# AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am</td>
<td>Welcome/Agenda</td>
<td>Bertha Johnson</td>
</tr>
<tr>
<td>9:15 am</td>
<td>Opening Remarks</td>
<td>Wanda Page</td>
</tr>
<tr>
<td>9:30 am</td>
<td>911 Calls for Service Project</td>
<td>Monica Chaparro, RTI International</td>
</tr>
<tr>
<td>11:30 am</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>11:45 am</td>
<td>Budget Guidelines</td>
<td>Bertha Johnson</td>
</tr>
<tr>
<td>12:45 pm</td>
<td>Closing Remarks</td>
<td>Wanda Page, Mayor and City Council</td>
</tr>
</tbody>
</table>

**Interpretación en español disponible**
**Date:** February 19, 2021

**To:** Wanda S. Page, Interim City Manager  
**From:** Monica Chaparro, Assistant Director of Budget and Management Services  
Bertha T. Johnson, Director of Budget and Management Services  
**Subject:** 911 Calls-for-Service Budget Retreat Agenda Item

**EXECUTIVE SUMMARY**
The 911 Calls-for-Service agenda item has several accompanying documents. This memo outlines those documents and communicates the desired outcomes and potential next steps for this agenda item.

**DESIRED OUTCOME AND NEXT STEPS**
City staff requests that the City Council and Administration receive information on: (a) the alternative responses to law enforcement research RTI has conducted and (b) the additional data analysis RTI performed in response to City Council and staff’s requests during the January 7 work session.

Additionally, staff requests that the City Council and Administration participate in discussion with RTI to help identify elements of interests and/or goals as it pertains to pilot exploration. Following the retreat discussion, City staff will work with RTI and appropriate partners to begin preliminary pilot planning activities. City staff and RTI will present pilot implementation plans to City Council during a City Council work session.

**ACCOMPANYING DOCUMENTS**
The following six documents accompany this agenda item:

1. **RTI Budget Retreat PowerPoint Presentation**
2. **Summary Document**
   Using RTI’s data tables, this staff-produced document provides highlights for the call natures City Council requested additional information for during the January 7 work session, and a summary table that highlights the 10 alternative responses RTI shares as part of the *Alternative Responses Research Packet*.
3. **Durham Police Department Focus Groups & Interview with Clinician**
   RTI conducted focus groups with Durham Police Department’s patrol officers of varying ranks and levels of experience to better understand the kinds of calls they feel could be more appropriately handled by other entities, or that they feel ill-equipped to respond to. Officers also provided insight into the acceptance of alternative models for response to crisis calls for service.
4. **Alternative Responses Research Packet**
   RTI identified several alternatives to law enforcement responses for calls for service. The Alternative Responses Research Packet includes:
   - Two (2) Overview Reports which provide valuable context:
     - *Alternative Police Responses to Citizens Calls to 911*
     - *Police Responses to Mental Health Crises*
Ten (10) Alternative Response Summaries which provide information on the individual programs:

- Defining, Identifying, and Responding to Mental Health Calls for Service: Developing and Piloting a Strategy for Better Measurement
- CAHOOTS: Crisis Assistance Helping Out on the Street
- Clinician and Law Enforcement Co-Response
- CAMP: Case Assessment Management Program
- CIT: Crisis Intervention Training
- LEAD: Law Enforcement Assisted Diversion
- Point of Dispatch Diversion
- Home Team: Homeless Outreach and Medical Emergency Team
- Law Enforcement Response to Non-Urgent Calls
- Family Liaison Officer Program

City of Durham staff, with guidance from RTI, developed a report that outlines an approach the City could use to identify available resources for implementing alternative responses:

- Inventorying Alternatives to Enforcement Resources: Plan for Identification & Documentation of Public Safety & Public Health Services

5. Durham Use of Force Analysis Report
RTI analyzed Durham Police Department’s use of force for the time period of October 29, 2017 to October 29, 2020.

6. Additional Requested Call Natures Analyses.
During the January 7 City Council work session, City Council and City staff requested additional analyses for the data areas noted below. RTI believed the best format was providing the data as an Excel document. The City is hosting the document at this Open Data link.

- General Assistance, Traffic Related, Quality of Life, and Mental Health
- Calls for Service cross-tabbed by public-initiated versus Police-initiated
Monica Croskey Chaparro, Assistant Budget & Management Services Director
Shannon Delaney, Design & Performance Strategist

SELECT HIGHLIGHTS
This document provides highlights for the call natures City Council requested additional analyses for during the January 7 work session. Those call natures were: Mental Health, Quality of Life, General Assistance, and Traffic Related call natures. City Council was provided the full dataset that RTI developed. This staff-produced document is intended to offer some highlights but given the significant amount of data, this document does not in any way cover all data points.

Lastly, because this document references RTI’s alternative responses research, staff developed a summary table for the alternative responses which is shared in the final pages of this document. RTI’s full alternative responses research is available in the Alternative Responses Research Packet.

MENTAL HEALTH
The public initiated an overwhelming majority of all Mental Health calls (96%). Five different call types make up the Mental Health call nature; of those, Crisis calls accounted for the majority (43%). The top two Close Codes for all call types were resolved without report, with 2-5% of Mental Health calls of any type requiring assistance/backup unit. Assist/backup Close Codes may offer one baseline metric to test effectiveness of any forthcoming pilot’s ability to decrease need for additional law enforcement interaction.

<table>
<thead>
<tr>
<th>Percent of Call Nature</th>
<th>Top 2 Close Codes</th>
<th>Assist/Backup as Close Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis</td>
<td>• 53% resolved w/o report</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>• 29% CIT resolved w/o report</td>
<td></td>
</tr>
<tr>
<td>Involuntary commitment</td>
<td>• 50% resolved w/o report</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>• 39% CIT resolved w/o report</td>
<td></td>
</tr>
<tr>
<td>Suicide threat</td>
<td>• 44% resolved w/o report</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>• 31% CIT resolved w/o report</td>
<td></td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>• 36% resolved w/o report</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>• 23% CIT resolved w/o report</td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td>• 68% resolved w/o report</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>• 16% CIT resolved w/o report</td>
<td></td>
</tr>
</tbody>
</table>

Information presented in RTI’s Alternative Response Research Packet acknowledges that responding to people exhibiting signs of a mental health crisis is one of the most challenging and complex problems that Police Officers and other first responders face, and is often exacerbated by poverty, co-occurring substance use and dependence, criminal victimization, as well as overrepresentation in the homeless population.

In RTI’s Durham Police Department Calls for Service Focus Group Report, Police Officers shared that “most crisis response calls they respond to (estimates of up to 90%) are related to mental health ... Several
officers referenced their Crisis Intervention Team (CIT) training as something that has increased their ability to de-escalate situations,” suggesting that it be part of DPD’s mandated training, in addition to having more coordinated support from the CIT within the DPD. As stated by one officer in the focus group, “One can’t expect every person to be the best mental health crisis responder, and the person kicking down the door, and [the person carrying out] several other police responsibilities, all at the same time. It takes so many different facets of personality, training, and abilities to respond to these calls that one person can’t be all of those people.”

Discussions with the DPD’s CIT Clinician aligned with many of these concerns and desires for better identifying mental health calls, as well as improved coordinated response, follow-through, and access to appropriate community resources.

QUALITY OF LIFE
Eight-nine percent (89%) of calls within the Quality of Life call nature were initiated by the public. Most of these calls were closed without report and without an arrest. There are 16 call types within the Quality of Life call nature. The two most common calls were trespassing or loitering and noise complaint; they accounted for 43% of the calls.

<table>
<thead>
<tr>
<th>Percent of Call Nature</th>
<th>Top 2 Close Codes</th>
<th>Arrest Report as Close Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trespass or loitering</td>
<td>• 82% resolved without report</td>
<td>1% (70)</td>
</tr>
<tr>
<td></td>
<td>• 7% incident report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 7% unfounded</td>
<td></td>
</tr>
<tr>
<td>Noise complaint</td>
<td>• 71% resolved without report</td>
<td>0% (2)</td>
</tr>
<tr>
<td></td>
<td>• 25% unfounded</td>
<td></td>
</tr>
</tbody>
</table>

Additionally, 9% of Quality of Life Nature calls were related to parking violations. Sixty-four percent (64%) of those were resolved without an incident report and a citation was issued in 25% of the calls. In the Point of Dispatch Diversion Technical Summary prepared by RTI, it was noted that: “In Berkeley, California, a new city Department of Transportation will be created that will be responsible for traffic enforcement rather than police. This effort will minimize community members’ daily interactions with police while still promoting traffic safety.”

There were 2,767 calls related to an animal problem or barking dog. “Referred to Durham County Sheriff Office” was the close code for 750 of those calls. In RTI’s Durham Police Department Calls for Service Focus Group Report, it was noted that Police Officers believed animal control issues were outside of law enforcement responsibility.

TRAFFIC RELATED
RTI’s Durham Police Department Calls for Service Report, shared with City Council in the January 7 work session, noted that of the 18 nature codes, Durham Police Department spends the third most amount of time on the Traffic Related nature code. Eight-nine percent (89%) of calls within the Traffic Related call nature were initiated by the public. Fifty percent (50%) of these calls were closed with an accident report. There are 13 call types within the Traffic Related call nature. The two most prevalent issues were motor vehicle accident and traffic hazard.
<table>
<thead>
<tr>
<th>Percent of Call Nature</th>
<th>Top 2 Close Codes</th>
<th>Arrest Report as Close Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle accident</td>
<td>50%</td>
<td>• 73% resolved without accident report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 15% resolved w/o report 7% unfounded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% (14)</td>
</tr>
<tr>
<td>Traffic hazard</td>
<td>19%</td>
<td>• 65% resolved without report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 21% unfounded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% (2)</td>
</tr>
</tbody>
</table>

There were 4,083 calls related to abandoned vehicles. Eighty-two (82%) percent of these calls were resolved without a report and 13% were resolved with an incident report. In the *Law Enforcement Response to Non-Urgent Calls* technical report, RTI discusses alternative response options that may be applicable for these types of calls.

**GENERAL ASSISTANCE**

There were over 195,000 calls within the General Assistance call nature. Sixty-four percent (64%) of these calls were initiated by the public with the remaining 36% being initiated by Police. RTI’s *Durham Police Department Calls for Service Report* noted that of the 18 nature codes, Durham Police Department spends the most amount of time on the General Assistance nature code.

There are 23 call types within the General Assistance call nature. These range from runaway, lost or found property, to school crossing and litter. The most common incident within this category was hang-ups (31%). The top two incident types, excluding hang-ups are provided in the table below.

<table>
<thead>
<tr>
<th>Percent of Call Nature</th>
<th>Top 2 Close Codes</th>
<th>Arrest Report as Close Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist person</td>
<td>16%</td>
<td>• 51% resolved w/o report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 42% incident report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1% (10)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>16%</td>
<td>• 93% resolved w/o report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2% incident report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% (31)</td>
</tr>
<tr>
<td>Attempt to locate</td>
<td>15%</td>
<td>• 63% missing information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 21% resolved w/o report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% (28)</td>
</tr>
</tbody>
</table>
## ALTERNATIVE RESPONSES SUMMARY TABLE

This is a City staff produced summary of RTI’s alternative responses research. RTI’s full alternative responses research is available in the *Alternative Responses Research Packet*.

<table>
<thead>
<tr>
<th>Program</th>
<th>Highlights</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Better Measurement of Mental Health Calls</td>
<td>• Addresses how to better classify mental health calls&lt;br&gt;• Offers two approaches: (a) going back to review text notes of calls or (b) technology modifications</td>
<td>• Someone to review text and manually recode (A)&lt;br&gt;• Technology modifications (B)&lt;br&gt;• Staff training on new processes</td>
</tr>
<tr>
<td>2. CAHOOTS</td>
<td>• Crisis workers and EMS respond to mental health crises&lt;br&gt;• Crisis counseling; wound cleaning; conflict resolution &amp; mediation; substance abuse</td>
<td>• Partners with a clinic that has $2.1M budget&lt;br&gt;• Eugene PD’s contract to support was $798K in 2018</td>
</tr>
<tr>
<td>3. Clinician and Law Enforcement Co-Response</td>
<td>• Pairs a police officer with a civilian clinician</td>
<td>• Police officers assigned full-time, mental health clinician(s), robust available mental health services</td>
</tr>
<tr>
<td>4. CAMP</td>
<td>• Focuses on high utilizers of mental health co-responder units &amp; those who are high risk to themselves, their communities, and the people who serve them&lt;br&gt;• Identify, monitor, and engage those subjects and to construct a case management approach that would link them to appropriate services.</td>
<td>• Police detectives and psychologists, nurses, and/or social workers</td>
</tr>
<tr>
<td>5. CIT</td>
<td>• Training intended to give police officers a working understanding of mental illness, psychiatric crises, and de-escalation techniques</td>
<td>• Training for staff</td>
</tr>
<tr>
<td>Program</td>
<td>Highlights</td>
<td>Resources Needed</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6. LEAD</td>
<td>• Aims to help individuals with behavioral health needs</td>
<td>• Working group of behavioral health resource /health services, law enforcement members, probation, district attorneys, housing reps, &amp; NPOs</td>
</tr>
<tr>
<td></td>
<td>• Case managers reach out to eligible individuals &amp; create intervention plans focused on individual wellness</td>
<td></td>
</tr>
<tr>
<td>7. Point of Dispatch Diversion</td>
<td>• 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</td>
<td>• If in-person diversion, would need social worker, crisis responder</td>
</tr>
</tbody>
</table>
| 8. Home Team                     | • San Francisco Fire Department created program to address the frequency of EMS use by some groups  
|                                  | • Partnered with social workers, nurses, students & probation officers to identify repeat users & address need | • Resources to locate, assess, & engage potential clients  
|                                  |                                                                                  | • Ability to refer/connect clients with needed services                         |
| 9. Response to Non-Urgent Calls  | • Can take the form of an in-person civilian response, telephone response units, & online reporting. | • If diverting to phone, may need to scale those resources  
|                                  |                                                                                  | • If diverting to technology-based, may need to acquire/adapt technology  
|                                  |                                                                                  | • If diverting to civilian-based, will need staff.                             |
| 10. Family Liaison Officer Program | • British Policing program that “embeds” Police Officers within families to support them through homicide investigations, traffic-death investigations, & “families of individuals killed by Police whilst preventing the commission of a crime” | • Training for police officers                                                  |
ALTERNATIVE POLICE RESPONSES TO CITIZENS’ CALLS TO 911

Citizens have relied on law enforcement to help address a range of criminal and noncriminal issues since police first organized, but the onset of 911 as a national crisis response system situated police as generalists for many of society’s problems (Cumming, Cumming, & Edell, 1965; Neusteter, Mapolski, Khogali, & O’Toole, 2019). Today, law enforcement agencies across the United States spend a significant proportion of resources responding to 911 calls for service, with some jurisdictions struggling to adequately handle the volume and breadth of call types. The vast majority of calls for service assigned to the police do not represent serious crimes. In fact, many are noncriminal in nature, with some of the largest categories related to traffic, disagreements or arguments, noise complaints, or requests for police assistance or information (e.g., welfare checks). Other calls are associated with drug overdoses, mental health crises, and people experiencing homelessness. In these circumstances, it is not always clear when or if a traditional criminal justice response involving the police as the primary responder is reasonable or necessary.

When a person calls 911, the calls are received by a call-taker in a local call center, also commonly referred to as a public service answering point. The 911 call-taker is expected to collect certain information on the type of emergency, the exact location, the time of occurrence, any known risks, and the identities of those involved (Neusteter et al., 2019). The next step is then to dispatch the appropriate emergency services, a responsibility handled by the call-taker or handed over to a specialized dispatcher to perform. The dispatcher also enters the call description code and the call priority into the computer-aided dispatch (CAD) system, which tells responders what response is needed and how quickly to respond. For 911 calls assigned to the police, the responding officer is expected to respond based on the priority level assigned, secure the scene, investigate based on the circumstances of the situation, and take appropriate action in addressing the needs of the call. This may involve closing the call with no further action, assisting a victim, referring an individual to an outside organization for services, providing a warning or citation, or making an arrest.

Many jurisdictions across the United States are re-examining how they address the needs of vulnerable populations, how they spend local police resources, and how to effectively reduce or alter the involvement of law enforcement for types of emergency calls. As such, identifying alternative responses to certain categories of 911 calls, including different ways the police can respond, and situations where a law enforcement presence may not be required at all, is a major topic of importance at national, state, and local levels. Many of these alternative responses aim to reduce the need for police intervention for the largest categories of noncriminal and nonviolent calls for service. A growing number of cities and counties have established programs for people experiencing homelessness, people with substance abuse disorders, and people experiencing mental illness (Barberi & Taxman, 2019; Bonkiewicz, Moyer, Magdanz, & Walsh, 2018; Herring, 2019). These programs have been created to improve outcomes for vulnerable populations, to better connect individuals with services, and to reduce the burden on first responders (Dupont & Cochran, 2000). This brief is intended to guide policy discussions by reviewing the research on police responses to 911 calls, discussing the historical foundation of crisis response programs, and offering recommended steps forward including the use of data-driven strategies to guide the analysis of the problem and the search for alternatives.

Who Calls the Police and Why?

Studies have demonstrated that 911 calls and crime tend to concentrate in areas with higher rates of social disorganization ( Sampson & Groves, 1989; Shaw & McKay, 1942; Sherman, Gartin, & Buerger, 1989; Sherman & Weisburd, 1995). Across cities, approximately 5% of places account for 50% of the calls for service (Weisburd, 2015). Neighborhood characteristics such as the number of people renting, the presence of businesses, the number of available jobs, the number of college graduates, the number of those not in the labor force, and the proximity to an urban center all significantly predict an area’s call volume (Neusteter et al., 2019; see also Xie & Baumer, 2019).

An important point to stress is that the vast majority of 911 calls to which police respond do not involve serious crimes. In a seminal study using calls for service data from the Chicago Police Department, Reiss (1971) divided...
calls into four categories: criminal matters, requests for assistance on noncriminal matters, complaints about police services, and providing information to the police. Other early research demonstrated that the majority of police calls concern nuisance abatement, traffic problems, or interpersonal disputes and that only 2% of calls involved a violent crime, with another 18% involving a property offense (Antunes & Scott, 1981; Cumming et al., 1965). Some calls often prioritized for a police response may not need a law enforcement officer for a successful resolution. Based on more recent data from places such as Los Angeles, New Orleans, and Boston, it was reported that generally about 4%-8% of calls involved violent crime. In an analysis of calls for service data for New Orleans (which included citizen- and police-initiated calls), it was reported that 5% pertained to major crimes, sex-based offenses, or crimes involving bodily harm, whereas 70% of calls were related to checks on people or property (which included events such as disturbance calls or alarm calls), and about 16% of calls were related to vehicles or traffic (Bump, 2020).

One ongoing challenge with analyzing calls for service data is that the CAD systems code a sizable number of calls as “other” (Neusteter et al., 2019). Underlying behavioral health factors pertaining to a call, such as mental health, can cut across a range of different call types, which creates challenges for accurately identifying and tracking prevalence within and across jurisdictions. In addition, studies have illustrated that police officers typically do review and, if necessary, change the final call type in the CAD system to make sure it accurately describes the nature of the call (McEwen, Ahn, Pendleton, Webster, & Williams, 2002). There is also a limited amount of research surrounding calls for service in recent decades. Many of the research studies examine calls for service as an outcome measure as the result of an intervention rather than examining the state of calls for service across the United States.

**How Have Police Responses to 911 Changed Over Time?**

Research on police calls for service and the search for alternatives to arrest is not a new phenomenon (Antunes & Scott, 1981; Bercal, 1970; Black, 1983). There is a longstanding body of research on police patrol responses that has examined different ways to handle certain types of calls with an eye on improving efficiency and crime outcomes. The President’s Crime Commission convened by Lyndon B. Johnson in response to the 1960s riots called for an overhaul of the policing profession (U.S. President’s Commission on Law Enforcement and Administration of Justice, 1967). The report provided recommendations for the criminal justice field and helped motivate a series of experiments concerning 911 police patrol and response decision making. One of the best known was the Kansas City Preventive Patrol Experiment, which found that increased random police patrols had no impact on reducing crime or on resident perceptions of safety (Kelling, Pate, Dieckman, & Brown, 1974). The Wilmington Split-Force Experiment was designed to create patrol specialization, splitting patrol into a call for service “basic” patrol response function and a crime prevention “structured” patrol service. The split force sought to improve the effectiveness of police patrols because the Kansas City study had shown that random patrols did not work in reducing crime. A follow-on study with the Wilmington Police Department came at a time when police departments were facing growing calls to improve their services to the public while also reducing their budgets. Findings showed that by appropriately designating calls for service to different levels of service, the police department was able to increase its efficiency by 16%. This practice allowed for a more nuanced approach to calls for service including using telephone reporting for minor offenses and scheduling appointments for nonemergency incidents (Cahn & Tien, 1981).

During the same period, the U.S. Department of Justice’s National Institute of Justice funded a review of police-led programs in the crisis response areas along with the public sentiment concerning those responses (Sumrall, Roberts, Farmer, & Crow, 1981). Results showed that 80% of the responding agencies were using some type of alternative response including civilian response, telephone reporting, appointment scheduling, mail-in reporting, or referral to other agencies (Sumrall et al., 1981). Police had yet to develop alternative responses for people experiencing mental illness, homelessness, or drug-related problems.

**What 911 Responses Have Been Developed to Address Drug-Related Problems?**

In the area of drug-related 911 calls, including drug overdoses, there have been growing demands to identify and implement programs that deflect and divert individuals away from the criminal justice system and into substance abuse treatment. Many of these alternative responses include multiagency collaborations and partnerships that are required to navigate the complex, multifaceted issues that people face. The Seattle Police Department’s Law Enforcement Assisted Diversion (LEAD) program asks officers to identify eligible participants at the point where they would normally be arrested for a low-level offense. The “pre-arrest diversion” diverts individuals from jail and instead places them in contact with a case worker who assists them in getting access to resources, including legal
services, housing, employment or food assistance, and mental health services. An evaluation study found that outcomes for LEAD participants significantly improved as compared with outcomes for people who were traditionally processed through the criminal justice system; they were more likely to have stable housing and employment after having participated in LEAD (Clifasefi, Lonczak, & Collins, 2017). Additionally, participants were less likely to be re-arrested and re-incarcerated (Collins, Lonczak, & Clifasefi, 2017, 2019). Other pre-arrest diversion programs that employed medication-assisted treatment (MAT) have shown significant results in reducing future offending for people with substance abuse disorders (Substance Abuse and Mental Health Services Administration, 2019).

MAT programs demonstrate success for people with substance abuse disorders, addressing the problem with a combination of pharmaceutical intervention and cognitive behavioral therapy (Keen, Oliver, Rowse, & Mathers, 2001). MAT programs help with the physical aspects of withdrawal, while cognitive behavioral therapy helps the client create new behaviors. The U.S. Food and Drug Administration has approved three medications for preventing opioid relapse: buprenorphine, naltrexone, and methadone. A systematic review of randomized controlled trials of MAT programs found that MAT augments treatment retention, reduces illicit opioid use, and assists with withdrawals (Connery, 2015).

**Alternative 911 Responses for People Experiencing Mental Illness**

Over the past decades, a growing number of law enforcement agencies have implemented a range of approaches to address 911 responses to people exhibiting signs of mental health disorders. One of the most common models has been the use of Crisis Intervention Teams (CIT). Using the Memphis Model, CIT officers are given 40 hours of training, so they can safely intervene when people are experiencing a mental health crisis (CIT International, 2012). Instead of being arrested and jailed, people with mental illness were more likely to receive an appropriate health care referral when CIT officers responded (Steadman et al., 2001). CIT officers are expected to de-escalate the crisis situation and decrease the risk of injury to the patient, their family, and the responding officers, but evidence of these outcomes is limited and mixed (Seo, Kim, & Kruis, 2020; Taheri, 2016).

Other jurisdictions have implemented co-responder models where law enforcement officers respond with a mental health worker to citizens who are in a mental health crisis. The Los Angeles Police Department (LAPD) established its own Mental Evaluation Unit in 1993, using a Systemwide Mental Assessment Response Team (SMART) unit that partnered CIT-trained officers with Los Angeles County Department of Mental Health workers to respond to people in a mental health crisis. In 2006, LAPD created the Case Assessment Management Program (CAMP), which paired a Department of Mental Health worker with an LAPD officer to work proactively to address 911 high utilizers who had higher risk of being involved in lethal confrontations with the police, including situations in which subjects barricaded themselves, threatened officers with weapons, and engaged in other violent behavior. CAMP was created to fill a service need that was not specifically addressed by LAPD’s SMART. As part of CAMP, the co-responders work with the clients’ families, outpatient services, and advocates to meet their clients’ need. In 2006, CAMP saw 192 clients; 54 of them had an identified violent criminal history with mental illness; 93 had nonviolent criminal history with mental illness, and 45 had an identified mental illness with no criminal history. The program was able to successfully link 48 of the 192 clients to services (Bureau of Justice Assistance, 2016).

Another program, which is getting widespread attention across the nation, is Crisis Assistance Helping Out On The Streets (CAHOOTS). CAHOOTS pairs clinicians with emergency medical services workers to respond to people having mental health crises. Clinicians typically represent nonprofit organizations that are not associated with the city. None of these programs have been empirically evaluated, but they have been shown to reduce the number of calls for service to which the police department responds. CAHOOTS was launched in 1989 by social activists in Eugene, Oregon, and in its first year, it handled 17% of the 96,115 calls for service that the Eugene Police Department received (Elinson, 2018).

**Alternative 911 Responses to General Nuisance and Disorder**

As summarized earlier, police must also respond to a wide range of calls that fall into the general categories of nuisance abatement, conflict resolution, and interpersonal disputes. When dealing with these types of issues, problem- and community-oriented policing have been shown to be effective in important ways. Problem-oriented policing (POP) involves the identification of specific problems in order to develop appropriate solutions, rather than simply arresting people (Weisburd, Telep, Hinkle, & Eck, 2010). Community-oriented policing leverages members of the community in cooperation with the police to unpack problems and actively participate in implementing solutions (Gill, Weisburd, Telep, Vitter, & Bennett, 2014). For example, residents working with police may develop and implement a neighborhood watch program to reduce crime. A systematic review of...
POPs revealed it to have an overall modest but statistically significant impact on crime and disorder (Weisburd et al., 2010). Evaluations of community-oriented policing show significant improvements in citizen satisfaction with police, perceptions of disorder, and police legitimacy, but community-oriented policing’s effects on crime are mixed (Gill et al., 2014). When POP and community-oriented policing strategies are used, there are significant crime reduction effects and improvements in citizen-police relations (Braga & Weisburd, 2006). Other diversion strategies include giving warnings before making arrests. One study found that participants who received a warning for low-level marijuana offenses reported reductions in future drug use and reduced contacts with the justice system compared with those who were arrested (Dennison, Stewart, & Hurren, 2006).

**Police Officer Views on Alternative Responses**

Police officers hold their own views on possible changes to policing responses to 911, including the shift of some types of calls away from the primary responsibility of law enforcement. More positive views of alternative policing strategies appear to increase with years of policing experience. For instance, a study that interviewed police officers in Baltimore showed that seasoned officers were significantly less likely to believe that traditional policing policies are most effective and that people who use drugs should be arrested (Rouhani et al., 2019). Seasoned officers were also more comfortable referring drug users to social services as compared with less-experienced officers. Police officers report that the biggest barrier to implementing alternative responses is the police culture, whereas organizational leadership and collaboration with community stakeholders facilitate the use of arrest alternatives (Barberi & Taxman, 2019). Officers who hold positive attitudes toward rehabilitation are more likely to divert offenders (Schaible, Gant, & Ames, 2020).

**Conclusions**

In the overarching theme of policing reform, the nation finds itself with a critical opportunity to conceptualize and implement different approaches to the more traditional policing-led responses for certain types of 911 calls, including those that would benefit from a more specialized, multidisciplinary response. Although the research foundation is still a work in progress, the good news is that there appears to be an increase in city and county jurisdictions that are open to alternative strategies, providing a chance to drastically increase what we know about what works, and under what circumstances. More guidance is also needed for jurisdictions on how to best implement and sustain programs with fidelity over the long term.

In the problem identification process, one of the first steps should be to examine the calls for service data to determine the needs of the citizenry.

- What types of calls are occurring most often, and could certain categories of calls be handled by another entity?
- Where are the calls occurring? What issues are occurring in the neighborhood that if alleviated would help with collective efficacy and social order (e.g., improved lighting, employment opportunities, better management of properties, increased guardianship over public areas, or community activities that bring the neighborhood together)?
- Who generates the most calls? Are there high utilizers of the 911 system, and why are they high utilizers? Focus on the areas where the calls for service concentrate.

The next step is to inventory and assess the types of resources and programs currently available in not only the immediate jurisdiction, but also the surrounding county.

- What services does the city or county offer, and are those services known and available 24/7 so that officers do not have to be? Sometimes police are the only city resource available to respond at certain hours of the day—can this be remedied?

The final step is identifying the public safety priorities of the city to determine how to balance competing interests:

- What is the goal of creating an alternative response? How can jurisdictions create a response that balances the needs of the community?
- How will the alternative responses affect the level of victim services? Will community members feel that their city services have been diminished?
- How will cities respond to demands for police services when police services are no longer offered for that particular problem?

Policing is at an inflection point. Just as the role of law enforcement was re-examined by the President’s Commission during the 1960s, the most recent decade of televised examples of the divide between the police and vulnerable populations has led to a fundamental questioning of the role of police in society. Attempts to
integrate alternative responses to 911 calls should be driven by research and data and should be responsive to the needs of the populations served. The distribution of calls in socioeconomically disadvantaged areas has remained stable for decades, with a large percentage of the calls requiring more social and legal support than enforcement of the law. The alternative responses detailed here, relating to drug use, mental illness, and social disorder, attempt to leverage police, social and medical services, and community resources to respond to the diverse needs of the citizens. To reduce the potential for negative interactions between the police and the public and to advance more targeted and sustained social interventions, alternative responses could be offered for the calls that do not involve weapons, criminal activity, or any type of violent or otherwise dangerous behavior. These alternative responses should be further studied to determine whether the approaches were more effective and efficient and ultimately caused less harm to the community.

Endnotes
1. The National Emergency Number Association estimates that approximately 240 million 911 calls for service are made annually in the United States, a figure which includes calls to police, fire departments, and emergency medical services.
2. “Medication-assisted treatment (MAT) is the use of Food and Drug Administration (FDA)-approved medication for the treatment of a specific substance use disorder in combination with clinically indicated behavioral or cognitive-behavioral counseling and other indicated services. Currently, medications are available to treat tobacco, alcohol, and OUD, and research is underway to identify effective medications for other substances as well” (Substance Abuse and Mental Health Services Administration, 2019, p. 4).

References


**Contacts**

Renee Mitchell
rjmitchell@rti.org

Kevin J. Strom
kstrom@rti.org

Brian Aagaard
baagaard@rti.org

[www.rti.org/policing](http://www.rti.org/policing)

RTI International is a trade name of Research Triangle Institute. RTI and the RTI logo are U.S. registered trademarks of Research Triangle Institute.
SUMMARIZING THE EVIDENCE: Police Responses to Mental Health Crises

“The public mental health system and the criminal justice system must collaborate so that police officers have several alternatives, not just arrest or hospitalization, when handling mentally ill persons in the community” (Teplin, 2000, p. 13).

“The goal of a law enforcement officer in an encounter with an individual in crisis is to select the most appropriate course of action: maximizing the safety of civilians, officers, and the person in crisis” (James & James, 2017, p. 2).

This brief examines three broad categories of law enforcement approaches to handling 911 calls concerning people experiencing mental health crises:

- Crisis Intervention Team (CIT) approaches that are centered on coordinated community responses that emphasize mental health training for police
- Co-responder models that pair a law enforcement officer with a clinician or social worker
- Third-party strategies, in which outside organizations take responsibility for responding to the 911 calls

Collectively, these approaches are designed to improve access to services, reduce injury to officers and civilians, decrease arrests and justice system involvement, and maintain public order. For each approach, we give an overview, including examples of programs; summarize the research literature; and suggest how jurisdictions can use the available evidence. Recommended next steps for jurisdictions to consider include inventorying available resources, studying their data to better define gaps and needs, creating a multidisciplinary working group to guide decision making, and pilot testing innovative strategies that address local needs and objectives.

Overview

Responding to people exhibiting signs of a mental health crisis is one of the most complex problems that police officers and other first responders face. The lack of a structured mental health care system across the United States stresses communities and limits options for people in crisis. It also disproportionately burdens law enforcement agencies and hospital emergency departments (Hogan & Goldman, 2020). Calls for service related to individuals suffering from mental illness—often exacerbated by poverty, co-occurring substance use and dependence, criminal victimization, and overrepresentation in the homeless population—pose significant challenges not only for law enforcement, but also for others who work across the public health and social service systems.

Approximately 3%–10% of all police calls for service in the United States are related to mental health issues (Chappell, 2013; Cordner, 2006; Engel & Silver, 2001). However, estimating the prevalence of mental health–related 911 calls is challenging because of the differences in how jurisdictions define and track this information (Neusteter, Mapolski, Khogali, & O'Toole, 2019). Data that are used to classify the initial call for service can also be inaccurate, with the call misclassified as a mental health incident or improperly coded without this information. In addition, responding officers may have imperfect information as to the most appropriate options for training and may lack specifics on the most appropriate local mental health referral resources. In addition, enforcing existing laws and local ordinances pertaining to public space is sometimes in direct contrast to the necessarily high standards for making an arrest or seeking involuntary confinement for a person with mental illness.

A mental health crisis is defined as a “situation in which a person’s behavior puts them at risk of hurting themselves and/or prevents them from being able to care for themselves or function effectively” (National Alliance on Mental Illness, 2020).
When responding to a 911 call related to mental illness, police officers consider several interests:

1. What is the person’s mental health capacity, and is there any known history of mental health–related problems?
2. Will the person voluntarily go with the officer to be screened for mental health services?
3. If not, does the person have independent capacity, or are they a candidate for involuntary commitment?
4. Does it appear that a crime has been committed, and if so, is there cause for an arrest?
5. Can another action be taken to help the person discontinue the behavior or relocate them to another area (Bittner, 1967; Lamb, Weinberger, & DeCuir, 2002)?

Too often, the options available to law enforcement are limited and do not resolve underlying needs, which leaves many people spiraling downward until contact with law enforcement results in arrest, involuntary confinement, injury, or death (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). In general, an officer who contacts a person who is not a danger to themselves or others or who is gravely disabled as a result of a mental disorder cannot take the person into protective custody to be seen for treatment by a mental health provider (see text box above). This limitation also applies to mental health workers, such as social workers or clinicians dispatched to 911 calls concerning people with mental illness. In addition, some people may refuse treatment or services, risking future relapses with potentially severe consequences to themselves and/or the public. Eventually, the person with mental illness may be injured or placed on a 24-hour hold or in jail for a crime committed as a result of untreated symptoms, perpetuating a cycle of arrest, release, and recidivate (Lewandowski, 2018).

The following sections review the major categories of law enforcement strategies and programs for mental health–related incidents—CIT, co-responder models, and third-party responder models.

**Crisis Intervention Teams**

The CIT program was created in 1988 after a man with mental illness and a history of substance abuse was killed by Memphis police (Dupont & Cochran, 2000). Sometimes referred to as the “Memphis Model,” the CIT model presents an alternative to arrest for people in mental health crisis who can be diverted to psychiatric services. In 2005, the first national CIT conference was convened, and the CIT model quickly spread to other cities, evolving into what is now CIT International. The framework of CIT was developed with the input of law enforcement officers, mental health advocates from the National Alliance on Mental Illness (NAMI), and mental health consumers and their families. One of the major goals of the CIT program is to strengthen relationships among the police department, community mental health stakeholders, and mental health consumers (CIT International, 2012).

The CIT program was originally designed to train police officers who volunteered to participate, with the idea that officers who agreed to participate would be more open to the training. Research has shown that voluntarily trained officers are more effective in diverting people in crisis to services than officers not trained in the CIT model (Compton et al., 2014a; Compton, Bakeman, Broussard, D’Orio, & Watson, 2017; Compton, Broussard, Munetz, Oliva, & Watson, 2011; van den Brink et al., 2012). NAMI and CIT International suggest that CIT training be conducted by mental health clinicians, advocates, and police trainers and cover information on the signs and symptoms of mental illnesses, mental health treatment, co-occurring disorders, legal issues, and de-escalation techniques (Compton et al., 2011). The training promoted by CIT International is a 40-hour course that teaches officers to recognize the characteristics of mental illness, to de-escalate situations, and to share information about the community’s mental health resources (Ellis, 2014; Ritter, Teller, Munetz, & Bonfine, 2010).

The CIT program has been replicated in more than 3,000 agencies across the United States and abroad and has shown consistent positive effects on officers’ attitudes toward and self-confidence in responding to mental health calls for service. However, the peer-reviewed literature has not shown effectiveness of the program in reducing officer or citizen injuries, reducing the use of force, or reducing the number of arrests (Peterson & Densley, 2018; Rogers, McNiel, & Binder, 2019). Table 1 summarizes results of several CIT evaluations since 2010.

---

**For the purposes of involuntary confinement in the state of North Carolina, N.C. General Statutes §122C-261 requires a determination that mental illness is present and that as a result of that mental illness, the person is a danger to self or others or needs treatment to prevent further disability or deterioration that would predictably result in dangerousness.**
### Table 1. Examples of Research Methods Used to Evaluate CIT

<table>
<thead>
<tr>
<th>Type of Study</th>
<th>Summary of Findings</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-agency comparison</td>
<td>Officers who have undergone CIT training experience significant increases in knowledge of behavioral health and increased self-efficacy in responding to these calls, relative to officers who have not undergone training.</td>
<td>Compton et al., 2014b; Davidson, 2016; Ritter et al., 2010</td>
</tr>
<tr>
<td>Quasi-experimental pre-/post-survey design</td>
<td>Differential training effects depending on the type of CIT curriculum given</td>
<td>Helfgott, Strah, Atherley, &amp; Neidhart, 2020</td>
</tr>
<tr>
<td></td>
<td>Improved officers’ ability to resolve mental health crisis situations using social tactics instead of physical force and referrals to mental health services.</td>
<td>Canada, Angell, &amp; Watson, 2010</td>
</tr>
<tr>
<td>Pre-/post-survey</td>
<td>Improvements in knowledge, perceptions, and attitudes toward people with mental illness</td>
<td>Ellis, 2014</td>
</tr>
<tr>
<td>Scenario-based vignettes</td>
<td>In scenarios involving behavioral crisis, CIT-trained officers consistently endorsed use of de-escalation over physical force, at a rate significantly higher than in a comparison group of officers who had not undergone 40-hour CIT training.</td>
<td>Compton et al., 2011</td>
</tr>
<tr>
<td>Pre-/post-survey</td>
<td>Officers exhibited significantly more confidence in their interactions with people with mental illness and felt that their fellow officers were more prepared</td>
<td>Ritter et al., 2010</td>
</tr>
<tr>
<td>Pre-/post-survey, structured interviews, ride-along observations</td>
<td>CIT training changed officers’ perceptions and their street-level practices with people with mental illness, emotional or behavioral issues, or both. In addition, police officers are taking fewer people into custody for involuntary treatment and are instead transporting more individuals for voluntary treatment.</td>
<td>Hassell, 2020</td>
</tr>
</tbody>
</table>

### Co-Responder Models

Co-responder strategies pair police officers with civilians who are mental health clinicians or social workers or who have a background in a related field. It is the dominant response model in the United Kingdom. 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 is the second contact who performs a mental health assessment (Dempsey, Quanbeck, Bush, & Kruger, 2020; Puntis et al., 2018). For example, the Los Angeles County Sheriff’s Department developed the Mental Evaluation Team in 1992, the Los Angeles Police Department developed the Systemwide Mental Assessment Response Teams in 1993, and the San Diego County Sheriff’s Office and San Diego Police Department began their Psychiatric Emergency Response Team in 1996 (Dempsey et al., 2020; Lamb, Shaner, Elliot, DeCuir, & Foltz, 1995). Additional community response teams were created in the decades that followed in places such as Seattle, Washington; Cleveland, Ohio; Boston, Massachusetts; and DeKalb County, Georgia (Watson, Compton, & Pope, 2019).

From a research perspective, co-responder models suffer from some of the same underlying issues as the CIT model, including a lack of rigorously designed research, a lack of standardization across implementation efforts, and limited documentation of the methods used to evaluate the programs. Overall, research on co-responder models has shown that these programs are associated with a reduction in arrests, but it is unclear whether the outcome is due solely to the co-responder model or is also influenced by changes in policy or in the availability of mental health provisions that occurred during a similar period (Puntis et al., 2018). Some studies on co-responder models in specific jurisdictions have also shown that officers have favorable attitudes toward the program, that consumers were satisfied with the services they received, and that rates of being placed on an involuntary commitment were reduced (Watson et al., 2019).

Other co-responder models incorporate emergency medical services (EMS) or the fire department rather than police services, because people with mental illness also have frequent contact with these providers. One example is the Homeless Outreach & Medical Emergency (HOME) Team program in San Francisco, California, created by the San Francisco Fire Department to address high utilization...
of EMS by some individuals. The HOME Team is one of the first known efforts by fire departments or EMS personnel to have specially trained paramedics work with frequent emergency services users to divert them to other types of care (San Francisco Fire Department, n.d.). In an approach similar to those of police co-responder models, the San Francisco Fire Department partnered with social workers, nurses, students, and probation officers to identify frequent users of the 911 system, defined as anyone who called 911 four times or more during a month. Clients were redirected from emergency departments to services that included case management, primary care housing, and substance abuse treatment. The HOME Team often transported clients directly to those service providers.

In the only evaluation of the HOME Team, Tangherlini and colleagues (2016) found that, before implementation, 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%) of 29,984 transports, a statistically significant decline. The average contact per frequent user also decreased from about 19 contacts per month before the HOME Team was implemented to 9 contacts per month after the first contact with the HOME Team. Although this evidence is promising, the study used a non-experimental pre-/post-survey research design, and the HOME Team model would greatly benefit from replication studies with more rigorous designs such as randomized controlled trials (Weisburd, Lum, & Petrosino, 2001).

### Third-Party Responder Models

Popular programs like Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene, Oregon, are also expanding across the country. In these third-party models, 911 calls for service concerning people who are in a mental health crisis but not violent are dispatched to a nonpolice organization, often a nonprofit entity not affiliated with a city. The third-party responder model deploys a mental health worker to connect the person in crisis with city resources or assist them with transportation to mental health services. Although these types of programs have not been rigorously evaluated, the CAHOOTS program has shown the ability to be applied broadly, covering approximately 10% of the calls made to the Eugene Police Department (Eugene Police Department Crime Analysis Unit, 2020). In 2019, the most common CAHOOTS calls were check welfare (30%), assist public/police (29%), and transport (24%). A CAHOOTS response unit was dispatched to 17,700 public-initiated calls for service and arrived on scene for the vast majority (15,879) of these calls (Eugene Police Department Crime Analysis Unit, 2020). Of the 15,879 calls they arrived on, 13,854 were CAHOOTS only and the remainder were CAHOOTS/Eugene Police Department co-responded calls. Among the CAHOOTS-only calls, only 311 required additional police backup after initial contact with subjects on the scene, with criminal trespass calls the most likely to result in requests for backup.

CAHOOTS provides services to the public that the police do not generally provide, such as performing health and welfare checks on a large homeless population, performing wound cleaning, offering rides to shelter or food, and providing general assistance for daily coping. When examining the calls that CAHOOTS diverts from Eugene Police Department, it is estimated that CAHOOTS answered 5,458 calls for service that would have been otherwise answered by Eugene Police Department, which demonstrates a divert rate of 10%. Some programs, like the Respond, Empower, Advocate, Listen Program of Lincoln, Nebraska, have shown a reduction in emergency protective custody orders but only in 1–2 years after contact by a peer-based mental health support person (Bonkiewicz, Moyer, Magdanz, & Walsh, 2018). Other programs, like the Support Team Assistance Response program in Denver, Colorado, which are CAHOOTS replications, are just starting.

### Implementing an Effective Strategy in Your Jurisdiction

The long-standing challenges that society faces in addressing mental health are multifaceted. Clear answers and direction are needed. Although there are some signs of positive outcomes from the CIT, co-responder, and third-party models, overall, the body of evidence is still very much a work in progress (Peterson & Densley, 2018; Seo, Kim, & Kruis, 2020; Taheri, 2016). Most of the research to date is based on pre-/post-training data, a research design with limitations (Weisburd et al., 2001). Mental health programs that are led or supported by law enforcement have been adopted in the United States without sufficient clarity about what works, under what conditions, and for whom. Given the importance of this topic, rapidly expanding the evidence base for these programs, including specifying the outcomes used to determine their effectiveness, must be a priority.

What is apparent is that when developing an approach to 911 calls for service concerning people in mental health crisis, jurisdictions should adopt a data-driven, research-based approach to select programs that are specific to their particular needs. One of the first steps to achieve this goal is to clarify the particular questions and goals that a jurisdiction hopes to achieve in implementing a program. Cities and counties should examine their call-for-service data to determine the area’s level of need, review the resources currently available in the city and county, and determine where gaps in systems could be filled.
Possible next steps that a jurisdiction can take to begin implementing new programs or strengthening existing ones include the following:

1. **Establish Goals**: Efforts to improve outcomes of 911 calls involving people with mental illness start with the question of what the jurisdiction is trying to accomplish and what needs will drive service delivery.

2. **Take Inventory**: Establish a complete list of all relevant resources and programs at the city and county level across the area.

3. **Reach Out**: Take a comprehensive approach toward identifying and talking to relevant stakeholders, including community members with lived experiences, groups such as NAMI, and other local organizations.

4. **Consult the Data**: Examine all available data including not only 911 calls across police, fire, and EMS, but also data from social service and community care providers to diagnose problems and resource needs and to identify gaps.

5. **Build the Team**: Create a multidisciplinary working group that includes city and county leaders and other experts from social services, public works, schools, public health, law enforcement, and the community. Work with this team to identify and select candidate programs to pilot test.

6. **Test and Evaluate**: Implement and pilot test programs that address specific areas of need, and develop a process to rapidly evaluate these programs in the field using the most rigorous methods possible. Identifying cross-cutting outcome measures that can be considered shared objectives by all involved may also be beneficial.

7. **Look at the Big Picture**: Consider what other types of jurisdictional and agency-level changes are necessary to address systemic barriers and to establish more sustainable, cross-disciplinary efforts that address cross-cutting needs. For example, examine how longer-term funding and staffing can be addressed, as well as laws or ordinances that may serve as barriers to positive change. Ultimately, the goal should be to establish programs that are viewed as beneficial for the entire community and all participating organizations.

**References**


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), 603–607. https://doi.org/10.1017/S1049023X16000790


**Contacts**

Renee Mitchell
rmitchell@rti.org

Kevin J. Strom
kstrom@rti.org

Brian Aagaard
baagaard@rti.org

[www.rti.org/policing](http://www.rti.org/policing)

RTI International is a trade name of Research Triangle Institute. RTI and the RTI logo are U.S. registered trademarks of Research Triangle Institute.
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.

PURPOSE

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.

BACKGROUND

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 1980s1 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

---

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.

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.
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.

For more information, please contact Brian Aagaard at baagaard@rti.org, Renee Mitchell at rjmitchell@rti.org, or visit www.rti.org/policing.
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 al., 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.


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.

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.
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.
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. 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. 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.

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. 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. 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. 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). 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.

---

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.
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. In Berkeley, California, a new city Department of Transportation will be created that will be responsible for traffic enforcement rather than police. 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.

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.

---

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.


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.


For more information, please contact Brian Aagaard at baagaard@rti.org, Renee Mitchell at rjmitchell@rti.org, or visit www.rti.org/policing.
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/
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.
The role of Family Liaison Officer is one that is unique to British Policing. At the turn of this century, stung by criticism of the way the Police treated the families of those killed in violent circumstances; all United Kingdom Police Forces adopted the role of a Family Liaison Officer (FLO) in all major crime enquiries where death or extremely serious injury had occurred. For the past 20 years, highly trained Police Officers have been embedded within families to support the family through the rigours of the investigation and subsequent legal process. The benefits to British Policing have included

- Allowing Police enquiry teams to build up a picture of the family dynamics, which has frequently identified an offender within the family or a known associate as the suspect.
- Providing Senior Leadership Team and the family with a single point of contact between each other, preventing mixed messages and communication errors and breakdowns. Speaking with honesty and transparency, especially with complex cases, usually leads to the reputation of the Police Major Enquiry Investigation teams being enhanced.
- Supporting the family through the judicial process, from Mortuary and Coroner procedure through to High Court jurisdiction.
- Reinforces public perception that Law Enforcement Agencies are acting with the interests of the victim, the family and its citizens at its core.

Over time, the Family Liaison Officers function has stretched beyond murder enquiries, with FLO’s being deployed following terror attacks, both in the United Kingdom and abroad, as well as deaths during road traffic accidents. Such is the success of FLO’s that they are now deployed at the request of The Foreign and Commonwealth Office to families of UK Nationals who have lost their lives following natural disasters abroad, such as The Tsunami or the recent earthquake in Nepal.

Perhaps one of the most successful use of the tactic was deploying FLO’s to the families of individuals killed by Police whilst preventing the commission of a crime. This also includes UK based families of terrorists killed either abroad or within the UK. This deployment within the very heart of the family of a deceased criminal or terrorist has led to

- Identifying associates who may be involved in crimes or in particular, the identification of radicalised individuals within the family, as well as further attack planning
- Noticeable intelligence gains across all arenas of crime especially Terror
- Preventing significant discord around Police tactics from within the family and the community.

ChalMan Training was formed by former New Scotland Yard Officers from The Counter Terrorism Command. With decades of experience and having dealt with dozens of families over the years, ChalMan Training is in a unique position to offer its services to Law Enforcement across the world to train this valuable tactic.

We aim to take a significant number of students through bespoke training, incorporating the host nation legal and coroner process within the learning. Our training will have immediate benefit, allowing deployment immediately after the course is complete. Throughout our dealings with you, we will aim to;

- Have quality assured all deployments undertaken by students within families
- Dynamically adapted the training, based on the experiences of past students deployments
• Trained supervisors around the complexities of managing FLO’s and the peripheral actions arising from deploying FLO’s
• Trained several trainers to allow the host nation to own the training, move the tactic forward, train and develop local officers themselves.

Engaging with ChalMan Training will bring the host nation a new approach to victim engagement. Empowering Police Officers with the skills and confidence to provide a high-end service to victim’s families will not only ensure the integrity of the investigation but its use will also ensure that the citizens of the host nation get the highest quality of compassionate Policing.

Included below is a course timetable which gives an insight into what we are trying to achieve. It is a draft curriculum and will be adapted to reflect the needs of the host nation as well as the existing processes within the Coroner and Court structures.
## Day One

<table>
<thead>
<tr>
<th>Course Introduction</th>
<th>History of Family Liaison</th>
<th>Case Study - Sousse Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety Admin Introductions – Icebreaker Course overview</td>
<td>Provide an insight into the history around the development of Family Liaison in the UK. Discuss several case histories where the role of the FLO helped in providing significant impact to reputation of UK policing and CT Operations. Discuss how this role may impact in the region for future policing and public confidence.</td>
<td>Describe the incident of the 26th June 2016 Sousse - Tunisia Terror attack. Highlight how local practices can affect your response. Discuss issues arising out of this incident which impacted on family members and survivors. Illustrate issues that may affect those working/responding in...</td>
</tr>
</tbody>
</table>

### Active and Effective Listening

<table>
<thead>
<tr>
<th>Skills and attributes Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline the FBI behavioural change staircase. Identify what skills or attributes make a good listener. Explain the application of active listening techniques. Demonstrate the application of active listening.</td>
</tr>
<tr>
<td>Identify the necessary skills and attributes required to perform the role. Discuss significant skills and their impact in performing the role.</td>
</tr>
</tbody>
</table>
# Day Two

<table>
<thead>
<tr>
<th>First Contact &amp; Risk Assessment</th>
<th>Roles and Responsibilities</th>
<th>Family Liaison Strategy and Coordination.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the significance of a good first impression.</td>
<td>Discuss the roles and responsibilities of a FLO.</td>
<td>Define the Command and Control structure.</td>
</tr>
<tr>
<td>Identify signs and body language as a Threat</td>
<td>Outline the significant responsibilities</td>
<td>Outline the role of the Coordinator</td>
</tr>
<tr>
<td>Provide an awareness into dynamic risk assessment module.</td>
<td>Explain the chain of Command with the role.</td>
<td>Discuss the importance of a FLO strategy.</td>
</tr>
<tr>
<td>Outline what material may be searched when preparing a Risk assessment prior to deployment.</td>
<td></td>
<td>Prepare a draft FLO Strategy (FLC Course only)</td>
</tr>
<tr>
<td>Identify significant factors in preparing a Risk Assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of the Contact Officer</th>
<th>Delivering the difficult message</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain how the role developed within UK CT policing.</td>
<td>Discuss the significance of delivering bad news and its impact.</td>
<td></td>
</tr>
<tr>
<td>Identify the differing role when deployed as a Contact Officer.</td>
<td>Explain basis awareness around grief and associated behaviour can impact relationships.</td>
<td></td>
</tr>
<tr>
<td>Provide an insight into the challenges of Contact Officer deployment following WESTMINISTER Terror attack 2017. <strong>CASE STUDY</strong></td>
<td>Highlight “Red flags” Dos and don’ts both verbal and Non-Verbal.</td>
<td></td>
</tr>
<tr>
<td>Day Three</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coroners Expectations</strong></td>
<td><strong>Recording Contact Family Liaison Log</strong></td>
<td><strong>Family Tree and its significance</strong></td>
</tr>
<tr>
<td>Outline the roles and Responsibilities of Coroner.</td>
<td>Discuss the significance of accurate and timely information, which may be required for a legal or Coronial process.</td>
<td>Explain the significance of a family tree within a FLO deployment.</td>
</tr>
<tr>
<td>Discuss the impact of Coroners recommendations on the travel Industry.</td>
<td>Identify the various methods of collation of information.</td>
<td>Prepare a documented family Tree.</td>
</tr>
<tr>
<td>Highlight the importance of the disclosure process and your legal responsibilities.</td>
<td>Provide an awareness of how to record information which will stand up to scrutiny at a later date.</td>
<td></td>
</tr>
<tr>
<td><strong>Media and Social Media its Impact</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline the importance of a media strategy and discuss the impact of both media and social media on an incident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain the benefits of working with the Media.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discuss media intrusion and how best to deal with the issue’s families face.

Discover some examples from Case studies in the challenges faced in relation to social media.

Provide some tips and best practices when dealing with media and social media platforms.

| Day Four |
|-----------------------|-----------------------|-----------------------|
| **Working in Crisis with Partner Agencies.** | **Identifying and Managing Stress & Trauma** | **Hostage Taking Deployments** |
| Identify Interested parties who may be involved in a Crisis response. | Identify the sources of hazards and stress while deployed within a Crisis Incident. | Outline the Government policy for dealing with Hostage taking. |
| Discuss International Crisis response. | Discuss the signs and symptoms of Stress and Trauma. | Discuss the challenges faced within a hostage taking deployment. |
| Describe Local Crisis Response model. | Explore how to manage Stress, coping mechanisms and the shared responsibility for you and your colleagues | Provide an awareness of Hostage International. |
| Discuss how to manage Stress post incident within your organisation. | Provide an insight into the TRiM process. | |
| **Disaster Victim Recovery Identification** | **Case Study In–Amenas, Algeria** |  |
| Provide an awareness of the Interpol DVRI Process. | Provide an insight into the events surrounding the attack |  |
Outline the role of a FLO in the anti-mortem process.

Identify the various stages of the DVRI process.

Explain the Anti Mortem Form completion.

Complete a Yellow Anti Mortem document in relation to a Contact Officer deployment.

<table>
<thead>
<tr>
<th>Day Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of the Contact Officer</td>
</tr>
<tr>
<td>Explain how the role developed within UK CT policing.</td>
</tr>
<tr>
<td>Identify the differing role when deployed as a Contact Officer.</td>
</tr>
<tr>
<td>Provide an insight into the challenges of Contact Officer deployment following WESTMINISTER Terror Attack 2017.</td>
</tr>
<tr>
<td>CASE STUDY</td>
</tr>
<tr>
<td>Course Review &amp; Closure</td>
</tr>
</tbody>
</table>
Inventorying Alternatives to Enforcement Resources: Plan for Identification & Documentation of Public Safety & Public Health Services

The implementation of alternatives to traditional law enforcement responses is dependent on local resources that would make the strategy viable. Therefore, it is critical to know what resources currently exist (or could exist) within a community. It is also important to develop a comprehensive understanding of the demand for resources; it is possible that there is strong public demand for resources that do not exist. The analysis of 911 call for service data is a central part of understanding community demand for public safety and public health resources, and the associated response, but further contextual information is also needed. Inventorying public and community-based resource providers, cataloguing the types of services they provide, and understanding community needs they are encountering provides useful complimentary information. This plan describes the methods that will be used to accomplish the aforementioned tasks.

Data Collection Plan

Three methods would be employed to inventory existing public safety and public health resources in a community. The first data collection method would involve collating existing resource lists and conducting a structured internet scan to confirm that identified resources remain currently active. The structured internet scan would also identify the specific services and when and where they are available. The second method would involve communicating to the public through as many channels that are feasible to request that resources providers share information about any relevant services they offer. The third method would involve the fielding of a brief survey to the Fire, Police, and Emergency Management Services first responders to solicit information about resource providers that they commonly refer to or are aware of from their work.

Audience for Deliverables & Iterative Feedback Loop Process

There are three audiences for the inventory of public health and public safety resources: stakeholders in city government, first responders, and community members. The presentation of the inventory would need to be customized to each audience. Stakeholders in city government would benefit from having the inventory structured in a way that would allow them to assess if a potential alternative response strategy
could be feasible based on the resources available in their community. The first responder audience would be best served by organizing the inventory in a way that can be easily queried so they can match the needs of individuals they are responding to with the appropriate resource. For the inventory to be a trusted source of information the resources would need to be reviewed and updated on a continual basis. Finally, and importantly, the information in the inventory would need to be formatted in a way that it can be delivered and understood by members of the community.

Identifying Resource Gaps

The inventory would also serve city government stakeholders by identifying gaps where resource availability (either public or private) is not adequately meeting demand. Identifying gaps would be accomplished in three ways. The first is through a comparison of the resident-initiated 911 calls for service, which represents demand for public safety resources, with the resources and services identified in the inventory. The second component of the survey of first responders would collect information about what needs first responders are encountering where they perceive a lack of resources or availability to make a referral. Finally, the project team would conduct virtual groups with resource providers to understand the types of demand for the services they offer.

Improved Measurement of Alternative to Enforcement Referrals

To better document first responder referrals it will be necessary to increase the number close codes to align with the resources identified in the inventory. Doing so would facilitate future analysis and allow city government stakeholders to determine which alternative to enforcement resources (both public and private) are being relied upon in the community.
EXECUTIVE SUMMARY

RTI International conducted focus groups with patrol officers of varying ranks and levels of experience to better understand the types of calls for service (CFS) that officers handle. Specifically, officers were asked about the kinds of calls they feel could be more appropriately handled by other entities, or that they feel ill-equipped to respond to because of lack of training or the necessary support staff. Officers also provided insight into the acceptance of alternative models for response to crisis CFS. The main takeaways from these focus groups are as follows:

- Officers feel that they are the least equipped to respond to mental health or crisis-related calls. On-the-job experience is the best way to learn how to handle them.
- In general, officers do not see mental health-related CFS as calls that should be responded to solely by the police (or by the police at all, depending on the situation). When they do respond to these calls, they see value in having a mental health professional respond with them. They seem amenable to instituting co-responder programs.
- Officers are interested in having a law enforcement supervisor or retired officer in the dispatch role to determine which calls truly require a law enforcement response and which calls could be diverted to another public service group.
- Officers feel that the civil issues they respond to, especially truancy, child-parent disputes, and neighbor disputes, impede them from their actual duty of deterring crime and protecting Durham citizens.
- Officers highly encourage City Council members to do a ride-along in an active area during a busy time to better understand the issues that officers face daily and to foster collaboration for developing solutions to these issues.

This report describes the focus groups that were held with Durham police officers, along with more detail about these results and others.
INTRODUCTION

While analyzing quantitative calls-for-service (CFS) data allows for a demand-driven understanding of public safety resources (public calls to 911), understanding the experiences of officers responding to these calls is equally important for determining whether emergency CFS may be better served by alternatives to the traditional law enforcement response. Therefore, as a companion to the analysis of CFS data, focus groups were planned in agreement with Durham Police Department (DPD) to allow officers and first-line supervisors a forum to express their experiences and thoughts. The focus groups provided rich, qualitative data that will help researchers, police practitioners, and city government to identify (1) which types of CFS officers feel least-equipped and trained to handle; (2) what support, if any would make them feel more equipped to effectively respond; and (3) how much officers accept alternative models for response to crisis CFS. Together with the analysis of the CFS data, this approach will help city officials better align public resources with the needs expressed by each CFS and by local law enforcement officers.

FOCUS GROUP METHODOLOGY

Through the City of Durham, RTI established contacts with DPD command staff. In communications with them, we determined how the focus groups participants should be grouped, based on rank within the department, and agreed to include a diverse representation of officers. The groups were divided into corporals/sergeants, senior patrol officers, patrol officers, and recruits with four to six officers invited to each group. The command staff provided us with a list of officers from each group that would be able to participate along with their email addresses. We contacted each group of officers individually via email to establish a time for the focus groups, which lasted 90 minutes each and were conducted via Zoom. Each focus group included RTI project staff facilitators and a notetaker. The meetings were not recorded, and no identifying information was collected. In the beginning of each focus group, an RTI facilitator read an explanation of informed consent to the participants and asked them to verbally consent to participate in the conversation. Upon receiving consent from each participant, the facilitator would ask the group questions from a previously developed discussion guide (Appendix A). The focus groups were semistructured: the conversations followed mostly from the questions in this guide; however, the facilitator could ask additional questions to probe important topics raised. There was also time at the end of the meeting for the participants to ask questions about the project. The actual number of participants varied depending on availability. Table 1 details the number and experience level of participants in each group.
Table 1. Focus Group Participants

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Participants</th>
<th>Years of Service</th>
<th>Date of Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporals/sergeants</td>
<td>3</td>
<td>13-20</td>
<td>11/23/20</td>
</tr>
<tr>
<td>Senior patrol officers</td>
<td>1</td>
<td>5</td>
<td>12/10/20</td>
</tr>
<tr>
<td>Patrol officers</td>
<td>3</td>
<td>2+</td>
<td>11/18/20</td>
</tr>
<tr>
<td>Recruits</td>
<td>4</td>
<td>&lt;1 to 1</td>
<td>11/30/20</td>
</tr>
</tbody>
</table>

A master list of constructs for coding the focus group notes was developed. It covered topics addressed by specific questions in the focus group guide, as well as other key themes that were raised by participants. These constructs included CFS types, attitudes about alternative response to CFS, officer training and experience needs, and other emerging issues. The list of constructs and subconstructs was created before the interview notes were coded and included definitions where appropriate.¹ The qualitative data were then coded using NVivo 12.0. See Appendix B for a more detailed description and definitions for each construct and subconstruct.

RESULTS

This section describes key themes that emerged from participants’ comments in the focus group. These summaries represent pooled responses (comments from all four focus groups).

WITHIN THE SCOPE OF LAW ENFORCEMENT

Officers shared that most crisis response calls they respond to (estimates of up to 90%) are related to mental health. Many officers expressed that even though these calls are outside of skills taught to law enforcement, they still believe that they are the group that needs to respond because they perceive that the situations are highly unpredictable and sometimes dangerous. Officers also expressed that they genuinely want to see people who are suffering through their mental illness receive the help and support they need to thrive. To this end, officers are aware of several resources in the Durham area that they can leverage to help people who are in crisis, such as Duke Hospital, Durham Recovery, Extensions Inc., and the Mobile Crisis Response Team. However, knowledge of these resources is dependent on experience, with newer officers having less awareness. Officers voiced that these resources are helpful but expressed their frustration with limitations such as access issues. For example, these teams are not available during night shift when a large number of these types of calls are received, requiring emergency committals to aid people.

OFFICERS ALSO SHARED THEIR FRUSTRATION ABOUT RESPONDING TO CFS THAT THEY FELT WERE OUTSIDE OF THE SCOPE OF LAW ENFORCEMENT, SUCH AS THOSE THAT ARE CIVILIAN AND NONCRIMINAL IN NATURE. THESE CALLS REQUIRE VALUABLE TIME THAT THEY COULD BE USING TO PATROL NEIGHBORHOODS, AND THEY TAKE OFFICERS AWAY FROM ADDRESSING VIOLENT CRIME. SOME EXAMPLES OF CALLS FROM THE PUBLIC THAT OFFICERS FELT WERE OUTSIDE OF LAW ENFORCEMENT RESPONSIBILITY ARE TRUANCY CALLS, CHILD AND PARENT DISPUTES, ANIMAL CONTROL CALLS, AND CIVILIAN DISPUTES. ADDITIONALLY, OFFICERS NOTED THAT THEY SOMETIMES RECEIVE CALLS FROM PUBLIC AGENCIES ABOUT ISSUES THAT THE AGENCIES SHOULD BE ADDRESSING THEMSELVES, SUCH AS CALLS FROM THE LOCAL HEALTH DEPARTMENT ASKING WHETHER FACILITIES HAVE COVID-POSITIVE RESIDENTS, LOCAL HEALTH INSPECTORS REQUESTING OFFICERS TO CITE RESTAURANTS, AND EMERGENCY MEDICAL SERVICES REQUESTING THAT AN OFFICER FORCE ENTRY INTO A HOME.

USE OF FORCE

USE OF FORCE IS A MAJOR CONCERN FOR BOTH LAW ENFORCEMENT AND THE PUBLIC ON SCENE DURING A CFS RESPONSE. OFFICERS SHARED ANECDOTALLY THAT USE OF FORCE MOST OFTEN HAPPENS ON DOMESTIC ASSAULT OR VIOLENCE CALLS. A FEW OFFICERS ALSO MENTIONED THAT NOISE COMPLAINTS INVOLVING INTOXICATED PEOPLE HAVE RECENTLY REQUIRED THE USE OF FORCE. ONE OFFICER STATED,

“Anytime someone is taken into physical custody, the officer runs the risk of force occurring, but in the end it’s up to the person being arrested.”

Several officers referenced their Crisis Intervention Team (CIT) training as something that has increased their ability to de-escalate situations. They suggested that it needs to be part of the department’s mandated training.

ATTITUDES ABOUT ALTERNATIVE RESPONSE TO CFS

ALTERNATIVE CFS RESPONSE OPTIONS

A common recommendation throughout the focus groups was to have more support from the CIT, or “George Unit,” within the DPD. The officers felt that having more officers on the force overall would be beneficial, especially if they were trained to handle mental health calls and had the time that those types of calls require. A few officers also mentioned that they would like to receive the CIT training and be able to serve in both a crisis intervention and police officer capacity. There was general agreement that having more officers on patrol would benefit not only the police department, but also the community. Officers would have more time to spend on certain calls to be able to help solve the problem. Overall, they felt that a co-responder model would work well, but a social worker shouldn’t be sent into dangerous situations alone. An officer would still need to be present in case the situation turned dangerous. The officer could assess the situation before turning it over to the social worker, and then remain on standby.
To help reduce the number of calls officers must respond to, but are unable to actually resolve, officers suggested placing a department supervisor on dispatch to be able to make decisions about which CFS patrol will actually respond to. The supervisor could speak with the person on the telephone and determine whether police are actually needed for that situation, such as a property dispute or a child not wanting to go to school. Alternative, more beneficial resources could be recommended to the person by phone rather than by sending patrol.

**INCREASED FEEDBACK ON CFS FOLLOW UP**

Officers stated that it would be helpful if they could receive more follow-up from CIT and other services regarding the cases that they refer to them. Sometimes an officer will call CIT or another service to check in on a person who frequently calls 911 for mental health reasons and the officer will not hear what has been done for that person. If the officer is then called back to that same person in crisis, they will not be aware of what was previously provided to them. Participants suggested having at least one CIT officer per district that works the same hours as patrol so that they are always on call and can respond to the situation as it’s happening (as opposed to the next morning).

**OFFICER TRAINING AND EXPERIENCE NEEDS**

Officer training needs and experience levels came up during the focus groups as two major factors that determine how officers respond to a call and the outcome of the call. Mental health calls were classified as the most difficult calls to handle, with most officers saying that the experience they gained on the job was the only thing that helped them feel comfortable responding to them. One officer stated,

“One can’t expect every person to be the best mental health crisis responder, and the person kicking down the door, and [the person carrying out] several other police responsibilities, all at the same time. It takes so many different facets of personality, training, and abilities to respond to these calls that one person can’t be all of those people.”

**TRAINING NEEDS**

Overall, officers believed that the Durham Police Training Academy does a good job of training patrol officers on CIT techniques and on ways to de-escalate situations involving a mental health crisis. Many officers said that scenario-based trainings are helpful, but they have their limitations because every real-life scenario is highly unpredictable. Most officers stated that they would like to have more opportunities for training regarding mental health and CIT trainings, which have been on hold because of COVID-19. Only one officer also suggested that the academy would benefit from more regular, long-term physical combative and weapons training.
EXPERIENCE IN THE FIELD

Despite everything that recruits learn in the academy, most officers agree that the only way to truly recognize and respond properly to a crisis or mental health-related call is through on-the-job experience. One officer stated,

“Any situation can turn into a dangerous or scary situation at any moment. You can’t really train for that unless you’ve been on the street interacting with the community—the best way to do it is to practice it. I’m not sure you can ever train someone to handle a person going through a crisis without doing it.”

More experienced officers fear that the younger recruits may struggle with responding to these types of calls and may be more prone to using force because they are overwhelmed.

OTHER EMERGING ISSUES

During the focus groups, several other issues emerged that were not originally included in this study’s scope but that need to be acknowledged as either underlying factors or outcomes of the issues previously discussed. These emerging issues included lack of context before arriving on scene, lack of time permitted on scene, community perceptions, and suggestions for City Council.

LACK OF CONTEXT BEFORE ARRIVING ON SCENE

Several officers mentioned that they never really know what kind of situation they are responding to when they are responding to a CFS, because the 911 dispatcher often does not have the full picture from the caller to provide an accurate description to the officer. One officer expressed,

“Dispatchers don’t get the whole picture, either, so can’t hand the whole picture on to patrol—for instance, one of these situations may actually be a domestic call, disguised over the phone because someone [the aggressor] is listening.”

The lack of detail on a call can lead to officers’ having their guard up and being overly cautious when responding to a citizen CFS. This approach can affect their tone and body language, and then the citizen may perceive them as short-tempered or disengaged. This negative interaction could cause the situation to escalate and, in the long term, degrade the officer’s relationship with the community.
COMMUNITY PERCEPTIONS

Throughout the focus groups, officers shared what effect they believe community perceptions can have on their response to CFS and on their interactions with citizens. One officer expressed their frustration by stating,

“The biggest misconception that I’m dealing with right now is that law enforcement is the only entity involved with stopping the rise of violent crime. Police are one cog in the machine. Granted, they are the public face of the judicial branch – they are the team that people see out enforcing the law. However, they have orders; they have memos; and they have directives that dictate what they should and should not do. They are also tasked with making good, solid arrests, that for a slew of reasons get dismissed, and then, the public holds police officers responsible, when by all accounts they have done their job. In these cases, the public does not understand that the officers’ arrests were made in good faith and that there are a lot of other entities involved besides law enforcement.”

Other common misconceptions that officers mentioned included that the public thinks that if an officer arrives on scene, there will always be an arrest regardless of the situation, that police can show up almost immediately after a call is initiated (i.e., not understanding that patrol officers are very spread out in each district), and that response by multiple officers is a bad sign or overwhelming when it could be that an officer is there just for training or support. Another main concern among officers is that when an officer makes a mistake, that mistake is shown and promoted through the media to the exclusion of any good that the police do as a whole entity.
SUGGESTIONS FOR CITY COUNCIL

The main suggestion that the officers had for Durham City Council was for each member of the council to take part in a ride-along with an officer during the night shift and in the areas where they receive the most calls. Officers believe that this will be the best way for members of City Council to understand what patrol officers deal with on a regular basis and gain insight into their decision-making process on scene. During a ride-along, officers would like to ask council members questions like, “How would you suggest handling this call?” so they can gain the same insight into the council members’ decision-making process. The goal of these ride-alongs would be for both groups to create a shared understanding to improve public safety programming for the citizens of Durham.

Furthermore, officers recommended that City Council engage in efforts to communicate the role of the police department to the public. Specifically, more education is needed about the appropriate use of 911 and alternative resources for non-emergencies, including the department’s non-emergency line and other agencies that support the public.

INTERVIEW WITH DPD CLINICIAN

We also interviewed a licensed clinical social worker housed within the DPD. The clinician was asked about their role, how they interact with officers on calls, and what general feedback they have on their time with the department.

ROLES AND RESPONSIBILITIES

Before COVID-19, the process for the clinician to respond to CFS would be that an officer would respond to the call, file a report, and send that report to the CIT unit, where the corporal of that unit would decide who gets what cases. If that case was assigned to the clinician, they would then triage with the officer and talk to the person about their situation and what services can be provided through the department, the community, or both. The clinician would occasionally start brief counseling sessions with the person until they could be connected with a long-term counselor. The clinician stated that they are often assigned “frequent flier” cases of people with severe and persistent mental illness and that they will often redirect certain calls from 911 to their own phone. They will also respond to some live calls from people in crisis that come in while they are working. In those cases, when possible, they will ride out with an officer in the same car. The clinician keeps up with all contacts made with people, in addition to the records that DPD keeps.
WHAT WORKS AND WHAT COULD CHANGE

For certain calls, especially the ones from frequent fliers, the clinician feels that it would be helpful to have documentation that this person has a mental illness and they repeatedly call 911. In those cases, the clinician or another member of the CIT could respond directly instead of having a patrol officer spend hours on a scene that they might not be best equipped to handle. The clinician understands the difference between calls that can be addressed by a clinician alone and those that police need to be involved in. However, the clinician and CIT officers are not available 24 hours a day, so they often have to follow up on calls that took place the previous night or a few days ago. The clinician mentioned a time that they followed up on a report assigned to them and the person did not remember why they had called 911 or what had happened.

The clinician stated that a significant amount of the reports that are later assigned to them for follow-up were first classified as something other than a mental health call (e.g., disturbance, theft, break-in). The responding officers realized that there was no sign of any disturbance having taken place, but instead that the person was experiencing a mental health crisis. Because dispatch categorized the call as a disturbance, theft, break-in, etc., the percentage of mental health-related CFS in the data is smaller than what DPD is actually seeing. A better representation of how many mental health-related calls patrol officers and CIT or the clinician respond to would require a change in the way calls are categorized at the time of intake. If someone in dispatch could recognize the signs of a mental health call and categorize it properly, then CIT could be contacted and sent out immediately to help, instead of patrol responding alone to what they believe is a disturbance but is actually someone in crisis.

CONCLUSION AND RECOMMENDATIONS

Overall, officers expressed a sincere desire to help those in the community with mental health issues. However, they also shared multiple barriers to being able to help effectively, including lack of training, lack of time on calls to respond effectively, and limited information provided at dispatch and after an incident. These focus groups brought to light multiple opportunities for improving officers’ ability to effectively handle these calls and improving service for community members struggling with mental health issues:

• Incorporating CIT training in the department’s mandated trainings so every officer learns these skills
• Placing a police supervisor on dispatch to make appropriate decisions about which CFS should result in dispatch of a patrol officer
• Providing more follow-up to officers from CIT and other service providers on the cases referred to them
• Providing more support to less experienced officers when they respond to mental health-related calls, as they may feel overwhelmed in these situations and therefore be more likely to use force
• City Council members going on ride-alongs with officers in high-activity areas during night shift to create a shared understanding of issues and opportunities for collaboration to improve response
• City Council educating the public on the role of law enforcement and the appropriate use of 911
• Training dispatchers to recognize signs of a mental health call and how to categorize in order to identify when CIT should be involved
• Staffing CIT officers and a clinician 24 hours a day so that they can respond to mental health cases immediately
APPENDIX A: DURHAM POLICE DEPARTMENT FOCUS GROUP PROTOCOL

FOCUS GROUP PURPOSE & GOALS

The overarching purpose of this project is to work with city management in a cohort of cities across the Carolinas to analyze their calls for service data to determine the nature of demand for public safety resources, how public safety resources are deployed to respond to this demand, and whether the responses are aligned with community need. Based on this analysis, these jurisdictions will implement evidence-based alternative responses for specific types of calls for service that are suitable for a non-law enforcement response. RTI will then work with each jurisdiction to test and evaluate the impact of the alternative response strategies on key outcomes including arrests, citations, and use of force.²

In addition to the quantitative analysis of call for service data the project team is proposing a series of focus groups with line officers and first line supervisors to learn more about challenges they face when responding to calls for service that are crisis response or non-violent in nature. The proposed focus groups would be presented as an option for any of the cohort cities that are interested in pursuing that line of research. The main research question that the project team is seeking to answer is understanding the types and nature of calls for service that officers feel ill equipped to respond to due to lack of specific training or a need for additional support staff. Additionally, the experience of these officers can also provide insight into the acceptance of alternative models for response to crisis calls for service.

FOCUS GROUP LOGISTICS

The project team has established points of contact within the Durham and Greensboro Police Department. The points of contact will help to facilitate the focus groups by identifying a convenience sample of participants that reflect a diversity of experience, geographic deployment, and unit affiliation within the patrol divisions of each respective agency.

- Three focus groups for each of the patrol officer-level positions and one focus group of patrol first line supervisors will be conducted.
- Each focus group will be conducted virtually via Zoom and will be scheduled for 90 minutes.
- Each focus group will consist of four to six officers, depending on availability.

² Crisis Assistance Helping Out on The Streets, Eugene, Oregon.
• All focus group participants will be of like-rank.
• The focus groups will be facilitated by RTI project staff and will include a facilitator and note-taker. The sessions will not be recorded and identifying information will not be collected.
• Further information about confidentiality and data collection are addressed in the informed consent subsection.

COMMUNICATION PLAN AND REPORTING

The project team will provide City Management in Durham and Greensboro with weekly progress status updates via e-mail. The status updates will include progress to date, the number of focus groups conducted, deidentified information about the participants, and raise any questions that should be addressed by the broader working group. At the conclusion of the focus groups the qualitative data will be transferred to an Analyst that will systematically code the data using NVIVO, a qualitative coding software. The coding themes will then be summarized into a short report that will be made available to City leadership and the DPD and GPD Executive Staff.

INFORMED CONSENT

Today’s focus group is part of a broader project focused on understanding with emergency calls for service that may be better served with alternatives to a traditional law enforcement response. Information from this focus group will be used to help researchers and police practitioners understand (1) which types of calls officers feel least-equipped and undertrained when responding, and (2) what support, if any would make you feel equipped to effectively respond.

There are no right or wrong answers to the questions I will be asking. We just want to hear your perspectives on these topics. Our discussion will last no more than 90 minutes. Your participation today is voluntary. We believe that the information you provide today is critically important. However, some of this discussion may cause you to recall difficult or anxiety-provoking memories related to your experience working law enforcement. You do not have to answer any of the questions asked, and you may stop participating in this focus group at any time.

We will not be recording this session. We want to give you our full attention and be able to understand your ideas and opinions so we’ll be having a colleague taking notes. No one except project staff will see these notes. The notes will be used to document key ideas, themes, and suggestions from the sessions. Once the key ideas and themes have been written up, the transcript will be permanently deleted. No identifying information, including your names, will be included in the write-ups of key ideas, themes, and suggestions.
The summaries of ideas from the sessions will be housed on our secure project share drive and used only for the purposes of report development and refinement. Again, the report that will be developed from this focus group will contain no identifying information and only present themes in summary form and in aggregate.

To protect one another’s privacy and encourage open discussion, I ask that you not repeat any of what you hear today. If you have any questions about this project, or any of the information that has just been communicated to you please contact Brian Aagaard (baagaard@rti.org, 919-815-8321).

I need to ask you formally: Do you consent to participate in this conversation: Yes    No

FOCUS GROUP DISCUSSION GUIDE

• What are the types and nature of calls for service that you, as officers feel least equipped and least trained to respond to?

• What alternatives to enforcement strategies are officers already using, or are aware of?

• What resources exist within the communities (both public and non-public) that could assist in alternative responses?

• For calls where officers feel under-equipped and under-trained what resources, training, information (especially from the emergency communicators), or policies would allow them to better resolve the call for service?

• Are there calls for service that officers routinely respond to that do not require a law enforcement response, specifically for non-criminal calls or calls associated with crimes of despair?

• What is the most misunderstood aspect of law enforcement work, especially as it relates to responding to citizen-initiated calls for service?

• Can you reflect on whether you think implicit bias has an impact in the way that calls for service are handled, either at the individual level or organizationally?
## APPENDIX B: CONSTRUCT AND SUBCONSTRUCT DESCRIPTION FOR QUALITATIVE ANALYSIS

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Description</th>
<th>Number of References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calls for Service (CFS) Type</strong></td>
<td>Types of CFS that come into Durham Police Department that could fall within or outside the scope of law enforcement responsibilities</td>
<td>54</td>
</tr>
<tr>
<td>I. General</td>
<td>Context for CFS</td>
<td>5</td>
</tr>
<tr>
<td>II. Outside LE Scope</td>
<td>CFS that fall outside the scope of law enforcement responsibilities</td>
<td>23</td>
</tr>
<tr>
<td>i. General</td>
<td>Context for CFS that fall outside the scope of law enforcement responsibilities</td>
<td>14</td>
</tr>
<tr>
<td>ii. Types of Calls</td>
<td>Examples of CFS that fall outside the scope of law enforcement responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>III. Within LE Scope</td>
<td>CFS that fall within the scope of law enforcement responsibilities</td>
<td>44</td>
</tr>
<tr>
<td>i. General</td>
<td>Context for CFS that fall within the scope of law enforcement responsibilities</td>
<td>8</td>
</tr>
<tr>
<td>ii. Successes</td>
<td>Examples of factors that allow officers to respond to CFS properly</td>
<td>11</td>
</tr>
<tr>
<td>iii. Challenges</td>
<td>Examples of factors that can prevent officers from responding to CFS properly, like resources being unavailable to assist a person in crisis (e.g., offices closed depending on time of day, shelters full)</td>
<td>7</td>
</tr>
<tr>
<td>iv. Use of Force</td>
<td>Examples of CFS within the scope of law enforcement responsibilities that could/have led to use of force</td>
<td>18</td>
</tr>
<tr>
<td><strong>Potential Solutions for Improving CFS Response</strong></td>
<td>Examples of potential solutions for improving CFS response</td>
<td>54</td>
</tr>
<tr>
<td>I. General</td>
<td>Context for potential solutions for improving CFS response</td>
<td>14</td>
</tr>
<tr>
<td>II. Alternative CFS CFS Response Options</td>
<td>Examples of alternative CFS response options</td>
<td>40</td>
</tr>
<tr>
<td>i. General</td>
<td>Context for alternative CFS response options</td>
<td>18</td>
</tr>
<tr>
<td>ii. Challenges</td>
<td>Examples of things that could impact alternative CFS response options</td>
<td>20</td>
</tr>
<tr>
<td>iii. Benefits</td>
<td>Examples of things that could facilitate alternative CFS response options</td>
<td>2</td>
</tr>
<tr>
<td>III. Increased Feedback on CFS Follow-up</td>
<td>Context for officer’s desire for increased feedback on CFS follow-up</td>
<td>3</td>
</tr>
<tr>
<td><strong>Officer Training &amp; Experience Needs</strong></td>
<td>Examples of the impact of officer training and experience, or lack thereof, on CFS response</td>
<td>30</td>
</tr>
<tr>
<td>I. General</td>
<td>Context for the impact of officer training and experience on CFS response and needs for improving both</td>
<td>9</td>
</tr>
<tr>
<td>II. Training Needs</td>
<td>Examples of training needs for improving CFS response</td>
<td>10</td>
</tr>
<tr>
<td>III. On-the-Job Experience</td>
<td>Examples of the impact of officer training and experience, or lack thereof, on CFS response</td>
<td>11</td>
</tr>
<tr>
<td>Nodes</td>
<td>Description</td>
<td>Number of References</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Other Emerging Issues</td>
<td>Examples of other issues that impact CFS response and community relations</td>
<td>54</td>
</tr>
<tr>
<td>I. General</td>
<td>Context for other issues that impact CFS response and community relations</td>
<td>6</td>
</tr>
<tr>
<td>II. Lack of Context Before Arriving on Scene</td>
<td>Examples of the impact of receiving a lack of context before arriving on scene by dispatcher on CFS response</td>
<td>4</td>
</tr>
<tr>
<td>III. Lack of Time on Scene</td>
<td>Examples of how lack of time officers are given to stay on a scene and the lack of staffing on CFS response</td>
<td>14</td>
</tr>
<tr>
<td>IV. Community Perceptions</td>
<td>Examples of community perceptions on CFS response</td>
<td>25</td>
</tr>
<tr>
<td>V. Suggestions for City Council</td>
<td>Examples of suggestions officers have for City Council gaining a better understanding of police-community issues</td>
<td>5</td>
</tr>
</tbody>
</table>
Summary of Use of Force by the Durham Police Department

RTI International examined the 911 calls-for-service data from Durham, NC, and analyzed important call outcomes (like arrest, a police report). Police use of force is documented not in calls-for-service data but in a separate database (IAPro BlueTeam). The following non-identifiable information from BlueTeam and documentation regarding reporting on use of force was supplied to RTI in a data set and overview from the department’s Analytical Services Division:

For the requested time period (October 29, 2017, to October 29, 2020), 213 types of force were used in connection with 174 calls for service:

- In 141 calls for service, one type of force was used by one officer.
- In 33 calls for service, one or more types of force were used by one or more officers.
- There was one use of force for which no call-for-service information was located.
- There was one use of force for which the disposition is still pending.
- After all edits and redactions, the following data fields remain:

  - IA Random (UoF) – A four-digit, randomly generated number to replace the true IA Number
  - Incident Type (UoF) – This is universally ‘Use of force’ for all the rows in the data set
  - Force Used (UoF) – The types of force used by the officers involved in the incident
  - Force Seq (UoF) – An artificial number to identify specific information related to the incident (not the order in which types of force were applied)
  - Force Cnt (UoF) – An artificial number to identify the total types of force applied by the officers involved in the incident
  - Disposition (UoF) – The outcome of the use of force investigation; one from 2020 appears to still be pending
  - Year (CAD) – The year in which the call for service occurred
  - Call Source (CAD) – The source of the call for service
  - Nature (CAD) – The nature of the call for service
  - Patrol Beat (CAD) – The location of the call of service
  - Close Code (CAD) – The disposition of the call for service
Durham Police Department General Order 4008 R-17

General Order 4008 R-17 outlines the situations in which the Durham Police Department documents use of force:

<table>
<thead>
<tr>
<th>When a Use of Force Report is NOT Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although the circumstances will be documented in the Incident Report (IR), a separate Use of Force Report is not required in the following circumstances:</td>
</tr>
<tr>
<td>- Use of non-physical force and no injury to citizen;</td>
</tr>
<tr>
<td>- Use of soft empty hand techniques or leverage weapon techniques with no apparent injury to the citizen, unless the citizen claims injury;</td>
</tr>
<tr>
<td>- When an individual is injured due to his/her own actions absent any physical contact or intervention from an officer; however, officers must notify their supervisor of the injury and the circumstances in an incident report. Supervisors will complete an Injury to Citizens Report utilizing the Blue Team software and submit the same to the Professional Standards Division (PSD) for review.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When a Use of Force Report IS Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unless otherwise specified by department policy, officers will immediately notify the district or duty supervisor and a Use of Force Report will be submitted whenever an officer:</td>
</tr>
<tr>
<td>- Uses any force that results in an injury;</td>
</tr>
<tr>
<td>- Uses physical force (other than soft empty hand techniques or leverage weapon techniques), a lethal or less-than-lethal weapon;</td>
</tr>
<tr>
<td>- Has an assigned police canine bite an individual; or</td>
</tr>
<tr>
<td>- Intentionally discharges a firearm on- or off-duty, regardless of whether it results in injury, and for reasons other than training, approved departmental programs or circumstances covered in G.O. 4009 – Firearms &amp; Conducted Electrical Weapons Discharge Reports.</td>
</tr>
<tr>
<td>- Utilizes deadly force through the use of a motor vehicle to engage in a legal intervention to stop a vehicle in accordance with G.O. 4019 – Vehicle Pursuits.</td>
</tr>
</tbody>
</table>

Statistics on Durham Police Department’s Use of Force in the Study Period

From October 29, 2017, to October 29, 2020, there were 948,201 calls for service in Durham, of which 174 resulted in the use of force (0.018% of calls). Of these calls, 480,690 were initiated by a citizen and 467,487 were initiated by an officer (data was missing for 24 calls). Sixty of the officer-initiated calls resulted in the use of force (0.012%), as did 114 of the publicly initiated calls (0.024%).

Table 1: Count of Use of Force by Call Nature

<table>
<thead>
<tr>
<th>Call Nature</th>
<th>Analysis Nature Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>Domestic/family</td>
<td>18</td>
</tr>
<tr>
<td>Disturbance</td>
<td>Disturbance</td>
<td>14</td>
</tr>
<tr>
<td>Trespass or unwanted</td>
<td>Quality of life</td>
<td>11</td>
</tr>
<tr>
<td>Vehicle stop</td>
<td>Proactive policing</td>
<td>10</td>
</tr>
<tr>
<td>Call Nature</td>
<td>Analysis Nature Group</td>
<td>Count</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Foot pursuit</td>
<td>In-progress other</td>
<td>8</td>
</tr>
<tr>
<td>Physical domestic disturbance</td>
<td>Domestic/family</td>
<td>6</td>
</tr>
<tr>
<td>Unknown problem police</td>
<td>In-progress other</td>
<td>6</td>
</tr>
<tr>
<td>Fight</td>
<td>Disturbance</td>
<td>5</td>
</tr>
<tr>
<td>Mental disorder</td>
<td>Mental health</td>
<td>4</td>
</tr>
<tr>
<td>Attempt to locate</td>
<td>General assistance</td>
<td>4</td>
</tr>
<tr>
<td>Domestic with a weapon</td>
<td>Domestic/family</td>
<td>4</td>
</tr>
<tr>
<td>Intoxicated person</td>
<td>Quality of life</td>
<td>4</td>
</tr>
<tr>
<td>Physical disturbance</td>
<td>Disturbance</td>
<td>4</td>
</tr>
<tr>
<td>Suspicious person</td>
<td>In-progress other</td>
<td>4</td>
</tr>
<tr>
<td>Wanted person</td>
<td>Warrant service</td>
<td>4</td>
</tr>
<tr>
<td>Traffic incident</td>
<td>Traffic related</td>
<td>3</td>
</tr>
<tr>
<td>Assault</td>
<td>All other violent</td>
<td>3</td>
</tr>
<tr>
<td>Assist other agency</td>
<td>General assistance</td>
<td>3</td>
</tr>
<tr>
<td>Larceny</td>
<td>All other property</td>
<td>3</td>
</tr>
<tr>
<td>Theft or larceny</td>
<td>All other property</td>
<td>3</td>
</tr>
<tr>
<td>Assist EMS</td>
<td>Medical fire assist</td>
<td>2</td>
</tr>
<tr>
<td>Assist person</td>
<td>General assistance</td>
<td>2</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>Mental health</td>
<td>2</td>
</tr>
<tr>
<td>Drugs</td>
<td>Quality of life</td>
<td>2</td>
</tr>
<tr>
<td>Follow up</td>
<td>General assistance</td>
<td>2</td>
</tr>
<tr>
<td>Involuntary commitment</td>
<td>Mental health</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Physical domestic dist—weapon</td>
<td>Domestic/family</td>
<td>2</td>
</tr>
<tr>
<td>Sound of shots</td>
<td>Quality of life</td>
<td>2</td>
</tr>
<tr>
<td>Suspicious circumstances</td>
<td>In-progress other</td>
<td>2</td>
</tr>
<tr>
<td>Suspicious person with weapon</td>
<td>In-progress other</td>
<td>2</td>
</tr>
<tr>
<td>Threats</td>
<td>All other violent</td>
<td>2</td>
</tr>
<tr>
<td>Verbal domestic disturbance</td>
<td>Domestic/family</td>
<td>2</td>
</tr>
<tr>
<td>Welfare check</td>
<td>Quality of life</td>
<td>2</td>
</tr>
<tr>
<td>Armed robbery</td>
<td>In-progress violent</td>
<td>1</td>
</tr>
<tr>
<td>Break-in in progress</td>
<td>All other property</td>
<td>1</td>
</tr>
<tr>
<td>Break-in vehicle</td>
<td>All other property</td>
<td>1</td>
</tr>
<tr>
<td>Crisis</td>
<td>Mental health</td>
<td>1</td>
</tr>
<tr>
<td>Damage to property</td>
<td>All other property</td>
<td>1</td>
</tr>
<tr>
<td>Disturbance with weapon</td>
<td>Disturbance</td>
<td>1</td>
</tr>
<tr>
<td>Drug sale</td>
<td>Quality of life</td>
<td>1</td>
</tr>
<tr>
<td>Drug use or possession</td>
<td>Quality of life</td>
<td>1</td>
</tr>
<tr>
<td>Foot patrol</td>
<td>Directed patrol</td>
<td>1</td>
</tr>
<tr>
<td>Hang-up</td>
<td>General assistance</td>
<td>1</td>
</tr>
<tr>
<td>Intoxicated driver</td>
<td>Traffic related</td>
<td>1</td>
</tr>
<tr>
<td>Call Nature</td>
<td>Analysis Nature Group</td>
<td>Count</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Larceny of vehicle</td>
<td>All other property</td>
<td>1</td>
</tr>
<tr>
<td>Motor vehicle collision fire</td>
<td>Traffic related</td>
<td>1</td>
</tr>
<tr>
<td>Officer needs assistance</td>
<td>In-progress other</td>
<td>1</td>
</tr>
<tr>
<td>Overdose or poisoning</td>
<td>In-progress other</td>
<td>1</td>
</tr>
<tr>
<td>Protest</td>
<td>General assistance</td>
<td>1</td>
</tr>
<tr>
<td>Residential B&amp;E IP</td>
<td>All other property</td>
<td>1</td>
</tr>
<tr>
<td>Stalking</td>
<td>All other violent</td>
<td>1</td>
</tr>
<tr>
<td>Suicide threat</td>
<td>Mental health</td>
<td>1</td>
</tr>
<tr>
<td>Suspicious activity</td>
<td>In-progress other</td>
<td>1</td>
</tr>
<tr>
<td>Suspicious vehicle</td>
<td>In-progress other</td>
<td>1</td>
</tr>
<tr>
<td>Unknown problem EMS</td>
<td>Medical fire assist</td>
<td>1</td>
</tr>
<tr>
<td>Verbal domestic dist—weapon</td>
<td>Domestic/family</td>
<td>1</td>
</tr>
<tr>
<td>Verbal family disturbance</td>
<td>Domestic/family</td>
<td>1</td>
</tr>
<tr>
<td>Warrant or subpoena service</td>
<td>Warrant service</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>174</strong></td>
</tr>
</tbody>
</table>

Table 2: Count of Use of Force by Use of Force Type

<table>
<thead>
<tr>
<th>Type of Force</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft hands (w/injury)</td>
<td>83</td>
</tr>
<tr>
<td>Hard empty hands</td>
<td>28</td>
</tr>
<tr>
<td>TASER (CEW)</td>
<td>21</td>
</tr>
<tr>
<td>Aerosol weapon</td>
<td>19</td>
</tr>
<tr>
<td>Other (explain in narr)</td>
<td>15</td>
</tr>
<tr>
<td>Canine</td>
<td>2</td>
</tr>
<tr>
<td>Firearm</td>
<td>2</td>
</tr>
<tr>
<td>Stun/distract technique</td>
<td>2</td>
</tr>
<tr>
<td>Canine—bite</td>
<td>1</td>
</tr>
<tr>
<td>Impact weapon</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>174</strong></td>
</tr>
</tbody>
</table>
Calls for Service Research: Understanding Alternative Responses

February 26, 2021
Project Work to Date

• Phase I: Collect and analyze Durham’s 911 LEA call for service data
  • Call for Service Short Report
  • Call for Service Long Report
  • Call for Service Short Report by Call Initiation (public versus police-initiated)
  • Use of Force Analysis and Report
• Phase II: Scan literature and field of practice to identify alternative response strategies
  • Two Alternative Response Overviews
  • Alternative Response Technical Summaries
• Other project activities
  • Focus Group Report & Clinician Interview
  • Inventorying of Resources Plan
  • Defining, Identifying, Documenting Mental Health CFS Pilot Proposal
Response Strategy Considerations:

1. Reduce police-public contact and pair the appropriate response resource with community need.
2. Be operationally and fiscally efficient.
3. Meet community expectations for how 911 calls are responded to and resolved.
4. Meet the legal requirements of state statutes.
5. Maintain or promote public safety.
Calls for Service Research

- Residents have relied on the police for many of the same issues for over five decades
- Much of the research is focused on interventions rather than about the nature of the call
- Solutions are too often implemented without sufficient resources and plans for sustainability and data can be narrowly assessed
Who Calls 911 and Why?

- Most police calls tend to come from socioeconomic disadvantaged areas
- Majority of calls are for assistance (support), nuisance abatement, traffic problems, or the regulation of interpersonal disputes
- Only 20 percent of calls involve violent or property crime
Where do 911 calls concentrate?: Use of City Services Concentrate Among People, Places, and Property

- The law of crime concentration has demonstrated that typically, 5% of a city’s street segments will generate 50% of a city’s calls for service.
- The top ten percent of repeat offenders generally account for nearly two-thirds of the offenses.
- One thousand people, within one percent of City of Camden’s (NJ) medical facilities, generated 30 percent of its cost.
- Depression and PTSD concentrate in high crime and call for service areas.
How are 911 calls resolved?

- Most calls do not result in arrest
- Most calls require the officer to perform some type of support role involving consensual resolution
- Officers work within the structural and organizational restraints imposed by the law and their organizations but mostly work to resolve issues without resorting to enforcing the law
  • The biggest challenge to mental health partnerships is that most police agencies do not have a method for labeling or coding calls involving an individual with a mental health disorder.

• Boston Co-responder Program
  • Mental Health Call supposed to be labeled as “Emotionally Disturbed Person” (EDP)
  • No way to track calls if the primary nature of the call is not EDP
  • Result is that unknown number of mental health calls are going unreported

• If mental health is not the primary issue, then this data is often not captured in the CAD system
RTI Conducted focus groups with members of the Durham Police Department:

- Overview of key findings
- Putting quantitative analysis into context
- Helping to fill gaps from quantitative analysis
Defining and Identifying Mental Health CFS

There are two approaches for better measuring the proportion of calls related to mental health:

- Retrospectively review the unstructured text in the 911 call notes field to identify calls involving a person experiencing mental health symptoms.

- **Potential pilot**: modify existing practices to implement the CAD technology in a way that allows for the better capture and documentation.

**Analytical Insight:** Only 2% of calls initiated by the public have a mental health component. The nature of how CAD data are organized and the focus group data suggests that this is a substantial undercount for calls related to individuals experiencing mental health issues.
Overview: There is no one-size-fits-all approach to implementing alternative responses that exist in other jurisdictions.

Purpose: The purpose of a customized approach is to tailor an alternative response (that was developed to meet the specific needs of another jurisdiction) to meet local needs.

Call Natures Appropriate for Alternative Response: Flexible and dependent on outcomes of interest.
Alternative Strategies: CAHOOTS

Overview: A program that pairs crisis workers—clinicians or social workers—with emergency medical services (EMS) workers to respond to people experiencing mental health crises.

Purpose: 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.

Call Natures Appropriate for Alternative Response: The CAHOOTS team handles conflict resolution, welfare checks, substance abuse, suicide threats, wound care, transportation and other mental health-related calls.

Analytical Insight: Only 2% of Intoxicated Person calls and 4% of Welfare Checks result in an incident report, suggesting that individuals on these types of calls may require services other than LEA resources.
Overview: 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.

Purpose: To reduce the use of EMS by high-frequency users by engaging them in long-term solutions that addressed their primary need.

Analytical Insight: DPD responded to 10,178 assist Fire and assist EMS calls during the study period, representing 2% of calls not initiated by officers.

Call Natures Appropriate for Alternative Response: Non-law Enforcement EMS calls and attempt to decrease future reliance on 911
Overview: A component of LAPD’s SMART initiative, the intent of this intervention to focus on high-risk individuals and link them to mental health services before an untreated mental health issue escalated.

Purpose: The purpose of this intervention was to prevent incidents where LAPD officers used force on people experiencing mental health issues.

Call Natures Appropriate for Alternative Response: Attempts to decrease future reliance on 911.

Analytical Insight: Focus group participants uniformly reported engaging in repeated contacts with familiar faces while responding to an array of calls.
Alternative Strategies: LEAD

Overview: The purpose of a LEAD program is to decrease recidivism for low-level offenses and increase wellness for individuals.

Purpose: The major aim is to prevent criminalization of those with behavioral health problems and reduce spending for the criminal justice system in the process.

Analytical Insight: Focus group participants began the process of inventorying public and private resources to refer individuals in need. More information about that inventory is provided later.

Call Natures Appropriate for Alternative Response: Acute mental health calls and attempt to decrease future reliance on 911.
Overview: 40-hour training developed with the National Alliance on Mental Illness and community providers to help officers understand different types of mental illnesses.

Purpose: The goal of this intervention is to divert to appropriate social services while reducing injury to both officers and citizens, use of force, and arrests.

Call Natures Appropriate for Alternative Response: Acute mental health calls and attempt to decrease future reliance on 911.

Analytical Insight: Just over half (50.3%) of all calls referred to CIT in Durham were not related to the mental health call nature (and over a quarter were related to a disturbance, domestic/family call, or general assistance).
Alternative Strategies: Co-responder Model

**Overview:** Pairs police officers with civilians who are mental health clinicians or social workers. Police officer provides safety assessment; civilian performs mental health assessment.

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

**Call Natures Appropriate for Alternative Response:** Co-responders are responding on-scene via 911, as secondary responders, or can focused on follow-on support after initial 911 call (or both).

**Analytical Insight:** DPD has an embedded mental health clinician that responds to calls in the field and in follow-ups. More information is included in the focus group report.
Alternative Strategies: Diversion at Dispatch

Overview: This intervention 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.

Purpose: Point of Dispatch Diversion refers to the strategy of employing alternative crisis response services to address 911 calls.

Call Natures Appropriate for Alternative Response: Emergency calls that typically result in transport to a hospital Emergency Department.

Analytical Insight: Point of dispatch diversion requires an accurate understanding of the call nature at the time of dispatch. 6.7% of calls from a one-month sample of data had a different initial call nature than final call nature.
Alternative Strategies: Non-Urgent Call Diversion

**Overview:** Alternative responses to non-urgent calls have taken the form of an in-person civilian response, telephone response units, and online reporting.

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

**Analytical Insight:** Alarm calls represent 11.8% of all calls initiated by the public during the analysis period. There were 56,972 alarm calls in Durham during that time. Only one resulted in an arrest.

**Call Natures Appropriate for Alternative Response:** Non-urgent calls, minor traffic accidents, calls that don’t require law enforcement action.
Alternative Strategies: Family Liaison Program

Overview: The role of Family Liaison Officer is one that is unique to British Policing.

Purpose: All United Kingdom Police Forces adopted the role of a Family Liaison Officer (FLO) in all major crime enquiries where death or extremely serious injury had occurred. For the past 20 years, highly trained Police Officers have been embedded within families to support the family through the rigors of the investigation and subsequent legal process.

Call Natures Appropriate for Alternative Response: N/A, not an alternate response strategy.
Overview: The implementation of alternatives to traditional law enforcement responses is dependent on local resources that would make the strategy viable. It is critical to know what resources currently exist (or could exist) within a community. It is also important to develop a comprehensive understanding of the demand for resources.

Purpose: Inventorying public and community-based resource providers, cataloguing the types of services they provide, and understanding community needs they are encountering.
• Initial call designations are not necessarily a good predictor of how calls end up being resolved
• Mental health issues are not well documented on calls for service
• Citizens are not asked if they would prefer a response other than a police officer
• Although calls for service can be categorized into “non-police type calls”, there is no way to distinguish whether call outcomes are the result of the potential for law enforcement action. The potential for arrest or other mechanisms of enforcement may play a role in getting members of the public to voluntarily choose desired behavior; this authority does not exist for a non-sworn city employee or a third-party employee.
Verifying Information

Much of what is being cited is repeating the same inaccurate or complete statistics:

- The cost savings to cities being reported about CAHOOTS is not accurate
- The percent of calls attributed to violent crime is not accurate
- The ratio of risk attributed to potentially fatal encounters by the mentally ill is not accurate
There is a lack of program fidelity across cities which makes research findings difficult to generalize.
- This means we need to test practices within individual police agencies.

Different cities and police departments have access to different resources.
- Another reason to develop a tailored approach.

Access to community resources is one of the most important aspects of a successful mental health program no matter what type of program is employed.
- Understanding what is available to the community is important whether a police officer, social worker, or EMT is responding to the call.

Testing is the only way to determine that these practices are not only effective but safeguard that they are not harmful to the community.
Potential Path Forward

• Reduce police-public contact and pair the appropriate response resource with community need.
  • Two potential pilots: 1) expand and evaluate existing DPD co-response strategy and 2) pilot mental health identification and documentation plan.

• Be operationally and fiscally efficient.
  • Potential pilot: systematically identify which call natures to divert to P2C.

• Meet community expectations for how 911 calls are responded to and resolved.
  • Potential pilot: survey callers about willingness to accept alternative responses for a subset of call natures.

• Meet the legal requirements of state statutes while maintaining or promoting public safety.
INTRODUCTION

The development of budget guidelines is a best practice and supports The Citywide Strategic Plan Goal, Innovative and High-Performing Organization. One of the objectives of this goal is to promote organizational sustainability:

- Strategic Sustainability -- realistic vision and goals
- Program and Service Sustainability -- high-quality services and programs
- Personnel Sustainability – effective and reliable personnel
- Financial Sustainability – recurring revenues equal to recurring expenditures, adequate financial reserve and contingency planning.

The General Fund is the primary fund for the city and supports 22 of the 25 city departments including 2,427 employees.

The Interim City Manager shall use the following Budget Development Guidelines to prepare the FY 2021-22 Proposed Budget.

OVERALL

The budget should prioritize funding based on the City’s Strategic Plan, needs related to accommodate population growth, State and/or Federal mandates and initiatives consistent with the City Council's priorities.

REVENUES

For FY 2020-21, the two largest sources of revenue to support General Fund operations are local property taxes (51.7%) and local sales taxes (29.9%) representing 81.6% ($175M) of the fund’s $214.6M budget. Local property taxes also fully support the Debt Service Fund which accounts for the City’s General Fund debt service obligations. The property tax appropriation for the Debt Service Fund is $39.1M for FY2020-21.

The City must use a strategic approach to balance the budget by assessing revenue enhancement opportunities and cost control. The FY 2021-22 Budget must support the City’s Strategic Plan and identify funding to enhance priority programs and services while considering potential revenue losses.

- The tax rate for the General Fund will remain at the current rate of 30.83 cents (per $100 assessed value).
- The tax rate for the Debt Service Fund will remain at the current rate of 11.00 cents (per $100 assessed value).
The tax rate for the **Solid Waste Fund** will remain at the current rate of **5.59 cents** (per $100 assessed value).

The tax rate for the **Dedicated Housing Fund** will increase **1.38 cents** (per $100 assessed value) from the current rate of **2.0 cents** (per $100 assessed value) to **3.38 cents** (per $100 assessed value) to fund debt service on bonds approved as part of the $95 million affordable housing bond passed in November 2019.

The tax rate for the **Transit Operating Fund** will remain at **3.75 cents** (per $100 assessed value).

The tax rate for the downtown **Business Improvement District (BID)** will remain at **7.00 cents** (per $100 assessed value).

The allocation for the **Half Penny For Parks Program** will remain at 1/2 cent of the proposed tax rate.

Fund balance in the General Fund will not be projected to fall below **12.0%** at the end of FY 2021-22.

**Non-recurring funds will not be directed toward recurring uses.**

**Proposed water and sewer rate increases** will not exceed an average of **3.6%** for the average Tier 3 customer

- This represents the 3.4% rate increase that was projected for FY22 from last year’s projection with an adjustment for eliminating delinquent and late fees.

**Fee adjustments** will be considered, as appropriate, to align fee revenues with cost of services for better cost recovery rates.

**Proposed increase in Stormwater rates** for typical residential customer (tier 2) shall not exceed **$0.51** per month.

**EXPENDITURES**

To balance expenditures against forecasted revenues, the Interim City Manager will continue to monitor performance data to guide focused discussions with City departments regarding program and service priorities. This includes possible areas for elimination, reduction, reorganization, new partnerships, and/or alternative service delivery models that address the performance and efficiency of City programs.

**City employees are at the core of City services.** One objective under the City’s **Innovative & High Performing Organization Goal is to “cultivate a diverse, engaged, and healthy workforce dedicated to public service.”** Attracting, training and retaining a
competent, high quality workforce is essential to being a high performing organization. Therefore, we will continue to consider employee compensation adjustments as a priority.

The following pay and benefit components will be proposed:

- Pay adjustments will be considered for General employees up to 2.0% (and where necessary greater than 2.0% to ensure that no employee falls below new structure minimums), Police up to 4.0% and Fire up to 3.5%. In addition, bonuses will considered for all employees at the following levels; $1,500 for employees earning less than $50,000, $1,250 for employees earning over $50,000 up to $90,000 and $1,000 for employees earning over $90,000.
- Supplemental Retirement -401(k) –5.0% (no increase over FY2020-21 budget).
- Medical Insurance for all employees - no increase for the City
- Dental insurance – 7% average increase for the City
- 11.35% budgeted for employer contribution to the Local Government Employees’ Retirement System (LGERS), a 1.20% increase over the FY2020-21 budget of 10.15%.
- The dedicated street resurfacing funding will remain at $6,000,000 for FY 2021-22 and up to an additional $4,000,000 from fund balance will be considered for FY2021-22.

- Funding for the Maintenance Replacement Project Plan will be considered to increase by $100,000 from $1,000,000 for FY 2020-21 to $1,100,000 for FY2021-22.

- Fleet replacement funding for the General Fund will be provided in accordance with the Fleet department’s 10-year recommendation plan within the debt model.

- Funding for City Council budget requests will be considered up to $600,370 ($212,400 one-time, $387,970 recurring).

- Programs may be considered for down-sizing or discontinuation.