Police Internal Audit Report

Crisis Response Team Audit

Contents

Auditor's Conclusion

June 30, 2022

Internal Audit has completed the Crisis Response Team Program Review. We conducted this engagement as part of our 2021 Annual Police Audit Plan.

The audit objectives were to:

- Determine if the Crisis Response Team (CRT) is effectively receiving and responding to incidents involving people with mental health or other specialized needs.
- Evaluate if resources staffing CRT are adequate to respond to mental health calls.

To these ends, Internal Audit:

- Interviewed police personnel,
- Reviewed APD policies and standards,
- Reviewed leading practices,
- Reviewed CRT processes, and
- Applied other methods as needed.

Based on the results of our engagement procedures, additional data is needed to determine the effectiveness of receiving and responding to incidents and the adequacy of CRT staffing resources. We have identified issues and made recommendations in the Issue Details section of this report. We want to acknowledge the cooperation and assistance of the Crisis Response Team Sgt., Program Manager, and CRT team members during this engagement.

Wayne Sommer

Wayne C. Sommer, CPA, CGMA
Internal Audit Manager

Audit Profile

Audit Team

Wayne Sommer, CPA, CGMA – Internal Audit Manager
Michelle Crawford, M.Acct, CIA, CFE, CRMA – Police Auditor

Background

The Crisis Response Team (CRT) is a collaborative effort between Aurora Police Department and the Aurora Mental Health Center (AuMHC) with a mission to provide trauma-informed, compassionate care to individuals experiencing a mental health crisis. This co-responder model helps to prevent unnecessary incarceration/hospitalization and helps to reduce the amount of Patrol officer resources spent on mental health situations.

When calls for service involve a person experiencing a mental health crisis, it is critical that the police interaction remain positive and follow department policies and procedures.

The Aurora Police Department has additional resources for crisis response, including patrol officers trained in Crisis Intervention (CIT) and the Aurora Mobile Response Team (AMRT.) The AMRT is composed of one paramedic and one clinician who respond to low-level calls pertaining to someone in crisis. We documented an example of how these three approaches work in the Appendix.

Scope

Our scope of work covered Crisis Response Team policies in place as of October 2021 and practices in place through January 2022. [1]

[1] The original audit scope was January 1, 2020 through the end of test work. Due to data limitations, we revised the scope to focus on current practices.

City Manager Response

During the preparation of the 2021 Budget a pilot program to create a non-police based behavioral health response program was proposed. There were several reasons for the proposal and ultimate Council approval of the program. One reason was the challenges faced by the partially grant funded Crisis Response Team (CRT) program already operating in the Police Department. As we launched what became known as the Aurora Mobile Response Team (AMRT) with a paramedic and clinician in September of 2021, we were also in discussion about the 2022 audit plan for the Police Auditor.

Some of the concerns about the CRT program that led to requesting the audit have been confirmed. The informal arrangement between Police and Aurora Mental Health Center, provider of clinicians for the program, doesn't provide for accountability by either party or reliability of the service. Failure by both parties to identify any metrics contribute to the lack of accountability and hampers any measure of effectiveness and future planning for program improvements. We have also not made progress among Aurora Mental Health Center, Police and our 911 operation in better defining, tracking, and analyzing calls for service, again losing the opportunity to make improvements to the program.

I am encouraged by recent efforts made as the Program Manager of AMRT has been acting as manager of both that program and CRT. CRT has been operating without a program manager for some time which has contributed to some of the issues identified. In addition, a new Sergeant was assigned to CRT and he and the AMRT program manager have worked well together to make improvements. They have already taken advantage of recommendations made by the Police Auditor.

The CRT Audit as presented by the Police Auditor provides substantive and significant recommendations that when implemented will help the CRT program better serve Aurorans who experience, or show signs of, behavioral distress. Improvements to the CRT program will have the added benefit of better working with AMRT, police officers on the street and Aurora Fire Rescue. We must commit to these improvements in order to best serve some of our most vulnerable population.

James Twombly
Aurora City Manager

Issue Details

Receipt of Incidents

To determine if the Crisis Response Team (CRT) effectively received incidents of persons in crisis, we worked with the CRT and Aurora911 to review the current processes. Unfortunately, the City lacks formal procedures for handling calls for persons in crisis and dispatching CRT and CIT (Crisis Intervention Team) trained officers. As a result, we could not determine the effectiveness of the receipt of incidents. Our recommendation to address this is below in ISS.1.

ISS.1 - Aurora911

Aurora911 does not follow all leading practices for handling calls for people in crisis.

If Aurora911 receives a call requesting a CIT officer or the Crisis Response Team, they will air that request over the radio while dispatching a patrol unit. Aurora911 does not dispatch CIT officers or the CRT to calls.

Training

Per CIT International, "A core element of CIT is training emergency communications to ensure that call-taking and dispatch are aligned with the goals of CIT. All emergency communicators have several responsibilities in an agency with a CIT program."[2] The Justice Center and the Bureau of Justice Assistance created a checklist for agencies to determine how their policies and practices align with the elements of a successful Police-Mental Health Collaboration Program (PMHC).

The following training areas are leading practices for call-taking and dispatch:

- Training on the structure and goals of the PMHC program,
- Procedures for receiving and dispatching calls involving people with a mental health crisis,
- Gathering information from a caller, determining whether a mental health crisis might be occurring, and appropriate questions to ask callers,
- Beginning to de-escalate callers and situations,
- If applicable, transferring a call to a crisis line or warm line,
- Identifying and dispatching appropriately trained CIT officers, and
- Communicating with mental health services or the CIT officer all the available information about the mental health crisis.

Aurora911 does not have protocols to determine whether a mental health crisis is occurring or how to handle those calls. Currently, a crisis line is not in use. There is a need for formal training for Aurora911 to align procedures with crisis response leading practices.

[2] Crisis Intervention Team (CIT) International: *Crisis Intervention Team Programs: A best practice guide for transforming community responses to Mental Health Crises*

Receiving calls

CIT International identified common issues to address within CIT Programs:

> *Call-taking and dispatch.* The policy should describe the call-taker's role in gathering mental health information from callers and transferring calls to crisis lines, if appropriate.
>
> *Procedures in case a CIT officer is not available for a crisis event.* The policy should guide dispatchers in case all CIT officers are responding to calls. Many agencies choose to dispatch a supervisor or cast a wider call for CIT officers outside the district where the call for service originated.[3]

Recommendation

We recommend Aurora911 follow leading practices including,

- Developing training for employees handling mental health crisis calls,
- Developing procedures for identifying and handling mental health crisis calls,
- Working with the Crisis Response Team to develop procedures for dispatching CRT and CIT officers as appropriate, and
- Evaluating the use of a crisis line.

Management Response

Aurora911 response:

***Training**:* Aurora911 fully supports the continued and specialized development of our professionals' abilities to understand and navigate mental health related calls and additionally, emergency calls requiring varying degrees of de-escalation techniques. We are committed to ensuring all team members are equipped with the ability to do so. De-escalation does much more than increase a caller's cooperation and state of calm; the ability to de-escalate significantly benefits the overall mental and emotional resiliency of the 911 Professional. In 2021, we initiated a plan to introduce CIT certification training for all members. When we became aware of the work of Human Resources to provide the NERPSC resource to Aurora public safety agencies, we made the decision to pend training until the resource was formalized in Aurora (CIT training is included through NERPSC at no additional charge). Our intent is to include this training into our basic training process and promote career enrichment through continuing education beyond the initial certification. As we continue to grow our Professional Development Team, our capacity for enhancing continuing education will continue to expand and include more specialized areas of skill development for all members of our team.

Once the NERPSC is available to Aurora911 in 2022, we will begin the process of training all personnel at the baseline and explore enhancement training on an ongoing basis.

[3] Ibid.

Crisis Line: Aurora911 is in the initial phase of introducing a Nurse Triage Line for low acuity medical calls through a grant provided by DHSEM. However, this resource is for medical calls and is not a crisis line. We currently offer crisis line contact information for any caller who requests it, but do not warm transfer the caller. It is reasonable to introduce the use of a mental health crisis line into call triage, but before this can occur, the issue of inadequate protocol for event categorization must first be addressed for police (see next response). In the interim, Aurora911 will explore the introduction of crisis line protocol for first party callers who are solely calling to report their own mental health crisis when no other crime, threat to self or others, or medical emergency is being reported.

Protocol for call triage and resource deployment: The ability of Aurora911 to triage and properly respond to mental health related calls rests largely on the ability to create standardized, consistent call intake protocols. Currently, Aurora911 Professionals utilize Emergency Medical Dispatch (EMD) and Emergency Fire Dispatch (EFD) protocols through ProQA, under the International Academies of Emergency Dispatch (IAED). The department previously utilized Emergency Police Dispatch (EPD) protocols, but discontinued the program in 2019, due to pushback from police responders.

Since my arrival as Director in 2020, I have actively sought to understand what occurred with EPD, and why it was discontinued. Through my assessment, I have concluded that the APD's resistance to EPD was not related to a flawed protocol system, but to an ineffective implementation and change management process. The protocol system by itself is not arbitrary or limiting. To the contrary, it provides the police organization the authority and latitude to identify response plans, thresholds, priorities; all of which are identified in this audit as missing or inadequate, but greatly needed. It also provides the call taker with a consistent and standardized framework for assessing calls and identifying a determinant code which prescribes a response plan. This process is crucial when there are a variety of responses available. Unfortunately, the time and energy investment needed to properly set up, test and deploy EPD in Aurora did not occur. On November 16, 2016, all three protocols were launched in Aurora simultaneously, which is not a best practice. The result was frustration and resistance, which went largely unaddressed through reassessment, revision, and retesting. In the absence of effective change management processes, officer resistance increased in volume and became the justification to eliminate the EPD program.

By discontinuing EPD protocol, and by reducing the number of event types and priority levels available to a call taker, calls for service have been generalized and lumped into broad categories which afford no specific framework to launch alternative resources, beyond guidance toward AMRT referral. Aurora911 is tasked with the responsibility of building and maintaining a homegrown police protocol, which operates separately from ProQA. Not only does this practice create inconsistency and segregation of process for call takers, but it also greatly increases exposure to liability for Aurora911, APD and the City of Aurora. Consistency and standardization serve as a foundation for success in a 911 center fielding well over a half-million calls annually.

The current system for assessing police calls is not adequate to incorporate alternative responses in the long term, nor does it provide the granularity required for capturing meaningful data for how various resources are utilized in Aurora.

Aurora911 recommends reintroduction and implementation of EPD protocol and is invested in the necessary work to reintroduce the formalized protocol system which will adequately address the complexities of police calls and provides the framework necessary for call takers to consistently identify the correct resource for every call (crisis line, CIT, CRT, AMRT, or APD). As the continuum of response continues to expand, so too can the protocol system through thresholds and recommendations identified by key stakeholders. In addition to the reimplementation of EPD protocol, steps must be taken to increase the number of identified event types, CAD status and activity codes, response plans and priority levels to more readily identify, track and report responses beyond an officer. This must be done through a collective effort of all involved stakeholders and have endorsement and active participation by department leadership to ensure an effective change management process.

Because the city is in the process of transitioning to a new CAD system in September 2022, we recommend this change process occur after the conclusion of this transition, so as not to overwhelm staff. In the interim, stakeholders can work collaboratively to prepare for another round of change management.

APD Crisis Response Team response: CRT agrees to work in collaboration with dispatch to:

- Assist with the development of protocols as needed for dispatching, and
- Assist with developing protocols for warm transfers to the Colorado Crisis Line.

Targeted Implementation Dates:
Training: July 2023
Procedures and protocols: December 31, 2023
Crisis Line: December 31, 2023
Issue Owner: Aurora911 Director
Issue Final Approver: Jason Batchelor, Deputy City Manager

Response to Incidents

We evaluated available data to determine if CRT effectively responded to incidents involving persons in crisis. The City does not have the necessary data points to establish a population for only calls involving persons in crisis or responses to calls that involve a mental health crisis. As a result, we cannot determine if the response to incidents of persons in crisis is adequate. We identified areas of improvement related to data collection and its use below in ISS.2 and ISS.3.

ISS.2 - Mental health calls for service

There is no citywide data available that shows how many mental health calls for service were received or responded to. The current Computer-Aided Dispatch (CAD) system does not have a category code for mental health calls.

As a result, mental health related calls for service include multiple categories. While officers can use a mental health crisis category as a final category, they do not consistently use it. Also, there is no department guidance or training on the use of the mental health category.

CIT International and the Bureau of Justice Assistance (BJA) recommend using a dispatch code to designate mental health calls for service. The policy should describe the requirement to code calls appropriately as mental health crisis calls and dispatch a CIT or CRT officer when indicated. Coding the calls in the dispatch system as a mental health call allows reporting data about mental health-related calls.

Without a verifiably complete population of calls for service involving persons in crisis, it is not possible to test for the effectiveness of the response to persons in crisis incidents.

We randomly selected one week of calls for service to understand what data existed for *persons in crisis* calls. The random selection was not a statistical sample, and the information cannot be extrapolated across all calls for service. We used our professional judgment to remove specific call categories to narrow the population of calls for our review. For the remaining population, approximately 1,800 calls for service, we reviewed call remarks and identified 117 calls with a *person in crisis* to which CRT could have responded.

The categorization for call types we reviewed varied across multiple categories. While some officers used the mental health crisis final category, others did not. There is no formal guidance or training on documenting crisis calls, including documentation when other factors, such as criminal activity occurred. We created a pivot table showing the various CAD and final case type categorizations used in the appendix.

The new CAD system may have additional capabilities, including creating a mental health crisis clearance code that officers could use. Officers would use the clearance code as a subcategory indicating the call included someone in crisis while allowing officers to document the primary reason for the call as the final category.

Improved tracking of mental health related calls will help improve the deployment of crisis response resources, including the Aurora Mobile Response Team.

The Justice Center and the BJA also recommend that the CAD system be capable of flagging:

- Repeat addresses associated with mental health calls for service,
- People with mental illnesses who are repeatedly in contact with law enforcement, and
- People who pose a verifiable threat to officers.

The CAD system includes these features, and they are currently in use.

Recommendation

We recommend Aurora Police Department work with Information Technology and Aurora911 to identify and implement the most efficient and effective methods to track mental health calls for service. We also recommend that APD use the mental health calls for service data to ensure the appropriate deployment of resources to *persons in crisis*.

Management Response

APD Crisis Response Team response: CRT agrees to work in collaboration with Aurora911 to assist with appropriately coding calls for service.

Aurora911 response: **Categorization and data tracking of mental health related calls** – As mentioned in Aurora911's response to ISS.2, APD's 2019 discontinuation of EPD protocol and subsequent reduction of event types into fewer, generalized event categories has resulted in a significantly ineffective method of identifying, capturing, and reporting public safety activity involving mental health related calls. We fully support the migration to more robust event types, and the addition of additional CAD codes to further identify action taken in the course of a call. Most mental health calls are not initially reported to 911 as mental health related. Instead, they are often reported by a second party witness as suspicious activity, a disturbance, or another potential crime based on the behavior of the subject. Additional event types should be created when enough information is available to more appropriately categorize a call as mental health. However, a single category is insufficient to use for all mental health calls. While some calls may be exclusively a mental health call, there are also events where a crime or medical emergency has occurred with a mental health element. As programs such as AMRT and CRT become more complex, it will be necessary for us to adequately capture calls which are referred to and from these resources, so that we better understand the full extent of how they are utilized. We must also capture data which encapsulates the referral path and final disposition of the call. This can be achieved through appropriate CAD status and disposition codes, which document action taken versus a NIBRS crime code, which only identifies a crime category. Combining a formal EPD protocol system with a robust, adaptable method of documenting events in CAD will not only more accurately deploy the most appropriate resource for every situation but will also provide more accurate and comprehensive data that will allow us to properly meet the needs of the community with the correct resources.

Targeted Implementation Date: June 30, 2023
Issue Owner: Crisis Response Team Sgt.
Issue Final Approver: Division Chief of Metro Operations

ISS.3 - Data collection and analysis

APD should expand its collection of data points.

The Crisis Response Team collects data related to contacts using a monthly tracking spreadsheet.

We randomly selected one month of the tracking spreadsheet and compared it to calls for service information and body-worn camera footage, the tracking spreadsheet documented all associated contacts involving persons in crisis.

CIT International, the Justice Center and the Bureau of Justice Assistance have identified data points for workload, performance, and outcome measures. Below are the leading practice data points and whether they are collected.

Data Point	**Currently collected**	**Comments**
Number of mental health calls for service	No	See ISS. 2.
Repeat mental health calls for service to the same address	Partially	CRT tracks contacts but did not identify repeat individuals at the beginning of our audit. However, they have begun to develop methods to track repeat individuals.
Number of 911 calls transferred to a crisis line	No	See ISS. 1.
Number of mental health calls to which a CIT officer is available to respond	No	Not tracked.
Injuries during mental health calls (to the officer, person in crisis, or bystanders)	Partially	Use of force injuries documented, no other injury categories listed on the spreadsheet.
Disposition of calls	Yes	Tracked in the CRT spreadsheet.
Use of Force	Yes	Tracked in the CRT spreadsheet.
Arrests of people with mental illnesses	Partially	Tracked for CRT calls within the spreadsheet.
Time officers wait in emergency rooms before transferring custody	Partially	Officer length of contact tracked in the CRT spreadsheet.

The spreadsheet collects multiple other data sets, including demographic information, if CRT facilitated the return of law enforcement to service, and if formal action was diverted due to CRT. The spreadsheet does not identify whether the contact involved an individual officer or the co-responder team. In addition, due to clinician staffing, not all contacts will involve a co-responder team.

Expanding the data points collected can help to provide a more comprehensive picture of the crisis response system and can assist in directing deployment of resources.

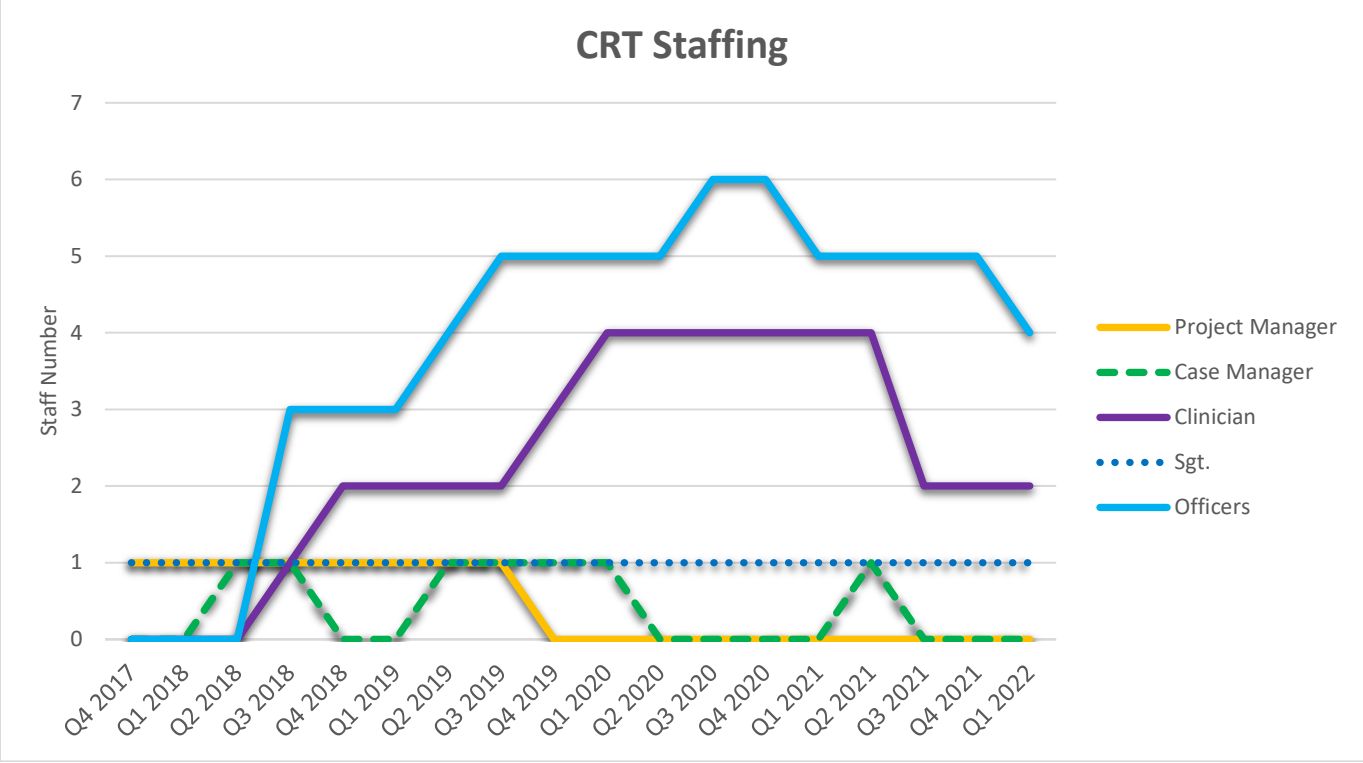
Recommendation
We recommend CRT track the additional data points identified.

Management Response
CRT agrees and is currently in the process of updating contact spreadsheet to reflect recommendations listed for data collection and analysis in accordance with best practices.

Targeted Implementation Date: June 30, 2023
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Division Chief of Metro Operations

ISS.4 – Staffing
The Crisis Response Team program manager, case manager, and clinician positions have not been consistently staffed throughout the program. Aurora Mental Health Center (AuMHC) is responsible for providing staffing for the clinicians and case manager. We could not locate any written requirements for the AuMHC staffing levels. The grant agreement only included a dollar amount for personnel; it did not specify the number or type of personnel. We could not determine the baseline staffing level of clinicians.

City personnel provided us with the quarterly staffing levels for the case manager, clinicians, program manager, Sgt., and officers. Below is a chart showing the information provided.



Clinician positions are in high demand across the state, and difficulties in hiring and retention are impacting co-responder teams across the state. We spoke with different co-responder programs in Colorado that have taken different approaches to staff their clinician positions.

- *Partner with a Mental or Behavioral Health Agency*

  Salary: The partner agency controls pay and benefits; depending on the agency, there may be less flexibility to adjust salaries to increase hiring and retention.

  Personnel management: The partner agency is responsible for managing the employees, including providing clinical oversight, supervision, support, and maintaining the mental health records. The City would not have any authority regarding the performance or supervision of the partner agency employees.

  Agency records: Allows clinicians to access partner agency records when available and allows a more straightforward referral process for services at the partner agency.

  Aurora currently uses this model and partners Aurora Mental Health Center. The ability to adjust salaries for co-responder clinicians varies by agency. AuMHC personnel stated while they do not have flexibility to adjust salaries, they have recently implemented shift differential pay and hazard pay.

- *Hire as City employees*

  Salary: The City would control pay and benefits and have authority to adjust salary rates to increase hiring and retention.

  Personnel Management: The City would provide direct supervision and oversight of employees. Considerations for this option include staffing to provide clinical oversight and supervision, having the proper insurance coverage for any licensing requirements, legal expertise needed, an electronic health record system, and the creation of policies.

  Agency Records: Clinicians would likely lose access to AuMHC agency records.

- *Contract for Services*

  Issue a request for proposal for providers to provide the clinicians.

  Salary: This option may allow more flexibility to adjust pay and benefits, resulting in better hiring and retention rates.

  Personnel Management: The provider is responsible for managing the employees, including providing clinical oversight, supervision, support, and maintaining the mental health records. The City would not have any authority regarding the performance or supervision of the partner agency employees.

  Agency Records: Clinicians would likely lose access to AuMHC agency records.

According to the Center for Police Research and Policy Best Practice Guide, Assessing the Impact of Co-responder Team Programs, "The use of this response model across communities and across time has resulted in substantial variation in the implementation of co-responder team programs (see Krider et al., 2020). For example, a recent systematic review of co-responder teams identified 19 unique programs described across 26 research articles (Puntis et al., 2018). In many cases, variation in program implementation is a direct product of efforts to tailor the co-responder team to the specific needs of individual communities. However, resource constraints – including access to funding, staff, equipment, and behavioral health services – also play a role in the operationalization and implementation of the co-responder team approach (Dyer et al., 2015)."

As the grant funding ends for this program, the City needs to evaluate how it will staff the clinical positions moving forward to ensure the staffing level meets the program's needs. Without adequate clinician and case manager staffing, the program becomes a Crisis Intervention Team program instead of a co-responder program.

Recommendation

We recommend that the City issues a Request for Information or a Request for Proposals to evaluate staffing options for clinicians and a case manager and then determine which option and partner best serves the City's and community's needs.

Management Response

CRT leadership recognizes the difficulties regarding the recruitment and retention of qualified clinical staff. CRT leadership is dedicated to working with the City leadership and Housing and Community Services leadership (AMRT) to evaluate available staffing options, potentially through a Request for Interest or Request for Proposals, within the Denver Metro that would be able to meet the expectations of the Crisis Response Team and any other necessary clinical staffing.

Targeted Implementation Date: December 31, 2022
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Division Chief of Metro Operations

ISS.5 – Memorandum of Understanding

The Aurora Police Department and Aurora Mental Health Center (AuMHC) do not have a memorandum of understanding (MOU) for the Crisis Response Program. While there is an intergovernmental agreement, the agreement is for the use of grant funds for the Crisis Response Program and does not address operational areas of the program.

The City provided a copy of an undated MOU that was never signed by Aurora Mental Health Center but was signed by the City of Aurora in January 2019. The MOU included areas that future agreements should also include:

- Aurora Mental Health personnel should be jointly selected for the Crisis Response Team by both APD and Aurora Mental Health Center.
- Candidates will be screened by agencies and must pass an APD background check.
- APD shall issue AuMHC personnel facilities access badges to enable access to APD district offices, headquarters, the Public Safety Training Center, and all associated gates.
- AuMHC shall issue APD CRT personnel building access badges to the AuMHC walk-in clinic.
- APD CRT personnel will sign and date the confidentiality agreement regarding the use of AuMHC building access.

CIT International and the Justice Center and the Bureau of Justice Assistance have identified areas that should be included in a Memorandum of Understanding (MOU), such as:

- Resources each organization commits,
- How law enforcement and Clinicians interact on scene,
- Coordination of follow-up for individuals,
- Roles of each organization regarding training, program monitoring, and community outreach,
- Policies and procedures governing access, exchange, release, and storage of information between the agencies, and
- Roles and responsibilities for data collection and analysis.

None of the identified areas above are addressed. CIT International's best practices include an example of an MOU. The example states that "An MOU should be developed by both parties coming together and agreeing to general protocols. A common protocol serves the community well both in terms of community safety and accessing appropriate individual services."

Without a documented MOU outlining the expectations and responsibilities of each agency, including resources and protocols, there is the potential for misunderstanding and unmet needs or services.

Recommendation

We recommend that Aurora Police Department work with the Aurora Mental Health Center to develop an MOU incorporating the areas identified as leading practices.

Management Response

CRT agrees and is currently in the process of creating an updated Memorandum of Understanding with our partner agency, AuMHC, to outline personnel obligations, facilities access, confidentiality, and other relevant scope of work in accordance with leading practices.

Targeted Implementation Date: December 31, 2022
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Division Chief of Metro Operations

ISS.6 - Follow leading practices

Aurora Police Department (APD) lacks strong policies governing interactions with individuals with mental health disorders, procedures for crisis intervention trained (CIT) officers, and procedures for the Crisis Response Team (CRT.)

APD created the CRT in 2018, while APD drafted standard operating procedures (SOPs) in 2021; as of December 2021, no SOPs were in effect. As a result, the only guidance for crisis response is a directive on dealing with persons with mental health disorders, last updated April 2019.

We used the following abbreviations throughout this section:

- Standard Operating Procedure (SOP)
- Crisis Intervention Team (CIT)
- Crisis Response Team (CRT)
- Person in crisis (PIC)
- Police Mental Health Collaboration program (PMHC)
- International Association of Chiefs of Police (IACP)
- Policy Research Inc. (PRI)
- Lieutenant (Lt.)
- Sergeant (Sgt.)

Leading practices referenced

Crisis Intervention Team (CIT) International:[4] *Crisis Intervention Team Programs: A best practice guide for transforming community responses to Mental Health Crises* Published August 2019

International Association of Chiefs of Police[5]: *Responding to Persons Experiencing a Mental Health Crisis Published* August 2018

Policy Research Inc. and National League of Cities[6]: *Responding to individuals in behavioral crisis via co-responder models: Role of cities, counties, law enforcement, and providers.* Published January 2020

Justice Center and Bureau of Justice Assistance[7]: *Police Mental Health Collaboration Programs, a checklist for law enforcement program managers.*

[4] CIT International leading organization for Crisis Intervention Team training and certification.
[5] IACP is the world's largest professional association for police leaders
[6] Policy Research Inc. is a not-for-profit whose work revolves around behavioral services research and technical assistance. National League of Cities is comprised of city leaders focused on improving the quality of life for their constituents.
[7]The Council of State Governments Justice Center is a national nonprofit organization that uses its members with policy and research expertise to develop strategies that increase public safety and strengthen communities. Bureau of Justice Center is a federal program that provides leadership and services in grant administration and criminal justice policy development to support strategies to achieve safer communities.

We compiled leading practices by area and identified whether APD incorporates those practices into its policies. Below is a summary followed by the detailed practices and policies.

Meets leading practice	Partially meets	Does not meet
CIT Coordinator	Terminology	CRT Policies
Leads on calls	Program goals	Performance measures
Interviews or interrogations	Training	Resources
	Assessing the call	Officer selection
	Emergency hold	Calls for service
	Alternatives	Actions
	Transport	Restraints
	After action documentation	Transfer of Care

Crisis Response Team Policies
The Crisis Response Team lacks policies and procedures for its operations. Leading practices recommend jointly developed written policies and procedures outlining roles, responsibilities of the law enforcement agency and health agency, staffing, training, information sharing, and work standards.

Staffing
A leading practice is co-response teams have 24/7 availability or at least coverage during peak calls. Policies do not address staffing for the co-responder teams.

Data collection
The Justice Center recommends identifying which personnel is responsible for collecting and analyzing program data. The draft CRT SOPs reference the CIT data collection sheet. Still, they do not recognize who is responsible for collecting and analyzing programmatic data, specifically for the co-responder program.

Information Sharing
The Justice Center recommends that protocols govern:

- the exchange of information between law enforcement personnel and mental health program partners,
- information to be shared,
- circumstances for sharing, and
- the process for sharing.

The Justice Center also recommends sharing progress reports regularly with the agency chief executive, other agency designees, and key staff from partner organizations. Sharing information and progress reports should also include other city programs, such as the Aurora Mobile Response Team and the Aurora Fire Rescue Community Health Program.

There are no CRT SOPs, and the draft SOPs did not address the leading practices identified.

Terminology
The inclusion of a glossary of terms in policy allows crisis response teams to become familiar with common words and standard definitions. Words to define are mental health crisis, mental illness, and terminology that mental health clinicians and officers on crisis response teams frequently use.

APD should work with their mental health partners to ensure they use appropriate language and do not use terms that may be considered offensive, such as *deranged* or *disturbed*. We did not see either of these terms used during our policy review. Still, we believe it is essential to review terminology periodically.

Directive 6.13 defines some words, but not words that would be used frequently by APD or mental health clinicians. This partially addresses leading practices.

Program goals
APD should expand program goals for Crisis Intervention Trained officers and the Crisis Response Team to include leading practices.

The Goals of a CIT Program per CIT International are:

1. To improve safety during law enforcement encounters with people experiencing a mental health crisis for everyone involved.
2. To increase connections to effective and timely mental health services for people in a mental health crisis.
3. To use law enforcement strategically during crisis situations—such as when there is an imminent threat to safety or a criminal concern—and increase the role of mental health professionals, peer support specialists, and other community supports.
4. To reduce the trauma that people experience during a mental health crisis and thus contribute to their long-term recovery.

Directive 8.36 states the purpose of CIT as*,* "CIT attempts to reduce violence, injuries, and potential litigation through the rendering of appropriate services to subjects in need of counseling or therapy. Training in CIT provides officers understanding of the impact of mental illness on individuals. Trained CIT officers learn skills to help in the verbal de-escalation of a high-risk situation involving the mentally ill. Successful intervention may lead to a reduction in the need to utilize the Criminal Justice System." The stated purpose aligns with the first program goal from CIT International but does not address the other goals.

Per Policy Research Inc. (PRI), co-responder program goals "Can include providing clinical support on the scene, conducting screening and assessments, reviewing what is known about client history, and navigating and referring to community resources. Many co-responder models involve clinicians who provide proactive follow-up support to encourage client service and treatment engagement."

The Justice Center also recommends written policies and procedures describing the program. The Crisis Response Team drafted SOPs; however, they do not include goals and do not adequately describe the program.

Performance Measures
Performance measures are an important tool in monitoring and measuring program success. In addition, these measures should be used to inform resource allocations, including expanding program capacity, adding staff positions, funding, training, and shifting resources.

When determining performance measures, the Justice Center recommends considering qualitative and quantitative data on program operations and goals and perceptions of officers, behavioral health professionals, and community members. The Justice Center also recommends performance management meetings between program staff and patrol supervisors.

Policy and procedures do not address any performance measures. The CRT currently tracks program statistics including the number of diversions.

CIT Coordinator
A leading practice from CIT International is to assign a CIT coordinator who runs the program and serves as a liaison. Directive 8.36.5 defines the CIT coordinator's responsibilities and states that the Technical Services Bureau Captain assigns the duties, adequately incorporating this leading practice.

Resources
Leading practices from CIT International and CALEA recommend the policy describes for officers any available resources and addresses procedures for accessing those resources. The Bureau of Justice Assistance (BJA) and the Justice Center recommend that as part of designing the program, stakeholders' catalog:

- available resources in the community,
- criteria or restrictions in accessing them,
- capacity, and
- availability.

Policies and procedures do not address resources.

Training
Leading practices address aspects of training, including types and frequency. Below is a summary of training-related leading practices.

Crisis Intervention Training
CIT International recommends recruiting and training officers until there are enough CIT officers to provide coverage for all districts and patrol shifts, 365 days a year. This may come out to 20 or 25 percent of officers in large agencies. IACP One Mind Campaign recommends that at least 20% of the sworn force of the police agency be CIT trained and operational.

Leading practices for CIT training include significant community involvement, scenarios, and training evaluations. In addition, CIT International identifies specific training topics such as mental health, community support and resources, and de-escalation.

Continuing education is a core element of CIT. It enables officers to keep their skills current, focus on advanced topics, and receive reminders of their role as CIT officers. It also serves as reinforcement for CIT officers regarding their skills and identity as CIT officers.

According to CIT International,

> *"Mandatory CIT Training Can Damage Your Program*. Some poorly performing CIT officers might seem like a small price for a better-trained force overall, but a CIT-trained officer who does not believe in the mission of CIT is a liability. Forced to take on the role, reluctant officers might act with indifference or even cruelty towards a person with mental illness. A few officers who create hostility during the training week can sour the experience for other officers, as well as that of the mental health professionals, individuals with mental illness, and family members who help teach the course.
>
> With mandatory training, any officer misconduct towards a person with mental illness undermines your entire CIT program because community members see a CIT-trained officer who is behaving badly and may assume that the program is a failure. Researchers looked at officers' knowledge, skills, attitudes, self-confidence in dealing with crisis situations, use of de-escalation, and use of force–and found that volunteers performed better across the board. Department of Justice investigations of law enforcement agencies in Portland, Oregon, and Cleveland, Ohio specifically cited the shift to a train-all approach as the beginning of the end of CIT programs."

Policy and procedures do not address CIT training. Policies also do not address the additional training for officers assigned to the Crisis Response Team.

All Officers

CIT International recommends mental health training for all officers to help recognize a mental health crisis, call for a CIT officer, and keep the scene safe. The IACP recommends Mental Health First Aid training department wide. The Justice Center recommends mental health training at the recruit, in-service, and specialized training levels that is responsive to the needs of the community and demands for service. In addition, CALEA standards used for accreditation require training to include access to the court system and applicable case law.

Officers, deputies, and supervisors who respond to calls for service involving people with mental illnesses should receive training to prepare for these encounters, including de-escalation training.

The IACP recommends providing mental health training in academies and routinely implementing updated training in department roll calls with a focus on responding effectively to persons affected by mental illness as a core responsibility of all police officers.

Directive 6.13.5 states that Department members will receive initial training on dealing with mental health disorders during the basic academy for sworn members. Non-sworn members receive the training as part of orientation/probation. All members who encounter the public receive annual refresher training. This policy addresses leading practices but does not identify the types of training provided.

Leadership
A leading practice is for agency leadership to receive education and training on the police role in responding to people with mental illness, proven approaches, and skills required for an effective program.

Co-Responder training
Leading practices recommend educating behavioral health staff in law enforcement's unique working conditions and demands. Mental health professionals who work within the PMHC program receive training or hands-on experience on topics including:

- Law enforcement policies and procedures,
- Participating in an officer ride-along,
- Observing 911 call-taking and dispatching functions, and
- Observing booking and jail intake procedures.

A leading practice is also to ensure quality staff training for behavioral health personnel and law enforcement, including CIT, mental illness, information sharing, special populations, use of force, naloxone administration, and team building. Policy and procedures do not address the co-responder training.

Frequency of training
Training should be reviewed and or updated annually. Directive 6.13.5 states that all members who encounter the public receive annual refresher training; however, policy and procedures do not address all types of training and how often the training is reviewed or updated.

Officer selection
CIT International recommends that CIT officers be chosen for their suitability to become specialists in responding to mental health crises. Per CIT International, "Training officers who do not have the specific interest, personal motivation, or skills to be CIT officers is not encouraged. It is more important that the officers trained have self-selected and volunteered to be CIT officers."

CIT International recommends a minimum of two years of service as a patrol officer. They recommend using a written application (including describing their interest in CIT), an interview explaining why they want to be a CIT officer,

and a supervisor recommendation. The selection review should include their service record and a review of their disciplinary record.

Directive 8.36.5 states that the CIT coordinator will select volunteer officers for CIT certification. However, this does not follow the leading practice, and the policies do not address any other elements from leading practices.

Additionally, policies and procedures do not address requirements or the process for selection of officers to serve on the Crisis Response Team.

Calls for service
The Justice Center recommends establishing under which situations or types of calls the CRT will be deployed and determining what assessments, supports, and services the team will provide.

Directive 6.13 states that when possible, one or more members of the Crisis Response Team should be assigned to handle calls involving a person in crisis because of a mental health issue. The draft CRT SOPs address responsibility for case management of persons contacted by law enforcement and steps if a call is inappropriate for the team; however, policy and procedures do not address the situations and types of calls the CRT will be deployed to or detailed assessments, supports, or services the team provides. The current policies and procedures do not adequately address leading practices.

Lead on calls
CIT International recommends policies clarify that a CIT officer is generally the lead officer on a mental health call. Describing the CIT officer's role in the policy clarifies that role for CIT officers, their fellow patrol officers, and their supervisors. The policy should clearly describe the leadership role of a CIT officer. In general, a CIT officer takes control of a mental health event either as the initial responding officer or at the request of the responding officer. In cases where the scene is safe and mental health providers are on-site, the officer can play a supporting role or go back into service to handle other calls.

Directive 8.36.2 states that once engaged; the certified member is in-charge of the intervention portion of the event until relieved by a supervisor or department negotiator. The policy addresses the leading practice; however, APD should expand the policy to clarify the role of a clinician on-site.

Assessing the call
CALEA recommends guidelines for recognizing persons suffering from mental health issues. The IACP recommends officers use indicators to assess whether a person in crisis represents a potential danger to themselves, the officer, or others. They also recommend:

- Continuing to use de-escalation techniques and communication skills to avoid escalating the situation,
- Removing any dangerous weapons from the area, and

- Where applicable, ensuring that the appropriate personnel have initiated the process for the petition for involuntary committal.

The Justice Center recommends these protocols for responding officers:
- Assessing whether a crime has been committed,
- Determining whether the person's behavior indicates that mental illness may be a factor,
- Ascertaining whether the person appears to present a danger to self or others, and
- Using skills to safely de-escalate situations involving someone behaving erratically or in crisis.

The IACP recommends policy address the response for when an officer determines an individual in crisis is a potential threat to themselves, officers, or others, and law enforcement intervention is required. The IACP includes 13 areas for consideration in this situation, including requesting a backup officer and seeking CIT officers or CRT assistance.

Directive 8.36.2 addresses CIT officers using appropriate tactics to protect themselves and those in crisis, including cover officers. Directive 6.13.2 includes steps taken when encountering an individual believed to be mentally ill but does not address assessing the person. Draft CRT SOP 2.3 instructs CRT officers to use active listening and de-escalation techniques to gain voluntary compliance when practical and safe. Policies do not address all components of these leading practices.

Emergency holds
CIT International recommends creating clear guidance for officers on behaviors that qualify an individual for an emergency psychiatric evaluation and guidance to describe the behavior to medical or crisis staff. In addition, the IACP recommends that officers request the assistance of crisis-trained personnel to assist in the custody and admission process and interviews or interrogations when possible.

Directive 6.13.3 details the process for a mental health hold, including a form, but does not include guidance requesting CIT or CRT assistance or guidelines on describing the behavior.

Alternatives
CALEA recommends ensuring the best treatment options are used to keep those with mental health issues out of the criminal justice system by addressing alternatives to arrest within policy. Such options could include citations, summonses, referrals, informal resolutions, and warnings. In addition, the Justice Center recommends that when no formal action is taken, officers can connect the person with a friend or family member, peer support, or treatment crisis center.

The Justice Center recommends protocols including procedures for officers to engage services of the person's current mental health provider,

a mobile crisis team, or other mental health specialists. They also recommend, when possible, providing the person in crisis and their family members with resource information.

Directive 6.13 states that when possible, one or more members of the Crisis Response Team should be assigned to handle calls involving a person in crisis because of a mental health issue. If the CRT is unavailable, CIT members or any sworn member may respond. Policy partially addresses leading practices.

Actions
The IACP recommends several courses of action for officers when responding to a person in crisis:

- Offer mental health referral information to the individual, family members, or both,
- Assist in accommodating a voluntary admission for the individual,
- Take the individual into custody and provide transportation to a mental health facility for an involuntary psychiatric evaluation, or
- Make an arrest.

While this may be in practice, the policy and procedures do not address this leading practice.

Restraints
A leading practice is for officers to be aware that the application or use of restraints may aggravate any aggression displayed by a person in crisis. Protocols should describe the use of restraints when detaining people for emergency evaluation. Policy and procedures do not address this leading practice.

Transport
A leading practice is to provide guidance on when an officer can use discretion to reduce trauma and humiliation to the transported individual; examples include allowing transport in a family car or ambulance. In addition, officers should receive guidance on the procedures for coordinating with other agencies involved in transport, such as EMS. Directive 6.13.3 states that transportation to the walk-in clinic or the emergency room may be done by the member or other means. The policy partially addresses leading practices, but the policy does not define "other means."

Transfer of care
Leading practices recommend policy describes any procedure that facilitates the transfer of custody with a receiving center (emergency department, clinic, crisis center), a jail, or diversion center. Policies and procedures do not address this leading practice.

Interviews or Interrogations
CALEA recommends specific guidelines for personnel to follow in dealing with persons they suspect suffer from mental health issues during contacts on the street and during interviews and interrogations.

Directive 6.13.3 gives guidance when interviewing or interrogating an individual experiencing a mental health crisis or who has a mental health disorder. The policy adequately addresses this leading practice.

After incident documentation
The IACP recommends that officers document the incident, regardless of whether the individual is taken into custody. The documentation could include:

- where it occurred,
- an explanation if referred to another agency,
- circumstances of the incident including observed behavior,
- when an individual is transported for psychiatric evaluation, and
- providing documentation to clinicians describing the circumstances and behavior.

Directive 8.36.4 references a data collection sheet and completes a report detailing the actions taken and outside services provided. Draft CRT SOP 2.3 requires CRT officers to document each contact in the records management system. Policy partially addresses this leading practice except for what information is required.

Recommendation

We recommend APD develops SOPs that include leading practices for the Crisis Response Team in cooperation with the clinicians and updates its directives to reflect leading practices.

Management Response

CRT agrees to:

- Update CRT SOPS to include staffing, information sharing, and data collection and policies will also reflect collaboration with AMRT and the AFR Community Health Program.
- Review policies annually to ensure proper terminology and include program goals and a glossary of commonly used terms.
- Updated program goals to reflect CIT International recommendations
- Create performance measures in collaboration with evaluation partners and referenced in the SOPs
- The CRT Sgt. will assume the position of CIT coordinator and the job description of CRT Sgt. will reflect this.
- Update the SOP to include where officers can access resources and outline CIT training for officers in the department as referenced by CIT International recommendations.
- Develop directives to provide guidance to officers in assessing mental health calls for service, requesting CIT/ CRT/ AMRT assistance, and other alternatives to ensure best treatment options.
- Review restraint protocols for persons in mental health crisis and revise as needed.
- Clearly outline transport and transfer of care protocols in policy.
- Update the policy to reflect the information to be collected in reference to documentation for mental health calls for service.

These updates will be made in cooperation with the CRT chain of command, CRT program manager, and clinicians to reflect leading practices outline above.

Targeted Implementation Date: October 31, 2022
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Metro Operations Division Chief

ISS.7 - Program governance

The Crisis Response Team needs to develop a formal and structured approach to program governance.

CIT International recommends a steering committee to work together to improve and guide crisis response. CIT International, IACP, Justice Center and the BJA all include recommendations for parties to be involved, including:

- People living with mental illness and their family members,
- Law enforcement officers,
- Mental health professionals,
- Mental health advocates,
- Community member, and
- Community leaders.

The committee should discuss the committee's purpose, frequency of meetings, shared resources, objectives and goals, programmatic concerns, and how information changes in the programs.

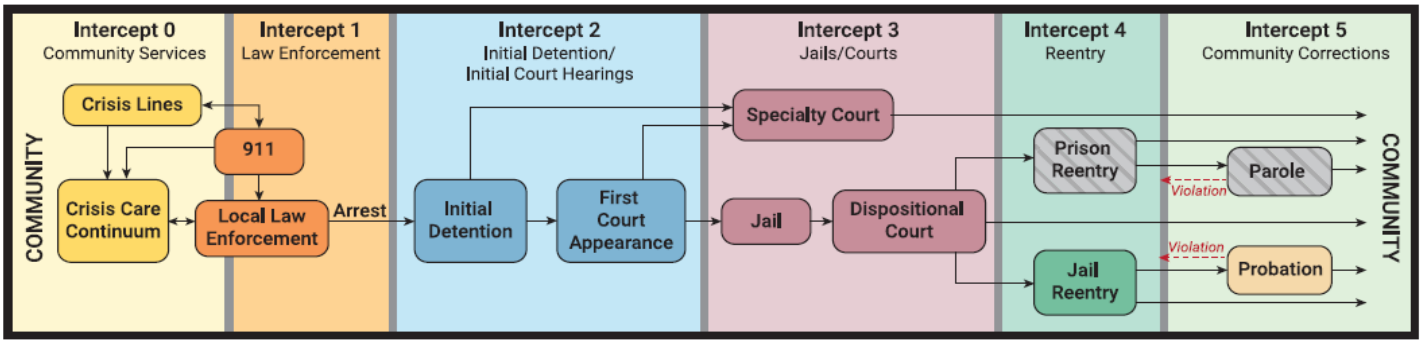
The Justice Center and the Bureau of Justice Assistance recommend that program goals capture the big picture that the program is meant to achieve. In contrast, objectives outline program activities that, if achieved, will meet those goals. The goals should be well-articulated in writing and shared among all partners and the community and reviewed periodically.

Sequential Intercept Model

CIT International's leading practices guide includes using the sequential intercept model. However, Aurora Police does not currently use this model.

> "The model illustrates opportunities at every state of the justice system for individuals with mental illness to be diverted away from the justice system. The system is most effective when there are strong crisis services at Intercept 0, allowing access to mental health services without any contact with the justice system. It is also easier and more effective, if justice system involvement does occur, to serve people and get them on the path to recovery if they can be diverted from the justice system early, such as at Intercept 1."

The graphic below is from CIT International leading practices and is an example of the Sequential Intercept Model.



Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law, 35*(5-6), 380-395. https://doi.org/10.1002/bsl.2300

CIT International recommends "holding a mapping workshop with stakeholders to identify the current practices of the crisis response system, identify gaps and opportunities, and look for funding opportunities if needed. Sequential Intercept Model is used to understand how people with mental illness interact with the criminal justice system. Stakeholders typically discuss each intercept in turn, trying to gain a clear understanding of their community's services, strengths, and gaps. Then, they focus on priority issues. The workshop concludes with a strategic action planning process to help communities tackle their top priorities."[8]

Using a collaborative approach to program governance ensures a comprehensive and effective program.

Recommendation

We recommend developing a Crisis Intervention Team Steering Committee that incorporates leading practices identified above.

Management Response

CRT agrees and the CRT Sgt is currently enrolled in the CIT train the trainer program and will create a CIT steering committee; working in concert with APD Community Relations and AuMHC to create a synergistic group.

Targeted Implementation Date: September 30, 2022
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Division Chief of Metro Operations

ISS.8 - Program feedback and awareness

The Crisis Response Team needs to be more proactive in seeking feedback from community members and families impacted by mental illness and promoting awareness for the program.

[8] Ibid.

CIT International states that feedback can help reinforce the data you collect or put it into the appropriate context. They suggest collecting the following feedback:

- News stories about your program,
- Testimonials from individuals and family members,
- Concerns from individuals and family members,
- Letters of support from individuals and family members, and
- Officer feedback about the training.

CIT International also recommends raising awareness of the program, so individuals know their options during a crisis. The IACP recommends using technology to enhance awareness of mental health services, such as a social media feed.

Program awareness should also be internal within APD to ensure that officers are aware of the role of CIT officers and the Crisis Response Team and available resources for persons in crisis.

Recommendation

We recommend that APD work with APD Media Relations Office, APD Community Relations, City Communications, and Aurora Mental Health Center to identify additional methods for collecting feedback and raising awareness for the program.

Management Response

CRT agrees and will work with City of Aurora communications and APD Community Relations to spread awareness of CRT to community members. CRT is working with ARI (Aurora Research Institute) to develop a formal process to receive post contact feedback from individuals contacted by the CRT.

Targeted Implementation Date: December 31, 2022
Issue Owner: Crisis Response Team Sgt. and CRT Program Manager
Issue Final Approver: Division Chief of Metro Operations

Appendix

Persons in Crisis calls for service categories

The data below is for the period January 16 through 22, 2022 and includes calls for service with someone in crisis where CRT could have responded. The source of the information for this list, the Computer-Aided Dispatch system, was not audited. This is for informational purposes as an example of the various calls for service types involving someone in crisis. The pivot table below shows the case type from the Computer-Aided Dispatch (CAD) system in bold, final case types in italics, and the final case type of mental health crisis is underlined.

Case Type and Final Case Type	Count of final case type
ADMIN	
FOLLOW-UP/REPORT WRITE	1
AREA WATCH	
CHECKED AREA/AREA WATCH	1
CONTACT MADE	1
ATRISK - MISSING AT RISK PERSONS	
RUNAWAY	1
DEATH	
ASSIST INTRA-AGENCY	1
DOMINJ - DOMESTIC WITH INJURIES	
MENTAL HEALTH CRISIS	1
FAMILY DISPUTE	
MENTAL HEALTH CRISIS	*3*
FIRE ASSIST	
ASSIST FIRE DEPARTMENT	7
CONTACT MADE	1
MISSING PERSON	1
SUICIDE ATTEMPT	1
FOLLOW-UP	
CONTACT MADE	1
FOLLOW-UP/REPORT WRITE	2
MENTAL HEALTH CRISIS	*2*
MISSING PERSON	
MENTAL HEALTH CRISIS	*1*
MISSING PERSON	1
OSA - OUTSIDE AGENCY ASSIST	
CONTACT MADE	1
RETURN - RETURNED MISSING PERSON	
RUNAWAY	2
SUIA - SUICIDE ATTEMPT	
ASSIST INTRA-AGENCY	1

CONTACT MADE	1
MENTAL HEALTH CRISIS	*4*
SUICIDE ATTEMPT	1
SUIT - SUICIDE THREAT	
ADMINISTRATIVE/DETAIL	1
CHECKED WELFARE	3
CONTACT MADE	8
MENTAL HEALTH CRISIS	*8*
SUICIDE ATTEMPT	1
Blank	1
SUSPICIOUS	
MENTAL HEALTH CRISIS	*1*
TRESPASS	
Blank	1
UNK - UNKNOWN PROBLEM	
CHECKED AREA/AREA WATCH	1
CHECKED WELFARE	1
WEL - WELFARE CHECK	
ASSIST FIRE DEPARTMENT	1
ASSIST INTRA-AGENCY	2
CHECKED AREA/AREA WATCH	3
CHECKED WELFARE	9
CONTACT MADE	13
FAMILY OFFENSE	1
MENTAL HEALTH CRISIS	*9*
SUSPISCIOUS ACTIVITY	3
Blank	3
WELINJ - WELFARE CHECK WITH INJURIES	
ASSIST FIRE DEPARTMENT	4
CHECKED WELFARE	2
CONTACT MADE	1
FAMILY OFFENSE	1
MENTAL HEALTH CRISIS	*1*
WFAM - FAMILY DISPUTE WITH A WEAPON	
CONTACT MADE	1
MENTAL HEALTH CRISIS	*1*
Grand Total	117

Example of response to crisis call

This flowchart shows how a call for someone in crisis may be routed to the Crisis Response Team (CRT), Aurora Mobile Response Team (AMRT), or CIT officers, or no special response.