Raleigh Coalition's Alternative Response Unit

Proposal drafted by the Raleigh HEART Coalition

September 2023

RALEIGH COALITION PARTNER ORGANIZATIONS

ACLU North Carolina

CJJ Carolina Jews for Justice

Forward Justice

Mindology
A Mindcare Wellness Center

Democracy Out Loud
Peaceful Persistent Power

WILSON
Center for Science and Justice
at Duke Law

Raleigh Mennonite Church

North Carolina Justice Center

Daybreak Oneness

Siembra NC

EMANCIPATE

Contents

EXECUTIVE SUMMARY

The Raleigh H.E.A.R.T. Coalition[1] presents the following as a proposal for the creation of an alternative response unit in Raleigh, NC, aimed at conserving police resources, decreasing the use of emergency departments, decreasing police killings, increasing cost savings, and decreasing the crime rate. This proposal seeks to assist Raleigh City Council and the Raleigh City Manager in crafting a program that is sustainable and effective at clinically helping those in crisis.

In a three year analysis of Raleigh's 911 call data by RTI International, the Raleigh Police Department spent over ***2.1 million minutes or 35,000 hours*** responding to Mental Health calls.[2] In total, RPD spends a ***quarter of its time*** responding to Mental Health, Quality of Life, Domestic/Family, and General Assistance calls.[3] It is becoming increasingly evident that cities across the country need to take a larger role in addressing the rise in mental health crises that are leading to significant overcrowding of jails and emergency departments. The current system in place often relies on law enforcement and emergency responders to manage mental health emergencies, which can lead to negative consequences, sometimes fatal, for individuals in crisis. To truly tackle this issue, cities must prioritize innovative solutions that provide individuals with the proper resources and support they need. By investing in mental health resources, cities can address the root causes of these issues, improve the well-being of individuals within their communities, and reduce the number of people killed by the police. Raleigh can start tackling the rise in mental health crises by adopting an alternative response model that treats mental health as a medical issue, not a police matter.

The current issues and problems surrounding police response to mental health emergencies are multifold. Police officers often lack specialized training in understanding and de-escalating mental health crises, leading to potential mishandling and escalation of already vulnerable situations. This can further exacerbate the emotional distress of individuals in crisis and potentially result in unnecessary use of force or harm. It's estimated that 1 in 4 people killed by the police were experiencing a mental health crisis.[4] Moreover, the presence of armed law enforcement officers can be intimidating and exacerbate anxiety for those experiencing a mental health crisis, potentially leading to a breakdown in communication and a heightened risk of harm. Relying solely on police response prevents individuals from receiving the appropriate long-term care and support they need and results in overcrowding of systems not designed to provide mental health services, such as jails. Altogether, these issues highlight the urgent need for alternative response models that prioritize mental health resources and trained professionals to effectively address mental health emergencies in a compassionate and supportive manner.

Several cities throughout the United States have adopted alternative responder models to improve responses to mental health crises, conserve and focus law enforcement resources on violent crime, and minimize negative outcomes that frequently occur when individuals having a mental health crisis are exposed to armed law enforcement officials. Multiple local governments in North Carolina have also adopted alternative response models, including Durham, NC, Jacksonville, NC, Greensboro, NC, Mecklenburg County, Chapel Hill, NC, and Winston-Salem, NC.[5]

1 More information about the Raleigh H.E.A.R.T. Coalition can be found on our website at whatifraleighhadaheart.org
2 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf
3 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf
4 https://www.nasmhpd.org/sites/default/files/2020paper11.pdf
5 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf

PROBLEMS WITH CURRENT EMERGENCY RESPONSE SYSTEMS

The current emergency response systems dispatch police officers to address mental health crises instead of clinical specialists trained to address these crises. Raleigh has yet to develop a comprehensive strategy for real-time response to people experiencing mental health crises. The lack of such systems places individuals in crisis at a disadvantage, forcing them to choose between limited options: arrest and booking in jails or transport to overcrowded emergency departments (EDs) where they often wait for hours or days with inadequate care. In June 2023, the Wake County Sheriff's department reported a concerning rise in calls related to mental health crises, highlighting the urgent need for effective response systems.[6] Here are some of the challenges we currently face in Wake County:

Wake Hospitals Can't Keep Up

*There's been a **40% increase** in the need for mental health care in Wake County hospitals, causing increased wait times for appropriate care.*[7]

In 2022, Wake County Hospitals witnessed 17,117 emergency visits by 13,155 individuals seeking mental health or substance abuse assistance which attributed to an over-reliance on 911 calls for mental health emergencies and a lack of transportation options beyond police and emergency medical services (EMS).[8]

Click here for an analysis on Raleigh's 911 Call Data

Criminalization of Mental Health

***65% of Wake County prisoners** have a mental illness, and the Wake County Detention Center is considered the state's largest mental health facility, increasing taxpayer costs tremendously.*[9]

The prevalence of individuals with mental illness and substance use disorders in jails and prisons are three to four times that of the general population.[10] These inmates are incarcerated for twice as long, with only 37% receiving any mental health treatment while incarcerated.[11] Those that do receive treatment often face difficulties continuing their treatment regimen once in prison because only about 50% continue to receive their medication.[12]

6 https://www.cbs17.com/news/local-news/wake-county-news/nearly-400-in-wake-co-sheriffs-office-trained-to-handle-rise-in-crisis-mental-health-calls/

7 https://www.northcarolinahealthnews.org/2022/08/22/emergency-department-burden-shown-in-mental-health-data/; https://www.newsobserver.com/news/local/counties/wake-county/article275406686.html

8 https://www.newsobserver.com/news/local/counties/wake-county/article275406686.html

9 https://apnews.com/article/health-prisons-d4c1d2a6062eb5640a875c93aefb2308

10 https://www.ohchr.org/sites/default/files/Documents/Issues/RuleOfLaw/OverIncarceration/ACLU.pdf

11 https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated

12 https://www.pbs.org/wgbh/frontline/article/mental-health-system-north-carolina-jails/; https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

Police Killings of Those in Mental Health Crisis

***25% of people killed by police** were experiencing a mental health crisis[13], that number increases to almost **40% for metropolitan areas** like Raleigh.[14]*

In general, individuals with untreated mental illness are 16 times more likely to be killed during a police incident.[15] The stakes are even higher for Raleigh's Black residents; Black Americans with mental illness are 10 times more likely to be killed by the police than white Americans who do not have a mental illness.[16] A joint report by the Treatment Advocacy Center and the National Sheriffs' Association found that "**reducing encounters between on-duty law enforcement and individuals with the most severe psychiatric diseases may represent the single most immediate, practical strategy for reducing fatal police shootings in the United States**."[17]

CIT Training Is Not Sufficient

*As of February 2022, 420 RPD officers were CIT trained, yet the population of individuals with mental illness in jails **has drastically increased** and hospitals remained overwhelmed with ED demand.[18]*

Crisis Intervention Team (CIT) is a certification granted to self-selected police officers that complete 40 hours of instruction on how to respond to behavioral health crisis calls, de-escalate the situation, and direct people to external services.[19] Officers receive CIT training from community mental health workers, people with mental illness (PMI) and their families and advocates, and other police officers familiar with CIT. RPD CIT training primarily focuses on de-escalation and safe restraint.[20] While CIT programs have some beneficial effects, a 40 hour training cannot and does not equip officers with the level of skill and expertise contained by a mental health professional. This level of expertise is required to attack the root of the problem.

CIT doesn't address the issue of overwhelmed emergency departments and mental health facilities, both of which impose significant costs on taxpayers.[21] In essence, CIT programs may, at best, shift the financial burden from police budgets to community mental health budgets.[22] Research on the effectiveness of CIT programs reveals limited cost savings, marginal differences between CIT-trained and untrained officers regarding persons with mental illness (PMI) being diverted to psychiatric emergency services, and an inconsistent reduction in the risk of mortality during emergency police interactions.[23] Despite CIT's inception in the 1990s, police shootings involving PMI remain prevalent, and psychiatric facilities continue to grapple

13 https://www.nasmhpd.org/sites/default/files/2020paper11.pdf
14 https://static1.squarespace.com/static/5ee39ec764dbd7179cf1243c/t/60ca7e7399f1b5306c8226c3/1623883385572/Crisis+Response+Guide.pdf
15 https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf
16 https://www.nasmhpd.org/sites/default/files/2020paper11.pdf
17 https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf at 1.
18 https://www.northcarolinahealthnews.org/2022/08/22/emergency-department-burden-shown-in-mental-health-data/; https://www.newsobserver.com/news/local/counties/wake-county/article275406686.html; https://raleighnc.gov/safety/rpd-addresses-mental-health
19 https://www.vera.org/behavioral-health-crisis-alternatives; https://jaapl.org/content/47/4/414.long
20 https://raleighnc.gov/safety/rpd-addresses-mental-health
21 https://jaapl.org/content/47/4/414.long#sec-7
22 https://jaapl.org/content/47/4/414.long#sec-7
23 https://jaapl.org/content/47/4/414.long#sec-7

with overwhelming demand. While CIT yields favorable results in terms of officer satisfaction and reducing stigma toward PMI, numerous studies indicate that it falls short in significantly addressing the problems that an alternative crisis unit could alleviate.[24]

Having mental health professionals present during a mental health crisis offers more than just transportation to an emergency department. These experts possess the skills to provide immediate counseling, assess PMI needs, de-escalate crises more effectively, build rapport with individuals, and eventually leverage their medical expertise to connect them with the necessary services. This approach has demonstrated success in reducing the PMI population in jails and easing the burden on emergency departments and psychiatric facilities.

BENEFITS OF AN ALTERNATIVE RESPONSE SYSTEM

There are several proven benefits of an alternative crisis unit, including a reduction in jail populations, a reduction on the demand for emergency department and psychiatric facility beds, greater access to services for community members in need, increase in efficiency of officer time allowing them to focus on violent crime posing a risk to public safety, a drop in reported crimes, and significant community cost savings.

Research and benefits of alternative response units around the country

Colorado - STAR

A Stanford study of Denver's alternative response program, STAR, which diverts 911 calls from police to teams of mental health professionals for nonviolent emergencies, found a 34% drop in crimes reported.[25] The same study found that the direct costs of the alternative response program were four times lower than police-only responses. The study also highlighted that approximately two-thirds of the emergency calls involving disorder, mental health, medical, and noncriminal calls could be diverted to community response teams instead. Allowing for the diversion of these types of nonviolent calls could **save RPD up to 40% of the time** it currently spends on these types of calls, allowing for a significant shift of police resources to nonviolent and property related crimes.[26] The study estimated that minor offenses such as loitering and making false statements cost the criminal justice system roughly $500 to $600 per offense.[27] In addition to saving criminal justice system resources, individuals that have an interaction with alternative crisis teams instead of police were nearly 85% more likely to receive an intervention **other than hospitalization**.[28]

Oregon - CAHOOTS

CAHOOTS is another example of an alternative crisis program in Oregon. In 2019, CAHOOTS responded to 24,000 calls for service, about 20% of total dispatches.[29] Out of the 24,000 calls, only 150 required police

24 https://pubmed.ncbi.nlm.nih.gov/31551327/
25 https://news.stanford.edu/2022/06/08/stanford-study-shows-benefits-reinventing-911-responses/; https://www.science.org/doi/10.1126/sciadv.abm2106
26 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 17.
27 https://www.science.org/doi/10.1126/sciadv.abm2106
28 https://www.nami.org/Blogs/NAMI-Blog/July-2022/Mobile-Crisis-Teams-Providing-an-Alternative-to-Law-Enforcement-for-Mental-Health-Crises
29 https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html

backup.[30] The program saves the city of Eugene, Oregon, about $8.5 million in public safety costs every year and $14 million in ambulance trips and ER costs.[31] CAHOOTS staffers respond to substance addiction crises, psychotic episodes, homeless residents and threats of suicide.[32] They also make house calls to counsel depressed children at their parents' request, and they're contacted by public onlookers when someone isn't in a position to call CAHOOTS themselves, a call that would traditionally be made to police and categorized as a public disturbance.

PROPOSAL FOR RALEIGH'S ALTERNATIVE RESPONSE UNIT

In a Spring 2021 survey of more than 270 law enforcement agencies in North Carolina, 70% of responders said they wanted to learn more about crisis response programs.[33] Law enforcement officers have been vocal about the need for specialized, expert support when answering these types of calls and even been open to the idea that, when it is safe, law enforcement response may not be necessary at all.

Point of Dispatch Diversion

Embedding licensed mental health professionals into Raleigh's Emergency Communications Department is the single most important aspect of any adopted alternative response model. Without this Point of Dispatch Diversion, the burden falls on individual officers that have already responded to the scene to make assessments that are outside of the scope of their expertise. This does nothing to eliminate ineffective uses of officers' time or conserve police resources, goals that are especially critical now given high policing staff-shortages. Additionally, under this model, the person experiencing a mental health crisis is still met with an armed response. The existence of the mental health close code in Raleigh's CAD system provides a foundation for a Point of Dispatch Diversion program.[34] In cities that have a Point of Dispatch Diversion model, dispatch is sometimes not necessary at all because a mental health clinician embedded into the 911 call center will be able to treat or assist some individuals over the phone, resulting in an in-person response being unnecessary and additional cost savings.[35]

Existing North Carolina Point of Diversion Programs

Jacksonville, NC

In 2016, the Jacksonville City Council, the Police Chief, and the Public Safety Director began to discuss alternative responses for mental health emergencies.[36] The Police Chief informed the City Council that every year the department was putting 17,000 public safety hours into mental health emergencies—the equivalent of eight full-time police officers and $1,000,000 that could be used for other public safety purposes.[37] Given that RTI's 911 call data analysis showed RPD spent almost 35,000 hours on calls that can be diverted elsewhere, Jacksonville, NC, provides a great example of the cost savings to Raleigh.[38]

30 https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html
31 https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html
32 https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html
33 https://ncdoj.gov/wp-content/uploads/2022/01/TREC_Reimagining-911_InfoSheet.pdf
34 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 43.
35 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf
36 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 40
37 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf
38 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 17.

Jacksonville's alternative response unit is dispatched directly through the 911 call center.[39] The call center flags calls for service that are potential mental health or substance use issues, dispatch then contacts an available unit member to accompany law enforcement to the scene. Additionally, unit members monitor calls and self-dispatch if their services are needed.

Durham, NC

Durham's Crisis Call Diversion program embeds licensed mental health clinicians in its 911 call center to triage, assess, and respond to non-emergent and non-life-threatening behavioral and mental health related calls for service.[40] The Crisis Call Counselors embedded in Durham's 911 call center serve eight major functions: assess 911 caller's needs and complete a safety plan, divert non-emergent crisis calls that do not require in-person support, connect people to resources to support future mental health related needs, dispatch community response teams, consult with 911 dispatchers to provide more information, de-escalate situations prior to the arrival of first responders, support responders as unanticipated mental health related issues arise, and follow up with 911 callers after a crisis to provide additional assistance.[41] From June 28, 2022, to August 30, 2023, there were 2,626 calls that were diverted from police.[42] This was only for the pilot area and with the limited time frames established for the pilot. Of those calls, 0% needed police backup. There were 1,458 eligible calls coded as a mental health crisis and 608 eligible calls coded as a suicide threat.[43]

When analyzing whether a call should be diverted, call-takers first ask 911 callers: "Are you aware or does it appear the subject is in mental health crisis?"[44] If the caller responds in the affirmative, the call is then diverted to Durham's Crisis Call Diversion, which involves an embedded counselor conferencing into the call to listen through the rest of the protocol questions. Nonviolent behavioral health calls are then routed to a community response team of three individuals, an EMT, a licensed clinician, and a peer support specialist.[45] If there is a threat of violence, the call is routed to a co-response unit, which consists of a licensed clinician and a CIT-trained police officer. Durham's criteria for a licensed clinician is an individual that has 3 years of post-graduate experience and over 1,000 hours of supervised work.[46]

Greensboro, NC

In 2020, Greensboro created the Behavioral Health Response Team (BHRT).[47] The unit is dispatched in a number of ways, including dispatching in response to mental health calls diverted from law enforcement.[48] Reducing the number of PMI in jails and overcrowded hospitals and conserving police resources were major motivations for the creation of this unit and the model in which it is dispatched. BHRT's annual 2022 report states, "Guilford Metro 9-1-1 receives thousands of mental health crisis calls. Before BHRT was created, law enforcement officials had to respond because there wasn't another option. Those in need could end up hospitalized or taken into police custody."[49]

---

39 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 40.
40 https://www.durhamnc.gov/4576/Community-Safety
41 https://www.durhamnc.gov/4576/Community-Safety
42 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f
43 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f
44 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 42.
45 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 43.
46 https://www.durhamnc.gov/Faq.aspx?QID=770
47 https://user-kcmpnye.cld.bz/Behavioral-Health-Response-Team-2022-Annual-Report
48 https://user-kcmpnye.cld.bz/Behavioral-Health-Response-Team-2022-Annual-Report/4/
49 https://user-kcmpnye.cld.bz/Behavioral-Health-Response-Team-2022-Annual-Report

In 2022, the unit responded to 2,357 calls.[50] The 2022 annual report includes testimonials from individuals serviced by the unit, one testimonial highlights the benefits of the unit being dispatch immediately to the scene from 911, stating, "BHRT arrived and were able to quickly connect with my husband and calm him down so that he felt safe and heard."

Winston-Salem, NC

Winston-Salem recently began a pilot alternative response program that includes Point of Dispatch Diversion.[51] The unit is titled Behavioral Evaluation and Response Team (BEAR) and was formed "out of community concern that the presence of uniformed first responders on a mental health call escalate the situation" and once the city realized that 37% of its 911 calls were mental health related.[52] When a call for service comes in, 911 communications will screen the calls and determine whether the BEAR team should be dispatched instead of the police. The BEAR team handles any nonviolent calls where the caller seems to be in need of mental health or other community resources.[53] Kristin Ryan, the BEAR unit's director, lauded the benefits of allowing officers to focus on violent crimes that actually relate to public safety, stating, "[s]ometimes those calls take several hours, so us being that alternative will free up law enforcement for many hours of services that they could be doing more of a public safety type of activity."[54] The team averages about 6-8 calls a day.[55]

If the Raleigh City Council seriously desires to better serve both our community and our police officers, they must utilize a Point of Dispatch Diversion program and embed mental health clinicians into Raleigh's Emergency Communications Department.

Community Response Teams

Community Response Teams are in-person alternative crisis response teams that are dispatched for non-violent behavioral health calls and other non-urgent, non-violent calls that do not require armed officers and are an ineffective use of officers' time and resources. These teams generally consist of two or three unarmed skilled responders that are a combination of nurses, paramedics, EMTs, mental health clinicians, peer support specialists, and crisis counselors. Community Response Teams are dispatched for calls involving non-violent mental health crises, welfare checks, nuisance or intoxication, suicide threats, trespass, or homeless individuals. The existence of a Point of Dispatch Diversion program is essential to effective Community Response Teams. Without a Point of Dispatch Diversion program, Community Response Teams would have to rely on individual officer referral, which is less effective.

50 https://user-kcmpnye.cld.bz/Behavioral-Health-Response-Team-2022-Annual-Report/2/
51 https://www.cityofws.org/3400/Behavioral-Evaluation-Response-Team
52 https://myfox8.com/news/north-carolina/winston-salem/winston-salem-bear-team-responds-to-mental-health-calls-as-alternative-to-police/
53 https://www.wxii12.com/article/bear-team-designed-to-answer-mental-health-calls-now-up-and-running-in-winston-salem/43944211
54 https://www.wxii12.com/article/bear-team-designed-to-answer-mental-health-calls-now-up-and-running-in-winston-salem/43944211
55 https://myfox8.com/news/north-carolina/winston-salem/winston-salem-bear-team-responds-to-mental-health-calls-as-alternative-to-police/

Existing North Carolina Community Response Teams

Durham, NC

Durham's Community Response Teams provide rapid, trauma-informed care for 911 calls involving non-violent behavioral and mental health needs and quality of life concerns. Durham's Community Response Teams consist of three unarmed responders, a licensed clinician, a peer support specialist, and an advanced EMT, that arrive in non-police vehicles and wear plainclothes and shirts identifying them as community responders.[56] Durham defines a peer support specialist as someone who knows the community, has relevant lived experience, and has been trained as a specialist. The peer support specialists are critical to building trust and relationships between community members and responders. The advanced EMTs and licensed clinicians work to assess and provide emergency care to the individuals in crisis. In addition to resolving issues on the scene, the Community Response Teams also transport individuals to non-emergency facilities and follow up with the individuals they encounter after 48 hours.

From June 28, 2022, to August 30, 2023, Durham's pilot Community Response Teams responded to 2,848 calls[57] and the H.E.A.R.T. program received 13,199 calls eligible for a response by its Community Response Team.[58] Call types included trespass or unwanted, mental health crisis, non-urgent welfare checks, urgent welfare checks, nuisance or intoxication, and suicide threat. Trespass or unwanted, and mental health crises were the top two call types and consisted of 1,277 calls. Of the total calls responded to by Community Response Teams, 10.53% of the calls needed transport, .04% of these calls needed police backup, and 2.77% of these calls needed EMS support.[59] Not only do the Community Response Teams conserve police time and resources, they also reduce unnecessary emergency department use. This is critical in a time where emergency departments are overwhelmed and a large number of individuals that are transported to the emergency department for mental health treatment are transported by police officers.

Winston-Salem, NC

The BEAR Team consists of six crisis counselors and social workers who are stationed at fire departments around the city in order to ensure a rapid response. The crisis counselors are all mental health professionals. When discussing the importance of diverting calls from police to the BEAR community response team, Assistant City Manager Patrice Toney stated, "Police officers are very well trained. They're trained for de-escalation, but they cannot be everything to every situation."[60]

---

56 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 44.

57 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f

58 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f

59 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f

60 https://myfox8.com/news/north-carolina/winston-salem/winston-salem-bear-team-responds-to-mental-health-calls-as-alternative-to-police/

Co-Responder Teams

Existing North Carolina Co-Responder Models

Jacksonville, NC

Similar to most co-responder models in this country, Jacksonville's co-response includes a licensed mental health clinician, referred to as a Crisis Counselor, who is a clinical neuropsychologist. From May 2017 to May 2023, the unit responded to 12,085 calls for service, which is approximately 2,015 calls a year.[61]

Chapel Hill, NC

Chapel Hill's co-responder program has been in operation for decades. The co-responder unit consists of 8 full-time employees: 6 crisis counselors, 1 peer support specialist, and 1 transit crisis counselor.[62] The crisis counselors are all licensed mental health clinicians.[63] The peer support specialist is an individual with lived experience dealing with mental health and substance abuse issues, who is trained and certified to engage peers in a collaborative, supportive manner.[64] The unit responds to calls related to: intimate partner or sexual violence, victims of crimes, persons experiencing a mental health crisis or persistent mental health concerns, suicide threats, missing persons or runaway juveniles, and many more.[65] In 2022, the unit responded to 3,522 events.[66]

Durham, NC

Durham's co-response model pairs licensed mental health clinicians with CIT trained officers and is dispatched directly from the 911 call center. From June 28, 2022, to August 30, 2023, the co-response unit responded to 1,550 calls and needed EMS or transportation support for about 1.42% of those calls.[67]

Charlotte, NC

In 2019, Charlotte Mecklenburg Police Department implemented Community Policing Crisis Response Teams (CPCRT). These teams consist of master's level mental health clinicians paired with CIT trained officers.[68] In total there are 12 mental health clinicians and 12 CIT officers in the unit. The Santé Group handles staffing the clinician positions and runs the unit.[69] The program is designed to serve as a "jail and hospital diversion program" and the licensed mental health professionals on the unit are a crucial piece to successful diversion.[70] The unit is available 24/7.[71]

---

61 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf
62 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf
63 https://thelocalreporter.press/chpd-crisis-unit-a-pioneer-and-national-model/
64 https://thelocalreporter.press/chpd-crisis-unit-a-pioneer-and-national-model/
65 https://thelocalreporter.press/chpd-crisis-unit-a-pioneer-and-national-model/
66 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf
67 https://app.powerbigov.us/view?r=eyJrIjoiMWQ1YzViMGYtYmI1MC00NWM3LTg1NWUtMjdjNzk3NWNlYzU0IiwidCI-6IjI5N2RlZjgyLTk0MzktNDM4OC1hODA4LTM1NDhhNGVjZjQ3ZCJ9&pageName=ReportSection7606ef27f6ee056e6f9f
68 https://www.wccbcharlotte.com/2019/04/26/cmpd-launches-community-policing-crisis-response-team/
69 https://www.thesantegroup.org/where-we-work/mecklenburg-county-nc/#:~:text=Our%20CPCRT%20team%20consists%20of,calls%20within%20the%20Mecklenburg%20Community.
70 https://www.thesantegroup.org/where-we-work/mecklenburg-county-nc/#:~:text=Our%20CPCRT%20team%20consists%20of,calls%20within%20the%20Mecklenburg%20Community.
71 https://www.wccbcharlotte.com/2019/04/26/cmpd-launches-community-policing-crisis-response-team/

Greensboro, NC

In 2021, Greensboro launched the Behavioral Health Response Team (BHRT), a co-response team. Eligible 911 calls are diverted directly to the BHRT's co-response unit.[72] The unit consists of 8 police officers, including the BHRT corporal and sergeant, 7 clinicians, 1 outreach coordinator, and 1 paramedic. Of the team's seven clinicians: three are fully licensed Clinical Mental Health Counselors, two are provisionally licensed Clinical Social Work Associates, one counselor is also a dually licensed Clinical Addiction Specialist Associate, and two have master's degrees in related fields and are pursuing licensure in the future.[73] The program maintains a crisis counselor on call 24/7.[74]

Improving and Expanding ACORNS Reach

Currently Raleigh already has co-response teams under ACORNS. ACORNS co-response teams consist of social workers and CIT trained officers. However, ACORNS co-response units respond to the scene only after they are contacted or "referred" by an officer that has already responded to the scene.[75] This model does not take advantage of the cost savings and savings of police time that would be gained if the call was diverted straight to the ACORNS unit by the 911 call center. This model also does not decrease armed response to mental health calls because the individuals have already faced an armed response before ACORNS is contacted. Additionally, with Crisis Call Diversion, rather than receiving information about the caller's issues and the scene from an officer, the ACORNS unit would receive information directly from a licensed mental health professional that would be able to provide them with a much deeper assessment of the mental health crisis and the subject.

Members of ACORNS and RPD Chief Patterson have already expressed a desire to allow ACORNS to be directly dispatched through the 911 call center, with the appropriate staff. In January 2023, Raleigh Police Lt. Renae Lockhart, who runs the ACORNS unit, told the Raleigh City Council that, with additional staff, "[ACORNS] can actually be able to be dispatched to certain groups of calls."[76] Relying on officer referral prevents ACORNS from reaching its full potential as a co-responder model and prevents Raleigh from reaping the benefits such models can provide. In August 2022, it was report that only 12 of the 680 calls ACORNS assisted with over the last year were connected with mental commitments and zero suicide calls.[77] In contrast, Raleigh officers handled over a 1,000 suicide-related calls and more than 3,200 calls related to mental commitments.[78] The number of calls handled by ACORNS is far lower than the number of calls handled by other co-responder units in North Carolina, in part because of the way ACORNS is dispatched.

ACORNS staff currently consists of three police officers, six social workers, and a social worker supervisor. There are no peer support specialists on the ACORNS team. Peer support specialists, individuals with lived experience dealing with mental health or substance abuse, help bridge the gap between law enforcement officers, mental health professionals, and the community. The addition of a peer support specialist to ACORNS will result in the unit being able to build deeper relationships with community members, increasing the likelihood community members will use the services provided by ACORNS and increase knowledge of ACORNS existence among community members. Additionally, if the true goal is diversion and cost savings, not simply de-escalation, ACORNS must ensure that the social workers on their team are licensed clinical social workers so they can appropriately serve the role of licensed mental health clinicians, who are able

72 https://www.charlottenc.gov/files/assets/police/documents/supportdocs/cmpd_citdoc.pdf
73 https://www.greensboro-nc.gov/departments/executive/office-of-community-safety/bhrt
74 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 45.
75 https://raleighnc.gov/safety/acorns
76 https://abc11.com/raleigh-police-acorns-mental-health-crisis/12714281/
77 https://abc11.com/acorns-raleigh-police-mental-health-crisis-unit/12139143/
78 https://abc11.com/acorns-raleigh-police-mental-health-crisis-unit/12139143/

to assess and treat individuals and have a greater understanding of medical options available for long-term treatment. The expertise and skill of licensed mental health clinicians are of tremendous value to co-responder models and the data showing costs savings and jail and hospital diversion are based on co-response teams that contain licensed clinicians.

ACORNS must be housed outside of the Raleigh Police Department. For an ACORNS' co-response team consisting of mental health clinicians to be truly transformative, mental health professionals must be able to take lead in certain circumstances. Currently, ACORNS is subject to the Raleigh Police Department chain of command which consists of a strict protocol governing officer responses to the scene. Removing ACORNS from RPD and housing it with the other proposed programs, Crisis Call Diversion and Community Response Teams, makes sense logistically and allows for more flexibility when co-response teams are dispatched to the scene. Additionally, it allows for licensed mental health clinicians that have significant skill and expertise in handling these situations to take lead when appropriate and necessary.

In addition to its limited co-response, ACORNS provides care navigation services that range from providing showers and laundry, to medical needs and internet access. These care navigation services are desperately needed and a key aspect of any successful alternative crisis model. Individuals on the Crisis Call Diversion team and Community Response Teams would need to integrate and educate themselves on the services provided, and housing ACORNS with these teams in another department will foster those connections in a way that keeping them in separate departments could not.

Location of Raleigh's Alternative Response Unit

The alternative response unit must be housed in a department that ensures the program's longevity and sustainability. With each new police chief comes new policies and ideals, this, in addition to the barriers posed by requiring the program to operate within the chain of command, is further reason why the program should be housed outside of the police department. The Raleigh Coalition proposes two options for housing of the unit: in a newly created department centered around community safety, or in the already existing Emergency Communications department.

The most effective option that ensures the program's independence and longevity is the creation of a new department. This will provide for cleaner evaluation of funding, staffing, and other needs of the program. While creating a new department seems like a heavier lift, it avoids having to integrate the program into an already existing department with an already existing culture and staff. Integration into the Emergency Communications department may require more technical planning and additional training of already existing staff. However, the Emergency Communications department is currently the only existing department that would have a part in the program through Point of Dispatch Diversion. Given the department will already have to undergo some reconstruction and training, if City Council wishes to avoid creating a new department, housing the program in the Emergency Communications department makes the most sense. Additionally, housing the program in the Emergency Communications department will still ensure independence from the police department and there will be some overlap between the alternative response unit's budget and the already existing budget of the department.

Necessary Key Partners

In every city that has implemented an alternative response unit, local officials almost unanimously list the importance of establishing key partnerships as fundamental to the program's success. Key partners range from first responders, to health care institutions, to community organizations. Without a doubt, Raleigh's Police Department, including ACORNS, Raleigh's Fire Department, and Wake County EMS must be included in the planning process and utilized as key partners. Without buy-in from first responders, the program cannot

maintain success and longevity. The Raleigh Coalition met with ACORNS prior to drafting this proposal and has since requested feedback on this proposal to ensure that the process is already starting with collaboration from first responders. The Coalition also met with the Medical Director for Wake County EMS and the Chief Medical Officer for Wake County, Jose Cabanas, who has expressed a tremendous willingness to support a unit like this. Below are other key partners for existing North Carolina programs similar to the one proposed by the coalition.

In Jacksonville, NC, the council established a multi-agency team of key partners consisting of: Dix Crisis Intervention Center, local hospitals, CG Counseling, Onslow County Health Department, Onslow County Community Paramedics, Veterans Justice Initiative, Veterans Services of the Carolinas, and Trillium Health Resources.[79]

In Chapel-Hill, NC, key partners for the planning and implementation of the program were: Orange County Rape Crisis Center, Orange County Community Paramedics, Orange County Criminal Justice Resource Department, UNC & Duke Hospitals, The University of North Carolina at Chapel Hill, Interfaith Council for Social Service, Compass Center, Freedom House Recovery Center, and Alliance Health.[80]

Similarly, Durham, NC, formed a multi-agency planning team with the following partners: Emergency Medical Services, Durham Police Department, Department of Emergency Communications Center [911], Durham Fire Department, Alliance Health, Criminal Justice Resource Center, UNC School of Social Work, Housing for New Hope, Research Triangle Institute (RTI), and Recovery Innovations to plan its pilot.[81] Durham city council also conducted multiple ride-alongs with Durham police officers and interviews with peer support specialists, community health workers, mental health professionals, and met with local community organizations to help plan.[82]

Finally, Durham received assistance from an incredible resource, the Harvard Kennedy School Government Performance Lab ("GPL"). The GPL has a program entitled, "The Alternative 911 Emergency Response Community of Practice." The program is open to governments exploring, planning, implementing, or expanding alternative 911 emergency response teams. Designed exclusively for government staff, the community of practice provides representatives from over 70 governments across the country with practical tools and actionable insights emerging from the GPL's alternative 911 emergency response work and research. The community of practice convenes monthly, providing a space for participants to engage with government peers on topics such as: outcomes tracking, team training, request for proposal (RFP) design, community outreach, stakeholder collaboration, scaling and expanding pilot programs. On the program's website, Ryan Smith, Durham's City Manager, boasted of the program's technical assistance, stating, "The GPL Implementation Cohort is one of the best technical assistance experiences I've participated in. Sometimes, technical assistance requires a lot of producing extra deliverables for the organization, which becomes added work, and there is none of that here. This is striking that sweet spot of helping us with wherever we are at." The program could be an excellent resource to the Raleigh City Council for more technical aspects of the unit's implementation.

The Raleigh Coalition has met with several possible key partners over the past couple of months, including: the Wilson Center for Science and Justice, RTI, the UNC School of Government, which currently has an ongoing alternative responder project designed to assist municipalities interested in learning about implementation of these programs, and NAMI. Wake County has existing contracts with a possible healthcare partner, Alliance Health, and there are other healthcare institutions that currently support

79 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 39.
80 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 36.
81 https://www.durhamnc.gov/Faq.aspx?QID=775
82 https://www.durhamnc.gov/Faq.aspx?QID=775

existing alternative response programs, such as RHA Behavioral Health, which assists with the alternative response program in Burlington, NC, and The Santé Group, which assists with the alternative response program in Charlotte, NC. Healthcare institutions and academic institutions, such as the NC State and UNC Schools of Social Work, are also possible partners that can assist in staffing as well as planning. The Santé Group for instance handles all medical staffing for Charlotte's alternative response program, as does RHA for Burlington's program.

Lastly, many municipalities with existing alternative response programs, like the one proposed by the Raleigh Coalition, have expressed a deep desire and willingness to collaborate and support other municipalities attempting to implement similar programs. Captain Brian Sanders of the Charlotte-Mecklenburg Police Department ("CMPD") stated in 2021 that 12 police departments within the state reached out to CMPD because they wanted to model its program. The Raleigh Coalition also contains many community organizations that are more than willing to offer support and assistance to the Raleigh City Council in any way needed.

The creation of a multi-agency planning team that includes first responders, the Emergency Communications department leadership, health care institutions, and community organizations is critical to the success and sustainability of an alternative response unit. In addition to implementation planning, assistance, and coordination, the team also serves to assist in tweaking and perfecting the unit as time goes on.

Funding of Raleigh's Alternative Response Unit

From the Raleigh Coalition's conversations with Raleigh City Council, the Coalition understands that City Council intends for some funding to come from the existing sales tax windfall; however, there are multiple other options for funding in the form of state and federal grants. Other North Carolina cities that have implemented alternative response units have taken advantage of some of this funding.

In Jacksonville, the city utilized the Governor's Crime Commission grants to fund their crisis counselor and social worker positions.[83] The city also used the Bureau of Justice Assistance's Comprehensive Opioid & Substance Use Prevention Program (COSSUP) to fund a substance abuse counselor position.[84] Winston-Salem received $700,000 in grant funding from the American Rescue Plan Act to fund their entire pilot program.[85] Durham's budget, provided in Appendix C below, utilized Federal grants as well, although the exact grants are not named in the budget. In March 2023, Chapel-Hill received $1.2 million in state grant funds from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services in the North Carolina Department of Health and Human Services.[86] Similarly, Greensboro funded its co-responder program with $300,000 in state-awarded grant money.[87] Collaborating with other municipalities that have received grant funding at the state and federal level will assist Raleigh in finding available grant opportunities.

83 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 39.
84 https://cjil.sog.unc.edu/wp-content/uploads/sites/19452/2023/07/ARP-Final-Report_2023.7.31.pdf at 39.
85 https://triad-city-beat.com/winston-salem-looks-to-implement-police-free-response-option-while-greensboros-co-response-model-enters-third-year/
86 https://www.dailytarheel.com/article/2023/03/city-grant-law-enforcement-mental-health
87 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf at 45.

Appendix A-RTI 911 Call Data Analysis

RALEIGH'S 911 CALL DATA ANALYSIS

For full report click here

In 2022, RTI International partnered with the Raleigh City Manager's Office, the Raleigh Police Department, the Raleigh Office of Strategy and Innovation, and other relevant City departments for the Carolina Cohort of Cities project.[88] The below analysis highlights key aspects of RTI's report. The purpose of the Carolina Cohort of Cities project was to analyze 3 years of 911 call data and provide Raleigh leadership with "the opportunity to make decisions based on data that would meet community desires to appropriately address need and police desires to learn about alternative approaches." The seven participating cities and their relevant respective data, such as population, are shown below.

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

RTI examined 986,612 call events from Raleigh's computer-aided dispatch (CAD) ranging from October 1, 2017, to October 31, 2020. Police agencies differ in how they record incoming 911 event information, with high degrees of variation in the classification of event nature, close code, and event source. Raleigh had over 500 distinct classifications for event nature, 84 close code options, and 4 event source options. With the assistance of crime analysts and Raleigh stakeholders, RTI was able to aggregate all of the events into 18 event natures, eight close codes, and two event sources.

88 https://www.rti.org/sites/default/files/cohort_of_cities_final_report_09292022.pdf

Table 3. Standardized Categories for Event Description Formatting

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

LE = Law enforcement

Table 4 below shows the population and yearly events for each city in the cohort and their event rate per 1,000 community members. Raleigh had an average of 320,016 yearly events with a population of 474,069 resulting in an average event rate per 1,000 community members of 675. Durham had an average of 298,972 yearly events with a population of 278,993 resulting in an event rate per 1,000 community members of 1,072. Despite the higher population, Raleigh had a statistically significant lower event rate than Durham, as well as an event rate below the average for the seven city cohort.

Table 4. Yearly Event Volume and Rate across Cities

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

Table 6 below shows the prevalence of each event nature for the aggregate data of the seven city cohort. Event categories are exclusive and each event was only counted in one category. General assistance consists of police community contacts, welfare checks, and police assistance for other needs. General assistance and quality of life events, both of which contain scenarios that could be dealt with by an unarmed Community Response Team, such as welfare checks, were two of the top three categories of events. Mental Health and Domestic/Family account for a combined 4.3% of all events and 6.8% of all community events. Isolating community-initiated events provides a clearer picture of community priorities and the demands on police from community members.

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

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

Table 10 below shows a breakdown of the amount of time Raleigh Police Department (RPD) spent responding to each of these events. This data shows that during the collection period, RPD spent over 2.1 million minutes responding to Mental Health calls. In total, RPD spent a quarter of its time responding to Mental Health, Quality of Life, Domestic/Family, and General Assistance calls. While it would not be appropriate for unarmed Community Response Teams to respond to all of these calls, a portion of the calls related to welfare checks, nonviolent domestic incidents, and incidents where family members are calling because a loved one is in crisis can be diverted to unarmed teams.

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

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

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

In addition to collecting data over a multi-year span, RTI also utilized data analysis to track trends for each event nature. Figure 3 below shows trends for each event nature broken down by city. Significant increases in event volume are represented by red shading, and significant decreases in event volume are represented by green shading. Non-significant trends are grayed out and black cells represent data that were not relevant based on reported event volume. Raleigh experienced increases in both Mental Health events and Domestic/family events, as well as general Disturbance calls which included community members calling about raucous related to individuals experiencing homelessness.

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

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

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

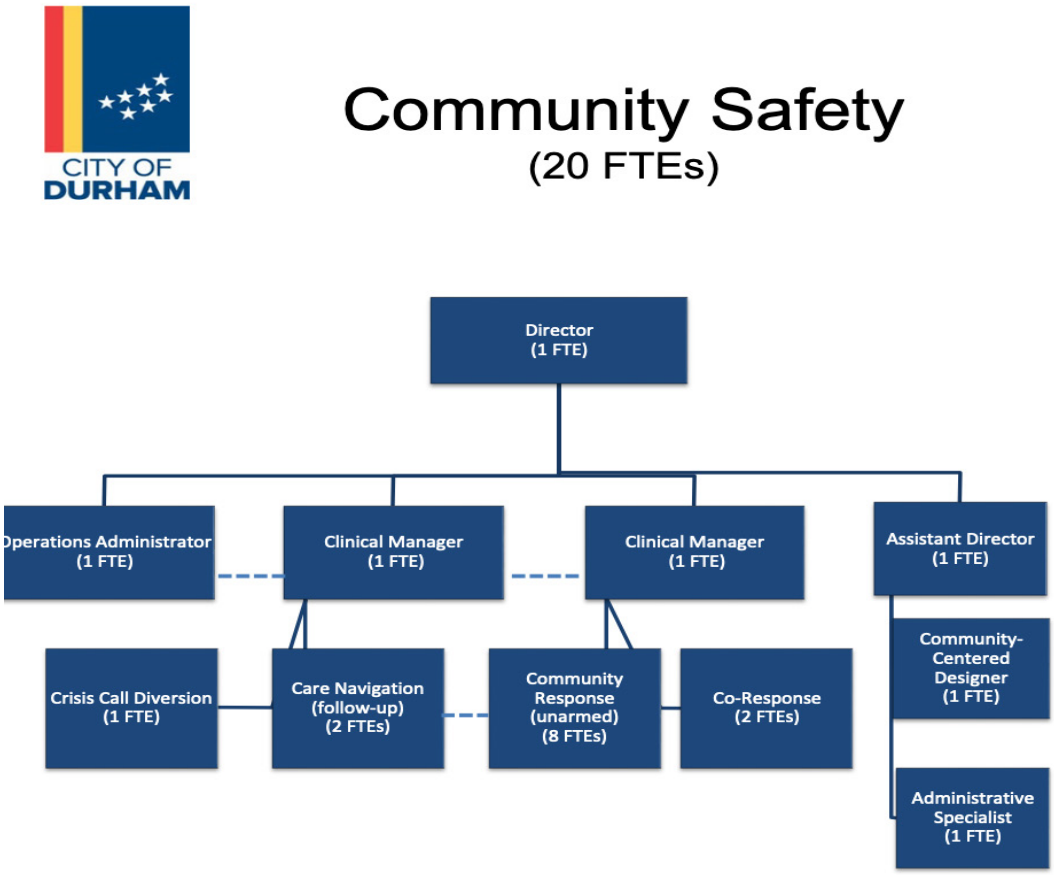
RTI's data analysis also included an analysis of close codes. The description of the event disposition, measured in the data as the event close code, is a useful measure for the outcomes of police interactions with the public and the general operational approach of the department. Table 7 below shows the aggregate data of event close codes for the seven city cohort. Despite Mental Health being 1.4% of all events, as shown in Table 6, event close code data shows that an event was coded Mental Health/CIT only .2% of the time. This data shows that rather than report a close code of Mental Health, these scenarios ended either through arrest or some other code, preventing the community members involved from getting treatment in the most effective manner. Referral outside of law enforcement was similarly low at .1 percent.

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

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

Appendix B-Example Job Descriptions/Department Structure for Raleigh's Alternative Response Unit

Durham hires master's level social workers or related fields, peer support specialists (GED level), and EMTs. The city uses a variety of strategies to fill these positions that range from traditional processes (posting open positions on the City's website), to using a paid LinkedIn recruiter tool to proactively reach out to potential candidates and encourage them to apply, to working with local schools of social work and professional organizations. The city manager has expressed confidence that all open positions this year will be filled which would take the Community Safety Department to a 50-person department. Starting the first week of September, Durham's Community Safety Department will be hiring 14 people and the city manager has expressed that recent hiring has been easier than during the program's first year when the program did not have an established track record.



Example Position Description for Crisis Response Clinicians

Hiring Range: $56,576 - $75,000

DCSD is currently hiring for Crisis Response Clinicians interested in any of the four program areas below. Many of our Crisis Response Clinicians rotate through at least two programs, and most are cross-trained between programs. While not everyone will serve in multiple programs, we are looking for candidates excited about working in multiple programs. In the application process, you will have an opportunity to let us know which programs you are most interested in as well as any you would not want to serve in.

- **Crisis Call Diversion** embeds licensed clinicians into Durham's 911 call center to triage, assess, and respond remotely to behavioral health related calls that can be resolved over the phone. It also supports in-person response and provides follow-up check-ins when appropriate for people who previously encountered emergency services. Its primary goal is to provide individuals with quality remote care and/or connect individuals to in-person care.
- **The Community Response Team** program sends three-person teams—consisting of a Crisis Response Clinician, a Peer Support Specialist, and EMT—to 911 calls for service involving behavioral health and quality of life concerns. CRT responds in-person without law enforcement and has a strong track record of safety (responders report feeling safe on over 99 percent of calls). Crisis Response Clinicians are responsible for behavioral health assessment, crisis intervention, and de-escalation in collaboration with their teammates. Crisis Response Clinicians act as team leads.
- **Co-Response** dispatches a Crisis Response Clinician with a Crisis Intervention Trained (CIT) police officer to the highest risk calls involving behavioral and mental health, substance use, and conflict mediation needs. The Crisis Response Clinician is responsible for behavioral health assessments, therapeutic interventions, and de-escalation in collaboration with the CIT officer.
- The **Care Navigation** program assigns two-person teams—consisting of a Crisis Response Clinician and a Peer Support Specialist—to follow-up with residents within 48 hours of initial encounter with one of the crisis response teams mentioned above. Care Navigators' primary goal is to connect residents to the care they want and need within 30 days of initial encounter.

Crisis Response Clinicians will receive general administrative direction and clinical supervision from the Shift Supervisors. They will not carry out supervisory tasks.

Schedule: 40 hours per week, consisting of three in-person 12 hour shifts and four hours of administrative work time. Responders are assigned shift hours of either 9 am to 9 pm or noon to midnight. Shift hours remain the same (i.e. those assigned to a 9 am to 9 pm shift never work noon to midnight, and vice versa). Responders will work one out of every three weekends. They will also have a six to seven day break every six weeks (built into their schedule). More information on schedule will be given during the interview process.

Duties/Responsibilities

- Respond to 911 calls related to behavioral and mental health, substance use, Intellectual Developmental Disability crises, and quality of life concerns using, people-centered and trauma-informed crisis intervention strategies.
- Develop highly collaborative, trusting, and productive relationships with other crisis response team members. Screen and assess individuals experiencing behavioral and mental health, substance use, Intellectual Developmental Disability, and quality of life related calls crises.
- Work closely with team members to de-escalate crisis situations and provide therapeutic interventions to individuals experiencing crisis.
- Develop individual care plans that identify the needs and barriers to treatment for individuals experiencing crisis and draw on the knowledge and insights of other team members.
- Maintain strong working knowledge of DSM5 diagnostic criteria, particularly for substance use, Severe Mental Illness (SMI) and Severe Persistent Mental Illness (SPMI), and Intellectual Developmental Disability.
- Provide "second response" follow-up to individuals who experienced crises, and others potentially affected by

that crisis, to assess if and how further support might be extended.
• Assure that connections are made to services and supports based on individual choice and clinical assessment. Facilitate warm handoffs to other services as needed, which could involve directly transporting the individual in assigned work vehicle.
• Maintain accurate and up-to-date documentation as required by program deliverables and departmental, local, state, and federal policy and requirements.
• Develop and maintain clear, open, timely, cooperative, and collaborative communication and working relations with all staff, clients, community partners, and partner agencies.
• Participate in clinical and administrative supervision, case conferences, staff meetings, in-service training, continuing education units, and other staff development activities.
• Contribute to strategic planning activities and conversations regarding the performance and direction of the department, particularly in regard to crisis response and departmental culture.
• Demonstrate a high level of resilience and self-care as part of maintaining wellness in a high crisis and first responder position.

Minimum Qualifications & Experience

- Master's degree in social work, psychology, or related human services field.
- One year of relevant experience
- Provisionally licensed or fully licensed professional within any of the following areas:
    - Licensed or Provisionally Licensed Clinical Addiction Specialist (LCAS/A)
    - Licensed or Provisionally Licensed Clinical Mental Health Counselor (LCMHC/A)
    - Licensed or Provisionally Licensed Clinical Social Worker (LCSW/A)
    - Licensed or Provisionally Licensed Marriage and Family Therapist (LMFT/A)
- A track record of demonstrating initiative and sound judgment when handling ambiguity.
- Ability to maintain confidentiality, and particularly HIPAA confidentiality, at all times.
- Must be able to travel to and from worksite and other locations within Durham
- Must be able to walk/stand up to 75% of any assigned shift.
- A commitment to and interest in the mission of the department: to enhance public safety through community-centered approaches to prevention and intervention as alternatives to policing and the criminal legal system.
- A commitment to equity, which could include having already attended racial equity trainings.

Additional Preferred Skills

- Two or more years of crisis response experience.
- Experience working with Peer Support Specialists or other individuals with lived experience with behavioral and mental health, substance use, and/or Intellectual Developmental Disability crises.
- Prior experience in outreach/engagement to populations experiencing frequent behavioral and mental health, substance use, and/or Intellectual Developmental Disability crises.
- Strong knowledge and experience with service delivery documentation (including counseling/treatment planning), HIPAA/• • • Confidentiality standards, utilization review, and data management.
- Ability to speak two or more languages, with a high priority on Spanish.
- Familiarity with Durham health systems and community resources/services for physical health behavioral and mental health, substance use, Intellectual Developmental Disability, family dynamics, sexual/physical abuse, Veterans' Services, vocational rehabilitation, housing, justice involvement, and other services.
- Advanced collaboration and interpersonal skills with the ability to build consensus and promote the exchange of information among team members and partners.
- A commitment to, knowledge of, and affection for Durham and its communities, which could include living in Durham.

Example Position Description for Peer Support Specialist

Hiring range: $44,601 - $58,000

DCSD is currently hiring Peer Support Specialists for our Care Navigation and Community Response Teams. DCSD recognizes lived experience as an important form of expertise that helps better position our teams to provide compassionate care. Please review the program descriptions below. Note that many of our Peer Support Specialists rotate through our two programs. While not everyone will serve in both programs, we are looking for candidates excited about working in multiple programs. In the application process, you will have an opportunity to let us know which programs you are most interested in as well as any you would not want to serve in.

• The **Community Response Team** program sends three-person teams—consisting of a Crisis Response Clinician (who functions as a team lead), a Peer Support Specialist, and EMT—to 911 calls for service involving behavioral health and quality of life related concerns. Note that CRT responds in-person without law enforcement. CRT responds in-person without law enforcement and has a strong track record of safety (responders report feeling safe on over 99 percent of calls). Peer Support Specialists are encouraged to regularly engage with residents by providing input on community resources and previous lived experience. They are also asked to provide creative and supportive intervention and de-escalation in collaboration with their teammates.
• The **Care Navigation** program assigns two-person teams—consisting of a Crisis Response Clinician (who functions as a team lead) and a Peer Support Specialist—to follow-up with residents within 48 hours of initial encounter with one of the crisis response teams mentioned above. Care Navigators' with a primary goal of connecting residents to the care they want and need within 30 days of initial encounter.

Peer Support Specialists will receive general administrative direction and clinical supervision from the Shift Supervisors. They will not carry out supervisory tasks.

Schedule: 40 hours per week, consisting of three in-person 12 hour shifts and four hours of administrative work time. Responders are assigned shift hours of either 9 am to 9 pm or noon to midnight. Shift hours remain the same (i.e. those assigned to a 9 am to 9 pm shift never work noon to midnight, and vice versa). Responders will work one out of every three weekends. They will also have a six to seven day break every six weeks (built into their schedule). More information on schedule will be given during the interview process.

Duties & Responsibilities:

• Respond to 911 calls related to mental health, behavioral health, and substance use crises using people-centered and trauma-informed crisis intervention strategies.
• Develop highly collaborative, trusting, and productive relationships with other Community Responder Team members.
• Provide culturally competent peer support to individuals experiencing non-violent, mental and behavioral health crises, substance use crises, or Intellectual Developmental Disability crises, or quality of life crises.
• Act as an advocate for individuals in crisis and individuals on-scene, ensuring their needs are met and barriers to treatment are removed.
• Assist peers in identifying and engaging various community resources and supports.
• Work collaboratively with CRT members to assess the needs of individuals experiencing crises and assist in developing response plans.
• Follow-up to assure that connections are made to services and supports based on peer choice and clinician assessment. •
• Facilitates warm handoffs to other services as needed.
• Maintain accurate and up-to-date documentation as required by the agency, local, state, and federal policy and requirements.
• Meet with peers to establish and maintain a positive and trusting relationship that is person-centered, strengths-based, and trauma-informed.

• Develop and maintain clear, open, timely, cooperative, and collaborative communication and working relations with all staff, clients, and partner agencies.
• Participate in clinical and administrative supervision, case conferences, staff meetings, in-service training, and other staff development activities. Integrate peer voices in planning, policy, and evaluation conversations.
• Contribute to strategic planning activities and conversations regarding the performance and direction of the department, particularly in regard to crisis response and departmental culture.
• Demonstrate a high level of resilience and self-care as part of maintaining wellness in a high crisis and first responder position.

Minimum Qualifications and Experience:

• High school diploma (or GED).
• At least 2-3 years of direct lived experience with substance use, behavioral health, or criminal justice systems.
• Completion of a mental health certificate program, peer support specialist certificate, or equivalent education.
• Two years of peer counseling or related experience working with diverse constituencies.
• Previous professional experience in crisis response or crisis intervention roles.
• Knowledge of:
    • the signs and symptoms of mental illness (i.e. auditory and visual hallucinations, aggressive talk and behavior, thoughts of self-harm or harm towards others, isolation, etc.), and
    • methods and techniques used in crisis intervention and crisis de-escalation (i.e. Crisis Intervention Training, Seeking • • Safety, Motivational Interviewing).
• A track record of demonstrating initiative and sound judgment when handling ambiguity.
• Must be able to travel to and from worksite and other locations within Durham.
• Basic computer knowledge and skills.
• Must be able to walk/stand up to 75%of any assigned shift. Note: The team will be transported in vans to crisis call locations.
• A commitment to and interest in the mission of the department: to enhance public safety through community-centered approaches to prevention and intervention as alternatives to policing and the criminal legal system.
• A commitment to equity, which could include having already attended racial equity trainings.

Strong candidates may also have:

• Significant experience with crisis response.
• Prior experience in outreach/engagement to populations under inordinate stress.
• Personal lived experience with those struggling with symptoms of mental illness, Intellectual Developmental Disabilities, alcohol or other drug use, justice involvement and/or homelessness.
• Strong knowledge and experience with service delivery (including counseling/treatment planning), documentation, clinical coverage policies (NC Service Definitions, i.e. ACT, CST IOP, SACOT, Innovation Wavier), utilization review, and data management.
• Ability to maintain confidentiality/HIPPA standards at all times.
• Ability to speak two or more languages, with a high priority on Spanish.
• Familiarity with Durham health systems and community resources/services for physical health behavioral and mental health, substance use, Intellectual Developmental Disability, family dynamics, sexual/physical abuse, Veterans' Services, vocational rehabilitation, housing, justice involvement, referral processes, and other services.
• Advanced collaboration and interpersonal skills with the ability to build consensus and promote the exchange of information among team members and partners.
• A commitment to, knowledge of, and affection for Durham and its communities, which could include living in Durham.

Example Position Description for Community Responder EMT

DCSD is currently hiring EMTs for our Community Response Teams. However, there may be some minimal overlap with our Care Navigation Team. Please review the program descriptions below.

• The **Community Response Team** program sends three-person teams—consisting of a Crisis Response Clinician (who functions as team lead), a Peer Support Specialist, and EMT—to 911 calls for service involving behavioral health and quality of life related concerns. Note that CRT responds in-person without law enforcement. EMTs are encouraged to regularly engage with residents by medical care and screening to community members. They are also asked to provide creative and supportive intervention and de-escalation in collaboration with their teammates.
• The **Care Navigation** program assigns two-person teams—consisting of a Crisis Response Clinician (who functions as team lead) and a Peer Support Specialist or EMT—to follow-up with residents within 48 hours of initial encounter with one of the crisis response teams mentioned above. Care Navigators' with a primary goal of connecting residents to the care they want and need within 30 days of initial encounter.

EMTs will receive general administrative direction and clinical supervision from the Shift Supervisors. They will receive medical direction from Durham County's EMS Medical Director. They will not carry out supervisory tasks.

Schedule: 40 hours per week, consisting of three in-person 12 hour shifts and four hours of administrative work time. Responders are assigned shift hours of either 9 am to 9 pm or noon to midnight. Shift hours remain the same (i.e. those assigned to a 9 am to 9 pm shift never work noon to midnight, and vice versa). Responders will work one out of every three weekends. They will also have a six to seven day break every six weeks (built into their schedule). More information on schedule will be given during the interview process.

Duties & Responsibilities:

• Respond to 911 calls related to mental and behavioral health, substance use, and/or Intellectual Developmental Disability crises using people-centered and trauma-informed crisis intervention strategies.
• Develop highly collaborative, trusting, and productive relationships with other Community Responder Team members.
• Provide prehospital medical care to sick or injured persons experiencing non-violent mental and behavioral health, substance use, and/or Intellectual Developmental Disability crises.
• Administers medications and performs medical procedures that have been approved for AEMT by the North Carolina Office of Emergency Medical Service.
• Advise on and attend to any potential underlying physical complications or conditions the individual in crisis may be experiencing.
• Work collaboratively with CRT/CN members to assess the needs of individuals experiencing crises and assist in developing response plans.
• Follow-up to assure that connections are made to services and supports based on peer choice and clinician assessment. • • Facilitates warm handoffs to other services as needed.
• Maintains medical equipment and supplies in proper working order.
• Maintain accurate and up-to-date documentation as required by program deliverables and local, state, and federal policy and requirements.
• Develop and maintain clear, open, timely, cooperative, and collaborative communication and working relations with all staff, clients, and partner agencies.
• Maintains all continuing education required for the AEMT level within Durham County and NC OEMS.
• Participate in supervision meetings, case conferences, staff meetings, in-service training, and other staff development activities.
• Contribute to strategic planning activities and conversations regarding the performance and direction of the department, particularly in regard to crisis response and departmental culture.

• Demonstrate a high level of resilience and self-care as part of maintaining wellness in a high crisis and first responder position.

Minimum Qualifications and Experience:

• Graduation from high school or GED supplemented by courses in emergency medical care.
• One year experience as an EMT required.
• Certification by the NC Office of Emergency Medical Services (NC OEMS) as an Advanced EMT required.
• Eligible to function under the auspices of the Durham County Office of Emergency Services, EMS Division, and Medical Director.
• Must have a valid NC driver's license.
• A track record of demonstrating initiative and sound judgment when handling ambiguity.
• Must be able to travel to and from worksite and other locations within Durham
• Must be able to walk/stand up to 75% of any assigned shift. Note: The team will be transported in vans to crisis call locations
• Must be able to lift over 100 lbs occasionally, 50-100 lbs. frequently, or up to 20-50 lbs constantly.
• A commitment to and interest in the mission of the department: to enhance public safety through community-centered approaches to prevention and intervention as alternatives to policing and the criminal legal system.
• A commitment to equity, which could include having already attended racial equity trainings.

Strong candidates may also have:

• Significant experience with crisis response.
• Crisis Intervention Team certification
• Experience working with Peer Support Specialists or other individuals with lived experience with behavioral and mental health, substance use, and/or Intellectual Developmental Disability crises.
• Prior experience in outreach/engagement to populations experiencing frequent behavioral and mental health, substance use, and/or Intellectual Developmental Disability crises.
• Working knowledge of city and county geography, including location of roads, streets, hospitals, and other medical care facilities.
• Ability to speak two or more languages, with a high priority on Spanish.
• Working knowledge of radio communications equipment.
• Ability to drive a vehicle safely under various weather conditions.
• Strong knowledge and experience with service delivery documentation (including counseling/treatment planning), HIPAA standards/confidentiality, utilization review, and data management.
• Ability to maintain confidentiality, and particularly HIPAA confidentiality, at all times.
• Familiarity with Durham health systems and community resources/services for physical health behavioral and mental health, substance use, Intellectual Developmental Disability, family dynamics, sexual/physical abuse, Veterans' Services, vocational rehabilitation, housing, justice involvement, referral processes, and other services.
• Advanced collaboration and interpersonal skills with the ability to build consensus and promote the exchange of information among team members and partners.
• A commitment to, knowledge of, and affection for Durham and its communities, which could include living in Durham.

Appendix C- Durham, NC, 2022-2023 Budget for H.E.A.R.T.

PUBLIC SAFETY
BUDGET SUMMARY

Non-Grant Appropriations	Actual FY 2020-21	Adopted FY 2021-22	Estimated FY 2021-22	Adopted FY 2022-23	Change
Community Safety	$ -	$ 4,015,465	$ 2,459,102	$ 4,787,854	19.2%
Emergency Communications	5,945,887	8,761,877	8,047,460	8,930,361	1.9%
Emergency Management	282,723	293,556	293,556	293,556	0.0%
Fire	37,840,191	38,905,209	43,783,045	44,698,408	14.9%
Police	65,425,587	68,902,146	68,343,424	75,695,264	0.0%
Pay Adjustments/Others	-	2,734,487	2,734,487	566,358	-79.3%
Transfers to Other Funds	37,985	44,251	29,555	64,109	44.9%
Total Appropriations	**$109,532,373**	**$123,656,991**	**$125,690,629**	**$ 135,035,910**	**9.2%**
Full Time Employees	1187	1197	1197	1209	12
Part Time	-	-	-	-	-

DEPARTMENT DESCRIPTION

Community Safety

General Fund: $4,787,854
20 FTEs
Grant Funds: $139,000

In its second year, the department will have three primary functions: piloting alternative response models for 911 calls for service, collaborating with community members to identify and test new approaches to public safety, and managing and evaluating existing contracts and external partnerships intended to advance public safety.

Durham, NC, Full 2022-2023 Adopted Budget

For questions about the Raleigh HEART Coalition or its efforts to bring an alternative crisis unit to Raleigh, visit www.whatifraleighhadaheart.org or contact Jaelyn Miller at jaelyn@emancipatenc.org.