on a voluntary basis, to community-based, residential, or inpatient services and provide follow-up services for up to 90 days.

From 2015 to 2018, all APD calls for service that included EMCOT engagement yielded jail diversion rates at 98% or 99%. Emergency detention diversion is equally impressive with yearly percentages ranging from 88% to 93%. When EMCOT is engaged at the request of EMS, hospital diversion rates range from 76% to 81%. Individual outcomes for people receiving EMCOT services indicate that the vast majority remain in the community with supportive services. For more information on EMCOT's outcomes, see the EMCOT report provided by Integral Care in Appendix C.

To better understand EMCOT utilization, we completed GIS mapping of first responder referrals to EMCOT and dispatches of EMCOT workers to active first responder call scenes from 2015 through 2018. Maps 16 and 17 show these data points, which are nearly identical, with similar counts of referrals and dispatches. This means that most referrals for EMCOT resulted in dispatches, suggesting a well-defined policy for the program's use by first responders.

In both maps, the areas with the highest calls for EMCOT were in zip codes 78723, 78741, and 78745. Other zip codes along IH-35 also had high EMCOT referrals and dispatches. However, unlike the maps of all calls to Integral Care's hotline and calls resulting in MCOT dispatch, which show that areas of North Austin have high call volumes (particularly zip codes 78753 and 78660), the next two maps show that calls resulting in EMCOT dispatches do not have a proportionately higher number of EMCOT referrals or dispatches in North Austin. These patterns resemble the crisis call for service patterns for APD and EMS.

Map 16: EMCOT Referrals from First Responders, by Zip Code of Incidence (1/1/2015 through 12/31/2018)



Map 17: EMCOT Dispatches, by Zip Code of Incidence (1/1/2015 through 12/31/2018)

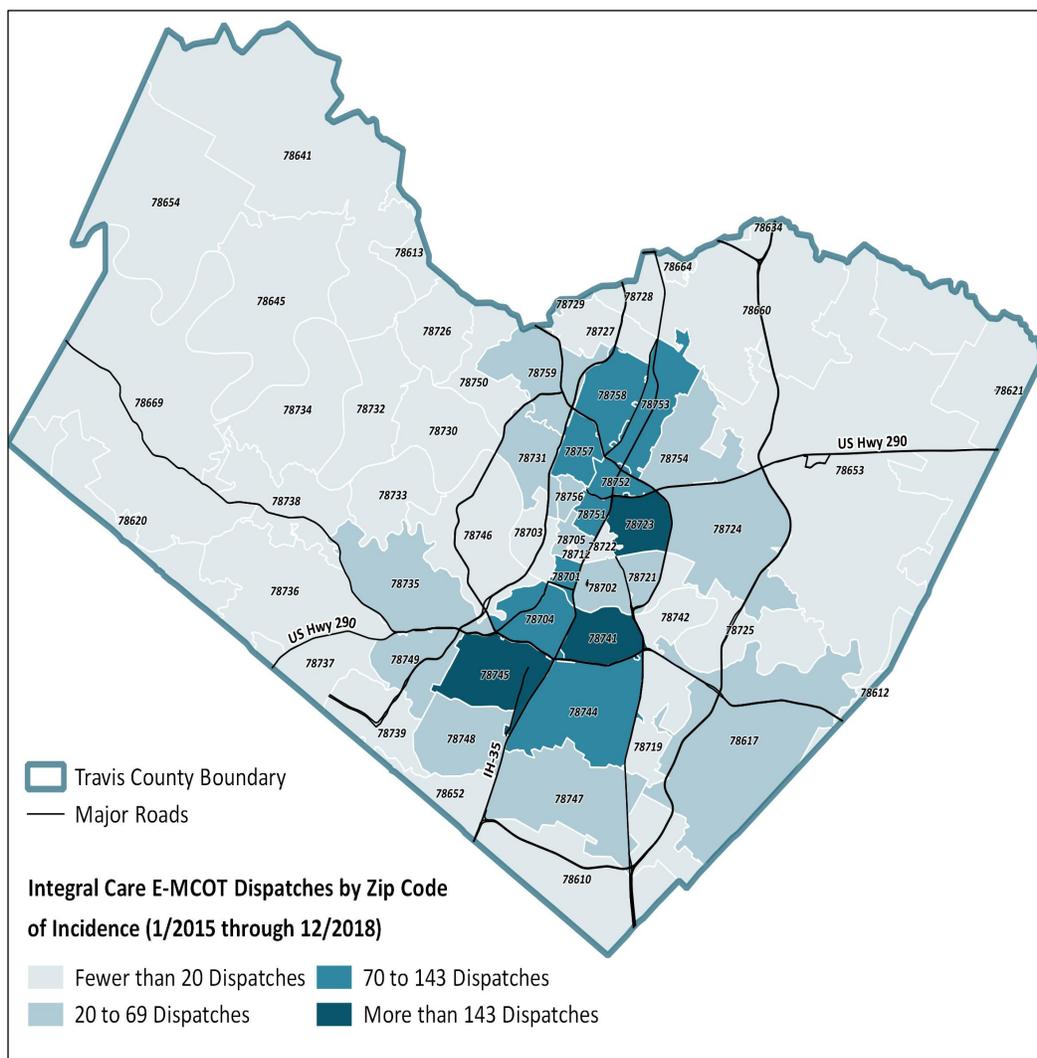
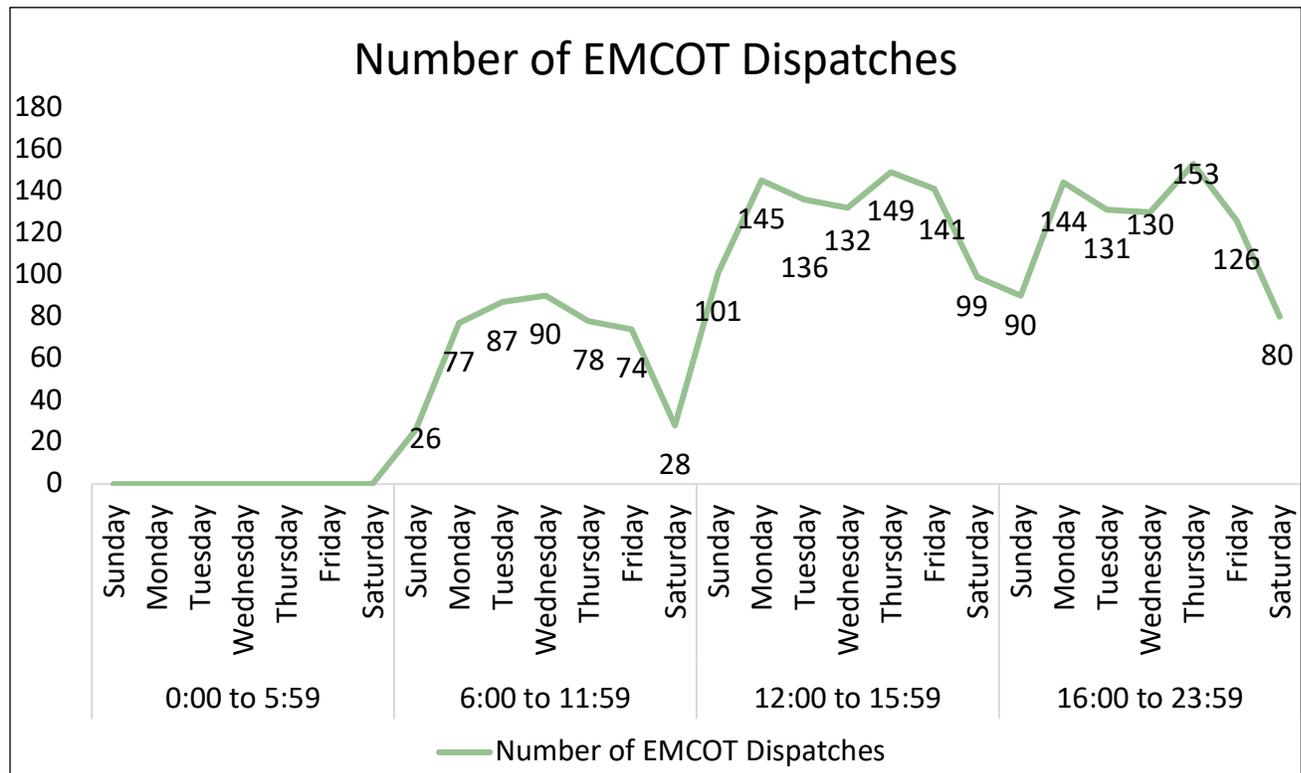


Chart 5 shows the time-of-day and day-of-week frequency pattern for EMCOT dispatches. We can see that EMCOT is most often dispatched in the evening hours, with peak utilization after noon on weekdays. This pattern is consistent with APD and EMS crisis call for service dispatches; however, EMCOT hours do not fully cover those peak hours. Although highly valued by the first responder community, we learned through stakeholder meetings and roundtable discussions that EMCOT workers are not always available. Barriers to their availability were identified as high call volume with limited staffing patterns, safety concerns preventing a clinician from quickly responding directly to a scene, and distance to travel and traffic congestion considerations. The departments do not collect data on instances of when an officer or medic attempted to request an EMCOT worker and one was not available.

EMCOT is operational Monday through Friday from 6:00 a.m. to 10:00 p.m., and on weekends and holidays from 10:00 a.m. to 8:00 p.m. Peak crisis call for service hours are 4:00 p.m. to midnight, seven days a week.

Chart 5: Time of Day and Day of Week Frequency for EMCOT Dispatches (2015-2018)



Integral Care used the 1115 Medicaid Transformation Waiver’s Delivery System Reform Incentive Payments (DSRIP) program to establish its Expanded Mobile Crisis Outreach Team. The DSRIP program’s initial six-year demonstration period ended December 2017. Because of changes in the waiver, future DSRIP funding will be allocated differently in order to meet the requirements of the new waiver. APD and EMS are concerned about this change in funding since it may jeopardize the EMCOT program, which has proven to be valuable in managing low-risk crisis calls for service. We recommend that local stakeholders consider supporting the continuation and expansion of this program, which would increase utilization of these services and provide a quality return on the city’s investment. We discuss this support in greater detail in the recommendation section of this report.

Impressions and Findings

- MCOT and EMCOT both perform vital functions for people in crisis.
- MCOT dispatches decrease at the very time APD and EMS crisis calls for service increase. However, a more detailed study is required to determine if increases for APD occur in

the same geographic regions in which MCOT dispatch decreases occur, as well as to determine any potentially causal factors .

- EMCOT dispatches are consistent with APD and EMS crisis call for service hours, but reports from stakeholders indicate this is not adequate to meet the need.

Austin Police Department Crisis Intervention Team (CIT) and Training

The Austin Police Department has a robust curriculum for crisis intervention training. Starting in January 2019, each cadet officer will receive the 40-hour Texas Commission on Law Enforcement (TCOLE) *Crisis Intervention Training* course (Course #1850) while attending the basic police officer academy. This training goes well beyond what is required by the state licensing body for peace officers (TCOLE), which holds a 16-hour requirement for basic peace officer mental health training.

After completing the basic academy training, officers also have the opportunity to enroll in the 40-hour advanced *Mental Health Peace Officer* training course (TCOLE Course #4001), which is offered twice a year and open to all eligible officers. After completing the advanced course, an Austin police officer becomes eligible to seek one of an allotted 162 Crisis Intervention Team (CIT) certified patrol officer²¹ stipend positions, discussed later in this section.

Since April 2018, all Austin police officers are required to take an eight-hour de-escalation training course, in addition to crisis intervention training. This course, *Limiting the Use of Force in Public Interaction* (TCOLE 1849), has been incorporated into the basic academy training and is also offered as an in-service educational course for all officers. As of the time this report was being written, APD predicted that all officers in the department will have completed the training by September 2019.

APD has taken steps to address emerging developments in crisis intervention by including a 10-hour, bi-annual crisis intervention training/CIT refresher course (TCOLE Course #3843) into its regular training schedule. This refresher training will begin in September 2019, which coincides with the next TCOLE training cycle, and will be required for all APD CIT-certified patrol officers receiving a stipend.

Past CIT training sessions have consistently featured guest speakers, community partners, and advocates from the community, including the National Alliance on Mental Illness (NAMI) Austin, Integral Care, the Arc of Texas, Military Veteran Peer Network, and adult protective services. Recently, the CIT program has made changes to its documentation process and updated each

²¹ TCOLE does not recognize or provide certification for officers as Certified CIT Officers, and no such certification exists in Texas. This is a designation APD uses to recognize officers who have completed TCOLE Course 4001, *Mental Health Peace Officer Course* (also commonly referred to as *Advanced CIT*) and who receive a monthly stipend.

training syllabus to reflect the guest speakers and advocates that co-train and present material at each crisis intervention training course. Eighty percent (80%) of cadet CIT training is co-taught with outside agencies. These efforts are exceptional and meet or exceed best practice recommendations and standards.

The Crisis Intervention Division is also responsible for providing the department with updated crisis intervention training bulletins; preparing material for mandated continuing education, including on-line training; conducting all departmental mental health training; and producing demonstration videos. Examples of this information and on-line training include:

- Crisis intervention policy updates,
- Updates to emergency detention procedures,
- Legislative updates,
- EMCOT procedures,
- Community resource bulletins and updates,
- Psychiatric hospital policy and availability updates, and
- Available training resources and opportunities external to APD.

The CIT Unit is also responsible for following up with people who had previous contact with the police department as a result of a mental health crisis. While this effort is commendable, having law enforcement conduct a follow-up to determine a person's ongoing need for mental health care can be stigmatizing by indicating follow-up contacts require a police presence. Also, this opportunity for an immediate connection to care is conducted in isolation from any community-based service providers.

The **Community Health Paramedic Program (CHP)** with Austin-Travis County EMS was established in 2006 to develop new ways to serve people who call 911 for non-emergent needs or conditions that could be better addressed by other services. The goal of the CHP program is to connect people with chronic care needs to education and resources to reduce their reliance on local emergency departments for primary care. To achieve this goal, CHP has developed partnerships with various local agencies, including Integral Care, Central Health, and Community Care. Through these partnerships, CHP is able to provide referrals and supportive services to streamline communications amongst providers and increase successful linkages to care.

The CHP program includes a team of nine (9) medics and one commander. The team engages patients in their homes or community settings to establish referrals and appointments with a primary care doctor, provide referrals to mental health services, and provide education on resources throughout Austin to address each individual's needs before a medical or mental health crisis arises.

We believe it would be beneficial for the APD to consider a partnership between CHP and CIT for this follow-up function. We discuss this partnership in greater detail in the recommendation section of this report.

Certified CIT Officers and CIT Stipend

The Austin Police Department's current strength is 1,786 officers. Within the department, 42% of the workforce (767 officers), of all ranks, have completed advanced CIT training (TCOLE 4001). While this is commendable and necessary for institutional and chain-of-command knowledge of CIT practices and needs, the primary goal of any CIT training program should be to ensure 911 and crisis calls for service are answered by an officer with appropriate CIT training²². To accomplish this, the majority of CIT-trained officers should be with the patrol division.

There are 728 officers assigned to patrol, including the Park and Lake Patrol Units and the airport detail. Of those officers, 199 (27.3%) have received the advanced TCOLE 4001 course required to be considered by APD as certified in CIT. In addition to the CIT-certified patrol officers, 112 supervisors assigned to the Parks, Lakes, and Mounted Patrol Units and the airport detail have completed the advanced TCOLE 4001 course. This is well within the national standard when measured against the Specialist Model supported by CIT International²³. However, because of labor contracts, there are only 148 CIT-certified patrol officer stipend positions assigned to the patrol units, with an additional 14 stipend positions that are distributed among the Park and Mounted Patrol Units and the airport detail, for a total 162 stipend positions.

The primary function of the APD CIT-certified patrol officer who receives a stipend is to assess and perform emergency detentions when requested and appropriate. However, while only 162 CIT-certified patrol officers receive a monthly stipend for performing these duties, the remaining CIT-certified patrol officers who are assigned to the Park, Lake, and Mounted units and the airport detail can and do respond to mental health calls if a stipend CIT-certified officer

²² Watson, A. C., & Fulambarker, A. J. (2012). The Crisis Intervention Team model of police response to mental health crises: A primer for mental health practitioners. *Best Practices in Mental Health, 8*(2), 71.

Bratina, M. P., Carrero, K. M., Kim, B., & Merlo, A. V. (2018). Crisis intervention team training: When police encounter persons with mental illness. *Police Practice and Research, 1*-18.

Comartin, E. B., Swanson, L., & Kubiak, S. (2019). Mental health crisis location and police transportation decisions: The impact of crisis intervention team training on crisis center utilization. *Journal of Contemporary Criminal Justice, 35*(2), 241-260.

²³ Compton MT, Bakeman R, Broussard B, D'Orio B, Watson AC. (2017). Police officers' volunteering for (rather than being assigned to) Crisis Intervention Team (CIT) training: Evidence for a beneficial self-selection effect. *Behavioral Science Law, 1*-10.

is unavailable. In addition to responding to mental health calls, all CIT-trained officers can perform all of a stipend CIT-certified patrol officer's job functions, and are authorized to do so under Texas Health and Safety Code 573.²⁴ With this in mind, it is unclear what purpose the stipend serves. Moreover, it seems the stipend actually constrains CIT-trained officers' availability to respond to calls or perform duties when there is a preference for an officer with CIT training who is being paid a stipend to respond, rather than having the nearest trained officer respond. Further, with limited stipend availability, requiring only officers who are receiving a stipend to complete refresher training – as opposed to requiring all officers to complete this training – further constrains APD's efforts to ensure that over 25% of any given patrol shift (officers with a primary responsibility for answering all emergency calls) has advanced CIT training and availability, in accordance with CIT International best practice standards.

Austin Police Department Dispatch and 911 Call Takers

The first contact made by a person needing immediate help is typically with a 911 call taker. The call taker will attempt to gather all necessary information from the caller, such as the location of the emergency, type of emergency, and the level of immediate threat to the caller or third party, before processing the call to a dispatcher. Once an emergency call is processed and sent to the dispatcher, the dispatcher then conveys that information to the officer and supports with any additional or requested information as the officer responds. This requires the ability to recognize the presence of a mental health element to a crisis call, ask appropriate and informative questions, seek additional input, and equip an officer with all necessary information.

At APD, 911 call takers complete four weeks of classroom training along with an additional four to six weeks of on-the-job training before they are permitted to perform all aspects of their job description in the emergency call center. Dispatchers complete five weeks of classroom training as well as eight to 12 weeks of on-the-job training before they are permitted to work on their own. Training curriculums for both positions include the *Basic Telecommunicator Certification* (TCOLE Course #1301) and a 24-hour *Crisis Communication Course* (TCOLE Course # 2120). Although a section of instruction in Course # 2120 is dedicated to identifying callers with mental health care needs, it is one of ten topics included in a three-day course. The course covers the topics quickly with little or no classroom role play or practice.

In addition to these TCOLE courses, both 911 call takers and dispatchers receive instruction on standard operating protocols and call classification, including protocols for labeling or titling crisis calls for service. The APD Crisis Intervention Team also provides a one-hour training class on crisis intervention.

²⁴ For more, see: <https://statutes.capitol.texas.gov/Docs/HS/htm/HS.573.htm>

APD's training for call takers and dispatchers does not appear to equip these invaluable front-line professionals for the central responsibilities of recognizing and managing mental health crisis calls. However, training a call taker will not fully address the needs for triaging mental health emergency calls. We recommend that the City of Austin strongly consider integrating EMCOT telehealth response units and clinical call triage services from Integral Care into the dispatch center's functions. We provide additional details about this consideration in the recommendation section of this report.

Impressions and Findings

- APD CIT training meets or exceeds best practice standards.
- APD has done an excellent job of ensuring department-wide knowledge of CIT through chain-of-command buy-in and extended chain-of-command training.
- APD has recently undertaken efforts to better document training, including training provided by guest speakers and co-trainers.
- APD has instituted CIT refresher training as well as advanced de-escalation training.
- APD refers to officers receiving TCOLE 4001 as CIT certified; however, this is strictly an internal designation.
- APD provides a CIT stipend at an estimated cost to the city of almost \$350,000 a year. However, all officers are authorized under Texas Health and Safety Code 573 to perform these functions; officers who are trained but do not receive a stipend should be expected to perform these functions.
- The CIT stipend and internal certification designation may limit the reach of CIT refresher training to all officers, posing as a barrier to ensure the broadest coverage of CIT trained patrol officers as possible.
- APD 911 call taker and dispatcher training meets state standards, however, it does not include comprehensive training on the identification and management of crisis calls for service.
- CIT Unit officers conduct follow-up calls and visits for people with mental health needs without a behavioral health partner present. This increases the risk of stigmatizing mental health needs in Austin and separates that follow-up contact from community behavioral health at a time when the person may be most vulnerable and in need of an immediate connection to services.
- The HOST team is an innovative collaborative initiative in Austin that conducts proactive as well as follow-up outreach to people who are homeless and have complex care needs. The CIT Unit program should consider merging outreach efforts with the HOST team for behavioral health follow-up efforts.

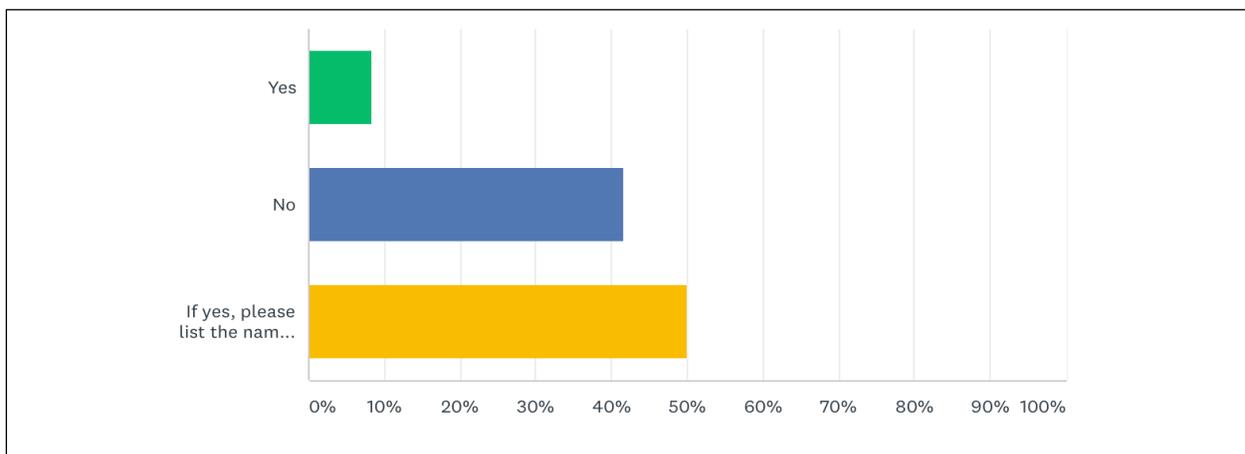
Stakeholder and Committee Feedback

Through a series of roundtable discussions, individual communications, an online survey, and several small group coffee shop meetings, stakeholders enthusiastically described their concerns, impressions, and desires for a robust and responsive system focused on early intervention and connection to care.

Seventy-six percent of the stakeholder committee completed an online survey²⁵ containing the three most common themes from the first four roundtable discussions. Those who did not participate cited barriers with their email security systems. Stakeholders have a great sense of pride regarding many of the programs that are unique to Austin. The majority of respondents did not believe a program currently exists in Austin that addresses the ability of first responders to connect individuals to care at the earliest point of contact. However, 50% of respondents who did believe a current program addresses first responders’ ability to divert individuals in need of mental health care to the appropriate care as quickly as possible cited EMCOT as that program. See Chart 6 below.

Chart 6: Do you believe there is a current program in Austin that is successful now, yet not large enough/adequate to meet the service capacity need? If so, please name it.^{26,27}

(Respondents were asked to consider options that quickly connect people with mental health care needs to care who make contact with law enforcement during crisis.)



Additional survey responses also reflected roundtable and small group discussions. Stakeholders were committed to ensuring a reduction in instances of response to resistance by establishing care connections at the earliest point possible. Chart 7 shows that over 60% of the

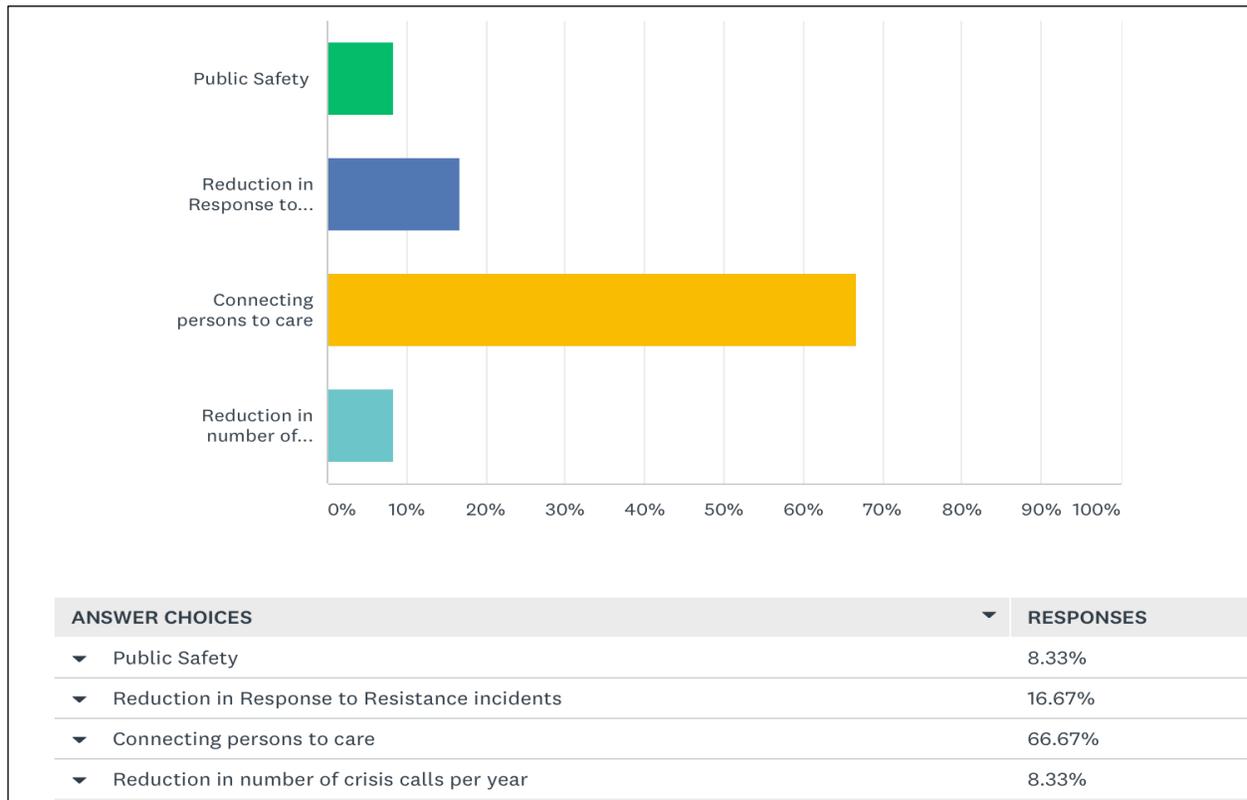
²⁵ See Appendix F.

²⁶ Language of this question has been modified in the report for the reader’s clarity. To see the exact question, refer to Appendix F, Question 3.

²⁷ Yes answers sorted to most common program, revealing EMCOT was most heavily supported by respondents.

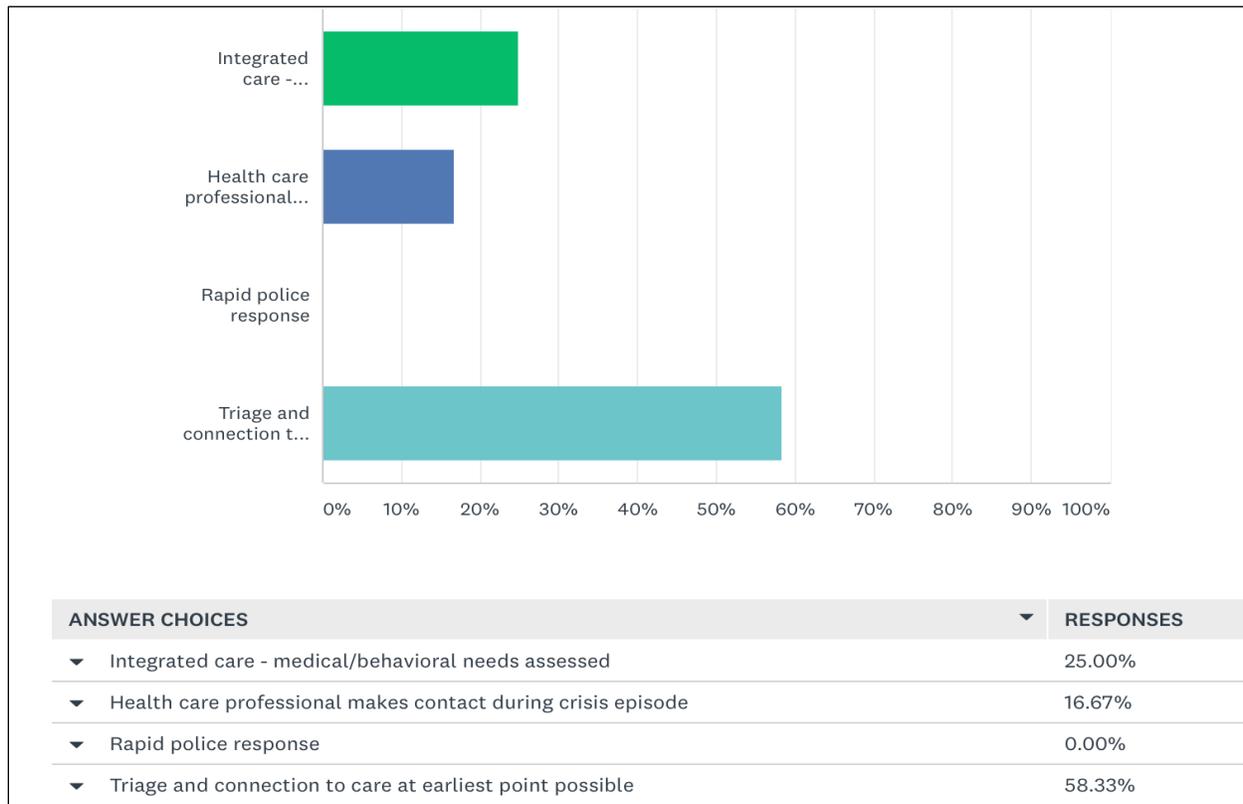
survey respondents shared the primary concern of building a systemic response that focused on providing these care connections to Austin’s residents who are in need of services and at risk of involvement with the criminal justice system.

Chart 7: What is your primary concern regarding Austin Police Department’s mental health or crisis response practices?



Lastly, as the stakeholder committee explored programs from Texas and across the country, a recurring theme was their commitment to providing behavioral health interventions and services to people in need at the earliest point possible. While the stakeholder committee noted it was vital for APD to improve its ability to recognize, respond, and manage behavioral health calls, the committee also expressed firm beliefs regarding dignity in care, de-stigmatization of crisis response, and appropriate and compassionate delivery of services as guiding principles for reducing police interactions with people in crisis. Chart 8 shows the survey results regarding primary concerns for program design, which were heavily in favor of early triage and integrated care.

Chart 8: When considering program design for mental health crisis response, what is the most important element to you?



Program Recommendations

The following program recommendations emphasize the creation of a collaborative system of prevention, intervention, and continuity of care. Ensuring that vulnerable people in need of care have access to services before they need to call 911 can decrease the risk of engagement with law enforcement or arrest.

However, there will undoubtedly remain a need for Austin police officers to respond to crisis calls for service. By creating a system that is rooted in high quality training; adheres to policy, oversight, and accountability; and deploys the most current best practices in crisis response programs, the risk of officers having to use response to resistance tactics should be greatly reduced when they inevitably have to respond to a crisis call for service.

In considering recommendations to strengthen crisis response in Austin, it is worth noting that there are evolving models that integrate crisis response within a general health framework. In such models, the primary response usually involves an EMT as a core part of the response. There are recommendations in this report (such as the recommendations to incorporate telehealth into the response system) that begin this type of integration between law enforcement, mental health, and healthcare.

Recommendation 1: APD Chief’s Mental Health Program and Response Advisory Function Developed Within the Behavioral Health and Criminal Justice Advisory Committee

The Travis County Behavioral Health & Criminal Justice Advisory Committee (BHCJAC), a collaboration of Travis County criminal justice and behavioral health stakeholders, is an independent entity that works within a non-partisan framework to identify, build, and support strong systems in Travis County. The mission of the Travis County BHCJAC is to develop and sustain a planning partnership to support people with behavioral health needs and to promote justice and public safety. It has 24 members representing various entities from the City of Austin and Travis County (e.g., Downtown Austin Community Court, APD, and Central Health) and behavioral health stakeholders (e.g., Integral Care, NAMI Central Texas, members of the advocacy community, and people with lived experience with mental health conditions).

The BHCJAC has adopted a set of guiding principles based on the shared value that the behavioral health needs of people in the community are best addressed through treatment alternatives rather than through the criminal justice system, jail, or prison.

Thus, this is an ideal group to serve as an advisory body to the Chief of Police for issues related to crisis calls for service (mental health responses). We recommend that the Travis County BHCJAC consider if its charter allows for this advisory role and, if not, amend the charter to reflect a new function of advising the Austin Chief of Police on responses to people in crisis and the development of any additional behavioral health-related programs.

We also recommend that APD provide quarterly reports to the BHCJAC on crisis call for service items, including the number of crisis calls for service, location of frequent crisis calls for service, response to resistance on all crisis calls (with limited case review as information allows), and the number of hours routine patrol spends managing crisis calls for service. APD should include in these reports any collaborations developed to conduct outreach and engagement to ensure people with mental health care needs are not subject to unnecessary stigma.

In addition, we recommend that the Travis County BHCJAC review CIT calls and provide structured feedback to the Chief of Police. This review should be conducted by the committee’s entire membership, not an abbreviated workgroup; this would reinforce comprehensive, independent, and multidisciplinary advisement.

This advisory function would allow the department to have an independent and dynamic review of efforts for ongoing improvements, supports, and highlights of exceptional efforts that have an impact on Austin residents in need of care.

Recommendation 2: Mental Health Training for Call Takers

We recommend that the Austin Police Department (APD), in collaboration with NAMI Central Texas and Integral Care, create an evidence-based and research-informed mental health crisis call identification and management training²⁸ for all call takers. The training should be of high quality, with academic or external professional review. Topics should cover, but not be limited to, active listening, mental health symptom recognition, communication techniques for people experiencing a mental health crisis, and verbal de-escalation. Instruction should be provided in partnership with community-based partners, including Integral Care, Austin State Hospital, Austin Lakes Hospital, or other behavioral health professionals. Each call taker should receive this training and demonstrate competency as a core part of their duties. Several curriculum examples exist and have been deployed with success in areas across the state and country. We recommend that APD establish a goal, and associated training schedule, to train all call takers within 12 months of the adoption of the new training course. All new call takers should be required to complete this training and demonstrate competency in the material before being released to work on their own.

Associated Cost: \$100,000

Curriculum development and academic review should be considered as budget items in funding staff time to create the curriculum, conduct academic or professional review, and staff overtime to supplement the call center during training times.

Recommendation 3: Mental Health Integrated Dispatch

Serving as the first contact a person makes when calling 911 for a crisis, the call center is a vital triage point. As we noted earlier in this report, there have been critical times when behavioral health elements may not have been understood by the call taker or passed along to the responding officer. Further, there are times when a law enforcement response may not be the most appropriate response for the person calling 911. A trained licensed professional plays an invaluable role in triaging these needs, ensuring assignment to the most appropriate resources available, and supporting the officer with all necessary and available details while he or she is on scene.

While Houston offers an example to consider, we recognize that the experience of one city may or may not be relevant to another. However, there still may be lessons learned or applicable elements. Houston Police Department and the Harris Center initiated a collaborative Crisis Call Diversion (CCD) program in 2015 and, since that time, the program has demonstrated strong

²⁸ Chicago Police Department's call center training is an excellent example of evidence based and research informed mental health identification and call management training for call takers and dispatchers. For more information see: <https://www.chicagotribune.com/news/local/breaking/ct-911-operators-mental-health-training-met-20170225-story.html>

efficacy in diverting non-emergent CIT calls away from police and EMS to CCD clinicians embedded in the call center. The clinicians, who are employed by the Harris Center, link the caller to needed services rather than dispatching a police unit or ambulance to the scene. The CCD program has provided cost savings, and, more importantly, significant cost avoidance to Houston first responder agencies. Initial research estimated the program provided Houston agencies with over \$1.3 million in cost avoidance netting first responder agencies over \$860,000 in cost savings in the first year of operations²⁹ while connecting thousands of Houston area residents to mental health care services during times of crisis.

If a similar program were developed in Austin we recommend that the City of Austin collaborate with Integral Care to place clinicians directly on the dispatch floor as an integrated component of 911 operations. Implementation and program design should reflect the needs of Austin and consider modifications, including participating at an earlier triage point with call takers, ability to divert calls to the most appropriate resources such as EMCOT or EMS, as well as providing support and appropriate information to officers on scene.

Additionally, the Call Center Clinicians (C3) should hold Criminal Justice Information Systems (CJIS) clearance and complete TCOLE call taker training to allow them to enter information directly into the Computer Automated Dispatch (CAD) system and communicate directly with the officer on scene; however, these clinicians should not be placed in a primary call answering or dispatch position. The C3 position should be developed in such a way that its function serves as a support and add-on service to any 911 call taker or dispatcher handling a call with a suspected or confirmed behavioral health crisis element. The C3 staff member should have access to Integral Care computer and data systems while in the call center, and policies should support the sharing of necessary information with police as well as EMS to reduce the risk of escalation and poor outcomes for crisis calls for service. Lastly, the Austin 911 call center should amend policies to direct all call takers to ask, “Do you need police, fire, EMS, or mental health,” for every 911 call and immediately transfer any mental health 911 call to a 911 call taker who has completed and demonstrated competency in mental health training for call takers, adding on a C3 staff member when available. These policy amendments should also address when it is appropriate to connect callers who do not need a police response to more appropriate services, such as EMS units that have telehealth connections, and include a follow up from Community Paramedics, EMCOT, HOST, or the C3 staff at the appropriate time.

Deployment Times

The C3 position is not needed 24 hours a day. Data analysis of APD crisis calls for service, EMS crisis emergency calls, MCOT, and EMCOT frequency supports that this position should be deployed in the call center Sunday through Saturday from 8:00 a.m. to midnight.

²⁹ For more information, see: <https://www.houstoncit.org/crisis-call-diversion-program/>

Associated Cost: \$300,000

Costs include salary, fringe benefits, and supplies for two licensed Call Center Clinicians. Additional staffing for this program will be included in an EMCOT expansion.

Recommendation 4: Sustainability of EMCOT, Including Telehealth Expansion

The EMCOT program has proven to be an invaluable part of the crisis response system in Austin. The structure of the program, which allows for direct dispatch of crisis staff members on crisis calls for service with officers, permits rapid assessment and immediate connections to care for vulnerable people across the city. However, the program has limitations that need to be addressed within any plans to sustain and expand its use.

Because of the unpredictable nature of police calls for service, crisis workers are not able to deploy to every call in which they could be of benefit. Further, as we heard in multiple stakeholder committee meetings, there are times when this response is significantly delayed, if not impossible, because staffing patterns do not meet the need. To bring the program to scale, it needs to be sustainable and ensure that the city receives a quality return on its investment. This return can reasonably be measured in the form of reductions in repeat callers for crisis services, response to resistance episodes, the time officers and EMS staff spend on mental health calls, and time spent on emergency detentions.

There is evidence in Texas and in cities across the country that mobile telehealth is proving to be a workforce multiplier, significantly enhancing systems and making it possible to immediately connect people to crisis and health services.

For example, the Harris County Sheriff's Department began a telehealth crisis intervention pilot in early 2017 modeled from Houston Fire Department's Project ETHAN (Emergency TeleHealth and Navigation), which connects people who have requested an ambulance for low acuity care needs directly to an emergency department physician for triage prior to, and most often in lieu of, transport to a hospital. In the initial test phase (phase 1) of the Harris County Sheriff's Tele-Crisis Intervention Response Team (Tele-CIRT) project, five deputies were equipped with iPads connected to a telepsychiatry provider for 30 days. The University of Texas School of Public Health Houston completed an evaluation of the 30-day pilot and found a total cost savings of over \$26,000 across 31 calls.³⁰ In addition to these cost savings, 26% of people served through Tele-CIRT were diverted from hospital admission and 6.5% were diverted from jail. The program has now moved to phase 3, deploying 20 deputies supported by two telehealth clinicians employed by the Harris Center. With this 10 to 1 ratio between officer and clinician, the program has proven to be an immediate workforce multiplier for crisis intervention services.

³⁰ For more information, see: <http://www.harriscountycit.org/diversion/special-projects/>

Austin is uniquely situated to create its own system that specifically meets the city's unique needs while demonstrating innovation that could be a model for peer cities across the country.

The EMCOT program should be sustained in its current size and scope. However, this investment should also include an expansion of the program through the use of telehealth for immediate access to crisis screening while limiting the cost of adding staff. Mobile telehealth equipment should be placed in APD patrol vehicles and Austin EMS ambulances in city council districts 1, 3, and 9 as well as in the areas along I-35 noted in Maps 8 and 9. EMCOT telehealth clinicians should be bilingual, or have access to translation services, to address the finding that the highest rates of response to resistance during a crisis call for service occurred in areas where people of Hispanic descent live. Protocols should be developed in collaboration with APD, EMS, and Integral Care to maximize the use of telehealth connections with EMCOT for crisis screenings in order to expand the reach and capacity of EMCOT, expand the scope of calls that clinicians can respond to without introducing additional risk to the clinician, and decrease any wait time for clinicians' arrival, which would put officers and ambulances back into service more rapidly.

Deployment Times

We recommend that EMCOT clinicians assigned to the telehealth service be housed at the 911 call center and work as EMCOT telehealth crisis screeners while also supporting C3 functions. Co-location for EMCOT telehealth services is a workforce multiplier for the C3 function while also integrating this first responder focused service directly into the first responder work flow. This consolidated workplace model enhances cross systems collaboration and increases shared learning and debriefing opportunities. A clinician should not serve as the primary C3 while also on shift as a full-time EMCOT clinician – this would diminish the effectiveness of either function and undermine any investments made in this program. Rather, the clinician should be cross-trained to staff both positions and provide support when needed while on shift in either position. Using this model, based on call data cross-referenced with EMCOT data³¹, we recommend having one EMCOT telehealth clinician on duty, Monday through Friday from 8:00 a.m. to 3:00 p.m. Evening coverage, the time of day with the highest number of crisis calls for service to both APD and EMS, is recommended to include two EMCOT telehealth clinicians from 3:00 p.m. to midnight. Recommended weekend coverage includes one EMCOT clinician on duty on Saturday and Sunday from 3:00 p.m. to 11:00 p.m. We recommend this staffing in addition to current EMCOT deployment patterns and clinicians.

During the term of city funding, partners should collaborate with the city to identify a strategic plan to sustain this program beyond the initial funding period. This collaboration should include

³¹ See Chart 1 and Chart 5.

stakeholders such as Central Health, Integral Care, Travis County, and others who would benefit from program activities. The city should also collect and evaluate outcomes including the expanded program's impact on APD and EMS resources and reductions in individual crisis recidivism, response to resistance, misdemeanor arrests for people experiencing mental health crises, and other metrics as determined by Integral Care, the City of Austin, and APD.

Associated Cost: \$2.8 million per year

Costs for this expanded program model include \$1.8 million to sustain the current program. Expansion costs include a projected \$200,000 for telehealth equipment, software, and contracts; \$450,000 for three additional licensed EMCOT clinicians; \$200,000 for an advanced practice nurse to address the clinical needs of people encountered by EMCOT/law enforcement/EMS; and, finally, an additional \$150,000 for contracted physician time to oversee the prescriber. Total costs for EMCOT sustainability and expansion is projected at \$2.8 million a year, inclusive of all staff, fringe benefits, training, and equipment.

Recommendation 5: Collaboration with APD Crisis Intervention Team and Community Health Paramedic Program

The Community Health Paramedic (CHP) program in Austin is another excellent example of innovation that meets the city's unique needs. The CHP program is the only program we reviewed during this engagement that included proactive pre-crisis interventions. This pre-crisis intervention model is not only compassionate and commendable, it could also contribute to large savings for health care systems across the city.

The APD CIT Unit currently provides similar outreach services as the CHP program. However, these services are reactive, not proactive, and do not include coordination with partners in health care, social services, or behavioral health care. We recommend that the APD coordinate with the CHP program to integrate CIT outreach and follow up for crisis calls with the CHP's services. This integration should include assigning at least one of the CIT Unit team members to the CHP program full time to conduct additional outreach, serving people in crisis who call the 911 call center or have an interaction with APD while they are experiencing a behavioral health crisis. To ensure adequate staffing, an EMCOT telehealth connection should be integrated into the CHP team to support CIT follow up and outreach.

APD should reevaluate the practice of CIT officers conducting mental health outreach checks without having a behavioral health, paramedic, or social services partner present. APD should consider the risk of liability as well as the stigma created when mental health outreach is delivered by a police agency.

Deployment Times

Collaborative outreach and engagement efforts with the CIT and the CHP program should take place Monday through Friday from 8:00 a.m. to 6:00 p.m.

Associated Cost: \$0

Although there is no projected cost for this collaboration, if the City of Austin discontinues the use of the CIT stipend (which has resulted in limiting rather than enhancing mental health response functions and training), the department could reinvest the nearly \$350,000 from stipends to support and develop the prevention and intervention function between the CHP program and CIT Unit.

Recommendation 6: Community Outreach in Collaboration with NAMI Central Texas

An interesting finding in response to resistance patterns included a high number of response to resistance at Levels 1 and 2 in areas where people of Hispanic descent living in poverty resided. Further study is needed to fully understand this finding. However, we encourage the APD to work closely with NAMI Central Texas to develop Spanish language materials for its “What to Do” educational program. This program provides people living with mental illness, and their loved ones, with quick checklists of what to tell police when calling for help and what to do to ensure effective communication with police when they arrive. These materials should be provided at community locations across the area identified in Map 11. Also, officers working in this area should provide these materials to people they come into contact with in the course of their duties.

In addition to developing these materials, we recommend that APD and NAMI Central Texas partner with local organizations such as The Hispanic Alliance to host community meetings for introducing these materials, and officers, to people throughout the areas noted in Map 11.

This effort should also be extended to Asian American communities in collaboration with an existing organization such as the Asian American Resource Center.

Associated Cost: \$25,000 or less

This includes costs for materials production, printing, and four community meetings a year.

We believe these six program recommendations provide Austin with an opportunity to support and expand programs proven to be effective while introducing innovation to create a system unique to the City of Austin.

Appendices

Appendix A: Stakeholder Committee Membership

Name	Organization
Kelvin Alston	Community Member
Donald Baker	Austin Police Department
Dayna Blazey	Travis County District Attorney's Office
Sherry Blyth	Integral Care
Shannon Carr	Austin Area Mental Health Consumers
Joseph Chacon	Austin Police Department
Dawn Handley	Integral Care
Andy Hofmeister	Austin-Travis County Emergency Medical Services
Chad Hooten	Dell Seton (Yellow Pod)
Joseph Meyer	Family Member
Mindy Montford	Travis County District Attorney's Office
Justin Newsom	Austin Police Department
Chelsi West Ohueri	Austin Justice Coalition / Grassroots Leadership
Randy Ortega	City of Austin, City Attorney's Office
Wes Priddy	Travis County Sheriff's Office
Karen Ranus	NAMI Central Texas
Melissa McRoy Shearer	Travis County Mental Health Public Defender
Reggie Smith	Austin Justice Coalition / Grassroots Leadership
Peter Valdez	City of Austin, Community Court

Appendix B: Integral Care Program Descriptions

This section includes descriptions of the Hotline, MCOT, EMCOT, ACT, FACT, Housing First ACT, and Homeless Services (includes services at ARCH).

Hotline

A. Definition

A hotline is a continuously available telephone service staffed by trained and competent crisis staff who provide information, screening and intervention, support, and referrals to callers 24 hours a day, seven days a week. Any entity providing hotline services for any portion of the day must be accredited by the American Association of Suicidology (AAS).

B. Goals

The goals of a hotline are to provide immediate telephone response to a real or potential crisis situation and to initiate immediate activation and coordination of the mental health crisis response system.

C. Description

The hotline, known as the Integral Care Crisis Helpline, is an integrated component of the overall crisis program; it operates continuously and is accessible toll-free throughout the local service area. The hotline serves as the first point of contact for mental health crises in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services for the caller, if necessary. Trained and competent paraprofessionals may answer the hotline and provide information and non-crisis referrals; however, a trained and competent qualified mental health professional in community services (QMHP-CS) is required to provide screening and assessment of the nature and seriousness of the call. The initial assessment leads to immediate and appropriate referrals for assistance or treatment. The hotline facilitates referrals to 911, a Mobile Crisis Outreach Team, or other crisis services, and conducts follow-up contacts to ensure that callers have successfully accessed the referred services. If an emergency is not evident after further screening or assessment, the hotline includes referral to other appropriate resources within or outside the local mental health authority (LMHA) or local behavioral health authority (LBHA). The hotline works in close collaboration with local law enforcement, 211, and 911 systems.

Mobile Crisis Outreach Team

A. Definition

Mobile Crisis Outreach Teams (MCOTs) provide a combination of crisis services, including emergency care, urgent care, and crisis follow up and relapse prevention to children, youth, and adults in the community.

Emergency care services are mental health community services or other necessary interventions directed to address the immediate needs of a person in crisis in order to assure the safety of the individual and others who may be placed at risk by the person's behaviors. Services can include, but are not limited to, psychiatric evaluations, administration of medications, hospitalization, stabilization, or resolution of the crisis.

According to requirements of 25 Texas Administrative Code (TAC), Subchapter G, §412.314, (1)(B), *emergency care services*, if it is determined during a screening that an individual is experiencing a crisis that may require emergency care services, the QMHP-CS must:

- (i) Take immediate action to address the emergency situation to ensure the safety of all parties involved,
- (ii) Activate the immediate screening and assessment processes as described in §412.321 of this title (relating to Crisis Services), and
- (iii) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.

Urgent care services are mental health community services or other necessary interventions provided to people in crisis who do not need emergency care services, but who are potentially at risk of serious deterioration.

According to requirements of 25 TAC, Subchapter G, §412.314,(1) (C), *urgent care services*, if the screening indicates that a person needs urgent care services, a QMHP-CS shall, within eight hours of the initial incoming hotline call or notification of a potential crisis situation:

- (i) Perform a face-to-face assessment, and
- (ii) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.

B. Goals

The overarching goal for a Mobile Crisis Outreach Team (MCOT) and Expanded Mobile Crisis Outreach Team (EMCOT) is to prevent the overuse and misuse of psychiatric hospitalizations, emergency department admissions, emergency detentions, and arrests during a mental health crisis.

C. Description

MCOT receives all dispatches through the Integral Care Crisis Helpline. Crisis relapse prevention services can last up to 90 days. The minimum staffing requirement to provide services is a QMHP-CS. Licensed professionals of the healing arts (LPHA) and advance practice nurses (APN) can also provide assessments. The current staff composition for MCOT is eight (8) full-time equivalent (FTE) LPHAs (including the program manager and team lead), four (4) FTE QMHPs, and a 0.5 FTE APN.

EMCOT provides an array of crisis services and crisis relapse prevention services identical to those provided by MCOT, but this team receives all of its dispatches/requests for services through first responders and the criminal justice system. EMCOT co-locates with first responders (APD, Austin-Travis County EMS, and the Travis County Sheriff’s Office). Staff composition is 14 FTE LPHAs (including a practice manager and three team leads), six (6) FTE QMHPs, and one (1) FTE APN.

Classic Assertive Community Treatment

A. Definition

Assertive Community Treatment (ACT) is an evidence-based practice model designed to provide treatment, rehabilitation, and support services to people who are diagnosed with a serious mental illness and whose needs have not been well met by more traditional mental health services.

B. Goal

The goal of ACT is to provide multidisciplinary mental health care, meet treatment goals, foster personal growth, and facilitate connections to the community and support networks.

C. Description

The ACT team provides services that are directly tailored to meet a person’s specific needs. ACT teams are multidisciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation. Based on the team members’ respective areas of expertise, they collaborate to deliver integrated services of the consumer’s choice, help them make progress towards goals, and adjust services over time to meet the individual’s changing needs and objectives. The staff-to-recipient ratio is small (one clinician for every 10 recipients), and services are provided 24 hours a day, seven days a week, for as long as they are needed.

Forensic ACT

A. Definition

Forensic ACT (FACT) enhances ACT to serve people who have extensive criminal justice involvement and experience recurring and lengthy inpatient mental health hospitalizations or crisis episodes. Many participants in FACT programs are homeless.

B. Goal

To goal of FACT is to stop the revolving door of incarceration for people living with serious mental illness. The FACT team offers medical and mental health care, counseling, medications, family education, peer support, and Permanent Supportive Housing (PSH).

C. Description

FACT is a partnership between Integral Care, the Travis County Sheriff's Office, Downtown Austin Community Court, APD, and Central Health. The team brings together the expertise and unique services of individual team members to collaboratively meet the needs of individuals who have had high utilization of the criminal justice system. The program uses the ACT model as a foundation for providing services, which is enhanced with permanent housing subsidies and collaboration with criminal justice system partners to use participants' current legal involvement as leverage to further engage in ongoing mental health support.

Housing First ACT

A. Definition

Housing First ACT enhances ACT to serve people who have experienced or are currently experiencing chronic homelessness and multiple complex health conditions.

B. Goal

The goal of Housing First ACT is to serve people who require intensive supports to obtain and maintain housing in order to achieve wellness and recovery.

C. Description

Housing First ACT uses the ACT model as a foundation for providing services, which is enhanced by a strong connection to the Housing First philosophy, harm reduction practices, PSH, and strong collaborations with outreach and engagement programs throughout the community. Together, these services address the complex needs of the people in the community who are chronically homeless.

Homeless Services (includes ARCH)

Homeless services teams with Integral Care provide assertive outreach and support to adults in the community who are experiencing literal or chronic homelessness and who also live with mental health conditions, substance use issues, or other chronic medical issues. Services include case management, medical and mental health care, nursing support, referrals to shelters, supported employment, access to SOAR,³² and alcohol and drug treatment. Teams work to link people to housing and to Texas Homeless Network's Coordinated Entry process. Integral Care also has access to reserved beds/mats at the Austin Resource Center for the Homeless (ARCH) for people who are engaged with case management or with an outreach team. Intakes for services are also available on a limited basis at the ARCH.

³² SOAR stands for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery.

Integral Care also provides PSH to people identified as eligible through Coordinated Entry or who are chronically homeless and demonstrate a need for intensive mental health support. Housing vouchers are provided through a partnership with local city and county housing authorities. Rapid rehousing services are also available for people experiencing literal homelessness and are in need of a short-term rental subsidy. Both programs provide in-home supported housing skills training, case management, living skills, access to medical and mental health care, landlord outreach support, supported employment, SOAR, and counseling services.

Appendix C: Integral Care’s Expanded Mobile Crisis Outreach Team (EMCOT) Program Outcomes

The Expanded Mobile Crisis Outreach Team (EMCOT) partners with first responders in the City of Austin and Travis County to provide real-time response and co-response to individuals experiencing a mental health crisis.

On the Sequential Intercept Model (SIM), EMCOT focuses their efforts on Intercept One—when law enforcement has been activated during a mental health crisis. EMCOT data regarding diversions from emergency departments, emergency detentions, and arrests are tracked by Integral Care’s One Data team. The following are the operational definitions of “diversion.”

- **Diversion from Arrest:** Upon completion of the EMCOT crisis assessment and intervention, this refers to any disposition that does not include arrest.
- **Diversion from Any Involuntary Placement:** Upon completion of the EMCOT crisis assessment and intervention, this refers to any disposition that does not include arrests or emergency detentions.
- **Diversion from Emergency Room/Department:** Upon completion of the EMCOT crisis assessment and intervention, this refers to any disposition that does not include admission to an emergency department.

Table A1: Diversions, Fiscal Year 2015 (September 2014- August 2015)

Source of Referral	Diversion Rate
Law Enforcement	
Diversion from Arrest	99.4%
Diversion from Any Involuntary Placement (Arrest, Hospital, Psychiatric Care)	88.7%
EMS	
Diversion from Emergency Room/Department	76.0%

Table A2: Diversions, Fiscal Year 2016 (September 2015- August 2016)

Source of Referral	Diversion Rate
Law Enforcement	
Diversion from Arrest	99.3%
Diversion from Any Involuntary Placement (Arrest, Hospital, Psychiatric Care)	88.9%
EMS	
Diversion from Emergency Room/Department	81.6%

Table A3: Diversions, Fiscal Year 2017 (September 2016- August 2017)

Source of Referral	Diversion Rate
Law Enforcement	
Diversion from Arrest	98.7%
Diversion from Any Involuntary Placement (Arrest, Hospital, Psychiatric Care)	93.3%
EMS	
Diversion from Emergency Room/Department	75.1%

Table A4: Diversions, Fiscal Year 2018 (September 2017- August 2018)

Source of Referral	Diversion Rate
Law Enforcement	
Diversion from Arrest	100%
Diversion from Any Involuntary Placement (Arrest, Hospital, Psychiatric Care)	89.0%
EMS	
Diversion from Emergency Room/Department	79.0 %

EMCOT can provide up to 90 days of crisis relapse prevention services, or crisis follow-up services. All services are provided in the community, regardless of service type—crisis assessment, case management, crisis counseling, or medical evaluation. EMCOT goes anywhere in the community to serve its clients, whether it is a private residence, a school, an emergency department, a hospital, a parking lot, a jail, or a retail shop. EMCOT literally meets clients where they are to reduce barriers to receiving high quality mental health services. There are two goals EMCOT strives to meet when providing crisis follow-up services: (1) ensure that the individual experiencing a mental health crisis receives treatment and support for the duration of the crisis episode, and (2) ensure referral or linkage to an ongoing community treatment team or supports.

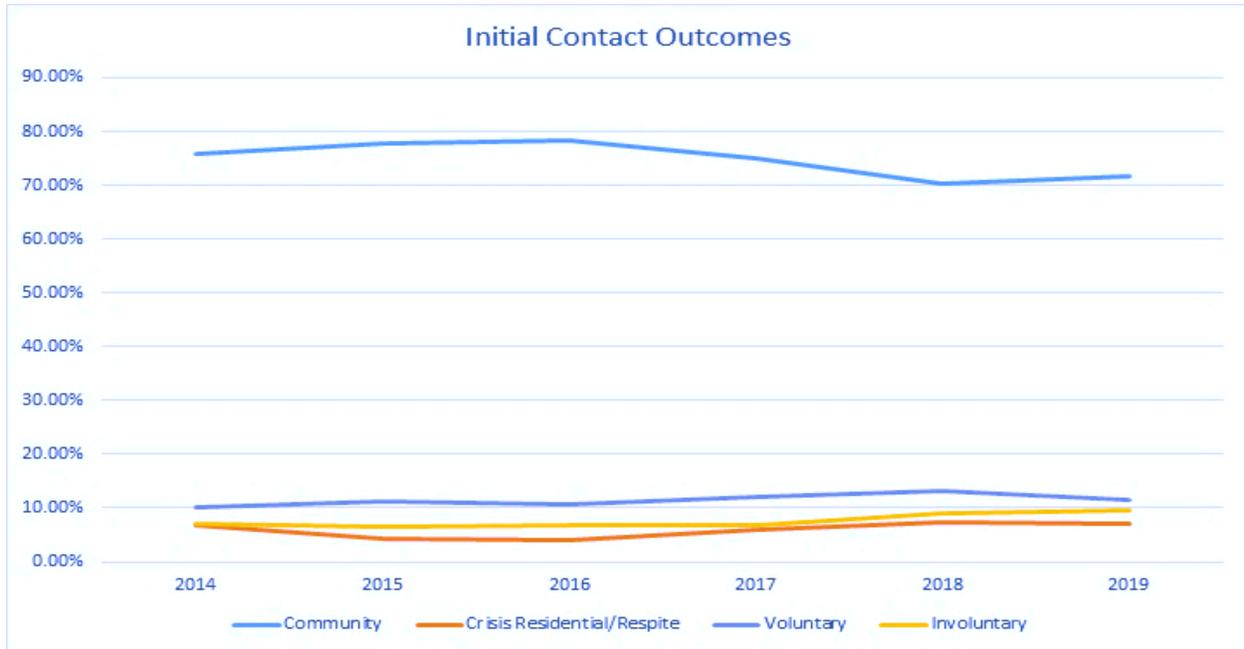
Table A5: Average Number of Visits per Individual Receiving EMCOT Services

FY 2015	FY 2016	FY 2017	FY 2018
4	4	3	2

Outcomes for consumers following EMCOT crisis assessment indicate that the vast majority of individuals who receive EMCOT services remain in the community with follow-up services to support them through their crisis episode. This is cost-effective and supports treatment in the

least restrictive environment of care for the individual. With early intervention and appropriate treatment, individuals have better recovery outcomes.

Chart A1: EMCOT Initial Contact Outcomes



Appendix D: Data Tables, APD and EMS

This section provides additional data on Austin Police Department (APD) and Austin-Travis County Emergency Medical Services (EMS). Tables A7 and A8 can also be found in the body of the report.

Table A6: Number of Crisis Calls for Service to APD and EMS, by City Council District (2016–2018)

City Council District	Number of Calls to APD ³³	Number of Calls to EMS ³⁴
1	4,895	1,905
2	3,247	1,180
3	4,474	1,837
4	3,954	1,852
5	2,724	1,155
6	1,677	729
7	3,358	1,205
8	1,241	449
9	4,489	2,217
10	1,929	528

Table A7: Addresses with the 1st to 10th Highest Volume of Crisis Calls for Service to APD

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
Dell Seton Medical Center (15 th / Red River)	882	797	90%
St. David's North Austin Medical Center	508	410	81%
Seton Medical Center	507	423	83%
St David's South Austin Medical Center	500	428	86%
Integral Care (56 East Avenue)	408	211	52%
Seton Northwest Hospital	305	238	78%
Austin Oaks Hospital	273	115	42%
St. David's Medical Center (32 nd / Red River)	247	211	85%

³³ Forty (40) calls had missing coordinates or fell outside of city council boundaries.

³⁴ Thirty-one (31) calls had missing coordinates or fell outside of city council boundaries.

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
CommUnity Care – Austin Resource Center for the Homeless (ARCH)	177	83	47%
Psychiatric Emergency Services (12th / Airport)	166	94	57%

Table A8: Addresses with the 11th to 20th Highest Volume of Crisis Calls for Service to APD

Locations	Number of APD Calls	Number of Calls Resulting in Emergency Detention	% Resulting in Emergency Detention
Burnet Road (Zoe’s Safe Place)	155	53	34%
CrossCreek Hospital	135	77	57%
Payton Gin Road (Near Target)	131	93	71%
8th and Neches (The Salvation Army)	125	50	40%
Austin Lakes Hospital	118	86	73%
35th and Mills (Near Seton Shoal Creek)	102	76	75%
Mueller and Barbara Jordan Boulevard	88	67	76%
East Ben White Boulevard (Near the Pointe at Ben White)	86	21	24%
Greyhound Bus Station (Koenig Lane)	80	40	50%
8th and IH-35 Frontage Road South (Near APD)	79	16	20%

Table A9: Addresses with the 1st to 10th Highest Volume of Crisis Calls for Service to EMS (2016–2018)

Location	Number of EMS Calls
Integral Care (56 East Avenue)	164
CommUnity Care – ARCH	157
Burnet/Ashdale Drive (One Block North of Burnet/Anderson)	103
8th/Neches (The Salvation Army)	75
7600 Cognac Cove (Residential)	58
Koenig/Clayton Lane (Greyhound Bus Station)	55

Location	Number of EMS Calls
Heyerdahl Drive (Group Home)	43
12 th / Airport (Psychiatric Emergency Services)	43
Payton Gin Road (Near Target)	39
Miriam / Real Street (Heritage Park Nursing Home)	37

Table A10: Addresses with the 11th to 20th Highest Volume of Crisis Calls for Service to EMS (2016–2018)

Location	Number of EMS Calls
HWY 71 / FM 973 (Travis County Adult Probation, SMART Unit)	36
Clock Tower / Norwood Park Drive (Norwood Park Shopping Center)	34
IH-35/Ben White (Murphy USA Gas Station)	31
Oltorf / Riverside (Bus Stop)	30
Nickols Avenue (Near Entrance to Springdale Neighborhood Park)	29
Stassney / Radam Circle (Rite-Away Pharmacy)	28
11803 Pearce Lane (Residential)	27
4600 Connelly (Residential)	27
2 nd / Chalmers (Bus Stop)	27
Gaston Plaza Drive (University Hills)	26

Appendix E: Demographic and Response to Resistance Maps

City of Austin Demographics

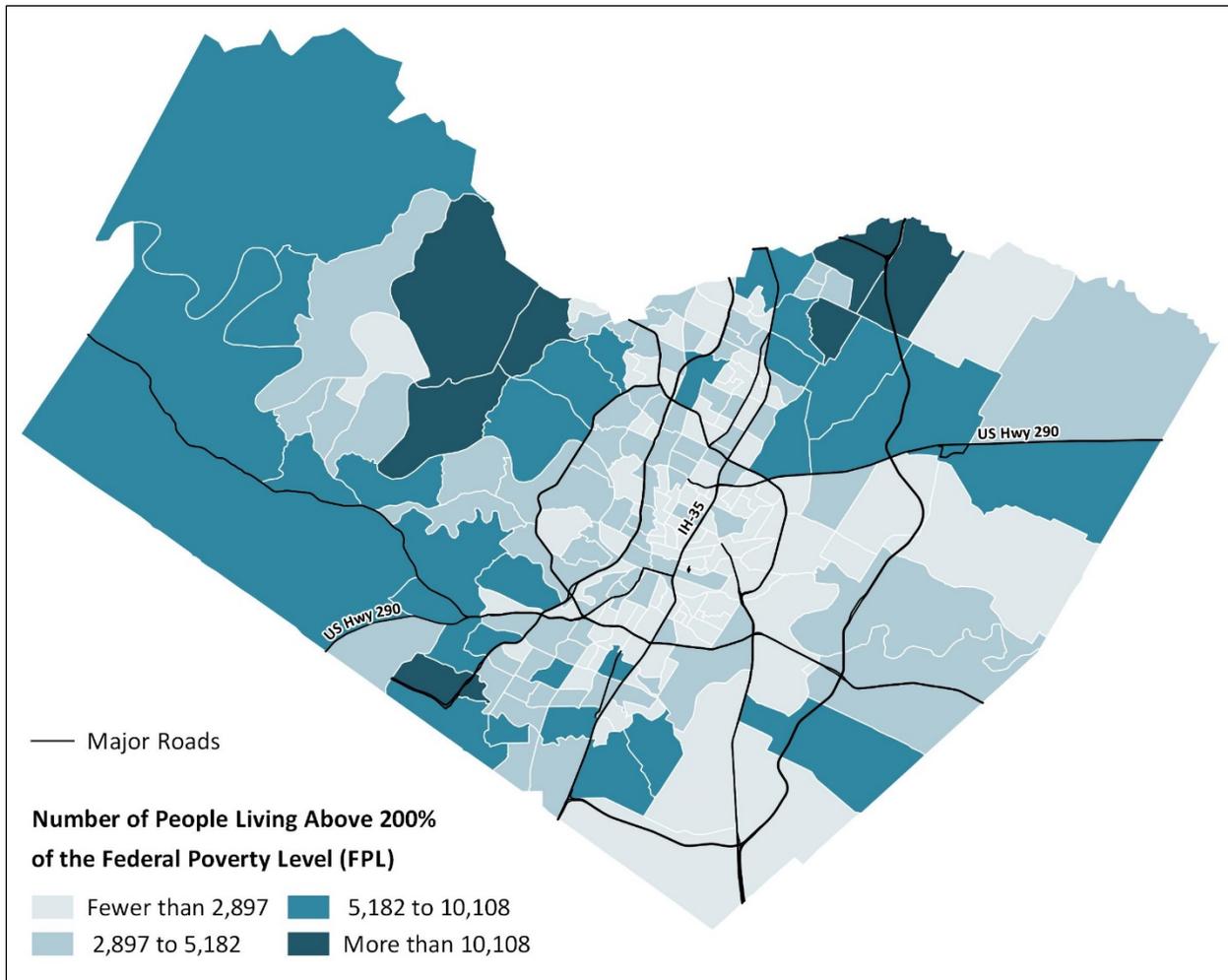
The first five maps on the following pages show the geographic spread of various demographic groups in Travis County. All demographic maps rely on data from the American Community Survey 2017 5-Year Estimates.

Map A1 shows where all people living above 200% of the federal poverty level (FPL) reside. This map reveals that the locations with the highest number of people living outside of poverty (identified by the darkest areas on the map) primarily include the western areas of Travis County as well as areas in northeast Travis County, including Pflugerville. In contrast, Map A2 shows that people living below 200% FPL reside in the remaining areas of town, including nearly all areas of East Austin and in North Austin along Interstate Highway (IH)-35.

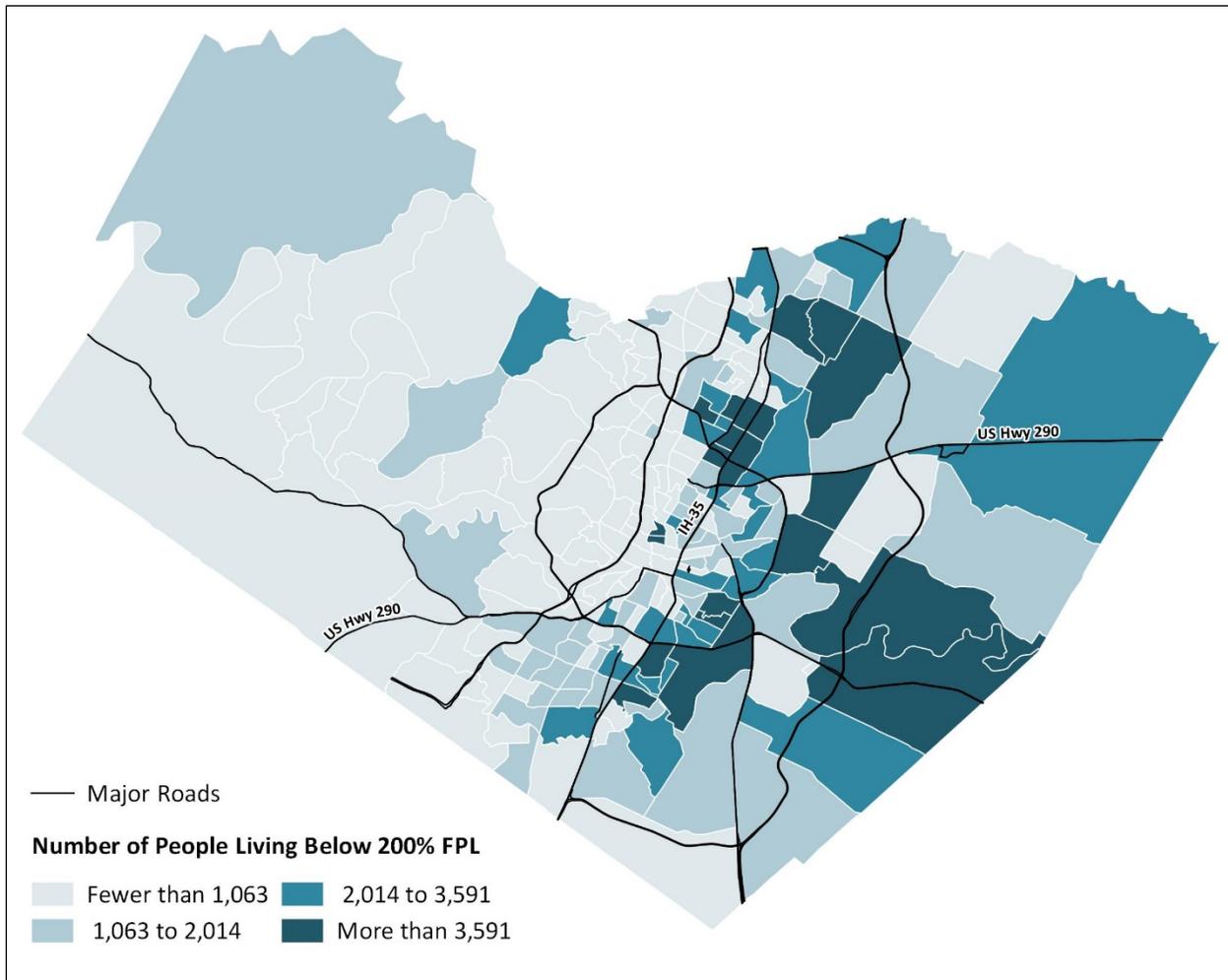
The next three maps show where people of color living below 100% FPL reside. Map A3 shows that African American people in poverty live in Central and North Austin just east of IH-35 and in far east Travis County. Similarly, Latino/Hispanic people living in poverty (Map A4) primarily live in the eastern portions of Travis County, particularly Southeast Austin. There is also an area in North Austin near the intersection of Highway 183 and IH-35 where a high number of Hispanic people in poverty live. Asian people in poverty live in many areas of Austin, including West, North, and Central Austin. The single area with the highest number of Asians in poverty is in downtown Austin; however, North and Northeast Austin have more census tracts with a moderate number of Asian people living in poverty.

When compared to the maps that show locations where police response to resistance took place (see Response to Resistance section in the main body of this report), these maps can help show patterns of police responses, including areas or demographic groups that may experience incidents of police using of force.

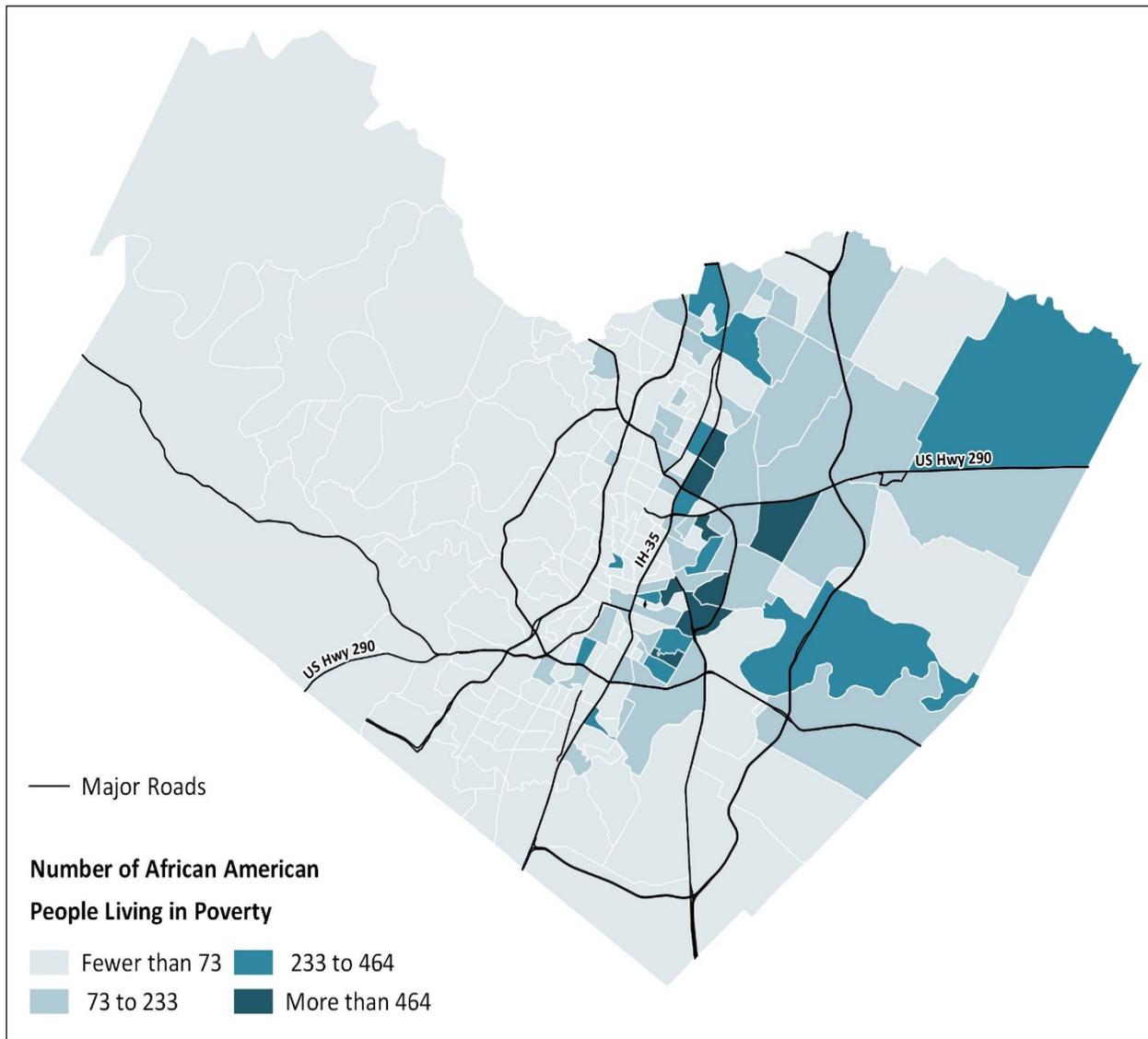
Map A1: All People Living Above 200% FPL, by Census Tract (2017)



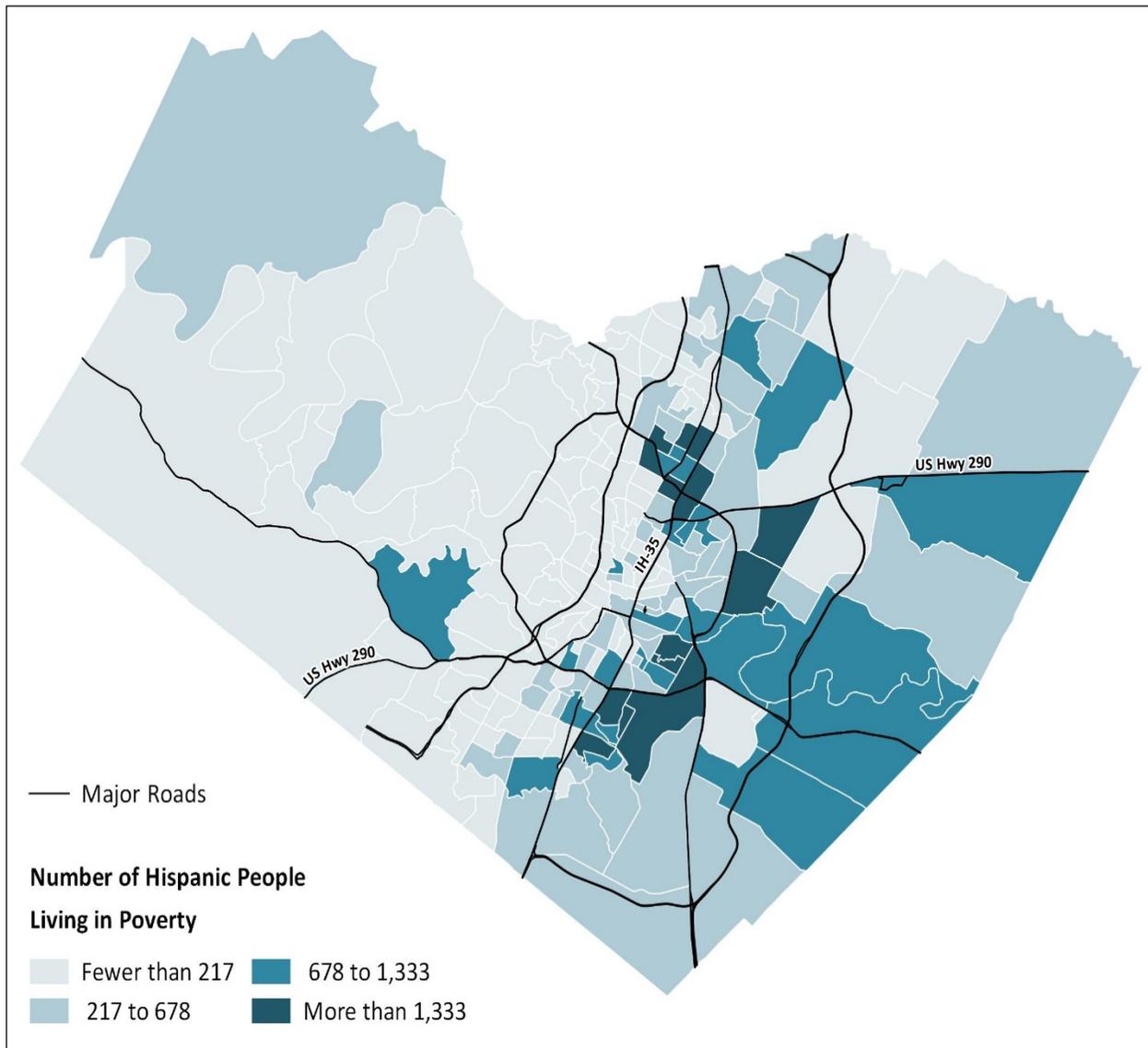
Map A2: All People Living Below 200% FPL, by Census Tract (2017)



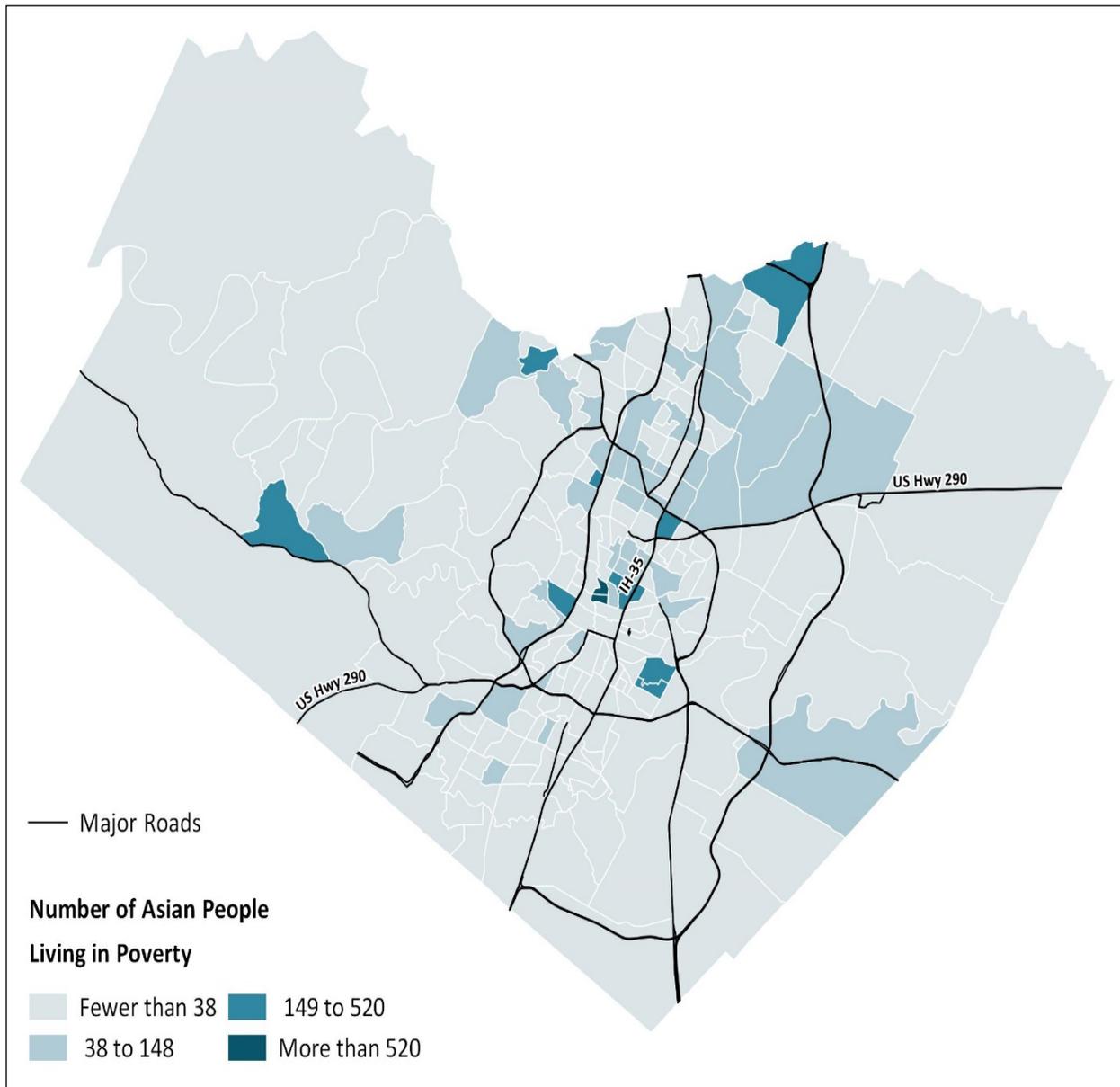
Map A3: African American People Living in Poverty, by Census Tract (2017)



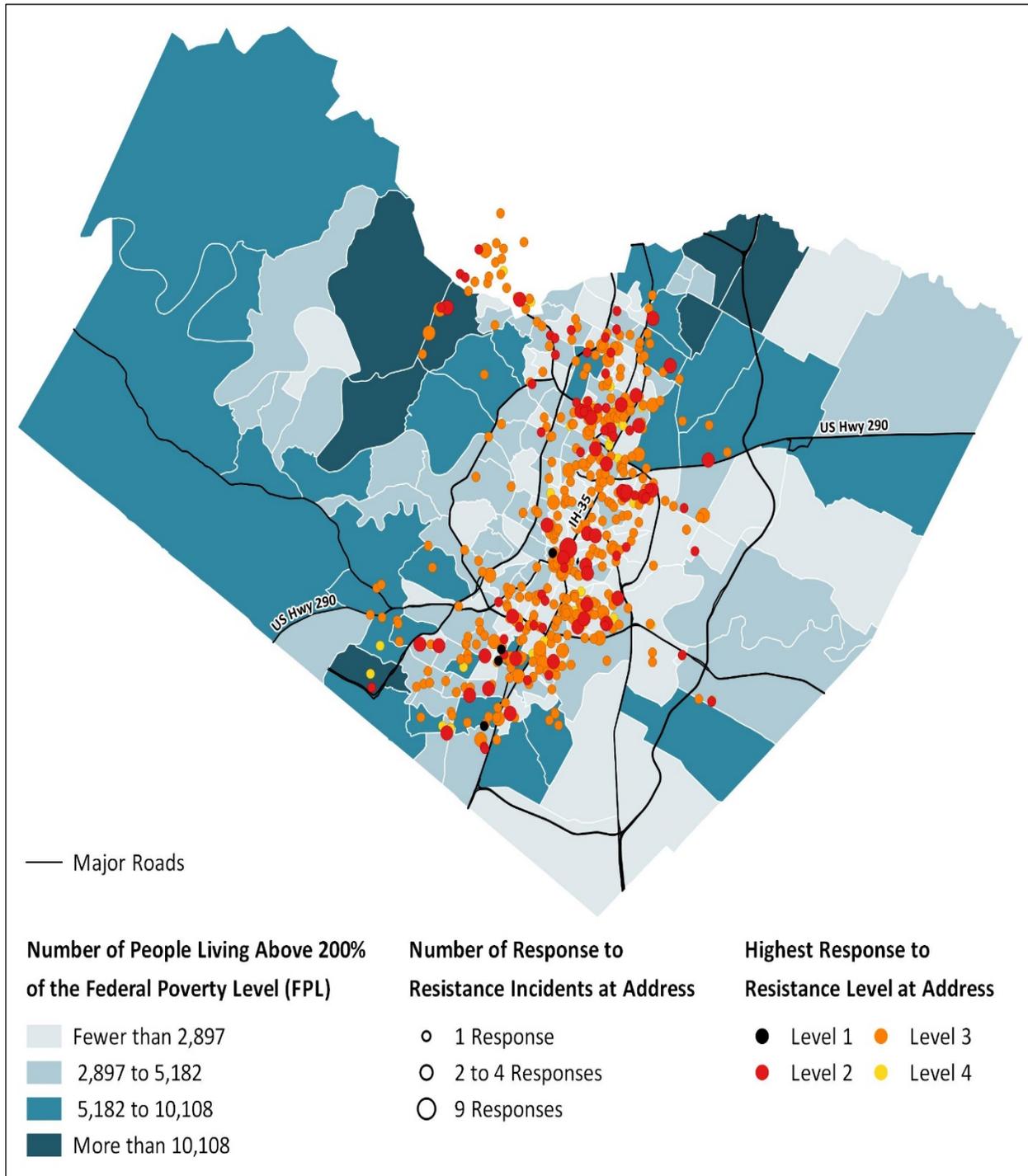
Map A4: Latino/Hispanic People Living in Poverty, by Census Tract (2017)



Map A5: Asian People Living in Poverty, by Census Tract (2017)



Map A6: All Response to Resistance, by Address (2016–2018) and People Living Above 200% FPL in 2017



Appendix F: Online Survey

A brief online survey, intended to take less than 10 minutes to access and complete, was administered through Survey Monkey to all stakeholder committee members. The survey questions were developed based on common themes generated through roundtable and small group discussions.

Question 1: What is your primary concern regarding Austin PD's MH or Crisis Response practices?

- Public Safety
- Reduction in Response to Resistance
- Connecting Persons to Care
- Reduction in Number of Crisis Calls Per Year

Question 2: When considering a program design for MH Crisis Response what is the most important element to you?

- Integrated Care/Medical and Behavioral Needs Assessed
- Health Care Professional Makes Contact During Crisis Episode
- Rapid Police Response
- Triage and Connection to Care at the Earliest Point Possible

Question 3: Is there a program in Austin that you believe is successful now yet not large enough/inadequate capacity to meet the need?

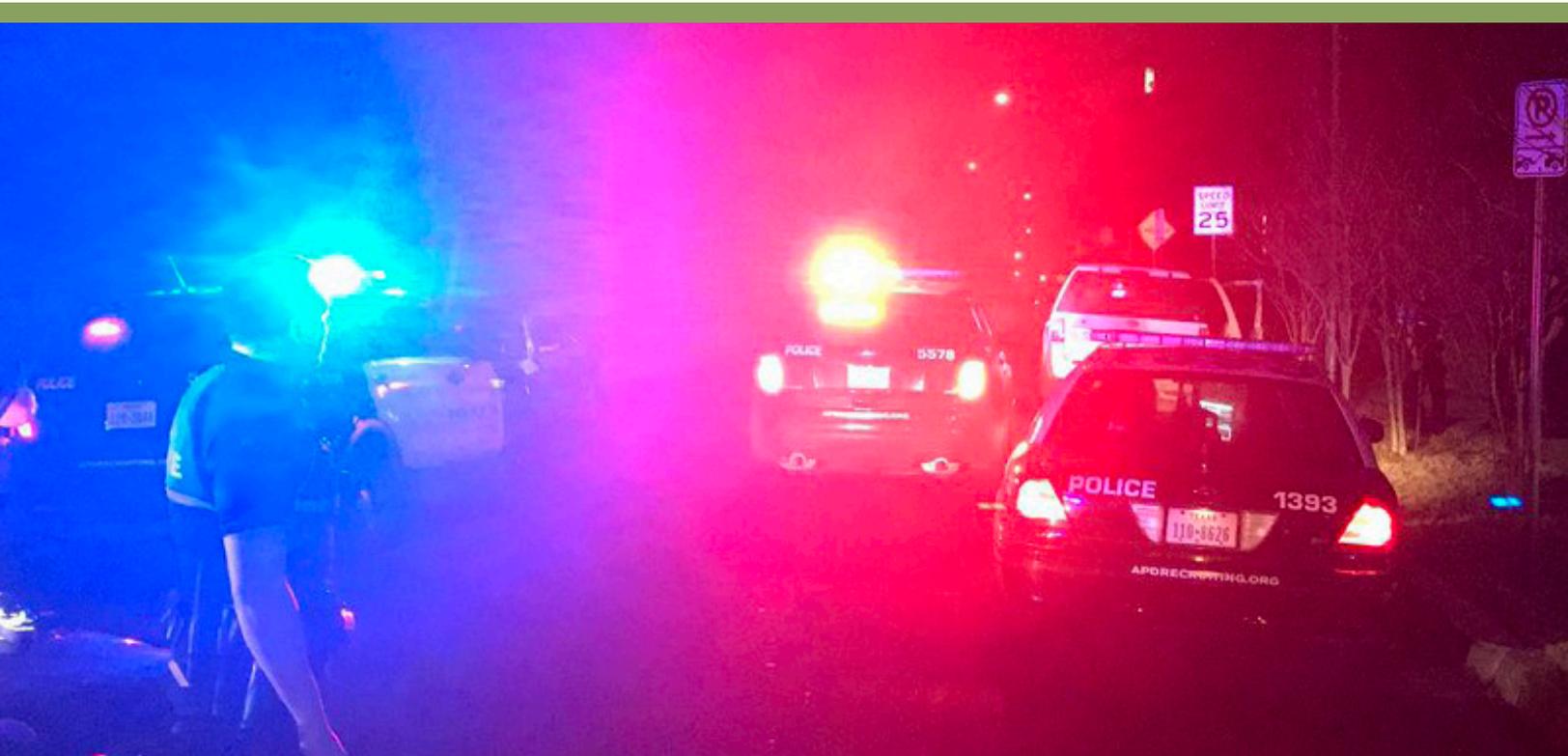
- Yes
- No

Free Text: If Yes, please list the name of the program and agency of operation.

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.

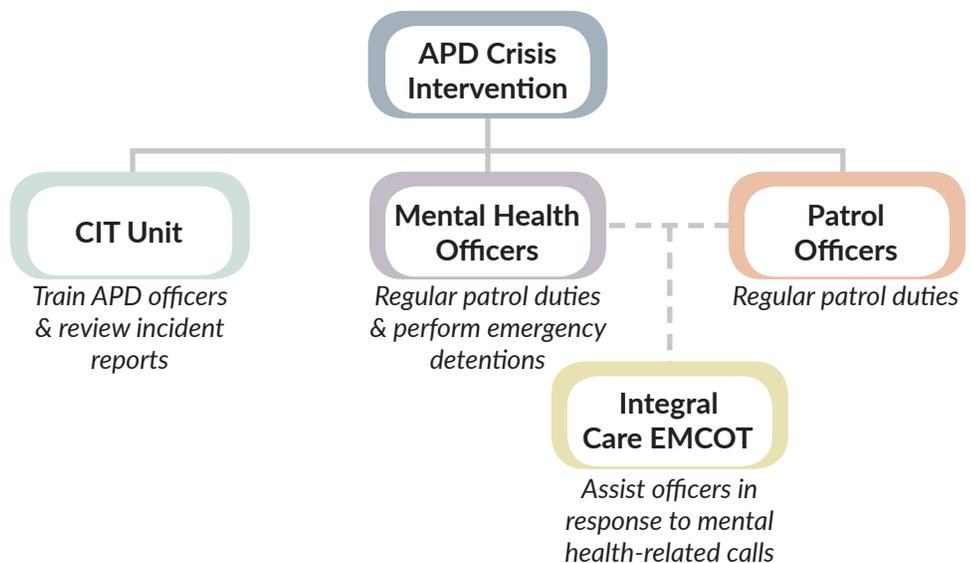
Background

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.

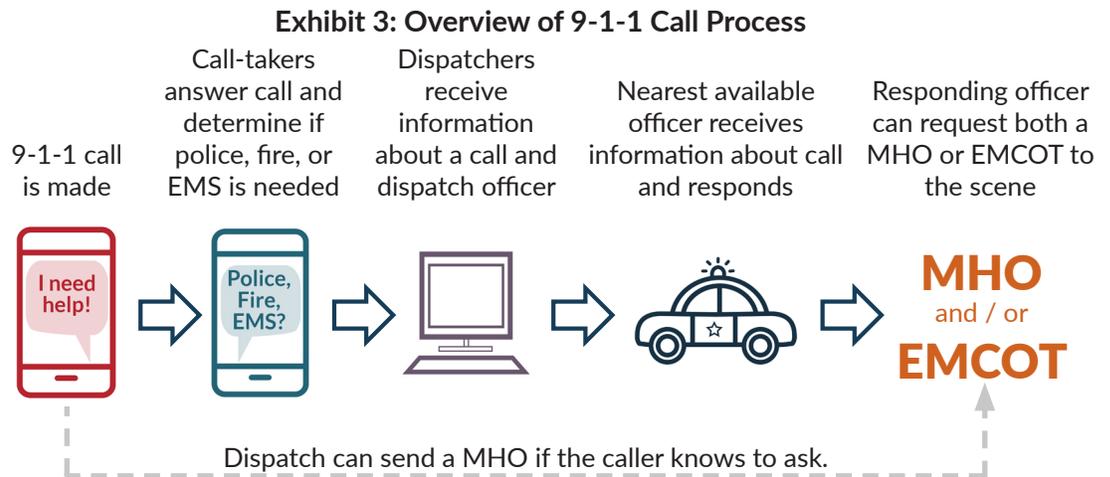
The best practice Core Elements recommend that the nearest CIT-certified officer be identified and dispatched to lead the response to a crisis event. Also, mental health professionals should receive referrals from the police.

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.



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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