Bernalillo County Mobile Crisis Team Process Evaluation

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In this brief: This brief summarizes the evaluation of the Bernalillo County Mobile Crisis Teams (MCT). This includes how MCTs were dispatched, services provided on-scene, the status of referrals and follow-up services, and recommendations.

Highlights:

- MCT crisis interventions appear to be effective at immediate harm reduction.
- Between February 2018 and March 2020 MCTs were dispatched to almost 5,000 calls for service.
- MCTs averaged 3.1 dispatches per shift and arrived on scene to an average of 2.5 calls per shift.
- Almost 30% of calls were cancelled and for 19% of dispatched calls, MCT was unable to locate the potential client.
- Client follow-up and case management could make it possible to reach MCT goals focused on reduced contacts with the criminal justice system and medical systems and improvements in clients.
- During the time of the study there were 4 APD and 2 BCSO MCTs.
- The Bernalillo County MCTs are APD Officers and BCSO Deputies paired with licensed independent clinicians from HopeWorks.

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Introduction

Mobile Crisis Teams (MCTs) in Bernalillo County have been in the field since late February 2018. The Bernalillo County Sheriff's Office (BCSO) and Albuquerque Police Department (APD) implement a co-responder model for mobile crisis response: 911 calls with a mental health component are routed to 2-person teams comprised of a specially trained law enforcement officer and an independently licensed clinician from HopeWorks. From February 2018 to March 2020, MCTs were dispatched to almost 5,000 calls and clinicians assessed clients on more than 3,300 of those calls.

This report in brief summarizes the MCT Program Process Evaluation (June 2021). Information from multiple data sources were reviewed to show how the Bernalillo County MCTs are dispatched, how they function, what short-term outcomes they affect, and the long-term, systemic effects they might realize. The evaluation covers the program from its inception to the advent of the COVID-19 pandemic in New Mexico.

Background

In April 2015, the Bernalillo County Commission (BCC) hired Community Partners, Inc. (CPI) to develop a business plan for a regional, cohesive system of behavioral health care. Specific to mental health crisis intervention, CPI recommended the creation of a two-person civilian response teams consisting of, "a Licensed Mental Health Professional and a Behavioral Health Technician or Peer" and a uniformed law enforcement officer. In addition, the need for an MCT program is mentioned in a 2017 order to the *McClendon et al. v. City of Albuquerque* (McClendon) class action lawsuit filed in 1995 that resulted in a consent decree to address issues related to overcrowding in the Bernalillo County jail system. The issue of crisis intervention in encounters with APD Officers is an area of reform that is part of an ongoing court approved settlement agreement between the U.S. Department of Justice and the City of Albuquerque.

A voter approved non-sunsetting gross receipts tax (2015) funds the Bernalillo County Behavioral Health Initiative, including a portion of the MCT program as well as funds from the City of Albuquerque.

Mobile Crisis Teams

Generally, the goals of MCTs are: providing community-based services to stabilize persons experiencing emergencies in the least restrictive environment, to decrease arrests of mentally ill people in crisis, to reduce police officers' time handling psychiatric emergency situations (Scott, 2000), and to reduce hospitalization rates by diverting patients from hospital admission into community-based treatment (Guo et al., 2001).

There are multiple objectives for the co-responding police-mental health program including: de-escalating crises, preventing injuries to individuals in crisis and the response team, linking individuals who are experiencing psychiatric emergencies to appropriate services in the community, and reducing pressure on both the justice system (e.g. by decreasing arrests and officer's time involved with handling psychiatric emergency situations) as well as the health care system (e.g. by decreasing unnecessary visits to the emergency department) (Borum 2000; Matheson et al. 2005; Scott 2000).

These programs often aim to be accountable and cost effective as well. In general, however, there is limited literature on the effectiveness of co-responding models.

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- MCT members were appropriately credentialed for their roles.
- LEOs believed the training for their role was adequate; there was no consensus among the clinicians about the adequacy of their training.
- From dispatch to call clearance, an average MCT call lasted about 75 minutes.
- Behavioral Health and Suicide-Related CFS represent 47% of MCT en route calls.
- The most prevalent diagnosis for clients was schizophrenia spectrum disorder (13%); 38% of clients had multiple diagnoses.
- About 62% of clients were transported to psychiatric emergency departments for evaluation, 34% were left in the community and about 2% were arrested.
- MCT interactions with clients appeared to be consistent with many best practices for dealing with individuals experiencing a behavioral health crisis and with APD and BCSO guidelines.
- Client follow up and case management are underdeveloped aspects of the MCT program.

The Bernalillo County MCT Program

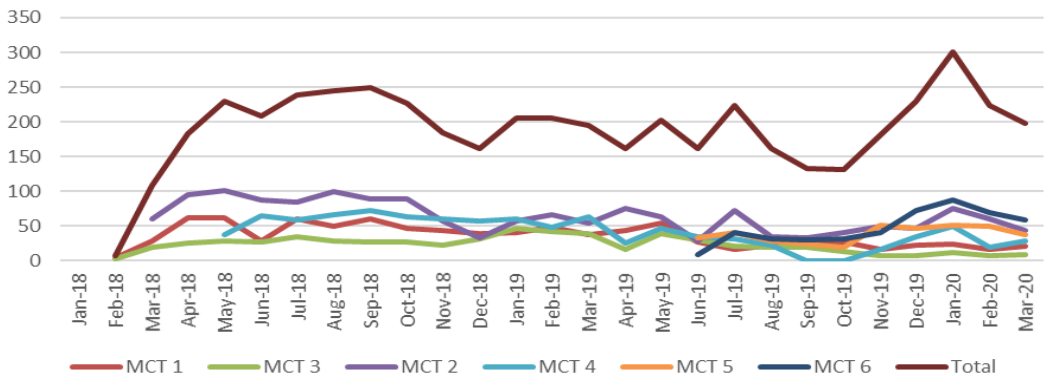
The Albuquerque Police Department provides specific guidance to APD officers for responding to individuals experiencing a behavioral health issue and/or crisis (APD SOP 2-19). This includes information on MCTs. The Bernalillo County Sheriff's Department has a similar policy for response to individuals in behavioral health crisis that does not explicitly reference MCTs.

The MCT program started with three teams and evolved to six teams. APD has four MCTs (MCT 2, MCT 4, MCT 5, and MCT 6) and BCSO has two MCTs (MCT 1 and MCT 3). Teams generally work 10 hour shifts, 4 days a week, covering hours from 8 a.m. to 10:00 p.m., every day of the week. The highest demand for MCTs occurs Monday through Thursday from 10 a.m. to 6 p.m.

MCT Deployment: Calls for Service

MCTs are dispatched through the City of Albuquerque Emergency Operations Center (EOC), the Bernalillo County Emergency Communications Department (ECD), or at the request of an officer or deputy in the field.

Figure 1:
MCT Total Dispatches and Team Dispatches by Month



METHODS AND DATA SOURCES

The study used a mixed-methods approach including qualitative and quantitative data. The evaluation is based on a synthesis of data from five sources, two have been collected by ISR CARA and three

Name	Source	Dates
Calls for Service (CFS)	APD & BCSO	February 2018*- March 2020
Clinician Forms	HopeWorks	February 2018*- March 2020
Ride-along Observations	ISR CARA	November 2018 –August 2019
MCT Member Survey	ISR CARA	October 2020

are from collaborating MCT agencies.

CFS data are generated ty the City of Albuquerque Emergency Operations Center and the Bernalillo County Emergency Communication. Through analysis of their timed tracking of call events from call start to clearance, CFS data provide insight into how MCTs were deployed.

Clinician Forms were generated by MCT clinicians for all CFS and include assessment and diagnosis information, the call referral source, and the call disposition.

Trained ISR CARA staff conducted 17 **ride-along observations** for which they characterized the call, described MCT member interactions, and described interactions with clients and others.

Past and active MCT members from law enforcement and HopeWorks were invited to participate in an **on-line survey.** Respondents were asked about their perceptions of the MCT program, working as a team, the behavioral health service continuum, recommendations for program improvement, and much more.

A human subject approval was obtained from the University of New Mexico Main Campus Institutional Review Board (IRB) prior to the collection of ride-along and survey data.

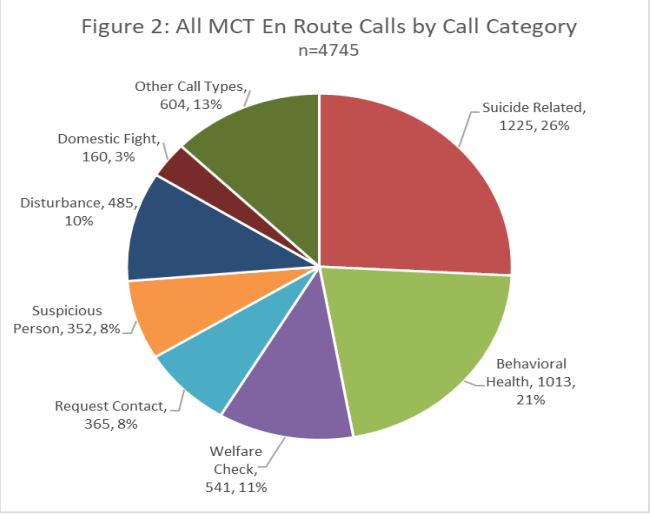
Communications personnel complete 20 hours of behavioral health training including suicide intervention, crisis management, and understanding the roles and functions of the various crisis intervention responders.

From the program's inception in February 2018 to the end of March 2020, MCTs were dispatched to 4,953 calls for service, 4,725 for which MCTs indicated they were en route (about 96% of calls dispatched,) and 3,960 noted an arrival on-scene time (about 80% of calls dispatched).

Figure 1 reports MCT total dispatches by team, month and year. The largest number of MCT CFS dispatches (300) occurred in January 2020. With the exception of MCT 2, most of the teams appear to have had a fairly consistent number of dispatches over time until around May 2019. From May 2019 through October 2019 there were fewer dispatched calls for all teams.

From dispatch to call clearance, an average MCT call lasted about 75 minutes. MCTs averaged 3.1 dispatches per shift and arrived on scene to an average of 2.5 calls per shift. Calls dispatched from an EOC accounted for 43% of total MCT CFS with field officers as the second largest referral source (36%).

There were 4,745 CFS with an en route time from February 2018-March 2020. Behavioral health and suicide-related calls accounted for almost half (47%) of these calls. Suicide-related calls represented slightly more than a quarter (26%) of MCT CFS. MCT calls to check on the



status of a person (i.e., welfare check, request for contact, suspicious person) made up 27% of the CFS. The disturbance category (10%) includes calls for loud music/ party, shots fired, aggravated driver, and panhandlers.

Domestic fight accounted for the smallest portion (3%) of the CFS. At 13%, the 'other call types' category is the third largest call category for MCTs; this catchall includes traffic stops, wanted persons, fights, and about 70 other call classifications.

CFS call types are law enforcement-based; clinicians categorized calls by chief complaint. Calls related to suicide were the single largest category in CFS (26%) and clinician datasets (41%). Psychosis (21%) and aggressive/ threatening behavior (14%) round out the top three chief complaints; they accounted for 75.2% of dispatched calls.

MCT On-Scene Service Delivery

Based on clinician records only about half of the dispatched calls resulted in a client assessment. Almost 30% of calls were cancelled and for 19% of dispatched calls, MCT was unable to locate the potential client. Officers invoked 43-1-10 on almost 10% of calls where no client was assessed versus less than 2% when MCT is involved.

Table 1: Clients Assessed

	Count	Percent
Assessed	1,670	50.3
Unassessed	1,649	49.7
Total	3,319	100.0

Clinician data suggest the majority of individuals were male (57%), non-Hispanic White (43%) or Hispanic (40%), and were between the ages of 25 and 54.

APD SOP 2-19 describes the expected services from MCTs, including: de-escalation, primary assessment, face-to-face crisis intervention, provision of referrals, and follow-up services. Ride-along observations and MCT member survey responses suggested call dispositions are affected by other CIT-trained officers who are on scene *before* the MCTs are allowed to engage the client. MCTs might further de-escalate clients and/or they might be instrumental in averting escalation, especially in cases of involuntary transport.

As reported by ISR observers, MCTs used a variety of methods for assessing the client's behavioral health crisis, including general mental health assessments. A majority of clients in a subsample of clinician records were diagnosed with multiple mental health issues (38%). Among those with multiple diagnoses, post-traumatic stress disorder was the most frequently noted, followed by depressive disorder and schizophrenia spectrum disorder. The most prevalent single diagnosis was schizophrenia spectrum disorder (13%).

Both agencies have SOPs with recommendations for responding to a mental health call including engaging with individuals in non-threatening and helpful ways. All APD officers and MCT members are required to complete basic CIT training (plus 8 hour enhanced training for MCTs).

ISR-CARA observers reported calm team member demeanors, quiet voices, and appropriate non-threatening physical distances. MCTs discussions with clients were often person-centered, considerate of client preferences in decision-making, built a sense of shared responsibility for plans and decisions, and established and reinforced client feelings of personal safety. Interactions with clients appeared to be consistent with many best practices for dealing with individuals experiencing a behavioral health crisis and with APD and BCSO guidelines. There did not appear to be an MCT protocol for client follow-up after a referrals. The provision of on-scene services by law enforcement and clinicians appears to have the greatest fidelity to the MCT model and best practices.

For most clients, their on-going assessment and diagnosis by the MCTs inform decisions about what happens to them at the end of the call for service. Because the clinician data is based on *dispatched calls for service,* not all of the recorded dispositions can be attributed to decisions made by the MCTs. Therefore, Table 3 presents the call dispositions only for clients contacted by the MCTs.

Table 3: Dispositions for Clients Contacted/Assessed

Disposition	Count	Percent
Left in the community	607	37.2
Transported CofE	623	38.2
Transported 43-1-10	122	7.5
Transported Voluntarily	176	10.8
Transported Medical	55	3.4
Arrested	29	1.8
Other/Unspecified	19	1.2
Total	1,631	100.0

For this group, almost 60% of calls were resolved with the client transported to an emergency department and 37% were left in the community. A majority of those transported went on the basis of a Certificate of Evaluation (CofE) with almost 8% transported based on a 43-1-10. Over the course of 25 months 29 people were arrested (1.8%).

Summary and Conclusion

Three major functional areas support the mission of the MCT program: delivering the MCTs to the people who need them; providing on-scene client services as interventions for people in behavioral health crises; and providing follow-up/case management services.

1. Over 25 months MCTs were dispatched to almost 5,000 calls for service. About 80% of CFS resulted in an MCT on-scene time for an average of 2.5 calls per team per shift. Half of the calls to which MCTs were dispatched did not result in client engagement. Improvement in the delivery of MCTs to potential clients requires integrated changes in SOPs, EOCs protocols, officer training, and the daily job descriptions for MCTs generally and for team members.
2. MCT members exhibited behaviors and practices in line with APD and BCSO SOPs for responding to people in mental health crisis.
3. Client follow-up and case management are underdeveloped aspects of the MCT program. Without them, "linkage to services" does not reach beyond the arrival of a client at an ER or the verbal or paper referral to community services. These are key aspects of the co-responder model and their absence decreases the likelihood of positive long-term client gains and desired system changes.

Currently, MCT crisis interventions appear to be effective at immediate harm reduction. Improving delivery of MCTs to potential clients will strengthen this effect. Without client follow-up and case management, the Bernalillo County MCT program is unlikely to reach its goals for long-term improvements in its client population or in the criminal justice, hospital, or social service systems. Absent stakeholder commitment to program improvements, expectations for the goals of the program may need adjustment.

RECOMMENDATIONS

1. Systematically plan for the future of the program. Develop a program theory with fully articulated and integrated processes and theories of change for clients and larger societal systems.
2. Align policies and procedures across law enforcement agencies for deployment of MCTS and MCT work expectations and standards; integrate MCTs into the suite of existing crisis intervention programs to maximize the use of its unique contributions.
3. Provide clear guidance to EOCs and law enforcement about the services MCTs provides and when it is appropriate to call an MCT. If necessary, explore 911 and dispatch triage models to establish best practices for these crucial allies.
4. Based on clearly articulated goals of the program, redesign administrative record-keeping for greater program accountability and effective management. This benefits the teams, agencies, and the community by setting expectations and providing transparent measurements of progress toward their attainment.

The UNM - Institute for Social Research Center for Applied Research and Analysis (ISR-CARA) is a leading provider of program evaluations and policy research in New Mexico. ISR-CARA staff members and faculty affiliates also have expertise in the fields of criminal justice, education, economics, substance abuse treatment programs, poverty and homelessness, domestic violence, employee workloads and staffing levels. For more information, please visit http://isr.unm.edu/centers/center-for-applied-research-and-analysis/index.html or call (505) 277-4257.

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