ACPP PRELIMINARY RESEARCH: ALTERNATIVE & CO-RESPONSE MODEL EXAMPLES AND ANALYSIS

EXAMPLES OF CO-RESPONSE/ALTERNATIVE MODELS

NEW JERSEY (STATEWIDE) – ARRIVE TOGETHER (**A**LTERNATIVE **R**ESPONSES TO **R**EDUCE **I**NSTANCES OF **V**IOLENCE AND **E**SCALATION)

- About ARRIVE Program (link), ARRIVE Data Dashboard (link)

Launched: December 2021 in Cumberland County, but now in all 21 counties in the state

- Five models:
    - **Co-Response Model**: Pairs state troopers with extensive training in behavioral health and de-escalation techniques (CIT) with a mental health professional who arrive at the scene simultaneously to provide the proper mental health services and de-escalate situations as needed.
    - **Follow-up Model**: Police identify potential individuals who may need mental health services, and then mental health professionals and community partners follow-up with the individuals without police there
    - **Close in time follow-up**: Mental health professionals can intervene as needed by police in the event that an individual needs mental health services. The partners then arrive at the scene to provide immediate care to the individuals.
    - **Telehealth Response****: Law enforcement respond on scene and mental health professionals join remotely via telephone or video conferencing
    - **Non-Law Enforcement Response****: Mental health professionals respond alone without an officer present (form of alternative response)

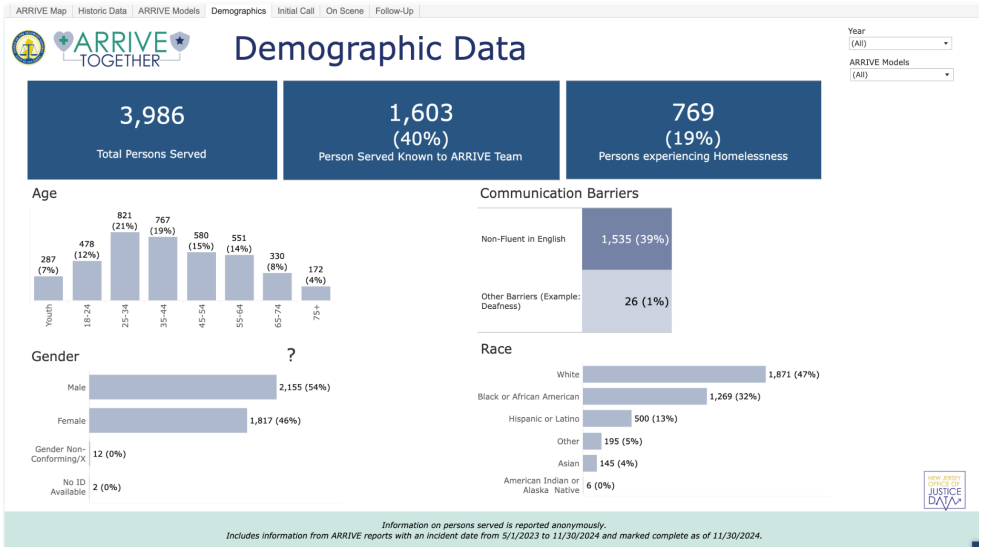
- **NOTES**: Though ARRIVE uses five models of response, the first three models (co-response, follow-up, & close in time follow-up) are predominantly used. Non-Law Enforcement and Telehealth responses make up approximately less than 10% of reports (2% and 5% respectively)

- Hours of operation and composition of teams per county amongst each of the models are not readily available

Data Transparency/Public Accessibility to Data:

- Overall:
  - Great representation of data
  - Easily accessible for public to view
  - Data is relatively current, with data as recent as 11/30/24

Demographic Data:

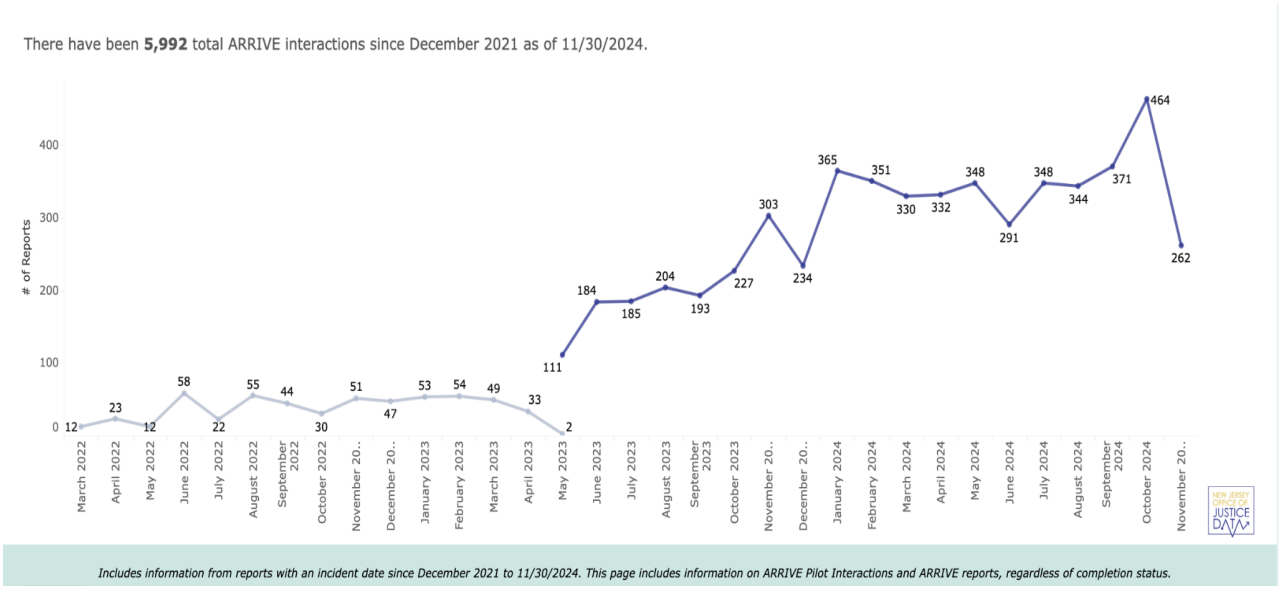


- Interesting to represent communication barriers in demographic data

- Based on the analysis and recommendations below from the Brookings report, the identifications of race may not be as consistent, depending on whether they use reporting from the ARRIVE team or from law enforcement

- Gender demographics are slightly misrepresented, as the transgender individuals identified in this data are counted under what gender is noted on their identification.

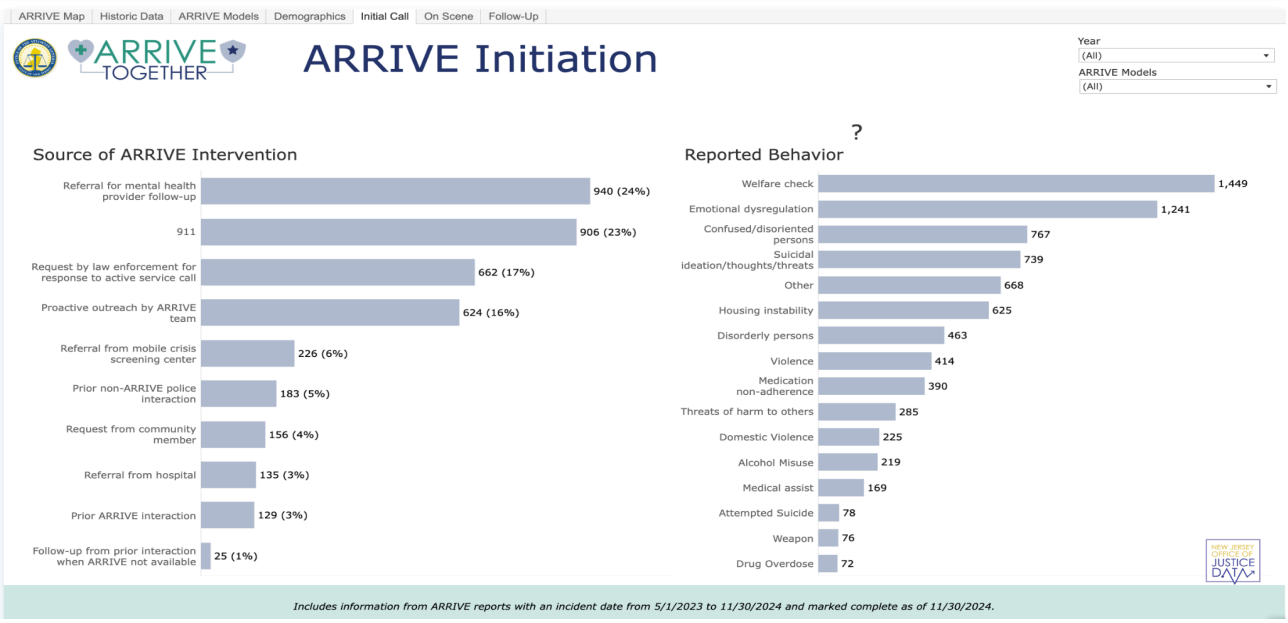
Total Interactions, Initiation, On-Site, and Follow-up Interventions (12/21–11/24)

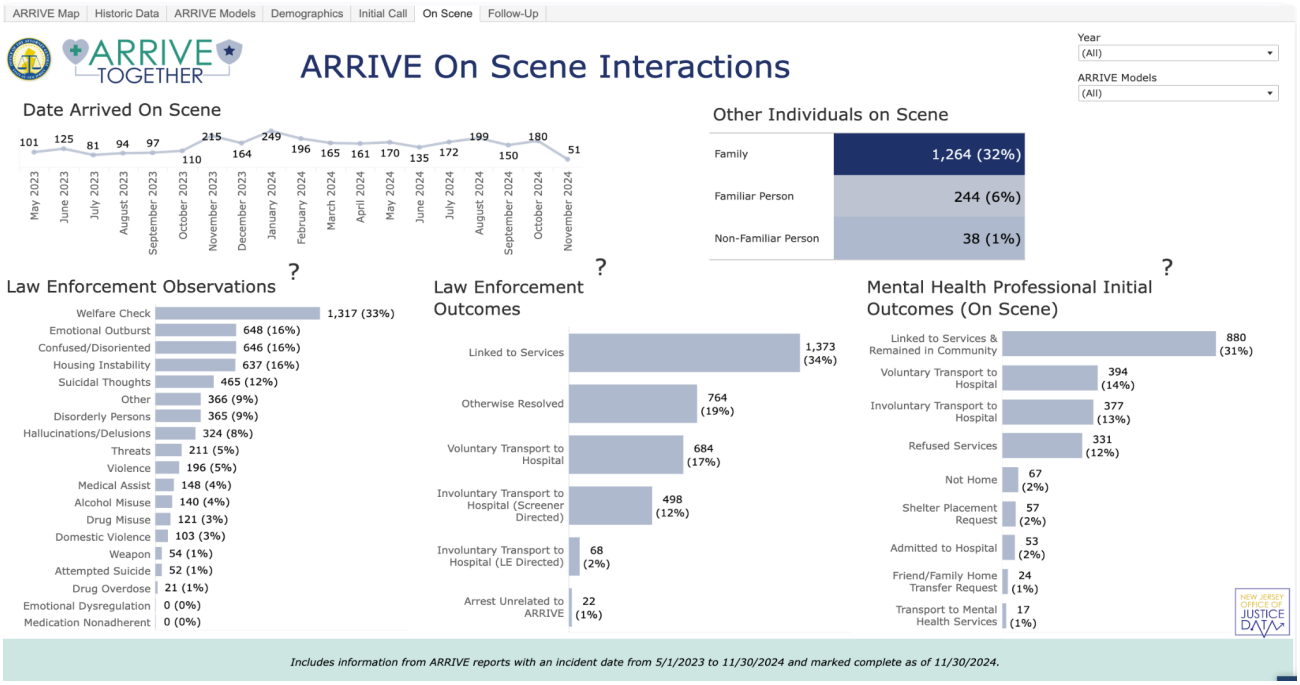


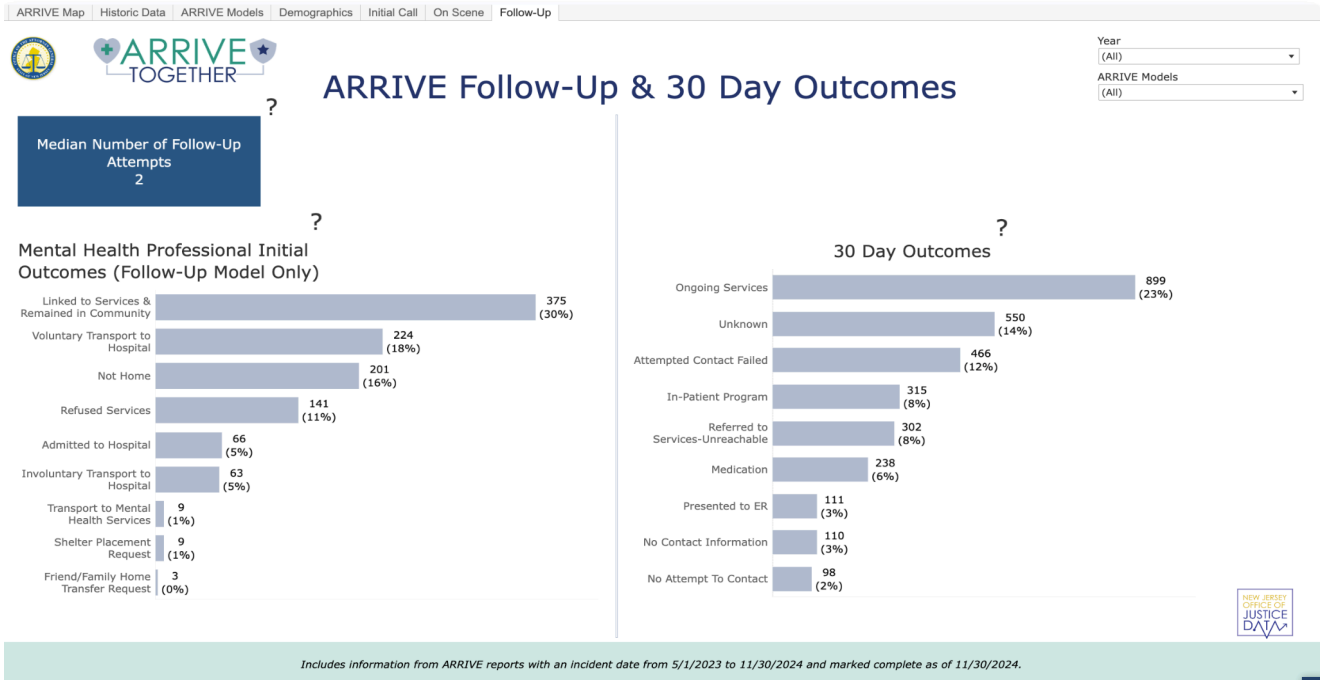
- Digestible representation of the ARRIVE interactions since the launch of the program

- This is the only graph under the “Historic Data” tab of the Data Dashboard

- Should include similar depictions in terms of arrests, especially comparing before and after implementation







Analysis by Brookings (link) – Data from 12/21–1/23 (342 calls)
Overall Consensus:

- Use of force was used in 3% of calls

- 98% of calls for service and follow-ups avoided arrest

- Though pilot data proves to be promising, there are still some gaps in reporting across jurisdictions, which can weaken the effectiveness the case of effectiveness

Recommendations:

- ARRIVE and similar programs must have a **detailed coding scheme** to track the type of mental health/mental illness symptoms and diagnoses that are being reported

- **Maintain complete and synchronized data collection and reporting across jurisdictions** to ensure validity and reliability.

- "It is important for ARRIVE team members to **describe how they use discretion** and how their **subjective judgements and behaviors may reduce their likelihood of using force** or arresting someone"

- **Clearer race/ethnicity identification** needs to be improved by law enforcement.

- It is important for an analysis such as this one to include the **demographics of the ARRIVE team**.

- Inclusion of **comparisons to non-ARRIVE Together** calls for service

- **State-level oversight** – ensures synchronization of information and sharing of best practices as well as the elimination of problematic processes

Overall, Brookings recommendations can serve as generalized quality metrics to measure the effectiveness of other co-response models

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VIRGINIA (ALEXANDRIA) – ACORP (**A**LEXANDRIA **C**O-**R**ESPONSE **P**ROGRAM)
ACORP Archived Page (link), ACORP Response to Effectiveness (link)

Launched: October 2021 in the city of Alexandria

- Consisted of three teams at the time of launch, but **since April of 2024, only two operating teams due to staff vacancies**

- Police officer with specialized behavioral health training, including CIT (Crisis Intervention Training) paired with Behavioral health therapist

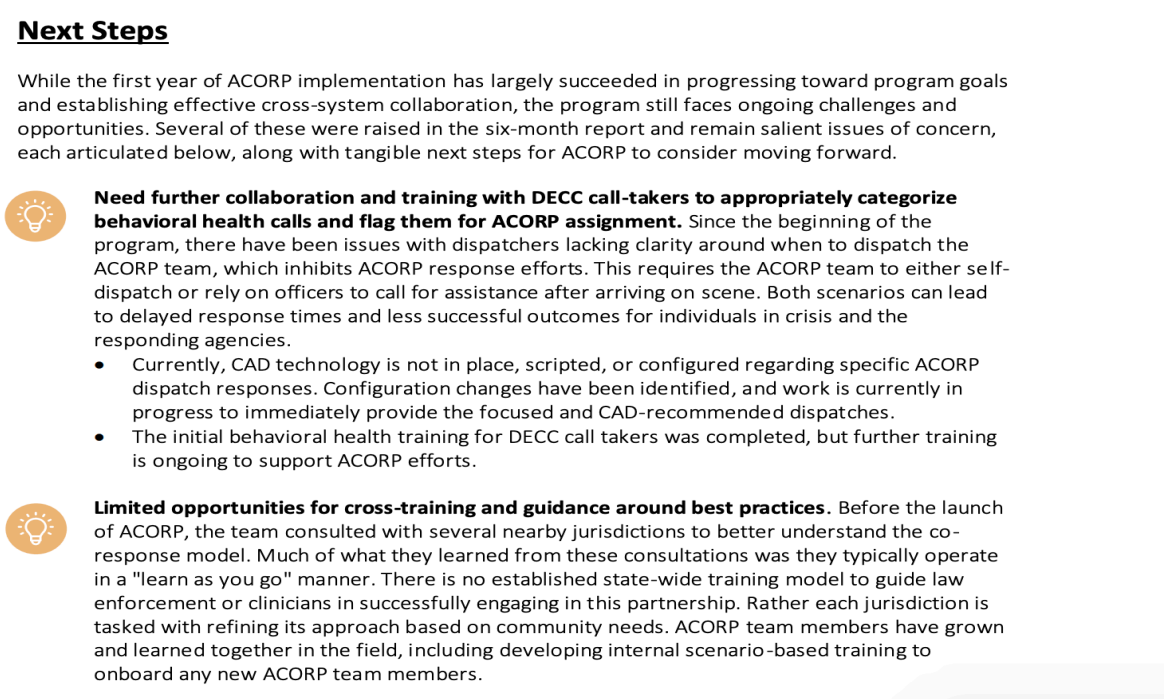
- Operates from Monday – Thursday from 10:00 AM - 9:30 PM
    - Captures approx (68.6%) of mental health calls received

Data Transparency/Public Accessibility to Data:

- Despite still being an active program, there is no official website (besides archived one linked above) from the city of Alexandria

- Most current data linked above (ACORP Response to Effectiveness), which provides little demographic and response data derived from their "internal ACORP dashboard" that does not appear to be accessible to the public

- Only accessible data analysis from external sources found is from a 2022 report conducted by OMNI Institute in 2022 (link)



Next Steps

While the first year of ACORP implementation has largely succeeded in progressing toward program goals and establishing effective cross-system collaboration, the program still faces ongoing challenges and opportunities. Several of these were raised in the six-month report and remain salient issues of concern, each articulated below, along with tangible next steps for ACORP to consider moving forward.

Need further collaboration and training with DECC call-takers to appropriately categorize behavioral health calls and flag them for ACORP assignment. Since the beginning of the program, there have been issues with dispatchers lacking clarity around when to dispatch the ACORP team, which inhibits ACORP response efforts. This requires the ACORP team to either self-dispatch or rely on officers to call for assistance after arriving on scene. Both scenarios can lead to delayed response times and less successful outcomes for individuals in crisis and the responding agencies.

- Currently, CAD technology is not in place, scripted, or configured regarding specific ACORP dispatch responses. Configuration changes have been identified, and work is currently in progress to immediately provide the focused and CAD-recommended dispatches.
- The initial behavioral health training for DECC call takers was completed, but further training is ongoing to support ACORP efforts.

Limited opportunities for cross-training and guidance around best practices. Before the launch of ACORP, the team consulted with several nearby jurisdictions to better understand the co-response model. Much of what they learned from these consultations was they typically operate in a "learn as you go" manner. There is no established state-wide training model to guide law enforcement or clinicians in successfully engaging in this partnership. Rather each jurisdiction is tasked with refining its approach based on community needs. ACORP team members have grown and learned together in the field, including developing internal scenario-based training to onboard any new ACORP team members.

Additionally, they are trying to identify and utilize existing training materials and attend National Co-Responder Conferences to gather additional resources. One of the largest current and ongoing training challenges is training additional teams while simultaneously responding to calls for service. As a result of this challenge, the last few months of the pilot show a decline in calls attended by ACORP because of the importance of prioritizing onboarding and administrative needs to promote the program's expansion.

Limited program capacity. As the data in this report indicated, the current ACORP team cannot fully meet the community's needs based on capacity constraints. Not only are there behavioral health calls for service that are not receiving an ACORP response, but the ACORP team is limited in terms of taking time off as needed for individual well-being and program sustainability. Program expansion will likely increase the team's ability to meet the community's needs and allow for appropriate and necessary breaks for existing and future team members.

Data limitations. While the data systems used for tracking ACORP efforts are great resources for most City functions, there are some limitations when it comes to utilizing them in the ACORP evaluation. Presently, the various data systems utilized in this pilot program do not communicate with one another, requiring manual input and matching of encounters. This introduces the possibility of human error and incomplete data collection. Additionally, the CAD currently does not allow for the required specificity in call outcomes. This results in hand-coding call outcomes based on officer documentation (which only exists in about 50% of cases). Additional data limitations include:

- Data collected by the program does not fully allow for best practices related to demographic data. More specifically, Race categories are mutually exclusive groups in ACORP data which is an inclusivity concern and results in imperfect mapping across census data. There are similar concerns with how Gender is reported, as ACORP only gathers information on a person's Sex, which does not include all of the categories needed to be fully inclusive.
- Data around transport destinations and substance use as a factor in the calls are currently unavailable. Although ACORP has started tracking these data points, it isn't reliable or consistent enough for reporting.

Recognizing that changes to data collection systems are costly and time prohibitive, the evaluation team, in partnership with OPA, operates within the parameters of the available data contained within these systems, which has limitations such as those outlined here. OPA and the evaluation team are committed to working within these systems in the most rigorous way possible---and are also committed to being transparent about the limitations of the data and margins of error that likely exist.

- The OPA and the evaluation team are working on expanding the mental health selection by officers into a more comprehensive "outcomes" question.
- The OPA and the evaluation team have updated CAD to allow the classification of calls in severity levels 1-4 (MARCUS alert levels) as of June 2022. However, as of 12-month reporting, this severity level reporting is not yet reliable and consistent. In the future, understanding the severity level of calls may allow prioritization of appropriate response teams (e.g., police may not need to go to calls of lower severity levels).

COLORADO (DENVER) – STAR (**S**UPPORT **T**EAM **A**SSISTED **R**ESPONSE PROGRAM)

About STAR Program (link)

- **Alternative response** team including behavioral health clinicians and paramedics to provide on-site care and adequate resources to individuals experiencing mental health distress and substance use disorders

- Responds to low-risk calls, where there are no significant safety concerns*
    - Cannot provide assistance to individuals presenting any harm to themselves or others (involuntary/302)

    - STAR is dispatched through Denver 9-1-1 Communications. All of the civilian call takers and dispatchers at the communications center are trained to triage STAR calls and send the most appropriate available response.

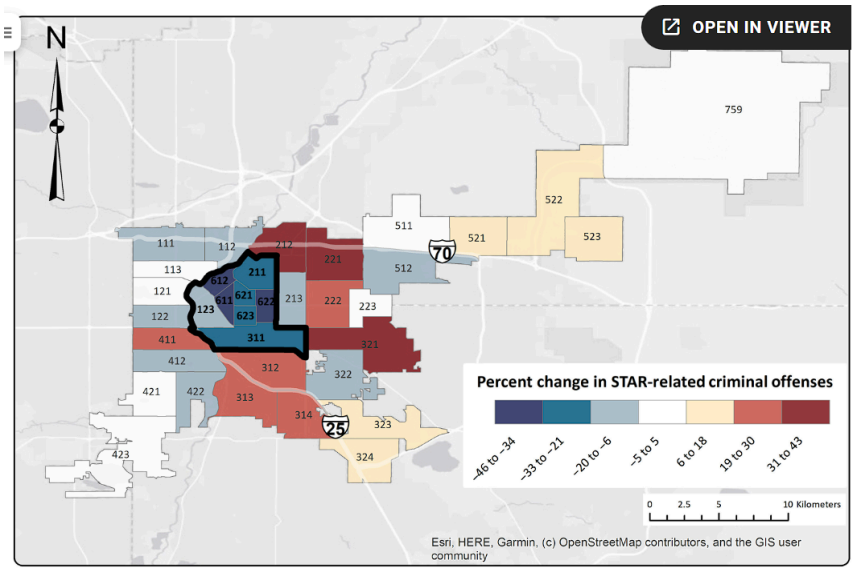
- Staff/Vehicles (current total count): 16 EMT/ paramedics, 16 behavioral health clinicians, 8 vans.

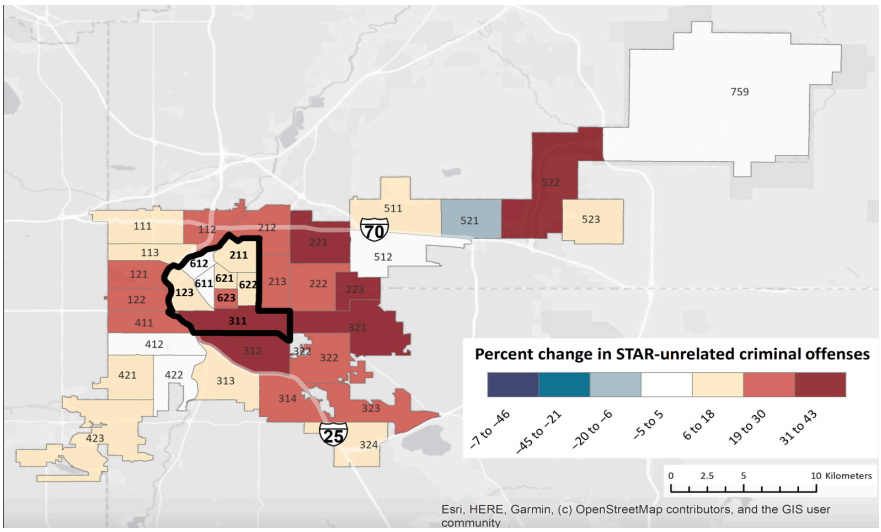
- Hours of Operation: 6 a.m. to 10 p.m. Monday - Sunday
    - Goal of expanding to 24/7 coverage by 2025

- Volume/Outcomes: Since June 1, 2020, STAR has responded to over 8,000 calls that would have otherwise been dispatched to police. 41% of individuals served by STAR were referred to formal mental health or substance use treatment. 38% of people served by STAR were transported to a community resource

Analysis conducted by the *Science Advances Journal* (link)

- Comparing STAR-Related and STAR-unrelated instances (potential baseline?)





- This estimated impact on the natural log of STAR-related crimes implies that the program reduced these targeted crimes by 34%
    - By contrast, the estimated effect of the STAR program on measured crimes that were not directly related to STAR services was comparatively small and statistically insignificant

- Great visual representation of criminal offense-reduction in STAR operating areas in Denver
    - Could serve as a model for other co-response programs to visualize their effectiveness

Other Sources of Analysis:

- Urban Institute, September 2024 (link)
- WellPower, 2023 (link)

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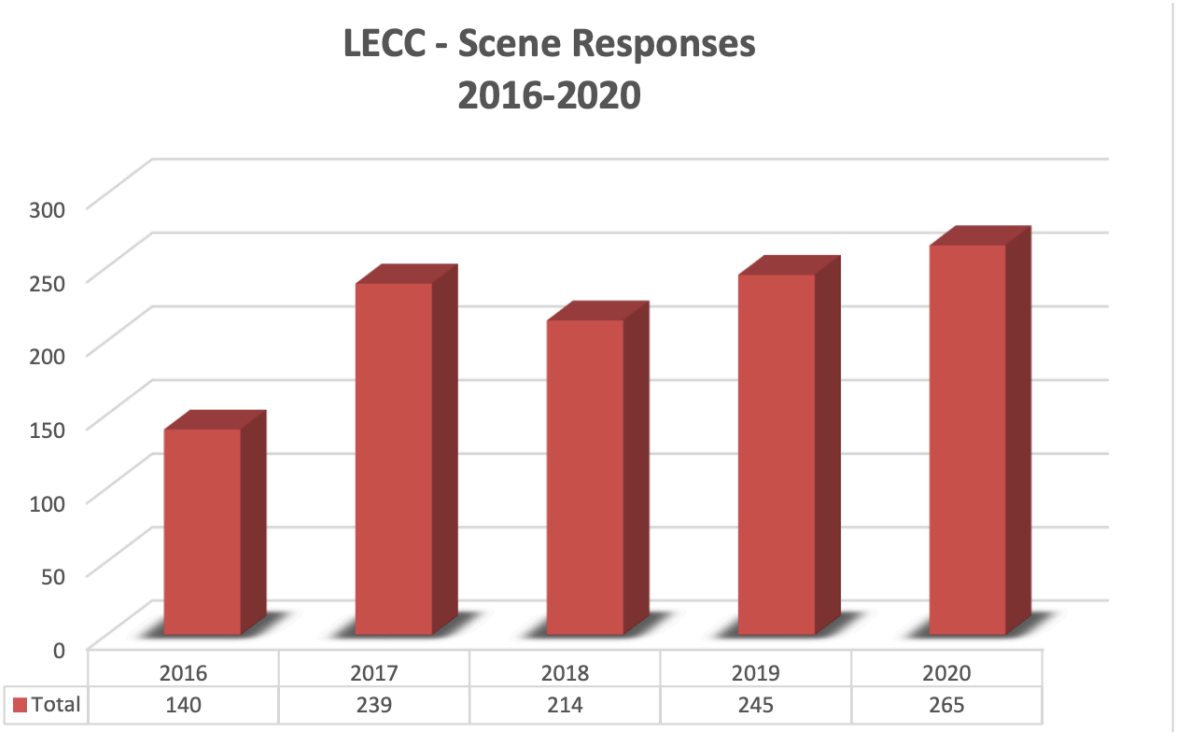
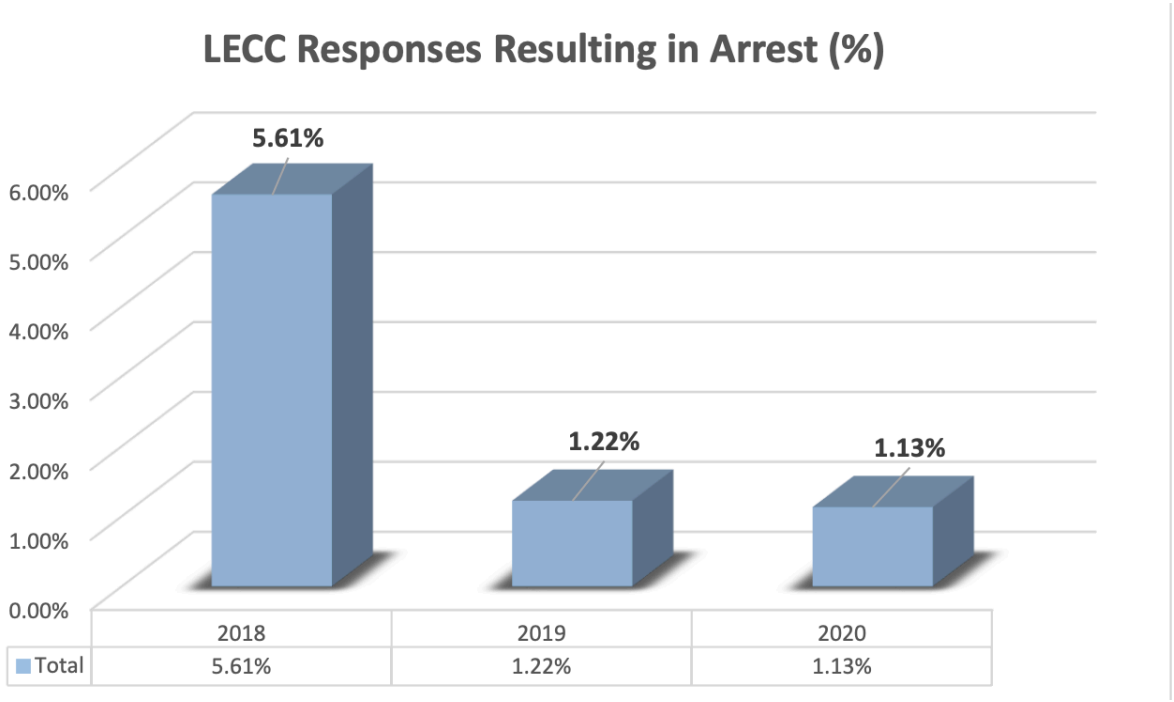
1. **NORTH CAROLINA (BURLINGTON) – LECC** (**L**aw **E**nforcement **C**risis **C**ounselor)

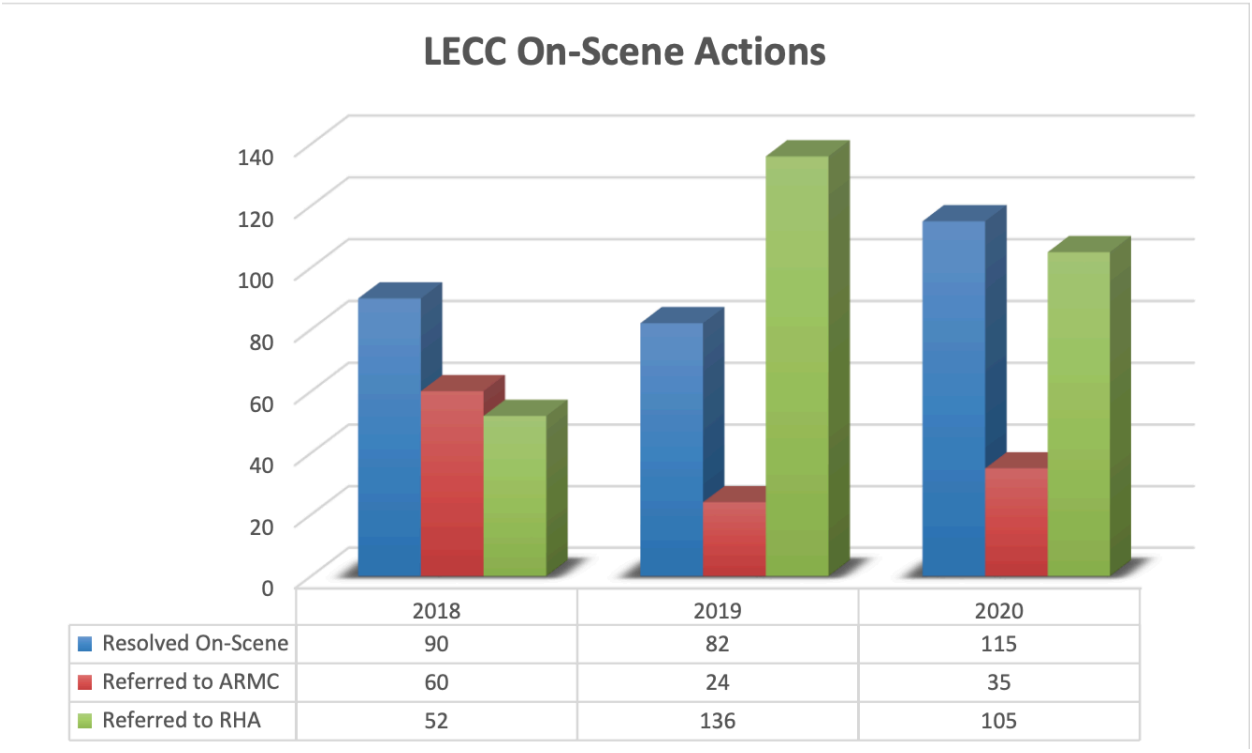
Launched: 2015 and expanded in 2016 in Burlington County

- A clinical mental health counselor responds with law enforcement to behavioral health-related calls, to provide care at the scene and connect people to services.

- The counselor also follows up with community members to prevent future involvement with law enforcement.







- Conducted in 2021 by the Burlington County Police Department (link)

- Further Analysis of this program and other co-response/alternative response models in North Carolina will be conducted and released for the public in 2025 (link)

INDIANA (INDIANAPOLIS) – CLCR (**C**linician **L**ed **C**ommunity **R**esponse)
About CLCR (link)

- Collaboration between the Indiana Office of Public Health and Safety and the

Analysis by the *Psychiatric Services Journal* (link)

- CRT vs. Normal in initial jail bookings: 5% (CRT) and 9% (Normal)
    - CRT resulted in a lower initial jail booking rate by 4% in a Weighted Logistic Regression Model
        - examines the relationship between CRT on emergency detention and booking outcomes as well as Normal calls on emergency detention and booking outcomes
    - Model also "weights" various factors to isolate skewing variables on emergency detention and booking outcomes.

a. Notable model is the unweighted chi square test by racial group in the multivariable tests (A hypothesis test to test if there are any variables statistically significant between races). The results indicate that black participants had lower rates of rearrest after a 12-month follow-up from 37% (Normal) to 25% (CRT).

RELEVANT STUDIES ANALYZING POLICE RESPONSE

Policing: An International Journal (PIJ) → The status of co-responders in law enforcement: findings from a national survey of law enforcement agencies (link)
Study conducted out of the University of Wyoming and George Mason University

- Analyzes CIT (497 teams) and Co-Response Models (232 programs)

- For the 232 responding agencies that did have co-responder teams, **39% only had one co-responder/qualified mental health professional accessible** by the department to respond to calls with an officer(i.e. one team)
    - 32% had two to three teams
    - 12% of agencies had four to six teams
    - Roughly 9% of agencies had seven or more teams

	N	%
Crisis Intervention Teams (CIT) and year adopted	497	87.5
Before 2000	13	2.6
2000–2009	138	27.8
2010–2019	235	47.3
2020–2023	48	9.7
Missing/not reported	*63*	*12.7*
Co-responder program and year adopted	232	40.8
Before 2000	3	1.3
2000–2009	8	3.4
2010–2019	94	40.5
2020–2023	106	45.7
Missing/not reported	*21*	*9.1*
Number of co-responder teams/qualified mental health professionals		
One	90	38.8
2–3	73	31.5
4–5	27	11.6
7+	20	8.6
Missing/not reported	*18*	*7.8*

- Variations in the composition, implementation, and availability of the

	N	%
Type of response by co-responder		
Rides with the police officer during patrol	136	58.6
Marked patrol vehicle	*68*	*50.0*
Unmarked patrol vehicle	*47*	*34.6*
Responds to mental/behavioral health calls separately from the officer	102	44.0
Provides support on the phone/radio to assist officers	104	44.8
Other type of support, such as follow-ups	50	21.6
Types of calls the team responds to		
Mental/behavioral health calls only	144	62.1
Other types of calls in addition to mental/behavioral health calls	82	35.3
Type of Uniform for Co-responder		
Soft-uniform	164	70.7
Tactical gear	43	18.5
Other responders with the team		
No	135	61.4
Yes; type	85	38.2
EMT	28	12.7
Case manager	6	2.7
Peer support specialist	10	4.5
Other	24	10.9
Hours of Operation		
24 h/day, 7 days/week	44	19.0
7 days/week, but not 24 h/day	45	19.4
Team operates on certain days of the week and times of day	128	55.2
Co-responder available by phone/radio		
Yes	122	52.6
No	58	25.0

  co-response teams
    - **Most teams operated on certain days of the week and certain times of the day (55.2%)** compared to limited 7 day/week (19.4%) and 24 hr/day, 7 day/week (19%)
- Varying definitions/characteristics of a QMHP

	N	%
Professional/educational background		
Clinical social worker (master's level)	151	65.1
Counselor/therapist (master's level)	100	43.1
Nurse	8	3.4
Nurse Practitioner	3	1.3
Psychologist	6	2.6
Other, such as bachelor's level education	32	13.8
License status		
No	21	9.1
No, but license-eligible	22	9.5
Yes	157	67.7
Don't know	24	10.3
Official Employer		
Public safety department (i.e. police)	33	14.2
Hospital	12	5.2
Community mental/behavioral health treatment	107	46.1
Municipal government	19	8.2
Independent contractor	7	3.0
Other, such as local, county, or state behavioral health	45	19.4
Law enforcement training received		
No law enforcement training	111	47.8
Yes; type	112	48.3
Use of Force	*40*	*35.7*
Maintaining personal and officer safety	*107*	*95.5*
State laws	*58*	*51.8*

- 48% of agencies said co-responders received no additional training from the law enforcement agencies.

- Only **31% of agencies had a plan to evaluate or track the effectiveness of their co-responder teams** by assessing outcomes such as use of force, arrests, officers' time spent on calls, repeat calls, and hospitalization.
    i. Evaluation and tracking were **sometimes tied to how programs were funded or managed (78% of programs were funded by local or state governments and 27% were funded by federal grants)**.

	N	%
Plans to Evaluate the program		
No	149	64.2
Yes; outcome	71	30.6
Use of Force	*24*	*33.8*
Arrests	*26*	*36.6*
Officer time spent on MH calls	*34*	*47.9*
Repeat call	*34*	*47.9*
Hospitalization	*33*	*46.5*
Other	*8*	*11.3*
Funding for the program		
Local municipality	130	56.0
State	52	22.4
Federal grant	62	26.7
Private grant	18	7.8
Endowment/donation	3	1.3
Other such as county	46	19.8

Source(s): Authors' own work

Academic Training to Inform Police Responses → Assessing the Impact of Co-Response Team Programs: A Review of Research (link)
Conducted out of the University of Cincinnati Center for Police Research and Policy

- Evaluated co-response models in:
  - Los Angeles, CA
  - Denver, CO
  - Eugene, OR
  - Portland, OR
  - San Antonio, TX
  - Tucson, AZ
  - Minneapolis, MN

Table 3. Program Elements to Facilitate Effective Implementation

Element	Description
1. Establishing Strong Inter-Agency Collaboration	Effective implementation of co-responder team programs was viewed to rely upon consistent collaboration between public safety agencies and behavioral health service providers in the community. Those programs led by collaborative project governance – that is, those programs informed by the oversight of a multi-disciplinary group comprised of executive members from the partner organizations – were observed to experience fewer issues with inter-agency communication and trust, information sharing, and program problem solving / decision making.
2. Outlining Clear Policies & Procedures	Stakeholders consistently identified the importance of the development of clearly stated policies and procedures to facilitate police-behavioral health collaboration and coordinate on-scene responses by co-responder teams. The flexibility of some co-responder team programs – created purposefully to allow for fluidity in team response to evolving crises – led to a lack of understanding regarding the focus of co-responder teams' actions in the community. For this reason, stakeholders acknowledged the need to outline the roles and responsibilities of co-responder team members in crisis response, finding that this coordination facilitates more seamless team responses to behavioral health crises.
3. Building the Co-Responder Team	Stakeholders consistently suggested the importance of identifying appropriate police and behavioral health professionals for involvement in co-responder team programs. Difficulties were observed in finding behavioral health professionals with both the skillset and temperament suitable for riding with police officers in crisis response. Similarly, stakeholders noted the importance of selecting officers open to a service-oriented style of policing and, ideally, have lived experiences with behavioral health. Pertinent to team building, stakeholders acknowledged the importance of cross-training co-responder team members to introduce the professionals to the culture, philosophies, language, and procedures of the partner agencies.
4. Advertising the Program in the Community	Several studies identified the importance of communicating the goals of co-responder team programs across the first responder and behavioral health agencies within the communities. Indeed, low awareness of co-responder team programs among first responders and health care providers resulted in low or inappropriate use of the team within the community. Co-responder team members also suggested the utility of police leadership publicizing the program's operations to enhance community awareness of services.
5. Identifying Available Behavioral Health Services	The availability of behavioral health services is a crucial component of any police-based behavioral health crisis response. Difficulties in co-responder team program implementation related to limitations in behavioral health services were regularly observed across studies. Stakeholders indicated the importance of front-end efforts in program development to conduct an inventory of available behavioral services in the community and expanding those services where possible.
6. Identifying Funding	Limitations in funding were viewed as a primary barrier to the effective implementation of co-responder team programs. Funding limitations affected several aspects of the co-responder team programs under study, including staffing, hours of operation, and resources (e.g., cars, computers) available to the co-responders. Although many stakeholders identified the need to expand programs to enhance co-responder teams' capacity to respond to behavioral health-related CFS promptly, funding restraints often did not permit such expansion. There is a clear need to identify consistent funding streams to develop and sustain these programs over time.

Table 4. Summary of Findings from Quantitative Evaluations of Co-Responder Team Programs

Outcome	Findings
Enhancing Crisis De-escalation	Few evaluations have assessed the impact of co-responder team programs on crisis de-escalation. The limited evidence suggests co-responder teams may be effective in de-escalating crises, with CFS managed by co-responder teams associated with fewer incidents of force and low rates of injury. However, more research is needed to understand the program's effects on these outcomes.
Increasing Connection to Services	There is some evidence that co-responder teams facilitate the connection of individuals in crisis to behavioral health services. However, the rate of referral to these community resources varies substantially across programs. Although descriptive evidence suggests that individuals often engage in the services they are referred to, the available literature provides limited insight into the long-term outcomes for those individuals. More research is needed to understand program effects on rates of referral to services. Additionally, further study of the long-term effects of referral to services is needed.
Reducing Pressure on the Criminal Justice System	*Arrest* Descriptive analyses consistently suggest low rates of arrest by co-responder teams. However, more research is needed to understand whether these rates are significantly different from arrest rates produced in police-only responses to behavioral health crises. *Police Detentions* Examinations of co-responder team programs in the United Kingdom consistently report lower mental health detention rates by police when co-responder teams are active. However, reductions in police detentions may be dictated by the type of services provided by the co-responder team (i.e., ride-along versus remote support). More research is needed to understand the program's effects on this outcome. *Officers' Time Spent on CFS* There is some evidence that the implementation of co-responder team programs can reduce the amount of time spent by first responding officers when managing behavioral health crises (i.e., time spent on the scene, time spent in ED). However, it is observed that the time-saving capacity of co-responder teams is dictated by the availability and reach of these teams in the community.
Reducing Pressure on the Health Care System	The available research provides mixed findings on the capacity of co-responder teams to reduce pressure on health care providers. Several studies suggest that CFS managed by co-responder teams result in fewer transports to the ED, although others find the opposite. There is also evidence that co-responder teams reduce the proportion of crisis incidents resulting in hospitalization and higher rates of conversion from ED referral to hospitalization. More research is needed to understand the variability in these findings.
Promoting Cost Effectiveness	There is preliminary evidence regarding the cost benefits of co-responder team programs for police agencies. However, these findings are consistently accompanied by warnings regarding data limitations that impact analyses. More research is needed to provide a more rigorous understanding of these programs' financial effect on police agencies and their co-responding partners.