Bernalillo County Behavioral Health Initiative: Mobile Crisis Teams (MCT) Process Evaluation

Prepared by:

Amelia Murphy, Ph.D.
Paul Guerin, Ph.D.
Lexxus Salazar

Prepared for:

Bernalillo County Department of Behavioral Health Services

UNIVERSITY OF NEW MEXICO, INSTITUTE FOR SOCIAL RESEARCH
CENTER FOR APPLIED RESEARCH AND ANALYSIS
JUNE 2021

Table of Contents

Introduction

Mobile Crisis Teams (MCTs) in Bernalillo County have been in the field since the end of 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.

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).

This process evaluation synthesizes information from multiple data sources 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. Evaluations of MCT programs are challenging for a variety of reasons including a lack of consensus on desired outcomes and how to measure those outcomes. We evaluate MCT performance based on current MCT literature, national standards and best practices, and the organizational expectations for the program.

Bernalillo County

Bernalillo County is located in New Mexico and encompasses the City of Albuquerque and the Villages of Tijeras and Los Ranchos de Albuquerque. Bernalillo County is about 1,167 square miles with Albuquerque (189 square miles) situated in the center. Bernalillo County had an estimated 679,121 residents in 2019 (US Census, 2020), and is primarily served by two law enforcement agencies, the Albuquerque Police Department (APD) and the Bernalillo County Sherriff's Office (BCSO). However, 83% (560,513) of the population resides in the City of Albuquerque that is predominately served by APD. BCSO primarily serves the 17% of the population that is scattered across the remaining 978 square miles surrounding the City. Although they have separate command structures, communications and dispatch systems, and Standard Operating Procedures (SOPs), the two law enforcement departments work across jurisdictional boundaries.

HopeWorks provides an array of services for Albuquerque's homeless population including behavioral health services, housing, a day shelter, and employment services. They provide the masters-level clinicians for the MCT program (see https://www.hopeworksnm.org/mct-2-0/).

Mental Health

The deinstitutionalization that occurred from the mid-50s through the 80s resulted in reduced access to services for people with severe mental illnesses. Homelessness and criminalization of a portion of this population are unintended consequences that effect health care, police, and support services (Lamb and Bachrach, 2001). Estimates of the prevalence of mental health issues present a piecemeal portrait of New Mexico, Bernalillo County, and Albuquerque.

At the state level, the Treatment Advocacy Center estimated the prevalence of severe mental illness in New Mexico at approximately 3.3% (TAC, 2017). The 2019 Behavioral Risk Factor Surveillance System Annual Report found that 14.5% of adult New Mexicans reported frequent mental distress (Whiteside, 2019, p. 3). The 2019 National Survey on Drug Use and Health looked at mental health service use among adults in New Mexico and found, "the prevalence of past-year mental health service among those with any mental illness was 43.6%." (SAMHSA, 2020, p33).

New Mexico's Indicator-Based Information System (NM-IBIS) states that 23.1% of adults in Bernalillo County reported mental distress lasting more than 6 days in 2016 (NM-IBIS, 2017a). From 2013 -2017, NM-IBIS reports 20.8 annual deaths by suicide per 100,000 population (NM-IBIS, 2017b). The 2012 National Survey on Drug Use and Health Report: Metro Brief focused on the Albuquerque SMA found that the annual average of adults experiencing a major depressive episode[1] was 6.6% from 2005-2010 (SAMHSA, 2012, p.5) On average, approximately 45% of the population in the Bernalillo County Metropolitan Detention Center (MDC) are clients in the Psychiatric Services Unit (PSU) with approximately 20% of those inmates having an serious mental illness diagnosis.

The Bernalillo County Behavioral Health Initiative (BHI)

In February 2015, the Bernalillo County Board of Commission (BCBC) and voters approved a new 1/8 cent, non-sunsetting gross receipts tax (GRT) to develop a unified and coordinated behavioral health system in the County and to improve access to care in Bernalillo County. This tax is expected to generate up to $17 million per year (CPI, 2016). These tax monies fund the Bernalillo County Behavioral Health Initiative (BHI), a series of programs to improve behavioral health outcomes in the community: the MCT program receives funding from this source and from the City of Albuquerque.

In April 2015, the BCC hired Community Partners, Inc. (CPI) to provide consultation and develop a business plan for a regional, cohesive system of behavioral health care. CPI assessed the behavioral health care delivery system and recommended a governing board structure and planning process that resulted in a comprehensive regional behavioral health business plan. With guidance from the community and governing board, the County began implementing the approved service components, including research and evaluation focused on the implementation and impact/outcomes of programs funded by the GRT.

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, [who] can provide a range of services, such as initial triage and assessment, crisis intervention, brief stabilization, and transportation of the person to the facility providing the most appropriate level of care"(2015, pg. 23). CPI based its recommendation, in part, on BCSO administrative data, estimating that an average of 128 calls for service per month

[1] For this study, "major depressive episode is defined in DSM-IV (APA) as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest of pleasure in daylily activities and had a majority of specified depression symptoms (SAMSHA, 2012, p 5).

were being responded to by law enforcement or fire fighters that should be diverted to a special mobile crisis response team.

In addition to being proposed in the CPI plan, 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. McClendon included all inmates and certified a subclass of "all persons with mental and/or developmental disabilities who are now, or in the future may be, detained at BCDC". The lawsuit involves treatment of detainees in the local jail as well as the causes of overcrowding including arrest practices involving APD and BCSO for subclass members. As part of the 2017 order the City Defendants were required to "…continue to collaborate in good faith with Bernalillo County in the development of and funding for mobile crisis teams to respond to mental health crisis calls, including alleged threats of suicide, self-harm or welfare checks, where appropriate. *(CIV 95-24 JAP/KBM 2017, p.6)* The order further stated that implementation of the program would be at the discretion of the City and County, contingent on appropriation of funds from the City.

The issue of crisis intervention in encounters with APD officers is also one of nine areas of reform that are part of an ongoing court approved settlement agreement (CASA) between the U.S. Department of Justice (DOJ) and the City of Albuquerque. In November 2012 the U.S. Department of Justice began an investigation into APD's policies and practices to determine whether APD engaged in a "pattern or practice of use of excessive force". This investigation resulted in a findings letter in April 2014 and a finalized CASA in June 2015. The settlement agreement included more than 300 policy and operational changes that cover nine areas of reform including crisis intervention. As part the crisis intervention reform APD provides 40 hours of basic crisis intervention training (CIT) in addition to state-mandated basic behavioral health training. APD has also developed an 8-hour enhanced CIT (eCIT) advanced training for volunteering officers. While MCT is not mentioned in the CASA, it falls within the crisis intervention reform area.

Ultimately, the County's Department of Behavioral Health Services (DBHS) determined that the MCT program would follow the law enforcement co-responder model with a specially trained law enforcement officer (LEO) paired with a licensed independent clinician. Working with the City of Albuquerque, the DBHS facilitated a collaboration between APD, BCSO, and the behavioral health provider HopeWorks (HW) to create the Bernalillo County Mobile Crisis Team program.

The MCT program was implemented in February 2018 with two MCTs and expanded to six teams by August 2019. During the time period covered in this study, the County and City jointly funded a maximum of six MCT teams serving all six APD area commands and the three BCSO area commands. Two teams have Bernalillo County sheriff's deputies and four teams have police officers from APD, each one paired with a licensed independent clinician. APD MCTs are part of the APD's Crisis Intervention Section (CIS), which also houses Crisis Intervention Unit detectives (CIU) and Crisis Outreach and Support Teams members (COAST). These teams are considered part of APD's Crisis Intervention Team (CIT) Program (APD SOP 1-37-2, p.1) and

are coordinated by a CIS lieutenant. They share the mission of work to stabilize individuals and link them to support resources in the community, including treatment. Unique within the CIS, MCT uniformed police travel with a licensed clinician in a marked police vehicle in response to 911 calls.

This report includes a number of sections. Following this introduction we provide a brief review of relevant literature focused on co-responding police response models that include a law enforcement officer paired with a clinician. Next, we describe our methods and data sources that included calls for service data, ride-along observations, a survey of MCT team members, and MCT clinician encounter records. This is followed by a description of the MCT program in Bernalillo County. Then the report follows the flow of a typical MCT call: dispatch, on-scene, call disposition, and follow up. The last two sections summarize the findings and discuss the next steps in evaluating the longer-term outcomes and potential systemic impacts of the MCT program.

Literature

The number of interactions between police officers and individuals who experience a mental health crisis is high and increasing in North America (Cotton and Coleman 2010). Between 7% and 31% of police calls involve a person with mental illness (Abbot 2011; Baess 2005; Wilson-Bates 2008). The increase in police involvement with mental illness is reported to be due to a number of factors including de-institutionalization (i.e. more individuals with psychiatric issues residing within the community), fewer psychiatric hospitals and hospital beds, decreased hospitalization, and changes in mental health laws (Fisher et al. 2006; Lamb et al. 2002). In a 2014 survey of more than 15% of Albuquerque Police Department (APD) field officers, Tinney and Rosenbaum found that officers estimated that 33% of their calls "involved mental illness as the primary factor for causing the situation." (2015, p.2)

Historically, the standard law enforcement response to calls for service involving individuals experiencing a mental health crisis has been by law enforcement officers without any specialized mental health training. Beginning in the late 1960s, and more clearly with the advent of community-oriented policing (COP) in the 1980s, law enforcement agencies began applying COP principles to enhance their response to mental health crises in community settings. Law enforcement agencies applying COP principles focus on building partnerships between law enforcement agencies and local communities and residents and proactively identifying problems and developing innovative solutions. The successful application of COP principles also involves changes to traditional law enforcement organizational features that support community-oriented policing and problem solving. Law enforcement responses applying COP principles have broadly followed several models:

- Police-based specialized police response. This police response model typically involves law enforcement officers with special mental health training who serve as the front line police response to mental health crises within the community. These officers may also act as liaisons to the mental health system. Officers in this model are certified crisis

intervention team (CIT) officers or those who have had some CIT training but have not completed the 40 hour course.

- Police-based specialized mental health response. This police-based model utilizes mental health professionals who are employed by a law enforcement agency to provide on-site and/or telephone consultations to police officers in the field and more recently, pairs officers and clinicians as a co-responding team in the field. This includes MCTs.
- Mental-health-based specialized mental health response. The mental-health-based model consists of a response to certain types of calls by the local community mental health service system and operates independently of the police department.

MCTs in Bernalillo County are an example of a police-based specialized mental health response. A co-responding police-mental health program comprises a collaboration of specially trained police officers and mental healthcare workers that provide on-site services to consumers in the community. As noted by Forchuk (2010), one of the strengths of a joint response is that police are specialists in handling situations that involve violence and potential injury, while mental health professionals are specialists in providing mental health consultation to officers and mental health care to individuals in crisis. As Rosenbaum (2010) explains: these teams are based on the idea that the more police and mental health workers collaborate, the better the two systems can serve consumers and each other effectively. Helfgott et al (2016) evaluated the Seattle Police Department's co-responder model (a mental health professional (MPH) and a dedicated CIT officer) to understand the unique contributions of the MPH to the response. They hypothesized that the involvement of the MPH would reduce the amount of time to resolve cases, reduce repeat client contacts, and increase the number of calls ending with referrals to non-law enforcement resources as client disposition. Their descriptive evaluation found a substantial shift in workload from regular patrol officers their co-responding team.

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). Furthermore, these programs often aim to be accountable and cost effective.

Connecting individuals in crisis with community services, rather than the justice system or acute care services, is thought to be the most appropriate way to support consumers and prevent reoccurrence of a crisis and 'revolving-door' recidivism. Some research has evaluated this claim. Steadman et al. (2000) examined three sites' dispatch calls and found that in situations where a specialized response was present, the co-responding police mental health program in Knoxville had the largest proportion of referrals to treatment services compared to the other models (36%, compared to 0% in Memphis's CIT model, and 3% in Birmingham's program whereby civilian

officers assist police officers in mental health crises). When the co-responding police- mental health program in Knoxville responded to a mental health crisis, they were more likely to refer an individual to case managers, mental health centers, or outpatient treatment, compared to the other two specialized models. This is not an isolated finding. In 2010, Kisely et al. found that individuals who had been in contact with the co-responding police-mental health program in Halifax showed greater service engagement than control subjects, as demonstrated by increased outpatient contacts.

A study by Lee et al. (2015) evaluated the referral activities of an Australian joint police-mental health mobile response unit (A-PACER), which was designed to improve the delivery of a community-based crisis response. Activity data were audited to demonstrate utilization and outcomes for referred people. Police officers and mental health clinicians in the catchment area were also surveyed to measure the unit's perceived impact. During the 6-month pilot, 296 contacts involving the unit occurred. Threatened suicide (33%), welfare concerns (22%) and psychotic episodes (18%) were the most common reasons for referral. The responses comprised direct admission to a psychiatric unit for 11% of contacts, transportation to a hospital emergency department for 32% of contacts, and community management for the remainder (57%). Police officers were highly supportive of the model and reported having observed benefits of the unit for consumers and police and improved collaboration between services (Lee et al. 2015).

In general, there is limited literature on the effectiveness of co-responding models. A systematic review of co-responder models of police mental health street triage by Puntis, et al. (2018) found that while this is an increasingly more common type of response to police calls for service with a suspected mental health component, there is a lack of research to determine the effectiveness of these programs or information about the outcomes for users of these services. Puntis, et al also found wide variation in how these programs are implemented (i.e. hours of operation, staffing, and how they respond to calls for service). A more recent systematic review and meta-analysis by Seo, Kim, and Kruis (2021) found that the three categories of police response models (CIT, co-response, and other models with reduced training hours), while all moderately effective for processing incidents, varied depending on the type of response model and the outcome of interest, such as time spent on scene, arrest, diversion, and use of force. The meta-analysis also found most research has been conducted on CIT.

The Bernalillo County MCT model includes the CIT and ECIT trained law enforcement personnel. CIT is a 40-hour intensive course conducted in collaboration with community behavioral health providers, mental health advocates, and people with lived experience. Police officers learn to recognize symptoms of mental illness and co-occurring disorders, how to interact with individuals experiencing behavioral health illness, and how to understand perspectives of individuals who have lived with mental illness (Dempsey et al., 2019).The course covers topics such as mental health and addiction, civil commitment laws, dealing with special populations, and local resources. Officers also build empathy, learn new communication skills, and learn techniques to de-escalate situations with people in mental health crisis. The use of

scenarios is meant to reinforce concepts and skills through practical application and builds relationships with community mental health providers and other officers (Usher et al. 2019).

In their review of research on CIT, Watson, et al. (2017) concluded that there was substantial research to support the positive effects of CIT on cognitive and attitudinal outcomes for law enforcement, including knowledge, attitudes, and self-efficacy in dealing with people exhibiting a wide range of mental and behavioral issues. Research associated with the effects of CIT training on officer behaviors, outcomes for the subjects, the agency, and community levels, was mixed. Krider et al (2020) make explicit the link between CIT and the co-responder model in their report on the variety of co-responder models available for city and county leadership to consider. "As a precursor to the co-responder model, the Crisis Intervention Team (CIT) program provides a strong foundation for law enforcement's response to individuals experiencing a behavioral health crisis." (p.4, 2020)

Government agencies, academic institutions, businesses, and organizations have all contributed the literature on mobile crisis response to people experiencing mental health crises. These sources provide guidance for best practices and implementation insights in areas from program development to the evaluation of crisis response teams. The reports below helped structure our primary data collection tools and inform the interpretation of evaluation findings.

In *Practice Guidelines: Core Elements in Responding to Mental Health Crises (*2009) an expert panel from the Substance Abuse and Mental Health Services Administration (SAMHSA) details the essential values underlying appropriate mental health crisis response. Examples are shared responsibility for problem-solving between the responder and client, and the establishment of feelings of personal safety. Given the dearth of literature on co-responder – client interactions, these values provide structure for assessing the observations of officer and clinician on-scene behaviors.

In 2018, the Indiana University Public Policy Institute Center for Criminal Justice Research published a mixed methods evaluation report on the implementation of the Indianapolis Mobile Crisis Assistance Teams (MCAT). MCAT was a three person co-responder model with teams that included police, clinicians and paramedics. Bailey, et al, (2018) incorporated focus groups, interviews, field observation, surveys, and analysis of MCAT response data to describe the implementation and performance of the MCATs. They derived program barriers (e.g. lack of clear policies) and facilitators (e.g., agency buy-in) from interviews with stakeholders and focus groups with the MCAT personnel. Researchers also examined call data for patterns in MCAT responses, call dispositions, and several other outcomes.

National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit (SAMHSA 2020) sets mobile crisis response in a framework of crisis systems of care. Crucial structural elements for the system include: crisis call centers coordinating in real time; centrally deployed, 24/7 mobile crisis response; 23-hour crisis receiving and stabilization resources; and principles to guide responder-client interactions. Essential principles include addressing recovery needs, the role of peers, and care that promotes safety and security for responders and clients. Although their response team exemplar is clinician-based, their minimum expectations are useful for any

mental health crisis response team: include a licensed/credential clinician for assessment; respond to people wherever they are and at any time there is a need; and conduct warm hand-offs for connections to facility-based care. Their best practices for MCT service delivery include the incorporation of peers; responding without law enforcement when practicable; GPS-based tracking to coordinate resources efficiently; and the scheduling of client follow ups to support ongoing care (p. 18.)

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 MCT. The Bernalillo County Sheriff's Department has a similar policy for response to individual in behavioral health crisis but does not have a specific MCT policy. APD's SOP 2-19 places in policy how this co-responder model should be implemented and is one point of comparison to determine the program's fidelity. Accordingly:

> *A Mobile Crisis Team (MCT) is a two-person unit comprised of mental health professionals who work with ECIT (Enhanced Crisis Intervention Team) officers and are responsible for responding to priority calls with a behavioral health component. They provide immediate behavioral health services once the scene is secure. MCTs are trained to complement the ECIT and CIU (Crisis Intervention Unit).* APD SOP 2-19-3-N.

Four major sections of *APD SOP 2-19* are of particular interest for this evaluation: Mobile Crisis Team responsibilities (*2-19-9 A.2*) lists the general responsibilities for MCTs; *Dispatch and calls* (*2-19-9 A.4*) discusses when and how MCTs should be dispatched and how they coordinate with other officers; *Services* (*2-19-9 A.5*) details the duties and expectations for the MCT clinician; and in *Referrals (2-19-9 A.6)* the SOP addresses certificates of evaluation, other community referrals and client follow-up. We use this policy as a guide for how the Bernalillo County MCTs should operate. Because Bernalillo County Sheriff's Office does not have a similar policy we apply the portions of the policy to all the MCTs. Bailey et al. (2018) found that flexible and formal policies and procedures facilitated successful co-responder MCT program implementation.

About this Process Evaluation

The time frame for this process evaluation is February 2018 through March 2020, covering the MCT program from its inception to the beginning of the coronavirus (COVID-19) in New Mexico. The first COVID-19 cases were confirmed on March 11, 2020, and on March 23, 2020, Governor Michelle Lujan Grisham issued a stay-at-home order for non-essential workers[2]. The effects of the public health restrictions and policing challenges related to the pandemic are not yet fully understood. For these reasons, our process evaluation covers the pre-COVID-19 time period. An outcome evaluation of the MCT program (forthcoming) will include a discussion of the effects of COVID-19 on the MCT program and the communities it serves.

Methods and Data Sources

No single source of data can provide an adequate understanding of the processes involved in the MCT program. This evaluation is based on five data sources, two have been collected by ISR CARA and three are from the collaborating MCT agencies. ISR CARA observation data are

[2] From: https://www.krqe.com/health/coronavirus-resources/timeline-coronavirus-in-new-mexico/

from ride-alongs with MCTs; the survey data is from a 2020 on-line survey of MCT members. Both law enforcement agencies provided call for service data (CFS) and the clinician forms are from HopeWorks. All of these sources acquire, store and process their data differently. Although this leads to complexities in comparability and interpretation, information from multiple sources provides a more nuanced understanding of some of the MCTs administrative processes and human interactions. Table 1 delineates the data sources and collection time frames. Individual data sources are described below.

Table 1: Data Sources

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 Survey	ISR CARA	October 2020

* MCTs 1 and 3 started taking calls February 26, 2018. Over three days they were dispatched to five calls.

Calls for Service

CFS data provides insight into how MCTs were deployed. APD and BCSO provide monthly CFS data to the ISR CARA. The data are generated by the City of Albuquerque Emergency Operations Center (EEOC) and the Bernalillo County Emergency Communications (BCEC). The files are merged so all MCT CFS in Bernalillo County are represented. Technical reports for DBHS and the MCT leadership team often report CFS information by MCT number. In addition to the time notations listed in Table 2, these records include: location; call type; and more specific geographic information.

Table 2: Call for Service Progression Time Notations

Notation	**Defined**
Start	The call for service is logged by Emergency Communications (EC).
Dispatch	The MCT unit is requested or assigned to go to the scene of the call for service.
En route	The MCT unit begins travel to the scene of the call for service.
Arrival on scene	The MCT unit arrives at the scene of the call for service.
Clear	The MCT is cleared to leave the scene and resume taking calls for service.
Total Time	This is the total time of the call for service from dispatch to call clearance. .

Data Limitations

A number of structural and administrative issues affect data quality and reliability. These limitations are not unusual for these types of studies. First, BCSO and APD have different communication systems, command structures, and policies and procedures. Second, the two agencies use different 10-codes for categorizing calls and different definitions of call dispositions. Third, cross-jurisdictional differences in communication systems affects call data when MCTs were dispatched to the other agencies' area commands specifically, how on-scene and call clearance times were logged. Fourth, how teams were dispatched and how teams responded to MCT calls varied by agency.

Clinician Forms

In general, clinician forms were generated for all CFS, whether or not there was client contact or assessment. The assessment forms were client-centered for the purpose of diagnosis and treatment but also included some data similar to the CFS data, including dispatch time, call start and call end times, and call duration in minutes. These forms include: contact type, demographics, referral source, the chief complaint that initiated the call, diagnosis, and call disposition. These forms round out our understanding of the situation, the clients and their issues, and resolution of MCT's crisis response.

Data Limitations

The forms and the data collected changed over time to better suit the needs of the clinicians in the field and measurement of program outcomes. A major revision of the assessment form occurred in spring 2019 when they added their Mental Status Exam and the Columbia-Suicide Severity Rating Scales (C-SSRS). Other changes included how client contacts and assessments were noted, and the way call disposition was recorded.

Table 3 shows the number of records collected under the original and revised forms, the time periods in which they were used and the number of records in each file source. Note the overlap in dates as both forms were used as they transitioned from the original to revised form. When possible variables collected under more than one coding scheme over time (e.g., age changed from ranges to a number of years old, call disposition went from a verbatim response to binary choices for the individual disposition options), were standardized for analysis with the goal of minimizing data loss. Due to these changes, some data is not available for the full study period. This is noted in the analyses.

Table 3: Clinician Data Collection Forms, Dates of Use and Number of Records

Form Number of Records	Source File	Time Period Used	Count	Percent
Original 1,852	2018	February 2018 - December 2018	1,051	31.7
	2019	January 2019- May 14, 2019	801	24.1
Revised 1,467	Assessed	May 1, 2019 –March 31, 2020	689	20.8
	Unassessed	May 1, 2019 –March 31, 2020	778	23.4
			3,319	100.0

Ride-along Observations

Trained ISR observers conducted 28 ride-along observations with MCTs between November 2018 and September 2019. The first 11 observations (10 with APD, 1 with BCSO) occurred from November 12, 2018 to February 11, 2019 and were exploratory: they aided in the refinement of the observation forms and provided training opportunities for observers. The effective date for IRB-approved data collection was February 25, 2019. Seventeen ride-along observations (10 with BCSO and 7 with APD) were conducted through August 20, 2019, covering 41 calls for service, 24 of which resulted in MCT/Client interactions. Table 4 provides information about the numbers of shifts and dispatches observed with each LE agency.

Table 4: Ride-along Observations by MCT Organization

	APD	BCSO	All
Observed Shifts	7	10	17
Total Number of Dispatched CFS	27	14	41
Range	2-5 Calls/Shift	0-3 Calls/Shift	0-5 Calls/Shift
Mean Number of CFS per Shift	3.9	1.4	2.4

Observers collected data using two different semi-structured observation forms. There was an observation form for calls for service and another form to capture interactions *between* calls for service. The observation form included information that characterized the call (i.e., time on scene, location, scene description, etc.), described MCT member interactions, and team interactions with clients and other officers. The shift form was a chronological record of what was happening when MCTs were not on an active call – the times before, between, and after calls – when paperwork, lunch, and team interactions were noted.

Preliminary findings were presented as part of an evaluation update presented by DBHS to the Bernalillo County Board of Commissioners (BCBC) on August 25, 2020 and as a brief report of evaluation takeaways for training and discussion on June 27, 2020. This report integrates and elaborates on these findings to provide a more detailed review of MCT implementation.

Data Limitations

The observations included every MCT for BCSO and APD, occurred on every day of the week but were based on convenience rather than a systematic sample of teams and dates. In the field, there were occasionally circumstances that made it difficult for the observers to hear or see the full interaction between an MCT and the client. The observations are a qualitative complement to, and best understood in the context of, the CFS and clinician forms. The observation findings are not generalizable to all MCT calls for service.

Survey of MCT Members

UNM ISR conducted an online survey in October 2020. Fifteen current and former MCT members were invited to participate: six law enforcement members from the APD and BCSO, and nine independently licensed clinicians (current and former) from HopeWorks. Nine team members completed the survey, a 60% response rate. The survey included questions about: team member training and work week; interactions with other first responders; working as a team; their perceived effectiveness; suggestions for program effectiveness; and many more. The perspectives of law enforcement officers and clinicians are distinguished where appropriate. To preserve the confidentiality of survey respondents results are presented in aggregate. This information cannot be generalized to the entire team. Please see Appendix B for the survey instrument.

Data Synthesis

These five data sources are complementary and provide unique contributions to the evaluation and different perspectives on the same topic. CFS data provide information about how MCTs are

deployed. Clinician data gives us a portrait of the individuals MCTs have encountered, and provide a source of call dispositions. Data from the ride-along observations offer another perspective of how the MCTs function in the field from trained observers. From the perspective of staff, we have a survey of MCT members who answered questions about their activities, how they were dispatched, how they see their teams working, and their views of the program.

Bernalillo County Mobile Crisis Teams

When fully staffed there are 12 current MCT members, six independently licensed clinicians from HopeWorks, four Albuquerque Police Officers and two Bernalillo County Sheriff's Deputies. All LEOs have 40 hours of CIT training and have participated in an 8-hour Enhanced CIT training. All the Clinicians are Licensed Clinical Professional Counselors (LPCCs), which is a licensure based on a master's or doctoral degree in counseling, an internship, and 3,000 hours of supervision.

The 2020 survey included questions about additional training, time on the job, other work-related issues, and demographic questions. As stated above, to preserve the confidentiality of MCT members, many of the findings are summary statements about their responses to the survey, indicating the answers of the majority only. Because not all team members participated in the survey, this report will not cover potentially identifying information including sex and to which law enforcement agency respondents belong. Some findings explore the differences between the perceptions of clinical and law enforcement team members.

Select Demographics and Training

The average age of respondents was 36 years. LEOs reported working in their professions for an average of just over eight years (8.3) and clinicians reported more almost 9.5 years. LEOs had worked with their agencies for most of their law enforcement professions and the clinicians averaged about two years working for HopeWorks. In addition to the training and licensure appropriate to their team roles, the majority of survey respondents had some advanced crisis-related training.

The 2020 survey asked MCT members to indicate their level of agreement with the statement, "I was adequately trained for my role in MCT." The majority of LEOs strongly agreed with the statement about the adequacy of their training. Clinician's responses ran the full gamut of the 5-point scale from strongly disagree to strongly agree. When asked about *each other's training*, LEO survey respondents all strongly agreed with the statement, "I believe my partner was adequately trained to perform his/her role in MCT." Clinicians had widely differing views of their LEO partners, with a slight majority disagreeing that the LEO training was adequate and the minority strongly agreeing their partners were adequately trained for their MCT roles.

Work Schedules and Work Days

One recommendation for effective mobile crisis team program is 24/7 availability of the MCTs. (SAMHSA, 2020) The Bernalillo County MCT program has based MCT schedules on the potential demand for the four call types that make up a small majority of calls for service to which teams are dispatched. The MCTs 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. APD updates the work schedules periodically, considering the distribution of behavioral health and suicide calls for service by day of the week and time of day. ISR CARA has provided this information as part of technical support for the MCT program.

APD has four MCTs (MCT 2, MCT 4, MCT 5, and MCT 6) and BCSO has two MCTs (MCT 1 and MCT 3). These teams came online at different times during the reporting period and have different work schedules. Table 5 reports the work schedule for each team at the time of this report including the time and days of the week they work from February 2018 to March 2020. Both BCSO teams started in February 2018 while APD's MCT 2 started a month later in March 2018, MCT 4 began work in May 2018, and MCT 5 and 6 began officially working in June 2019. There are at least two teams scheduled to work each day and teams typically begin work in the late morning to the early afternoon and work into the evening hours.

Table 5: Working Times by MCT

Team	Department	Beginning Month	Shift	Days of the Week
MCT 1	BCSO	February 2018	10 a.m. - 8 p.m.	Monday - Thursday
MCT 3		February 2018	1 p.m. - 11p.m.	Wednesday - Saturday
MCT 2	APD	March 2018	11 a.m. - 9 p.m.	Monday - Thursday
MCT 4		May 2018	12 p.m. - 10 p.m.	Thursday - Sunday
MCT 5		June 2019	10 a.m. - 8 p.m.	Wednesday – Saturday
MCT 6		June 2019	10 a.m. - 8 p.m.	Sunday - Wednesday

Table 6 reports additional detail on the days of the week each MCT team works. MCTs typically work four days a week on ten-hour shifts. Days worked are indicated as gray cells. MCT 1 and MCT 2 work on the same days (Monday – Thursday), MCT 3 works Wednesday through Saturday, MCT 4 works Thursday through Sunday, MCT 5 works Wednesday through Saturday, and MCT 6 works Sunday through Wednesday. Most teams work on Wednesday and Thursday (5), and Saturday and Sunday have the least teams working (2).

Table 6: Work Schedule for MCTs by Team and Day

Team	Department	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
MCT 1	BCSO							
MCT 3								
MCT 2	APD							
MCT 4								
MCT 5								
MCT 6								

Although MCTs work 10 hour shifts, not all of that time is spent with clients. There are meetings and paperwork, and the time that occurs between when a call is completed and when a team is dispatched to another call. Ride-along observers noted that the predominant activity during non-active call time was paperwork. Clinicians and officers alike have reporting requirements

specific to their organizations. Grumbling about the amount of paperwork and general commiserating were familiar themes in the observation notes.

Respondents to the 2020 survey were asked to estimate how many hours they worked in an average week and how much of that time was taken up by various tasks. The results are summarized in Table 7

Table 7: Average MCT Time Allocation per Week by Task, 2020 Survey

	LEO		Clinician	
Hours worked per week	40		41	
Averaged weekly time spent on…	Hours	Range	Hours	Range
Calls for service	26.7	20-40	14.4	8-25
Paperwork	10.0	na	3.8	2-10
Client follow-up	3.3	0-5	2.2	1-5
MCT specific meeting or trainings	2.7	1-5	2.2	1-5
Total	42.7		22.6	

Given that hours spent on these four MCT activities did not equal the reported number of average hours worked (LEOs 40 hours per week, clinicians 41 hours per week), it appears there were other clinician-specific activities or tasks that were not included in this set of questions. LEOs reported that an average of 30 hours a month (6.8 hours a week) of their MCT hours were superseded by non-MCT work tasks (e.g., court, SWAT duties.) For clinicians, the average was about 1.9 hours a week. Adding those hours to their weekly totals accounts for about 49.5 hours of LEO time and about 25 hours of clinician's time.

While clinicians and LEOs were closely aligned in their perceptions of how much time is spent in MCT-specific meetings or trainings, the wide variation in reported time spent on MCT calls for service is surprising given that they are supposed to respond as teams. One consideration might be how the two groups conceptualize a call for service, including how cancelled calls, waiting at a hospital, and non-active call time are factored in to their estimates. CFS data will provide a more objective estimate of how much time was spent on calls. Observation data provided a third perspective on what occurred when MCTs were on the job.

As reported by ISR observers on ride-alongs, calls tended to last about 30 minutes on-scene with a few running longer than an hour, and time spent at the hospital was seldom more than 30 minutes. For the observed shifts, the average number of CFS was between 0 and 5 per shift, with *days where there were no calls* and some days with calls but no client contact. The observations also give us some insight into what happens in the time between call for service.

Observations of MCTs patrolling the city or county between calls were rare. This created an opportunity for small talk among team members about families, sports and hobbies, politics, etc. While on patrol and over occasional lunches together, multiple MCTs would discuss calls and clients, and share stories and perspectives. This also created opportunities for small talk about families, sports and hobbies, politics, etc. These events might have helped create rapport within and across teams. Observations from the first few ride-alongs indicated there was some informal

cross-training occurring: clinicians and law enforcement would explain the hows and whys of their profession directly or through stories, thereby familiarizing the other to their culture and practices.

MCT Deployment: Calls for Service

MCTs are dispatched through the City of Albuquerque Emergency Operations Center (EOC), the Bernalillo County Emergency Communications Department (EDC), or at the request of an officer or deputy in the field. Communications personnel complete 20 hours of behavioral health training including telephonic suicide intervention, crisis management, and understanding the roles and functions of the various crisis intervention responders. The EOC also has regular in-service trainings on behavioral health topics. The role of these communications centers in triaging calls for appropriate response was not part of the initial plan for evaluating the MCT program but might have been useful context for some of the findings in this section.

Dispatch

The CFS data documents dispatched calls for MCTs. The CFS data does not provide client demographics or client disposition information, for those we look to the clinician data. 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). There were another 222 calls in which it appears more than one MCT was dispatched to the call. These calls were excluded from all analyses.

Table 8: Calls for Service

Unique Calls for Service	Unique Calls for Service with an MCT On Scene Time
4,953	3,960

Approximately 80% of the unique calls for service with an MCT dispatched had an MCT arrival on scene time. It is unclear why 20% of unique dispatched CFS do not have an on scene time. One reason might be that calls are sometimes cancelled before they are en route (5.4%). There are also issues in reporting on scene times when MCTs are working across agencies and some calls are cancelled en route due to developing situations on scene or if the time until the arrival of an MCT is too long for the first responding officers to wait.

Table 9 reports the number of calls for service for each team during the evaluation period. MCT 2 accounted for the largest number and percent of calls for service at 32.3%. As noted in Table 4, the six teams were not in the field for the same amount of time. For this evaluation time period, the BCSO MCTs have been in the field the longest at 25 months and MCTs 5 and 6 have been in the field for the shortest time, about 8 months. Additional factors to consider are the actual number of shifts each team worked (taking into account leave and non-MCT assignments), whether there tended to be more shifts with zero calls in some areas or times of day, and the call volume for APD is about 10 times BCSO's call volume

As noted earlier, the areas served by BSCO surround the city of Albuquerque and are more sparsely populated than APD's jurisdiction. This might affect the number of calls for service with a behavioral health element (demand) or the time it takes to reach a scene. It could be reflective of the differences between APD and BCSO in who determines whether a team responds to a CFS. Observers noted that BCSO teams may decline a call whereas the presumption for APD was to respond when dispatched.

Table 9: Count of Unique Calls for Service by MCT

Team	Department	Count	Percent
MCT 1	BCSO	932	18.8
MCT 3		605	12.2
MCT 2	APD	1,601	32.3
MCT 4		961	19.4
MCT 5		382	7.7
MCT 6		472	9.5
Total		4,953	100.0

Dispatched CFS are the beginning of the event chain described in Table 2. Table 10 shows the number of CFS dispatched, en route, and with an on-scene time indicated. The percentage of calls that progress from dispatch to arrival on scene can be a broad measure of efficiency in the delivery of services.

The MCT program as a whole had teams arrive on scene for 80% of dispatched calls for service or around 990 calls dispatched (20%) for which there is no arrival on scene time. Looking across the teams, BCSO has lower rates of arrivals on scene (53.4%-61%) than APD (87%-88.7%). The percentage of calls lost from dispatch to en route varies from about 1% (MCT 5) to 13% (MCT 1) with a program average of about 4%. From en route to arrival on scene, an additional 16% of calls were lost program-wide, ranging from 10% (MCTs 4 and 5) to 41% (MCT1). It is not clear what factors account for the differences across agencies or teams.

Table 10: Calls for Service Dispatch, En Route, and Arrival On-Scene by MCT

Team	Agency	Unique Calls Dispatched	En Route	Arrival On Scene Time Noted	% of Dispatched calls with arrival on scene times
MCT 1	BCSO	932	844	498	53.4%
MCT 3		605	529	369	61.0%
MCT 2	APD	1,601	1,582	1,461	91.3%
MCT 4		961	946	837	87.1%
MCT 5		382	377	339	88.7%
MCT 6		472	467	420	89.0%
Total		4,953	4,745	3,960	80.0%

To better understand the how often teams are dispatched or arrive on scene *per shift* we consider time in the field based on start dates (Table 5). Table 11 reports detailed information about calls dispatched, calls with an on scene MCT, the total number of shifts worked in which there was at least one call dispatched, the average number of dispatches by shift, and average number of calls on scene by shift. APD's MCTs are on average dispatched to more calls per shift and are on scene more calls per shift than BCSO MCTs. Total Shifts represents the number of shifts *for which a team was dispatched* and does not include any shifts for which there were no dispatched calls. We are not able to report the number of shifts worked for this reason. In the future it would be useful to track total shifts worked.

It is also important to note not all arrivals on scene result in a contact with an individual. Calls on scene are more of a loose indication of opportunities for engagement with a citizen than a description of individuals served. On average, MCTs arrived on scene to 2.5 calls per shift with MCT 3 responding to the fewest calls on average (1.8) followed by MCT 1 (2.4). MCT 2 responded to the most calls per shift with an average of 4.4 calls for service per shift.

Table 11: MCT Calls for Service, On Scene Calls, Shifts, and Averages

	Total Calls Dispatched	Total Calls On Scene	Total Shifts	Average Dispatches by Shift	Average Calls On Scene by Shift
MCT 1	932	498	360	2.6	1.4
MCT 3	605	369	306	2	1.2
MCT 2	1,601	1,461	375	4.3	3.9
MCT 4	961	873	276	3.5	3.2
MCT 5	382	339	127	3	2.7
MCT 6	472	420	142	3.3	3.0
Total	4,953	3,960	1,586	3.1	2.5

Table 12 reports the average time in minutes by each of the call events for an MCT CFS. On average, BCSO MCTs (MCT 1 and MCT 3) took 11.4 more minutes to arrive on scene from being en route compared to APD MCTs (MCT 2, MCT 4, MCT 5, and MCT 6).

Table 12: Average Time in Minutes by Call Event by MCT

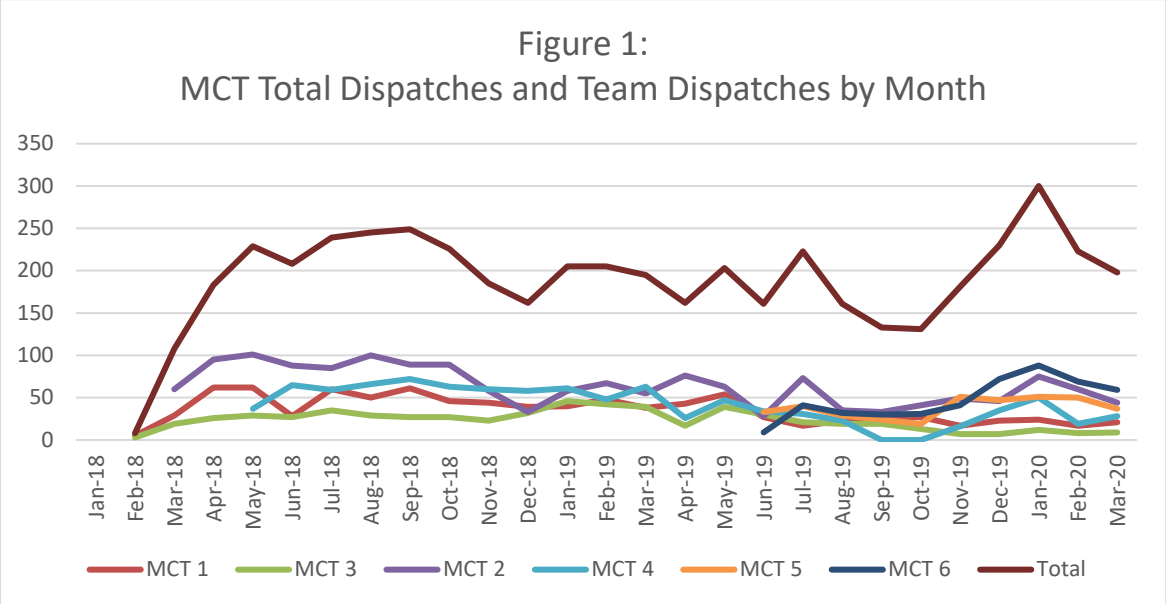
	Call Start until Call Clear	Call Start until MCT Dispatch	MCT Dispatch until Call Clear	MCT Dispatch until En route	MCT En route until On Scene	MCT On Scene until Call Cleared	Total Dispatches
MCT 1	89.3	21.0	77.5	1.5	32	64.9	932
MCT 3	108.1	43.6	97.1	2.9	33	83.6	605
MCT 2	95.2	29.6	66.3	0.4	11	56.8	1,601
MCT 4	113.7	27.0	86.8	0.9	13	75.9	961
MCT 5	93.2	35.8	58.5	0.2	10	51.7	382
MCT 6	93.1	34.9	58.9	0.2	11	50	472
Total	98.9	30.2	74.9	0.9	16	63.4	4,953

Table 13 reports on 4,953 calls for service with an on scene arrival time. On average MCTs spend 86.5 minutes from being dispatched until the call was cleared for calls for service with an on scene arrival time. While MCTs spent similar amounts of time in minutes and as a percent of the total call for service the average number of calls per shift varied considerably by MCT. On average APD MCTs responded to more calls for service per shift and spent a greater number of total minutes and percent of their available time per shift on calls for service, compared to BCSO teams.

Table 13: Average Time in Minutes by Call for Service and the Percent of Shift

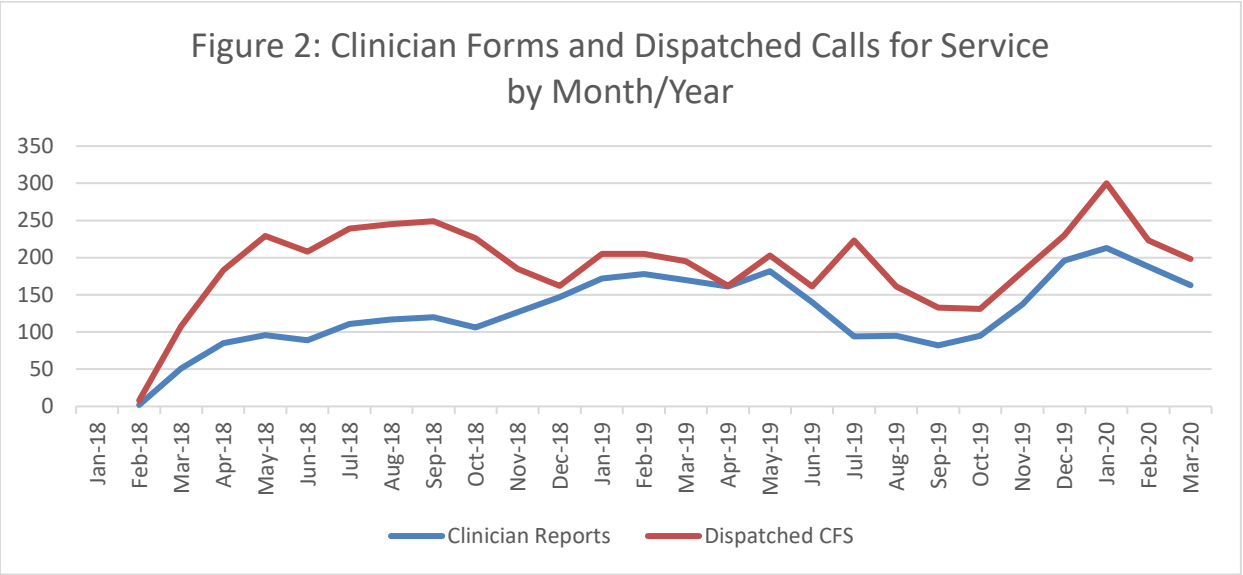
Team	Average Minutes Between MCT Dispatch until Call Cleared	Average Dispatches with an On Scene Time per Shift	Average Minutes Spent per Shift on CFS with an On Scene Time	Total Shift in Minutes	Percent of Total Shift in Minutes on a CFS
MCT 1	89.3	1.4	100.3	600	16.7
MCT 3	108.1	3.9	122.2	600	20.4
MCT 2	95.2	1.2	97.1	600	16.2
MCT 4	113.7	3.2	116.4	600	19.4
MCT 5	93.2	2.7	96.3	600	16.1
MCT 6	93.1	3.0	95.1	600	15.9
Total	89.3	2.5	100.3	600	16.7

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 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.

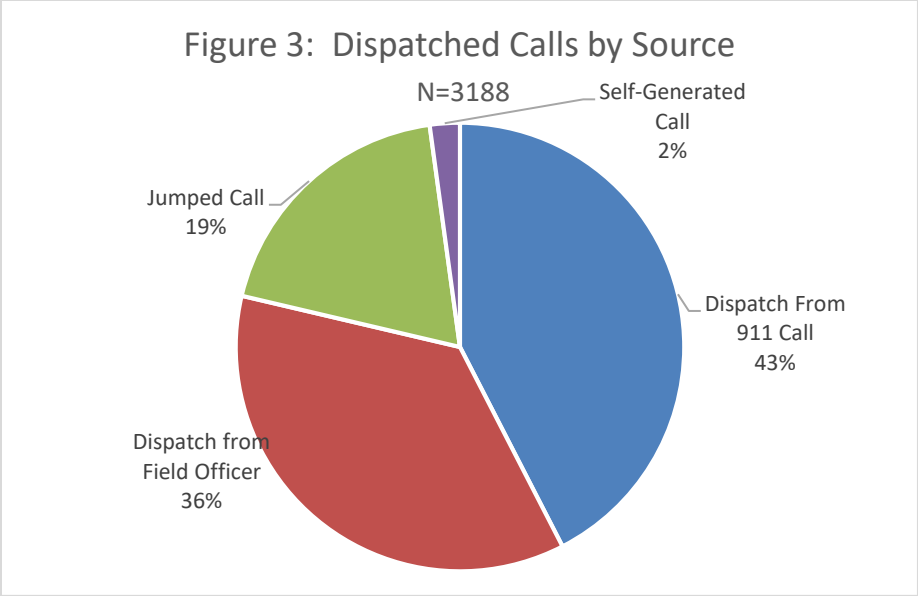


The number of dispatched calls is also available from the clinician records. Clinicians recorded 3,319 CFS during the study period including calls with no client contact and those that were canceled en route. Clinician forms represents about two-thirds (67%) of the 4,953 dispatched calls from the CFS data. However, it represents almost 84% of the 3,960 calls with an arrival on scene time. There are a variety of reasons for the differences in number of CFS and the number of clinician forms. This includes when clinicians began keeping records and when clinician record keeping begins in the call event progression. Figure 2 shows the distribution of clinician recorded calls for service by month and year and the total on scene calls for service from law enforcement.

Similar to dispatched CFS, the largest number of clinician forms (213) occurred in January 2020. The largest differences between dispatched CFS and clinician forms are in calendar year 2018; the clinician forms for several months are less than half of the dispatches in the CFS data. Over the course of the study period those differences diminished although the clinicians consistently recorded fewer forms than are in the CFS data.



MCT clinicians also collected the source of the dispatch that included by 911, a field officer, by jumping calls or self-generating the dispatch. Figure 3 shows that less than half of MCT calls (43%) came from 911 dispatch and 36% came from an officer or deputy in the field. According to the clinician records, MCTs rarely self-generate CFS but they do 'jump' calls that were not originally assigned to them. They might take the call from another team because they are closer to the call location or if a team is familiar with a particular individual. Jumped calls accounted for almost 20% of the dispatched calls.



Generally, two MCTs have worked on Sundays, four on Mondays and Tuesdays, five on Wednesdays and Thursdays, and three on Fridays and Saturdays. MCT shifts start anywhere from 8 a.m. – 10: a.m. and run until between 6 p.m. and 10 p.m. The number of dispatched calls for service is related to the number of teams working that day, with Wednesday and Thursday experiencing the most calls for service and Sunday the fewest.

Table 14: MCT Calls for Service Dispatched by Team and Day of the Week

	BCSO		APD					
	MCT 1	MCT 3	MCT 2	MCT 4	MCT 5	MCT 6	Total	
	Count	Count	Count	Count	Count	Count	Count	Percent
Sunday	0	1	19	195	6	120	341	6.9
Monday	249	2	391	29	32	114	817	16.5
Tuesday	272	34	398	40	28	123	895	18.1
Wednesday	222	149	383	91	79	80	1,004	20.3
Thursday	187	125	296	190	97	11	906	18.3
Friday	0	164	60	219	76	6	525	10.6
Saturday	2	130	54	197	64	18	465	9.4
Total	932	605	1601	961	382	472	4,953	100

MCTs are scheduled to meet the demand for crisis response to behavioral health calls. While Table 14 reports all MCT CFS by day and time, Table 15 examines the percentage of total CFS each cell (representing a specific time period on a specific day) contributes to the total calls for service in this study period.

Eight day/time combinations each contribute more than 5% of the total dispatched CFS (bolded numbers), with the largest contribution from the ~5 MCTs working on Wednesday from 10:00 a.m. – 2:00 p.m. The 10:00 a.m. – 2 p.m. time slots Monday through Thursday account for 32.3% of all MCT CFS while the 2:00 p.m. – 6:00 p.m. time for the same days accounts for another 25.2% of CFS. The majority (57.4%) of MCT CFS occurred between 10 a.m. and 6 p.m., Monday through Thursday.

Table 15: Percent of Total CFS Dispatched by Day of Week and Time of Day

Day of the Week	6-10am	10-2pm	2-6pm	6-10pm	10pm-2am	2am-6am	Total % by Day
Sunday	0.3%	2.4%	2.7%	1.5%	0.0%	0.0%	6.9%
Monday	0.9%	**7.6%**	**6.3%**	1.7%	0.0%	0.0%	16.5%
Tuesday	1.5%	**8.3%**	**6.2%**	2.1%	0.0%	0.1%	18.1%
Wednesday	1.6%	**9.2%**	**6.4%**	3.1%	0.0%	0.0%	20.3%
Thursday	1.5%	**7.2%**	**6.3%**	3.2%	0.1%	0.0%	18.3%
Friday	0.6%	3.4%	4.1%	2.3%	0.2%	0.0%	10.6%
Saturday	0.5%	2.9%	3.7%	2.1%	0.2%	0.1%	9.4%
Total % by Time Period	6.8%	40.9%	35.6%	16.0%	0.5%	0.1%	100.0%

Table 16 reports the MCT CFS by team and the time of day. The largest number of dispatched CFS start times occurred between 10 a.m. to 2 p.m. followed by 2 p.m. to 6 p.m.

Table 16: MCT Calls for Service by Team and Time of Day

	BCSO		APD					
	MCT 1	MCT 3	MCT 2	MCT 4	MCT 5	MCT 6	Total	
	Count	Count	Count	Count	Count	Count	Count	Percent
6 a.m.-10 a.m.	56	5	173	42	33	28	337	6.8
10 a.m. -2 p.m.	482	91	687	338	203	227	2,028	40.9
2 p.m. -6 p.m.	307	271	527	363	129	168	1,765	35.6
6 p.m. -10 p.m.	86	222	206	217	16	47	794	16
10 p.m. -2 a.m.	1	15	5	0	0	2	23	0.5
3 a.m. - 6 a.m.	1	1	2	0	0		4	0.1
Total	932	605	1,601	961	382	472	4,953	99.9

Call Types

APD *SOP 2-19-9-4 Dispatch and call*s notes: MCTs shall not be used for calls involving criminal investigations and MCTs only can be dispatched or requested by officers when there is a call involving a person experiencing a mental health crisis or mental health problem. Additionally, based on their training and SOP, dispatchers decide whether there is a behavioral health element and then contact the MCTs. The CFS data includes the 10-codes used to provide LEOs basic information about the nature of the call. This allows us to report the variety of CFS to which MCTs were dispatched.

More than 75 different 10-code categories resulted in an MCT dispatch for which either EEC/BCEC personnel, law enforcement, or an MCT determined there was a behavioral health component. These calls were collapsed into seven call types that made up 87% of the MCT CFS. A catchall category, 'other,' contains the remaining calls (13%).

Call Classification

APD and BSCO do no use the same call codes for the same kinds of calls. For example, BCSO has two call codes for suicidal behavior, 43-1A Attempted Suicide and 43-1T Suicidal Threats, whereas APD has one call code for all suicide-related behaviors: 43-1. These three call codes were combined to create a single call for service category: Suicide Related. Table 17 shows the call codes that make up the call categories used in this study.

Table 17: Calls for Service Categories by Agency and 10-Code

	APD	BCSO
Behavioral Health	10-40	10-40,10-40F
Contact Requested	10-25	10-25:10-25T
Suicide Related	10-43-1	10-43-1, 43-1A:43-1TO
Suspicious Person	10-31:31S	10-31:31V
Welfare Check	10-10-0	10-10
Domestic Fight	10-15; 10-15-1	10-15
Disturbance	10-39; 10-39-1 to 10-39-5	10-39
Other	All Other Code Types	All Other Code Types

Calls for Service by Call Category

A person experiencing a behavioral health crisis could be involved in any type of call, from a traffic stop to attempted suicide. And those calls can take more or less time depending on a variety of factors. Understanding the types of calls MCTs respond to and how much time calls take is an important step in evaluating whether the types of calls MCTs answer meet the expectations of administrators and MCT members, or if there are process changes that could result in a better allocation of this resource. Per APD SOP 2-19-9-2a, MCTs are primarily responsible for responding to priority one calls with a behavioral health component. There is recognition that they may need to respond to some priority two calls with a behavioral health element. Figure 4 shows the most common CFS call types for which an en route time was included.

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 accounts 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.

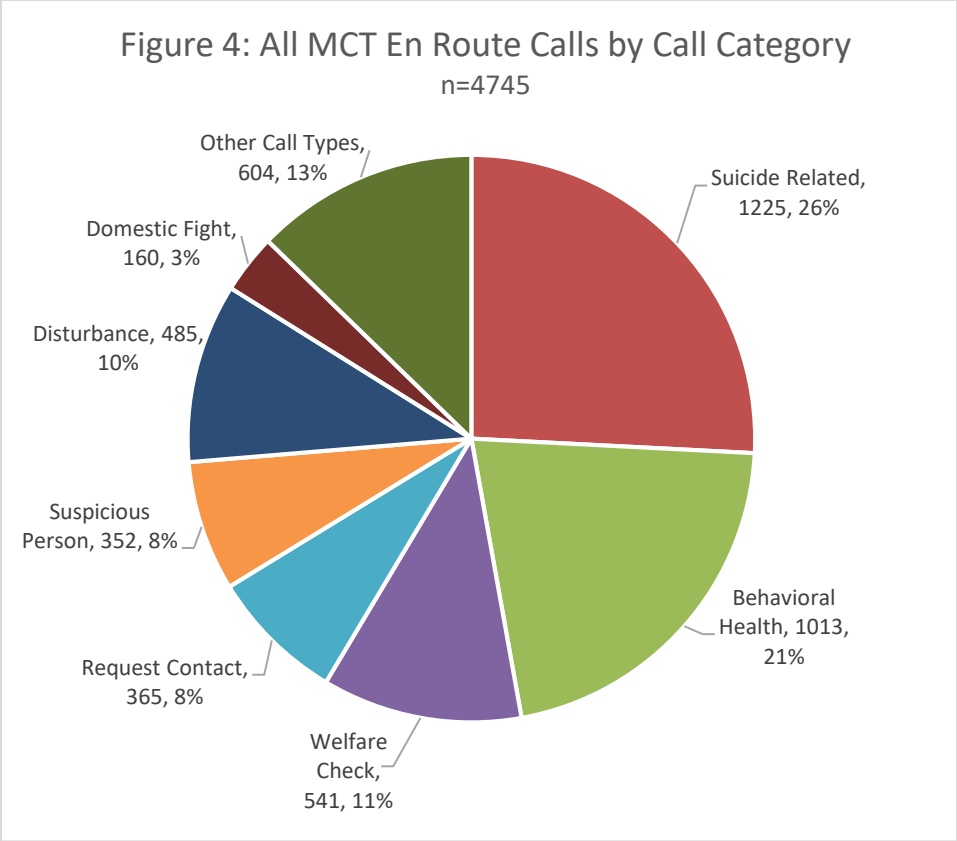


Table 18 reports dispatched calls for service by call type and MCT. For a full list of how the code types have been combined see Appendix A. Suicide and behavioral health calls made up 46.7% of all MCTs CFS. This was followed by other category calls (13.9%), welfare check calls (11.2%), and disturbance calls (10.1%). Four call types (suicide, behavioral health, welfare checks, and disturbance) accounted for 68% of all dispatched calls for service.

Table 18: Dispatched CFS Code Types by MCT

	BCSO		APD					
	MCT 1	MCT 3	MCT 2	MCT 4	MCT 5	MCT 6	Total	
Call Type	Count	Count	Count	Count	Count	Count	Count	Percent
Behavioral Health	271	226	218	160	77	92	1,044	21.1
Contact	8	144	3	82	67	67	371	7.5
Disturbance	61	203	29	101	49	56	499	10.1
Family Dispute	9	66	8	45	19	19	166	3.4
Other	220	185	116	78	30	60	689	13.9
Suicide	248	394	192	302	55	79	1,270	25.6
Suspicious	17	178	3	73	43	44	358	7.2
Welfare Check	98	205	36	120	42	55	556	11.2
Total	932	1,601	605	961	382	472	4,953	100

For the CFS data generated by the emergency communications centers, call types are aggregations of the APD and BCSO 10 codes (Table 17), a specialized verbal shorthand used to facilitate communications for law enforcement and other first responders. Clinician characterized

a call by the 'chief complaint,' a standardized entry on the Mobile Crisis Assessment and Non-Assessment forms. This represents the clinician's initial assessment of the potential mental health issue based on information relayed by the emergency communications staff. The health information used for determining the chief complaint was also recorded in detail. These data were collected for people whether or not the call resulted in clinician contact with the client. Table 19 shows the array of chief complaints recorded by clinicians during the study period.

The chief complaints of suicide, psychosis, and aggressive/threatening behavior account for 75.2% of dispatched calls. Despite the disparity in total numbers of dispatched CFS and clinician forms, the number of calls dealing with suicide are nearly identical, 1223 in the clinician forms and 1225 in the dispatched CFS data. Calls related to suicide make up the single largest category in both datasets, 26% of CFS and 41% of clinician records. Beyond the suicide-related CFS there is no comparability with the law enforcement characterization of calls. However, within the other category (10.5%), detailed notes included descriptions of welfare checks, suspicious persons, and requests for transport. They also included reports of people exhibiting odd behaviors or making delusional statements, potential signs of psychosis, that were not categorized as such for reasons of professional judgement or extenuating circumstances unknown to us. Calls with psychosis as the chief complaint accounted for 20.7% of calls and 13.5% were characterized as aggressive/threatening behavior.

Table 19: Chief Complaint from the Clinician Forms

Chief Complaint from Dispatch	Count	Percent
Suicidal	1,223	41.0
Psychosis	616	20.7
Aggressive/Threatening Behavior	403	13.5
Other	322	10.8
Substance Use	106	3.6
Mood Lability/Restriction	71	2.4
Homicidal	63	2.1
Childhood Disorder/Behavioral Issues	63	2.1
Degenerative Disorders	33	1.1
Homelessness	30	1.0
Medical	28	0.9
Developmental/Cognitive Issues	23	0.8
Total	2,981	100.0

Missing 338

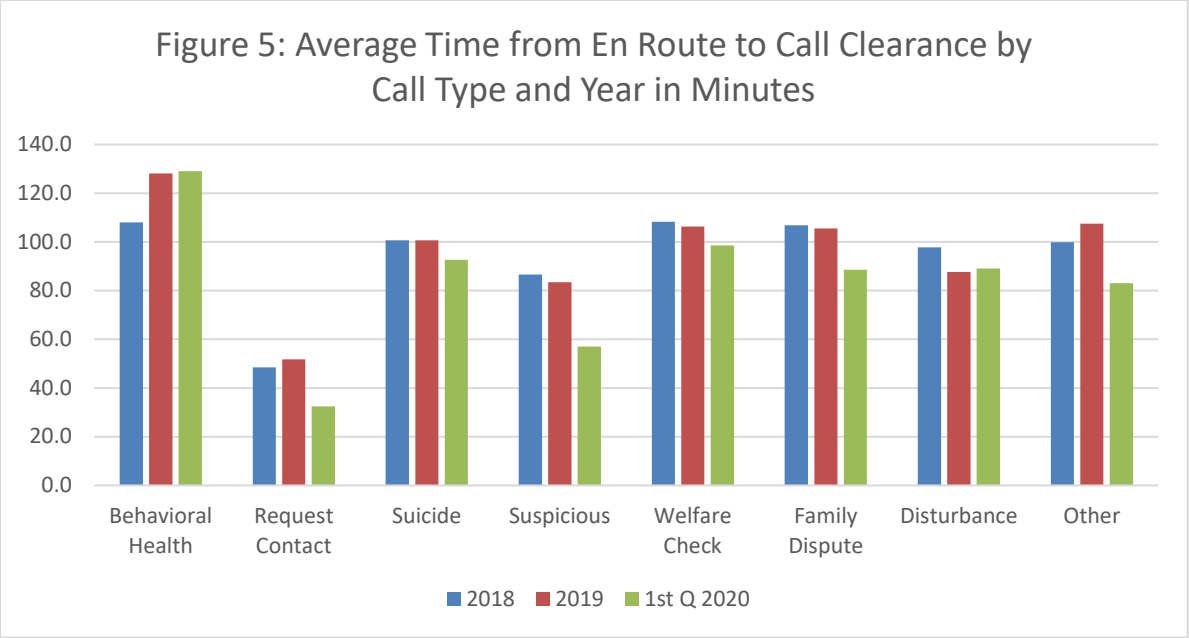
Another factor in assessing MCTs is how much time is spent, on average, on calls by type of call and by different parts of the call. Ideally, a call clearance time designates the completion of one call and the availability of the cleared unit to pursue another call. As noted earlier, call clearance is the stage of the call progression that is most subject to differences in agency protocols and cross jurisdictional issues. Table 20 presents the average duration of eight call types measured from call start to the call clearance in mean and median minutes, and by the different points within a call. The median is the point at which half the calls were longer than that time and half the calls were shorter in duration.

On average, the longest calls were behavioral health related calls (120.4 minutes) and the shortest calls were in response to a request for contact (45.3 minutes). Welfare check calls (106.3 minutes) are about 15 minutes shorter than behavioral health calls. The times associated with Call Start to Call Dispatch account for between 16% and 44% of the mean time for a given call type. This might be a function of how calls were prioritized or because MCTs are not the first units to a scene. This deserves further study.

Table 20: Average Time in Mean and Median Minutes by Call Event by Call Type

Call Type	Calls	Call Start to Call Dispatch in Minutes		Dispatch to En Route in Minutes		En Route to On Scene in Minutes		On Scene to Clear in Minutes		**Total** Start to Call Clear in Minutes		**Total** Dispatch to Call Clear in Minutes	
	Count	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Behavioral health	1,025	33.7	8	1.1	0	22.3	13	91.2	81	120.4	106	97.1	88
Request contact	363	16	0	0.3	0	3.4	0	27.9	16	45.3	19	34.2	15
Family dispute	148	38.6	19.5	0.8	0	16.1	13	57.8	47	102.9	82	65.8	60
Suicide	1,217	16.9	4	1	0	17.6	13	81.5	78	99.8	94	93.2	87
Suspicious Person	330	35.3	16	0.5	0	11.4	10	37.4	25	79.5	55.5	45.3	33
Welfare check	521	42.9	14	0.9	0	18	13	53.7	37	106.3	78	65.6	49
Other	652	36.6	8	1.4	0	14.8	7	57.9	34	101.3	61	68.2	39
Disturbance	472	37.5	22	0.9	0	12.5	11.5	51.4	33	91.5	76	54.4	43

Figure 5 shows that behavioral health calls have taken slightly long since the inception of the MCT program and, with a few exceptions, the amount of time for all other call types has decreased. In 2019 there were small increases in time in the request contact and other categories, related in part to the addition of two teams in May of that year. The trend appears to be holding for the first three months in 2020 (with the exception of disturbance calls) although the effects of COVID-19 on the length of calls cannot be predicted from these trends. Changes in time on the call might also be related to factors that influence how much time a call takes, such a number of units on scene, and disposition type.



As noted in Table 18 four types of calls for service accounted for 68% of the calls for service. These calls for service are suicide calls (25.6%), behavioral health calls (21.1%), welfare check calls (11.2%), and disturbance calls (10.1%). On average, 98.9 minutes elapsed from the time an MCT is dispatched until the time a CFS is cleared. On average it took 63.4 minutes from the time an MCT arrived on scene until a CFS was cleared. Of the three most frequent types of CFS to which MCTs respond, behavioral health CFS on average take the most time at 87.4 minutes from arrival on scene to clear. The majority of CFS have not resulted in an arrest or hospital transport (62.1%). Clinicians give another perspective on CFS; they note the potential behavioral/mental health element that might have prompted a call to 911, or a request from an officer, which resulted in dispatching a MCT.

Information about CFS and call types gives an approximation of how MCTs have been put into service as part of APD and BCSO's response to individuals experiencing a behavioral health crisis. Is there something about the process of call assignment by dispatch or field officers that could be improved the potential impact of the clinical skills and advanced crisis intervention training of law enforcement in the MCTs? What *are* the most appropriate calls for MCTs? As the MCT program matures there might be some opportunities for refinement beyond the behavioral health element criteria for MCT involvement.

Appropriateness of calls

According to *APD SOP 2-19*, every call to which an APD MCT is sent should have a behavioral health element. While the Bernalillo County Sheriff's Office does not have a similar policy, the process followed by all teams should generally meet this standard. Ride-along observers noted that MCT members had post-call discussions about whether a call had been "appropriate" for an MCT. In the 2020 survey of MCT members, they were asked about calls they thought were most appropriate for MCTs. Generally, these discussions and comments included field officers' use of the 43-1-10 statute for suicide-related calls.

NMSA 43-1-10 Emergency mental health evaluation and care gives law enforcement officers the ability to detain someone for emergency mental health evaluation and transportation for care at a hospital or mental health facility *without* a court order. When officers do this, they are said to "invoke 43-1-10." *Section A* of the statute lays out four criteria under which this action can be taken: if the person is subject to lawful arrest; if there are reasonable grounds to believe the person has just attempted suicide or is a danger to themselves or others; or when a qualified mental health professional certifies that a person's likelihood of serious harm to self or others warrants detention to prevent this harm. In the last case, a qualified mental health professional issues a certificate of evaluation (CofE), and, "Such certification shall constitute authority to transport the person." (p 1)

> *We get a lot of basic suicide or mental health calls that can be handled by a CIT/ECIT trained officer. Someone calls to report their own suicidal or homicidal ideations and an officer is hesitant or unwilling to enact 43-1-10 to force transportation.* MCT member

APD's *SOP 2-19-11 Procedures for Emergency Mental Health Evaluation* details for officers the criteria necessary for the detention and transport for evaluation pursuant to *NMSA 43-1-10*. For individuals who meet one of these criteria, *Section A.6 of APD SOP 2-29-11* instructs officers to put the person in protective custody and arrange transportation to an appropriate mental health facility. It also provides contact information for community hospitals that conduct mental health evaluations and about how to proceed once they arrive at the hospital. *Section A.11* states that when an officer determines a person is experiencing a mental health crisis or disorder but is not dangerous, the officer is to seek assistance from an MCT, the person's mental health provider, or other APD crisis response units if, "the individual would likely benefit from further crisis intervention, linkage to services, and/or education regarding services in the community." (p. 17)

Among MCT respondents, LEOs and clinicians alike mentioned this category of calls as one where they feel they are not always needed, especially when a field officer could have 'invoked 43-1-10'. MCT members were asked, "When your MCT is dispatched, how often is that call appropriate for an MCT?" On a scale of always, usually, about half the time, seldom, or never, the majority of clinicians and LEOs chose 'usually.' A follow up question asked them to describe the calls they believed were *not* appropriate for an MCT response.

Respondents rarely mentioned a call type; instead they described *characteristics* of an inappropriate call. The two most frequently mentioned characteristics were when the team member believed a field officer called MCT rather than invoke 43-1-10 in cases of suicide related calls, and when the subject was known to have an outstanding charge. Clinicians mentioned several safety issues that create situations where they thought MCTs cannot be used appropriately: when firearms are involved, pre-SWAT situations, and in cases of domestic violence. Other call characteristics respondents thought made a call inappropriate for MCT were: armed subjects, obvious excessive drug or alcohol use, domestic disputes/violence, and being used solely for a mental health transport. During one ride-along observation an MCT member joked about 'being an Uber' and noted there were several calls for an MCT they could not take while transporting a client for a field officer.

About 26% of dispatched MCT CFS in the study period were suicide related (see Table 16). Within the data sources used in this report there is no indication of what fraction of those calls could have been handled by a field officer instead of an MCT. This issue deserves additional attention and study. Focus groups with field officers, communications personnel, and MCT members would provide further insight into these situations and the use of 43-1-10 and MCTs.

When asked for what types of calls with a behavioral health element current MCTs are *best suited*, clinicians and LEOs both mentioned when the person exhibits active mental health symptoms or SMI, especially when it affects communication with law enforcement. Other factors that made a call appropriate for MCT response were the need for: on-site safety plans, therapy, CofEs, and resources. One team member's response illustrates how nuanced context can mean the difference between calls considered "appropriate: and" not appropriate".

> *Current MCTs are great for clients that do not present immediate threat to self or others, or where threatening circumstances are not immediately clear to field officers. Also, MCT is appropriate for calls where a client may verbalize a suicidal or homicidal ideation, but field officer suspects the situation may not be appropriate for emergency hospitalization (such as a person seeking the hospital over homeless-ness, or a child stating suicide but not demonstrating understanding of what they are saying).* MCT member, October 2020

MCT members were also asked what percentage of the calls they had responded to that required an MCT response. Among LEOs answers ranged from 50%-90%, averaging 74% of calls requiring an MCT; among clinicians, the range was 50-95%, averaging 81%. The characteristics that lead to a call being perceived as inappropriate might explain some of the reasons for clinicians and LEOs reporting that around 20%-25% of their calls did not require their presence. It would be useful to further study and understand if it would be possible to reduce the number and percent of MCT calls for which their presence is not necessary.

MCTs in the Field

The CFS data illustrates how the MCTs have been deployed during the study time period. We understand their scheduling, the kinds of calls they deal with, and how long those calls take. Call for service data is commonly used to assess various aspects of police performance and are useful in understanding some aspects of MCTs and their performance. CFS tell us about getting the clinician and ECIT trained law enforcement to the potential client– not about de-escalating people in mental health crises, creating safety plans, or connecting clients to behavioral health resources in the community. CFS cannot describe the population served on these calls, the end result of the client interactions, or how they arrived at that disposition.

Since the beginning of the program MCT clinicians have collected client level data for each call, including demographics, diagnosis, and details about the call dispositions. The amount and type of data collected has changed over time. These data provide insight into why a call takes as much time as it does and they are the basis for determining the short-term outcomes of the program in this report. Clinician data offers the best indication what currently happens in the field, *from the*

clinical perspective. Ride along observations and MCT survey responses augment the clinical forms to help create a creating a fuller depiction of daily client interactions.

We have been able to collect a sample of incident reports for calls for service for which an incident report was completed by an MCT officer. An analysis of these data was not available for this report. A review of these data will provide a view of calls with additional data from the perspective of the law enforcement officer. Together with clinician data this may provide us a more complete view of what occurs during calls for service.

Basic guidelines for MCT conduct in the field can be found in APD *SOP 2-19-9-4 Dispatch and call*s:

> *MCTS are instructed to arrive in the officer's vehicle and, other officers are to secure the scene before the MCT clinician engages the individual in question, assesses the individual and provide acute crisis services and referrals, as appropriate. Team members are expected to work together to provide swift and responsive services.* (p.12)

Observers confirmed that MCTs arrive together in the officer's vehicle. Some co-responder models use unmarked vehicles and law enforcement in plain clothes. In response to a question about policies and procedures that would improve MCT effectiveness, one respondent offered, "MCT should respond with two plain clothes officers and a masters level clinician. They should be called to the scene first to make sure the scene is safe, build the rapport and determine if any others need to be called."

The literature on whether MCTs reduce officer injury and officer safety is mixed. As noted above, the Bernalillo County MCT program requires the scene to be secured *by other officers* before a clinician is allowed on scene. Observations and clinician records indicate this is a standard practice, although sometimes an MCT officer will leave the clinician in the vehicle or at a safe distance from the scene while assisting other officers to secure the scene. Being on the scene does not mean there is client contact.

Table 8 reports 4,953 unique calls for service and 3,960 unique CFS with a recorded on scene time. Table 10 shows where those losses occur at each point in the call event progression that lead to the 20% reduction in MCTs arriving on scene. MCT clinicians created a record for each dispatched call, whether or not there was client contact. Their reasons for why there was no contact or assessment offer some explanation for the almost 1,000 lost calls.

Client Contact and Assessment

As noted in the data limitations for the clinician records, the form changes that occurred in May 2019 created inconsistencies in the data. The original version of the client record collected 'client contact' (yes or no) with an explanation for why there was no contact. After Spring 2019, clinicians used different forms for *assessed* clients and *unassessed* clients, and those collected 'type of contact' differently from each other, and from the original version. In the post-May 2019 forms, 'type of contact' choices were telephone and mobile visit on the *assessed* form and 'type of contact' was either cancelled in route; unable to locate; telephone, mobile visit, or other (with a text box for explanation) on the *unassessed* form.

Some kind of 'type of contact' is in all forms and was combined for analysis but it is only reliable for the records reporting a reason for no contact. There are 490 records in the *unassessed* file designated 'mobile visit,' for which there is no reason for no contact, suggesting there could have been some engagement but no assessment. Therefore, we cannot reliably account for number of contacts but we can account for the number of calls on which people assessed. Table 21 shows that clinicians assessed clients on roughly half of their recoded CFS dispatches. This is important because we know clients were not assessed almost 50% of the time clinicians were on scene and for which a form was completed. It would be very useful to understand in more detail why more clients were not assessed.

Table 21: Clients Assessed

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

Table 22 groups the reasons for non-assessment in to three broad categories: change in call status, decision made by others, and other. The 16 reasons below reflect the clinicians' single explanations for non-assessment, they did not give more than one for any given call. Several reasons clearly indicate no contact while others suggest contact with no assessment.

Canceled calls and missing clients comprised almost half the reasons given for non-assessment. About 30% of dispatched CFS were cancelled en route and another 19% were calls during which MCT was unable to locate the client. There are many reasons a call is cancelled. Examples include: traffic or other factors may slow response times and the situation is resolved by on-scene law enforcement, there is a team in closer proximity to the location than the one originally dispatched, or another officer requests to take the call. Other changes in call status that resulted in no client assessment were disengagement (1.8%), the determination by MCT or others that a call was not appropriated for MCT (2/4%), and when the scene could not be secured for the clinician (0.9%).

An additional 40% of calls that were not assessed by clinicians were calls where the decision on how the call was disposed was made by someone that was not part of the MCT. On-scene law enforcement invoking 43-1-10 accounted for 10% of calls with no clinician assessment. EMS and LEOs making decisions without clinician assessment (8.8% and 6.1%, respectively), medical only calls (3.4%), and arrest (2.4%) were additional reasons for non-assessment. Another decision-maker in these interactions was the potential client: 7.6% of all dispatched CFS that resulted in no assessment were because the person refused contact with MCT or the clinician. Consultation, telephone contact, and transport accounted for another 5% of reasons for no assessment with about 2% making up a catchall category for the remaining reasons.

Table 22: Reasons for No Assessment

	Reason	Count	Percent
Change in call status	Call cancelled	336	29.1
	Unable to locate	218	18.9
	Disengaged	21	1.8
	Not MCT call	28	2.4
	Unsafe	10	0.9
	Total	613	53.1
Decision made by others	43-1-10 Invoked	113	9.8
	EMS made decision to transport	102	8.8
	LE only contact/decision	71	6.1
	Medical only	39	3.4
	Arrested	28	2.4
	Refused contact	88	7.6
	Existing C of E	24	2.1
	Total	465	40.2
Other	Consult Only	30	2.6
	Transport only	8	0.7
	Other	21	1.8
	Telephone	18	1.6
	Total	77	6.7
	Total	1,155	100

All versions of the clinician form collected information about the caller and the subject of the call regardless of whether the dispatch resulted in an assessment (e.g., chief complaint and location). This information was gathered from the dispatchers and records available through the LEOs mobile data terminal. The 2020 survey asked MCT members about the importance of several types of information in 1) preparing for interactions with a client, and 2) the ensuring safety for the MCT while on a call. The scale was from 0 – not at all important to 10 - critically important. With the exception of an up-to-date medical history (6.4 for preparation and 6.7 for safety), the importance of all the sources averaged higher than 8 on the 11-point scale. For preparation, recent contact with law enforcement and the behavioral health considerations of the call were both rated 8.6. The two most important information sources for MCT on-scene safety were information about recent contact with law enforcement and what was happening on-scene (both rating 8.8 on the importance scale). An up-to-date criminal history was slightly more important for team safety (8.7) than for preparation prior to arrival on scene (8.2). LEOs and clinicians diverged most in their assessments of the importance of having an up-to-date medical history for call preparation and safety, with LEOs assigning both as 8, and clinicians assigning 5.2 and 5.6 respectively.

As noted in the discussion of clinician call classification, prior to arrival on-scene the clinician took note of the potential mental health issue involved on the call (chief complaint) based on information relayed by the emergency communications staff to the team. Beyond the administrative record keeping function aspect of the chief complaint, Table 17 above begins to characterize the population served by the MCTs. Over 40% of the CFS involved individuals who were reportedly suicidal, 21% were suffering from psychosis, 3.6% were having a behavioral health crisis related to substance use, and 13.5 % were exhibiting aggressive/threatening behavior.

On Scene

BCSO Rules and Procedures and APD SOPs include descriptions of their crisis intervention protocols (*BCSD Rules and Regulations 354* and *SOP 1-37*, respectively). During the study period BCSO did not have rules and regulations specific to its MCTs although *354* details procedures for handling the mentally ill, suspected mentally ill and people in crisis. This is similar to *APD SOP 2-19 Response to Behavioral Health Issues*. Specific to MCTs, *APD SOP 2-19-9 Mobile Crisis Teams A* discusses their duties and responsibilities: respond to priority one and two calls; provide consultation to other law enforcement; assess individuals for current and near-future risk to self and others; de-escalate the situation if needed; and resolve the crisis safely. Additionally, teams are discouraged from separating and clinician safety is reiterated.

In this section the focus moves from the details of call response to the delivery of MCT services. We begin with a description of MCT's clientele and then explore MCT interactions with clients, team members, and other first responders in the course of the delivery of MCT services.

Client Demographic Information/Population Served

The clinician records included basic demographic information to further characterize MCT's clients. These data are derived from a mixture of client self-identification, existing information about the client and, sometimes, a best guess by the clinician or LEO. These are not robust descriptions of the MCT client population: they are suggestive rather than definitive. They have also been collected differently over time, including the addition of a transgender designation and collecting years of age instead of indicating an age range.

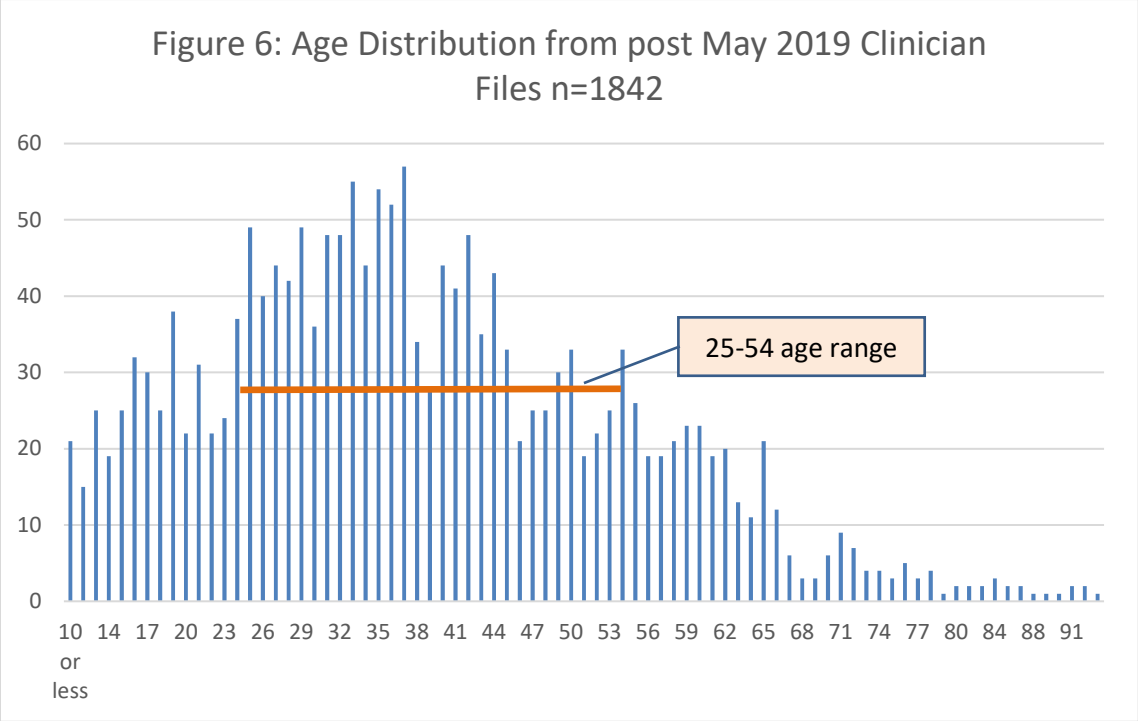
MCT clients tended to be male (56.7%, Table 23), and between the ages of 25-54 (61.4%, Table 24). Table 24 includes all clinician records with an age designated by age range. For the 1,842 assessments with a numeric age (new form), Figure 6 shows the distribution by year with the 25-54 age range noted for comparison.

Table 23: Client Sex/Gender

	Count	Percent
Male	1,732	56.7
Female	1,266	41.4
Transgender	16	0.5
Unknown	42	1.4
Total	3,056	100.0
Missing	263	
Total Cases	3,319	

Table 24: Client Age Range

	Count	Percent
5-17	284	9.9
18-24	321	11.2
25-54	1,754	61.4
55-64	305	10.7
65+	192	6.7
Total	2,856	100.0
Missing	463	
Total Cases	3,319	



Both race and ethnicity were designated by the clinician (not self-reported) for about 64% the calls documented by clinicians. White non-Hispanics were the largest single group (43%) although the majority of clients were racial/ethnic minorities. This distribution is consistent with New Mexico's status as a majority-minority state.

Table 25: Client Race/Ethnicity

	Count	Percent
White	908	43.0
Hispanic	851	40.3
African American	102	4.8
American Indian or Alaska Native	67	3.2
Other	182	8.6
Total	2,110	100.0

The demographics suggest that the population MCTs encountered was predominantly male, a majority were racial/ethnic minorities, and were between the ages of 25 and 54. Table 17 (above) shows that the chief complaint for 41% of MCT clients was suicide and for 21% it was psychosis.

Services

APD SOP 2-19 dictates that, "the MCT clinician and officers shall work together to provide swift and responsive services," as necessary and appropriate. They are specified as:

a. The MCT clinician shall provide services **beginning with de-escalation and primary assessment**. Such assessment may vary, depending on the situation. Such assessments may include a crisis assessment, mental status exams, and general mental health assessments to determine mental health diagnosis.
b. Once individuals have been assessed, the MCT clinician shall **conduct face-to- face crisis intervention services**. Services may also include, but are not limited to, crisis planning, referrals for other services, and recommendations for higher levels of care, which may or may not include certificates for evaluation.
c. The MCT clinician shall work to **provide referral services** to individuals in crisis. Referrals should be provided in a way that will allow for the MCT clinician to **follow up** to determine if individuals have obtained those services.
d. The MCT clinician shall **provide follow-up services** for individuals previously encountered during a crisis.
e. All services shall be documented in the agency's Electronic Health Record System and on other forms as directed and provided by St. Martin's Hopeworks Behavioral Health leadership team.

Services 2-19-9 A.5, p. 12; emphasis added.

As reported by ISR observers, MCTs used a variety of methods for assessing the client's behavioral health crisis, including general mental health assessments. Often, while the clinician was talking to the client, officers would gather additional information from others on site, introducing them to the clinician as appropriate. Team separation sometimes occurred when an officer walked the scene to ensure it was safe for the clinician or when roles required it.

MCT members were asked about their status as second responders and their roles in de-escalating the scene on calls for service. Using the scale always, usually, about half the time, rarely, or never, clinicians and LEOs indicated that when their MCTs arrived on scene the initial contact with the client had usually been by other law enforcement officers. On the same scale, they reported their teams as usually de-escalated the scene and usually averted crisis escalation.

Ride-along observations and MCT member survey responses present a scenario wherein de-escalation is 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. This role clarification might be important for managing performance expectations for MCTs.

Roughly half of dispatched calls do not result in contact/assessment (Table 21). For the other half, a mental health diagnosis helped determine the types of services delivered. *APD SOP 2-19-5b* states that, "Only a trained mental health professional can diagnose behavioral health issues, mental disorders, or illness." (p. 4)

Diagnoses

The diagnosis data made available for this report was collected from February 2018- May 2019, representing about 25% of the records. Clinicians recorded a single diagnosis or a list of diagnoses for both assessed and unassessed clients. The detailed notes taken from caller information sometimes included a 'diagnosis' relayed by the person who made the 911 call. It is unclear how diagnoses for unassessed clients were made and there is no observation data on this point. Although limited to the first 15 months of the MCT program, this snapshot shows the potential reasons behind the chief complaints that initiated the call for service (Table 18). The diagnoses have been aggregated to broad categories and are presented in Table 26.

A large minority of clients (38.1%) were diagnosed with more than one mental health issue. Among those with multiple diagnoses, post-traumatic stress disorder (PTSD) was the most frequently noted followed by depressive disorder and schizophrenia spectrum disorder. Comorbidities tend to make diagnosis and treatment difficult.

Table 26: Broad Diagnoses Category

	Count	Percent
Multiple Diagnoses	343	38.1
Schizophrenia Spectrum Disorder	116	12.8
Depressive Disorder	71	7.8
Bipolar Affective Disorder	51	5.6
Post-Traumatic Stress Disorder (PTSD)	48	5.3
Substance Use Disorder	34	3.8
Dementia	20	2.2
Bipolar (unspecified)	17	1.9
Anxiety	14	1.5
Borderline Personality Disorder	11	1.2
Alcohol Use Disorder	10	1.1
Attention Deficit/Hyper Activity Disorder	9	1.0
Other	50	5.3
Unknown	111	12.3
Total	905	100.0

The three most frequent chief complaints associated with a dispatched call were suicide (41%), psychosis (27%), and aggressive and threatening behavior (10%). Table 27 shows how four of the most frequent diagnosis were classified in the initial chief complaint. This is useful for exploring the fit between the initial characterization of the call and the final diagnoses. For clients with a diagnoses of depressive disorder, 81.5% were initially classified as suicidal. The majority of people with schizophrenia spectrum disorder where initially characterized by psychosis as their chief complaint (52.2%). Among those with multiple diagnoses the most frequent chief complaint was suicidal (47.1%). This was true for those with depressive disorders (81.4%), PTSD (58.7%), and the other category (45.2%). The majority of those diagnosed with schizophrenia spectrum disorder had psychosis as a chief complaint (52.4%).

Table 27: Diagnosis by Chief Complaint

	Multiple Diagnoses		Schizophrenia Spectrum Disorder		Depressive Disorder		PTSD		Other		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Suicidal	161	47.1	21	18.3	57	81.4	27	58.7	145	45.2	411	46.0
Psychosis	54	15.8	60	52.2	2	2.9	6	13.0	56	17.4	178	19.9
Aggressive/ Threatening Behavior	48	14.0	28	24.3	4	5.7	4	8.7	32	10.0	116	13.0
Other	79	23.1	6	5.2	7	10.0	9	19.6	88	27.4	189	21.1
Total	342	100	115	100	70	100	46	100	321	100	894	100

Interactions with clients

APD and BCSO policy and training support appropriate responses to people in mental health crisis. Both agencies have SOPs with recommendations for responding to a mental health call including methods to create a calm environment and engage with individuals in non-threatening and helpful ways. All APD officers and MCT members are also required to complete basic CIT training (plus 8 hour enhanced training for MCTs). The 40-hour course is conducted in collaboration with community behavioral health providers, mental health advocates, and people with lived experience. Officers learn to recognize symptoms of mental illness and co-occurring disorders, how to interact with individuals experiencing behavioral health illness, and to understand the perspectives of individuals who have lived with mental illness (Dempsey et al., 2019).

In *Practice Guidelines: Core Elements in Responding to Mental Health Crises*, SAMHSA details essential values that can be used to assess the adequacy of police-client interactions. Collectively, the values describe a person-centered approach to addressing the immediate crisis and preventing subsequent crises (2009). These values and the associated best practices informed the analysis of the ride-along observations.

Observers reported calm team member demeanors, quiet voices, and appropriate non-threatening physical distances. Because MCTS were rarely the first responders on site, most of the crises appeared to have been de-escalated before the team members talked to client. Occasional escalations tended to occur when clients were transitioned to a police vehicle for transport; these were met with calming words and reassurances. MCTs discussions with clients were often person-centered, considering client preferences in decision-making, facilitating shared responsibilities for plans and decisions, and establishing and reinforcing client feelings of personal safety. An example was the MCT asked the client whether they preferred an EMS or law enforcement transport to the hospital. 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.

Referrals

The delivery of clinical services is a key component of the potential benefits an MCT offers over a regular officer response to a behavioral health crisis call. *Referrals (2-19-9 A.6)* dictates that MCTs: make needed referrals to medical, behavioral and social supports within the community, including certificates of evaluation filled out by the clinician; work with a HopeWorks clinician to coordinate referrals and follow-ups; and, if necessary, refer to the Crisis Intervention Unit for additional follow-up. In *Core Elements* experts suggest, "Adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements" (SAMHSA, 2009: p. 7, emphasis in the original)

Per APD SOP 2-19, the MCT clinicians were to provide referral services to individuals in crisis. In this section of their database the 1300+ responses are a mix of transportation notes, safety plans, referrals to other community providers, and provision of resources such as bus passes and community provider literature. Many of those do not meet the requirement of being structured for follow up with clients to see if they followed through or used the resources.

Call Dispositions

For most clients, the on-going assessment and diagnosis by the MCT inform decisions about what happens to the person at the end of the call for service. The stated goals of managing crises and providing sufficient services in the least restrictive environment are meant to reduce emergency department visits and arrests: evaluating these long-term, system impacts begin with the measurement of call dispositions. The clinician records use seven categories to detail arrests, client transportation, and "being left in the community."

If there was an outstanding warrant, a suspected criminal element to the call, or if a call evolved to include criminal behavior, a client could be arrested and transported to jail. Transportation to emergency services varied based on: the reason for the transport (43-1-10, a CofE, or medical necessity), and whether the transport was voluntary or involuntary. For the disposition 'left in the community,' the client could have remained at the contact site or with a friend or family member. Clinician records indicate that sometimes this category was used for calls that were disengaged and for people who could not be located. The frequency distribution of the broad call disposition categories is presented in Table 28.

Over the course of 25 months 56 people were arrested on MCT calls for service. Typical for all police contacts, arrests were rare (2.8%). Almost 62% of dispatched CFS were resolved with a client being transported to an emergency department and 34% were left in the community.

Table 28: Broad Call Disposition Categories

	Number	Percent
Transported (all categories)	1,219	61.9
Left in the community	661	33.6
Arrested	56	2.8
Other	32	1.6
Total	1,968	100.0

The descriptions of the dispositions *arrested* and *left in the community* appear above. The dispositions within the broad *transported* category not only reflect what happened to a client, they offer insight into why that client was transported. The circumstances and authority for transportation based on 43-1-10 were discussed in the appropriateness of calls section (law enforcement can detain and transport someone for emergency mental health evaluation *without* a court order). Transportation for medical reasons occurred when there were indications of physical harm or illness that required immediate medical attention. A transport was considered voluntary if a client said he or she either wanted to go to a psychiatric emergency department with police (or by ambulance), or would allow a friend or family member to take them there. The last category of dispositions is transported on a certificate of evaluation (CofE).

According to *APD SOP 2-19- 3 Definitions*, a Certificate of Evaluation is a document, completed by a qualified, licensed mental health professional which certifies that a person, as a result of a mental disorder, presents a likelihood of harming themselves or others and that immediate detention is necessary to prevent such harm or grave passive neglect. They are considered a type of referral to a higher level of care for evaluation or custody, often an emergency department for psychiatric hospitalization. The certificate also constitutes the authority for an officer to transport or arrange transport for that individual.

Our observations indicated that most of the time, the clinician's decision to write a CofE was supported by the law enforcement team member. On the rare occasion there was disagreement, the resolution was often for the more cautious outcome of writing the CofE. Observer descriptions of client behavior and clinician remarks associated with individuals exhibiting potentially harmful behaviors indicated appropriate use of this tool.

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. The data in Table 29 suggests that call disposition was recorded whether or not there was contact with or assessment of a client.

Table 29: Client Disposition by Client Contact/Assessment Status

	Contact/Assessment		No Contact/Assessment		Total	
Disposition	Count	Percent	Count	Percent	Count	Percent
Left in the community	607	37.2	54	16.0	661	33.6
Transported CofE	623	38.2	14	4.2	637	32.4
Transported 43-1-10	122	7.5	132	39.2	254	12.9
Transported Voluntarily	176	10.8	24	7.1	200	10.2
Transported Medical	55	3.4	73	21.7	128	2.9
Arrested	29	1.8	27	8.0	56	2.8
Other/Unspecified	19	1.2	13	3.9	32	1.6
Total	1,631	100.0	337	100	1,968	100
No contact or no assessment	8		1,309		1,317	
Missing			34		34	
Total	1,639		1,680		3,319	

About 26% of records with no client contact or assessment noted a disposition. Among those clients who had contact/assessment, the most frequent call disposition was *transported by CofE* (38.2%), closely followed by *left in the community* (37.2%). Among the clients who had no contact or assessment, the most frequent call disposition was *transported 43-1-10* (39.2%), followed by *transported medical* (21.7%).

Chief complaints are established at the outset of a call for service based on information the clinician gleans from dispatch and KDT-based resources. For the next two tables, the no contact/assessment cases have been removed and the dispositions simplified to four categories; *other* serves as a catchall category for the remaining transportation and arrest categories. Table 30 shows the call dispositions of contacted/assessed clients for three common chief complaints. Clients with *suicidal* as the chief complaint are nearly equally distributed across the disposition categories with slightly more of them transported on a CofE. Of the people for whom *psychosis* was the chief complaint, a plurality were transported on a CofE (46.0%) and this group had the highest proportion of clients left in the community (35%, compared to suicidal, 24.3% and aggressive/threatening behavior, 31.5%).

Table 30: Call Dispositions for Selected Chief Complaints among Contacted/Assessed Clients

Diagnosis	Suicidal		Psychosis		Aggressive/ Threatening Behaviors	
Disposition	Count	Percent	Count	Percent	Count	Percent
Left in the community	205	24.3	159	35.3	78	31.5
Transported CofE	229	27.1	207	46.0	101	40.7
Transported 43-1-10	203	24.1	16	3.6	10	4.0
Other	207	24.5	68	15.1	59	23.8
Total	844	100	450	100.0	248	100.0

Table 31 presents the dispositions for four of the most frequent diagnoses in the February 2018-May 2019 clinician records. The no contact/assessment cases have been removed and the dispositions simplified to four categories; *other* serves as a catchall category for the remaining transportation and arrest categories. Roughly half of those with multiple diagnosis or schizophrenia spectrum disorder were transported to an emergency department based on a CofE or 43-1-10; less than 30% of people with those diagnoses were *left in the community.* Almost 60% of clients with a depressive disorder were transported based on a CofE or 43-1-10 and 13.6% were *left in the community*. Almost half the clients with a single diagnosis of PTSD were left in the community.

Table 31: Call Dispositions for Selected Diagnoses

	Multiple Diagnoses		Schizophrenia Spectrum DO		Depressive DO		PTSD	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Left in the Community	83	26.2	28	27.5	9	13.6	20	47.6
Transported CofE	111	35.0	45	44.1	20	30.0	11	26.2
Transported 43-1-10	46	14.5	4	3.9	19	28.8	5	11.9
Other	77	24.3	25	24.5	18	27.3	6	14.3
Total	317	100	102	100	66	100	42	100

Almost 62% of MCT dispatched calls for service end with a client being transported for emergency services. In addition to disposition, clinicians not the end location for their clients, providing some insight into the community facilities available and used for crisis response. Table 32 shows the locations to which MCT clients are transported. The UNM Mental Health Center and Kaseman Presbyterian Hospital provide emergency and urgent psychiatric care for evaluating and treating people experiencing mental health crises. Most of the area hospitals provide evaluation resources as well. Transports to a hospital account for 66% of all end locations.

Observers noted that some MCTs had preferred hospitals, based in part on wait times and how welcoming and helpful emergency staff were at hospitals. Team members also generally agreed they felt appreciated by the emergency department staff.

Table 32: End Location[3] for Transported Clients

	Number	Percent
UNM System	482	27.3
Presbyterian-Kaseman	304	17.2
Lovelace	264	15.0
Presbyterian-Rust and Downtown	82	4.6
VA Hospital	32	1.8
Community Mental Health Provider	14	0.8
Other/unspecified	155	8.8
Metropolitan Detention Center (MDC)	44	2.5
Home	387	21.9
Total	1,764	100
Missing	1,555	
	3,319	

Follow-up and Case Management

The intended follow up and case management aspects of this program were nascent and not evaluable. Observers reported that referrals tended to be CoEs with occasional referrals to

[3] These data were written or typed out so there are many variations in spelling, abbreviations, and colloquial place references for these area resources. Some specificity was lost in recoding this information to the aggregated categories in this table.

HopeWorks offered to client families or friends. They heard little reference to tasks associated with case management or MCT client follow-up during time periods between calls for service. Until this part of the program is in place we are limited to evaluating the short-term outcomes focused on call resolution aspects of MCTs.

In the 2019 survey, MCT members stated they thought it was appropriate for MCTs to follow up with clients. For linking clients to case management services, they agreed it was an appropriate task for MCT, and that they were very effective delivering those services. Recall that in Table 7 above, clinicians and officers reported spending an average of 2-3 hours on client follow-up.

Team Perspectives

Call for service data and client records provided several of the data sources available to evaluate MCT performance. The MCT member survey provided some insight into some of the processes lead to those outputs. Respondents were asked about their interactions with each other, about the program in general, and the behavioral health resources available within Bernalillo County.

Within team interactions

In addition to client/team exchanges, ISR researchers on ride-alongs observed within team interactions. The literature does not appear to offer best practices for how team members should interact, nor are they dictated by policy. Collaboration and teamwork can be dependent on personalities and skills, and the concepts are difficult to operationalize in the field. The observed absence of bickering, disrespectful language and actions, and lack of gossip about other team staff were taken as indications of professionalism and collaboration.

Team members were asked several questions about working together. Asked to state how often "My MCT partner and I work well together," 77% of responding MCT members chose "Always." Communications among LEOs and clinicians is a key factor in successful MCTs. When asked how often the differences in their professional background made communication difficult between them, the majority of MCT members said rarely (67%).

According to observers, it appeared that the MCT members both understood and agreed upon their roles. The law enforcement team members were careful to make sure scenes were secure and that safety during the interviews or assessments was maintained as necessary. LEOs and clinicians alike strongly agreed that they trusted their MCT partner to keep them both safe.

> *100 % of APD is CIT trained and a moderate percentage is eCIT trained. 100% of BCSO deputies get 40 hour CIT block in the academy as well. Deputies and officers are well equipped to talk to people with a mental illness. As for assessing for mental illness and diagnosing, that should be left for licensed mental health providers (MCT therapists).* MCT member

Observers noted that team members tended to both listen to the client and agree about who should take the lead depending on the circumstance. There were no reported instances of team members stepping outside their respective roles or having conflict about the crisis assessment and intervention process. Disagreements about the issuance of CoEs appeared to be resolved professionally. Clinicians and LEOs stated they usually or always agreed on whether a client should be transported to emergency psychiatric services and when a client can safely stay where they were. Scene safety was frequently mentioned in the clinician notes. Role conflict within

teams and among first responders was identified by Bailey, et al (2018) as a barrier to MCT program implementation. Bernalillo County MCT members appear to have mostly resolved these issues among themselves; further work within the law enforcement agencies and with other first responders would continue to reduce this barrier.

Interactions with others

MCT calls for service include other officers and a client, and sometimes emergency medical teams and the client's friends and family. Surveys or focus groups with MCT clients and their families and friends are the best way to understand how MCTs were perceived by these groups. Those data will be collected as part of the outcome evaluation of the MCP program. In the interim, the MCT member surveys and ride along observations provide insight into a variety of these interactions.

MCT members were asked their level of agreement with statements about working with general field officers. The majority strongly agreed that officers allowed MCT to lead client interactions and deferred decision-making to MCT when they were on scene. They also strongly agreed that when MCTs were on duty, general field officers sought their advice when they were working with individuals experiencing a behavioral health crisis. Although MCT members mentioned that other law enforcement and dispatch should have a better idea of how to best utilize their training and expertise, they also indicated that when they were on scene, general field officers and MCT roles were well defined and respected.

Additionally, MCT members were asked about their perceptions of appreciation by others for MCT involvement on a call. The majority of MCT members strongly agreed that clients were appreciative of their involvement, as were their families and/or friends. A smaller majority strongly agreed that they were generally appreciated by emergency department staff. Ride-along observers reported that officers and clinicians were sometimes thanked by family members and that there seemed to be a mostly collegial relationship between MCTs and emergency department staff.

Research on the effects of crisis intervention training (CIT) on officers found positive effects on officer cognitive and attitudinal outcomes, including knowledge, attitudes, social stigma, and self-efficacy in dealing with people exhibiting a wide range of mental and behavioral issues (Watson, et al, 2017). At the time of the 2020 survey, MCT members were all CIT trained and had been working as MCTs for 12-36 months. Would they report changed attitudes in line with the findings for CIT? MCT members indicated their level of agreement with the statement, "Working on an MCT has improved my ability to work with individuals who have a mental illness." The majority of LEOs strongly agreed. There was more variation within the clinician responses, with the average level of agreement between somewhat agree and strongly agree. Given the differences in their professional preparation for dealing with individuals in mental health crisis, the slightly disparate perspectives between LEOs and clinicians on this issue is unsurprising. The fact that both groups believed their experiences with MCT improved their abilities to work with their client population is a positive outcome of the MCT program.

MCT Program Improvements

MCT members were asked, "What, if any, changes to policies and procedures do you think would improve the effectiveness of the MCT program?" and, "Is there anything else you need that would help you be more effective at your job?" Suggestion ranged from changing the MCT model to improving role clarity within the teams and across agencies. Their responses are summarized in Table 33.

Table 33: MCT Recommendations for Improved Effectiveness.

Category	Recommendations
Change the model	Two plainclothes officers and a masters level clinician as first responding team. Clinicians on call instead of riding along.
Inter-agency issues	Address inconsistencies across departments. Improve communication among higher level staff. Train clinicians with APD and BCSO, not just APD.
Clinicians	Provide knowledgeable and consistent oversight and support of clinicians. Provide appropriate clinical supervision.
Law enforcement	Distinguish the differences between MCT officers and ECIT officers
Procedures	Allow MCTs more flexibility to choose calls
Role clarity	Clarify roles, should officers be for safety only? Clarify whether MCT officers can override clinician decisions about mental health
Other	More MCTs. Train dispatch personnel and field officers to understand how to best use MCTs. More options for transport for clients.

Working within the Behavioral Health Continuum

MCT client encounters provide a 'front door' to the existing behavioral health continuum for individuals experiencing mental health crises who come into contact with law enforcement. Crisis and stabilization services delivered on scene extend the reach of the continuum into the community (Wertheimer, 2004), allowing people who might not otherwise access needed services. MCT members were asked to indicate their level of agreement with the statement, "There are appropriate community-based supports resource to aid MCT clients." For both clinicians and LEOs answers ranged from strongly agree to strongly disagree averaging to a neutral 'neither disagree nor agree."

> *MCT does the triage work in the field. We need a facility that will accept our clients with 'open arms' and a willingness to help with change.* MCT member

More specifically, MCTs were asked, "What alternatives to emergency psychiatric hospital services for MCT clients would you like to have in the community?" The identified behavioral health continuum gaps below are lightly edited.

- Care center for individuals in a mental health crisis.
- A true crisis center, something that does not exist in NM.
- Urgent care options.
- A second psych-only ER. UNM is overused and inappropriately used by LEOs.
- Psychiatric care that does not require ER clearance before admission.
- An urgent care but for mental health services.
- A crisis triage center that is more accessible to MCT and our clients.
- A programs/therapeutic model called "my living room" where people in crisis go to a safe and de-escalate if they can't be calmed at the scene or their safety is questionable.
- More beds for detox and PIP at MATS.
- CARE campus should open up with less strict requirements and referrals should be able to come from outside agencies, not just UNM psych.
- More substance use recovery IP support services and recovery programs offered by community mental health, not just state funded agencies.
- More homeless and substance abuse resources would be helpful to a certain extent because sometimes a client has had a bad experience with the Westside shelter or MATS and they don't want to go back.

The lack of community-based resources can also affect MCT members. In their study of MCT program implementation barriers and facilitators, Bailey et al noted that limited treatment resources, "… have the potential to foster frustration and burnout for team members" (2018, p. 7). The insufficiency of community treatment services for MCT clients is not unique to the Bernalillo County MCT program.

Summary

In their categorization of potential outcomes for CIT programs, Watson, et al, 2017, noted that they occurred within four different levels: individual officer, client/subject, agency, and community/society. This is a useful construct for framing the processes and outcomes for MCTs as well. For many of the stages of an MCT call for service, the strengths and weakness of the process at that stage have the potential to influence: the performance of teams, client outcomes, program success, and the community. This process evaluation has focused on team and agency performance with some attention to short-term outcomes for clients. Long term outcomes for clients and a full understanding of service system impacts within the larger community will be the focus of a future outcome evaluation (see Future Research below).

This section covers the three major functional areas that 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. In addition, there are two encompassing issues important for moving from this pilot program to fully-realized MCT program: record-keeping for program management and transparency, and comprehensive planning for a more effective MCT program.

Delivering MCTs to Potential Clients

MCTs were dispatched to almost 5,000 calls for service. On average, 80% of those CFS resulted in an MCT on-scene time with some teams losing over 40% of their calls during this transition and others losing 9% of dispatched calls for service. CFS data showed that 47% of dispatched CFS were either suicide-related or a general behavioral health calls. Clinician records classified about 43% of MCT calls as originating from dispatch and 36% initiated by officers and deputies in the field. Additionally, half of the calls to which MCTs were dispatched did not result in client engagement. CFS and clinician data both recorded over 1,200 suicide-related calls, about 13% of the CFS in the clinician records. Over 50% of 43-1-10 CFS dispositions were for clients who were not assessed by clinicians. If any of these numbers were not as expected, there are improvements to be made in EOCs, officer training, and record keeping. Improvement in the delivery of MCTs to potential clients requires systemic change and will primarily affect the opportunity for client engagement.

Emergency operations center personnel are the first point of contact for callers and perform the initial assessment that determines whether a call includes a behavioral health element for which an MCT response is appropriate. Their screening protocols and the training associated with this vital task were not part of the original evaluation plan. The degree of standardization of triage protocols and call prioritization across the centers is also unknown. The factors influencing the call start to call dispatch times are not well known. Discussions about how MCTs are deployed, including whether they are reaching the people who would most benefit from their services would benefit by incorporating emergency operations into the research. Research like this may provide information that is useful for improving the process used for triaging and dispatching CFS. Considering that 57% of MCT CFS did not originate from dispatch, incorporating officer and deputy perspectives will be important. Any changes in policies and procedures or training to improve the dispatch of MCTs should also be directed to law enforcement. This was echoed in the 2020 survey of MCT members: LEOs and clinicians alike said their jobs would be easier if more field officers understood MCT's role.

Cross jurisdiction communication difficulties not only affect the delivery of MCTs to scenes, they affect the ability to calculate call for service times and all the associated measures based on that information. Observers suggested that this occurs more often when BCSO responds within the City limits, which occurs more frequently than APD responding to calls within the County. MCT members and observers noted there was a disparity between BCSO and APD MCTs in the level of discretion they had in responding to a call. The creation of MCT-specific rules and regulations for BCSO is currently underway and might reduce this disparity.

Analysis of the MCT CFS data created a detailed record of time-based performance measures. They potentially form a baseline of comparison for future studies but there should be a context for evaluating these data. There is no literature to support a best practice for length of time for an MCT call so creating expectations for what constitutes poor, acceptable or excellent performance will be important going forward. Rubrics should take into account call priority level, call type, agency, call load, and officer availability, among other things. Further exploration of CFS data with additional detailed analyses will provide support for empirically-based decisions in call assignment, general staffing, and perhaps the location of MCTs.

Another barrier to getting teams to potential clients is the structure and flow of the MCSs' work days. CFS data (Tables 11 and 13), MCT member responses to a use of time question (Table 4), and observations point to the need to understand how MCTs spend their time when not on a call. An MCT member offered, "MCT has the potential to be a great program, however, there seems to be a lot of time spent not working." This could be a function of when and for what MCTs are dispatched or unclear job specifications, both of which can be addressed with further research and within the agencies' collaborative discussions. Improvements in CFS dispatch and daily team time management could result in more individuals receiving these 'front door' services.

On-Scene Client Services

The provision of on-scene services by law enforcement and clinicians appears to have the greatest fidelity to the MCT model and best practices: this directly benefits engaged clients and their families and friends. MCT members exhibited behaviors and practices in line with APD and BCSO SOPs for responding to people in mental health crisis, and with the values discussed in *Core Elements*. Additionally, clinicians appeared to have met SAMHSA best practices in this area including: screening for mental health, substance use, medical, and immediate safety issues; reviewing current medical histories; and co-creating strengths-based solutions.

SAMHSA's essential elements of responding to mental health crisis includes prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*" (SAMHSA, 2009: p. 7, emphasis in the original). There was little evidence of crisis planning in the clinician records although this might be due to inconsistent documentation of this service.

Providing linkages to services for stabilization and recovery is a program area that does not appear to be fully developed. There is an exception: referrals for psychiatric evaluation was the single largest category of clinician referrals (about 18%), this is an important linkage to services that might be overlooked when a goal of MCTs is to *decrease* the use of emergency hospital services. If the assumption is that MCTs diverts clients *from emergency services* to less restrictive care options (not supported in the literature) then referrals to ED service might be discouraged. If the assumption is that MCTs reach people who might not otherwise have the opportunity for linkage to services, referrals for a psychiatric evaluation might be accepted as the best option with no expectation of increasing or decreasing their issuance. How this issue is

clarified in the short-term will influence whether the long-term effects of MCT on ED use is realistic or attainable.

APD SOP 2-19-9 5 Services states that the MCT clinician shall provide referral services to individuals in crisis and those referrals should be structured in a way that facilitates follow-up by the clinician. This did not seem to be the case, even with referrals for psychiatric evaluation. A person could enter and exit the hospital in a matter of minutes or hours, throw away a resource card, or develop a relationship with a local service provider; without follow-up there is no way to know what effect a referral might have on the current or future status of the client. Integration of best practices for referrals might increase client access to services.

Proper documentation of the referrals and any follow-up would show patterns of use and identify gaps in the behavioral health continuum for future funding. MCT LEOs and clinicians expressed what they see as limited options for referrals to community-based services. Addressing the gaps identified by MCT members potentially benefits individuals, agencies, and the community. Research from a national survey of police departments suggests that both the number and type of community based mental health resources available in an area affects diversion from arrest and involuntary commitment among law enforcement, generally (Jachimowski et al., 2020). Expanding the number of placement resources available for MCTs broadens the array of 'least restrictive environments' and could impact short- and long-term client outcomes. Expanding the number and type of opportunities for referral within the behavioral health continuum should improve both short- and long-term client outcomes.

Follow-up and Case Management

For the first 25 months of the MCT program, follow-up and case management were non-existent or nascent. This is likely due to incomplete program design (including articulating the roles and responsibilities for LEOs and clinicians for this function), and insufficient staffing. Without this component, "linkage to services" does not reach beyond the arrival of a client at an ER or the verbal or paper referral to community services. Clients who have appointments made for them are more likely to keep those appointments; a 'warm hand-off' is considered a best practice for increasing the likelihood of engagement in services; and active case management that addresses the mental, physical, and social aspects of client's lives can result in a decrease in frequency of contact with law enforcement and hospitals. (SAMHSA 2009). Future discussions about how and by whom follow up and case management services could be delivered should consider best practices for timing and method of follow-up, and how to affect a 'warm hand-off' in the CFS circumstances.

Administrative Record-Keeping for Program Management and Accountability

These recommendations are not primarily for the use of evaluators: they are improvements in administrative record-keeping for daily program management and accountability. From CFS to clinician data, there is the need for a collaborative redesign of data collection instruments. Data gaps have been identified throughout this document and, if addressed, will provide a much clearer picture of MCT program performance. This benefits the teams, agencies, and the community by setting expectations and transparent measurement of their successes and challenges.

Generally, call dispositions are law enforcement codes designating the status of a call when it is cleared; they are often used as measures of MCT success. However, current categorizations of call dispositions in the clinician records are a mix of ambiguous terms (left in the community), authorities to transport (43-1-10, CofE), and client willingness to be transported. Using mutually exclusive categories to capture each of the elements of interest would allow a more nuanced understanding of client status at the time of the end of the call. Perhaps reframing these data at the clinician level (recognizing law enforcement has other reporting requirements) from "call disposition" to "client status" would reflect the program's focus more appropriately. With many clients, the call disposition should be the beginning of the next phase of MCT services.

An oft repeated goal of MCTs is to resolve the mental health crisis in the least restrictive environment. When that environment is the client's home location, this is referred to colloquially as being 'left in the community,' and it seems to be valued as the default best option for all clients. Sometimes getting a person to needed psychiatric services is *the best option for that person*. And in the professional judgment of MCT clinicians, that was true for over 60% of MCT clients who were transported. Being left in the community is perhaps more appropriately labeled "client remains at location." And what matters in evaluating team performance is the status of the clients who remain in place. Are they in the company of their natural supports? Do they have safety plans? Was there a discussion about reducing access to lethal means? MCTs appear to use some of these best practices: having them recorded appropriately will also facilitate the follow-up and case management aspects as they are developed.

Clinician records noted the arrest of 2.8% of clients (Table 28). Table 29 shows that among those who were contacted/assessed by MCT, arrests represent 1.8% of call dispositions, similar to other CIT-related incidents (Winograd, 2018). For those who were not contacted/assessed by MCT, arrests account for 8.0% of the call dispositions noted. This is interesting for both the delivery of MCT services to potential clients (e.g., an arrest for an outstanding warrant occurs before MCT arrives, resulting in call cancelation) and for evaluating program performance based on call dispositions. If a goal of the Bernalillo County MCT program is to reduce arrests of people experiencing a mental health crisis, additional information will be needed to ascertain this potential effect. The call disposition "arrest" could be expanded to include whether the arrest was for an outstanding misdemeanor or felony warrant (which might account for level of discretion a LEO can use) or for client behavior on the call that resulted in an arrest. An arrest for which there was no officer discretion should be able to be identified so calculations of call dispositions can be reflective of a choice made by an MCT LEO. Additionally, *who* made the arrest (MCT LEO or another LEO on-scene) is important to capture appropriately. This information exists in other reports filed by LEOs with their respective departments but having it noted in the clinician files would improve accessibility to the information for program administrators.

Although its effects can be devastating in any given instance, the use of force by police is an extremely rare event. Jacobs (2020) examined APD use of force events from 2016-2019 and found an average of 626 force events per year for an average 408,000 CFS and14,556 arrests per year. More specifically to CFS involving a behavioral health element, Winograd et al. reviewed 2018 Crisis Intervention Team data and found that 1% of APD officer encounters involved a use

of force (2019). If a stated goal of the MCT program is to reduce use of force in law enforcement encounters with people in behavioral health crises, relevant data should be systematically collected by MCT members or made available to program administrators on a regular basis.

Comprehensive Planning

As of June 1, 2021 the MCT program will have been active for over three years. The program has grown to six teams and has adapted to the challenges of a global pandemic. It is transitioning from a single behavioral health provider to the City and County each providing clinicians, and to integrating a non-law enforcement response team. This appears to be an opportune time to reflect on the successes and challenges of the past three years and *systematically* plan the future of the program. An effective way to understand the links between the program resources, activities, short- and long- term outcomes, and desired system-wide effects of the program is to develop a MCT Program Theory.

A program theory includes both a logic model (representing the theory of change for people or systems) and a theory of action (similar to a process map) to make possible the desired changes. The complexity of the MCT program would benefit from the articulation of linked process maps to capture the details of how MCTs are dispatched, their activities in the field, and in client follow-up and case management. Nested logic models would detail the societal level changes and the step-by-step journey of clients as they progress from states of mental health crisis to more stable, healthy lives. The goal of "reduced engagement with the criminal justice system" requires something(s) to happen within a client's world to change the circumstances that lead to that involvement. How does MCT facilitate that progression?

Logic models and process maps are most effective if they are facilitated by a neutral third party and co-created by a diverse group of stakeholders, in this case, leadership, management and front line personnel from: the emergency communication centers, APD and BCSO, current MCT clinicians and law enforcement, former HopeWorks clinicians, and general field officer and deputies. For the development of some aspects of the process maps and logic models, stakeholders might include people with lived experience, other community behavioral health providers, representatives from psychiatric emergency departments, and former clients of the MCT program.

The process of developing an MCT Program Theory could lead to adjustments in program expectations or a clear articulation of the agency commitments required to bring to bear the resources to create the program envisioned through this process. It could also lead to reallocating some resources to achieve similar goals, like embedding clinicians in the EOCs or increasing the use of crisis intervention text and telephone referrals for non-emergency behavioral health calls as ways to more efficiently target the MCTs' use. There is knowledge and experience enough to be intentional about every aspect of the program going forward.

Future Research

The largest gaps in our understanding of the MCT *processes* are the role of communications/dispatch and officers in triaging calls for service; the clarification of when the subject of a call is considered contacted and assessed, the meaning of ambiguous call disposition classifications, and the absence of client follow-up and case management. Focus groups with emergency communications center personnel and reviews of training and operational documentation for the emergency operations will provide information critical for any potential changes to how MCTs are deployed. Conversations with MCT clinicians and agency leadership could result in refinement of the clinician record data collection tools to address the questions of contact/assessment and call disposition. There needs to be agency collaboration, buy-in, sufficient funding, and detailed planning to integrate into the program the critical functions of follow-up and case management.

There are three outstanding questions to be addressed in the *outcome* evaluation:

1. What is the added benefit of MCT response to individuals experiencing behavioral health crises?

   In the context of fully CIT trained law enforcement personnel in both BCSO and APD, and several specialized behavioral crisis response teams (CIU, COAST), MCTs unique contribution is the provision of LEOs with enhanced CIT training and the on-scene clinical services of mental health assessment, diagnosis, treatment, referrals community based resources; and referrals to higher levels of treatment through a CofE. Along the lines of the Helfgott et al (2016) study, did the presence of a clinician decrease repeat client contacts and time on scene? What differences are there *between regular field officer responses and MCT responses* in the performance measures discussed in calls for service and on the disposition of calls*?* For example, if there are differences between the two in total time on the call, is it for all of the call types or only on a specific call type, i.e., suicide CFS? Do MCTs provide community behavioral referrals more frequently than regular field officer?

2. What are the long-term outcomes for clients who encounter MCTs?

   Client focus groups or a series of surveys over time can yield both perceptions of the impact of MCT contact and self-reported system involvement. Surveys or focus groups with clients can explore other individual level outcomes such as changes in: mental and physical health, relationships, employment status, use of justice, medical and social services, etc.

3. What effects does MCT crisis intervention have on client justice system involvement, emergency medical service use, and social service use?

   Connecting clients to their emergency department, arrest, and jail data will provide empirical evidence of system involvement and provide the basis for a benefit-cost analysis of the program.

Conclusion

In the first 25 months of the program, MCTs have been dispatched to almost 5,000 calls for service, arrived on scene for 3,960 of those calls, and written CofEs for over 600 clients. Over 60% of dispatched CFS resulted in a client being transported to emergency psychiatric or medical services. Fewer than 3% of clients were arrested. MCT members appear to use best practices in dealing with people in behavioral health crisis and their actions are in alignment with BCSO and APD SOPs addressing response to individuals in mental health crisis.

Alignment of policies and procedures across the law enforcement agencies and improved communication and program support from leadership could address the identified challenges in call triage for MCT dispatch by EOCs and law enforcement, expectations for use of time during shifts, and role clarity between clinicians and law enforcement officers on-scene and in determining the disposition clients. A reassessment of program expectations that value the "front door" aspects of MCT and moves away from traditional police performance measures would provide a clearer understanding of program performance and potential impacts. Additionally, redefining client dispositions to include indicators of best practices for crisis intervention would further detail the potential added value of MCT response to individuals experiencing mental health crises. Although there are individuals for whom MCTs intervention might have been the needed "front door" to services, without follow-up and case management for clients, the Bernalillo County MCT program cannot realistically expect to reach its goals for long-term improvements in its client population or in the criminal justice, hospital, or social service systems in Bernalillo County.

References

Abbott, S.E. (2011). Evaluating the impact of a jail diversion program on police officer's attitudes toward the mentally ill. (Doctoral dissertation).

Albuquerque Police Department Procedural Orders (2020) Standard Operating Procedure (SOP) 1-37 Crisis Intervention Section and Program https://www.cabq.gov/police/standard-operating-procedures/standard-operating-procedures-manual

Albuquerque Police Department Procedural Orders (2020) Standard Operating Procedure (SOP) 2-19 Response to Behavioral Health Issues https://www.cabq.gov/police/standard-operating-procedures/standard-operating-procedures-manual

Baess, E. (2005). Integrated Mobile Crisis Response Team (IMCRT): Review of pairing police with mental health outreach services. Victoria, BC: Vancouver Island Health Authority.

Bailey, K, S.R. Paquet, B.R. Ray, E. Grommon, E.M. Lowder, and E. Sightes (2018). Barriers and facilitators to implementing an urban co-reponding police=mental health team. *Health and Justice*. https://doi.org/10.1168/s40352-018-0079-0

Bernalillo County Sheriff's Department Rules and Regulations *BCSD Rules and Regulations 354*

Community Partners, Inc. (2015). Behavioral Health Business Plan (prepared for the Bernalillo County Bernalillo County Board of County Commissioners). December.

Cotton, D., & Coleman, T. G. (2010). Canadian police agencies and their interactions with persons with a mental illness: A systems approach. Police Practice and Research: An International Journal, 11(4), 301-314.

Dempsey, C, C Quanbeck, C Bush, and K Druger. (2019) Decriminalizing mental illness: specialized policing responses *CNS Spectrums*, 1-15. doi:10.1017/S1092852919001640

Dempsey, C. (2016). Beating mental illness: Crisis intervention team training and law enforcement response trends. *S. Cal. Interdisc. LJ*, *26*, 323.

Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminological informed framework for mental health policy and services research. Administration and Policy in Mental Health and Mental Health Services Research, 33, 544–557.

Forchuk, C., Jensen, E., Martin, M. L., Csiernik, R., & Atyeo, H. (2010). Psychiatric crisis services in three communities. *Canadian Journal of Community Mental Health*, 29, 73–86.

Guo, S., Biegel, D., Johnsen, J., and Dyches, H. (2001). Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. Psychiatric Services, 52(2), 223-228.

Helfgott, J., M Hickman and A Labossiere. (2016) A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program. *International Journal of Law and Psychiatry* 44 109-122.

Jachimowski, K.G., C.J. Smathers, L.N. Smathers, and R.J. Lemmon. (2020) The impact of Mental Health Resources on Police Officer Action. Journal of Police and Criminal Psychology. https://doi.ord/10.1007/s11896-020-09395-x

Jacobs, K. S., 2020. Albuquerque Police Department Annual Use of Force Report 2016-2019, Albuquerque Police Department Internal Affairs Force Division.

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Canadian Journal of Psychiatry, 55*(10), 662–668.

Krider, A. et al. 2020 Responding to individuals in behavioral health crisis via co-responder model: the Roles of Cities, Counties, Law Enforcement and Providers. Policy Research Institute and the National League of Cities. January.

Lamb, R and L. Bachrach, 2001. Some Perspectives on Deinstitutionalization. Psychiatric Services. v52:8. August https://doi.org/10.1176/appi.ps.52.8.1039

Lee, S., et al. (2015). Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. International Journal of Mental Health Nursing, 24, 538-546.

McClendon v. City of Albuquerque, 29 F. Supp. 2d 1267 (D.N.M. 1996)

New Mexico IBIS 2017a. Health Highlight Report for Bernalillo County. New Mexico's Indicator-Based Information System. Retrieved from:https://ibis.health.state.nm.us/community/highlight/profile/MentHlthAdult.Cnty/GeoCnty/1.html

New Mexico -IBIS, 2017b Health Highlight Report for Bernalillo County, Suicide Death. New Mexico's Indicator-Based Information System. Retrieved from https://ibis.health.state.nm.us/community/highlight/profile/SuicDeath.Cnty/GeoCnty/1.html

New Mexico Statues Chapter 43 Commitment Procedures Article 1 – Mental Health and Developmental Disabilities Section 43-1-10 Emergency mental health evaluation and care.

Puntis, S., et al. (2018). A systematic review of co-responder models of police mental health 'street triage' *BMC psychiatry*, *18*(1), 256.

Rosenbaum, N. (2010). Street-level psychiatry-a psychiatrist's role with the Albuquerque police department's crisis outreach and support team. *Journal of Police Crisis Negotiations*, 10(1), 175–181.

SAMHSA, 2009. Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Services Administration.

SAMHSA 2013 The NSDUH Report Metro Brief Substance Use and Mental Disorders in the Albuquerque MSA

SAMHSA 2020. Behavioral Health Barometer: New Mexico, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–NM. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Scott, R. (2000). Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction [Electronic version]. *Psychiatric Services*, *51*(9), 1153-1156

Seo, C., Kim, B., & Kruis, N. E. (2021). A Meta-Analysis of Police Response Models for Handling People with Mental Illnesses: Cross-Country Evidence on the Effectiveness. *International criminal justice review, 31*(2), 182-202.

Steadman, H.J., FP Morrisey, MW Deane and R Borum. (1999) Police response to emotionally disturbed persons: analyzing new models of police interaction with mental health system. A report submitted to US DOJ. December

Tinney, M and N Rosenbaum. 2015. Police perceptions of the percentage of contacts in Albuquerque, nm that involve people living with mental illness. December.

Treatment Advocacy Center 2017. New Mexico. Retrieved from https://www.treatmentadvocacycenter.org/browse-by-state/new-mexico

U.S. Centers for Disease Control and Prevention (CDC), BRFSS Prevalence and Trends Data, https://www.cdc.gov/brfss/brfssprevalence.

Watson AC, MT Compton, JN Draine. The crisis intervention team (CIT) model: An evidence-based policing practice? Behav Sci Law. 2017;35:431–441. https://doi.org/10.1002/bsl.2304

Wertheimer, D. (2004). Crisis Triage Services Continuum Recommendations Final Consultant Report (pp. 1-41, Consultant Report). (City of Albuquerque Behavioral Health Crisis Triage Planning Initiative). Seattle, WA: Kelly Point Partners.

Whiteside, C. 2019. Health Behaviors and Conditions of Adult New Mexicans, Results from the New Mexico Behavioral Risk Facto Surveillance system. Report from the NM Department of Health.

Wilson-Bates, F. (2008). Lost in transition: How a lack of capacity in the mental health system is failing Vancouver's mentally ill and draining policing resources. Vancouver.

Winograd, P., K. Brown and M Dietzel 2019. An overview of behavioral health related incidents in Albuquerque. Report prepared for Albuquerque Police Department. Spring.

Winograd, P. 2018 An analysis of arrest and disposition data related to the McClendon Settlement Agreement: data gathered between April 28, 2017 and April 28, 2018. Report prepared for the City of Albuquerque Police Department. October.

Additional information on McClendon v. City of Albuquerque.
https://www.cabq.gov/police/mcclendon-v-city-of-albuquerque-settlement
https://www.cabq.gov/police/documents-related-to-apds-settlement-agreement
https://www.cabq.gov/police/news/settlement-agreement-city-of-albuquerque-justice-department

Appendix A Calls for Service Categorized

Table A.1 reports how we report categorizations and then the call descriptions and codes as ISR receives them by their associated law enforcement department.

Report Categorizations by Call Codes and Law Enforcement Department			
Report Categorizations	Call Descriptions	Call Codes	Department
Behavioral Health	Behavioral Hlth	40	APD
Behavioral Health	MENTAL PATIENT	40	BCSO
Contact	CONTACT REF THREATS	25T	BCSO
Contact	Contact	25	APD
Contact	MAKE CONTACT W/	25	BCSO
Other	911 HANG-UP	911H	BCSO
Other	911 MISUSE/ABUSE	911M	BCSO
Other	911 OPEN LINE	911O	BCSO
Other	COVER/ASSIST	82	BCSO
Other	Cover assistance	82	APD
Other	E911 hang up	31-1	APD
Other	Fire call	33	APD
Other	INVESTIGATION	27	BCSO
Other	Investigation of	27	APD
Other	Juvenile call	30	APD
Other	MISC INFORMATION	49	BCSO
Other	MISSING PERSON	28	BCSO
Other	MISSING PERSON - RETURNED	28R	BCSO
Other	Message for deli	51	APD
Other	Missing person	28	APD
Other	PHONE CALL	21	BCSO
Other	PHONE CALL	21	APD
Other	RESCUE CALL	43	BCSO
Other	Rescue call	43	APD
Other	SWAT TEAM	76	BCSO
Other	Tac plan	74	APD
Other	Use of Force	27-U	APD
Other	WANTED CHECK	29	BCSO
Other	Wanted person	29	APD
Property	AUTO THEFT	27-7	BCSO
Property	Auto Theft	27-7	APD
Property	BURGLARY - RESIDENTIAL/COMMERCIAL WEAPON INV/IMPL	27-5AG	BCSO
Property	BURGLARY RESIDENTIAL	27-5R	BCSO
Property	Burglary Auto	27-5A	APD
Property	Burglary Comm	27-5C	APD
Property	Burglary Res	27-5R	APD
Property	DISTURBANCE	39	BCSO
Property	Disturbance	39	APD
Property	LARCENY	27-6	BCSO
Property	LARCENY IN PROGRESS	27-6P	BCSO
Property	Onsite Disturban	39S	APD
Property	Theft/fraud/embe	27-6	APD
Property	VANDALISM	38	BCSO
Property	Vandalism	38	APD
Public Order	ACCIDENT NO INJURIES	44	BCSO

Public Order	ACCIDENT WITH INJURIES	45	BCSO
Public Order	AUDIBLE ALARM	52	BCSO
Public Order	Audible alarm	52	APD
Public Order	DOWN AND OUT	D/O	BCSO
Public Order	HIT AND RUN ACCIDENT NO INJURIES	44H	BCSO
Public Order	MOTORIST ASSIST	MA	BCSO
Public Order	OVERDOSE	OD	BCSO
Public Order	Panhandlers	39-5	APD
Public Order	Shots fired	39-3	APD
Public Order	TRAFFIC STOP	54	BCSO
Public Order	Traffic stop	54	APD
Public Order	traff acc injuri	45	APD
Public Order	traff acc no inj	44	APD
Suicide	SUICIDE ATTEMPT	43-1A	BCSO
Suicide	SUICIDE THREATS	43-1T	BCSO
Suicide	Suicide	43-1	APD
Suicide	Suicide	43-1	BCSO
Suspicious	Onsite Suspiciou	31S	APD
Suspicious	SUSIPICIOUS VEHICLE	31V	BCSO
Suspicious	SUSPICIOUS PERSON	31	BCSO
Suspicious	Susp Pers/Vehs	31	APD
Training and Community Events	Community Activy	75-1	APD
Training and Community Events	Trng. Instructor	75-3	APD
Violent	ARMED SUBJECT	ARMD	BCSO
Violent	ASSAULT	27-4	BCSO
Violent	Aggr assault/bat	27-4	APD
Violent	Child Neglect	30-3	APD
Violent	DOMESTIC VIOLENCE	15	BCSO
Violent	FIGHT	32	BCSO
Violent	Family dispute	15	APD
Violent	ROBBERY STRONG ARMED	27-3	BCSO
Violent	SHOOTING WITH VICTIM	27-8	BCSO
Violent	SHOTS FIRED IN THE AREA	27-8A	BCSO
Violent	STABBING VICTIM	27-9	BCSO
Violent	Sex offense	23	APD
Violent	Sexual Abuse	30-2	APD
Violent	Shooting	27-8	APD
Violent	Stabbing	27-9	APD
Welfare Check	WELFARE CHECK	10	BCSO
Welfare Check	Welfare check	10-10	BCSO
Welfare Check	Welfare check	10-10	APD

Appendix B MCT Member Survey

To open the full instrument, hover cursor over survey below, right click→Acrobat Document Object →Open. The survey will open in Abode Acrobat.

MCT Program Survey Fall 2020

Q1: Bernalillo County Behavioral Health Initiatives: Mobile Crisis Teams (MCT): Research Informed Consent for On-Line Survey
Fall 2020

Paul Guerin, from the Institute for Social Research is conducting a research project. The purpose of the research is to survey MCT staff about the MCT program. You are being asked to participate because you are currently or recently were an MCT member.

Your participation will involve completing a survey. The survey should take between 15 and 30 minutes to complete. The survey includes questions about your work experience, your experiences as an MCT member, the types of calls your team has answered, team member roles, perceptions of clients, and barriers. Your involvement in the research is voluntary, and you may choose not to participate. You can refuse to answer any of the questions at any time. There are no names or identifying information associated with your responses. There are no known risks in this research, but some individuals may experience discomfort or loss of privacy when answering questions. Data will be stored on UNM servers located at UNM IT, which are encrypted and protected by a firewall and passwords and meets all UNM requirement. The survey data will be maintained for the duration of the study and the study may continue for a number of years. Your information collected for this project will NOT be used or shared for future research, even if we remove the identifiable information like your name or date of birth.

The findings from this project will provide information that will be used to help understand how the MCT program works. There will be no direct benefit and only expected generalized benefits. If published, results will be presented in summary form only.

If you have any questions, concerns, or complaints about the research, please feel free to call Paul Guerin at 505-277-4215. If you have questions regarding your rights as a research participant, or about what you should do in case of any harm to you, or if you want to obtain information or offer input, please contact the UNM Office of the IRB (OIRB) at (505) 277-2644 or irb.unm.edu.

By clicking START you will be agreeing to participate in the above described research.

Q2: How long have you worked in your profession as law enforcement or in clinical services:Please enter the number of years and round months to the nearest quarter of a year: 1-3 months = .25; 4-6 months =.5; 7-9 months =.75. over 9 months please round to the next whole number.

Years ☐

Q3: How many years have you worked on the MCT Program?Please enter the number of years and round months to the nearest quarter of a year: 1-3 months = .25; 4-6 months =.5; 7-9 months =.75. over 9 months please round to the next whole number.

Years ☐

Page 1 of 10