

# Study of Alternative Strategies to Traditional Police Response: Greensboro, North Carolina's Behavioral Health Response Team (BHRT)



## Background

Over the past decade, there has been a proliferation of programs designed to respond to non-violent, mental health and quality-of-life 911 calls for service (CFS) as alternatives to traditional police response. In most communities, law enforcement remains primarily responsible for responding to 911 CFS; however, research suggests that a large proportion of calls could be handled without sending an armed officer or resolved administratively<sup>1</sup>. These alternative response programs range from dispatching specially trained police officers, to pairing officers and clinicians as co-responders, to approaches that involve no officer presence at all, such as dispatching unarmed clinicians affiliated with city departments or third-party responders, or providing remote clinical support by phone<sup>2,3</sup>.

Although early evidence points to promising outcomes<sup>4,5</sup>, rigorous research remains limited. To support the developing evidence base, Arnold Ventures funded RTI International to conduct an evaluation of the Behavioral Health Response Team (BHRT) program in Greensboro, North Carolina. RTI's evaluation includes three components: (1) a process evaluation to assess program implementation; (2) a quasi-experimental evaluation to examine the incident-level impacts of BHRT responses on arrests, citations, offense reports, and transports; and (3) a net-benefit cost analysis. This report brief offers an overview of the program and study methods and highlights key outcome and cost findings.

## Overview of BHRT Program

BHRT is a co-response program that pairs counselors with Crisis Intervention Team-trained (CIT) officers to respond to mental health-related 911 calls for service.



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First implemented in December 2020, it is funded by the city of Greensboro and operated by Greensboro's Community Safety Department (GCSD). BHRT-eligible 911 calls are identified by emergency communications call-takers using a set of call-nature codes and supplemental mental health calls to designate eligible calls. BHRT is principally dispatched by emergency communications; however, the team may also self-dispatch to eligible calls. The BHRT counselors and officers share offices in the Greensboro Police Department (GPD) and travel to the scene together in an unmarked car. The program also includes a community health paramedic to support minor medical issues. Counselors may provide follow-up service referrals, and an outreach coordinator provides additional post-response support.

The program operates weekdays, 12 hours per day. If BHRT is unavailable, either because the team is on another call or the call occurs outside operating hours, patrol is dispatched.

## Study Methods

The primary aim of the study was to implement a robust research design to assess whether BHRT alternative responses are associated with differences in operational timing, service resolution, enforcement and documentation, and cost outcomes when compared with patrol-only responses to similar eligible incidents. To achieve this aim, we used a quasi-experimental design that took advantage of the fact that BHRT cannot respond to every eligible call. When BHRT is available, the call receives a BHRT response; when the team is busy or offline, the call is handled by patrol. This capacity-driven variation creates a comparison group from the same pool of BHRT eligible calls.

The analysis draws on three administrative data sources: 1) BHRT administrative data documenting alternative response activities; 2) Greensboro Emergency Communications Computer Aided Dispatch (CAD) data, which provide information on the 911 calls to which BHRT and police are dispatched; and 3) Greensboro Police Department Record Management System (RMS) data, which captures arrests, citations, and offense reports resulting from 911 calls. These data were collected for the period July 1, 2022, through June 30, 2025.

The analytic sample was constructed using the subset of event types, operating windows, and priority levels that reflected the calls to which BHRT was plausibly deployed in practice. The event types were then grouped into broader categories based on call type, observed call volume, and the need to preserve stable treatment/comparison samples. To make BHRT and patrol-only calls as comparable as possible, the analysis accounted for available pre-dispatch characteristics,

such as time of day, month, and dispatch priority. When differences remained between the groups, inverse probability of treatment weighting (IPTW) was used to adjust the patrol-only calls so they more closely resembled calls that received a BHRT response. This helped create a stronger comparison between the two groups.

## Key Findings

### *BHRT Response*

During the two-and-a-half-year observation period, BHRT responded to 8,116 unique call events, accounting for approximately 1.8% of all police calls for service. Consistent with BHRT's mission, the largest share of calls responded to were mental health related. A little over half of call events were for mental health or suicide-related calls (53.2%), while welfare checks (7.6%), disorder/disturbance (7.3%), and suspicious activity (4.2%) made up smaller shares.

Counselor follow-up accounted for 15% of calls, and 12.7% did not fit into a specific category, including infrequent responses to general assistance, missing persons, and larceny calls, among others. BHRT also responded to a broad range of priority levels, with nearly a third (32.3%) classified as Priority 1. The majority of BHRT responses occurred in individuals' homes (43.9%), followed by a community setting (28.9%). The paramedic was included in 12.6% (1,024) of BHRT calls.

The BHRT team responded to roughly half (46.7%) of all call events independently, while the remaining calls involved mixed-unit responses with both BHRT and patrol. Thirty-nine percent of calls involved simultaneous BHRT and patrol dispatch, reflecting situations where patrol units were incidentally attached to a call event or, less frequently, higher-acuity events that required

multiple units. Only a small share of mixed-unit responses (2.1%) resulted from patrol being added as backup to BHRT.

In addition to serving as a primary dispatch response, BHRT served as backup for patrol in 12.2% of calls. Compared to BHRT's direct-dispatch workload, these backup deployments tend to involve slightly higher-priority incidents and are more concentrated in disturbance/disorder and suspicious activity calls. Operationally, these backup requests position BHRT to support patrol officers during evolving, high-acuity events, thereby reducing the need for additional patrol resources and facilitating service-oriented transport dispositions.

### **Officer's Perspectives of BHRT**

A survey of GPD staff found the majority (77%) were extremely-moderately familiar with the BHRT program. GPD respondents expressed high ratings of trust (72%), helpfulness with mental health calls (74%), and felt that BHRT was safe responding to calls (81%). Officer exposure to BHRT enhanced confidence in BHRT responders. GPD staff who were extremely familiar with BHRT were significantly more likely to report that the team was safer and more effective at responding to mental health calls. Many open-ended narrative comments praised BHRT's helpfulness in responding to mental health calls and suggested operations should be expanded to night and weekend shifts.

### **BHRT Call Resolutions**

Counselors document call resolutions in their internal data system (N=5,341). For the majority of calls (48.8%), BHRT effectively resolved the situation by de-escalating and stabilizing the individual, facilitating access to needed services and resources, and coordinating care arrangements with family, friends, and service providers. Counselors routinely conduct suicide and violence risk assessments and do not restrict these assessments to calls initially categorized as "suicide."

Among 3,526 suicide risk evaluations, 7.8% were categorized as medium risk and 5.4% as high risk. Importantly, nearly half of individuals identified as high-risk were involved in call events that were not categorized as suicidal at dispatch.

Consistent with BHRT's mission, voluntary hospitalizations occurred at more than twice the rate of involuntary hospitalizations, with 16.9% compared to 6.7%. BHRT also provided information and referrals in 12.5% of calls to individuals and family members who were not in immediate need or ready to access services, while a slightly smaller percentage (11.3%) of individuals declined BHRT services.

### **BHRT on Incident Outcomes**

To estimate the incident level outcomes, we compared the calls where BHRT was dispatched at the initial call assignment (treatment) to the eligible calls handled by patrol only (comparison), examining outcomes for five call types. **Table 1** presents the analytic sample of BHRT-eligible calls occurring during operational hours, along with the proportion of calls responded to by BHRT versus patrol.

### **Response Time and Transports**

Across event types, there are small net-differences between BHRT and patrol response times. BHRT is faster overall for welfare checks (-4.00 minutes) and suspicious activity (-1.12 minutes), while patrol is faster overall for mental health calls (2.65 minutes) and suicide-related calls (2.27 minutes). Differences for disorder are small in magnitude (0.80 minutes) despite statistical significance. Minor differences in response time (time between dispatch and on-scene arrival) were an operational consequence of BHRT's centralized, capacity-limited team rather than the nearest patrol unit available.

Table 1. BHRT Analytic Sample

Event Type	Contributing call events	BHRT N (%)	Patrol N (%)
Mental (N=8,555)	Mental Subject/Commit Serv; Involuntary Commitment (IVC); Mental Disorder; Psych/Abnormal Behavior	2,916 (33%)	5,639 (63.9%)
Suicide (N=1,924)	Threatening Suicide; Suicide-EMS Needed	1,017 (52.9%)	907 (47.1%)
Welfare Check (N=9,130)	Check Welfare/Assist Family	548 (6.0%)	8,582 (94.0%)
Disorder (N=34,405)	Disorderly Subject or Crowd; Disorder Family; Trespasser	346 (N=1.0%)	34,059 (99.0%)
Suspicious (N=15,548)	Suspicious Activity; Suspicious Subject	262 (N=1.7%)	15,286 (98.3%)

BHRT had longer on-scene durations compared to patrol-only responses. In a pooled analysis of all behavioral health calls, BHRT events lasted, on average, 35 minutes longer than comparable patrol events. Given BHRT’s on-scene assessment and service coordination activities, this finding is not surprising.

Across the behavioral-health event types, incidents where BHRT was dispatched were more likely to result in transport or a change in location. The magnitude of this difference varied by call type, with transport occurring in 28% of mental/IVC calls and approximately 73% of suicide-related calls. While patrol frequently resolves behavioral-health calls through transport, BHRT’s involvement in these call types increases the likelihood of concluding events with movement to services or safer settings rather than resolution solely through on-scene stabilization.

### Offense Reports and Enforcement Actions

Our analysis revealed that the criminal legal outcomes of interest in this evaluation (offense reports, citations, arrests, and use of force) were rare across the universe of calls. In fact, among the 8,116 call events included in the evaluation, only 305 (3.8%) involved any criminal legal outcome. For suicide, welfare check, and suspicious call event types, these outcomes occurred too infrequently to support stable subgroup-specific causal modeling.

**Table 2** presents the modeled results for offense reporting and arrests for the two call events with sufficient offense report and arrest data. An examination of mental health-related calls, the largest BHRT event category, showed no differences between BHRT and traditional patrol-only responses.

Table 2. BHRT Offense Report and Enforcement Actions Modeled Results

	BHRT Adjusted Mean	Patrol Adjusted Mean	Marginal Mean Difference	95% CI
<b>Offense Report</b>				
Mental	1.42	1.30	0.12	[-4.0 to-2.3]
Disorder	3.05	5.22	-2.17***	[-2.9 to-0.6]
<b>Arrests</b>				
Mental	0.00	0.05	-0.08	[-.5 to+.3]
Disorder	5.97	7.08	-1.12***	[-1.5 to-0.7]

\*\*\*p<.001, \*\*p<.01, ^p<.05

For disorder call events, there is a modest statistically significant lower predicted probability of offense reports and arrests when BHRT is dispatched.

Because BHRT responses sometimes include patrol units (i.e., simultaneous dispatch), we conducted a sensitivity analysis comparing incidents where only BHRT responded to similar patrol-only responses for mental health events. This “pure vs. pure” comparison clarifies how mixed-unit deployments influence resource intensity and outcomes. While the sample of patrol events shows a similar rate of criminal legal outcomes to the larger sample, BHRT-only responses had zero instances of arrest, citation, or use of force, and only two offense reports. Given these low counts, these patterns should be viewed as descriptive evidence supporting the service-oriented role of BHRT rather than definitive causal estimates. Collectively, these findings suggest that the few enforcement outcomes observed in BHRT-involved incidents are concentrated in mixed-response scenarios rather than BHRT-only deployments.

### Costs

The cost analysis compares the economic costs of BHRT responses with traditional patrol responses. Costs include travel to the scene, staff time on scene, documentation, and immediate outcomes such as citations, arrests, and transports. Activities that occur after the call, such as service referrals or follow-up work, are not included. Costs were estimated using an ingredients-based approach, which calculates the cost of each 911 call by identifying the resources used,

assigning a cost to each resource, and summing them to produce a total cost per call. The analysis focuses on short-term criminal justice costs and does not include longer-term costs related to arrests, such as court proceedings or incarceration. As a result, total justice system costs may be underestimated. Cost estimates were informed by program interviews, CAD and RMS data, and published research.

We conducted two cost analyses using different treatment samples: (1) BHRT responses at dispatch and (2) BHRT-only responses, each compared with patrol-only responses. This approach was used because simultaneous responses are common at dispatch events, requiring more resources than responses handled by a single unit, which affects cost estimates. **Table 3** presents the predicted means for both models.

For the BHRT-at-dispatch model, we find that BHRT-at-dispatch costs more across all event types. The mental/IVC calls, the difference is \$124.67 and for welfare checks the difference is \$76. For all event types, the differences are statistically significant at the  $p < 0.001$  level.

However, response cost differences are reduced when comparing the BHRT-only sample to patrol. For mental/IVC events, BHRT-only costs \$194.52 per incident compared to \$153.15 for patrol, a difference of \$41.27.

**Table 3. BHRT-at-dispatch and BHRT-only Cost per Incident Predicted Means**

	BHRT-at-Dispatch Model			BHRT Only Model		
	BHRT-at-dispatch	Patrol	Difference	BHRT-Only	Patrol <sup>a</sup>	Difference
Mental	\$270.13	\$145.47	\$124.67***	\$194.42	\$153.15	\$41.27***
Suicide	\$347.00	\$198.20	\$148.80***	\$218.21	\$176.81	\$41.40**
Welfare Check	\$145.07	\$68.11	\$76.96***	\$125.55	\$68.01	\$57.54**
Disorder	\$401.53	\$248.37	\$153.17***	\$138.08	\$157.48	-\$19.40***
Suspicious	\$169.80	\$76.50	\$93.30***	\$121.64	\$86.32	\$35.31***

<sup>a</sup>Estimated patrol costs differ due to model weighting, \*  $p \leq 0.01$  \*\*\* $p \leq 0.001$

For welfare checks, BHRT-only costs \$125.55 per incident compared to \$68.01 for patrol, a difference of \$57.54. For disorder/disturbance calls, BHRT-only costs \$19.40 less per incident compared to patrol. All event types are statistically significant at the  $p < 0.001$  level, except for suicide-related ( $p = 0.006$ ).

## Limitations

This evaluation uses a strong quasi-experimental design that takes advantage of real-world limits in the availability of alternative response teams, but it is not a randomized controlled trial. By focusing on comparable, eligible events and adjusting for observed differences at dispatch, the analysis provides a reasonable comparison between alternative response and patrol-only handling of 911 calls. However, assignment was not truly random, and some differences between events may remain unmeasured, particularly where dispatcher discretion, mixed responses, or post-dispatch changes influenced who responded. As a result, findings should be interpreted with caution and viewed as credible evidence of likely incident-level effects under real-world conditions rather than definitive causal proof.

## Conclusions

Our evaluation finds only modest differences in incident-level criminal justice outcomes between BHRT-at-dispatch and patrol, largely because offense reports, arrests, and citations are rare across both groups. We do find that BHRT-at-dispatch shows a lower predicted probability of offense reports and arrests for disorder events. This event group includes trespassing calls, which BHRT staff describe as especially challenging because they are not always driven by mental health needs. Disorder events also show the largest difference in incident duration between BHRT and patrol, suggesting that BHRT invests more time in de-escalation and non-enforcement resolution than patrol. Additionally, BHRT frequently assists GPD on calls outside its core scope while rarely requiring patrol backup.

One area in which BHRT appears to outperform patrol is the increased probability of transport. Further, the higher proportion of voluntary—rather than involuntary—hospitalizations documented in BHRT administrative data is a significant benefit to individuals in crisis. Although research on involuntary commitment outcomes is mixed, advocates generally favor voluntary treatment because it reduces the negative effects associated with coercion, trauma, and involvement in court processes.

Although this evaluation does not directly measure time savings for GPD, BHRT's primary call types, mental health and suicide-related incidents, are among the most time-intensive for patrol officers, who spend more than an hour on average responding to these events. Findings from the GPD Survey show that officers value BHRT's role in handling these calls and recognize the time, complexity, and skill required for effective de-escalation. Notably, when BHRT responds independently, these events result in no enforcement actions in our study.

The cost analysis finds that BHRT is more expensive than patrol, largely because it often involves more responders and longer on-scene time. This difference is most pronounced in the BHRT-at-dispatch group, which includes many calls where patrol also responded. Notably, our study finds that when BHRT responds independently to these events, it does so without any resulting enforcement actions.

This study takes a justice-system perspective and focuses on short-term, incident-level outcomes. BHRT likely has broader effects on service access, engagement, and longer-term behavioral health outcomes that this analysis cannot capture. It may also generate downstream cost savings by avoiding arrests and their associated expenses,

including court processing, incarceration, and recidivism. Importantly, BHRT was designed to improve responses to behavioral health incidents, not simply to reduce arrests. Further research is needed to measure the outcomes most central to the program's goals.

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