CIT Is On The Scene: Is Anyone Better Off?

A Working Analysis Of CIT Implementation & Impact
In Albuquerque, New Mexico

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Compassion In Action

The Professionals In The Albuquerque Police Department’s Crisis Intervention Unit
Introduction

Effective CIT programs are built on core elements including partnerships among law enforcement, advocacy groups, and mental health providers; community ownership; policies and procedures; highly-trained professionals in law enforcement and mental health advocacy; a rich curriculum; mental health emergency services and other support services. Assembling all of these elements into a coherent program is clearly a challenge in itself.

Once these elements are in place, it is essential to measure the impact of the CIT Program on the quality of life for individuals dealing with mental illness; on the perceptions and confidence of police officers; on the effectiveness of community supports; and on the sense of vibrancy of the community at large. A number of communities, including Albuquerque, have many of the CIT program elements in place. Now we face the challenge of really understanding if we are making a difference and if anyone is better off.
### How Might We Think About CIT Core Elements And Outcomes?

<table>
<thead>
<tr>
<th>Core Elements</th>
<th>Outcome Questions</th>
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</thead>
<tbody>
<tr>
<td>Highly Trained Professionals in Law Enforcement &amp; Mental Health Advocacy; A Rich curriculum; Policies and Procedures</td>
<td>1. How do we evaluate the reduction of use of force with individuals dealing with mental health issues?</td>
</tr>
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<td>2. How do we evaluate the effectiveness of jail diversion efforts?</td>
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<td>3. How do we evaluate the impact of repeat encounters with the same individuals?</td>
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<td>4. How do we evaluate the quality of the ECIT Training for officers particularly in the quality of interactions these officers have with individuals dealing with mental health issues?</td>
</tr>
<tr>
<td>Mental Health Emergency Services and Other Support Services</td>
<td>5. How do we evaluate the impact of our relationships with mental health emergency services and other support services?</td>
</tr>
<tr>
<td>Partnerships Among Law Enforcement, Advocacy Groups, and Mental Health Providers; Community Ownership</td>
<td>6. How do we evaluate the impact of our partnerships with other law enforcement agencies, advocacy groups, and the community?</td>
</tr>
</tbody>
</table>
What Can We Learn From The Broader Fields Of Evaluation?
Theory of Change And The Consequences Of Our Actions

Consequential Validity
• What is our theory of change? If we put all the pieces of a CIT program together, what do we think will happen?
• What are the intended impacts of our decisions and actions?
• What are the unintended impacts of our decisions and actions?

Theory Of Change
We believe that recovery is possible for people living with mental illness and/or addiction who are in crisis.

THEREFORE
We support teamwork and collaboration.
AND
We educate to provide safe and compassionate interventions.
AND
We promote diversions into mental health systems of care.
AND
We strive for continued improvement of outcomes through effective CIT programs.

SO THAT
Our people, our communities, our families, our friends, and our loved ones can live lives filled with dignity, understanding, kindness, and hope.

Adapted From The CIT Strategic Plan, November 2015 – November 2017
Process Evaluations Vs Impact Evaluations

“There are two types of evaluation. You should conduct both... Process evaluation ask the following questions: Did the response occur as planned? ... Did you do what you said you would do?...

An impact evaluation asks the following questions: Did the problem decline? If so, did the response cause the decline?“

<table>
<thead>
<tr>
<th>Impact Evaluation Results</th>
<th>Process Evaluation Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem declined</td>
<td>A. Evidence that the response caused the decline</td>
</tr>
<tr>
<td>Problem did not decline</td>
<td>B. Evidence that the response was ineffective, and that a different response should be tried</td>
</tr>
</tbody>
</table>
Developmental Evaluation

Types of Questions Answered By Developmental Evaluation

- What is developing or emerging as the CIT Program takes shape?
- What variations in effects are we seeing?
- What do the initial results reveal about expected progress?
- What seems to be working and not working?
- What elements merit more attention or changes?
- How is the larger system or environment responding to the CIT Program?
- How should the CIT Program be adapted in response to changing circumstances?
- How can the CIT Program adapt to the context in ways that are within the Program’s control?

Measuring Social Benefit

Questions To Consider

• Are we working with the partners in law enforcement, advocacy groups and mental health providers who can best achieve impact?
• Are we responsive to our partners and treat them fairly?
• Are our goals with each of our partners clear and achievable?
• Have we and our partners advanced the field by influencing the thinking of policy makers, funders, thought leaders, or the public?
• Are we helping our partners improve their effectiveness?
• What is the aggregated impact directly caused by our partnerships?

Adapted From The Center For Effective Philanthropy, 2002. Indicators of Effectiveness: Understanding and Improving Foundation Performance.
<table>
<thead>
<tr>
<th>Policy Question</th>
<th>Data Questions</th>
<th>Practice &amp; Policy Questions</th>
<th>Political Questions</th>
</tr>
</thead>
</table>
| **How Do We Minimize Police Use Of Force With People Living With Mental Illness?** | • How many calls for service are related to people living with mental illness?  
• What are the demographics and other characteristics of the individuals with mental illness encountered by the police?  
• How was the encounter resolved?  
• Did the encounter result in the use of force? | • How do we learn the important lessons after difficult incidents?  
• How do we train police officers to handle encounters with people living with mental illness?  
• How do we improve the collaboration between the police and mental health system?  
• How do we make sure that enough money is available to address the issue we face? | • Who has the power to influence communities to take better care of people living with mental illness?  
• Who can change how funding resources are allocated?  
• Who has the influence to make sure that families, police, mental health providers, and others to work together? |
## How Might We Evaluate CIT Efforts?

<table>
<thead>
<tr>
<th>Key Evaluation Questions</th>
<th>Types Of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data</td>
</tr>
<tr>
<td><strong>How Much Did We Do?</strong></td>
<td>How many interactions did we have? How many officers trained? How many support services &amp; resources deployed?</td>
</tr>
<tr>
<td><strong>How Well Did We Do It?</strong></td>
<td>Measures of appropriate officer responses. Measures of appropriate service and resource deployment.</td>
</tr>
<tr>
<td><strong>Is Anyone Better Off?</strong></td>
<td>Improvements in the circumstances of individuals experiencing a mental health crisis. Improvements in skills, attitudes, and behaviors of police officers. Stronger community collaboration and increased resources available to assist people living with mental illness.</td>
</tr>
</tbody>
</table>

Based On Mark Friedman and Results Based Accountability
Is Anyone Better Off?

1. How do we evaluate the reduction of use of force with individuals dealing with mental health issues?
2. How do we evaluate the effectiveness of jail diversion efforts?
3. How do we evaluate the impact of repeat encounters with the same individuals?
4. How do we evaluate the quality of the ECIT Training for officers particularly in the quality of interactions these officers have with individuals dealing with mental health issues?
5. How do we evaluate the impact of our relationships with mental health emergency services and other support services?
6. How do we evaluate the impact of our partnerships with other law enforcement agencies, advocacy groups, and the community?
Definitions and Limitations

1. Basic Crisis Intervention Team (CIT) Training: APD’s goal is that all field service officers will successfully complete the Basic 40 Hour Crisis Intervention Team Training. Over 550 APD cadets and officers have completed Basic CIT Training since 2014. Approximately 99% of field officers are CIT trained.

2. Enhance Crisis Intervention Team (ECIT) Training: APD’s goal is that 40% of the field services officers will complete an additional 8 hours specialized training in order to better handle calls involving individuals affected by a behavioral health disorder or experiencing a behavioral health crisis. ECIT training was first implemented in October, 2016 and over 100 APD field officers have completed the ECIT training as of July, 2017.

3. Throughout this presentation we refer to behavioral health related computer aided dispatch (CAD) incidents. These are calls that are categorized as suicide or behavioral health in CAD descriptions. If CAD calls turn into incidents that required police reports, these reports may be categorized as suicide, behavioral health, mental commit, mental patient, or psychiatric evaluation depending on which record system is used and what year the report was filed.

4. We fully understand that our data is based on behavioral health related incidents which are known to be behavioral health related by law enforcement at the time of occurrence. There are probably many incidents which are classified in other ways which have a behavioral health components and are missed in our analyses.

5. We are committed to improving our data collection and analyses and we have made some important strides so far. But clearly, complete and accurate data in law enforcement is a journey rather than a destination.
The Number Of APD’s BH-Related CAD Calls Has Increased 60.4% Since 2010. It Is Very Likely Those Calls Will Continue To Increase

APD CAD Calls All Priorities

Source: APD CIU 3.10.17
APD Field Officers Filed Almost 19,000 BH-Related ARS Reports Between 2010 and 2016 (Number of Reports By Beat)
How APD Field Officers’ BH-Related ARS Reports Have Changed By Beat Over Time From 2014 To 2016

3,484 BH-Related Field Reports In 2014

3,259 BH-Related Field Reports In 2015

2,730 BH-Related Field Reports In 2016
The Change In BH Reports By Beat From 2014 To 2016

Legend
Percent Difference
In CIT Reports From
2014 To 2016

-80.6% - -52.9%
-52.8% - -36.2%
-36.1% - -20.6%
-20.5% - -2.6%
-2.5% - 21.4%
21.5% - 50%
50.1% - 150%
How do we evaluate the reduction of use of force with individuals dealing with mental health issues?

Evaluation Questions To Consider:
• Did use of force decline?
• If so, what caused the decline?
All Calls For Service Vs. Use Of Force Incidents
August 2016 To January 2017

USE OF FORCE INCIDENTS IN IMR 5 REPORTING PERIOD (248):
.1% (ONE TENTH OF ONE PERCENT) OF 227,619 CALLS FOR SERVICE INVOLVED ANY USE OF FORCE

SERIOUS USE OF FORCE INCIDENTS IN IMR 5 REPORTING PERIOD (34):
.015% (15 THOUSANDTHS OF ONE PERCENT) OF 227,619 CALLS FOR SERVICE
Use Of Force Cases By Year By Behavioral Health Related Category

Policy on UOF Reporting Changed In January 2016

Data Are Preliminary And These Are Cases Which Were Known To Law Enforcement As Behavioral Health Related At The Time
The Types Of Use Of Force By Officer Reports By Year Behavioral Health Related Category

<table>
<thead>
<tr>
<th>Type Of Force</th>
<th>Incident Not BH</th>
<th>BH-Related Incident</th>
<th>Incident BH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm Bar, Hand/Foots Impact</td>
<td>12.0%</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>ECW</td>
<td>13.8%</td>
<td>0.6%</td>
<td></td>
</tr>
<tr>
<td>Empty Hand</td>
<td>17.1%</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>Firearm - OIS &amp; Firearms</td>
<td>0.4%</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>Impact Weapon</td>
<td>9.5%</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>K9</td>
<td>3.2%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>OC Spray</td>
<td>3.4%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Solo or Group Take Down</td>
<td>23.3%</td>
<td>1.2%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>12.3%</td>
<td>0.7%</td>
<td></td>
</tr>
</tbody>
</table>

Data Are Preliminary And These Are Cases Which Were Known To Law Enforcement As Behavioral Health Related At The Time
The 41 Use Of Force Cases Involving Firearms By Year By Behavioral Health Related Category

Data Are Preliminary And These Are Cases Which Were Known To Law Enforcement As Behavioral Health Related At The Time

8/8/17 Incident under review
Thoughts To Consider

- Each use of force or firearm discharge is important. Numbers are not the only story.
- Identifying all types of use of force and whether incidents are behavioral health related is complex. Both of these factors requires careful vetting.
- The UOF reports in behavioral health related incidents has been a consistently low percentage of the overall uses of force. In addition, the types of force used in these incidents have been on the lower level of force types. Please note that one inappropriate use of force is too many, but the overall pattern argues the APD is minimizing the use of force with individuals suffering from behavioral health crisis.
- The FAD reports in behavioral health related incidents indicates that the incident on August 8, 2017 was the first firearm discharge to have occurred since May of 2014. That incident is under review.
How do we evaluate the effectiveness of jail diversion efforts?

Evaluation Questions To Consider:
• What seems to be working and not working?
• How is the larger system responding to the APD’s efforts?
• How can APD adapt to the larger system in ways that are within APD’s control?
The Number of Behavioral Health Related CAD From January To June 2017

- January: 533
- February: 472
- March: 553
- April: 601
- May: 605
- June: 581
The Number And Percentage Of The Dispositions Of BH Related CAD From January To June 2017

- No Law Enforcement Action Needed: 585 (47.0%)
- Transport To Emergency Services: 540 (43.4%)
- Other Law Enforcement Resolution: 81 (6.5%)
- Arrests or Summons: 24 (1.9%)
- Suicide: 15 (1.2%)
How do we evaluate the impact of our relationships with mental health emergency services and other support services?

Evaluation Questions To Consider:
• Are we responsive to our partners and are we treating them fairly?
• Are our goals with our partners clear and achievable?
• Are we helping our partners improve their effectiveness?
• What is the aggregated impact directly caused by our partnerships?
<table>
<thead>
<tr>
<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
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<tbody>
<tr>
<td>University of New</td>
<td>88</td>
<td>59</td>
<td>83</td>
<td>107</td>
<td>134</td>
<td>102</td>
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<tr>
<td>Mexico</td>
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<tr>
<td>Kaseman</td>
<td>63</td>
<td>57</td>
<td>60</td>
<td>79</td>
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<td>Lovelace</td>
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<td>24</td>
<td>31</td>
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<td>Presbyterian</td>
<td>29</td>
<td>23</td>
<td>21</td>
<td>18</td>
<td>26</td>
<td>34</td>
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<tr>
<td>Rust Medical Center</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>11</td>
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<tr>
<td>VA</td>
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<td>6</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>7</td>
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<tr>
<td>Sandoval Regional</td>
<td>1</td>
<td></td>
<td>3</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Medical Center</td>
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<tr>
<td>Haven Behavioral</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Health</td>
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Thoughts To Consider

• CIU has built strong relationships with emergency room doctors.
• Hospitals are the most expensive option.
• Hospitals have limited resources.
• How do we track the individuals who repeatedly use emergency services and intervene in ways that are more effective?
• Jail diversion can sometimes be treatment diversion.
• The issues of behavior health and drug use.
SOP 2-19-8 Diversion From Jail

Department personnel will divert individuals with behavioral health disorders or who are in behavioral health crisis from jail through the following measures:

A. Individuals with behavioral health disorders or in behavioral health crisis may have encounters with law enforcement for misdemeanor and/or petty misdemeanor crimes, including non-violent felonies. When possible, those persons may be better served by jail diversion, which can include the following:
1. Issuing a verbal warning;
2. Issuing a citation;
3. Giving a summons for misdemeanors or submitting a non-violent felony case to the District Attorney;
4. Transporting the person to a mental health provider either voluntarily or involuntarily pursuant to NMSA 43-1-10; or
5. Disengagement.

B. Jail diversion through issuance of citations or summons/submission of a case is subject to an officer’s discretion and is typically appropriate unless:
1. The individual, subject to lawful arrest, fails to identify himself or herself satisfactorily;
2. The individual refuses to sign the citation;
3. Arrest or taking the individual into custody is necessary to prevent imminent harm to the individual or others, or it is necessary to remove the individual from the scene of the offense;
4. The individual has no ties to the jurisdiction reasonably sufficient to ensure their appearance and there is substantial likelihood that violators would refuse to respond to the citation;
5. The individual is intoxicated to the point that they no longer have control of their faculties.

If one or more of these factors are present and the individual is displaying signs of a behavioral health disorder or crisis, the officer will evaluate whether arrest, transport to a mental health facility, or disengagement is appropriate. This decision will be made based on the severity of the crime, the perceived connection between the behavioral health disorder or crisis and the criminal conduct, and whether the officer believes the individual will be better served by one option more than another.

C. When the individual’s criminal behavior appears to stem from a behavioral health disorder and he or she would be better served in a treatment location than in a criminal justice setting, officers should seek such interventions in lieu of criminal charges:
1. CITO, ECIT, MCT, and CIS will work with behavioral health care providers within the community to deter the individual from future contact with the criminal justice system:
   a. CIS will hold quarterly meetings with University of New Mexico. In addition, CIS will hold meetings with personnel from Presbyterian Kemanan Hospital, HealthCare for the Homeless, St. Martin’s Hospitality Center, New Mexico Solutions and others as needed or requested to ensure familiarization with diversionary goals.
   b. Officers will testify at civil commitment proceedings to promote mental health resolution rather than criminal sanctions.
2. CITO, ECIT, MCT, and CIU Detectives will make referrals to CIS and use COAST and/or Crisis Intervention Unit Clinicians, to reduce the likelihood of future behavioral health crises, and thus reduce the possibility of contact with the criminal justice system by evaluating the situation and connecting appropriate services available to individuals living with behavioral health disorders.
3. On active CIU cases, CIU Detectives may coordinate with the Pre-Trial Services Diversionary unit in the court system to address the needs of individuals living with behavioral health disorders.
4. The primary officer will retain case responsibility if a citation, summons, or case is submitted. CIU/COAST assists if the individual needs follow-up intervention.
5. If the individual is not appropriate for jail diversion, the officer should ensure that the individual is referred to the Psychiatric Services Unit within the detention facility. If no incident report is required, a CIT data analyst can use the CIT data analysis.
How do we evaluate the impact of repeat encounters with the same individuals?

Evaluation Questions To Consider:
• What variations in effects are we seeing?
• What seems to be working and not working?
• What elements merit more attention or change?
• What are the intended impacts of our decisions and actions?
• What are the unintended impacts of our decisions and actions?
The Power of Stories: Mr. A

- Mr. A is in his mid-30’s and living with schizophrenia and serious substance abuse.
- Mr. A has had several violent encounters with police.
- Mr. A has felony warrants including False Imprisonment, Battery upon a Household Member, Resisting and Evading An Officer, Aggravated Battery With A Deadly Weapon Resulting in Great Bodily Harm.
- Mr. A has a history of using methamphetamines and other narcotics.
- Mr. A has numerous documented contacts with police officers between 2012 and 2017.
Mr. A

12/22/2012
Placed in custody for causing a disturbance at a church.

1/7/2015
Officers received calls that Mr. A was threatening neighbors. Detectives attempted to make contact but no contact was made.

1/8/2015
Mr. A was located and arrested.

5/11/15
Mr. A was released from hospital and booked into jail. His house was posted substandard.

5/8/15
Mr. A stabbed a person with a broken piece of mirror then barricaded himself in his house. This resulted in a SWAT Response. Mr. A fought through taser and K9 and injured a SWAT Officer.

5/13/15
Mr. A’s case was assigned to CIU who began working with District Attorney and Pre Trial Services.

6/18/15
Field Officers inform CIU that Mr. A is inside his residence which is still posted substandard.

What Seems To Be Working And Not Working?
6/9/2015
CIU visited with Mr. A and learned that he was not currently receiving services. His aunt had bonded him out of jail.

6/16/15
CIU visited Mr. A in jail and he was receptive to the visit.

4/14/16
CIU was informed that Mr. A was inside his residence. Mr. A was taken into custody and transported to the hospital and then jail.

1/26/2017
CIU worked with field officers to take Mr. A to jail.

6/10/2016
Mr. A's aunt called to say he had pushed her several times. Officer responded to the call and Mr. A was taken into custody.

4/4/2016
CIU learned that Mr. A was no longer in jail. He could not be contacted and had an outstanding felony warrant. CIU issued a safety bulletin.

7/14/16
Mr. A’s aunt bonded him out of jail and he is staying with her. Mr. A is currently receiving medication and is compliant. However, hospital services did not get Mr. A into a program for receiving his medications.

What Seems To Be Working And Not Working?
Mr. A (Continued)

What Seems To Be Working And Not Working?

2/15/17
CIU receives a call from Mr. A who is out of jail and requesting assistance from CIU in working with probation officer.

2/21/17-2/27/17
CIU conducts multiple visits with Mr. A who has good rapport with detectives but is having issues.

2/27/17
CIU and field officers conduct a pickup order with Mr. A who goes willingly to the doctor.

3/1/17 – 6/7/17
CIU conducts nine home visits with Mr. A who is taking medication, living in a new address and seems to be doing well.

2/3/17
CIU visits with Mr. A in jail.
Thoughts To Consider

• The amount of time and effort that CIU detectives and clinicians put into building relationships with individuals is impressive.

• When possible, the importance of slowing down the interaction between individuals and officers.

• Helping individuals who face both drug addiction and mental health issues requires specialized systems of support.

• Every part of the behavioral health system has to be working in order to have a long term impact on individuals.

• Careful analysis of case studies is important both for the field and for individual agencies.
How do we evaluate the quality of the ECIT training for officers?

Evaluation Questions To Consider:
• Are we doing what we said we would do?
• What variations in effects are we seeing?
• What seems to be working and not working?
• What elements merit more attention or change?
• What are the intended impacts of our decisions and actions?
• What are the unintended impacts of our decisions and actions?
SOP 2-19-7 ECIT Response To Behavioral Health Situations

2-19-7 Response

A. In responding to an individual experiencing a behavioral health crisis, an officer will de-escalate and calm the situation until a supervisor or ECIT or MCT arrives to control the scene and direct operations.

1. ECIT, MCT, or CIU will take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input from ECIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when it is safe.

2. The responding officer will request a backup officer whenever the individual will be taken into custody (either for booking or for emergency mental health evaluation). If the responding officer is a CITO, the officer should specifically request an ECIT officer or MCT as backup.

3. Officers should take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet non-threatening tone and manner when approaching or conversing with the individual. Where possible, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally, and there is no need to rush or force the situation.

4. Officers should move slowly and do not excite or agitate the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care, assistance and resources.
The Number Of Officers And Others Receiving ECIT Training From October 2016 To July 2017

- **Detectives & Inside Officers**
  - October 2016: 11
  - November 2016: 9
  - December 2016: 2
  - January 2017: 1

- **ECIT Civilians**
  - November 2016: 8

- **Field Officers**
  - October 2016: 18
  - November 2016: 29
  - December 2016: 2
  - January 2017: 1
  - February 2017: 6
  - March 2017: 11
  - April 2017: 7
  - May 2017: 18
  - June 2017: 11

- **Outside Agencies**
  - October 2016: 1
  - November 2016: 3
  - December 2016: 3
  - January 2017: 1
  - February 2017: 1
The Number And Percent Of Behavioral Health Related CAD That Were Covered By Field Officers With ECIT Training From January 2017 To June 2017

<table>
<thead>
<tr>
<th>Officers Not ECIT Trained</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>12.3%</td>
<td>11.5%</td>
<td>15.4%</td>
<td>19.6%</td>
<td>18.2%</td>
<td>19.3%</td>
</tr>
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<table>
<thead>
<tr>
<th>Officers ECIT Trained</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Officers Not ECIT Trained</td>
<td>71</td>
<td>58</td>
<td>87</td>
<td>118</td>
<td>110</td>
<td>112</td>
</tr>
<tr>
<td>%</td>
<td>12.3%</td>
<td>11.5%</td>
<td>15.4%</td>
<td>19.6%</td>
<td>18.2%</td>
<td>19.3%</td>
</tr>
</tbody>
</table>
The Number Behavioral Health Related CAD Compared To Other CAD From January 2017 To June 2017

<table>
<thead>
<tr>
<th>All Other CAD</th>
<th>Behavioral Health Related CAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>8,882</td>
<td>104</td>
</tr>
<tr>
<td>9,191</td>
<td>125</td>
</tr>
<tr>
<td>8,829</td>
<td>148</td>
</tr>
<tr>
<td>8,743</td>
<td>117</td>
</tr>
<tr>
<td>9,086</td>
<td>101</td>
</tr>
<tr>
<td>9,262</td>
<td>129</td>
</tr>
<tr>
<td>8,819</td>
<td>124</td>
</tr>
<tr>
<td>8,998</td>
<td>123</td>
</tr>
<tr>
<td>8,830</td>
<td>94</td>
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<tr>
<td>8,957</td>
<td>123</td>
</tr>
<tr>
<td>9,131</td>
<td>147</td>
</tr>
<tr>
<td>8,920</td>
<td>116</td>
</tr>
<tr>
<td>8,819</td>
<td>129</td>
</tr>
<tr>
<td>9,138</td>
<td>158</td>
</tr>
<tr>
<td>9,125</td>
<td>132</td>
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<tr>
<td>9,401</td>
<td>128</td>
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<tr>
<td>9,035</td>
<td>145</td>
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<tr>
<td>9,067</td>
<td>114</td>
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<tr>
<td>9,544</td>
<td>146</td>
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<tr>
<td>9,219</td>
<td>146</td>
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<tr>
<td>9,944</td>
<td>120</td>
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<tr>
<td>10,003</td>
<td>145</td>
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<tr>
<td>9,852</td>
<td>137</td>
</tr>
<tr>
<td>9,702</td>
<td>135</td>
</tr>
<tr>
<td></td>
<td>119</td>
</tr>
</tbody>
</table>

From January 1, 2017 to June 30, 2017.
Duration For Selected CAD Calls, In Hours, From When The Officer Is Dispatched To The Time The CAD Is Closed
The Number Of Behavioral Health Related CAD By Beat And The Percent Of Those Calls That Were Covered By Field Officers With ECIT Training From January 2017 To June 2017
Beats With High Numbers Of Behavioral Health Related CADS And Low Percentages Of Those CADS Covered By Field Officers With ECIT Training From January 2017 To June 2017

<table>
<thead>
<tr>
<th>Beat</th>
<th>Total BH CAD</th>
<th>Percent Covered By ECIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>413</td>
<td>130</td>
<td>10.0%</td>
</tr>
<tr>
<td>423</td>
<td>114</td>
<td>13.2%</td>
</tr>
<tr>
<td>422</td>
<td>107</td>
<td>10.3%</td>
</tr>
<tr>
<td>523</td>
<td>102</td>
<td>18.6%</td>
</tr>
<tr>
<td>532</td>
<td>95</td>
<td>5.3%</td>
</tr>
<tr>
<td>531</td>
<td>93</td>
<td>11.8%</td>
</tr>
<tr>
<td>336</td>
<td>83</td>
<td>18.1%</td>
</tr>
<tr>
<td>431</td>
<td>81</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

How Might We Think About How To Deploy Our Limited Resources?
The Disposition Of Behavioral Health Related CAD By ECIT Trained Field Officers And Non ECIT Trained Field Officers

Data Are Preliminary And These Are Cases Which Were Known To Law Enforcement As Behavioral Health Related At The Time
Use Of Force In Behavioral Health Related CAD From January 1, 2017 To June 30, 2017
By Officer Who Were ECIT Trained Compared To Officers Who Were Not ECIT Trained

Data Are Preliminary And These Are Cases Which Were Known To Law Enforcement As Behavioral Health Related At The Time

- No Use Of Force: Officers Not ECIT Trained - 2,873
- Some Use Of Force, No Firearms Discharged: Officers Not ECIT Trained - 556

8/8/17 Incident under review
Thoughts To Consider

- **How Does APD Determine Which CIT Calls Need To Be Covered By ECIT?**
  - All CIT CADs including both original and final call type?
  - Determination by Emergency Communications 911 and Dispatch Operators?
  - By Priority, Location and History?

- **How Does APD Determine How Officers Are Deployed?**
  - By Shift?
  - By Area Command?
  - By Days?

- **When Do CIU Detectives Get Deployed?**

- **What Changes Need To Be Made To SOP and Telecommunicator Training?**
  - What is the process for an ECIT officer to be pulled from an active dispatch to a high priority CIT CAD?
How do we evaluate the impact of our partnerships with other law enforcement agencies, advocacy groups, and the community?

Evaluation Questions To Consider:
• Are we responsive to our partners and are we treating them fairly?
• Are our relationships with our partners strong enough to overcome turf and trust issues?
• Are our goals with our partners clear and achievable?
• Are we helping our partners improve their effectiveness?
• What is the aggregated impact directly caused by our partnerships?
Some Of Our Partners

- Mental Health Response Advisory Committee
- City Of Albuquerque Family & Community Services
How Partners Can Help Each Other Improve Their Effectiveness

HOUSE OFFICER AFFILIATION AGREEMENT

The Regents of the University of New Mexico, for its public operation known as the Health Sciences Center, specifically for the School of Medicine (the “University”), and Albuquerque Police Department, Crisis Intervention Unit (the “Institution”), agree:

RECITALS

A. The caseload at the Institution is adequate to provide an opportunity for University resident physicians (“House Officers”) to obtain practical and didactic exposure to patient management under the supervision of the medical staff of the Institution.

B. The purposes of this Agreement are:

1. To establish a training and educational program for House Officers while on rotation at the Institution;

2. To ensure a close working relationship between the University and the Institution;

3. To benefit both the University and the Institution through provision of quality medical education and training by allowing participation by House Officers in the delivery of health care services by the medical staff of the Institution;

4. To provide House Officers with opportunities to acquire specific skills and knowledge in designated specialty areas through experience in patient care delivery by qualified physicians; and

5. To enable House Officers to become knowledgeable about operational aspects of various types of health delivery systems.

1. RESPONSIBILITIES OF THE INSTITUTION

A. The Institution will:

1. Accept for training the number of House Officers to be determined jointly by the Institution and the University.

2. Make available its clinical and related facilities and its personnel to provide quality learning experiences for House Officers during their educational rotation at the Institution under the supervision of qualified Institution personnel.

APD And The University Have Signed An Agreement That Enables Resident Physicians To Get Education Credit When Working With APD
2016 BH-Related CAD Calls For APD And BCSD Combined By Beat
Priority 1 & 2 Calls Only

Legend: Number OF BH-Related CAD Calls Per Beat

Source: APD & BCSD 3.28.17
Request For Proposals For Behavioral Health Clinicians For Mobile Crisis Teams
The Crisis Intervention Team Knowledge Network ECHO
EVALUATION

“I will keep in mind that individuals with this disorder are very smart and can catch on to my reactions and behavior. Even though the likelihood that things are happening as they say are probably not, it is still very real and scary for them.” - APD Officer

- Interviews with stakeholders
- Online survey that will assess satisfaction with the technology and curriculum and impact on self-efficacy
- Online survey to assess impact on knowledge related to the content presented in the session
THE CIT ECHO: YEAR 1 OUTCOMES

Who is participating?

The CIT Knowledge Network connects law enforcement and public safety agencies from across the state of New Mexico, as well as Oregon, Washington, Minnesota, Wisconsin, New York, Maryland and Texas.

THE AGENCIES WE REACH

- Fire Department (9.02%)
- Police Department (57.14%)
- Probation Department (12.78%)
- Sheriff Department (9.77%)
- Other (11.28%)

Participants from the Police Department

- Detectives (5.19%)
- Lieutenants (5.19%)
- Sergeants (22.06%)
- Officers (58.44%)
- Crisis Specialists (9.09%)

42 didactic presentations
Over 40 complex cases staffed by officers
125 officers attended a session
The Number Of Murders In Albuquerque 1990 To 2016

The Average Number Of Murders In Albuquerque Is 45.3 Per Year

* 2015 FBI UCR Murder Numbers Do Not Include 4 Negligent Homicides
** 2016 Murder Numbers Are Not Official UCR Yet
The Types Of Murders In Albuquerque 2012 To 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Child Abuse</th>
<th>Dispute or Fighting</th>
<th>Domestic Violence</th>
<th>Drug Related</th>
<th>During Other Felony</th>
<th>Gang Related</th>
<th>Murder Suicide</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2</td>
<td>16</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>1</td>
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<tr>
<td>2013</td>
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<td>3</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>8</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
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<tr>
<td>2016</td>
<td>1</td>
<td>17</td>
<td>5</td>
<td>11</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Achievements We Have Made

New county tax bears first fruit

By Martin Salazar / Journal Staff Writer
Saturday, August 5th, 2017 at 11:40am

A group of PB&J preschoolers and their parents get ready for the first graduation ceremony last month. PB&J is one of eight organizations sharing $3 million a year for two years from Bernalillo County’s behavioral health tax to combat adverse childhood experiences, such as abuse and neglect. Not all PB&J students have experienced such trauma. (Mark Brinker/Albuquerque Journal)

Health

APD, UNM praised for response to mentally ill

Initiative keeps the vulnerable out of jail

BY ROSEMARY AXELROD

A multivigilant initiative between Albuquerque’s Police Department and Psychiatric Services at the University of New Mexico has caught the attention of local and national agencies around the state and nation in the past year.

The first issue of the New Mexico Journal of Psychiatry included a profile of the APD/UNM Collaborative Task Force, which is a joint effort between the UNM Department of Psychiatry and Behavioral Sciences and APD. The collaborative was created to help police officers better understand how to interact with mentally ill people so they can minimize stressful situations, avoid sending them to jail and connect them with appropriate care.

“Without the task force, the Albuquerque Police Department’s Youth Division doesn’t know what to do,” said Dr. Antonio Pelayo, a UNM professor and director of the Child and Family Laboratory. “The task force has allowed our collaboration with APD to grow, and we’re able to work together to help people who need it.”

The task force is part of a larger effort to improve mental health care in the city. UNM and APD are currently working on developing a mental health crisis line, which will provide access to emergency services.

The task force has also increased awareness of mental health issues among APD officers and psychologists. The group meets regularly to discuss cases and develop strategies to improve mental health care in the city. The collaboration between APD and UNM is a model for other cities, and it has helped to create a more supportive and understanding police force.

Albuquerque Journal

Albuquerque, Revising Approach Toward the Homeless, Offers Them Jobs

BY FERNANDA SANTOS

DECEMBER 1, 2016

The New York Times

Counties approve $30M tax hike on property lines

By Dan McKay / Journal Staff Writer

Thursday, February 26th, 2015 at 11:40am

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Tatum McIntyre says she begged police, at one point, to take her daughter back to the hospital.

It was the only way, she thought, to get her treatment she needed for bipolar disorder.

Another mother, Deborah Barkoff, said she’s not sure whether her adopted son — an addict who has attempted suicide — is dead or alive.
Challenges We Face

New strategy aims to tackle Albuquerque's top property crime offenders

Advocates fear looming cuts to behavioral health services

$17M in new taxes; no mental health programs yet

DOJ INVESTIGATION OF APD

Federal officials have found that APD violates citizens' rights with excessive force. Read the full findings here.
Evaluation Copified

• Did We Do What We Said We Would Do?
• How Well Did We Do It?
• What Seems To Be Working And Not Working?
• What Needs More Attention Or To Be Changed?
• How Are Officers, Individuals and Families, The Mental Health System And The Wider Community Responding To Our CIT Program?
• How Can We Help Our CIT Program Adapt To The Wider Context In Ways That Are Within Our Control?
• Are We Creating Any Unintended Side Effects?
• Is Anyone Better Off?
Thank You

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Matthew Tinney – mtinney@cabq.gov

Lawrence Saavedra – ldsaavedra@cabq.gov