Late Backup

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 training[1] 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 initiatied a collaborative Crisis Call Diversion (CCD) program in 2015 and, since that time, the program has demonstrated strong

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[1] 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 operations[2] 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 conections, 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.

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[2] 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.[3] 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.

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[3] For more information, see: http://www.harriscountycit.org/diversion/special-projects/

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.

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 data[4], 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

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[4] See Chart 1 and Chart 5.

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.