Implementing and Evaluating Alternatives to Traditional Police Responses

Carolina Cohort of Cities Calls for Service (CFS)

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Executive Summary

In the wake of George Floyd's murder, there was a shared desire among city and town governments to align 911 public safety and public health resources with the needs and circumstances of the local community. The City of Durham, North Carolina recognized an opportunity for shared learning and reached out to city and town managers and police department executives across North and South Carolina. With RTI International and the University of Chicago Health Lab serving as research partners, Durham city leaders formed a cohort of jurisdictions that included: Burlington, Cary, Durham, Greensboro, Raleigh, and Winston-Salem in North Carolina, and Rock Hill, South Carolina.

The project was grounded in the reality that police alone cannot meet every crisis response need, particularly for calls that are non-criminal in nature. Each city sought to determine whether there are better ways to handle certain types of emergency and non-emergency 911 calls; thus began a collaborative process of examining where a non-police response or response that partnered police with other service providers could provide a more effective and sustainable solution. The goal was to employ a data-driven approach when considering alternative responses for respective jurisdictions.

The project began with each site building out their project team, which in many instances included partners from the city, county, and community. An analysis of each cohort city's call for service data was then conducted and results of the analyses were shared with the sites to help them understand the scope of need in their communities, orient them toward their most pressing problems, and identify frequently recurring situations where alternatives to police response might be more appropriate. Existing public safety departments—especially police departments—in each cohort city played an essential role in the process of reviewing the results and developing consensus about which alternative responses would be impactful.

An inventory of the different response programs and services in place, both at the city and county level, was also carried out in order to identify programs or resources that could be leveraged for any newly created pilots. RTI project staff also compiled and shared a series of alternative response strategy overviews with the sites for consideration of pilot options, which along with the 911 analysis results, were presented to city councils and other representatives from city leadership and community organizations. RTI staff provided technical assistance to guide decision-making around the selection and implementation of site-selected pilots and helped design evaluation plans for implemented strategies.

The following summarizes key observations, lessons learned, and recommendations that came out of the project.

The Value of a Data-Driven Approach: Across the Cohort sites, we found tremendous benefit in implementing a cross-site approach with a foundation in data. Cross-site learning was achieved across units of local government, including city management and budget, 911 operations, law enforcement, and behavioral health professionals. A path informed by data also provided direction and support for city and county government stakeholders taking on the challenge of implementing 911-based responses in an ever-shifting political landscape.

Benefits of a Building Blocks Mindset: Local governments that rethink 911 response should acknowledge the interconnectedness of all public safety and public health responses when implementing new programs. This includes not just connecting new programs but existing

departments at the city and county levels. In some instances, jurisdictions may start with one particular component of response, such as a co-responder program that is focused on 911 call follow-up, and then build out other areas depending on priorities, needs, and available resources. In other instances, jurisdictions can stand-up a new department which integrated both new and existing programs. As an example, in Durham, NC, the city had developed a new Community Safety Department (DCSD) to oversee and coordinate all four key areas of response—crisis call diversion through clinicians in 911, clinician and police co-response, non-sworn response to behavioral health calls, and follow-up care. The Community Safety Department is a peer first response agency with the police, fire, and emergency medical service departments within the city and county of Durham.

The Need for Standardization: Despite national standards for computer-aided dispatch (CAD), there was significant variation in the calls for service (CFS) datasets across the cohort cities, even in instances where cities use the exact same type of CAD system. Variations exist due to divergent policies and practices from both the 911 emergency call center operators and first responders in the field. A key aspect of this project was standardizing the CFS data across sites, which highlighted the need for improved standards nationally.

Better Identification and Documentation of Mental Health Events: Mental health-related calls are underreported in the 911 system. Across the Cohort sites, these calls represented 1 to 2% of all calls, but because of the types of procedures in place and CAD's inability to classify calls into more than one nature/type, calls that involve an underlying mental health component are often not reported as such. The ability to identify the call nature/call type AND whether mental health played a role in the call is essential to better understand the proportion of calls related to behavioral or mental health.

Limitations of CAD: There are a number of limitations associated with relying on CAD systems and CFS data to assess the need for alternative responses and tracking relevant activity. The 911 system has been too siloed within the greater emergency response and criminal-legal system. In particular, health and police data are rarely (if ever) integrated into a single system. CAD also lacks a broader set of outcomes for 911 calls or the ability to identify high-rate repeat callers because of its structure as an events-based rather than person-based system. In addition, CAD systems have limited steps for tracking follow-up and after-care responses at the city, county, or community level.

Recommendations for Selection and Implementation of Alternative Response Programs

The cohort jurisdictions were not the first to explore alternative public safety responses, but their group collaboration and partnership with an independent research institute offered a holistic approach to addressing a pressing and challenging topic. Key steps for program selection and implementation include the following:

1. Identify project champions.
2. Develop partnerships.
3. Set jurisdictional goals.
4. Establish comprehensive data collection strategy.
5. Analyze all available data.
6. Consider the full universe of calls.
7. Inventory response resources.

8. Develop a plan to address relevant state laws.
9. Consult the evidence base on what works, what's promising, what doesn't work.
10. Select and implement pilot programs.
11. Take on a process of ongoing evaluation and refinement.
12. Address sustainability by evaluating staffing and developing a long-term staffing plan.
13. Solicit community input and long-term engagement.
14. Determine the impact of 988, the new nationwide suicide and crisis phone line.[1]

As described in the following chapters, the evidence base for alternative responses to 911 is a work in progress. Many of the current programs are not fully supported by research, as few alternative response programs have been sufficiently resourced to the levels required for rigorous evaluations – but this is evolving. The work undertaken by the cohort cities provides a strong foundation on which to learn and develop new programs.

[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) operates the recently launched 988 suicide and crisis lifeline. More information about 988 can be found in Chapter 6: Findings and Recommendations.

Chapter 1: Overview of the Carolina Cohort of Cities Project

In 2021, RTI International launched the Carolina Cohort of Cities project to examine alternative response strategies that have the potential to improve public safety agencies' ability to serve the community. The project, which was created in partnership with the University of Chicago Health Lab, includes seven cities across North and South Carolina and focuses on alternative response strategies, such as how to better identify and respond to mental health crises, to better train police officers to respond to mental health-related emergencies, and to pair police officers with trained clinicians or remove officers from certain 911 responses altogether. Some alternative responses occur outside or concurrently with the 911 system, and are considered *second responses*, which occur after initial 911 responses and often include linkages to behavior health services.

The start of the project can be traced back to summer 2020, when the city council of Durham, North Carolina asked the city's Office of Strategy and Performance to examine data on 911 calls to answer fundamental questions around community needs for mental health and police response. In the wake of George Floyd's murder, there was a shared desire among police and communities to ensure that necessary responses and resources were being provided for particular types of 911 calls. Knowing that peer cities in neighboring municipalities were facing similar challenges, Durham leadership recognized an opportunity for shared learning and reached out to city and town managers and police department executives across North and South Carolina to participate in an initiative to examine 911 responses and to consider alternative emergency responses. They formed a cohort of seven jurisdictions: Burlington, Cary, Durham, Greensboro, Raleigh, and Winston-Salem in North Carolina, and Rock Hill, South Carolina.

The City of Durham and RTI were already partnering on efforts to better support individuals in crisis and came together around the need to chart a path forward using data and evidence. RTI joined the Cohort of Cities project as a research partner to collaborate with the sites on analyzing available data on 911 Calls for Service (CFS)[2] and police-initiated activity and to review the research on alternatives to traditional police responses. The results of the analyses were shared with the sites to help them understand the scope of need in their communities, orient them toward their most pressing problems, and identify frequently recurring situations where alternatives to police response might be more appropriate.

RTI staff also provided technical assistance to guide decision-making around the selection and implementation of site-selected pilots and helped design evaluation plans for implemented strategies. In this spirit, RTI compiled and shared a series of alternative response strategy overviews with the sites for consideration of pilot options.

This report provides a comprehensive overview of each phase of the project team's work with the cohort cities. Key learnings from the analysis, intervention design, and program implementation are described in detail. Chapter 2 provides the methodological approach to examining site data, with descriptive statistics that informed decision-making in the sites. Chapter 3 contains a synthesis of options and Appendix A details overviews for each. Chapter 4 focuses on each of the seven sites and provides information on key local factors. Chapter 5 covers each site's progress and highlights the ways in which similar pilot strategies vary between sites. Chapter 6 summarizes the keys lessons learned and recommendations for other jurisdictions considering alternative response options.

[2] Calls for service (CFS) are also referred to as "events" throughout the report.

Chapter 2: Analysis and Key Takeaways from Calls for Service Data

This chapter provides an overview of the analysis conducted on the police CAD events provided by the seven cohort cities. CAD events are entries into the CAD system (i.e., the CAD software the department uses) in which a multitude of factors are recorded. Events largely come from two sources: the first are CFS, or community-initiated events. Community-initiated events are those where a community member calls 911 to request assistance. The second major source of events are officer-initiated events—that is, when an officer starts an event, often because they see an issue or someone is flagging them down. Both community- and officer-initiated events are analyzed in this project.

The first section describes data management processes, which allowed for more meaningful categorization of the event data, as well as cross-site comparisons. The second section provides general observations about patterns in the types of events police are addressing and in the outcomes of those events.

Data Source and Analytic Process

Approximately 3 years of event data were obtained from each of the seven participating cities. Each dataset was initially processed to omit events immaterial to the analysis, including events that were dispatched to EMS or fire services or referred to other police departments. We also excluded duplicate event entries, test events, and those that were labeled as canceled by either dispatch or the officer. The relevance of these omission criteria varied by city but were evenly applied to identify the universe of relevant events. Table 1 describes the date range and the total number of events included in the analysis. Across all cities, we include nearly 4 million events in the subsequent analyses.

Table 1. Description of Included Events

City	Date Range	Total Events
Burlington	10/01/2017–09/30/2020	176,757
Cary	01/01/2017–10/02/2020	398,110
Durham	11/01/2017–10/31/2020	896,916
Greensboro	01/01/2017–12/31/2019	700,942
Raleigh	10/01/2017–10/31/2020	986,612
Rock Hill	09/01/2017–08/31/2020	241,726
Winston-Salem	01/01/2017–08/30/2020	577,915
Total		*3,978,978*

Police agencies differ in how they record incoming 911 event information, with high degrees of variation in the classification of event nature, close code, and event source. Respectively, these three elements are related to the type of event, how the event was handled by police, and from where the event originated. A key stage in the analytic process is understanding the scope of how events are measured, which facilitates the reclassification of event information into fewer broader categories. Aggregating the event data allows for standardization across jurisdictions and more meaningful and intuitive interpretations of the event data. Table 2 details the variability in event measurement across the seven cities. On the low end, Rock Hill had 93 distinct classifications of event nature, while Raleigh had over 500. The number of close code designations that classify how a call was resolved also varied across the cities, with a high of 84 close code options in Raleigh and a low of 17 in Greensboro.

Table 2. Event Description Formatting across Cities

City	Event Natures	Close Codes	Event Source
Burlington	134	23	2
Cary	302	27	18
Durham	350	32	16
Greensboro	156	17	20
Raleigh	505*	84	4
Rock Hill	93	19	2
Winston-Salem	181	27	2

Raleigh has some duplicate event natures due to formatting differences depending on event source.

With the assistance and input of crime analysts and other key stakeholders in each city, we were able to aggregate all events into 18 event natures, eight close codes, and two event sources. The new categories are inclusive of every event; however, due to differences in data collection across cities, not all the new categories are utilized by each site. The categorizations are detailed in Table 3 and provide the basis of the analyses presented.

Table 3. Standardized Categories for Event Description Formatting

Event Natures	Close Codes	Event Source
Alarm	Arrest	Community-initiated
All other property	Closed investigation	Police-initiated
All other violent	Mental health/CIT	
Deceased person	Noncustodial police action	
Disturbance	Ongoing investigation	
Domestic/family	Other, no arrest	
General assistance	Referred outside of LE	
Hang-up	Resolved without report	
In-progress other		
In-progress violent		
Medical fire assist		
Mental health		
Police administrative		
Proactive policing		
Quality of life		
Sex offenses		
Traffic-related		
Warrant service		

LE = Law enforcement

Analysis Results

Event Volume

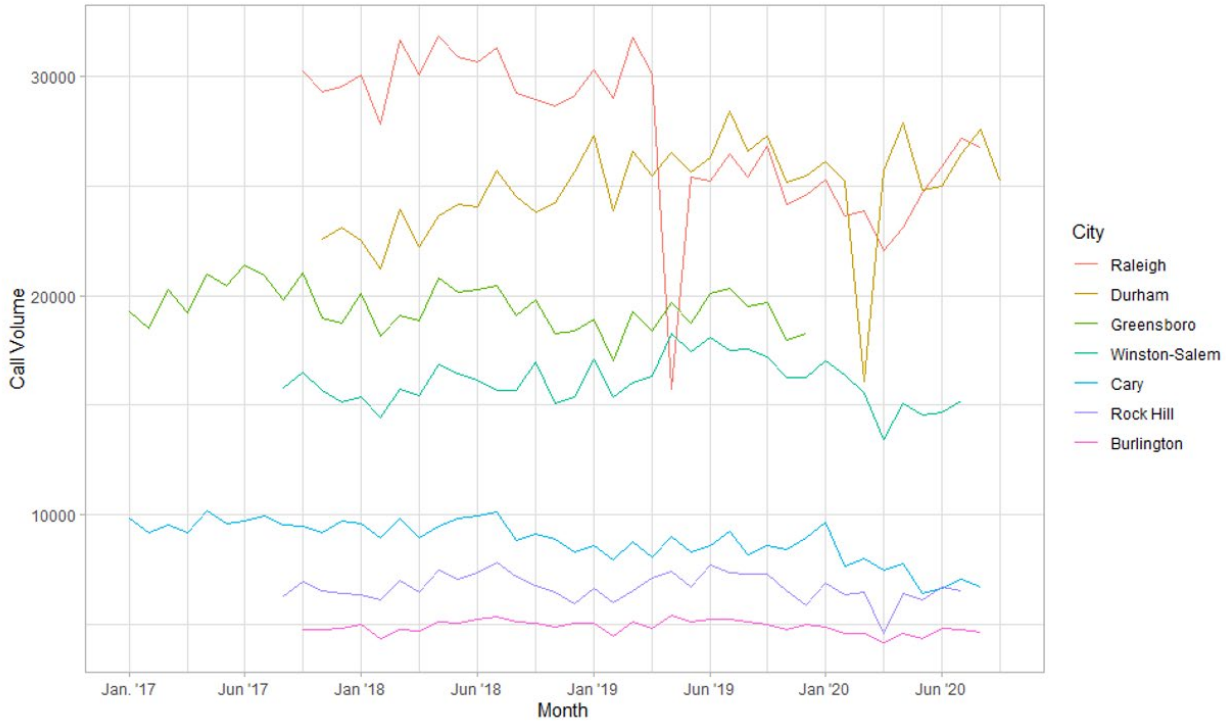
This analysis includes around 4 million events across seven cities. Although the cities differ in size and therefore event volume, the average is approximately 15,835 events per month in each jurisdiction. To contextualize the cities across varied timeframes and population sizes, the average yearly number of events and the rate per 1,000 community members are provided in Table 4. The population estimates for each city are sourced from the 2019 U.S. Census. Notably, in Burlington, Durham, and Rock Hill, the average events per year exceed the number of community members of that city.

Table 4. Yearly Event Volume and Rate across Cities

City	Population (2019)	Yearly Events	Event Rate/1,000
Burlington	54,606	58,919	1,079
Cary	170,282	103,945	610
Durham	278,993	298,972	1,072
Greensboro	296,710	233,647	787
Raleigh	474,069	320,016	675
Rock Hill	75,048	80,575	1,074
Winston-Salem	247,945	154,110	622
Average	*228,236*	*178,598*	*783*

Given access to event data over 3 to 4 years, we also analyzed the change in event volume over time. Figure 1 summarizes the changes in overall event volume over each city's reporting period.

Figure 1. Event Volume over Study Period

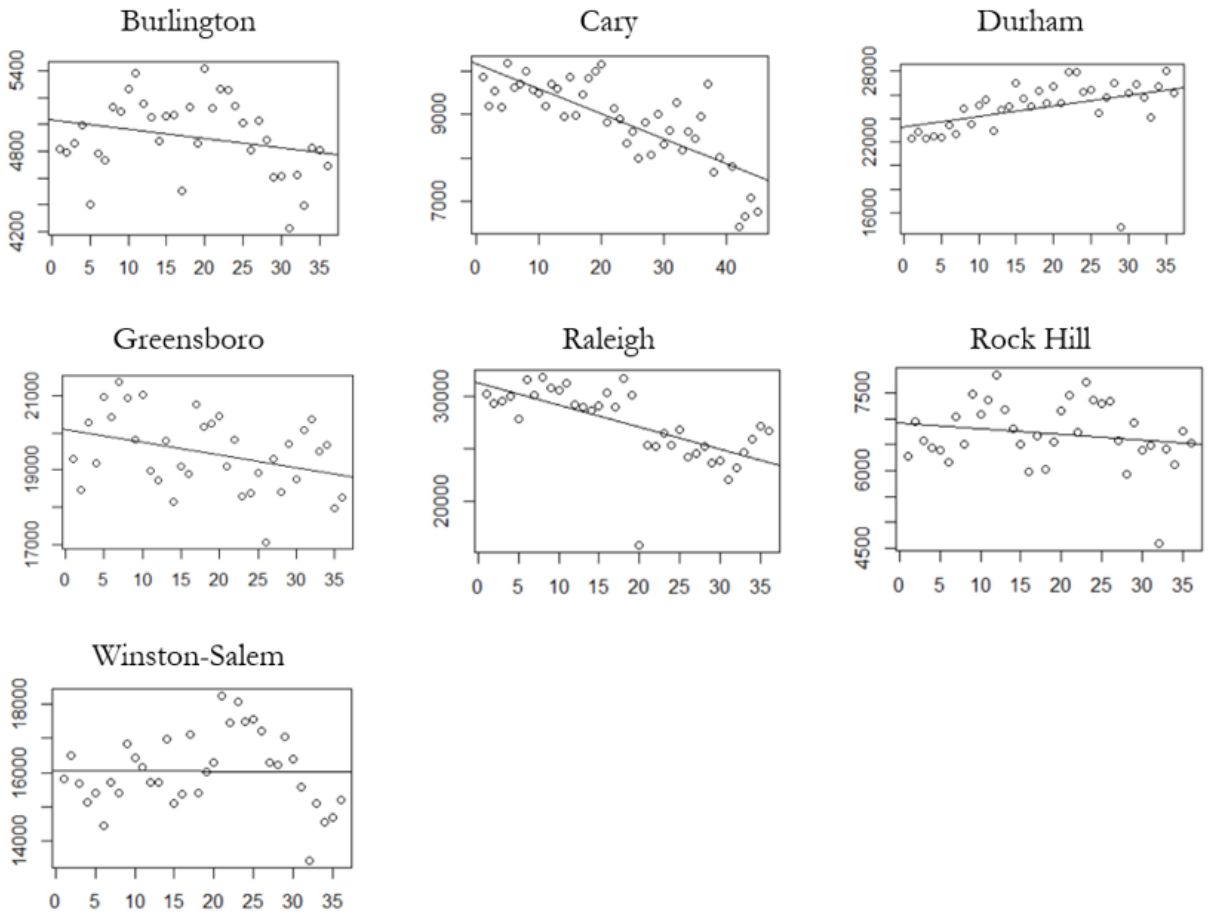


Most cities experienced a decline in overall event volume over the study period. The volatility in Raleigh in spring 2019 appears to be a result of change in data collection protocols rather than organic change. Although not visible at this scale, Burlington's trend in event volume may not be linear, with an increase in the middle of the reporting period and consistent decline since mid-2019 (see Figure 2). Durham was the only city in our sample to report a statistically significant increase in event volume. The effects of the COVID-19 pandemic on decreasing event volume in the spring 2020 are evident but appear to be short-lived. The statistical analyses of the trendlines regressions of event volume predicted by month are reported in Table 5 and Figure 2.

Table 5. Event Volume Regression Results

City	Trendline Significance	Direction
Burlington	Not statistically significant R^2=.07, F(1, 34) = 2.42, p=.129	Decrease
Cary	Statistically significant R^2=.61, F(1, 42) = 68.78, p=.000	Decrease
Durham	Statistically significant R^2=.15, F(1, 34) = 6.00, p=.020	Increase
Greensboro	Statistically significant R^2=.10, F(1, 34) = 4.99, p=.032	Decrease
Raleigh	Statistically significant R^2=.42, F(1, 34) = 24.96, p=.000	Decrease
Rock Hill	Not statistically significant R^2=.03, F(1, 34) = 1.19, p=.284	Decrease
Winston-Salem	Not statistically significant R^2=.00, F(1, 34) = 0.00, p=.970	Stable

Figure 2. Event Volume Trendlines



Event Nature

The description of the event nature is a useful measure for the most common demands on police time and resources. Table 6 shows the percentage of events in each of the 18 broad categories. Event categories are mutually exclusive, and events are only counted in a single category. As shown, most events are not for serious violent crimes or apparent emergencies. Violent events only account for between 0.3% and 4.1% of events in Cary and Winston-Salem, respectively. The most common categories are proactive policing (18.6%), general assistance (14.9%), quality of life (11.6%) traffic-related (10.3%), and property crimes (10.1%). The prevalence of these events warrant specificity about the types of events that make up these categories. Proactive policing largely comprises directed or general patrol initiated by officers. General assistance consists of police community contacts, welfare checks, and police assistance for other needs. Quality of life events include animal CFS,[3] vice crimes and misdemeanors, and graffiti. Traffic events refer to both enforcement of traffic laws and response to collisions. Property crimes (other) are reports of burglaries, larceny, and shoplifting not-in-progress.

[3] Animal-related calls for service include events like a dog being off a leash.

This general pattern of event nature prevalence is aligned across the seven cohort cities, with general assistance, quality of life, proactive policing, and traffic events consistently ranked as the top event nature types and making up between 45.1% of all events in Greensboro and 67.2% of all events in Cary. However, Table 6 does show the variability in event natures due to either differences in measurement or true event volume. Notably, proactive policing is not represented in the event data provided by Winston-Salem and hang-up events are not included in Greensboro data. The high proportion of general assistance events in Rock Hill (24.9%) is driven by a large volume of follow-up and miscellaneous investigations. Cary reports the highest percentage of "all other property" calls, driven largely by security checks. Beyond these variations, the breakdown of event types is similar across cities.

Table 6. Event Nature Prevalence (Universe of Events is 3,978,978)

Event Nature	All Events	Percentage Range	Community Events
Proactive policing	19.0%	0.0–41.7	0.3%
General assistance	15.3%	9.7–24.9	16.3%
Quality of life	11.7%	6.6–25.4	13.4%
All other property	10.2%	4.1–17.4	11.6%
Traffic-related	10.1%	7.2–13.7	14.1%
In-progress other	5.7%	3.8–10.9	7.6%
Police administrative	5.6%	0.0–10.3	2.0%
Alarm	5.3%	3.7–6.4	9.7%
Disturbance	4.2%	0.8–6.6	6.7%
Domestic/family	2.9%	1.1–5.8	4.6%
Hang-up	2.8%	0.0–6.3	4.7%
Warrant service	2.1%	1.0–4.7	1.0%
Medical fire assist	1.5%	0.3–4.8	2.3%
Mental health	1.4%	0.7–2.4	2.4%
All other violent	1.4%	0.0–2.3	2.0%
In-progress violent	0.6%	0.1–1.8	1.0%
Sex offenses	0.2%	0.1–0.4	0.3%
Deceased person	0.1%	0.0–0.1	0.1%
Missing event nature	0.0% (n = 1012)	0.0–0.0	0.0% (n = 485)

Table 6 also demonstrates the difference in community-initiated events. Whereas the sum of all events in this analysis represents the priorities of both the police and community, isolating community-initiated events provides a clearer picture of community priorities and the demands on police from community members. Although proactive policing is noticeably and logically absent, community events retain a similar focus on general assistance, traffic-related, quality of life, property crimes, and alarm CFS (consisting of residential and commercial alarms).

Given the multiple years of event data, we were interested in looking at the volume of individual event natures over time and across cities. Figure 3 summarizes trends in event nature volume over the reporting periods for each city. The slope of each event nature trend was determined using linear regression, with month predicting monthly event volume to identify the significance of the trendline. Figure 3 is intended as a visualization of trends across cities and of the event types contributing to the decline in overall event volume. Significant increases in event volume are represented by red shading, and significant decreases in event volume are represented by green shading. The darker

shades of both colors reflect an R^2 value greater than.50, indicating a substantively significant change over time. Non-significant trends are grayed out. Black cells represent data that were not relevant based on reported event volume.

Figure 3. Summary of Significant Changes in Event Volume by Event Nature

Event Nature	Burlington	Cary	Durham	Greensboro	Raleigh	Rock Hill	Winston-Salem
Alarm					R^2=.57		
All other property							
All other violent			R^2=.61	R^2=.50	R^2=.57		
Deceased person							
Disturbance			R^2=.69				
Domestic/family			R^2=.69				
General assistance							
Hang-up		R^2=.78					
In-progress other					R^2=.61		
In-progress violent							R^2=.50
Medical fire assist			R^2=.54		R^2=.61		
Mental health	R^2=.62						
Police administrative							
Proactive policing		R^2=.74			R^2=.54		
Quality of life							
Sex offenses							
Traffic-related							
Warrant service	R^2=.59						

* All darker shaded red and green cells have a p-value = .000.

Figure 3 can be used to better understand trends in event natures within a city and identify patterns in specific event types across cities. As indicated earlier, overall event volume in Burlington decreased over the study period, driven largely by decreases in proactive enforcement. However, there are several notable increases in mental health events and events related to violence and disturbances. Cary experienced substantial declines in most event nature categories, except for hang-up events, which reflect the largest change, going from around 100 to over 500 events per month. Durham is the only city with an increase in the total volume of events over the study period, largely driven by increases in disturbances and violent events. Greensboro experienced significant declines among most call nature categories and for total call volume as a whole. Raleigh also has some limited data quality issues due to apparent reclassification of event types originating outside of community events. As such, changes to alarm, proactive policing, and traffic-related events may be artificial. Event volume across all types was largely stable in both Rock Hill and Winston-Salem.

Looking across the cities, there are a few commonalities in event nature trends as well. Generally, alarm events significantly decreased in most cities, except for Raleigh, which made some reporting changes to this event code. There were similarly consistent decreases in general assistance, in progress (other), proactive policing, traffic-related, and warrant service events. These are further

explored in the *Proactive Policing* section, but those events likely to be initiated by officers consistently declined across cities, pointing toward changes in operational capacity or priority. Although not universal across the cities, it is important to highlight increases in some violent crimes, disturbances, and domestic/family events. The COVID-19 lockdowns that occurred toward the end of the reporting periods cannot be causally identified, but these events may play a role in the trends of event natures that increased and those that decreased.

Event Disposition

The description of the event disposition, measured in the data as the event close code, is a useful measure for the outcomes of police interactions with the public and the general operational approach of the department. Table 7 shows the percentage of events in each of the eight broad categories across cities. It is important to note that Greensboro close code data are excluded here due to measurement differences that prevented classification into the eight categories. Close code categories are mutually exclusive, and events are only counted in a single category. As shown, most events are handled without direct police intervention. The most common event dispositions are police administrative actions related to report-taking (or the lack thereof) and continued investigations. Punitive actions are relatively rare, with noncustodial police actions such as citations or warnings making up 9.8% of events and ending in arrest 4.3% of the time.

This general pattern of close code prevalence varies widely across the seven cohort cities. Although resolving an encounter without a report consistently ranked as the most common outcome, agency measurement differences and operational priorities make comparison across jurisdictions difficult. Table 7 reflects the variability in disposition codes; it is evident that cities utilize closed investigations, ongoing investigations, and resolution without report codes to varying degrees. About half of all events are resolved without report, although Raleigh, which classifies these as closed investigations (56.5%), is an exception. These differences also reflect operational decisions by officers. Rock Hill utilizes noncustodial police action (22.9%) in the form of issued warnings to a greater extent than other jurisdictions.

Table 7. Close Code Prevalence (Universe of Events is 3,278,036)

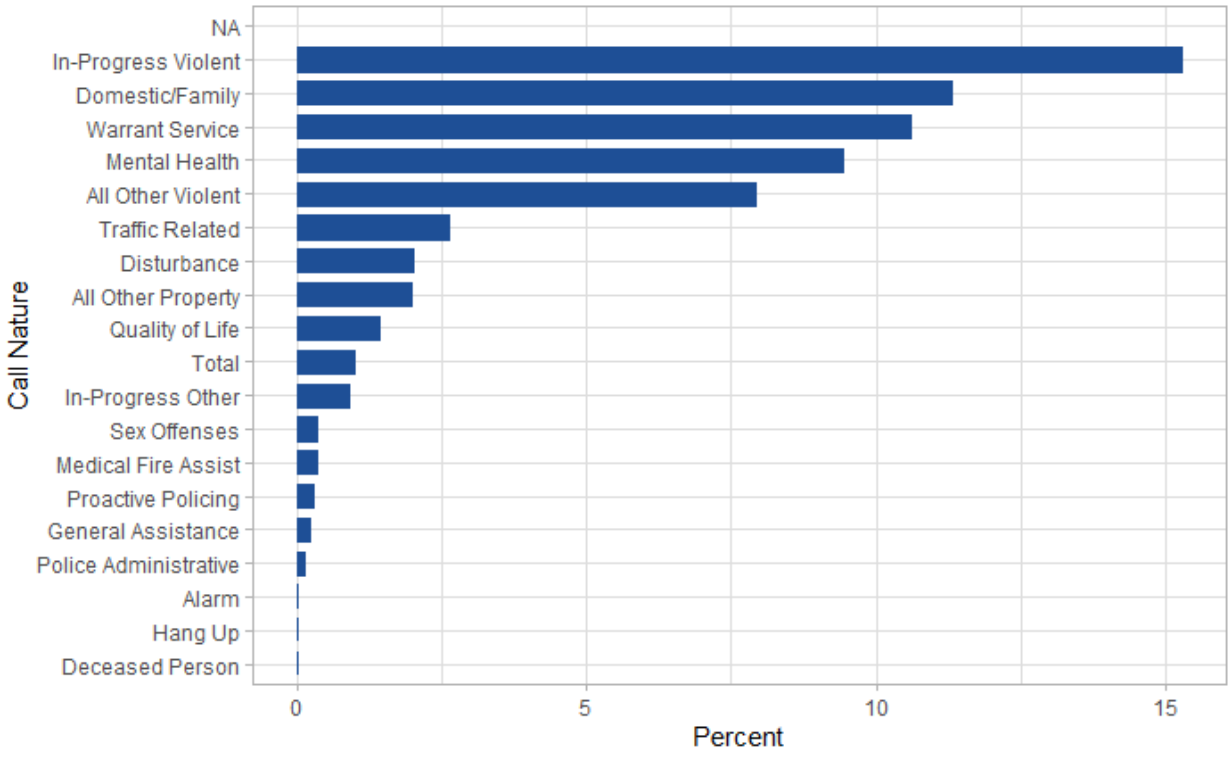
Event Nature	All Events	Percentage Range
Resolved without Report	45.7%	0.4–69.0
Closed Investigation	23.0%	4.4–56.5
Ongoing Investigation	12.3%	0.0–18.8
Noncustodial Police Action	9.8%	3.9–22.9
Other, No Arrest	4.6%	0.0–17.4
Arrest	4.3%	0.4–10.2
Mental Health/CIT	0.2%	0.0–0.7
Referred Outside LE	0.1%	0.0–0.2
Missing Close Code	0.0%	0.0–0.0
	(n = 87)	

Although arrest only accounts for 4.3% of all events, it warrants particular interest, as it reflects one of the more severe outcomes of an interaction between police and the public. The rates of arrest for

events across cities generally range from 0.4% to 1.2% with Raleigh (7.1%) and Winston-Salem (10.2%) serving as outliers. These numbers may be due to similarly coded reports being entered as arrest reports, which makes it impossible to extricate them from the actual arrest data using CAD data alone. The differential measurement of close codes, and arrest reports specifically, highlights a difficulty with event analysis. Raleigh reports that nearly a third of its proactive policing events end in arrest, which may indicate a data issue. Further, nearly 40% of Winston-Salem's deceased persons events end in arrest. These examples, along with the total exclusion of Greensboro data for similar reasons, point to the difficulty and danger of relying on event data alone. The realities of the data make further aggregation of arrests untenable.

Of the remaining cities, for which we believe we have reasonable arrest estimates, Burlington, Durham, and Rock Hill make arrests driven primarily by warrant service. Cary provides the most detailed examination of arrests as a function of event nature, present in Figure 4. In-progress violent crimes (simple assault, domestic assault) are the events most likely to end in arrest (15.3%). Although only 1% of total events end in arrest, more than 7.5% of domestic/family events, warrant service, mental health, and other violent events end in arrest. In particular, 9.4% of mental health events result in arrest.

Figure 4. Arrests by Event Nature in Cary



Proactive Policing

While the distribution of community-initiated event types can provide insight into the needs of the community, the volume and event natures associated with officer-initiated events can provide a proxy measure for the level of police proactivity and offers details as to how officers spend their time. Table 8 shows the breakdown of officer-initiated events for each city. Overall, 43.2% of events in the study were officer-initiated, though this varies across jurisdiction, ranging from 31.6% in Burlington to 58.0% in Cary.

Table 8. Officer-Initiated Event Prevalence

City	Officer-Initiated Events
Burlington	31.6%
Cary	58.0%
Durham	50.0%
Greensboro	35.6%
Raleigh	51.6%
Rock Hill	38.4%
Winston-Salem	32.4%
Average	43.9%

Figure 5. Officer-Initiated Event Volume over Study Period

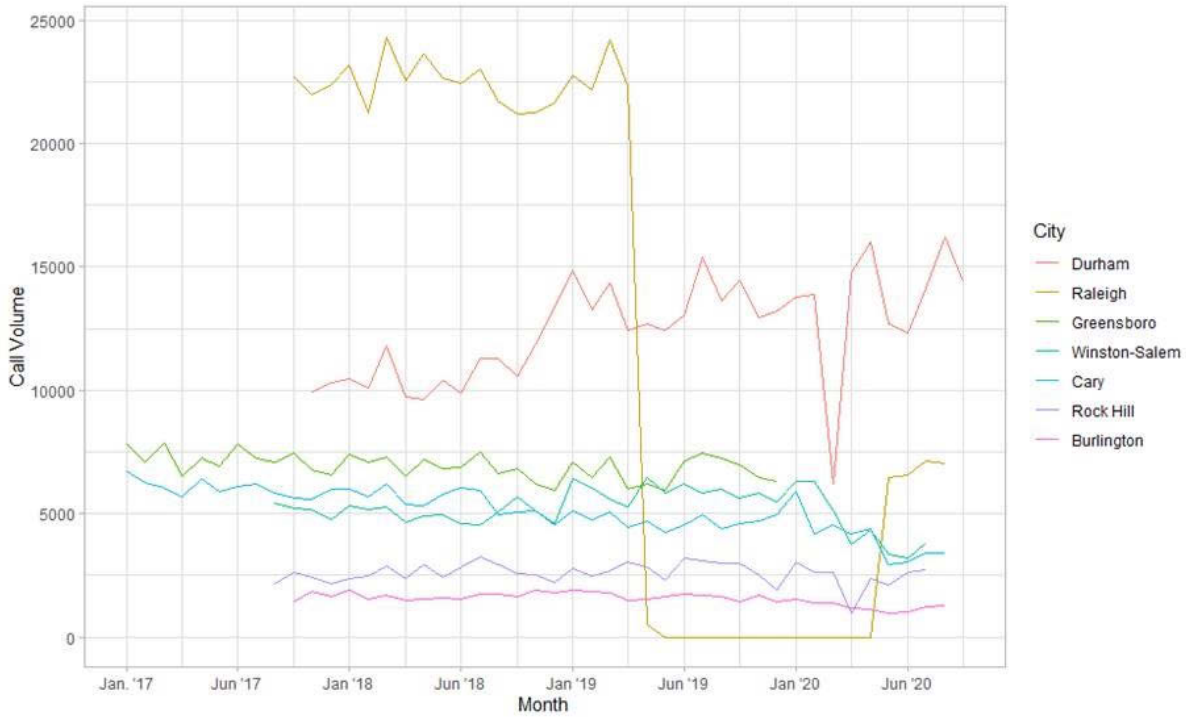


Figure 5 shows the volume of officer-initiated events across the seven cities. It is important to highlight the steep drop-off in Raleigh in the spring of 2019, due to a change in data collection and reporting rather than an actual drop in officer-initiated activity. Otherwise, officer-initiated events are relatively stable and in line with overall shifts in event volume. One additional observation is the decline in event volume in the spring of 2020 at the beginning of the COVID-19 pandemic. Raleigh,

in particular, shows a steep decline in officer-initiated activity; the downward trend is also evident in Cary, Winston-Salem, and Rock Hill.

The types of events that officers initiate differ from the events initiated by community members, as described in Table 6. Looking at the specific event nature categories that officers initiate can provide some evidence of how officers spend their time, what they encounter in the field, and how their priorities may differ from the events initiated by community members. Table 9 details the most common officer-initiated events and what percentage of those event types are initiated by officers, rather than by community members. As expected, proactive policing (43.5%), general assistance (14.1%), and quality of life (9.6%) are the most common event types initiated by officers. These are also among the event natures that community members do not frequently initiate. 99.2% of proactive policing events are initiated by officers, logically followed by police administrative (77.7%) and warrant service (68.3%).

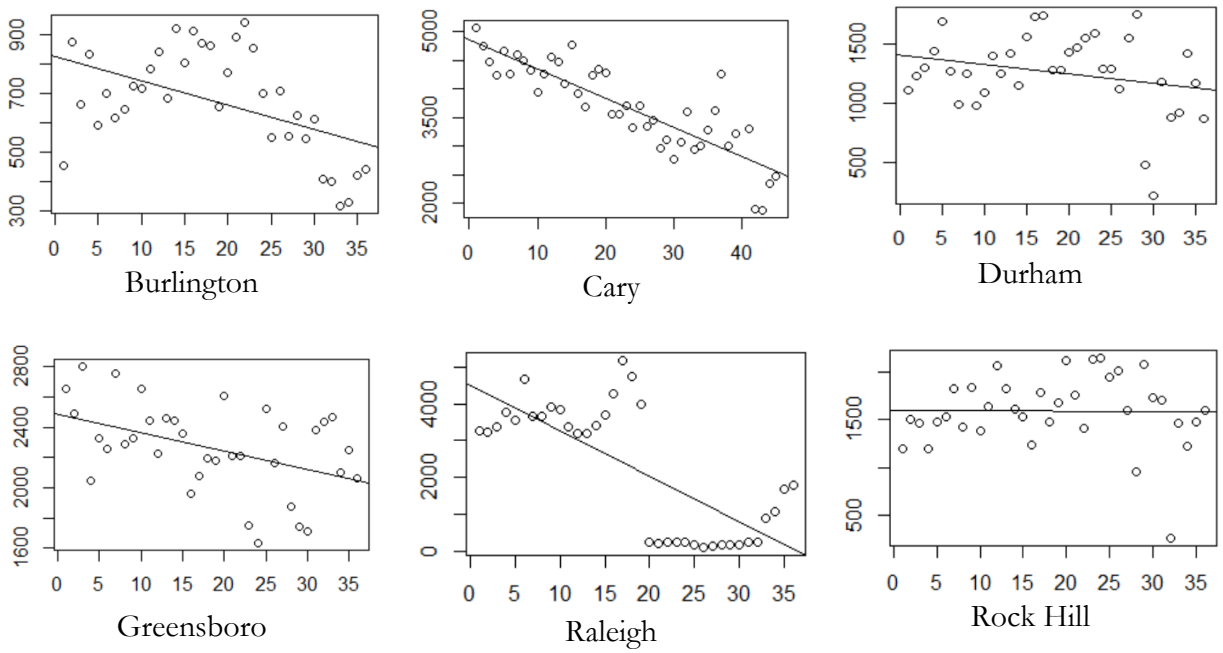
Table 9. Event Nature Classification of Officer-Initiated Events

Event Nature	Event Prevalence	% of Events Initiated by Officer
Proactive policing	43.5%	99.2%
General assistance	14.1%	41.0%
Police administrative	8.9%	77.7%
Quality of life	9.6%	36.3%
All other property	7.1%	32.9%
Traffic-related	5.6%	24.1%
In-progress other	3.7%	27.8%
Warrant service	2.8%	68.3%
Disturbance	1.2%	12.7%
Domestic/family	1.0%	14.4%
All other violent	0.7%	22.1%
Medical fire assist	0.6%	17.2%
Hang-up	0.6%	9.1%
In-progress violent	0.2%	16.4%
Mental health	0.2%	6.0%
Sex offenses	0.1%	19.2%
Alarm	0.1%	0.6%
Deceased person	0.0%	11.2%
Missing event nature	0.0% (n=259)	-

Despite officer-initiated activity being a global proxy measure for police proactivity, explicit proactive policing strategies, such as directed patrol, make up most officer-initiated events (43.5%). Across all the cities, however, the study period was marked with significant declines in proactive policing approaches, which could be attributed to the COVID-19 pandemic, the landscape of anti-police sentiment highlighted in 2020, or staffing shortages experienced across the profession. Apart from Winston-Salem, which did not explicitly record proactive policing events, the trend lines for proactive policing levels in all cities declined over the study period. Figure 6 shows the event volume for proactive policing in each site with the associated linear trendline. As previously noted, changes in the Raleigh event data are subject to apparent data reporting or classification changes during the reporting period. The decline in proactive policing was not statistically significant for Durham or Rock Hill but was profound in other cities. The volume of proactive policing events in Cary was cut

in half over the study period, from nearly 5,000 per month to around 2,500. Time alone accounts for around three-fourths of the variance in proactive policing (R^2=.74, F(1, 42)=119.6, p=.000). Additionally, traffic-related enforcement and warrant service event natures, which relate to police proactivity, significantly declined across jurisdictions.

Figure 6. Proactive Policing Event Volume Trendlines



Time Spent on Events

When available data supported the analyses, RTI also provided information on the total time spent on events by event nature classification for both officer- and community-initiated events. Execution of this analysis was limited due to data availability. The selected results for Raleigh are presented in Table 10. To determine the total time spent on each event, we subtracted the first dispatch time from the close time for each unit associated with the event. Unit-specific event time was then summed for each event incident to calculate the total time spent on an event. This information was then aggregated by event nature classification. As shown in Table 10, police administrative events, such as report writing and off-duty assignments, accounted for the greatest amount of time in minutes, over a quarter of all police time. This is followed by property-related events that were not in progress.

Table 10. Total Time on Event-by-Event Nature for Raleigh Police Department

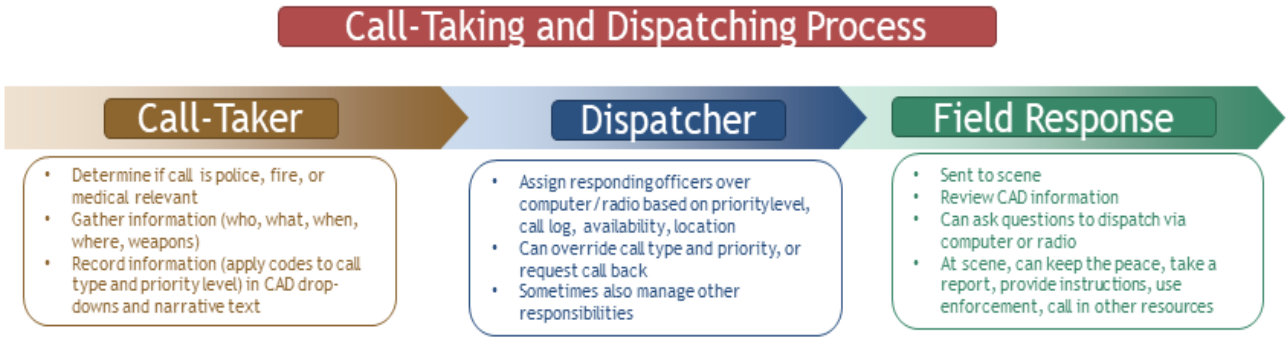
Event Nature	Total Number of Minutes	% of Total Time on Events
Police administrative	26,585,298	25.22%
All other property	13,334,227	12.65%
General assistance	11,902,428	11.29%
Traffic-related	11,068,356	10.50%
Quality of life	7,994,646	7.58%
In-progress violent	6,444,477	6.11%
Domestic/family	4,839,209	4.59%
In-progress other	4,717,695	4.48%
Disturbance	3,316,076	3.15%
All other violent	2,892,215	2.74%
Warrant service	2,872,380	2.73%
Medical fire assist	2,216,764	2.10%
Mental health	2,194,022	2.08%
Proactive policing	1,759,695	1.67%
Alarm	1,164,137	1.10%
Deceased person	865,566	0.82%
Sex offenses	725,391	0.69%
Hang-up	381,441	0.36%
Missing event nature	*133,440*	*0.13%*

* Incidents with less than 0 seconds (343 records) were omitted from the analytical sample. Additionally, records that had a time of greater than 40 hours on an event (~2200 records, or 0.17% of the incident data) were omitted.

Chapter 3: Response Strategy Overviews

The 911 system was designed to handle public safety or health emergencies including crimes in progress or other forms of immediate danger. However, most calls to 911 fall outside of that scope, ranging from noise complaints to minor traffic collisions or mental health crises. For some of those events, police involvement can be inefficient, unnecessary, or even harmful.[4] This begs the question of whether an alternative response can lead to better outcomes, including fewer negative interactions between community members and the police and increased trust in the police. Figure 7 provides a high-level overview of the call-taking and dispatching process, which shows the various points where an alternative response strategy could be effective.

Figure 7



This figure is adapted from *Transform911: Assessing the Landscape and Identifying New Areas of Action and Inquiry.*[5]

The 911 response system map in Figure 8 highlights where in the emergency response process each intervention might be applied. For example, methods of response can range from a sworn response (e.g., CIT), a co-responder model, or a 3rd party non-sworn response. Programs may have a primary goal of improving police-community interactions, reducing arrest, addressing mental health, supporting case management, improving assessment capabilities, or redirecting and reducing high utilizer calls. The strategies vary in their methods and goals, but consistent among them is a theme of partnership and connectivity.

Creating a common understanding across first responder agencies and public health and safety sectors, as well as throughout the community, is essential. For example, when an individual calls 911 during a mental health crisis, a broader knowledge of available resources, partners, and infrastructure is necessary to most effectively support the caller and connect them with assistance.

Given the widespread interest in non-sworn responses to CFS, it is critical to demonstrate their efficacy before the interventions are brought to scale. Several of the interventions previewed are being piloted in RTI's Cohort of Cities project and are in different stages of adoption in agencies across the country. This synthesis aims to provide an overview of the different strategies and the conditions required for their implementation.

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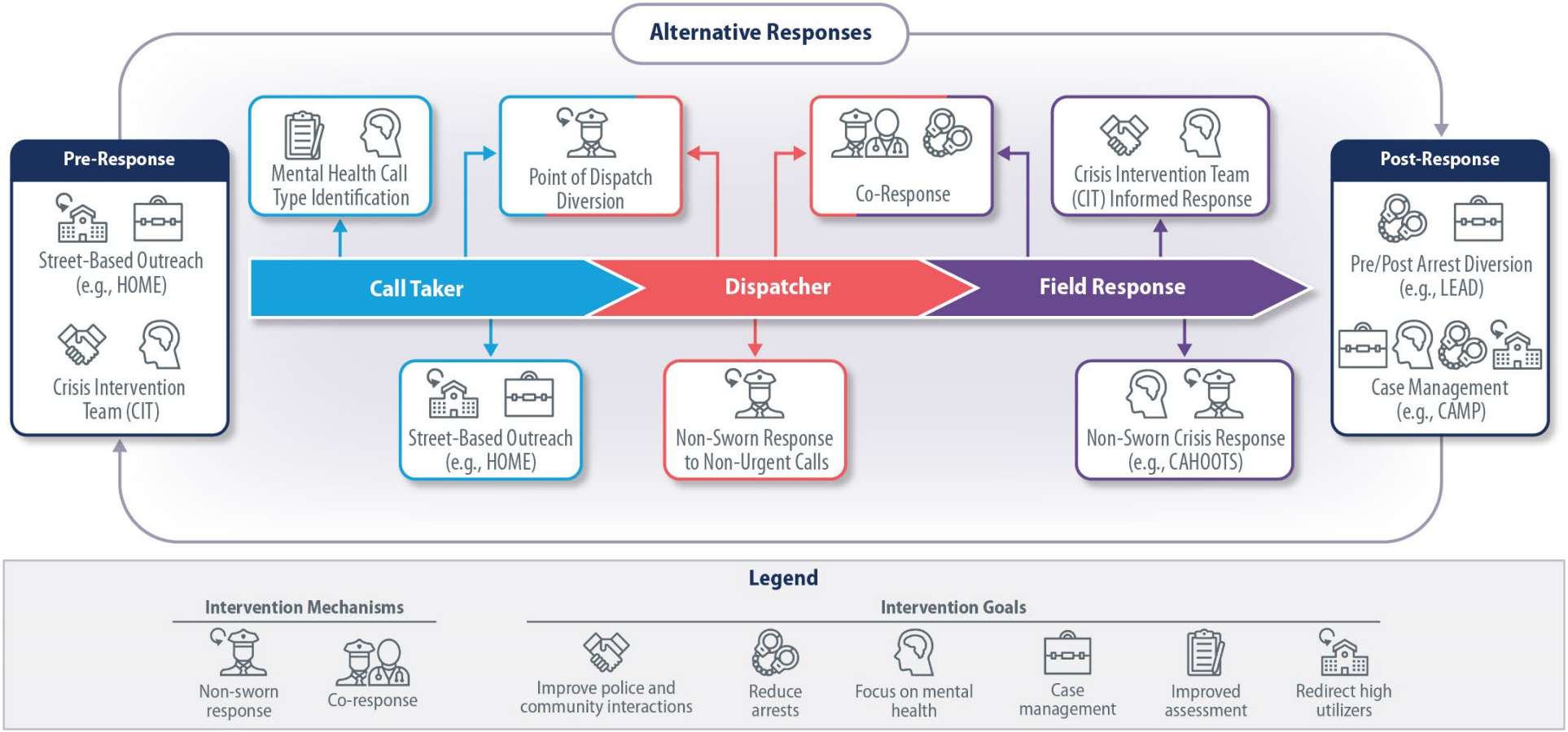
[4] System Assessment and Validation for Emergency Responders (SAVER). (2011, September). *TechNote: Computer Aided Dispatch Systems.* U.S. Department of Homeland Security. https://www.dhs.gov/sites/default/files/publications/CAD_TN_0911-508.pdf

[5] Transforming 911: Assessing the landscape and identifying new areas of action and inquiry. TRANSFORM911. (2022, February 28). Retrieved August 29, 2022, from https://www.transform911.org/resource-hub/transforming-911-report/

Figure 8


Alternative Responses
Pre-Response
Street-Based Outreach (e.g., HOME)
Crisis Intervention Team (CIT)
Mental Health Call Type Identification
Point of Dispatch Diversion
Co-Response
Crisis Intervention Team (CIT) Informed Response
Call Taker
Dispatcher
Field Response
Street-Based Outreach (e.g., HOME)
Non-Sworn Response to Non-Urgent Calls
Non-Sworn Crisis Response (e.g., CAHOOTS)
Post-Response
Pre/Post Arrest Diversion (e.g., LEAD)
Case Management (e.g., CAMP)
Legend
Intervention Mechanisms
Non-sworn response
Co-response
Intervention Goals
Improve police and community interactions
Reduce arrests
Focus on mental health
Case management
Improved assessment
Redirect high utilizers

Crisis Intervention Team (CIT)

Overview: Also known as "the Memphis Model," CIT training is a training for police officers that aims to change officers' attitudes toward, and interactions with, people with mental health conditions. The model employs training techniques to inform officers of mental health, psychiatric crises, and de-escalation techniques that can be used to improve outcomes between officers and community members who are experiencing mental health crises. When successfully applied, CIT can function as an alternative to arrest, as people in crisis can be diverted to appropriate mental health services. Unlike other models that seek to improve care for people with mental health conditions, this model does *not* seek to reduce interactions with the police, rather it seeks to improve upon those interactions and ensure the best possible outcomes.

Conditions for Implementation: The first step toward implementing CIT is providing officers the requisite 40-hour training course, which should be run by a multidisciplinary team of mental health clinicians and advocates. CIT International recommends that training be given mostly to officers who volunteer for the program, as they will be more inclined to apply its teachings and divert people in crisis to the appropriate supports. Some agencies, however, have implemented mandatory CIT training for some or all officers. CIT has also been adapted to train 911 professionals. The success of CIT is contingent on working partnerships between law enforcement and mental health partners, and prospective sites should consider the current capacity for collaboration between these entities.

Examples in the Field: As of 2019, the CIT Center at the University of Memphis reported that 2,700 CIT programs across 16% of police agencies are operating in the United States.

State of Evidence on Efficacy: High-quality evidence on the outcomes of CIT is limited and mixed. Systematic reviews of the literature have been hindered by the inconsistent measurement and definition of mental health crisis calls and outcomes between studies. Studies to date incorporate a mix of methodological approaches, including focus groups, self-evaluations, qualitative observations, and quasi-experimental designs. There are no experimental studies on CIT outcomes, limiting overall understanding of its effects. Existing research from systematic reviews shows little impact on official "observed officer behavior" outcomes—officer injury, citizen injury, arrests, and excessive use of force. The evidence for impact on arrests is mixed and the unique methodologies applied prevent a comprehensive comparison, although individual study results have demonstrated improved safety, increased voluntary transports to mental health facilities, and increased diversions to mental health services. Promising initial findings and the popularity of this approach highlight the need for continued and improved evaluations of this widespread program.

Alternatives in Practice: Homeless Outreach and Medical Emergency (HOME) Team San Francisco, CA

Overview: The San Francisco Fire Department's (SFPD) HOME Team program delivers comprehensive care, including linkages to social services and medical treatment, to frequent 911 utilizers. The HOME Team primarily serves people experiencing homelessness, poverty, mental illness, substance use, and those living with disabling conditions.

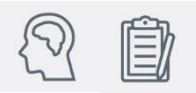
Conditions for Implementation: In San Francisco, where this program originated, anyone who calls 911 four or more times in a month is considered a frequent user and is targeted for outreach, either during a call or through proactive searches between calls. Run by an SFPD paramedic captain with a

social work degree, the HOME Team redirects clients from emergency services and toward case management, primary care housing, or substance use treatment, typically providing callers with transportation to those services. HOME Team staff use a blend of motivational interviewing techniques to encourage program participation, and report that this is the reason clients accepted referrals. Critically, the HOME Team does not attempt to replicate the effort of existing care providers or managers; rather, it works to increase the access to and combined efficacy of those services.

Examples in the Field: This program originated in San Francisco, CA. As of 2022, aspects of the program were being considered for replication in cohort city Winston-Salem, NC.

State of Evidence on Efficacy: In the only evaluation of the HOME Team, Tangherlini et al. (2016) examined 7 months of transport data before the creation of the HOME Team and compared the data to 7 months of transport data after its creation. Before the HOME Team program was in place, the study population accounted for 1,105 (2.9%) of the total 38,659 transports. However, after the HOME Team was implemented, the study population accounted for 508 (1.7%) out of 29,984 transports, a statistically significant decline. Additionally, the average number of contacts per person decreased from 18.7 contacts before the HOME Team was implemented to 8.6 contacts during the period when the HOME Team was underway.

Mental Health Call Type Definition and Identification



Overview: A call to 911 generates a description, but classifying that call can be challenging, due to the dynamic nature of certain situations and the short duration of the phone conversation. Researchers and practitioners have identified two methods to document whether calls are related to mental health in the computer-aided dispatch (CAD) system, which can work as a feedback loop to allow for future learning and processing of such calls.

First, where existing structures do not yet provide instruction on classification, those hoping to identify mental health-related calls should retrospectively review unstructured text in the CAD entry. If sufficient information is available, the unstructured text could be manually coded or analyzed through natural language processing. Then, integrate this information to inform the development of a mental health call classification protocol. Second, agencies can modify existing practices so that CAD systems support real-time data capture and documentation, which would allow calls with an underlying mental health-associated cause to be identified concurrently with the response.

This work is based on the principle that once mental health calls are properly documented and understood, the appropriate responses and treatments can be deployed.

Conditions for Implementation: Stakeholders would need to consider the following before developing a pilot:

- How would agencies standardize the decision-making process? Could existing diagnostic tools be adapted from other fields?
- How would information from a diagnostic tool be recorded in the CAD system?
- Would agencies be willing and able to train officers and 911 professionals on new processes?

Examples in the Field: Adapted from Washington, DC, and King County, WA, the Tucson, AZ, emergency communications center uses criteria-based dispatching (CBD) for call classification. CBD

is a tool that categorizes multiple call types together and then supplies a list of corresponding questions for use during the call-taking process, including a set of questions for people experiencing mental health crises.

State of Evidence on Prevalence: Research suggests that 7–10 percent of public and police contact involves an individual experiencing mental illness.[6] The proportion of calls that cannot be identified as being related to mental health will vary by jurisdiction, but the current 911 call taking, and response process almost certainly undercounts its prevalence is nearly all jurisdictions.[7] Research is still needed that demonstrates how improved processes can result in more accurately capturing the full extent of these calls.

Point of Dispatch Diversion

Overview: Point of dispatch diversion is an alternative response strategy that involves sending non-law enforcement personnel to respond to a 911 call or transferring the call to an individual who can address the issue over the phone. This can reduce contact between police and community members and provide more appropriate responses to the needs of the community. In-person response programs typically involve some combination of medical professionals, mental health counselors, EMTs, and specially trained police officers.

Conditions for Implementation: Areas with high volumes of individuals who frequently use emergency services could be a good fit for point of dispatch diversion strategies. The programs require funding to cover starting costs like hiring program planners and purchasing new equipment, but they have demonstrated significant return on investment. Program jurisdictions must also have social service programs that are willing and able to partner with law enforcement.

Examples in the Field: Variations of this strategy are being deployed across the country, with Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene, OR; the Community Assistance Liaison Program in St. Petersburg, FL; a co-response model where mental health professionals accompany police in responding to certain emergency calls in Grand Rapids, MI; and many other innovative practices throughout the United States.

State of Evidence on Efficacy: Although there are descriptive statistics about how many calls were fielded by various programs, there is little to no evidence to date regarding their efficacy.

Non-sworn Response to Non-urgent Calls

Overview: Most strategies discussed throughout this paper target critical call types, particularly involving mental or behavioral health crises. This strategy proposes alternative responses to non-critical calls, which make up a significant portion of call volume, but—for the sake of efficiency and avoiding unnecessary police-public contacts—could be best resolved *without* a sworn officer response. Typical examples of non-urgent calls amenable to remote response include traffic calls,

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[6] Lord, V. & Bjerregaard, B. (2014). Helping persons with mental illness: Partnerships between police and mobile crisis units. *Victims & Offenders. 9*(4): 455-474. https://doi.org/10.1080/15564886.2013.878263

[7] Mitchell, R. J., Wire, S., & Balog, A. (2022). The 'criminalization' of the cop: How incremental, systematic flaws lead to misunderstanding police calls for service involving persons with mental illness. *Policing: A Journal of Policy and Practice.* https://doi.org/10.1093/police/paac028

burglar alarms, and noise complaints. Alternative responses can take the form of telephone response units, online reporting, alternative in-person response, and generally redirecting law enforcement resources from non-urgent call types to those that do require a police response.

Examples in the Field: Berkeley, CA, announced that it would task unarmed civilians, rather than sworn officers, with handling traffic enforcement and issuing citations. Greensboro, NC, is exploring the potential for having unarmed civilians respond to certain types of traffic collisions (but not conduct enforcement). Currently, by North Carolina state statute, only two jurisdictions can legally apply this approach. Both Fayetteville and Wilmington, NC have civilian traffic collision investigators who respond to a subset of traffic collisions.

State of Evidence on Efficacy: Although there are descriptive statistics about how many calls were fielded by various programs, there is little to no evidence available to date regarding their efficacy.

Clinician and Law Enforcement Officer Co-response

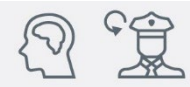
Overview: The co-responder model pairs a police officer with a civilian mental health clinician, social worker, or crisis worker for a two-pronged response. Initially considered a secondary response model, the first step is for the officer to conduct a safety assessment of the person experiencing a mental health crisis, followed by the mental health worker contacting the person to perform a mental health assessment. In current practice, some co-response programs deploy responders concurrently, but the tenet of civilians and police answering together remains. The program was designed with the purpose of reducing arrests, injuries, and involuntary commitments.

Conditions for Implementation: The program requires consistent funding for full-time police officers and mental health clinicians.

Examples in the Field: The co-responder model is the dominant model in the United Kingdom and in Canada.

State of Evidence on Efficacy: Several individual studies have demonstrated localized efficacy, but a systematic review of the co-responder studies revealed that no randomized controlled trials have been conducted. This lack of rigorous methodology limits the generalizability of the individual study findings to other cities.[8]

Crisis Assistance Helping Out On The Streets (CAHOOTS)



Overview: An example of point of dispatch diversion, CAHOOTS pairs a medic (a nurse or an EMT) with a crisis worker (typically a clinician or social worker) to respond to people experiencing mental health crises. CAHOOTS teams work to stabilize people in crisis, address urgent medical needs, and provide a link to the next step in treatment through assessment, referral, advocacy, or transportation. Though lacking in rigorous evaluation, existing programs have been shown to reduce the number of calls that police respond to and decrease public safety costs.

[8] Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayers, A., … & Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry, 18*(1), 256. https://doi.org/10.1186/s12888-018-1836-2

Conditions for Implementation: CAHOOTS programs are typically implemented by nonprofit organizations, in partnership with emergency communications centers that dispatch calls and police departments that supply vehicles for the program.

Examples in the Field: In 1989, the White Bird Clinic launched CAHOOTS in Eugene, OR. Emergency calls are triaged through one of the police department's service channels, and CAHOOTS teams consisting of a medic and experienced crisis worker are dispatched as appropriate.

State of Evidence on Efficacy: No rigorous evaluations have been conducted to date to examine the efficacy of the program; however, CAHOOTS is seen as a promising program and there is growing interest across state and local jurisdictions in implementing a CAHOOTS-type initiative.

Law Enforcement Assisted Diversion (LEAD)

Overview: Diversion programs for drug users and community policing strategies emerged in the 1990s with the goals of reducing arrest, imprisonment, and recidivism for people convicted of a low-level nonviolent offense. In present day, LEAD programs apply similar methods to assist individuals with behavioral health needs. LEAD programs are developed by working groups of police departments, prosecutor and defense offices, health services, housing and development groups, and nonprofit groups, and rely on officers or LEAD case managers to conduct outreach to eligible individuals. Case managers then design intervention plans for each participant, centering the participant's wellness and ultimately empowering them to find stable housing and employment. Individuals can be engaged in LEAD either before or after arrest.

Conditions for Implementation: LEAD programs require collaboration between police departments, nonprofit organizations, health and behavioral services, attorney's offices, and community members. It is recommended that new sites begin with a strong working group with defined roles and responsibilities, clear eligibility criteria for participation (typically low-level, nonviolent offenses), and proper training for officers and case managers. The various entities will need to be in consistent communication to close the loop on participant care.

Examples in the Field: There are dozens of LEAD programs in various stages of development across the country, including programs operating in Seattle, WA; Los Angeles, CA; Albany, NY; and Baltimore, MD.

State of Evidence on Efficacy: There is limited evidence for this program's success or efficacy. Most of these diversion programs are new and slow to start. Seattle's primary analysis showed that people were significantly more likely to have housing the month after their LEAD referral than in the month prior. It also showed overall increased housing, employment, and income among its participants. Seattle also observed more success with LEAD participants who were contacted more frequently by case managers and had strong follow-up conversations. Preliminary analysis showed 50% of referrals ending in enrollments, with half of those individuals not rearrested within the year.

Alternatives in Practice: Case Assessment Management Program (CAMP)
Los Angeles, CA

Overview: In 1993, the Los Angeles Police Department (LAPD) launched its Mental Evaluation Unit (MEU) to handle mental illness crisis CFS in support of patrol. Consisting of police officers and

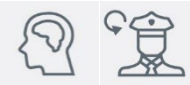
civilian employees from the Department of Mental Health (DMH), the MEU houses one of the first co-responder models for crisis response. Using that same infrastructure and partnership over a decade later, the MEU created CAMP for people who were high MEU utilizers and who posed a risk to themselves, their communities, or those who served them. The team of officers and DMH employees operating CAMP identifies those people and engages them in case management and linkages to appropriate services to develop long-term solutions for each individual. The program seeks to prevent unnecessary incarceration and hospitalization of people with mental illness. CAMP is responsible for managing cases involving people with a history of mental illness, ranging from those with a history of violent criminal activity caused by mental illness to those who frequently utilize police resources.

Conditions for Implementation: Critical to CAMP's implementation was the inception of the MEU, which supports the entire LAPD and triages all contacts with people who suffer from mental illness. The MEU's database allows CAMP staff to identify and target potential clients for the program.

Examples in the Field: Although aspects of CAMP have been broadly replicated, the comprehensive program is unique to Los Angeles.

State of Evidence on Efficacy: An outcome evaluation has not yet been conducted on this program.

Alternatives in Practice: Embedded Mental Health Call-Takers
Houston, TX



Overview: Mental health professionals from the Harris County Center for Mental Health and IDD (Intellectual and Developmental Disabilities) answer CFS alongside 911 professionals in the Houston Office of Emergency Management. They are embedded within Harris County's Crisis Call Diversion (CCD) program and work to decrease reliance on preventable emergency services for people experiencing mental health crises.

Conditions for Implementation: The CCD program is a multiagency collaboration between police, fire, emergency, and mental health centers that is designed to identify and redirect non-emergency, non-life-threatening CFS that have a mental health component. Instead of dispatching those calls for police response, they are resolved by the mental health professional tele-counselors located in the 911 emergency call center. Preliminary evidence suggests that a substantial number of mental health crisis 911 calls may have been handled more effectively by the embedded mental health call-takers, as opposed to traditional dispatched response.

Examples in the Field: The program has demonstrated savings to both the fire and police departments of Houston, and has been adapted in several places across the country, including Tucson, AZ and Chicago, IL.

State of Evidence on Efficacy: Although there are descriptive statistics about how many calls various programs have addressed, there is little to no evidence to date regarding their efficacy.

Chapter 4: Site Profiles

Chapter 3 provides descriptive information on each of the seven Carolina Cohort of Cities project sites, which ranged from large cities to midsized towns and cities in North and South Carolina. In addition to demographic information, each site profile describes how the city entered the cohort and what factors influenced decision-making on which, if any, pilots the city decided to implement. Each profile also includes site-specific measures of 911 CFS and policing resources, providing an insight into the city's landscape of need and allowing for cross-cohort comparisons. Last, each profile concludes with a site-specific alternative response strategy map, indicating which strategies that city is piloting or has fully operationalized as of May 2022.

With the exception of Rock Hill, SC, all the cohort cities operate under the same legislative statues in the state of North Carolina. The cohort comprises a diverse set of jurisdictions that vary in population, household income, crime, and city budgets. A common theme across the participating jurisdictions in the cohort was a curiosity about the demand for public safety resources in their community and a commitment to following a data-driven approach when considering resource allocation.

	Population	Median Household Income	Property Crime Rate (per 1,000 residents)	Violent Crime Rate (per 1,000 residents)	City Budget (FY21–22)
Durham	283,506	$61,692	38.9	8.7	$524.6 million
Greensboro	299,035	$49,492	36.4	9.1	$619.7 million
Raleigh	467,665	$69,720	21.3	4.2	$1,069.8 million
Winston-Salem	249,545	$47,269	21.5	4.5	$532.2 million
Burlington	57,303	$45,587	41.7	9.2	$62.4 million
Cary	174,721	$107,463	9.5	0.7	$289.1 million
Rock Hill	74,372	$51,874	31.5	6.9	$263.0 million
National		$67,521	20.3	3.7	

Example call natures for each of our final categories

Final Category	Example Call Nature
Alarm	residential alarms; bank alarms
All other property	larceny; fraud; damage to property
All other violent	Assault; threats; stalking
Deceased person	Deceased person;
Disturbance	Disturbance; harassment
Domestic/family	Domestic violence; neglect
General assistance	Assist person; follow-up
Hang-up	Hang-up; no response
In-progress other	Suspicious person; foot pursuit
In-progress violent	Robbery; shooting
Medical fire assist	Assist EMS; medical alarm

Mental health	Crisis; suicide attempt
Police administrative	Special assignment; message; transport
Proactive policing	Directed patrol; stop and talk
Quality of life	Noise; animal complaint; intoxicated person
Sex offenses	Rape; sexual assault
Traffic-related	Motor vehicle accident; hit and run
Warrant service	Wanted person; warrant or subpoena service

Durham, North Carolina

Durham

Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
283,506	$61,692	38.9	8.7	$524.6 million

Entry into the Cohort

During summer 2020, Durham City Council asked the City of Durham's Office of Strategy and Performance to assess community needs and requests by examining 911 call data. Durham leaders knew that other jurisdictions, including peer cities in North and South Carolina, were also being asked to rethink how police and other service providers can best meet community needs, so city leadership extended invitations to the other six cities in the Carolina Cohort of Cities project. RTI had existing partnerships with Durham on other initiatives, including an ongoing project that focused on better serving individuals in crisis. This partnership led to RTI joining the Cohort of Cities effort as a research partner and to the institute providing technical support in the review and implementation of pilot projects. Since the start of the project, the City of Durham has designed and implemented a new Community Safety Department, an organization that now serves as the lead for Durham's alternative response programs, which are coordinated with the Durham police and fire departments and Durham County emergency services (EMS).

CFS Snapshot

RTI examined 896,916 Durham CAD entries dated between November 1, 2017, and October 31, 2020. Fifty (50) percent of calls were community member-initiated, with the other half being officer-initiated. The most frequent call types are reported in the table below. Examples of theses call types can be found in the table at the beginning of Chapter 4, "Example call natures for each of our final categories."

Call Entry Type	Percentage of Calls
Proactive Policing	33.7%
General assistance	12.4%
All other property	8.0%
Traffic-related	7.4%
Quality of life	6.4%

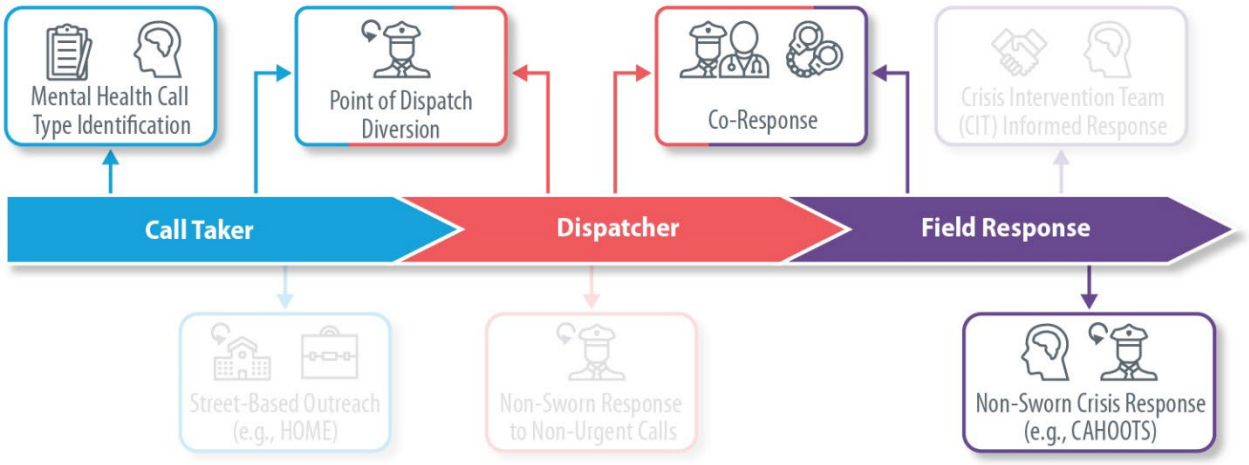
Emergency Response Resources as of April 2022

Police	
Sworn officers	537 authorized 432 actual
Professional staff	125 authorized 106 actual

Co-response	N/A
Mental health training	All officers receive in-service mental health training
CIT Training	223 trained officers
Budget	$68.9 million
Emergency Communications Center (ECC)	
Staff	86 authorized 74 actual
Budget	$8.8 million

Programs and Pilots

The highlighted portions of the map below indicate that, as of May 2022, Durham is piloting or running a program deploying that strategy. When deciding which pilots to implement, Durham took stock of its resources and the community need as presented in the CAD data. Given that the Durham police department regularly has a high number of officer vacancies, efficiency was key. The city council ultimately decided on three pilots that met the broadest need base. They targeted improvement of mental health identification and documentation, crisis call diversion for mental health-related calls, and co-response teams.



Greensboro, North Carolina

Greensboro				
Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
299,035	$49,492	36.4	9.1	$619.7 million

Entry into the Cohort

RTI partnered with the Greensboro City Manager's Office, the Greensboro police department, and other city departments on the Carolina Cohort of Cities project. The Greensboro police department had a strong existing research partnership with RTI, so joining the cohort was a natural fit. Greensboro already had a behavioral response program, and after reviewing RTI's analysis of the city's CFS data, the City decided to launch an alarm response verification pilot and advocate for non-sworn staff response to traffic collisions.

CFS Snapshot

RTI examined 700,942 Greensboro CAD entries between January 1, 2017, and December 31, 2019. Sixty-four (64) percent of these calls were community member-initiated, with 36% being officer-initiated. The most frequent call types are reported in the table below.

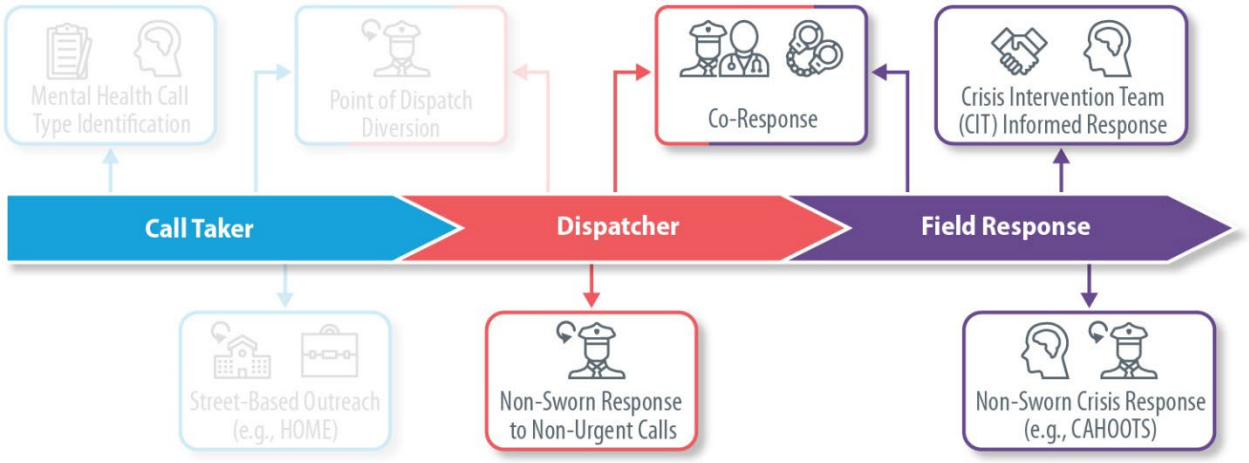
Call Entry Type	Frequency
Traffic	13.7%
Proactive policing	11.6%
In-progress nonviolent	10.9%
Police administration	10.3%
Quality of life	10.1%

Emergency Response Resources as of April 2022

Police	
Sworn officers	698 authorized 595 actual
Professional staff	114 authorized ~100 actual
Co-response	9 officers, including 1 corporal and 1 sergeant
Mental health training	All officers receive in-service mental health training
CIT training	184 trained officers 106 officers are signed up to complete the training in 2022
Budget	$83.7 million
ECC	
Staff	93 authorized 79 actual
Budget	$7.6 million

Programs and Pilots

The highlighted portions of the map below indicate that as of May 2022 Greensboro is piloting that strategy. Greensboro had a behavioral health co-response team prior to joining the cohort, and as of May 2022 is working on non-police response pilots for calls related to alarms and traffic. It was important for Greensboro city leadership that the behavioral health response teams include police officers, which they felt was more in keeping with local priorities. A major motivator for the non-police response pilots is to increase police staffing efficiency in an attempt to address current police shortages in Greensboro. With respect to Greensboro's CFS analyses, traffic calls ranked first, alarm calls ranked eighth, and behavioral health-related calls ranked 11th, despite suspected undercounting. Importantly, analysis of alarm calls suggested that more than 99% of calls were false alarms with no actual incident triggering the call.



Raleigh, North Carolina

Raleigh				
Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
467,665	$69,720	21.3	4.2	$1,069.8 million

Entry into the Cohort

RTI partnered with the Raleigh City Manager's Office, the Raleigh Police Department, and the Raleigh Office of Strategy and Innovation and other relevant City departments in the Carolina Cohort of Cities project. The Office of Strategy and Innovation has taken on a leadership role in Raleigh, as their organizational position has prepared them to coordinate efficiently across departments. When Durham reached out to Raleigh about joining the cohort, Raleigh leadership was excited by the opportunity to make decisions based on data that would meet community desires to appropriately address need and police desires to learn about alternative approaches. After RTI analyzed 3 years of call data, Raleigh leadership decided to launch pilots for tracking mental health calls, a non-sworn crash investigator unit, ECC communicator training, and alarm response verification. Raleigh already had a form of co-response known as ACORNS (Addressing Crisis through Outreach, Referrals, Networking and Service).[9]

CFS

RTI examined 986,612 Raleigh CAD entries between October 1, 2017, and October 31, 2020. Forty-eight (48) percent of these calls were community member initiated, with fifty-three (53) percent of calls being officer-initiated. The most frequent call types are reported in the table below.

Call Entry Type	Frequency
Not in-progress property	17%
General assistance	16.5%
Traffic-related	11.4%
Quality of life	8.5%
Proactive policing	8.1%

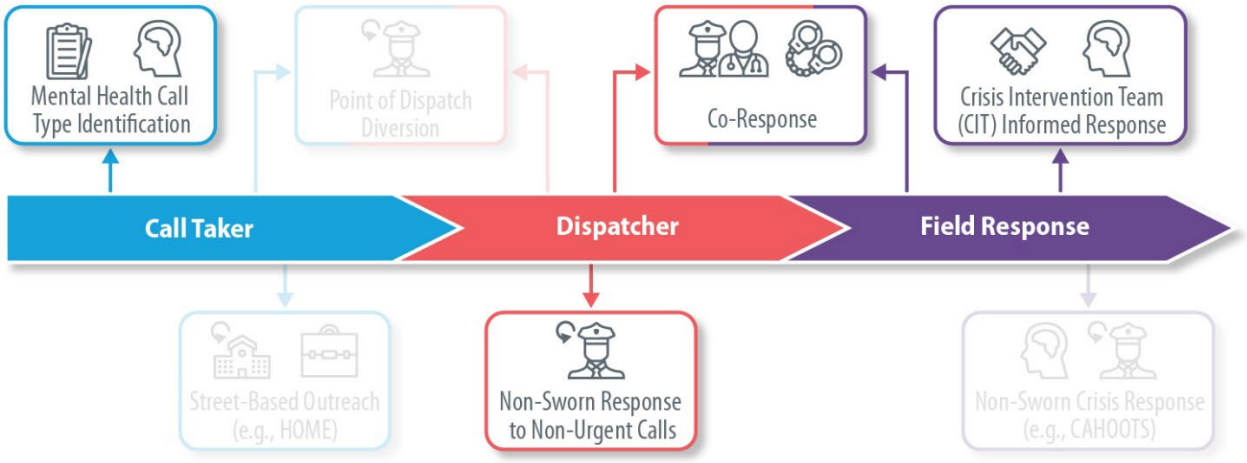
[9]More information about Raleigh's ACORNS program can be found in chapter 5.

Emergency Response Resources as of April 2022

Police	
Sworn officers	800 authorized
Professional staff	108 authorized
Mental health training	All officers receive in-service mental health training
CIT training	424 trained officers
Co-response	9 allocated employees: • 1 Sergeant ● 1 Detective • 3 Officers ● 3 Prof. staff
Budget	$116.5 Million
ECC	
Staff	129 authorized 92 actual
Emergency communications department budget *Emergency telephone system fund*	$11.4 million $2.9 million

Programs and Pilots

The highlighted portions of the map below indicate that, as of May 2022, Raleigh is piloting that strategy. Raleigh leadership recognized that their most frequent call types were not enforcement related and saw an opportunity to implement a non-sworn response. The city had launched a co-response program prior to the project, and after joining decided to pilot a new close code to better track mental health-related calls in their CAD system, push for alarm company verification of alarms, and as of May 2022 are considering legislation to allow for non-sworn crash investigators.



Winston-Salem, North Carolina

Winston-Salem

Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
249,545	$47,269	21.5	4.5	$532.2 million

Entry into the Cohort

When Winston-Salem accepted Durham and RTI's invitation to enter the cohort, the City was primarily focused on mental health call response. Over the past year, the city has had turnover at the assistant city manager position over public safety. Each assistant city manager had different priorities, and focus shifted accordingly in their tenures. Site leadership is now focused on reducing the need for officers to respond to non-urgent calls, since Winston-Salem has a shortage of about 100 officers (relative to authorized staffing). The city's main project motivations are to be responsive to public requests for alternatives and to increase efficiencies for police. The Winston-Salem Office of Budget and Performance Management, police department, attorney's office, and city council have been most active in the cohort, under the assistant city manager's leadership.

CFS

RTI examined 577,915 Winston-Salem CAD entries between September 1, 2017, and August 30, 2020. Sixty-eight (68) percent of these calls were community member initiated, with thirty-two (32) percent being officer-initiated. The most frequent call types are reported in the table below.

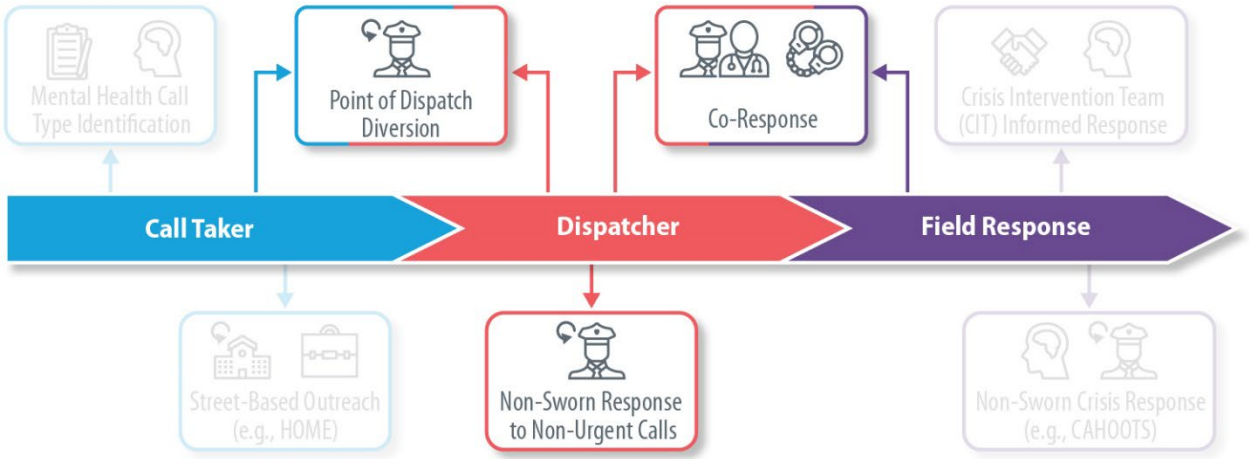
Call Entry Type	Percentage
Quality of life	25.4%
General assistance	21.4%
Traffic-related	11%
All other property	9.7%
Disturbance	6.5%

Emergency Response Resources as of April 2022

Police	
Sworn officers	528 authorized 417 actual
Professional staff	174 authorized 133 actual
Co-response	N/A
Mental health training	26 hours for all sworn officers in the Academy; 2–4 hours of in-service training per year
CIT training	40 hours, advanced training
Budget	$80.3 million
ECC	
Staff	47 authorized 21 actual
Budget	$2,646,878

Programs and Pilots

Given Winston-Salem's changes in leadership over the past year, the city has not yet implemented any cohort-related pilots. It is, however, considering pilots in alternative mental health response, non-sworn crash investigators, and CIT training for dispatch. With respect to alternative mental health response, Winston-Salem considered a Crisis Assistance Helping Out On The Streets (CAHOOTS)-style program, but current 911 dispatch protocols are not set up to allow for the complete removal of police from response. Alternatively, Winston-Salem has explored patrol assist calls (where officers call for clinician assistance when they are on scene) as well as a "hybrid" co-response, where clinicians respond in separate vehicle after a police officer secures the scene. The city's primary motivations for non-police alternative response are community preferences and the police officer shortage. Winston-Salem is also exploring proactive follow-up with frequent 911 callers. Winston-Salem had a preexisting telephone response unit prior to the cohort study and is currently transitioning to an online portal for non-urgent requests.



Burlington, North Carolina

Burlington				
Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
57,303	$45,587	41.7	9.2	$62.4 million

Entry into the Cohort

Burlington's role in the cohort is a bit different from those of the other sites. The main city-level involvement came from the Burlington police department, specifically a three-person team of a lieutenant, CAD administrator, and crime analyst. Burlington police department was committed to utilizing data to guide policing decision-making and viewed the cohort as an opportunity to join a network of like-minded jurisdiction agencies with similar populations and address similar problems. Burlington has a particular focus on a pilot program in crisis call diversion and the concentrated needs associated with group homes in the city, although it continues to attend monthly cohort calls to share progress and learn from the network.

CFS

RTI examined a total of 176,757 Burlington CAD entries between October 1, 2017, and September 30, 2020. Sixty-eight (68) percent of these calls were community member initiated, with thirty-two (32) percent being officer-initiated. The most frequent call types are reported in the table below.

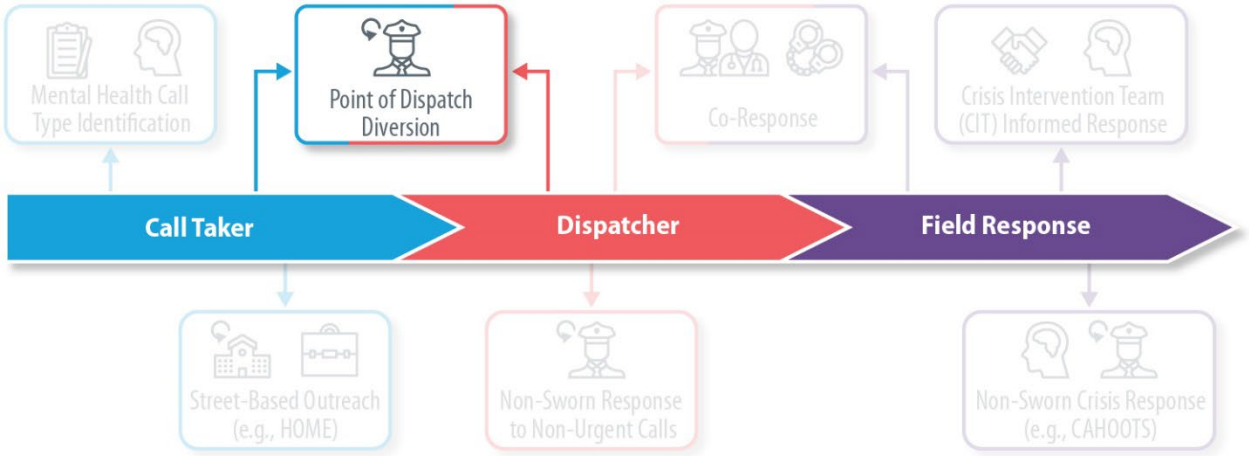
Call Entry Type	Percentage
General assistance	19.9%
Proactive policing	13.7%
Traffic-related	8.6%
In-progress other	8.5%
Police administrative	7.85%

Emergency Response Resources as of April 2022

Police	
Sworn officers	145 authorized 116 actual
Professional staff	47 authorized 44 actual
Co-response	No
Mental health training	Yes, 116 officers certified in mental health first aid
CIT Training	89 trained officers
Budget	$18.2 million
ECC	
Staff	21 authorized 20 actual
Budget	$2.1 million

Programs and Pilots

The highlighted portion of the map below indicates that as of May 2022 Burlington is piloting a program deploying that strategy. As of this writing, Burlington is rolling out a call diversion pilot, which will expand upon its existing tele serve unit that resolves incidents over the phone. Given the cultural values of Burlington, which is the smallest city in the cohort (i.e., when community members call 911 the norm is for the police to respond), the police department decided against co-response pilots. It chose the call diversion pilot with the expectation that it will reduce police workload, as "general assistance" was the most frequent CAD call type. The city's pilot for group homes also grew out of the CFS analysis but is not considered a pilot of the cohort study.



Cary, North Carolina

Cary				
Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21-22)
174,721	$107,463	9.5	0.7	$289.1 million

Entry into the Cohort

Cary initially joined the Cohort of Cities project to serve as a comparison city in the cohort in support of Durham. Cary is enthusiastic about strategic partnerships and was eager to receive data and research support from RTI and to learn from partner cities in the cohort. It saw the cohort project as a chance to work with RTI and simultaneously bolster its relationship with Durham. Throughout the study period, Cary experienced a number of changes, including the creation of a research and development innovation group in the town manager's office, a transition in police chief, and the establishment of a public safety office. In 2018, Cary introduced a pilot to promote 311 as a number to call with non-emergency requests for information or services, and in 2020 launched it as a full service arm of the Town Hall, in close partnership with 911. Though Cary is not launching any pilots as of May 2022, it is using its CFS data to better understand the landscape of need in its city and enhance its 311 development accordingly.

CFS

RTI examined 514,753 Cary CAD entries between September 1, 2016, and June 30, 2021. Fifty-eight (58) percent of these calls were officer-initiated, with fourty-two percent (42) being community member initiated. The most frequent call types are reported in the table below.

Call Entry Type	Percentage
Proactive policing	41.1%
General assistance	11.6%
Traffic-related	7.2%
Quality of life	6.7%
Alarm	6.4%

Emergency Response Resources as of April 2022

Police	
Sworn officers	243.5 authorized 199 actual
Professional staff	Unknown Unknown
Co-response	No
Mental health training	In-service training has multiple sections, updated each year for various mental health training
CIT Training	CIT Training provided to officers/telecommunicators
Budget	$25,634,273
ECC	
Staff	27 authorized 30 actual (includes over-hires)
Budget	$2,693,514

Programs and Pilots

As of May 2022, Cary is focusing on its 311 department and is not currently running any pilots. Moving forward the town plans to further develop their service protocol for their 911 and 311 operating systems with the establishment of their new public safety office. Specifically, Cary is exploring 311 operating policies, call diversion, categorization of calls, and establishing diversion protocol. For example, the town is reviewing the diversion of calls from the 311 to 911 system. Currently the systems operate independently, so they would like to establish a more fluid protocol, especially for calls of a more imminent nature. Cary is interested in reviewing privacy concerns regarding the collection of call data, such as flagging mental health related calls and protecting personal and sensitive information. These efforts will solidify a foundation for future work across Cary's public safety departments, which include onboarding new leadership. They will also revisit the CFS analysis for both 911 and 311 over the remainder of 2022 to identify priorities. Cary plans to continue working with the other cohort cities to learn from what they are doing, and will determine whether they will implement any of the pilots adapted by other cohort members.

Rock Hill, South Carolina

Rock Hill

Population	Median Household Income	Property Crime Rate (per 1,000 community members)	Violent Crime Rate (per 1,000 community members)	City Budget (FY21–22)
74,372	$51,874	31.5	6.9	$263.0 million

Entry into the Cohort

RTI partnered with the Rock Hill city manager's office and police department for the Carolina Cohort of Cities project. When the Durham Office of Innovation reached out to the Rock Hill city manager's office about joining the cohort, Rock Hill saw it as an opportunity to learn from other cities and measure its own success in keeping the community safe. This ability to compare across cities, combined with RTI's offer to analyze and provide baseline analyses for Rock Hill's CFS data led Rock Hill to join the cohort. Given that CFS show an overall decline, close to half of their calls were for proactive policing or general assistance, along with the small size of their jurisdiction and requisite lack of resources, the city is not running any pilots as of May 2022.

CFS

RTI examined 241,726 Rock Hill CAD entries between the dates of September 1, 2017, and August 31, 2020. Sixty-two (62) percent of these calls were community member-initiated, with 38% being officer-initiated. The most frequent call types are reported in the table below.

Call Entry Type	Frequency
General assistance	24.9%
Proactive policing	23.7%
Quality of life	8.2%
Traffic-related	7.7%
All other property	7.0%

Emergency Response Resources as of April 2022

Police	
Sworn officers	160 authorized
Professional staff	40 authorized
Co-response	No
Mental health training	No
CIT training	No
Budget	$18,549,717
ECC	
Staff	42 authorized
Budget	$4,770,000

Programs and Pilots

Rock Hill has not implemented any pilots to date, citing staffing shortages and the CFS report that the city interpreted as "what we're doing is working," but is looking into ways to appropriately divert mental health-related calls to mental health or substance use services. City representatives shared that the city council is supportive of alternative approaches, although the police department has expressed safety concerns about pairing mental health clinicians with officers. The police department has offered to instead potentially partner with a mental health agency to provide follow-up care as necessary. City management will refer to the CFS analysis reports that RTI provided as they determine Rock Hill's next steps in alternative response innovation.

Chapter 5: Pilot Response Strategies

This chapter describes the pilots and programs across the Carolina Cohort of Cities project and is organized by the alternative response strategy that each city was developing or evaluating through the course of this initiative. As of May 2022, all cities—with the exception of Rock Hill (SC), which had not implemented any pilots due to resource constraints—were piloting one or more programs. City leaders cited a range of factors that pushed them to look for potential changes in responses to some categories of 911 calls, including ongoing staffing shortages, a desire to create efficiencies, and a desire to reduce the burden on police for some categories of calls, including those with a behavioral health nexus. Each site tailored its program and implementation timeline in accordance with its size, resources, and community need, thus, no two sites have identical programs. There are several paths forward in the field of alternative response. This chapter highlights the successes and challenges faced by these six innovative sites as they incorporated new strategies in their public safety response. The most successful pilot implementations in terms of their level of planning and organization and quality of the implementation process occurred in jurisdictions that engaged a broad set of stakeholders but were driven by a consistent core of project champions. A common theme expressed across the cohort cities was the challenge of their ability to innovate being constrained by state statues (e.g., the North Carolina statute requiring a law enforcement response to traffic collisions that result in over $1,000 of damage). These successes and challenges will be detailed further in subsequent chapters.

Identification and Documentation of Mental Health-Related 911 Calls

When 911 receives a call, the call-taker must record a description and assign a call category. Notably, numerous sites in the Carolina Cohort of Cities project noted that mental and behavioral health-related calls were being underreported.[10] Burlington estimates that about half of their mental health calls are incorrectly coded. This happens for a variety of reasons—the mental health condition may not have been the primary purpose of the call and thus went unrecorded, the call-taker was not trained in recognizing mental health calls, or there was a lack of guidance on when and how to report such calls, to name a few. The resulting lack of accurate information hinders the ability to both understand the landscape of need in the community and to dispatch appropriate responses. Several sites noted this as an overarching goal of their pilots and programs, and two cities (Durham and Raleigh) designed pilots with the explicit goal of better documenting mental health-related calls. These efforts are described below.

Durham: Crisis Call Diversion Pilot

In summer 2022, Durham will begin to embed licensed mental health clinicians in its 911 call center to triage, assess, and respond to non-emergent and non-life-threatening behavioral- and mental health-related CFS. The goal of this pilot is to divert CFS away from the criminal justice system and to trained crisis counselors who can connect callers with the right response and care in real time. The city will also add a new question for all call-takers to ask 911 callers: "Are you aware or does it appear the subject is in mental health crisis?"

If the caller responds in the affirmative, the call will be diverted to crisis call diversion, which involves an embedded counselor conferencing in to listen through the rest of the protocol

[10] The problem of under-reporting mental and behavioral health-related calls is not unique to this cohort. For more information, visit https://www.vera.org/publications/understanding-police-enforcement-911-analysis.

questions. Calls can then be routed to one of two alternative crisis response pilots. The first is a community response team of three—an emergency medical technician, a licensed clinician, and a peer support specialist—who can respond to a subset of nonviolent behavioral health calls.[11] If there is a threat of violence, the call can be routed to a co-response unit consisting of a licensed social worker and a CIT-trained police officer. Embedded crisis call counselors will assess 911 callers' needs, divert non-emergent calls away from law enforcement where appropriate, connect community members with support, dispatch community response or co-response teams as appropriate, deescalate situations prior to the arrival of in-person responders, and follow up with callers after a crisis to check in and support linkages to any services.

Raleigh: Close Code Pilot and 911 Professional Mental Health Call Training Pilot

In Raleigh, officers are being trained on when to select two new close codes in the CAD system that categorize the type of incident that triggered a 911 call or police-initiated report—one for mental health-related calls and one to file a CIT report. Given that the Raleigh Police Department already houses the ACORNS program, which dispatches a social worker and officer team to respond to referrals and CFS, Raleigh will now have three methods of tracking mental health-related calls:

1. *ACORNS*: Predates the pilot; officers can resolve a call by selecting the ACORNS close code to indicate that the caller requires a referral. The ACORNS team will follow up accordingly.[12]
2. *CIT*: One of the two new close codes; officers will resolve a call with this code to indicate that someone was taken to the hospital for evaluation.
3. *Mental health-related CAD code*: The other new close code; a broad, catchall code for all mental health-related incidents that were not recorded as such in the call-taking or dispatching process. For example, an officer will use this close code if they respond to a noise complaint and realize there is a mental health issue on scene.

Raleigh is also exploring expanded mental health training for its 911 professionals. Stakeholder sessions were held with 911 professionals to explore how well-equipped they felt in taking and categorizing mental health calls. The themes of these discussions suggest that call-takers felt unprepared for this aspect of the job. In response, the city is examining training platforms that will train staff on how to handle mental health calls. Call-takers will be trained in and tasked with de-escalation of callers who are experiencing mental health crises. The city considered transferring such calls to a third-party call-taker who might be able to spend more time with callers, but concerns around both liability and the potential unwillingness of a caller to stay on through a transfer resulted in the cancellation of that potential strategy. As of 2022, Raleigh is in the process of implementing a Crisis Intervention Team-style training.

Point of Dispatch Diversion/Telephone Response

Point of dispatch diversion strategies redirect certain 911 calls from sworn officer response. This can involve sending an in-person non-sworn response or resolving the call on the phone, either by a trained call-taker in the emergency communications center, transferring the call to an individual outside of the center who can address the issue over the phone, or dispatching a non-sworn crisis response team. Though they are not yet piloting an alternative response, Rock Hill Police

[11] More information about Durham's Community Response Teams can be found *infra* in the Durham: Community Response Teams section of this chapter.
[12] More details on Raleigh's ACORNS program can be found *infra* on page 43.

Department analysts are monitoring innovations in mental and behavioral health-related call diversion, and as of May 2022 are working with a local mental health agency to think through such a program. Three cities in the cohort opted to implement point of dispatch diversion programs, and no two are identical. The variation across pilots demonstrates how these programs can be tailored to meet the needs and resource constraints of a given jurisdiction.

Burlington: Tele Serve Call Diversion Pilot

In Burlington, emergency dispatchers divert CFS that do not require an in-person police response to the city's tele serve unit. This tele serve unit handles a wide array of calls, including hang-ups, larceny reports that are made when the suspect is no longer on scene, calls for information, and identity theft reports. The primary purpose of this pilot is to divert qualifying CFS away from patrol officers to reduce workload and strain due to staffing shortages. This frees up officers' time to respond to calls that require their presence. This program has historically been staffed by officers on transitional duty who are in some way physically unable to respond to calls, but the pilot has diverted these duties to non-sworn staff, which would provide a cost-effective opportunity for long-term staffing. Burlington is in the process of expanding the pilot and permanently staffing the tele serve unit with three non-sworn staff members. This effort is complemented by a new online reporting mechanism for community members and big box stores experiencing retail theft to write their own reports and submit them directly, bypassing the need for an in-person response.

A process evaluation of the pilot diversion program reveals a valuable lesson for all agencies considering telephone diversion programs. Diversion presents a new operational avenue for dispatchers, but the programs can only be as successful as the dispatchers are in diverting qualifying calls. Initial efforts to setup a tele serve unit should be preceded by reorientation and buy-in from the 911 call center to divert when possible and exercise discretion in matching the diverted call volume to the capacity of the tele serve unit.

Durham: Community Response Teams

Launching in summer 2022, Community Response Teams will provide rapid, trauma-informed care for 911 CFS involving non-violent behavioral and mental health needs and quality of life concerns. This pilot will seek to send the right response for a person's specific needs and, by doing so, will aim to reduce law enforcement encounters and unnecessary emergency department use. Teams will comprise three unarmed skilled responders who will arrive in non-police vehicles and wear plainclothes and shirts identifying them as community responders:

1. A **licensed clinician** who has 3 years of postgraduate experience and over 1,000 hours of supervised work. They will screen and assess people experiencing mental health and substance use crises and provide community linkages and case management services as appropriate.
2. A **peer support specialist** who knows the community, has relevant lived experience, and has been trained as a specialist. This specialist will be tasked with deescalating situations, promoting engagement in services and care, fostering relationships between community member and other emergency responders, and building trust with community members so that they may be more open to receiving services and care in the future.
3. An **advanced EMT** who has been trained in providing advanced life support care. They will assess people for potential medical emergencies, provide pre-hospital emergency care, and help identify medical needs that may present initially as mental health needs.

This team will resolve issues on scene when possible but can also transport individuals to non-emergency facilities. They will also follow up with each individual after 48 hours.

Winston-Salem: Telephone Response Unit Program

Winston-Salem has a telephone response unit (TRU) that predates the Carolina Cohort of Cities project. The TRU serves as an alternative method of handling non-emergency CFS in order to avoid dispatching a patrol unit. Winston-Salem, like many of the other cohort cities as of May 2022, is dealing with a shortage in sworn officers, so the TRU can help relieve some of their workload and reduce the amount of time officers spend answering service calls that primarily involve information-gathering or report-taking. As of this writing, Winston-Salem is exploring creating an online portal where community members can report certain non-urgent calls. There are ongoing discussions of whether and to what degree they may require the public to use such a form, understanding that there will be instances where community members will want an in-person response despite it being an unnecessary and/or inefficient use of officer time.

Co-Response Programs

The co-responder model pairs a police officer with a non-sworn mental health clinician, social worker, or crisis worker for a two-pronged response. Implementation varies, and these responses can be deployed simultaneously or sequentially, with the officer arriving on scene prior to the non-sworn responder. Four of the cohort cities have co-response programs or pilots, and no two are identical.

Durham: Co-Response Pilot

Under their upcoming pilot, the highest-risk mental health calls will receive a co-response from a CIT-trained officer from the Durham Police Department, a licensed clinician, and peer support specialist from the Community Safety Department. The officer will arrive first and assess the scene for safety, and the clinician and peer support specialist will support the officer in de-escalation as necessary, providing therapeutic harm reduction responses to the person in crisis and their family members. Together, this co-response team will assess needs and connect the person in crisis with community-based care where appropriate. Durham expects to launch co-response teams in summer 2022.

Greensboro: Behavioral Health Response Team

Launched in 2021, Greensboro's Behavioral Health Response Team (BHRT) is a joint effort between the Greensboro Police Department and Office of Equity and Inclusion (OEI). One officer and one counselor are paired to respond to calls involving individuals in mental health crisis. Arriving on the scene together, the officer first conducts a safety assessment and makes initial contact with the community member before the counselor begins their interaction. There is also a structured follow-up process in place, whereby clinicians determine the most appropriate method (phone, in person, or letter) and make a minimum of two attempts to contact each community member who has received a BHRT response. Counselors have clinical flexibility to meet the individual needs of the community member and can help get them connected to a host of community-based services and supports.

The program is funded by a state-awarded grant of $300,000. It officially operates from 8 a.m. to 10 p.m. each day, but there is a counselor on call 24/7. As of January 2022, it was staffed by nine OEI employees (a lead clinician, seven crisis counselors, and a part-time outreach coordinator) who work directly with nine Greensboro police department officers (including a sergeant and a corporal).

During the evaluation period from August to December 2021, BHRT was dispatched to 589 calls, which were most frequently mental health crises, involuntary commitment calls, and suicidal ideation calls. This was supplemented by a large volume of subsequent contacts, both in person and by phone. The ability for follow-up action allows this program to target high utilizers of the 911 system, including one individual with whom there were 44 contacts during the study period. Connecting these high utilizers to assistance can have the largest effect on minimizing burden on emergency response systems.

Raleigh: ACORNS Program

Raleigh's ACORNS program deploys a sworn officer and social worker in partnership to assist individuals who are impacted by homelessness, mental health conditions, or substance use conditions. The teams do not respond directly to 911 calls; rather, they are deployed through an intake form, a community form request, or a close code in CAD that refers a caller for follow-up by the team. ACORNS operates out of the Raleigh Police Department. Their social workers are employed by the police department, but the unit is not located in police headquarters. Both the officer and social worker wear plainclothes to increase community receptivity to their presence.

Launched in August 2021, ACORNS will be evaluated as part of the Carolina Cohort of Cities project. RTI will examine 3 months of data, police officer surveys, and community feedback to understand the workload that this small team faces, gauge perceptions of the program, and determine how best to expand it. The evaluation is ongoing, but one emerging challenge is data sharing, as social workers who are charged with case management do not have access to the CAD system and thus are missing critical information.

Winston-Salem: Alternative Mental Health Response Pilot

In Winston-Salem's proposed Alternative Mental Health Response pilot, a police officer would arrive first on the scene of a potential mental health crisis to ensure that it is safe. Once the scene has been cleared, a clinician could arrive to take over and the officer will depart. The decision to pursue this pilot was partially driven by inspiration from the other cohort cities programs described above. When deciding to potentially launch this pilot, the police department considered a non-police response to mental health calls. However, it was decided that the hybrid co-response approach of officers and alternative responders would work best within the confines of Winston-Salem's dispatch protocols.

Non-sworn Response to Non-urgent Calls

These strategies propose alternative responses to non-emergency calls, for which a sworn officer response can be inefficient and ill-tailored to the situation. In the Carolina Cohort of Cities project, there are two types of calls for which multiple cities are trying to institute alternative responses: alarms and minor traffic crashes.

Alarm Response

Cohort Pilots and Programs: Greensboro and Raleigh

In the state of North Carolina, police officers are required to respond to every alarm call for service. Greensboro receives 12,000 to 13,000 such calls per year, 99.3% of which are false alarms. In 2019 and 2020, officers spent about half an hour on scene per alarm call. Similarly, over 99% of Raleigh's alarm calls are false alarms. This inefficient use of police time prompted both cities to propose changes to response protocol policy so that officers would not be required to be deployed to

residential or commercial alarms without verification. In both Raleigh and Greensboro, false alarm fines are levied on users instead of on the alarm company, making it difficult to incentivize the alarm company to follow through on policy.

Greensboro Alarm Verification

In Greensboro, a verified alarm response program city ordinance is anticipated to be on and upcoming city council agenda in 2022. The police department will launch a community engagement communications campaign and will meet with representatives from alarm companies to help them understand the city's new verification role. Greensboro plans to run a 6-month evaluation to gauge the amount of time spent by officers on alarm calls and understand whether there is a concurrent increase in burglaries. Under this pilot, 911 professionals and officers will assume that alarms are false unless it is verified by a 911 call or video from the alarm company. There will be some exceptions, including all alarm calls from between 10 p.m. and 6 a.m. as well as alarms that originate in schools, banks, and places that sell firearms. Greensboro police department leadership expects that this will free up significant officer time to spend on more pressing public safety issues.

Raleigh Alarm Verification

Raleigh is also exploring a to change policy so that alarm companies would have to verify that an alarm is real before police officers are deployed to respond. This change would involve registering alarms and companies so that there is current contact information for verification purposes. Raleigh stakeholders are still developing a response protocol for alarms that are not verified.

Non-sworn Crash Investigators

North Carolina state law mandates that law enforcement officers investigate all traffic crashes. In conversations with Carolina Cohort of Cities personnel, Greensboro and Raleigh leaders explained that the RTI-produced CFS reports show that officers spend a great deal of time on traffic incident calls. Since officers do not testify on crash reports unless the collision involves a crime, stakeholders resolved that officer time would be better spent responding to other 911 calls than taking collision reports. North Carolina cities Fayetteville and Wilmington have both successfully passed legislation allowing them to hire non-sworn personnel to respond to non-injury traffic calls. This has been in practice for nearly a decade to positive effect in both cities. Rather than changing statewide law, individual cities are attempting to pass local legislation allowing them to adopt this practice, although these types of local ordinances must be approved at the state level. Greensboro's ordinance is pending with the state; it passed the House and is currently sitting in Senate committee. Greensboro stakeholders are hoping to move the proposed ordinance to a vote in 2022. Durham, Raleigh, and Winston-Salem have all expressed interest in passing similar legislation and are in various stages of planning for this effort.

Chapter 6: Findings and Recommendations

This project brought together a cohort of cities seeking a data-driven solution to the complex problem of 911 response. This approach acknowledged that improvements to the public safety response were expected by elected officials and community members. While the long-term success of the cohort programs is not yet known, this project does address the methods by which a cohort of cities selected and implemented a range of strategies for responding to certain types of 911 calls. Key considerations and recommendations for how jurisdictions can utilize a data-driven process for selecting and implementing "alternative response" programs are discussed below.

Key Findings

The Value of a Data-Driven Approach: Across the project sites, we found tremendous benefit in implementing a cross-site approach with a foundation in data. Cross-site learning was achieved for decision-makers and participants across local government, including city management and budget, 911 operations, law enforcement, and behavioral health professionals. In many instances, these were stakeholders who had limited exposure to 911 data, particularly as it was aimed at certain key areas of the 911 response. A path informed by data can also provide durability and protection for city and county government stakeholders taking on the challenging goal of implementing 911-based responses in an ever-shifting political landscape.

Benefits of a Building Blocks Mindset: Jurisdictions benefit from a taking a broad view when assessing new and existing 911 programs and services. Local governments that seek to revisit 911 response should acknowledge the interconnectedness of all public safety and public health-oriented responses when implementing new programs. This includes not just connecting new programs but existing departments (including law enforcement, public safety, and public health) at the city and county levels. In some instances, jurisdictions may start with one particular component of response, such as a co-responder program that is focused on 911 call follow-up (for example, the ACORNS program in Raleigh), and then build out other areas depending on priorities, needs, and available resources. A different example is the Community Safety Department (DCSD) that was developed in Durham, NC to oversee and coordinate all four key areas of response—crisis call diversion through clinicians in 911, clinician and police co-response, non-sworn response to behavioral health calls, and follow-up care. The Community Safety Department is a peer first response agency with the police, fire, and emergency medical service departments within the city and county of Durham.

The Importance of Staffing: A common challenge across the cohort sites was staffing programs that were being implemented or expanded and creating a recruiting pipeline for specialized positions. Topics discussed included how best to staff the civilian clinician or social worker roles for co-responder or third-party response programs: for example, deciding whether to contract out to community-based organizations or to create positions within the structure of local government. Staffing limitations were also experienced in the implementation of a tele-response program in the 911 center, especially given competing job opportunities in local industry. Law enforcement agencies have also experienced significant staffing shortages among their sworn staff, a factor that was an important driver in the search for alternative responses to 911 calls.

The Impact of State Legislation: State laws that guide how local jurisdictions respond to certain types of 911 calls are an important yet underdiscussed topic across the field (e.g., laws that dictate the steps that both city and county law enforcement must take before serving orders on and transporting individuals who are the subject of involuntary commitment procedures). The

procedures required for mental health commitments can appear overly complicated to law enforcement officers unfamiliar with the process. State laws can also impact the ability of local jurisdictions to innovate. For example, in looking to implement a civilian-based response to minor traffic accidents, cohort sites became aware of the North Carolina statute requiring a law enforcement response to traffic collisions that result in over $1,000 of damage.

The Need for Standardization: There is no data standardization in CAD systems, which creates significant challenges when seeking to understand community needs and police responses within and across jurisdictions. Even in cities that have the same CAD systems, local customizations still introduce tremendous variance in the data. Variations exist due to different software vendors and programs, as well as local customization of data values. A major aspect of this project was standardizing the CAD data across sites, which highlights the need for improved national standards.

Challenges in Identifying and Documenting Mental Health: Mental health-related calls are underreported and there are widespread challenges in accurately identifying and tracking calls in which mental health may have played a role. However, due to current processes and limits on selecting more than one call nature, CAD does not allow for a more comprehensive identification approach toward classifying calls that involve a mental health component. The ability to identify the call nature/call type *and* indicate whether mental health played a role in the call is essential to better understanding the proportion of calls related to behavioral or mental health.

Limitations of CAD: There are a number of limitations associated with relying on CAD systems and data to assess needs for alternative responses and tracking relevant activity. The primary function of a CAD systems is to connect first responders to calls for assistance. As such, additional mechanisms to collect robust data are limited. The CAD system also lack a broader set of outcomes for 911 calls or the ability to identify high-rate repeat callers because of its structure as an events-based rather than individual-based system. High-frequency *locations* can be readily identified but jurisdictions are limited in understanding how many times an *individual* has come in contact with the police or any other public safety responder. CAD systems are designed to triage events in the here-and-now. There are limited steps for follow-up and after-care and the system is often siloed from other responses and after-care structure at the city/county or community level. Further, the 911 system has historically been siloed within the greater emergency response and criminal-legal system. In particular, health and police data are rarely (if ever) integrated into a single system.

Recommendations for Program Selection and Implementation

The cohort jurisdictions were not the first to explore alternative public safety responses, but their group collaboration and partnership with an independent research institute offered a holistic approach to addressing a pressing and challenging topic. One of the most critical recommendations is to empower project champions and have consistency in staffing among the project team. That team will be responsible for identifying outcomes of interest at the start of the project, forming partnerships, understanding demand for public safety resources through analysis and community engagement, inventorying response resources for potential pilots, considering the universe of call natures for potential responses, and considering how these programs will integrate with existing responses and new programs, such as the nationwide implementation of the 988 suicide and crisis phone line (which was formerly known as the National Suicide Prevention Lifeline).

1. Identify Project Champions: Identifying and empowering project champions to select and move ahead with pilot programs can shorten the implementation timeline, the ability to confidently message the reasoning behind pilot selection to decision-makers and the public, and a smoother transition from pilot selection to full project implementation in the community.
2. Develop Partnerships: In terms of level of planning and organization and quality of implementation process, the most successful pilot implementations were in jurisdictions that engaged a broad set of partners and stakeholders but were driven by a consistent core of project champions. Project partners should be multi-disciplinary in nature and include stakeholders from the city and county-level as well as community-based organizations.
3. Set Jurisdictional Goals: It is critical that jurisdictions identify the outcomes they are working to improve as early in the process as possible. Many jurisdictions reported an interest in reducing outcomes like arrest or use of force; instances of either are relatively rare compared to the universe of police activity more generally. Since the majority of calls do not result in arrest or use of force, consider an expanded set of outcomes, such the connection to resources for individuals in crisis, reduction in time officers spend on a particular call type, or cost savings achieved for the city.
4. Establish a Comprehensive Data Collection Strategy: Data should serve as the foundation for determining what works and what doesn't. This approach can inform the decision-making process to help ensure that any new strategies can be implemented as planned, have the support of the community, be sustained from a staffing and resources perspective, and, importantly, have strong likelihood of success. A first step here should be in inventorying and assembling all data sources that could be used to inform reform efforts. There are many data sources that should be considered, including: 911 Calls for Service data; crime incident and arrest data; automatic vehicle locator (AVL) data; 311 non-emergency calls; body-worn camera footage and associated meta-data; and data on community perceptions and experiences with crime and the police. CFS data includes citizen-initiated calls placed to 911, activity called in by an officer (for example, a traffic stop), and activities such as directed patrols within a particular neighborhood for community policing and crime prevention. CFS data also track EMS and fire responses to 911 calls. CFS can serve as a foundational data source for evaluating not only community needs and police activity but also the actions of other first responders.
5. Analyze Your Data: A purposeful and organized analysis of existing data, including 911 call for service data from the CAD system, should be an ongoing process. Using CFS data as a starting point can help inform what police do on a day-to-day basis, including the broad range of crime- and non-crime events that police play a primary role in addressing. Findings should be shared across a broad set of stakeholders in city government, including during meetings between city managers, law enforcement, and public health. Efforts should also be taken to routinely share data with community partners. Our experience with the cohort of cities demonstrates that even descriptive analyses of 911 call for service data are helpful to stakeholders and lead to more productive discussions about potential pilot programs. Considerations for analyzing 911 call for service data are detailed in the forthcoming publication in *Police Chief* magazine, "The Next Frontier - Using Police Activity Data to Expand Our Understanding of Community Needs."

6. Consider the Full Universe of Calls: Some call types which occupied disproportionate amounts of police officer time, such as commercial alarms or minor traffic accidents, were not initial priorities until the analysis results highlighted their impact on police officer time. In the case of commercial alarm calls, requiring the verification of alarm calls, as explored by several of the cohort cities, would save police and 911 resources, avoid unnecessary calls that could result in unknown outcomes, and open up more time for police to spend on crime prevention and relationship building.
7. Inventory Response Resources: As the analysis of call for service data and community input inform the *need* for programs, a comprehensive inventory of resources at the city, county, and state level can inform the *feasibility* of programs. As part of the development process, consider what resources exist within a given jurisdiction and what is most viable for program implementation. A good example of this comes from the City of Raleigh. When Raleigh started its co-responder program (ACORNS), it decided to focus only on follow-up and did not attempt to staff an around-the-clock unit responding to 911 calls. The goal of inventorying existing resources is not to eliminate potential programs in a jurisdiction; the intent is to highlight gaps between what the community needs or expects and what resources are currently available. The assessment of feasibility should be focused on whether those gaps can be effectively addressed by new pilot programs and should have both a near- and long-term focus on sustainability.
8. Develop a Plan to Address Relevant State Laws: State laws can have a major influence on how local cities, towns, and counties respond and handle certain types of 911 calls. This can be the case for behavior health calls, including calls that involving involuntary commitment procedures, or even traffic accidents. Conducting a thorough review of all relevant laws and creating an action plan for addressing critical changes or gaps in existing laws or ordinances should be a priority for any jurisdictions assessing 911 response.
9. Consult the Evidence Base on What Works, What's Promising, What Doesn't Work: Once a problem is defined using data, the next step should be to examine the available solutions to the problem and seek out those that include evidence-based practices. As described in Chapter 2, the evidence base for alternative responses to 911 is still a work in progress and many of the current programs are not fully supported by research.
10. Select and Implement Pilot Programs. Jurisdictions should select and implement pilot programs that align with their stated objectives and that can address particular needs. For instance, programs focused on improving certain processes and outcomes such as follow-up care and linkages with services or strategies for improving the identification and tracking of key characteristics such as calls involving a mental health component.
11. Carry Out Ongoing Evaluation and Refinement: An iterative review of data, the collection of new data, and rigorous evaluation will allow the cities in the cohort to refine their approaches, adapt to the needs of their communities, and set the stage for future research that will inform local practices and add to the body of scientific evidence.
12. Address Sustainability: Having sufficient numbers of qualified and trained staff is essential for the short and long-term success of any type of co-responder, 3rd party, or tele-serve response program. As such, conducting a comprehensive workload analysis and developing a staffing plan should be a priority. Similarly, creating a recruiting pipeline for specialized positions by working with local colleges or universities or nonprofit organizations is key for success.

13. Solicit Community Input and Long-Term Engagement: One of the most impressive activities that the cohort of cities project teams participated in was engaging their respective neighbors in creative and inclusive ways. Concurrent with the review of analytical findings, jurisdictions should develop a plan to effectively understand community demand for resources, their knowledge of existing responses, and their expectations of potential alternative responses. This plan should include a process for identifying and engaging vulnerable populations, justice-involved individuals, relevant community-based organizations, and incarcerated individuals in the county jail. These engagements should not be viewed as a one-time activity but part of a pattern of long-term engagement. Use engagement early and often to inform decision-making and identify key questions that the community has about potential programs. Finally, define the goals and community needs that are to be addressed. Multiple objectives can be simultaneously pursued: goals like improving the level of care provided to high-risk persons in need, reducing unnecessary interactions between the police and public, and linking 911 calls with follow-on services and after-care are not mutually exclusive.
14. Determine the Impact of Initiatives like 988 on Your Program: The National 988 Suicide and Crisis Lifeline initiative was activated right around the time this project was concluding. Feedback from stakeholders in the cohort suggested that there is a lack of understanding at the local level about how 988 will integrate with the existing emergency response system. Operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), the 988 program serves "as a first step towards a transformed crisis care system in America."[13] As new programs come online both locally and nationally, jurisdictions must consider how these initiatives complement, and not compete with, one another.

The Path Ahead for Alternative Responses to 911

The widespread adoption of alternative 911 response strategies offer great potential for change, including better linkage of the 911 system with other social services such as after-care programs. However, these changes also come with a certain degree of risk and uncertainty. Although it is encouraging that cities and towns across the U.S. are thinking creatively and moving with urgency, it is essential for jurisdictions to ensure that they are approaching this overall process with a critical eye. To mitigate the risk of implementing misapplied, poorly managed programs, jurisdictions should model their program selection and implementation after the cohort of cities' methodical and data-driven approach. The cohort cities should be commended for their willingness to use research, analysis, and community input as they develop programs intended to better meet demand for public safety resources. The next stages of this work can integrate more rigorous outcomes to inform jurisdictions about how the programs work and which work best. Furthermore, while the adoption of alternative responses is key to ensuring that each call to 911 is met with the right response at the right time, there are other critical pillars of a 911 system that equitably and reliably increases access to wellbeing for those who need emergency assistance, the professionals who staff 911, and those deployed to respond. The Transform911 blueprint[14] lays out a seven-point plan to achieve that vision.

[13] U.S. Department of Health & Human Services. (2022, July 7). *988 Suicide & Crisis Lifeline*. SAMHSA. https://www.samhsa.gov/find-help/988
[14] https://www.transform911.org/blueprint/

Appendix A

Alternative Response Strategy Overviews

HOME TEAM: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to give jurisdictions relevant information on specific programs that can serve as an alternative response to certain types of 911 calls.

BACKGROUND

Emergency Medical Services (EMS) are often disproportionately utilized by a small group of residents, with frequent users of EMS accounting for as much as 40% of the medical transports in some cities (Weiss et al., 2002). The most-common reasons for transport are age, mental illness, substance abuse, and housing status (LaCalle & Rabin, 2010; Martinez & Burt, 2006). The San Francisco Fire Department (SFFD) created a program called the Homeless Outreach and Medical Emergency (HOME) Team program to address the frequency of EMS utilization by some groups. The HOME Team is one of the first known efforts by EMS to have specially trained paramedics work with frequent emergency service users to divert them to other types of care. The program was created to "deliver comprehensive social services and medical treatment to frequent users of the 911 system. The population that the HOME Team serves includes the poor, homeless, mentally ill, elderly, disabled, and victims of substance abuse" (SFFD, 2020).

WHERE HAS THIS BEEN IMPLEMENTED?

The HOME Team has been implemented in San Francisco, CA.

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

To achieve its goal, the SFFD partnered with social workers, nurses, students, and probation officers to identify repeat users of the 911 system. At the city level, the SFFD, the SF Department of Public Health, and the SF Human Services Agency collaborated on the HOME Team.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

The HOME Team implementation in San Francisco required participation from the SF Fire Department, the SF Department of Public Health, and the SF Human Services Agency. Strong collaboration between analogous agencies in other cities is required for a similar program to be implemented.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

Frequent users were identified as anyone who called 911 four times or more during a month. A SFFD paramedic captain who held a degree in social work was assigned to manage the program. He worked directly with the clients to ensure they were accurately assessed and received appropriate services. The clients were identified either during a 911 call or as a result of proactive searches between 911 calls. Clients were redirected into services other than the emergency room, such as case management, primary care housing, or substance abuse treatment. The HOME Team often transported the client directly to those service providers. To encourage program participation, the captain used a blended interviewing technique dubbed the HOME Team Interventional Technique, which was a blend of motivational interviewing techniques and the Johnson Intervention (a specific technique for motivating people to enter drug treatment). The HOME Team felt this technique was the reason clients accepted the referrals. If clients were contacted during a 911 call, the clients signed a 911 patient refusal form before being redirected to ensure that the need was social services only. If clients did require a medical intervention, they were transported to the emergency department. The HOME Team program had medical oversight from the SFFD medical director and the medical director for the San Francisco EMS Agency.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

The purpose of the HOME Team was to reduce the use of EMS by high-frequency users by engaging them in long-term solutions that addressed their primary need.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

In the only evaluation of the HOME Team, Tangherlini et al. (2016) examined seven months of transport data before the creation of the HOME Team and compared the data to seven months of transport data after the creation of the HOME Team. Before the implementation of the HOME Team, the study population accounted for 1,105 (2.9%) of the total 38,659 transports. After the creation of the HOME Team, the study population accounted for 508 (1.7%) out of 29,984 transports, a statistically significant decline. Additionally, the average contact per frequent user decreased from 18.72 before the HOME Team was implemented to 8.61 after the HOME Team was implemented.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

The HOME Team did not rely on other agencies or social workers to locate, assess, or engage potential clients—the team did that themselves. Furthermore, the HOME Team did not attempt to replicate or replace the effort of existing care providers or program managers, but rather worked to make those services more effective and accessible.

LaCalle, E., & Rabin, E. (2010). Frequent users of emergency departments: the myths, the data, and the policy implications. Annals of emergency medicine, 56(1), 42–48. https://doi.org/10.1016/j.annemergmed.2010.01.032

Martinez, T. E., & Burt, M. R. (2006). Impact of permanent supportive housing on the use of acute care health services by homeless adults. Psychiatric services (Washington, D.C.), 57(7), 992–999. https://doi.org/10.1176/ps.2006.57.7.992

Tangherlini, N., Villar, J., Brown, J., Rodriguez, R. M., Yeh, C., Friedman, B. T., & Wada, P. (2016). The HOME team: evaluating the effect of an EMS-based outreach team to decrease the frequency of 911 use among high utilizers of EMS. Prehospital and disaster medicine, 31(6), 603.

Weiss, S. J., Ernst, A. A., Miller, P., & Russell, S. (2002). Repeat EMS transports among elderly emergency department patients. Prehospital emergency care : official journal of the National Association of EMS Physicians and the National Association of State EMS Directors, 6(1), 6–10. https://doi.org/10.1080/10903120290938698

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LEAD: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to give jurisdictions relevant information on specific programs that can serve as an alternative response to certain types of 911 calls.

BACKGROUND

Diversion programs for drug users emerged early in the 1990s along with community policing strategies. While these programs have adapted over time, the goals of reducing arrests, incarceration, and recidivism for low-level nonviolent offenses have remained consistent. Law Enforcement Assisted Diversion (LEAD) programs aim to help individuals with behavioral health needs, who are overrepresented in the criminal justice system. Numerous cities have implemented LEAD models with peer-driven outreach and engagement, using evidence based behavioral health services to provide an alternative response to arresting individuals. Programs developed within Seattle and Contra Costa County work to offer financial assistance for housing and employment, along with behavioral support.

Diversion programs are generated by collaborative working groups involving police departments, health services, housing and development groups, and nonprofit groups. They rely on officers in the field or LEAD case managers reaching out to eligible individuals and creating intervention plans focused on individual wellness. LEAD programs are meant to empower and enable program participants to find stable housing and employment and prevent recidivism. These programs require collaboration between government agencies and community members to reduce harm to individuals and the community and reallocate resources to more-severe crimes/offenses.

WHERE HAS THIS BEEN IMPLEMENTED?

Multiple cities have implemented LEAD programs, including Seattle, WA; Albany, NY; Contra Costa County (CoCo LEAD), CA; San Francisco, CA; and Los Angeles, CA.

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

The LEAD program is a behavioral health–driven program where multiagency groups aim to divert people from recidivism to community-based service. Agencies have implemented many variations of diversion programs. Success is rooted in places that have strong partnerships with law enforcement agencies, nonprofit organizations, health/behavioral services, and attorney offices. Sites looking to implement a LEAD-type program should consider having a strong working group from the start, with defined roles and responsibilities of all parties; a strong definition of what is diversion-eligible; proper protocol/educational training for officers, LEAD case managers, and behavioral health mentors; and consistent follow-up with all stakeholders to ensure satisfaction with the program elements.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

Multiple city resources are required for a successful LEAD program. An established working group formed of behavioral health resources/health services, law enforcement members, probation, district attorneys, housing/development, and non-profit organization members is key to a holistic view on the approach of diversion. Officers/law enforcement personnel will need extensive training on what is defined as diversion-eligible.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

All agencies have reported similar implementation. Most report that implementation was slow to start. They all emphasize starting with creation of inter-agency working groups (law enforcement, behavioral health, etc.) and strategic planning on decision making for diversion-eligible offenses. Eligibility criteria vary depending on the agency, but most say low-level nonviolent offenses (trespassing, drugs, prostitution) are eligible. Although implementation is difficult to start for larger agencies, some agencies have worked with smaller working groups within the department to trial the diversion program before branching out to all members. Other departments have formed units (LEAD case managers) to follow up with participants.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

The purpose of a LEAD program is to decrease recidivism for low-level offenses and increase wellness for individuals. The major aim is to prevent criminalization of those with behavioral health problems and reduce spending for the criminal justice system in the process.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

There is limited evidence for success and efficacy of the program. Most of these diversion programs are new and slow to start. In Seattle's primary analysis, they saw that people were significantly more likely to have housing the month after their LEAD referral compared with the month prior and saw overall increased housing, employment, and income among their participants. They also saw more success in LEAD participants who were contacted more-frequently by case managers and had strong follow-up conversations. CoCo LEAD preliminary analysis saw 50% of their referrals ending in enrollments, with half of those individuals not rearrested within the year.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

The primary aim of diversion programs is to increase individual wellness by referring participants to behavioral health resources. The resources do not exclusively pertain to mental health resources; they also address financial assistance with housing, employment, and sustainability. It is important for agencies to understand that the impetus is not on an already-established treatment program, but on individuals developing their own wellness plan.

For the success of this program, LEAD relies on officers in the field and their awareness of the options for diversion versus arrest. Agencies should think through how they disseminate this information to department members and how to obtain buy-in. Sufficient buy-in may be a large cultural shift for many police agencies; this initiative has failed at agencies that do not have stakeholder consensus on policy and participation from stakeholders.

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POINT OF DISPATCH DIVERSION: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to provide jurisdictions with relevant information on specific programs that can serve as an alternative response to address certain types of 911 calls.

BACKGROUND

Point of Dispatch Diversion refers to the strategy of employing alternative crisis response services to address 911 calls. It can take the form of sending non–law enforcement personnel to a crisis or transferring the 911 call to an individual who could address the issue over the phone. Diverting people from the criminal justice system benefits those individuals and the criminal justice system itself.

In-person alternative crisis response programs generally involve dispatching teams comprising some combination of nurses, paramedics, emergency medical technicians (EMTs), trained crisis interventionists, mental health workers, and specially trained police officers. CAHOOTS, a program in Eugene, Oregon, upon which many alternative response programs around the country are based, sends two-person teams made up of a medic (nurse, paramedic, or EMT) and a crisis interventionist, although many of the people it employs are cross-trained.[1] Over-the-phone Point of Dispatch Diversion usually involves either a mental health or other trained social services worker treating a person over the phone or referring them to resources like housing and employment opportunities.

1 Andrew, S. (2020). *This town of 170, 000 replaced some cops with medics and mental health workers. It's worked for over 30 years.* CNN.

WHERE HAS THIS BEEN IMPLEMENTED?

Point of Dispatch Diversion has been implemented all around the United States and internationally. Although CAHOOTS in Eugene, Oregon, is the most established program, there are many others including STAR (Support Team Assisted Response) in Denver, Colorado, which pairs a licensed social worker from the Mental Health Center of Denver with a paramedic from Denver Health, and the Psychiatric Emergency Response Team in Stockholm, Sweden, which sends a mental health ambulance carrying two mental health nurses and one paramedic to address mental health crises, particularly those related to suicide.[2] The police chief in Concord, New Hampshire, revealed in summer of 2020 that he plans to launch a mental health response team program called CORE (Coordinated Outreach, Referral, Engagement), which tentatively will send teams made up of a mental health clinician, an outreach worker in homelessness services, and a police officer.[3]

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

In response to protests this past year, some nonviolent calls in St. Petersburg, Florida, will also begin to be addressed within an alternative response model, the Community Assistance Liaison Program, for which the city is currently soliciting bids from social service companies.[4] Grand Rapids, Michigan, is similarly starting a program that will send non-sworn behavioral and mental health professionals along with police to certain emergency calls.[5] In Alexandria, Kentucky, the 17-person police department hired a single social worker, whose role is to enter a scene after the police to ensure that everyone has received the care they need.[6] In 2019, Olympia, Washington, started dispatching "crisis-responders" instead of armed officers to address nonviolent incidents (it should be noted, in this case, there is no strict protocol dictating when the unit gets called instead of the police, but it is usually contacted by social service providers or requested by the police).[7] The Los Angeles City Council unanimously approved legislation in summer of 2020 to create a model that would have trained community-based responders address nonviolent calls instead of police.[8]

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2 Ritz, J.-D. (2017). *The world's first mental health ambulance arrives in Sweden.* Apolitical.
3 Sciacca, A. (2020). *Concord police chief suggests forming a mental health response team to handle tense situations.* The Mercury News.
4 Solomon, J. (2020). *Police in St. Petersburg to step back from nonviolent emergency calls.* Tampa Bay News.
5 Devereaux, B. (2020). *Mental health workers would respond to police calls under Grand Rapids proposal.* Michigan Live.
6 Niemietz, B. (2020). *Small town police department saved money, lowered arrests by hiring social worker to assist cops.* Daily News.
7 Thompson, C. (2020). *This city stopped sending police to every 911 call.* The Marshall Project.
8 Hamedy, S., & Gauk-Roger, T. (2020). *Los Angeles City Council moves forward with plans to replace police officers with community-based responders for non-violent calls.* CNN.

Other cities that have or plan to implement alternative dispatch programs include Raleigh, North Carolina[9]; Chicago, Illinois; Aurora, Colorado[10]; New York, New York[11]; St. Louis, Missouri[12]; Albuquerque, New Mexico[13]; and Toronto, Canada.[14]

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

It should be noted that there are also programs that do not technically qualify as "Point of Dispatch Diversion" but share the goals of diverting people from the criminal justice system and addressing particular needs within the community. For example, the Seattle Police Department reassigned 100 officers to patrol from specialty units and added a 3pm to 1am shift to improve community engagement and make the department more responsive to the particular needs of the community, albeit at the loss of specialty units.[15] In Berkeley, California, a new city Department of Transportation will be created that will be responsible for traffic enforcement rather than police.[16] This effort will minimize community members' daily interactions with police while still promoting traffic safety. Community paramedicine, another branch of work toward diversion, involves trained community members or medics providing preventive health care services to vulnerable citizens often in the form of home visits. This model has been implemented, often in the form of an experiment, in numerous cities around the country.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

Although every jurisdiction could benefit from Point of Dispatch Diversion, there are some communities for which it might be most helpful. Areas with high volumes of individuals who frequently use emergency services like emergency rooms and 911 are especially good candidates for Point of Dispatch Diversion programs because those individuals may benefit disproportionately from tailored, trauma-informed mental health care and supportive social services. Pilot Point of Dispatch Diversion programs in New York and Chicago are starting by focusing on neighborhoods that contain the greatest number of vulnerable individuals, as determined by frequency of 911 calls pertaining to quality-of-life concerns. Besides the eligibility of the population being served, the readiness of law enforcement and other involved government agencies to embrace a progressive program must be assessed.

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9 Johnson, A. (2020). *Raleigh police to start sending social workers with officers on some 911 calls.* The News and Observer.
10 Hernandez, E. L. (2020). *Aurora could get a program already in place in Denver removing police from 911 calls.* Denverite.
11 Miller, R. W. (2020). *Pilot program will replace NYPD for mental health calls in 2 neighborhoods.* USA Today.
12 Zotos, A. (2020). *New St. Louis City program to divert mental health calls away from 911.* KMOV4.
13 Alcorn, T. (2021). *Albuquerque's vision for non-police first responders comes down to earth.* Solutions Journalism Network.
14 White, P. (2021). *Toronto to consider pilot program to create emergency mental health response teams to help those in crisis.* The Globe and Mail.
15 *Seattle police to redeploy 100 officers to 911 response.* (2020). U.S. News
16 Simpson, B. (2020). *Traffic enforcement has long been a cop's job. Berkeley may go another direction.* San Francisco Chronicle.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

Additional site-specific considerations are resources and capacity. Point of Diversion Programs usually end up paying for themselves (adding the social worker in Alexandria, Kentucky, saved the department $50,000 annually.[17] Starting costs might include hiring individuals to plan the program, purchasing new equipment ranging from vehicles to supplies for individuals experiencing homelessness and legal costs. Ongoing expenditures could be related to personnel or equipment/ supplies acquisition and maintenance, etc. Along with financial capacity, a jurisdiction must also have access to social service programs with which to partner.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

Although there are statistics about how many calls various programs addressed, there is little to no evidence regarding their efficacy. CAHOOTS is promising but it has never been comprehensively evaluated, and there are no agreed-upon metrics for assessing program efficacy. Organizations like RTI International and the UChicago Urban Health Lab are taking on the challenges of program development and evaluation.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

Point of Dispatch Diversion efforts that operate over the phone are also becoming increasingly common around the country and abroad. Some public safety answering points (PSAPs) can divert calls to 311, which offers information about city services or 211, which provides assistance reaching human services, specifically those related to health, social well-being, and community. This past year, the Federal Communications Commission approved 988 as the suicide prevention hotline, largely in response to the psychological distress of quarantine.[18] However, not all over-the-phone crisis response services are related to different phone numbers. Some PSAPs have begun integrating mental health workers into call-taking to handle time-sensitive mental health cases, like those involving suicidal individuals. In Scotland, there is the Mental Health Pathway, which evaluates the needs of callers and directs them into over-the-phone therapy or to a social services worker who can refer them to relevant services.

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17 Niemietz, B. (2020). *Small town police department saved money, lowered arrests by hiring social worker to assist cops.* Daily News.
18 Bote, J. (2020). *FCC unanimously approves 988 as new three-digit suicide prevention hotline.* USA Today.

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LAW ENFORCEMENT RESPONSE TO NON-URGENT CALLS: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to provide jurisdictions with relevant information on specific programs that can serve as an alternative response to address certain types of 911 calls.

BACKGROUND

Law enforcement agencies are tasked with responding to a wide range of incidents ranging from the critical, such as in-progress violent calls, to far less urgent calls for situations like shoplifting or minor traffic accidents. Law enforcement also responds to a broad array of civil, but not necessarily law enforcement, calls that do not fit neatly into any other city service's purview. Typically, alternatives to law enforcement responses have focused on the most critical call types, especially those related to mental or behavioral health. The law enforcement response to non-urgent calls or calls that do not require a law enforcement action (or the potential for a law enforcement action), however, are costly, inefficient, and lead to potentially unnecessary police-public contacts.

Alternative responses to non-urgent calls have taken the form of an in-person civilian response, telephone response units, and online reporting. Although these alternatives have existed for some time, the pandemic has accelerated and broadened their adoption out of necessity. In parallel with assessing which types of critical calls that would benefit from an alternative response, stakeholders should also consider reallocating law enforcement resources from non-urgent call types.

WHERE HAS THIS BEEN IMPLEMENTED?

Telephone response units have existed for decades and are commonly found in U.S. law enforcement agencies. Durham Police Department's telephone response unit specifically states that it "is responsible for handling calls for police services, either by telephone or in person, that do not require the dispatch of a patrol unit."[1] Online reporting is similarly ubiquitous; Raleigh Police Department's online reporting system allows for the public to report incidents related to theft, minor traffic accidents, and damage to property.[2] A recent report from the Center for American Progress suggests that many 911 calls are suited to a non-sworn response, "Using 911 data from eight cities, this report estimates that between 33 and 68 percent of police calls for service could be handled without sending an armed officer to the scene; between 21 and 38 percent could be addressed by Community Responders; and an additional 13 to 33 percent could be dealt with administratively without sending an armed officer to the scene."[3]

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

Although providing an alternative to a sworn law enforcement response is technically feasible, it is important to consider community expectations. Decades of traditional law enforcement responses in a community may condition the public to expect such a response. Stakeholders would need to understand what community expectations are in terms of which types of calls receive a law enforcement response and which receive an alternative response. Stakeholders would also need to recognize that community expectations may not be uniform across the populations they serve. Agencies would need to develop a mechanism to assess what community expectations are and how they can effectively communicate why certain calls receive different types of responses.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

City resources required for alternative responses to non-urgent calls are largely based in one of three categories: technology-based, civilian-based, and a hybrid technology-civilian–based response. Diverting non-urgent calls to existing alternative responses, like telephone response units or online reporting, would require the city to scale the resources associated with supporting those functions. The scaling of those resources could be informed by using historical 911 call for service data to provide an estimate for the increased workload associated with assuming the responsibility for certain call types. In the absence of technology, cities would be required to pay for the allocation and implementation of the hardware and software associated with establishing a telephone response unit or online reporting functionality.

1 https://durhamnc.gov/258/Telephone-Response-Unit
2 http://crc.raleighpd.org/
3 https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/28/492492/community-responder-model/

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

Alternative responses to non-urgent calls have taken the form of an in-person civilian response, telephone response units, and online reporting and are relatively common. However, substantially scaling the responsibility of any of the alternative responses beyond the least urgent call types would be a novel and unprecedented approach.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

Diverting non-urgent calls reduces the law enforcement workload and reduces the number of in-person police-public interactions.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

Technology-based alternative responses to non-urgent calls have not been rigorously evaluated for public satisfaction, but the responses are commonplace and do provide an effective solution for virtual reporting.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

Agencies would need to develop a mechanism to assess what community expectations are and how they can effectively communicate why certain calls receive different types of responses.

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CAHOOTS: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to summarize relevant information on specific programs that jurisdictions can use as alternative responses to certain types of 911 calls.

BACKGROUND

Crisis Assistance Helping Out On The Street (CAHOOTS) is one example of a program that pairs crisis workers—clinicians or social workers—with emergency medical services (EMS) workers to respond to people experiencing mental health crises. These programs are typically operated by nonprofit organizations rather than by cities. None of the CAHOOTS programs have been rigorously evaluated, but they have been shown to reduce the number of calls for service that police responds to.

In 1989, the White Bird Clinic launched CAHOOTS in Eugene, OR, with the City of Eugene supplying vehicles and 911 dispatch personnel. CAHOOTS, a mobile crisis intervention program, assists with or fully handles certain types of 911 calls. CAHOOTS teams work around the clock to immediately stabilize people in crisis and to address urgent medical needs, offer assessment, information referral, advocacy, and transportation to the next step in treatment. CAHOOTS workers also offer crisis counseling; wound cleaning; suicide prevention, risk assessment, and intervention; conflict resolution and mediation; grief and loss; substance abuse; housing crisis; first aid and non-emergency medical care; resource connection and referrals; and transportation to services. Emergency calls are triaged through the Central Lane Communication Center, part of the Eugene PD's service channels, and CAHOOTS teams are dispatched as appropriate. Each CAHOOTS response team vehicle is staffed with a medic (nurse or emergency medical technician) and an experienced crisis worker.

In 2019, these teams responded to 13,854 CAHOOTS calls, defined as calls in which only a CAHOOTS response team was both dispatched and arrived on scene for the call. Of those calls, 31% were to check on someone's welfare, 29% were to assist the public or police, 24% were to transport, and 6% were to respond to a suicidal subject. The remaining 10% of calls were for a variety of circumstances such as intoxicated subject, found syringe, traffic hazards, disorderly subjects, fire department assistance, or disoriented subjects. Calls to assist the public or police were generally those that the police would not respond to, including requests for injury evaluation, counseling, or general services. The transport services that CAHOOTS offers are considered non-police calls, as emergency services are not used to transport the public for non-emergency services. Also in 2019, CAHOOTS and the Eugene PD responded together to approximately 2,018 calls; the top five such call types were suicidal subject, check welfare, disorderly subject, dispute, and criminal trespass. CAHOOTS units had to call for police back-up on only 2% of CAHOOTS calls, on average; the exception was criminal trespass calls, for which they requested backup in 1 of every 3 calls. The number of calls that CAHOOTS responded to in 2019 leads to estimates that CAHOOTS diverts approximately 10% of calls (or 6,346 calls per year) that would have otherwise been answered by the Eugene PD. With an average pay of $18/hour for crisis workers and $26/hour for a new Eugene PD officer, this approach could have an overall financial benefit for the city.

WHERE HAS THIS BEEN IMPLEMENTED?

CAHOOTS has also been implemented in Denver, CO. Cities such as Austin, TX; Chicago, IL; Portland, OR; New York City, NY; and Oakland, CA, are examining the model for possible replication.

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

CAHOOTS is based on a long-standing model of community health care. It is only one of many programs operated by White Bird, a nonprofit collective organization whose community services also include behavioral health outpatient services, a medical clinic, a dental clinic, a crisis service center, Helping Out Our Teens in Schools (HOOTS), and a Navigation Empowerment Services Team (NEST), which helps connect homeless adults to available resources. In existence for over 50 years, White Bird has a vision to provide "compassionate, humanistic healthcare and supportive services to individuals in our community, so everyone receives the care they need." CAHOOTS was not created overnight and attached to a city program; it was created in response to a community need and founded on community bedrock.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

Eugene PD operates the 911 dispatch center and supplies vehicles for the program. White Bird is funded by both outside donations and the city; it does not have any federal funding. CAHOOTS is funded through a contract with the Eugene PD.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

The City of Denver has implemented CAHOOTS in conjunction with the Mental Health Center of Denver (mental health clinicians) and Denver Health (EMS). The program is being piloted in specific areas of the city from 10:00 a.m. to 6:00 p.m. It is not known what type of data are being collected or whether the program is being rigorously evaluated.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

CAHOOTS was developed as an innovative community-based public safety system to provide first response for individuals in crisis related to mental illness, homelessness, and addiction. The CAHOOTS team handles conflict resolution, welfare checks, substance abuse, suicide threats, and other mental health-related calls.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

No rigorous evaluations support the efficacy of the program; however, CAHOOTS is seen as a promising program and there is growing interest within local government across the law enforcement and behavioral health fields.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

White Bird's annual budget of $2.1 million funds mental health counseling and the dental, substance abuse, medical, and behavioral health clinics. The alternative to law enforcement portion of the budget is funded through the Eugene Police Department at $798,000 in 2018 an additional $281,000 added to that amount in fiscal year 2020. As one CAHOOTS practitioner stated, "If you do not have resources in place to take your clients to, then your mental health crisis workers' only options will be the hospitals and jails—the same as the police officers." The appropriate level of resources needs to be in place for a program like CAHOOTS to have effective and sustained outcomes.

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CAMP: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to give jurisdictions relevant information on specific programs that can serve as an alternative response to certain types of 911 calls.

BACKGROUND

The Los Angeles Police Department (LAPD) has maintained a Mental Evaluation Unit (MEU) since 1993, representing one of the first jurisdictions to develop a co-responder model for crisis response (Bureau of Justice Assistance, 2016). This unit consists of officers from LAPD and civilian employees from the Department of Mental Health (DMH). Despite the creation of the MEU, however, LAPD continued to face significant problems addressing the needs of their community, particularly among the highest service utilizers; the city and county spent millions of dollars in emergency resources on these individuals (Bureau of Justice Assistance, 2016). In direct response to this need, in 2005, the DMH-LAPD leadership created the Case Assessment Management Program (CAMP) for people who were high utilizers of the MEU and were a high risk to themselves, their communities, and the people who served them. The intent of the program was to identify, monitor, and engage those subjects and to construct a case management approach that would link them to appropriate services. As of 2016, LAPD received 15 to 20 new cases a week. CAMP consists of police detectives working along psychologists, nurses, or social workers from DMH to develop longer-term solutions for their individual clients. CAMP is responsible for the following:

- Managing cases that involve people with a history of violent criminal activity caused by mental illness.
- Managing cases that involve people with a history of mental illness whom law enforcement has responded to numerous times, deploying substantial police resources.

- Preventing unnecessary incarceration and/or hospitalization of people with mental illness.
- Maintaining a file of weapon confiscation receipts.

Examples of CAMP cases include the following:

- Subjects who are the most-frequent utilizers of 911 emergency services
- Subjects who attempt to force an officer to apply lethal force as a means of suicide
- Subjects who are the subject of a SWAT response or high-profile tactical operations
- Military veterans who suffer from post-traumatic stress disorder or other mental illness
- Subjects involved in acts of targeted school violence
- Mentally ill prohibited firearm possessors (to ensure the seizure of all known firearms per state law)
- Subjects enrolled in the State of California, DMH, Conditional Release Program (ConRep)

WHERE HAS THIS BEEN IMPLEMENTED?

To date, the CAMP program has only been implemented at the LAPD.

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

The CAMP program is embedded in the Crisis Response Support Section of LAPD, which is staffed by 61 sworn officers and 30 DMH clinicians. The Crisis Response Support Section contains the Threat Management Unit and the MEU. The primary mission of the MEU program is to handle mental illness crisis calls for service in support of patrol. Staff members evaluate people who pose a danger to themselves or others per Welfare and Institutions Code 5150. If the call does not meet these criteria, then those calls will be referred to patrol, other Los Angeles County Mental Health Resources, or Los Angeles County homeless resources.

The MEU contains a co-responder team, the CAMP program, a triage desk, and an admin-training detail. The co-responder team, called the Systemwide Mental Assessment Response Team (SMART), consists of an officer and a DMH clinician. SMART resembles one of the first co-responder models in the United States. The MEU Triage Desk supports the entire LAPD and triages all contacts with people who suffer from mental illness. Triage personnel advise and guide responding officers in the field and document all department contacts with people suffering from mental illness, or people who are in crisis, on a mental evaluation incident report. The database used to store the incident reports is kept outside of the police Record Management System and is protected from outside access. This protects the privacy of the people contacted. A mental health nurse sits alongside the triage officer and queries the DMH database to identify case managers, psychiatrists, or treatment centers. The triage staff member then decides whether to dispatch a SMART unit or to direct the patrol officers to transport the person directly to a mental health facility.

If the person has had repeated contact with police or has demonstrated high-risk behaviors, the case will be referred to the CAMP for more-intensive case management. The multilayered approach to mental health includes a co-deployed response and follow-up teams. This approach uses comprehensive data collection and information-sharing procedures.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

It is unclear exactly how many officers are currently assigned to the CAMP program.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

The CAMP program has not been implemented in any other cities

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

The purpose of this intervention was to prevent incidents where LAPD officers used force on people experiencing mental health issues. The intent was to focus on high-risk individuals and link them to mental health services before an untreated mental health issue escalated.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

An outcome evaluation has not been conducted on this program.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

LAPD's Department Manual specifically addresses contact with people experiencing mental health issues:

1/240.30 **Contact With Persons Suffering From a Mental Illness.** In police contacts with persons suffering from a mental illness, the goal of the Department is to provide a humane, cooperative, compassionate, and effective law enforcement response to persons within our community who are afflicted with mental illness. The Department seeks to reduce the potential for violence during police contacts involving people suffering from mental illness while simultaneously assessing the mental health services available to assist.

This requires a commitment to problem solving, partnership, and supporting a coordinated effort from law enforcement, mental health services and the greater community of Los Angeles.

Bureau of Justice Assistance. (2016, September) Los Angeles Police Department Mental Evaluation Unit Overview (https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/meu-program-outline-sept-2016.pdf)

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CIT: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to summarize relevant information on specific programs that jurisdictions can use as alternative responses to certain types of 911 calls.

BACKGROUND

Crisis Intervention Training (CIT), or the Memphis Model, was created in 1988 after a man with mental illness and a history of substance abuse was shot and killed by Memphis police officers. The CIT model aims to change officers' attitudes toward people with mental illness by giving the officers a working understanding of mental illness, psychiatric crises, and de-escalation techniques to improve outcomes in interactions with people with mental illness.

Beyond training, CIT functions as an alternative to arrest for people in mental health crisis who can be diverted to appropriate psychiatric services. While not the only path to successful implementation of CIT, removing barriers from the diversion process facilitates the officers' pursuit of alternatives to arrest. The likelihood of success for arrest diversion greatly increases when, for example, the program uses a central psychiatric emergency drop-off with a no-refusal policy and streamlined intake. The model was created with the input of law enforcement officers, mental health and addiction professionals, and mental health advocates from the National Alliance on Mental Illness (NAMI). Importantly, the model does not seek to reduce contact between police and the public but to improve outcomes of these interactions.

WHERE HAS THIS BEEN IMPLEMENTED?

As of 2019, the CIT Center at the University of Memphis reports that 2,700 CIT programs, in around 16% of police agencies, are operating in the United States. The CIT model has also been implemented in Canada, the United Kingdom, and Australia.

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

CIT has received widespread implementation in a wide array of jurisdiction sizes and types, in large part because of the accessibility of the training materials and the curriculum endorsed by the CIT Center and CIT International. The success of CIT more broadly is contingent on strong partnerships between law enforcement, mental health advocacy, and mental health facilities. Prospective sites should consider the current capacity for collaboration between these entities and the availability of mental health resources to achieve the primary goal of arrest diversion.

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

The primary investment is the 40-hour CIT training course, which teaches officers to recognize the characteristics of mental illness, use techniques to de-escalate situations with people with mental illness, and share information about the community resources for people with mental illness. The training should be provided by a cross-disciplinary team including mental health clinicians, consumer and family advocates, and police trainers. The other core element of the CIT model is the availability of mental health facilities and resources to maintain the capacity for arrest diversion to psychiatric facilities.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

Jurisdictions that have adopted CIT follow the CIT training course, which was developed by the Memphis Police Department and the National Alliance for Mental Illness and is now organized by CIT International. Although all agencies likely have similar implementation goals, the number of officers who receive the training varies, as do the capabilities of jurisdictions to sustain arrest diversion and meet mental health care needs. CIT International suggests that 10% of officers in a department receive the training. Self-selection into CIT training may identify those officers best equipped to respond to mental health crises. Thus, CIT International recommends that training should be given mostly to officers who volunteer for the program, as they are more likely to refer people to treatment than are officers who did not volunteer.

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

CIT was developed as a way to improve outcomes in interactions between the police and citizens experiencing both a mental health issue and a crisis situation. Improved interactions should reduce officer and citizen injuries, use of force, and arrests. The training is supplemented with infrastructure to increase diversion from arrest to psychiatric care and mental health resources.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

High-quality evidence on the outcomes of CIT is limited and mixed. Systematic reviews of the literature have been hindered by the inconsistent measurement and definition of mental health crisis calls and outcomes between studies. Studies present a methodological mix of studies including focus groups, self-evaluation, qualitative observations, and quasi-experimental designs. There are no experimental studies on the outcome of CIT, limiting overall understanding of its effects. Existing research from systematic reviews shows little impact on official "observed officer behavior" outcomes—officer injury, citizen injury, arrests, and excessive use of force. The evidence for impact on arrests is mixed, depending on the study, and the unique methodology prevents a comprehensive comparison. Individual studies, however, have demonstrated improved safety, more voluntary transports to mental health facilities, and increased diversion to mental health services. Overall, there is not a strong enough body of evidence to warrant the popularity of the CIT model. However, promising initial findings highlight the need for continued and improved evaluations of this widespread program.

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

A primary impetus behind the CIT program is to reduce arrest, injury, and use of force in interactions between the police and citizens with mental illness. To assess the anticipated impacts of this program on these outcomes, jurisdictions need to understand which calls for service produce these outcomes and whether these call responses would be under the purview of CIT-trained officers. These instances may arise outside the scope of what CIT training programs address and may be more adequately addressed with improved arrest-control training or other preventative methods rather than strictly by officer training.

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CLINICIAN AND LAW ENFORCEMENT OFFICER CO-RESPONSE: TECHNICAL OVERVIEW OF ALTERNATIVE RESPONSE STRATEGY

PURPOSE

These technical overviews are designed to give jurisdictions relevant information on specific programs that can serve as an alternative response to certain types of 911 calls.

BACKGROUND

The co-responder model pairs a police officer with a civilian mental health clinician, a social worker, or a crisis worker who has a background in a related field. This model is the dominant response model in the United Kingdom and Canada (Shapiro et al., 2015). Co-responder strategies are considered a "secondary" response model, meaning that the officer contacts the person who is suffering from a mental health crisis first to do a safety assessment, and the mental health worker contacts the person second to perform a mental health assessment (Dempsey et al., 2020; Puntis et al., 2018). Each team member uses their specific skill to the call to maintain public safety and provide alternatives for the person in crisis to reduce the need for hospitalization and entry into the criminal justice system (Lamanna et al., 2018; Lamb et al., 1995; Reuland & Cheney, 2005). For example, the Los Angeles Sheriff's Department developed the Mental Evaluation Team in 1992, the Los Angeles Police Department developed the Systemwide Mental Assessment Response Team (SMART) in 1993, and the San Diego Sheriff's Office and San Diego Police Department began their Psychiatric Response Team (PERT) in 1996 (Dempsey et al., 2020; Lamb et al., 1995). Overall, research on co-responder models has shown these programs are associated with a reduction in arrests (Puntis et al., 2018). It is unclear, however, whether the outcome is caused solely by the co-responder model or is also influenced by changes in policy or in the availability of mental health provisions that occurred during that time (Puntis et al., 2018).

WHERE HAS THIS BEEN IMPLEMENTED?

Additional community response teams were created in the decades that followed in places such as Seattle, Washington; Cleveland, Ohio; Boston, Massachusetts; Los Angeles Police and Sheriff's Department; Lincoln, Nebraska; Baltimore, Maryland; and DeKalb County, Georgia (Watson et al., 2017).

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

Some sites had difficulty recruiting and retaining a mental health clinician (Morabito et al., 2018). Other sites had difficulty matching the clinician's personality to station culture and had to shift clinicians from one precinct to another. This has led to involving officers in the clinician hiring process so the personality fits from the start. Additionally, clinicians had limited availability and could not always respond city-wide and 24-hours a day (Morabito et al., 2018).

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

Police officers assigned full-time to the program and a mental health clinician. The city needs robust available mental health services. Without access to mental health resources, officers and the clinicians are limited in their ability to assist people who fall within the "gray areas" (incidents that do not require a formal intervention) of mental health services (Wood et al., 2017). Cities also face inconsistent funding issues. Cities have lost clinician positions after the cessation of federal grant funding (Morabito et al., 2018).

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

Co-responder models vary as to whether the officer is in uniform or plain clothes (Kisely et al., 2010). Some co-responder models have focused on crime hot spots (White & Weisburd, 2017). Others have partnered with hospitals to staff the clinician rather than employing a mental health clinician as a city employee (Morabito et el., 2018).

WHAT IS THE PURPOSE OF THIS INTERVENTION/PROGRAM?

The purpose of the co-responder model is to reduce arrests, injuries, and involuntary commitments.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

Several individual studies demonstrated localized city-specific efficacy; however, when conducting a systematic review of the co-responder studies, researchers found that no randomized controlled trials were conducted. This lack of rigorous methodology limits the generalizability of the individual study findings to other cities (Puntis et al., 2018).

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

Some co-responder models have been around for decades, working in partnership with their county mental health departments. Although highlighted for their innovative work in the early 1990s and 2000s, recently, they have been overshadowed by other third-party nonprofit programs that have gained in popularity despite having no rigorous evaluations. The police officers who participate in the co-responder partnerships feel as though their programs offer a valuable service to people with mental health issues and a measure of safety to the public that other mental health programs cannot provide.

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DEFINING, IDENTIFYING, AND RESPONDING TO MENTAL HEALTH CALLS FOR SERVICE: DEVELOPING AND PILOTING A STRATEGY FOR BETTER MEASUREMENT

PURPOSE

This technical overview is designed to provide jurisdictions with information about ways to improve the documentation and tracking of mental health-related calls in the 911 computer-aided dispatch (CAD) system.

BACKGROUND

A call to 911 generates a description of the call's nature, either by the call taker or by the systematic program used to ask questions of the caller. Classifying certain types of calls, such as those concerning mental health, can be difficult because of the dynamic nature of certain situations and the limited amount of time to collect relevant details. However, either of two approaches could be used to document through the CAD system whether calls are related to mental health.

The first would be to retrospectively review the unstructured text in the 911 call notes field to identify calls involving a person experiencing mental health symptoms. If sufficient information is available in the call notes, these unstructured data could either be manually coded or analyzed through the use of natural language processing (NLP). NLP is a form of artificial intelligence that bridges the gap between computers and how humans regularly use language. Advances in NLP allow the coding of call event characteristics to be automated. Critically, NLP allows for the analysis of unstructured text data and could potentially allow a better understanding of the proportion of calls that are mental health-related than relying on the call nature designation alone.

The second approach would require an agency to modify existing practices to implement the CAD technology in a way that allows for the better capture and documentation of the proportion of calls that have an underlying cause associated with mental health.

Stakeholders would need to consider the following questions before developing and implementing a pilot:

- How would agencies standardize the decision-making process and protocols for an officer to code a call (regardless of nature) as being related to mental health? Could existing diagnostic tools be adapted from other fields consistently and efficiently?
- How would the information identified through the use of a diagnostic tool be recorded in the CAD system? Would the CAD system (and data entry process) be modified to allow that information to be entered into structured fields? Would the results from the officer's diagnostic assessment be entered into the call notes?
- Would agencies be willing to train officers and 911 calls takers on the new processes and conduct process and data quality reviews to ensure that any additional data collection requirements function as intended?
- Are there other types of factors related to a call (and outside of the general call nature) other than mental health that could or should be recorded?
- Are there any potential liabilities or unintended consequences associated with officers' making these types of determinations and recording them in the CAD system?

Answers to these questions are included in the sections below.

WHERE HAS THIS WORK BEEN IMPLEMENTED?

Alternative call-taking processes have existed for some time. For instance, criteria-based dispatching (CBD) was first implemented in King County, Washington, in the late 1980s[1] and more recently in Tucson, Arizona. A 2020 Vera Institute of Justice report describes CBD and how it may provide a useful framework for a pilot focused on changing the way information is collected and acted upon in emergency call responses:

> CBD systems categorize multiple call types together and supply a list of corresponding questions for use during the call-taking process. These questions and prompts are guidance suggestions for the call taker, ultimately trusting that the call taker will exercise discretion to use them appropriately. The system was initially developed for medical emergency-based calls and utilizing symptom criteria similar to those utilized in medical offices and hospitals. CBD has since expanded and been used in multiple departments for fire-related calls as well. Although readily used for medical and fire emergencies, CBD has been introduced in only a handful of jurisdictions for police calls [Washington, DC, Metro and Seattle, WA, police departments]. As a movement across the country has begun demanding changes to policing and public safety, the need to revisit 911 call-taking and dispatching methods has become urgent.[2]

1 https://www.kingcounty.gov/depts/health/emergency-medical-services/emd.aspx
2 https://www.vera.org/downloads/publications/a-new-way-of-911-call-taking.pdf

WHAT ARE THE SITE-SPECIFIC CONSIDERATIONS FOR WHERE THIS HAS BEEN IMPLEMENTED?

Agencies interested in a retroactive analysis of CAD notes would need to address several agency-specific considerations. The level of quality and consistency for CAD notes can vary widely within an agency depending on the standardization of practices across call takers. Information entered in CAD notes by responding officers also varies in quality and consistency within agencies. Agencies with internal call taking (rather than relying on an external emergency communications center) would have greater control over the standardization of the call notation process for both the call taker and the responding officer to facilitate a future retroactive analysis of CAD notes. Stakeholders would need to gauge an agency's willingness to increase burden on call takers, field operations, or both by standardizing CAD notes data collection.

Agencies piloting an additional data collection would need to address state-specific considerations. For example, in North Carolina, emergency communication centers typically use a highly scripted call-taking protocol (ProQA) that may not be conducive to modification. Rather than capture information through the call-taking process, officers in the field could theoretically complete a brief diagnostic tool and document their assessment in the CAD system. Research that has examined how officers assess a person's mental health suggests that the quality of information that officers rely on needs to be improved.[3] Furthermore, the literature highlights the challenge of making officers responsible for deciding whether a call is mental health-related:

> One of the factors that make police officers' assessments for mental illnesses challenging is that signs of a mental illness can look similar to signs of substance use. Evidence of this challenge can be found in nearly every hospital emergency room where even experienced psychiatrists frequently confuse signs of mental illness with those of substance use.[4]

A diagnostic tool customized for law enforcement use in the field would help improve the information officers are relying on to make decisions on a call-to-call basis. In turn, documentation of that information in the CAD system would improve the information that the agency uses to make decisions on an organizational level. Although challenges would need to be overcome—including developing standardized definitions and validating the diagnostic tool—this approach offers many benefits.

3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6707744/
4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6707744/

WHAT CITY RESOURCES ARE REQUIRED FOR THIS PROGRAM?

Improving the documentation of mental health-related calls in the 911 CAD system (either from standardizing the CAD notes process or having officers complete and document a diagnostic assessment) would require additional effort on the part of the law enforcement agency, and especially patrol units. Implementing a standard for CAD notes and training officers on how to complete and document a diagnostic assessment would represent a nontrivial investment of time and resources for an agency. The return on that investment would be higher quality data about the proportion of the law enforcement call workload that is related to mental health.

WHAT HAS IMPLEMENTATION LOOKED LIKE IN OTHER CITIES?

A host of interventions have focused on improving the response to people in crisis, but there has been less of a focus on the definition, identification, and documentation of mental health calls in the CAD system. Any efforts related to doing so would likely need to be customized to accommodate the agency-specific CAD, the population served, and the ability and willingness of an agency to complete and document a diagnostic assessment.

WHAT IS THE PURPOSE OF THIS WORK?

The purpose of this work is to improve the documentation of mental health-related calls in the CAD system. A pilot effort for the first approach would seek to answer whether existing data be used to better measure the proportion of law enforcement calls that have a connection to mental health. A pilot focused on the second approach, the development and implementation of a documented diagnostic tool, would seek to determine whether the approach is operationally feasible and ultimately scalable.

WHAT EVIDENCE EXISTS FOR THE EFFICACY OF THE PROGRAM?

A 2020 publication coupled an analysis of proactive activity documented in the CAD system with information collected from systematically observing in the field. The systematic observations indicated that much of the proactive work conducted by officers is unaccounted for; a similar methodology could be employed to determine the proportion of work mental health-related work that is currently unaccounted for in CAD systems. While systematic observations would be extremely challenging during the COVID-19 pandemic, body-worn camera recordings could be sampled and analyzed instead. This method could be used to compare observed officer activity to the proportion of mental health-related calls that can be identified in the CAD system before and after implementation of a documented diagnostic tool pilot.

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5 https://journals.sagepub.com/doi/abs/10.1177/1098611119896081

WHAT ARE SOME SPECIFIC CONSIDERATIONS ABOUT THIS PROGRAM THAT MAY NOT BE PUBLICLY AVAILABLE OR WIDELY KNOWN?

Piloting a program focused on the development and implementation of a documented mental health diagnostic tool may be met with skepticism, particularly about an officer's ability to make a determination about a person's mental state. It is important to note, however, that officers are already being asked to make determinations about individuals' mental health in many situations: when assisting with an involuntary commitment, making a referral to a community intervention team, or making a referral to another public health resource. Developing a common definition for the types of calls that should be coded as "mental health-related" would be an opportunity to engage stakeholders from both city government and the community. Providing officers with a diagnostic tool would standardize an assessment process they are already being tasked with doing. Documenting that information in the CAD system would give decision makers more information about the public safety response to mental health-related calls.

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