The HARRIS CENTER for Mental Health and IDD
Transforming Lives

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Memorandum

To: Wayne Young, Executive Director, The Harris Center for Mental Health & IDD (THC)

From: Amanda Jones, J.D., THC Director of Government and Public Affairs; Lt. Patrick Plourde, Houston Police Department; Kisha Lorio, M. Ed., LPC, Director of the Crisis Intervention Response Team; Sridatri Chakraborty, M.S., Health Analytics Data Analyst, Scott Hickey, Ph.D. Director of Health Analytics

Re: Crisis Intervention Response Team Evaluation

Date: August 21, 2020

Introduction

A primary goal of crisis intervention training (CIT) is to provide law enforcement officers with the tools to respond effectively to situations involving a person with mental illness in crisis and when appropriate, refer them to mental health services rather than incarceration. According to the Federal Bureau of Investigation, this goal is based on five objectives including reducing injuries to officers, alleviating harm to the person in crisis, promoting decriminalization of individuals with mental illness, reducing the stigma associated with mental illness, and using a team approach when responding to crises.

The model varies widely from jurisdiction to jurisdiction based upon local need, resources, and collaboration. In 2019, the Mental Health Division of the Houston Police Department consisted of 40 full-time personnel. The Houston Police Department's model includes training and response. The Crisis Intervention Training Unit trains more than 5,600 law enforcement personnel annually. The Crisis Intervention Response Teams (CIRT) can be thought of as a specific subset, a unique strategy existing alongside CIT-trained officers. A CIRT team consists of an HPD Officer and a master level clinician from The Harris Center.

The local Crisis Intervention Response Team (CIRT) is a specialized program responding to mental health crisis calls in our community. The program pairs a licensed, masters-level mental health clinician with a law enforcement partner. The mobile team responds to 911 dispatch calls and referrals from the Houston Police Department Mental Health Division, Harris County Sheriff's Office Mental Health Unit, and The Harris Center for Mental Health and IDD. The law enforcement officer researches the individual's criminal history and provides safety by securing the scene. The licensed masters-level clinician accesses medical records to research mental health history en route to the crisis. Once on scene, the clinician will provide a mental health assessment, determining the appropriate level of care (Is hospitalization indicated?), linkage/referral to services, and education on scene to family members or other concerned parties. Clinicians also act as consultants to law enforcement and assist with obtaining inpatient hospital beds. Law enforcement may provide transportation to an inpatient facility for individuals in severe crisis. CIRT completes follow-ups at the request of the referral source.

The philosophy of the Crisis Intervention Response Team (CIRT) is to promptly and accurately assess and treat individuals experiencing a mental health crisis to avoid unnecessary incarceration, and to utilize the least restrictive means of stabilizing consumers including linkage into outpatient services where indicated.

Best Practices

While there has not been enough research to date to declare CIT an "Evidence Based" practice, CIT has been called both a "Promising Practice" (International Association of Chiefs of Police, 2010) and a "Best Practice" model for law enforcement (Thompson & Borum, 2006). One of the core elements of the model is collaboration with community partners, including mental health providers (Dupont, Cochran & Pillsbury, 2007).

The U.S. Department of Justice's Bureau of Justice Assistance supports 10 urban and rural police departments to act as host sites to visiting law enforcement agencies and their mental health partners. HPD is one of the technical assistance sites for crisis intervention training.

- Houston (TX) Police Department
- Los Angeles (CA) Police Department
- Madison (WI) Police Department
- Portland (ME) Police Department
- Salt Lake City (UT) Police Department
- University of Florida Police Department
- Jackson County (OH) Sheriff's Office (regional)
- Madison County (TN) Sheriff's Office
- Tucson (AZ) Police Department
- Arlington (MA) Police Department

The US Substance Abuse and Mental Health Services Administration (SAMHSA) has identified standards for CIT (Practice Guidelines: Core Elements in Responding to Mental Health Crises, retrieved 8/13/20 from https://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/sma09-4427). The following is a comparison between HPD's CIRT model compared to the standard.

1) Standard: Staff that is appropriately trained and that has demonstrated competence in understanding the population of individuals served, including not only a clinical perspective, but also their lived experiences.

   CIRT Model: All Crisis Intervention Response Team clinicians are licensed professional counselors or licensed clinical social workers with crisis experience. Most clinicians have worked with law enforcement in the past in jails, prisons, or other community mental health facilities. CIRT clinicians and law enforcement are partners to ensure the best outcome for the individual in crisis. CIRT clinicians provide the assessment and the officers provide safety. Officers and deputies who work CIRT are all CIT officers (trained in mental health). The training is 40 hours initially and an additional 8 hours per year. These trainings include teachers with lived experience in serious mental illness.

2) Standard: Staff and staff leadership that understands, accepts and promotes the concepts of recovery and resilience, the value of consumer partnerships and consumer choice, and the balance between protection from harm and personal dignity and staff that has timely access to critical information, such as an individual's health history, psychiatric advance directive or crisis plan. Such access is, in part, reliant on effective systems for the retrieval of records, whether paper or electronic.

CIRT Model: CIRT leadership and staff have access to The Harris Center, Harris Health Epic and HCPC Sunrise medical records databases. When the CIRT team gets a 911 call or referral and if a name or date of birth is obtained, the individual is researched before the team arrives on scene. This helps the team build rapport quickly with the individual; reduces the need for the patient to repeat mental health and medical information; aids in a thorough assessment; increases continuity of care if the individual has a mental health history with The Harris Center, and improves continuity of care as the outpatient clinic staff is informed of the CIRT contact.

3) Standard: Staff that is afforded the flexibility and the resources, including the resource of time, to establish truly individualized person-centered plans to address the immediate crisis and beyond.

CIRT Model: The Crisis Intervention Response Team is single contact, and the goal is to assess for a mental health crisis, provide education to the individual in crisis and the family on scene, and link to services. If the individual is admitted to the hospital, the case is closed by CIRT due to privacy laws. If the patient has an open case with The Harris Center, the clinic caseworker and doctor are informed that the patient was admitted to the hospital, so the clinic can follow up. If the call is resolved on scene because the person was deemed to not be in crisis, the CIRT clinician makes a referral to The Harris Center clinic line to follow up with the individual.

4) Standard: Staff that is empowered to work in partnership with individuals being served and that is encouraged, with appropriate organizational oversight, to craft and implement novel solutions.

CIRT Model: CIRT staff are involved in community organizations like NAMI and MHA, and conduct community education and presentations of services offered.

5) Standard: An organizational culture that does not isolate its programs or its staff from its surrounding community and from the community of individuals being served. This means that the organization does not limit its focus to "specific" patient level interventions, but also positions itself to play a meaningful role in promoting "indicated" strategies for the high-risk population it serves and "universal" strategies that target prevention within the general population. The intent here is not to dissipate the resources or dilute the focus of an organization, but to assure recognition that its services are a part of a larger spectrum and that it actively contributes to and benefits from overall system refinements.

CIRT Model: The crisis intervention response program is field-based and takes calls 24/7 in the community. CIRT staff also attend community health fairs, present at high schools and colleges, and train new officers at the law enforcement CIT 1850 mental health class. CIRT conducts site visits for other law enforcement agencies who are interested in developing their own CIRT program and attends safety town hall meetings.

6) Standard: Coordination and collaboration with outside entities that serve as sources of referrals and to which the organization may make referrals. Such engagement should not be limited to service providers within formal networks, but should also include natural networks of support relevant to the individuals being served.

CIRT Model: The Crisis Intervention Response Team takes calls from 911 dispatch with a mental health component. The team also takes referrals from The Harris Center crisis line and Mobile Crisis Outreach Team that are calls from the community. CIRT is also on all SWAT calls and completes referrals from The Harris Center administrations and law enforcement that originated from the community.

7) Standard: Rigorous performance improvement programs that use data meaningfully to refine individuals' crisis care and improve program outcomes. Performance improvement programs

should also be used to identify and address risk factors or unmet needs that have an impact on referrals to the organization and the vulnerability to continuing crises of individuals served.

CIRT Model: The Crisis Intervention Response Team is involved in The Harris Center's performance improvement committees. Since CIRT is a crisis program, assessments must be entered into medical so information can be provided to the referral source in a timely matter. Since being involved with performance improvement, CIRT's compliance with performance improvement targets has improved from over 95% compliance to 99% compliance.

How Calls Reach CIRT

All calls come from the dispatcher via the Houston Emergency Center (HEC). 911 call-takers answer the phone lines when a citizen calls to report an emergency for police or fire response. The call takers follow a logic tree of questions based on the nature of the complaint. The call taker will generate the call slip summary with a specific title accompanied by a 4-digit numerical code that best matches the nature of the call (e.g. "3041 Disturbance/CIT") and assign a response priority that ranges from Code 1 to Code 7 (Code 1 being the highest priority). The call slip will contain a brief narrative of the complaint with limited details of involved persons and a possible phone number.

Once the calls slips are created, they are sent to a queue on the dispatch board broken down by patrol district boundaries (geographic area of the city divided into 22 patrol districts). The dispatcher will broadcast the call for service to the patrol officers via police radio and the next available unit will either volunteer or be dispatched to respond to the call for service.

CIRT does not adhere to any one specific district and beat. CIRT operates countywide and will be called upon by the request of any patrol unit or any district dispatcher. The call slips are then sent electronically to the police mobile data terminal which is controlled by computer aided dispatch (CAD). Both the CIRT officer and clinician can see the call slip details and run the consumer's name (if provided by the reportee) in the clinical database for any potential documented history of public mental health treatment. Often times, the clinician and officer will be able to know the history of their mental health prior to arrival (time permitting).

The Houston Emergency (call) Center receives approximately 1 million calls for service for HPD annually. When 911 call takers get preliminary information from the citizen calling in, they screen calls to determine if they would best be directed toward police or fire departments. Within their line of questions, the call-takers ask some basic questions related to mental health (does this involve someone with mental illness or someone in a mental health crisis?). If there is a link or component to mental health, the call-taker will label the call with one of the 28 types of CIT codes. Last year 40,500 calls were so labeled.

All new HPD officers receive Crisis Intervention Training, training in mental health and de-escalation techniques at the Police Academy. Gradually, the proportion of CIT-trained officers has increased as new officers have come onto the force. Last year, 72% of HPD CIT calls were dispatched to CIT-trained officers. Before officers are dispatched, calls are funneled through a classification and referral system.

CIRT Teams are dispatched as secondary (back-up) units to CIT calls. First line patrol units assigned to their respective districts and beats are dispatched as primary units to respond to CIT calls due to their closer proximity. The travel time for CIRT to respond to the call from dispatch time to arrival time can average 20 minutes depending on their current location throughout the entire city. CIT calls can be volatile, fluid and unpredictable in required time per call. Any delay to a reasonable response time could be detrimental to the safety of those involved at the scene as situations could deteriorate.

Crisis Call Diversion (CCD) is a partnership between the City of Houston, HPD, The Harris Center, and the Houston Fire Department. Mental health professionals are embedded at 911 call center for the City of Houston. If the 911 call is labeled with one of the 28 types of CIT call codes, then a mental health

professional will take the call. Some common responses include transfers to The Harris Center's crisis line, non-law enforcement mobile crisis response, community referrals, and development of suicide reduction "safety plans."

Call takers at the 911 call center sort calls into complaint types including 28 CIT categories. Originally, only calls without a criminal nexus and without threats of violence could be directly sent to the Crisis Call Diversion (CCD) terminal for their handling. Since February, some calls which are clearly mental health-related and also have a low-level criminal component may also be referred.

If CIRT workers are tied up on calls, any other CIT type calls will be sent to the dispatch board in queue awaiting a unit to be dispatched. During the CCD interaction over the phone with the concerned party, they may be capable of resolving the situation without needing a police or fire response (hence – successful diversion). CCD may find during the course of the phone conversation that police intervention is still needed. Sometimes the need is due to the request of the caller and at other times the crisis escalates necessitating an emergency response. The CCD counselor will send a message to the dispatcher advising them this call needs to be routed to police for their handling. After consultation with the caller and intervention or referral to mental health services, CCD calls are returned to the Emergency Call Center queue so law enforcement representatives can determine if further intervention is required.

There are three areas of opportunity to expand CCD call volume and impact: 1) expanding the filters on the types of calls CCD staff may assist on, 2) increasing calls that are directly transferred to CCD staff when the call initially comes into the Houston Emergency Center, and 3) expanding CCD hours of operation to include the 10PM to 6AM span. In February 2020 THC advocated to expand CCD eligible calls to include mental health (MH) coded calls regardless with or without a (low level) criminal nexus, as well as non-MH coded calls that may be "MH-adjacent" concerns. Previously, CCD was only allowed to intervene on 911 calls that: 1) did not have a criminal nexus, and 2) indicated a MH concern. The CCD program was approved by HPD to call back and assist on MH coded calls with or without a criminal component but weas not approved to intervene on calls that do not explicitly report an MH concern. The MH-adjacent call types are "family/non-family disturbances," "trespassers," "suspicious persons or events," and a "see complainant" code that indicates the call taker receiving the call could not determine the caller's need.

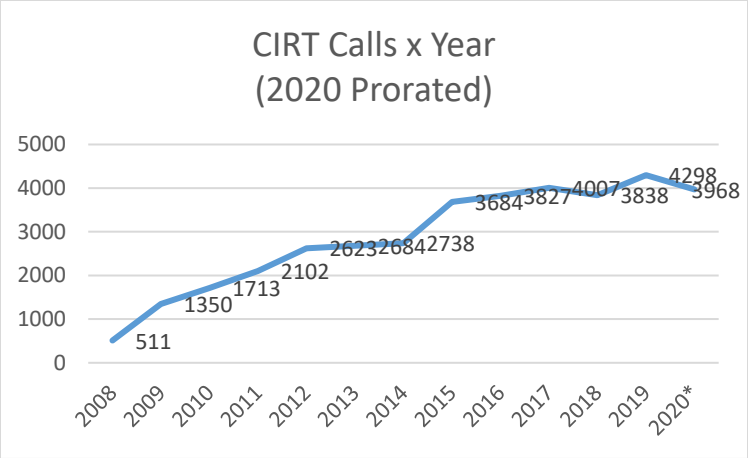
CCD call volume would likely also increase if the number of calls transferred directly to CCD counselors increased. At this time, the majority of CCD calls are cherry-picked by CCD staff from the 911 call board. Counselors review slips based on call code to confirm that they involve an MH concern. Calls screened using this method will result in staff phone contact with that caller.

Although established procedures direct that call takers should transfer calls to CCD staff, program mangers report this happens infrequently. Instead CCD staff make a second call. Time may be lost and opportunities for CCD intervention may, at times, fall by the wayside.

Numbers Served

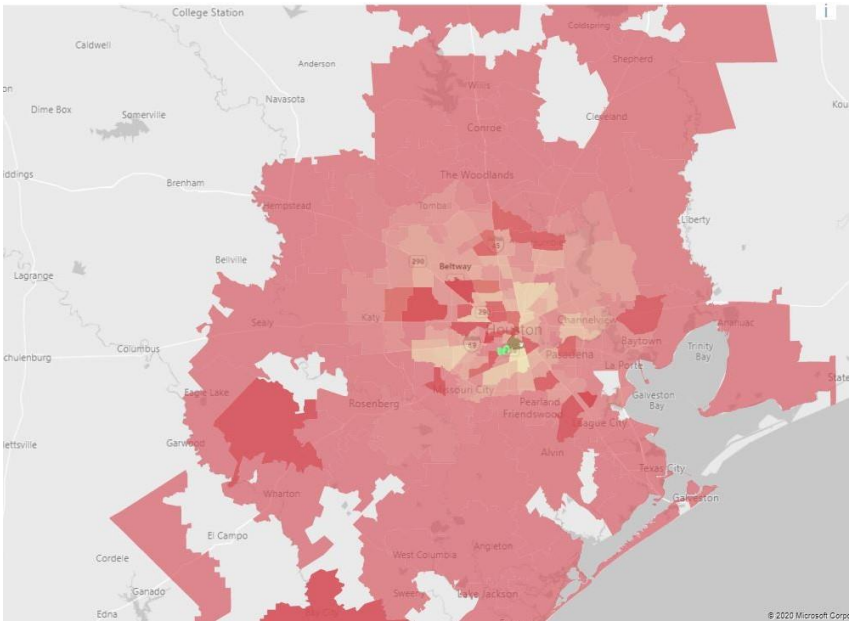
In state FY 2019, Crisis Call Diversion successfully resolved 2,300 calls which. As a result, no longer required intervention from law enforcement.

Since its inception in May 2008, the Crisis Intervention Response Team (CIRT) has completed 35,708 calls to 21,083 unique individuals. These numbers only include events in which face-to-face connection with the caller can be completed. They represent 75% of calls referred to CIRT. The program has increased its capacity in virtually every subsequent year. The growth of program productivity is presented in the graph below. Numbers for the current year (2020) have been prorated. Most frequently (72.6%), individuals served by the program are encountered only once. The range, however, extends to 34 encounters.

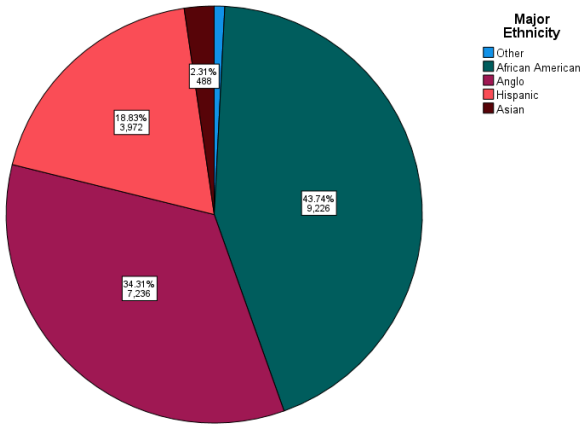


Client Demographics

That CIRT serves a regional function is illustrated by the heat map below where the frequencies of client residence zip codes are represented in colors. Pink areas (zip codes) represent low frequency zip codes while red, tan, brown and green areas represent increasing frequencies. These are data representing client places of residence, not locations of interventions.



The clients served were predominantly male (58.5%) vs. female (41.3%). The average age of participants was 36.4 years. Ninety percent were adults and ten percent were youth under 18 years old. The vast majority (94.8%) spoke English as their primary language. The major ethnic group categories were represented as follows: 43.7% African American, 34.3% Anglo, 18.83% Hispanic, 2.3% Asian American, and 0.8% "Other".



The modal (most frequently observed) participant had never married (62.8%), had completed 12 grades of education (22.2%), lived in their family home (62.8%) although 12.2% reported homelessness, and viewed themselves as outside the labor force (33.2%). Most (89.9%) reported incomes below the Federal Poverty Level. The mean annual income was $6,228. Almost half (43.5%) were medically uninsured. A slightly larger number (46.5%) had federally funded health insurance (Medicaid, Medicare or CHIPS).

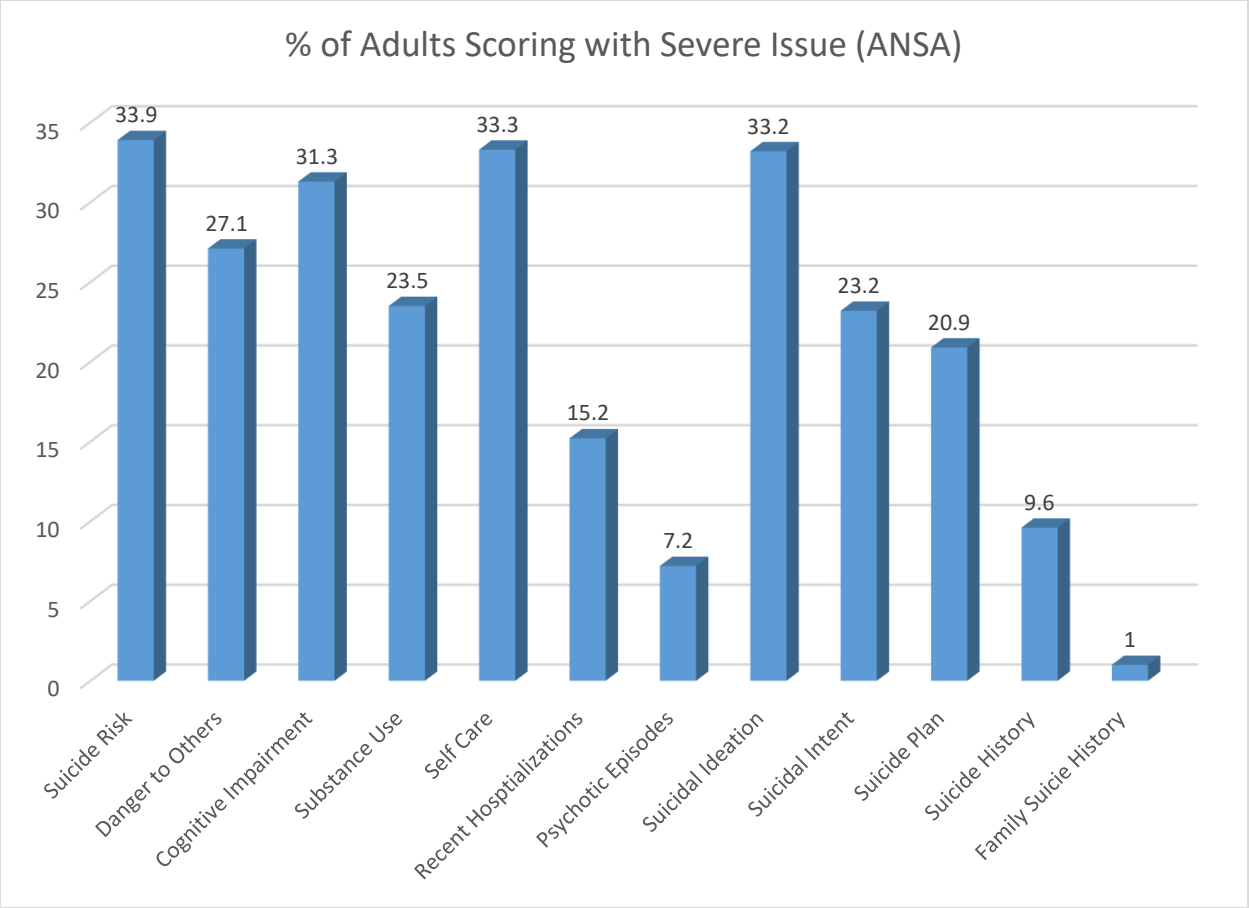
Diagnoses

The majority of diagnoses reflected serious mental illnesses, including Bipolar Disorders (29.8%), Schizophrenia Spectrum Disorders (27.3%), and Major Depressive Disorders (17.0%). The remaining 24.3% suffered other disorders.

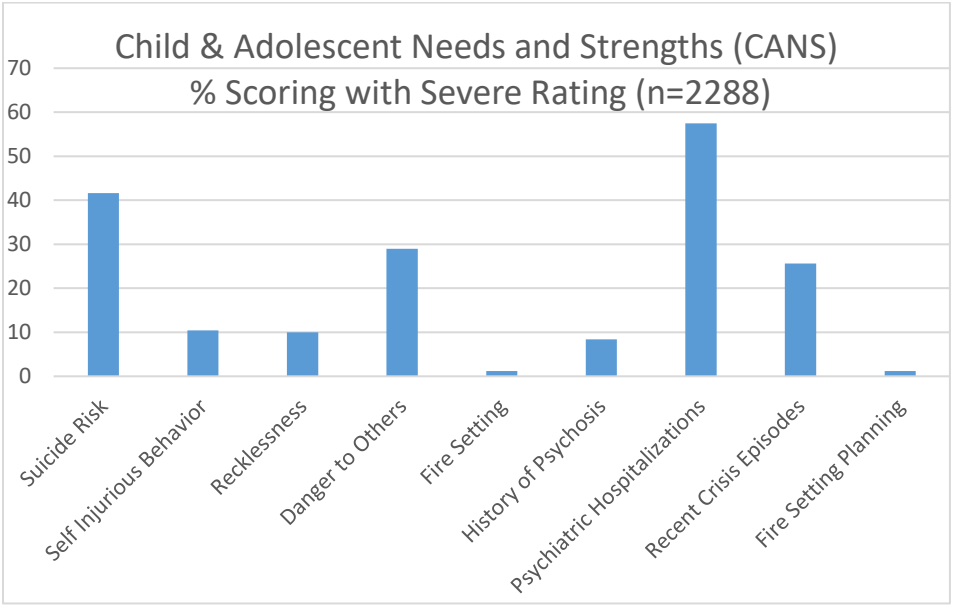
Notably, 34.6% of participants were diagnosed with secondary substance use disorders.

Problem Areas

Individuals served by CIRT are assessed using a standardized instrument widely adopted for mental health treatment planning and outcome evaluation, the Adult Needs and Strengths Assessment (ANSA). The brief crisis version is best suited to CIRT use. The graph below shows the percentage of the 22,336 assessments in which specific problem areas were rated as severe. One can observe that suicidality is the most prominent problem area, accounting for the three peak elevations. Danger to others and substance abuse issues are also frequent severe problem areas.



Similar results for 2,288 children and adolescents served by CIRT are presented below. Youth served by the program had often been treated in psychiatric hospital and emergency services prior to the encounter. Suicide risk and danger to others were the most frequent problem areas.



Outcomes

The primary goal of the CIRT program is to resolve mental health related calls to law enforcement which have no apparent criminal nexus and some potential risk of violence by responding to the mental health needs of the individual in crisis.

The dramatic success of this approach is illustrated in the table below. Dispositions of 25,227 calls recorded since 2014 are presented below. The program success in diverting individuals in mental health crisis away from the criminal justice system is evident in the rate (4.1%) of calls leading to incarcerations. Fewer than one in twenty individuals are transported to jail.

Successful crisis resolution is reflected in the proportion of calls resolved on the scene. About one in four crises (24.9%) are brought to immediate resolution with intervention by CIRT team staff.

About 70% of calls are resolved by transport to crisis or emergency services. The Harris Center's 24/7 Psychiatric Emergency Service (PES) located at the Neuropsychiatric Center (NPC) in the Texas Medical Center receives more than one third of clients (34.4%) encountered by CIRT.

Disposition	N	%
Resolved on Scene	6,287	24.9
Jails	1,157	4.1
PES/NPC	8,680	34.4
Sobering Center	42	0.2
Hospital Emergency Departments	9,061	36.4
Total	25,227	

A slightly larger number (36.4%) have been transported to 38 area hospital emergency departments. The ten most frequent hospital destinations are presented below.

Most Frequent Hospital Destinations		
Facility	**N**	**%**
Ben Taub	2488	9.9
St. Joseph	1495	5.9
Methodist	891	3.5
VA Medical Center	526	2.1
LBJ	310	1.2
Memorial Hermann	307	1.2
Northwest Medical	270	1.1
Bayshore	208	0.8
Methodist Willowbrook	203	0.8
Texas Children's	182	0.7

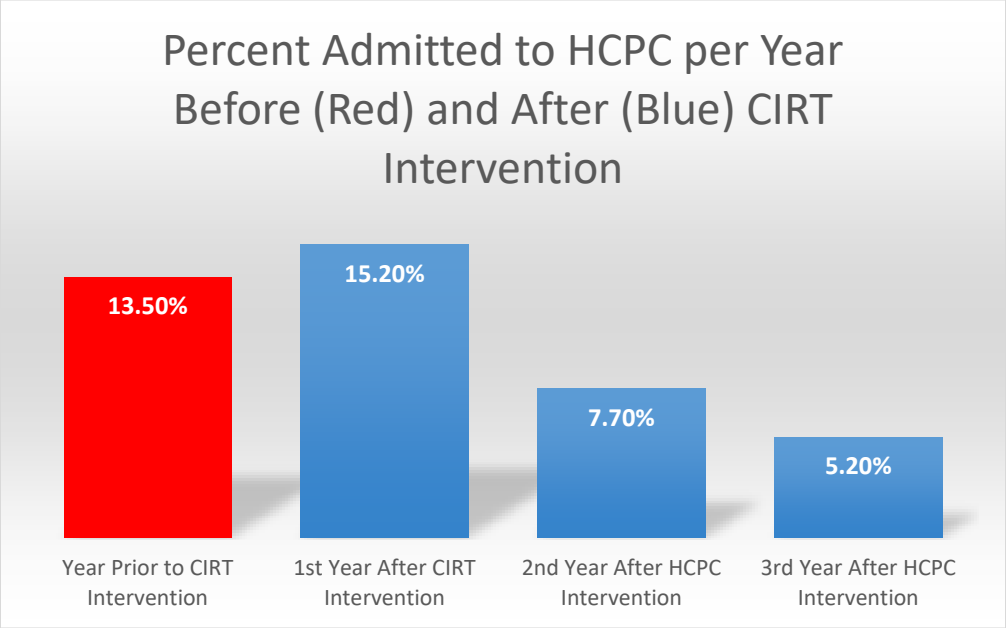
Of the calls resulting in hospital admission, most all are involuntary (94%) and require Emergency Detention Orders.

Association with The Harris Center

Individuals served by CIRT varied in terms of their historical involvement with The Harris Center. Exactly 15% of CIRT encounters involved clients who were concurrently actively involved with center services. More than two thirds (69.9%) received Center services at a subsequent date. These services may have included outpatient, crisis or public psychiatric hospital care. Insured clients could, of course, choose to pursue services from private providers.

Impact on Use of Harris County Psychiatric Center (HCPC)

Data were evaluated to determine if CIRT Team intervention had a longer-term impact on use of the county's public psychiatric hospital, HCPC. As has been observed in evaluation of intensive case management services, reductions in hospital admissions may take more than one year to accrue. It is as though the individual requires a year of intensive services to be "patched up" before improvement occurs. One can observe that the annual rate of admission actually increases from 13.5% prior to CIRT intervention to 15.2% in the first year following. Sharp reductions occur in Year 2 and Year 3. Lacking a comparison group, one can only conclude that these reductions may be due to intervention but may also represent regression to the mean or the natural course of crises in a client's lifetime. While longer-term benefits such as reduced use of public psychiatric hospitals are not the primary goal of this crisis program, it appears that these benefits may occur over a 2- or 3-year span.



Impact on Subsequent CIT Calls

The question of whether CIRT intervention is associated with reductions in subsequent CIT calls can be answered in two ways. First it has been observed that CIT calls actually increase from .13 calls per person during the year prior to the first CIRT call to .38 calls. This is a statistically significant increase. However, when CIRT clients are followed to the present date (average = 5.54 years since intervention) significant decreases in annualized rates are observed. The decrease from .88 annualized CIT calls per person to .08 annualized calls per person is noteworthy. One is reassured that a statistical test of the change is significant ($P<.001$) thought the effect size is small (partial eta squared =.004). One can conclude that there is a decrease in CIT calls following CIRT intervention, but that the decrease occurs over more than a one-year span.

Time Savings

Houston Police Department reported that CCD-screened calls use less officer time than other CIT calls. Officers responding to CIT calls generally logged 123 minutes per call. In contrast, CCD-screened calls

requires only 36 minutes of officer time. Their data indicated that, on average, each CCD call saved 87 minutes.

Conclusions

The use of CIRT Teams is effective in meeting the primary goal of diverting mental health crises from jails and from unnecessary use of law enforcement personnel. The data reported above support the conclusions that:

1) CIRT operates with adherence to SAMHSA best practice standards.
2) Call triage effectively sorts requests into Crisis Intervention Team codes and dispatches personnel appropriately to CIT-coded events. Calls diverted to CIRT do indeed have a mental health basis.
3) The high rate of CIRT diversion from jails (95.9%) indicates that the primary program goal is attained on a regular basis. Individuals, typically with serious mental illness, are diverted from jails, reducing the criminalization of mental illness.
4) The ability to resolve calls on scene (24.9%) reflects the value added by trained, experienced mental health professionals who appear to have demonstrated competence in de-escalation strategies.
5) Linkages to crisis services and emergency departments connect people in crisis with services intended to reduce danger to self and others.
6) CCD services dramatically reduce officer time for CIT calls.
7) Diversions initiate or enhance engagement with the mental health system which may produce longer-term benefits for both the individual and the public.

Appendix (Other Law Enforcement Collaborations)

Crisis Call Diversion (CCD)

Crisis Call Diversion (CCD) is a partnership between the City of Houston, Houston Police Department, The Harris Center, and the Houston Fire Department. Mental health professionals are embedded at the Houston Emergency Center, the 911 call center for the City of Houston. As noted above, if the 911 call is labeled with one of the 28 types of CIT call codes, then a mental health professional will take the call. In state FY 2019, more than 2,300 calls were diverted away from law enforcement. Some common responses include full de-escalation using active listening and motivational interviewing skills, transfers to The Harris Center's crisis line, non-law enforcement mobile crisis response, community referrals, and development of suicide reduction "safety plans."

Homeless Outreach Team (HOT)

The Homeless Outreach Team (HOT) is a team of specialized officers who collaborate with mental health care coordinators to assist individuals who are homeless. HOT goes to wherever the individuals are located. Six HPD officers are assigned to HOT. HOT reached 2,878 people in state FY 2019.

Chronic Consumer Stabilization Initiative (CCSI)

The Chronic Consumer Stabilization Initiative (CCSI) is a collaboration between HPD and The Harris Center. One HPD officer is assigned to CCSI. CCSI identified a group of people with serious mental illness who have frequent encounters with HPD. The Harris Center's care coordinators engage with these individuals to participate in community-based services and reduce the number of law enforcement encounters and psychiatric hospitalizations. A comparison of client outcomes one year before and after receiving CCSI services include:

• 61% reduction in admissions to psychiatric facilities;

• 66% reduction in Harris County Psychiatric Center in-patient days; and

• 66% decrease in overall encounters with law enforcement while on the CCSI program. CCSI currently serves 45 individuals diagnosed with serious and persistent mental illness. (HPD, Annual Report, 2019).

Clinician and Officer Remote Evaluation Program (CORE)

The Clinician and Officer Remote Evaluation Program (CORE) is a partnership between The Harris Center and the Harris County Sheriff's Office (HCSO). To improve response to calls involving a person with mental illness, the CORE program connects a law enforcement 1st responder with a mental health clinician using a tablet and HIPAA-compliant technology. CORE also maximizes the mental health workforce.

Harris County Mental Health Jail Diversion Program

The Harris County Mental Health Jail Diversion Program is a pre-booking jail diversion program for individuals with mental health who would have been arrested for low-level, non-violent offenses, like trespass. Law enforcement officers drop off these individuals at the Judge Ed Emmett Mental Health Diversion Center where they receive an array of community-based services, referrals, and linkages to other services, such as housing. The Harris County District Attorney, HPD, HCSO, and other law enforcement agencies are essential partners. The program diverted 1,795 individuals who would have otherwise been arrested in state FY 2019.