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Bringing Community Responders to Erie County

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PARTNERSHIP FOR THE PUBLIC GOOD

Acknowledgments

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ON THE COVER:

Street Crisis Response Team in San Francisco. Photo credit: Jenna Lane. Source: City & County of San Francisco. https://www.sf.gov/street-crisis-response-team

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Executive Summary

For decades, Americans have relied on 911 as the primary resource for help in any situation. When people call 911, police are almost always sent. Police have become the default responder for calls related to anything and everything other than fires and medical emergencies, regardless of the criminality or level of need involved. The calls that generate a police response range from the most severe and violent crime to the most mundane, everyday events – fender benders, illegally parked cars, barking dogs, fireworks, arguments, welfare checks, and kids skipping school.

In Buffalo, from 2020 to 2022, 82% of 911 calls were not about crime of any type. The plethora of issues laid at the feet of police has become increasingly recognized as a costly, inefficient, and dangerous approach to community needs, as police training and skills are mismatched with the response most needed in many situations. Nowhere is this mismatch more evident than in the effects of police response to mental health and substance use crises.

While many efforts across Erie County have been undertaken to reduce the harmful effects of police response to people with behavioral health needs, to date no police training, co-responder model, or mobile crisis team has removed the set of calls that are least appropriate for the police from their purview. While crisis intervention training (CIT), police-clinician co-response, crisis call diversion, and mobile crisis teams have demonstrated some benefits, vast deficiencies remain. Erie County lacks a peer-led, community-based approach for the community members who most need it, and many community needs that have nothing to do with violence or crime are unnecessarily criminalized and sent to police. Community responder teams fill this gap.

Community responders are first responders, equivalent to firefighters, paramedics, and police, who respond to non-violent, non-criminal 911 calls related to health and social needs. Teams are composed of health professionals and trained peers, who respond to calls independently, without police, and provide person-centered care. Teams provide emotional support including de-escalation and mediation, non-emergency medical care, basics like food and water, and linkage or transport to community resources such as shelters or treatment facilities for further care. Typical calls fielded by community responders include welfare checks, general assistance, conflict resolution, and needs related to mental health, substance use, poverty, and homelessness. While calls may involve a mental health or substance use need, not all do, and teams are trained to handle a range of non-crisis and crisis situations. An important benefit of community responders is that they can be deployed early, before a situation escalates into a crisis that may trigger a police response and a cascade of more costly and potentially traumatic interventions.

Community responders are **first responders,** equivalent to firefighters, paramedics, and police, who respond to non-violent, non-criminal 911 calls related to health and social needs.

Community responder teams have rapidly proliferated across the country, as jurisdictions recognize the value of approaching health needs with health--not punitive--responses. The cost savings to police, court, jail, ambulance, and hospital systems are significant, and programs have seen start-up costs repaid in as little as six months. Police officers have voiced their support for local programs, as they free officers to focus their attention on higher-priority issues like violent crime and reduce repeat calls. In places where community responders exist, issue-related public order crimes have decreased by over one-third. Programs have stellar safety records, with no deaths or serious injuries for staff or members of the public. Many programs respond to tens of thousands of calls a year and divert up to half of noncriminal calls from a police response. Community responder teams rarely need to call for backup, with programs requesting an ambulance or police assistance in less than 3% of all calls.

The success of community responders is earning national notice. In 2020, the federal Substance Abuse and Mental Health Service Administration (SAMHSA) issued national guidelines for behavioral health crisis care. Two of the best practices for mobile crisis response are to include peers in mobile crisis teams and for teams to respond without law enforcement in most circumstances. Similarly, the Department of Justice (DOJ), in its investigations of the Minneapolis and Louisville police departments, found that sending police by default to mental health calls is a violation of the Americans with Disabilities Act (ADA) and the Constitution, and violates the rights of people with psychiatric disabilities by treating their health needs as a criminal issue. Just like police would not be sent to someone having a heart attack, police do not need to be sent to every call involving a mental health crisis. Treating the two health conditions differently is discriminatory and infringes on the rights of people with disabilities.

It is rare for activists, police, federal and local governments, and people across the political spectrum to agree on an issue, especially one as charged as public safety, but they agree on this: community responders are a better way to handle non-violent, non-criminal health and social needs in the community. They can provide person-centered, compassionate health care, save police time and frustration, reduce costs to taxpayers, and solve community problems. They reduce trauma, intervene early, build trust, and strengthen the social fabric of neighborhoods by creating a safety net for people of all races, ages, abilities, and economic backgrounds. Residents feel safer knowing they have a trusted, appropriate resource they can call in a time of need. Buffalo and Erie County need community responders now, and a pilot program should be launched as soon as possible.

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Introduction

The growth of community responder teams (CRTs) across the United States is one of the most significant reforms to emerge from the national movement against police brutality fueled by the murder of George Floyd in 2020. Community responders are first responders, equivalent to police, fire, and emergency medical services (EMS). They respond independently to low-risk 911 calls related to health and social needs. Most often, the calls are related to mental health, substance use, poverty, homelessness, or other social disturbances or quality-of-life concerns. Teams are composed of health professionals and peers, and they take a person-centered approach to meeting the needs of the individual and community. They don't rely on force, coercion, or punishment.

Community responder teams have a host of benefits. Fundamentally, community responder teams ensure the right response at the right time to community needs. Rather than meeting a health or social need with a police response, community responders meet health needs with appropriate, timely healthcare. In responding to low-risk, non-violent calls, teams prevent crises by intervening with resources and support before a person reaches their breaking point. This reduces harm to the individual and the community, and it lessens the likelihood of a traumatic police encounter or an emergency hospitalization. Teams build trust by involving peers, who can create rapport and mutual understanding with people who have been harmed by traditional responses. Teams add capacity to the first response system, and they free up other first responders to focus on (and respond faster to) higher-priority calls. By providing care on-site and transporting individuals to longer-term facilities, when necessary, teams save time and money by reducing the strain on public resources like ambulances, emergency rooms, jails, and courts. Finally, teams contribute to safer, stronger communities by addressing the needs that are the root cause of many low-level crimes and social disturbances. In this way, community responder teams ensure that residents feel safe calling for help when they need it.

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Understanding 911 Calls for Service and Existing Responses

CALLS FOR SERVICE

An estimated 240 million calls are made to 911 in the U.S. each year.[1] Many people do not realize that 911 call centers (called Public Safety Answering Points, or PSAPs) are independent of each other and locally managed, which means that national 911 data is nonexistent.[2] To understand what happens when a 911 call is placed--including how the call is classified, what the call-taker says, how the call is handled, what type of responder is dispatched, and what happens on the scene--researchers are limited to studying individual PSAPs and hoping that the results generalize to PSAPs of similar size and location. There are no federal minimum standards required for data collection, workforce training, or 911 technology, and governance of the 911 system is split among various entities within federal, state, and local government.[3]

This means protocols and responses vary greatly depending on where a 911 call is placed. For example, the same situation might be coded "Mental health crisis" by one call-taker, but "Check Welfare" by another. Call-takers in one jurisdiction may be trained in recognizing implicit bias or instructing a caller in CPR, while a neighboring jurisdiction does neither. Some PSAPs can accommodate text and video calls, while others are not yet up to date on handling calls from cell phones instead of landlines.[4] Only in recent years—largely in response to protests against police violence—have studies begun to examine 911 call data to answer these questions.

A clear picture has emerged from these studies: 911 is commonly thought to be for emergencies only, but in reality, most calls do not involve an immediate threat to safety or a crime in progress. It is much more common for a 911 call to be about barking dogs, abandoned vehicles, or kids setting off fireworks than about a home invasion or a shooting. Yet, in most places, for most calls, police are sent as the default responder, regardless of the call type. Sending police officers to calls where they are not needed is dangerous, inefficient, and unnecessary, and jurisdictions across the country are taking steps to develop alternative responders to police.

Several studies have analyzed how many 911 calls could be diverted from police to other types of responders. Across studies, the largest category of 911 calls (between 32-75%) were for noncriminal complaints. These calls are often related to alarms, welfare checks, business checks, suspicion, disorder, or other disturbances—like arguments, noise, people, vehicles, or incidents that the caller finds suspicious or worrisome.[5] Another large percentage of calls (between 13-24%) are traffic-related issues. Around 10-15% of calls are related to property crimes. Most often, people are reporting thefts that have already occurred. A small percentage, only 3-6%, are related to violent crime.[6]

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HOW 911 WORKS IN ERIE COUNTY

Whether someone is calling 911 because they just witnessed a shooting, or because they found a diamond ring, the same series of events takes place. In Erie County, there are 20 different Public Safety Answering Points (PSAPs), 15 primary and 5 secondary locations.[7] All 911 calls placed on cell phones in Erie County first come through county-operated Central Police Services, where call-takers gather basic information such as location and a brief understanding of the situation. Then, calls originating outside the City of Buffalo are transferred to local dispatchers in the PSAP closest to the caller.[8]

For example, a caller in Amherst will first speak to a call-taker at Central Police Services, then will be transferred to a dispatcher in the Amherst Police Department, who will gather more information from the caller and dispatch a response based on Amherst PD protocol for how to handle the situation. All the PSAPs outside the City of Buffalo operate this way. However, each PSAP has its own codes for 911 calls, including a priority level assigned, which guides dispatchers' decision-making. For example, a call about someone sleeping on the ground behind a business might be coded as "check welfare," "person down," or "trespassing," depending on the PSAP and the call-taker.

Most municipalities in Erie County operate their PSAP within their local police department using civilian dispatchers employed by the police department. The exceptions are Amherst, Buffalo, and Springville, which have secondary PSAPs for fire or medical dispatch. For calls made in Buffalo, the caller will speak to a call-taker at Central Police Services but will not speak directly to a dispatcher in Buffalo Police or Fire departments. Instead, the Central Police Services call-taker will send the information gathered from the caller directly to the dispatchers, who then direct first responders.[9]

This variability in call-taking procedures means that every municipality in Erie County operates first responder programs a little differently. For new initiatives, such as diverting some 911 calls to crisis counselors (discussed below), jurisdictions have to opt-in to allow calls to be diverted from a traditional local response. Even though Erie County operates the 911 call center, each municipality has the final say over how 911 calls are dispatched in their service area.

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911 CALL DATA FOR ERIE COUNTY SHERIFF

Local 911 call data follows the national pattern. In 2019, the Erie County Sheriff's Office received 94,842 calls for police services.[10] Calls will often be sent to the Erie County Sheriff Police Services Division for a response by a road patrol deputy if the caller is in a rural area of Erie County that is not otherwise served by a local police department. Over 95% of these calls were "general" (noncriminal) calls for service. The largest share of calls, 49%, were for "police services," a catch-all category that can include things like traffic control, lost and found property, stranded motorists, and many other noncriminal scenarios. Other common calls were for "assist" and "warrants, summons, subpoenas," which each made up about 10% of calls. Calls for Emergency Medical Service (EMS) and Fire services composed about 8% of all calls, and a category called "person/suicide/misc" was around 5% of all calls.[11] Calls involving alleged crime were only 4.8% of all calls, and alleged violent crime made up just 1.3% of all calls. These percentages were similar in the three years prior to 2019.[12]

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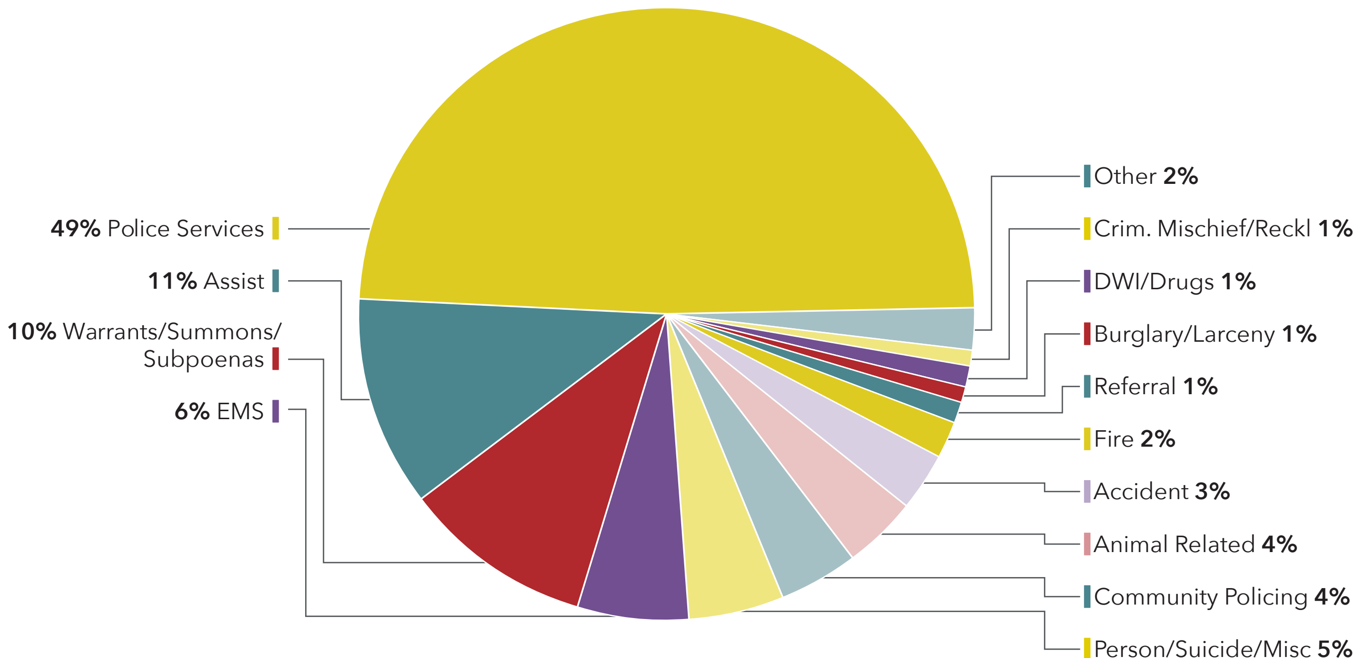
ERIE COUNTY SHERIFF'S OFFICE CALLS FOR POLICE SERVICES (2019)



911 CALL DATA FOR BUFFALO POLICE

To analyze calls to the Buffalo Police Department (BPD), Partnership for the Public Good obtained three years of 911 call data through a Freedom of Information Law (FOIL) request. We then sorted the data by call code, assigned priority level, and location. Buffalo police use a Computer Aided Dispatch (CAD) system, which tracks both 911 call data and police-initiated activities like patrols and traffic stops. To show a more complete picture of typical police activities, we included all activities (both caller-initiated and police-initiated) together in our analysis. For more information on our methodology, see Appendix A.

Buffalo Police Department 911 call data between 2020-2022 shows a similar pattern to national and county trends. Dispatchers prioritize 911 calls to police on a 7-point scale. Level 1 calls are the highest priority (such as shootings, fights, domestic violence, accidents with injuries, etc.), and Level 7 calls are the lowest priority (mostly ambulance calls and traffic stops). Calls can be assigned a higher priority if they are in progress, or if they just happened. If a situation has already ended, it will likely be deprioritized. For example, a "threat in progress" is priority level 3, but "threats/harassment" is a priority level 4. In the last three years, just 6% of 911 calls were Priority 1 or 2, while the remaining 94% were Priority 3 or lower.

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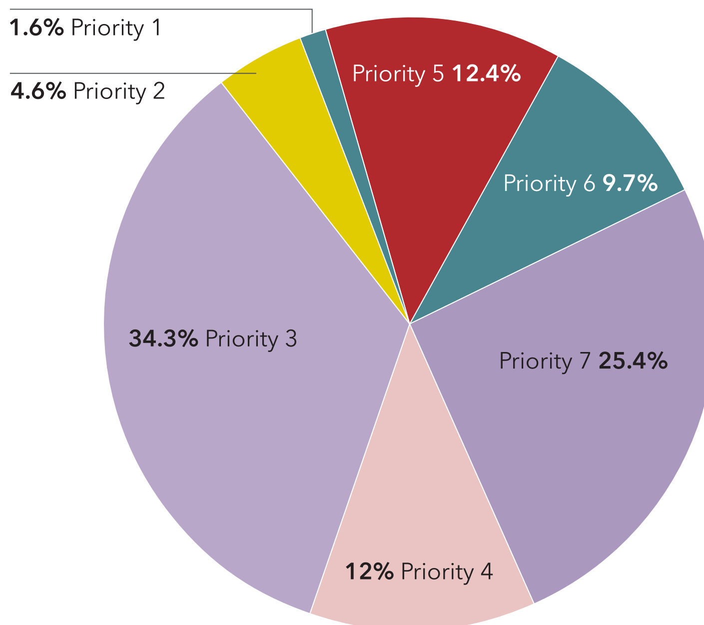
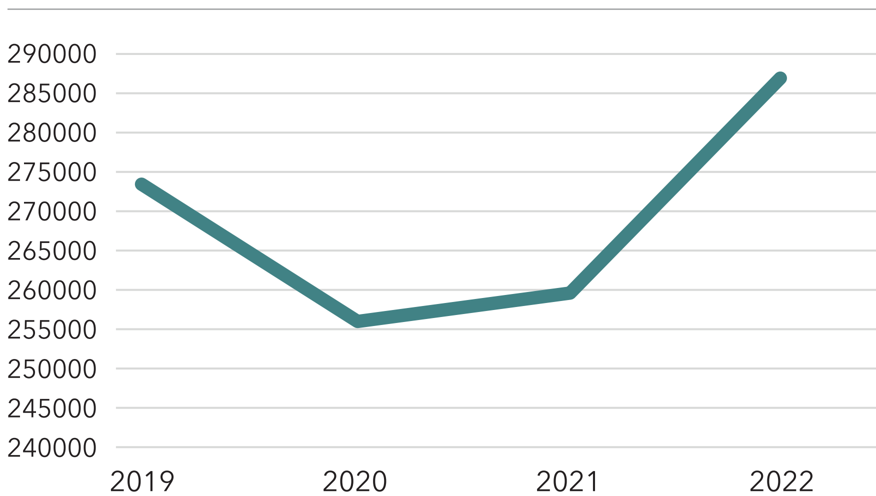
911 CALLS TO BPD BY PRIORITY



People call 911 for an incredible array of reasons. The BPD dispatch codes span 129 categories from the dire (home invasion, terrorist act, kidnapping), to the mundane (found property, animal loose, tow truck, fireworks). Most calls are somewhere in the middle. To make sense of the overwhelming volume of calls (over 287,250 in 2022), PPG sorted the calls into 9 categories: alarms, ambulance, crime, general assistance, health and welfare, social disturbance, trouble or dispute, vehicles and traffic, and other. To see which call codes were included in each category, see "Methodology" in Appendix A.

People call 911 for an incredible array of reasons.

TOTAL 911 CALLS TO BUFFALO POLICE DEPARTMENT BY YEAR, 2019-2022



Using these categories, a general picture of calls to 911 emerges. Just 18% of all 911 calls to BPD are about crimes of any type, which means 82% of calls are noncriminal. Police activity related to traffic or vehicles also makes up 18% of all calls (which includes police-initiated traffic stops). Police often accompany ambulances, and these calls make up 15% of all BPD calls. "Trouble or dispute" and "Other" calls each compose 13%. Together, these categories make up about 77% of all calls sent to BPD. The remaining 23% of calls are for general assistance (8%), health and welfare (8%), alarms (5%), and social disturbances (2%).

Community responder programs across the country typically focus their efforts on calls that often, but not always, involve underlying behavioral health needs. In Buffalo, these types of calls fall under the "Health and welfare" and "Social disturbance" categories. Together, these calls compose about 10% of all calls to BPD, or about 27,700 calls a year.

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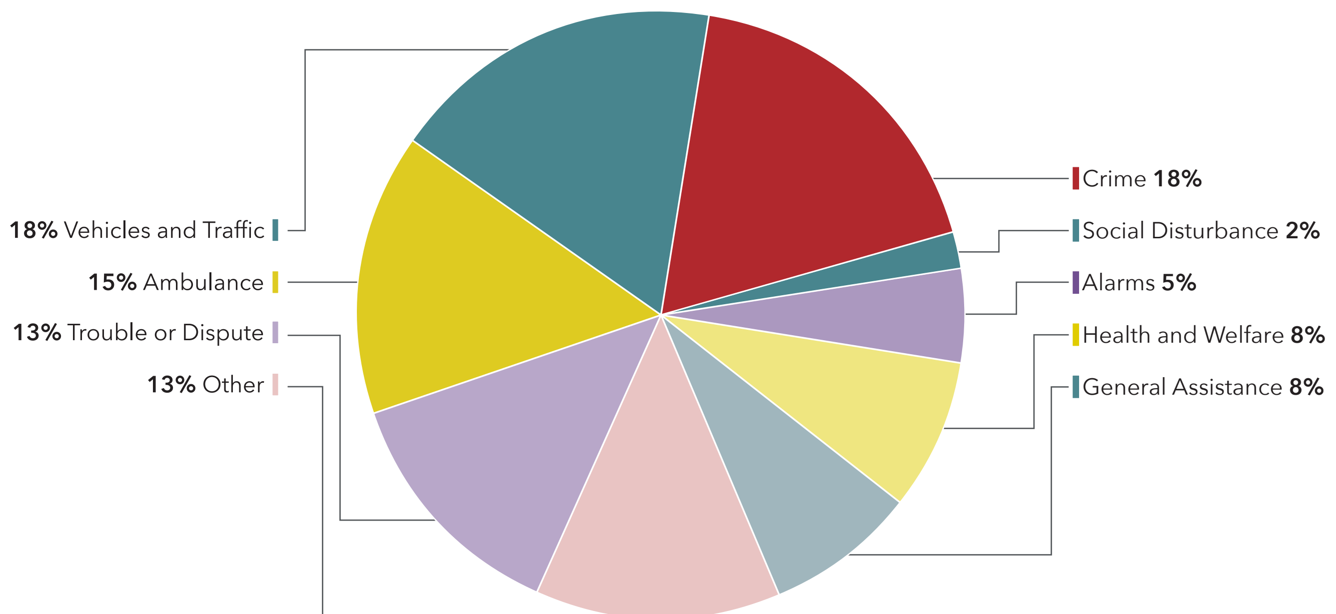
CALL TYPES



Current Responses to 911 calls

POLICE ARE THE DEFAULT RESPONSE

In Erie County, though three types of first responders can be dispatched to a 911 call (police officers, firefighters, and paramedics), police officers almost always respond. In 2023, Buffalo Police anticipated being sent to 245,000 calls, 4.5 times the 54,500 calls dispatched to Buffalo Fire and the 52,500 calls to EMS.[13] In total, out of 352,000 calls to 911, police are sent to 70%. They also respond alongside ambulances on 75% of ambulance calls. Official BPD policy dictates that police are not to be routinely dispatched to medical calls unless the dispatcher believes there may be a crime or threat to the safety of other first responders.[14] Yet, between 2020 and 2022, BPD responded to an average of 39,393 ambulance calls a year, out of approximately 52,500 total EMS calls. One reason for this is capacity. While BPD has over 812 sworn officer positions, plus other staff to cover just the City of Buffalo, American Medical Response (AMR) which operates the ambulance service in Buffalo and many surrounding towns has 350 EMTs, paramedics, dispatchers, and support staff to cover all of Erie and Niagara County.[15] Another likely reason is a lack of alternatives and the historical emphasis on policing as the solution to community problems. For the history of the growth of policing as a default response to 911, see Appendix B.

When a police officer encounters someone experiencing a mental health crisis, they have few options. They can attempt to resolve the situation, transport the individual to a hospital, or arrest them. In some cases, they can request assistance from mental health clinicians, who are increasingly being incorporated into police departments through co-response teams (more on this below). Yet, much of the time, if they believe the person is at risk of harming themselves or someone else, they will take the person to a hospital emergency room or call an ambulance to do so. Sometimes the person in crisis consents, at other times, the officer performs a "9.41," hold to transport them against their will ("9.41" references the corresponding section of NY Mental Hygiene Law). Being taken into police custody is alarming, even under normal circumstances. For people in crisis, who may also have previous traumatic experiences with police and the healthcare system, it can be traumatic. In the worst-case scenarios, situations escalate to violence and death.

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THE RISKS OF A POLICE RESPONSE

Sending police to a situation where they are not needed or wanted can be dangerous for officers and the public. In the U.S. in 2022, police killed 1,201 people, the highest number of police killings on record.[16] At least 103 people killed were unarmed.[17] Of the total deaths, 109 people were killed after police responded to a call related to a mental health crisis or welfare check.[18] In the same year, 58 officers were intentionally killed by an offender in the line of duty. Four of these officer deaths were related to encounters with "emotionally disturbed persons."[19] People of all races, ages, genders, and abilities have been killed by police. However, police responses are especially dangerous for people with disabilities, including mental health conditions, and Black Americans. Erie County has too many examples: India Cummings, Richard Metcalf, Willie Henley, Marcus Neal, Dominique Thomas, Jon Battison, Eddie Holmes, Lisa Haight, James Cushman, and others have died or been severely injured after unmet mental health needs escalated into crisis situations handled by police.

RISKS FOR PEOPLE WITH DISABILITIES AND MENTAL HEALTH CONDITIONS

The risks of encountering police are especially high for people with disabilities, including mental illness. People with diagnosed mental illnesses are 16 times more likely to be killed by police than those without.[20] One in every five people killed by the police has a known mental health condition, and researchers estimate that up to 50% of people killed by police have a disability of some kind.[21] Additionally, up to 33% of people with severe mental illness first access treatment due to a police encounter, which indicates the many gaps in the current mental health care system. Many people are unaware or unable to access timely, proactive care when they first need it, which leads to worsening symptoms, followed by crises.

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Disability rights advocates and the Department of Justice agree that police violence against people with disabilities is a form of illegal discrimination. The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities, and it ensures their right to equal opportunities and services, including city services like emergency response. In 2023, the Department of Justice (DOJ) published its investigations of the Minneapolis and Louisville Police Departments and concluded that sending police officers to behavioral health calls where their presence is not needed is a violation of the ADA.[22] A lawsuit with the same premise has been filed in Washington, D.C. by the ACLU.[23] The lawsuit and DOJ findings assert that subjecting people with behavioral health disabilities to ineffective and harmful treatment from police officers constitutes discrimination and violates their civil right to obtain the "same result" from government services as others.[24] The ADA mandates that government entities make "reasonable accommodations" to ensure equal treatment

of people with disabilities. The DOJ concluded that establishing robust civilian mobile crisis teams to respond instead of police to all appropriate low-risk calls qualifies as a reasonable accommodation and urged Minneapolis and other municipalities to do so as quickly as possible.[25] In May 2023, the DOJ and U.S Department of Health and Human Services issued guidance to state and local officials advising jurisdictions to "not assume that the proper response to a crisis is always to send law enforcement," but instead utilize non-police mobile teams to comply with the ADA.[26]

For more discussion on the impact of mental health stigma on discussions of public safety and policing, see Appendix C.

RISKS FOR BLACK AMERICANS

Black Americans are killed by police at the highest rate of any racial group.[27] Black Americans are over twice as likely to be killed in a police encounter than white Americans, regardless of mental health.[28] Rates of being killed by police are also slightly higher for Latino/Latina Americans compared to non-Latino/Latina white Americans. People of other races are killed at lower rates than these groups.[29]

In addition, the number of police encounters that result in nonfatal injuries and trauma is undoubtedly much higher than the rate of deadly encounters. However, these numbers are hard to assess as most police departments do not track or publicly report every instance of force.

While an unnecessary police response can be dangerous for anyone, people with disabilities and mental health conditions, Black Americans, and Latino/Latina Americans are at a higher risk than others. As a result, some communities have lost faith in the emergency response system—especially the police—and many people refuse to call 911, even as a last resort.[30] Without a trustworthy alternative, many people are left without care and without adequate support when they need it.

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Prior efforts to address these problems

Police violence in the U.S. is a long-standing problem, and advocates have tried to reduce police-related deaths—especially those related to mental health crises—for decades. Reforms have included:

Crisis Intervention Training (CIT): a 40-hour course to educate police officers on mental health issues and de-escalation techniques.

Co-responder programs: pairing police officers with mental health clinicians who go with police to some calls.

Crisis hotlines and mobile crisis teams: people experiencing mental health emergencies can call a crisis hotline and get assistance instead of calling 911. Mental health professionals are then sometimes sent in person to conduct assessments and provide referrals.

Most municipalities around the country have at least one of these initiatives in place. In Erie County, many cities and towns are served by all of them. Yet, major gaps remain.

CIT

In 1987, Memphis police officers killed Joseph Dewayne Robinson who was experiencing a mental health crisis. The following year, the department started Crisis Intervention Training (CIT), also known as the "Memphis Model." Police officers trained in CIT undergo forty hours of instruction in mental health-related topics, crisis resolution, and de-escalation skills. Officers who are CIT-trained are then dispatched to calls related to mental health and substance use when they are available. CIT is popular across the country, with 2,700 individual sites in operation and a coordinating organization, CIT International, providing a national forum.[31] CIT has two goals: (1) to reduce injuries and fatalities for both civilians and officers during mental health emergencies, and (2) to divert individuals with mental illnesses from the criminal justice system to the health care system for treatment.[32]

Research on CIT's impacts shows mixed results. Studies show that CIT programs reduce arrests and increase the number of people brought into psychiatric emergency rooms instead of jails and the criminal justice system.[33] On one hand, this is a positive outcome because it keeps people out of jail. On the other hand, CIT can strain existing mental health care systems—especially emergency rooms—because they're handling many more patients without additional resources. In addition, research has consistently shown that CIT improves officers' perceptions of their own conduct in mental health-related situations. CIT training improves officer attitudes, reduces stigma related to mental health issues, improves self-reported officer satisfaction, reduces self-reported use of force, and

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increases de-escalation in hypothetical scenarios.[34] However, when it comes to the original and most important goal of reducing violence, CIT does not show an effect.[35] CIT training does not decrease police violence or increase de-escalation in actual crisis situations.[36]

Further, most departments don't use the full CIT model. The original model is comprehensive. It includes training for 911 dispatchers; it asks police departments to cultivate relationships with community groups; it creates a barrier-free emergency center for people experiencing mental health crises; it requires ongoing evaluation and reporting; and it gives officers ongoing, in-depth training. Instead of all this, many departments simply do the 40-hour training for their officers.[37] Significantly, in 2020 CIT International signed an open letter calling for alternatives to police for behavioral health crisis response and to minimize law enforcement's role to co-respond only when there are safety or criminal concerns.[38]

CO-RESPONDER PROGRAMS

In 1991, the Los Angeles Police Department became the first in the nation to begin sending a mental health clinician with police for mental health-related calls.[39] Since then, co-responder programs have spread to at least 30 major cities across the U.S., though program operations vary significantly.[40] The Cheektowaga Police Department began the first co-response program in New York State in 2018.[41]

Evidence on the impact of co-response models is limited and mixed. Systematic reviews find that including a clinician in a police response may lead to fewer use-of-force incidents, injuries, arrests, involuntary transports, and hospitalizations. They may also result in more positive reports by those in crisis compared to a police-only response. However, not many high-quality studies have been done on co-response models, and the evidence that exists mostly comes from program evaluations that draw from small sample sizes and rely on the observations of those involved, which can be biased.[42]

BEHAVIORAL HEALTH TEAMS (BHT)

Some municipalities in Erie County (Buffalo, Cheektowaga, West Seneca, Town of Tonawanda, Hamburg, and the Niagara Frontier Transportation Authority) have co-responder programs called Behavioral Health Teams (BHT) that pair a clinician with an officer.[43] The clinicians are employed by Endeavor Health Services, work directly out of the police departments, and ride with the police officer in the squad car to calls.[44] On top of CIT training, BHT officers receive training in Mental Health First Aid and an 8-hour BHT training that reviews the SAFE Act and red flag laws, Kendra's Law and Assisted Outpatient Treatment (AOT), the Safe Options Support (SOS) program, levels of psychiatric care and local

Some municipalities in Erie County (Buffalo, Cheektowaga, West Seneca, Town of Tonawanda, Hamburg, and the Niagara Frontier Transportation Authority) have co-responder programs called **Behavioral Health Teams** (BHT) that pair a clinician with an officer.

resources, social determinants of health, substance use, harm reduction, safety planning, verbal influence, intellectual and developmental disability services, and tours of the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center, the Kirsten Vincent Respite and Recovery Center, and Horizon Village Terrace House.[45]

Specifics vary between programs. The BHT in Cheektowaga, Town of Tonawanda, and West Seneca police departments consist of one clinician paired with an officer. In Hamburg, one clinician is shared between three police departments. In these jurisdictions, the BHT police officer responds to all call types, not just behavioral health-related issues, and on non-behavioral-health calls the clinician waits in the car while the officer responds. Because of this arrangement, these BHT officers sometimes make arrests, while Buffalo BHT officers, who respond to behavioral health-related calls only, do not.[46] Buffalo is the only BHT with a dedicated police unit and has four clinicians. On average, across local BHTs the clinicians are paid $50,000 and the officers are paid $80,000 in a year.[47]

BUFFALO POLICE BEHAVIORAL HEALTH TEAM

In Buffalo, the BHT is a full unit dedicated solely to behavioral health calls and responses and is composed of six police officers, two lieutenants, three full-time master's level clinicians, one part-time clinician, and a police captain who acts as the program supervisor.[48] These staff are divided into three teams each composed of two officers and a clinician. Police officers can self-select for the BHT based on seniority, without interviewing for the job, which is an attractive option for officers wishing to only work daytime hours. This differs from the other local BHT programs, where officers are selected after interviewing and seniority is only one factor in selection.[49]

BHT teams, including the clinicians, are based in Buffalo Police Department buildings and ride together in BPD cars. Buffalo BHT officers wear "softer" uniforms compared to patrol officers and drive specially marked cars.[50] Buffalo BHTs operate seven days a week from 8 am to 6 pm and are paid overtime to respond to calls between 6-10 pm Monday through Friday.[51] In 2022, Buffalo BHTs responded to around 120 calls per month and provided follow-up for around 160 calls.[52] All BHTs follow up with people within 48 hours for calls they respond to, and will follow up with additional individuals upon request from other responding officers. For example, in emergencies such as a reported suicide in progress, the closest officer will respond to the call, even if they are not BHT or CIT-trained. However, these calls will be referred to the BHT for follow-up after the call is resolved.[53]

The Buffalo BHT responds to any type of call that has a behavioral health component, through self-dispatch or when requested by an officer.[54] BHTs can spend more time on calls than patrol officers, who at most spend about

Police officers can self-select for the BHT based on seniority, without interviewing for the job, which is an attractive option for officers wishing to only work daytime hours.

30 minutes per call.[55] Most often the calls going to the Buffalo BHT are coded as "suicide attempt," "suicide threat," "crisis services assist," or "mental health crisis," or the situation involves a traumatic incident or sudden death.[56] However, BHTs will sometimes go to domestic violence calls, "irate person," sex assault, and welfare checks depending on the circumstances. For calls where a weapon or violence is reported, BHTs will wait until police have cleared the scene to engage.[57] Once on-scene, clinicians listen, provide referrals, have conversations with family members, safety plan with all parties, and educate family members on de-escalation skills and community resources. If the person is unsheltered, teams will offer food, water, and other basics. In some cases, BHT clinicians will determine that the person in crisis needs hospital care, though clinicians try to preserve this option for only the "most extreme, violent delusions."[58] In these cases, if the person is uncooperative, BHT police officers will perform a "9.41" involuntary transport.

According to an evaluation of BHT completed by Endeavor Health Services, 69% of BHT encounters resulted in the person remaining in the community (not hospitalized or jailed). All BHTs in Erie County combined served over 2,000 individuals between 2021 (starting month unknown) and September 2023. The average response time was 25 minutes. About 4% of encounters resulted in arrest.[59]

CRISIS HOTLINES AND MOBILE CRISIS TEAMS

Alternatives to 911 like crisis hotlines and mobile crisis teams were created long before CIT and co-response models. The first crisis center opened in California in 1958, and for the next two decades, more crisis centers, suicide prevention hotlines, and mobile crisis teams (MCTs) were formed as mental health treatment shifted away from institutionalization in often-abusive long-term facilities to more disparate community-based settings.[60] At the same time, increased policing during the "tough on crime" years criminalized people with behavioral health needs, highlighting the need for an alternative to police for crisis response.[61] Today there are over 200 crisis centers around the country, many of which operate a crisis hotline and some form of an MCT.[62]

MCTs typically send mental health clinicians in person to conduct psychiatric assessments in the community, stabilize the person when possible, and either link them to community mental health resources or get them to a hospital if needed.[63] The difference between long-standing MCTs and more recent co-response models is that MCTs respond without police, at least initially, while co-response teams always involve a police officer. For most of their history, crisis services like these have existed without much federal support, often utilizing volunteers and soliciting donations to function.

MCTs typically **send mental health clinicians in person** to conduct psychiatric assessments in the community, stabilize the person when possible, and either link them to community mental health resources or get them to a hospital if needed.

988

In the 1990s, survivors of suicide loss began a movement that resulted in the U.S. adopting a national suicide prevention strategy in 2001, followed by the establishment of the National Suicide Prevention Lifeline in 2005.[64] In 2022, officials replaced the hotline number with 988, an easy-to-remember alternative to 911 for mental health-related calls.[65]

Before 988, the National Suicide Prevention Lifeline was a 1-800 seven-digit phone number that a person in crisis could call anywhere in the country to speak with a counselor. It was and is managed by Vibrant Emotional Health, in partnership with the federal Substance Abuse and Mental Health Services Administration (SAMHSA).[66] Local crisis centers can partner with Vibrant to become the designated answering point for calls, texts, and chat messages to the Lifeline in their locality, and must meet basic training requirements to do so.[67] Beyond this commonality, however, the services provided by crisis centers vary greatly. The rate of how quickly calls are answered, the quality of the counseling received, training beyond the basics, resources available in the locality, and whether the center can respond in person, how quickly, and how well all vary from center to center.[68]

When 988 was launched in July 2022, the transition was funded with $1 billion in federal dollars that largely went to Vibrant Emotional Health for infrastructure changes, and to states for workforce needs.[69] The most significant and immediate difference for the public was just the change in the phone number – which resulted in a 46% increase in call volume in the first year.[70] Today, when someone in crisis dials 988, their call is geo-routed to the nearest 988 call center for their location. Unlike 911, 988 does not use geo-location to determine a caller's exact address. However, in the 2% of calls where the counselor sends the call back to 911 because they are concerned about a person's safety, the 988 counselor can ask the 911 operator to use geolocation to locate the caller.[71]

Today, when someone in crisis dials 988, **their call is geo-routed to the nearest 988 call center for their location**.

CRISIS SERVICES, INC.

In Erie County, several mental health service providers operate some version of crisis intervention, stabilization, or helpline for their clients and/or the public, but the Lifeline designee and 988 answering point is Crisis Services, Inc. Crisis Services is a Buffalo-based non-profit that has provided crisis intervention services across Erie County since 1968. Crisis Services counselors provide a 24/7 crisis hotline with phone and text-based support and answer all 988 calls made from phones with a 716 area code, which covers the eight counties of Western New York.[72] In 2022, the hotline counselors answered 78,910 calls, 83% of which were "diverted from needing 911 emergency services."[73] According to agency leaders, most calls are resolved over the phone, though a small number (4,813 in 2022, or 6%

of calls[74]) will result in a crisis team being sent in person.[75]

Crisis Services Emergency Mobile Outreach Teams (often called simply "mobile outreach") are the mobile units of the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center—the region's only psychiatric emergency room.[76] Mobile outreach teams are composed of two mental health clinicians, one with a master's degree, and one with a bachelor's degree.[77] Teams are sent when the hotline counselor believes there is an imminent risk of harm to the person in crisis or others.[78] If the counselor believes harm is actively occurring during the call, police will be dispatched to the location instead of mobile outreach because, due to their higher numbers, closer proximity, and lights-and-sirens response, they are guaranteed to respond faster than the clinicians, who drive their personal vehicles, must obey the rules of the road, and typically have a response time of 30 minutes or longer.[79]

Once on scene, the clinicians perform an assessment and determine if the crisis can be resolved there or if hospitalization is required. In cases where hospitalization is recommended, the person in crisis or their family member will often drive themselves, or the team will call for an ambulance (Crisis Services teams do not personally transport individuals).[80] If the person is unwilling, teams will call for police backup to perform an involuntary transport.[81] Crisis Services teams are authorized to conduct "9.45" involuntary hospitalizations.[82] "9.45" refers to the section of NYS Mental Hygiene Law that authorizes the local director (in Erie County, the Commissioner of Mental Health) to send a person to a psychiatric hospital against their will if it is determined that the person "has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others."[83] In 2022, 55% of mobile outreach contacts were resolved without hospitalization.[84] Of the 45% who were taken to the hospital, 80% of the individuals were admitted for psychiatric care.[85]

According to Crisis Service's data from 2020, about 60% of mobile outreach responses were resolved by the team alone, police were called the other 40% of the time.[86] According to agency leaders, teams call for police backup if the person has been violent in the past, if there is a known weapon, or when performing a 9.45 and the person is not going willingly in the ambulance.[87] At times, the Crisis Services team may arrive with police in situations when third-party callers do not have enough information about the person in crisis and fear that harm is or has already taken place.

According to Crisis Service's data from 2020, about **60% of mobile outreach responses were resolved by the team alone,** police were called the other 40% of the time.

CRISIS CALL DIVERSION

Until very recently, most crisis hotlines and MCTs were not linked with 911 or the first response system. Callers had to know about the hotline and call their local hotline directly to speak to a counselor or be seen by a

crisis team. However, several municipalities have led the way in integrating mental health crisis counseling into the 911 system to resolve some calls over the phone and conserve first responder resources. This is done either by co-locating mental health clinicians in the 911 call-taking center, or by diverting eligible calls to the local crisis hotline after being triaged by a dispatcher. Houston, Texas and Tucson, Arizona were early adopters in embedding a mental health clinician in their 911 communications centers to triage mental health calls and resolve them over the phone when possible.[88] Broome County, New York began diverting some mental health-related calls to the local crisis hotline in 2018, which is the approach several jurisdictions in Erie County have since adopted.[89]

A pilot program to direct some 911 calls coded as "Mental health crisis" and "Suicidal threats priority 3" to Crisis Services was launched in 2021. After a short pilot, the program was adopted in several localities including Erie County Sheriff's Office, Buffalo, Lancaster, Cheektowaga, the City of Tonawanda, and Hamburg.[90] Today, 911 dispatchers in those jurisdictions use a flowchart to determine if a call related to mental health or suicide can be diverted to Crisis Services instead of sending police officers.[91] Callers have to consent to the diversion, and not all do. Additionally, the person in need cannot be in a public place, can't be requesting an ambulance, and must not have any weapons.[92] These restrictions, along with the hesitancy of dispatchers to route calls to Crisis Services (a common problem for crisis call diversion programs) have been a major impediment to the program's success, so much so that in the last 6 months of 2023, only 24 calls were diverted through this process.[93] If a call requires an in-person response, Crisis Services mobile outreach teams can be sent, or if the counselor decides there is an immediate risk of harm or the call is otherwise inappropriate for Crisis Services, the counselor can send the call back to 911 for police dispatch.[94] In the final six months of 2023, of the 24 calls that were diverted, eight callers hung up and two were sent back to 911.[95]

Today, 911 dispatchers in those jurisdictions **use a flowchart** to determine if a call related to mental health or suicide can be diverted to Crisis Services instead of sending police officers.

In April 2023, Erie County Central Police Services announced it would be creating two positions for Nurse Navigators in the central 911 call center. The nurses will provide medical advice to callers over the phone and divert some callers to other resources when an ambulance is unnecessary.[96]

EMERGING ALTERNATIVES TO HOSPITALIZATION

Just like with physical health needs, most mental health needs, even crises, do not require hospitalization. In a fully operational crisis system, studies suggest that around 14% of crisis calls will result in hospitalization.[97] Yet, in Erie County, gaps in the crisis system have often resulted in many people in crisis ending up at the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center. CPEP is often overcrowded, and sometimes people wait for days to be seen, often sleeping on the floor in

waiting rooms without basic necessities alongside many others awaiting care, some with acute symptoms.[98] Once the person is seen, their needs rarely meet the criteria for inpatient psychiatric care, so they are discharged a few hours later, sometimes feeling worse than when they went in.[99] This can worsen the person's current symptoms and discourage help-seeking in the future.

The "revolving door" of CPEP is frustrating to first responders too, who sometimes respond to the same individual multiple times and see them released after just a few hours, seemingly without any community support or improvement in their condition.[100] To alleviate these concerns, in addition to existing peer support warm lines, "living rooms," mental health urgent cares, and respite centers, a new 24-hour crisis stabilization center operated by Best Self Behavioral Health is under construction, and a recently completed crisis respite center, the Kristen Vincent Respite and Recovery Center opened its doors in April 2023.[101] In addition, until recently, ambulances were not allowed to transport a patient anywhere other than a hospital. A 2022 policy change now allows ambulances to bring people to an alternative destination, such as a crisis center, under certain circumstances.[102]

The "revolving door" of CPEP **is frustrating to first responders too,** who sometimes respond to the same individual multiple times and see them released after just a few hours, seemingly without any community support or improvement in their condition.

As important as having better options for care facilities is, relying on police and ambulances as the first responders to behavioral health needs contributes to facility over-crowding because neither police nor paramedics have the necessary training and expertise to do behavioral health assessments on scene. In contrast, high-performing mobile crisis teams can resolve 70% of calls without transporting the person to a facility for care.[103] Mental health professionals have long achieved this by conducting clinical assessments on-scene to determine the severity of the crisis and providing information or links to community resources, with the goal of stabilizing the immediate crisis and having the client connect to longer-term care (therapy, case management, medication, etc.) in the future.

COMPARING ENDEAVOR BEHAVIORAL HEALTH TEAMS AND CRISIS SERVICES MOBILE OUTREACH

There are many similarities between BHT and Mobile Outreach teams: both respond to mental health crisis calls with a licensed clinician, who attempts to de-escalate and resolve the situation on scene to avoid hospitalization. The clinician administers assessments, provides safety planning and community referrals, and follows up with the person within 24-48 hours. Both teams have the authority to place involuntary psychiatric holds and force hospitalization. Both programs are small in staff and funding, especially in comparison to other first responders, and respond to several thousand calls a year. Both teams are stretched thin: in some police jurisdictions, there is a single clinician designated to BHT, on Mobile Outreach teams there are just a few clinicians on call at a time

to cover all of Erie County, a geographically large county with nearly a million residents. Neither BHT nor Mobile Outreach teams will be the first to respond to calls for an in-progress suicide attempt or where there are weapons or a threat of violence; both teams rely on the nearest police patrol to get to the scene first. Both teams will follow up with the person in crisis after police indicate the scene is safe, sometimes hours or days later. Despite these similarities, there are important differences between these programs, and significant gaps in service remain.

BEHAVIORAL HEALTH TEAMS (ENDEAVOR)	MOBILE OUTREACH (CRISIS SERVICES)
- Team: 1-2 police officers, 1 clinician	- Team: 2 clinicians
- Always involve police (100% of calls)	- Sometimes involve police (40% of calls)
- Respond to a variety of call types related to behavioral health	- Only respond to mental health crisis calls where harm is imminent
- Available for limited hours a day	- Available 24/7
- Cover specific police jurisdiction	- Cover Erie County
- Dispatched by 911, or self-dispatched	- Dispatched after triage by a crisis hotline counselor (rarely through 911)
- Average response time is 25 minutes[104]	- 25% of calls have response time of 30 minutes or less[105]
- Contacts in 2022 (Buffalo): 3,348[106]	- Contacts in 2022 (Erie County): 4,813[107]
- Percentage of all calls dispatched to team: 0.5% (Buffalo only, 2022)	- Percentage of all calls sent to mobile team: 6% (WNY area, 2022)
- Use “9.41” psychiatric holds (a narrower standard, based only on the individual’s current symptoms, performed by police)	- Use “9.45” psychiatric holds (a broader standard, which accounts for the individual’s current symptoms and reports from family or therapists)
- In-community stabilization rate (data period unknown): 69%[108]	- In-community stabilization rate (2022): 55%[109]

It’s important to recognize that comparing a co-response program like BHT and a mobile crisis response team like Mobile Outreach is not an apples-to-apples comparison. BHTs, because they are paired with police, respond to a wider variety of calls, including non-crisis calls such as those about someone experiencing homelessness, welfare checks, and similar. Also, they do not have a counselor triaging and resolving most of their calls over the phone like Mobile Outreach.

In contrast, Mobile Outreach teams are only deployed after a phone counselor has determined the situation is a crisis that warrants an in-person response due to an imminent risk of harm. It is conceivable that individuals seen by Mobile Outreach are, in general, in more advanced crisis than those seen by BHT, which could contribute to a lower percentage of calls

being resolved in the community. At the same time, Mobile Outreach clinicians often utilize 9.45 powers which is a broader standard for issuing psychiatric holds (BHT does not use 9.45). It's very possible that Mobile Outreach teams are more likely to recommend hospitalization than BHT because of this difference.

There is also a huge difference in call volume and geographic area served. Buffalo BHT serves just the City of Buffalo, a relatively small area, but is dispatched by police dispatchers who processed over 287,000 calls in 2022. This makes the number of calls handled by BHT a drop in the bucket: less than 0.5% of all calls in Buffalo go to BHT as the first response.[110]

By contrast, many fewer calls are routed through Crisis Services hotlines each year (between 70,000-80,000 on average)[111] and those calls come from across Erie County (a land area almost 20 times larger than the City of Buffalo) and the counties beyond through 988. Response times, therefore, vary greatly, both between BHT and Mobile Outreach and within Mobile Outreach responses, since the number of clinicians on duty and the distance traveled varies depending on the caller's location. BHT teams are likely to arrive faster than Mobile Outreach – along with covering a much smaller area, they travel in police vehicles with the lights, sirens, and legal authority that comes with them.

WHY THESE EFFORTS FALL SHORT

An effective mental health crisis response system has three elements: someone to talk to, someone to respond, and somewhere to go.[112] In Erie County, hotlines and warmlines provide someone to talk to. With the addition and development of more crisis stabilization facilities, soon there will be somewhere (other than the hospital) to go. But the middle portion, someone to respond, is lacking in Erie County.

First, co-response programs like BHT do not address the problems with a police response because police are still present on every call. Police presence alone can heighten tensions and increase fear, which is counterproductive in most situations.[113] Most low-level calls do not need police to respond.[114] In addition, including police on every call is costly and wastes police time.[115]

Most low-level calls **do not need police to respond.** In addition, including police on every call is costly and wastes police time.

Second, no behavioral health first responder program, including BHT and Mobile Outreach, utilizes peers. A peer is someone with lived personal experience of recovery from the struggles being faced by the person they are helping.[116] The peer movement in mental health came to prominence in the 1970s in the wake of deinstitutionalization, as survivors of institutional psychiatric abuse banded together to help each other in the community.[117] The peer movement created support groups, drop-in centers, warmlines, organizations, and advocacy groups to push for human

rights for people with mental health conditions and an end to stigma and abuse. Today, peer support is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based best practice in providing mental health care, including crisis response.[118] Research has shown that including peer support in crisis care reduces future use of crisis and emergency services.[119] Peers bring an irreplaceable level of understanding to the job. Rather than a top-down provider-client relationship, peers relate to each other as equals with mutual experiences and challenges. Peers model the truth that recovery is possible and offer hope by their example. While there are peer-run warmlines, respite houses, programs, and organizations in Buffalo providing an array of services, including crisis intervention when the need arises, peers are not integrated into BHT or Mobile Outreach teams as first responders.

Relying on clinicians and police to respond to behavioral health crises without peers is inadequate. Police are tasked with protecting public order and public property, not to meet the health and social needs of the individual they are encountering. While licensed clinicians may have far more skills in recognizing and addressing mental health needs, they also have liability concerns and professional obligations associated with their licensure that require they take certain steps to protect their interests. While neither of these agendas is inherently wrong, unless there is a peer also present none of the responders can fully understand what it feels like to be the person in crisis or freely advocate for their needs and desires, including their right to autonomy and self-determination. This approach is known as person-centered care. A peer can center the needs of the person they are caring for because they are freed from the expectations and wishes of all other forces. It is not a peer's job to focus on the needs or desires of the business owner who made the 911 call, the family member who arrived on the scene, the private ambulance company, the police commissioner, the county mental health department, or the NYS Office of Professions who licenses the clinicians. Their sole responsibility is to connect with and advocate for the person they are serving. Without peers, crisis response teams fall short.

A peer can center the needs of the person they are caring for because they are freed from the expectations and wishes of all other forces.

Third, even though specialized responses like BHT and Mobile Outreach are in place, most behavioral health-related calls are not directed to these teams. What's more, almost all the everyday low-risk calls about social disturbances and quality-of-life concerns that often have underlying social and health-related causes receive a police response if the caller does not explicitly mention behavioral health. Therefore, while a civilian MCT can be deployed in an urgent situation where a person is suicidal, it's a common practice that police alone are deployed to much lower-risk situations, such as a person panhandling on a street corner. In Erie County, outside of a narrow range of behavioral health crisis calls, police alone are the only available response. No attempts at reform have gone far enough in

addressing this problem.

For many years, police have been tasked with the unfair and impossible burden of being the only consistent public response available for every community problem, anywhere, all the time.

Steps have been taken in the right direction – better police training, co-responders, mobile crisis teams, and other solutions all have a place in an emergency response system that fields calls with varying degrees of risk involved. Regardless of the development of new or existing alternatives, the police will inevitably interact with people in crisis, and how they are trained to respond in these situations matters. But today, most calls related to mental and behavioral health needs, emergency or not, are dispatched and responded to by police alone.

Relying on police overburdens them to the point that many lower-priority calls have hours-long wait times or never receive a response. When police are eventually dispatched, the situation might be over, or the police may not have adequate resources or training to offer necessary assistance. At best, officers can attempt to compensate for the fundamental mismatch between their training and role and the needs of the person in front of them by calling a co-response or mobile crisis team; at worst, situations escalate to violence and death. Police do not have the time and expertise to address the problems that often lead to the call in the first place (addiction, trauma, homelessness, etc.), which leads to repeat calls and widespread frustration. Considering that health professionals and peers are already successfully at work in the community with the exact training, expertise, and skills needed, sending police as the default response to all calls is nonsensical.

Community responder teams fundamentally alter this dynamic. Where community responder teams exist, police are not the default response to every call. Integrating and dispatching community responders connects the dots between community-based care and 911 and eliminates the middleman, freeing police and ambulances to focus their time and energy elsewhere. The whole system is streamlined with reduced wait times and costs at emergency rooms and jails. Most importantly, teams protect people in crisis from being further traumatized while at their most vulnerable and give them effective, timely, appropriate help.

For many years, police have been tasked with the **unfair and impossible burden** of being the only consistent public response available for every community problem, anywhere, all the time.

A New Way: The Community Responder Model

Crisis Assistance Helping Out On The Street (CAHOOTS), in Eugene, Oregon, is one of the oldest community responder programs in the country, with a 35-year history. Here is a story from a reporter observing CAHOOTS as they answered a call for a disorderly person in 2020.

"When CAHOOTS arrived, a military veteran in his 20s was standing with the officer on the corner, wearing a backpack, a toothbrush tucked behind his ear. He had to stay 200 feet away from the place where he'd been living, and he couldn't drive. 'I been drinking a bit, and—I'm not gonna lie—I want to keep drinking,' he said. He needed somewhere to stay, and a way to move his car to a place where he could safely leave it overnight with his stuff in the back. He had enough cash for a motel room, as long as it didn't require a big deposit. CAHOOTS staff and the veteran took out their phones and began looking up budget motels along a nearby strip, settling on one with a military discount and a low cash deposit. 'Do you know how to drive stick?' the man asked. CAHOOTS staff exchanged blank looks, then continued to spitball. Did the man have AAA? Was another CAHOOTS unit free to help? I (the reporter) felt a lump rising in my throat. I'd wanted to keep my reporterly distance, but I was also a person watching a trivial problem stand in the way as calls stacked up at the dispatch center. I drove the car three blocks to the motel with the staff member in the front seat. 'So much of what people call CAHOOTS for is just ordinary favors,' the staff member said. 'We're professional people who do this every day, but what was that? We were helping him make phone calls and move his car.'[120]

While individual community responder programs differ, the community responder model has four central components. Community responder programs:

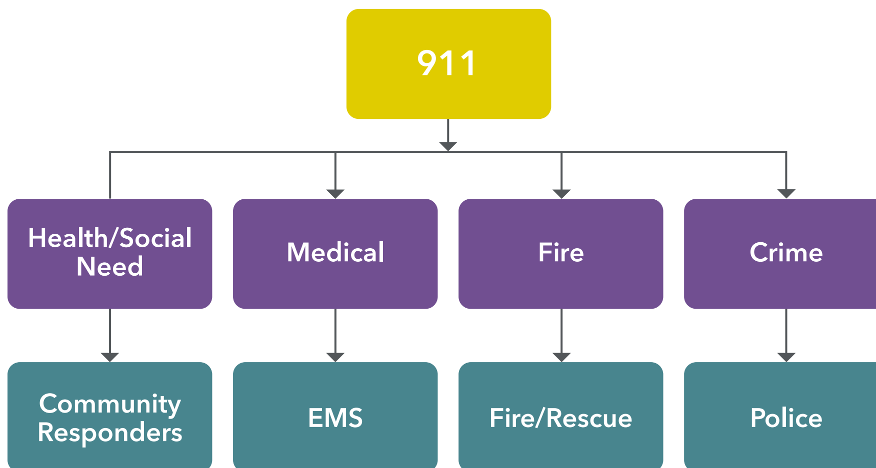
1. Respond to calls independently from police. This is a key difference from the co-responder model, where clinicians respond with police officers.
2. Dispatch teams of health professionals and peers, usually 2-3 people often including an Emergency Medical Technician (EMT), a peer, and a mental health professional.
3. Integrate into public systems to respond in person to 911, 988, or 311 calls within their purview. Many programs also have a direct phone number to allow teams to self-dispatch.
4. Respond only to non-violent, non-criminal calls for service related to health and social needs, usually before these situations have reached the level of a "crisis."

Crisis Assistance Helping Out On The Street (CAHOOTS), in Eugene, Oregon, is one of the oldest community responder programs in the country, with **a 35-year history.**

CAHOOTS team members in Eugene, Oregon. Photo by Todd Cooper. Source: Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-alternatives/cahoots

Community responder teams (CRTs) are the fourth arm of first response. Where law enforcement exists to address crime, firefighters to stop fires, and paramedics for medical emergencies, community responders exist to meet health and social needs.

4TH BRANCH OF THE EMERGENCY RESPONSE SYSTEM



Many community responder teams include at least one health professional with formal training, such as an EMT, a mental health clinician, or both. Other teams hire staff with the required personal attributes and train them in the skills they need without requiring a specific license or credential. The best teams prioritize hiring credible messengers, including peers. Peers may or may not be certified as professional peer support specialists, and programs have found various ways to include staff with a range of expertise and experiences. This ensures that teams have the necessary skills to assess and resolve crisis and non-crisis situations related to health and social issues and that the team members reflect and relate to the community they serve.

The level of crisis that a team can take on depends on the team's composition. Teams with EMTs may respond to more health-related calls, while teams with no licensed staff might be sent to more socially related calls, such as mediating arguments or mitigating quality-of-life concerns. In some localities where the community responder team has a clinician and is responsible for all behavioral health calls, the team might occasionally perform psychiatric holds.

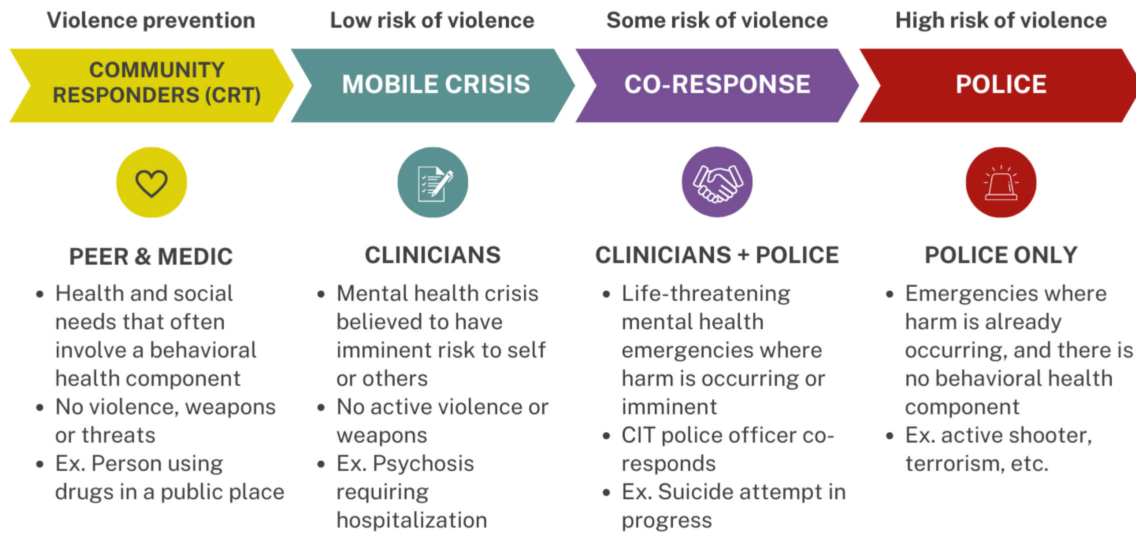
Usually, the CRT does not perform these holds in other places where separate MCT or co-response teams exist. In many jurisdictions, community responder teams supplement a spectrum of first responders, including CIT-trained police, co-responders, and mobile mental health crisis teams. They fill the gap at the lower-risk crisis prevention end of the spectrum where most calls fit—calls that merit a prompt in-person

Community responder teams (CRTs) are the fourth arm of first response. Where law enforcement exists to address crime, firefighters to stop fires, and paramedics for medical emergencies, **community responders exist to meet health and social needs.**

response but don't rise to the level of a crisis where there is an imminent risk of serious harm to self or others.

Common 911 call codes fielded by CRTs in other municipalities are "Check welfare," "Assist public," "Public intoxication," "Person down," "Syringe disposal," "Mental health crisis," "Trespassing," "Loitering," and similar calls that often involve a behavioral health or social need. Example scenarios include someone sleeping in a public location or on private property without permission, rambling and occasionally shouting at passerby, approaching cars at intersections to ask for money, crying uncontrollably at a bus stop, panhandling, using drugs in a public or business restroom, or being inappropriately dressed for the weather, wounded, or dehydrated. Teams can be dispatched to crisis and non-crisis situations in the selected call codes provided there are no weapons, violence, or serious crimes reported. Just like other first responders, they can be called to a scene by another first responder when needed. They can also call on others for backup.

SPECTRUM OF FIRST RESPONSE



WHAT COMMUNITY RESPONDERS DO

Once on scene, community responders provide immediate, person-centered assistance. Depending on the circumstances, this can look like active listening, de-escalation, problem-solving, and otherwise building rapport with the person to open lines of communication. Often, responders provide mental and physical first aid, assess vital signs, and

provide physical assistance as needed. Most teams travel in vans equipped with supplies for satisfying a range of basic needs: food, clothing, hygiene, personal care, and non-emergency medical care, such as treating a wound. If a good conversation, a granola bar, and some warm socks are not enough to meet the person's immediate needs, the team can provide transportation to facilities for longer-term support: places like shelters, crisis stabilization centers, detox or sobering centers, and similar. As a central part of the network of health and social services, team members can provide information and link people to follow-up care as needed.

Once on scene, community responders provide immediate, **person-centered** assistance.

Though all these services can be helpful at different times, the primary goal of the team is to build trust. Many people with unmet needs, particularly those who face marginalization and stigma due to race, sexuality, gender identity, disability, and other identities, have been hurt or traumatized by the individuals and systems meant to help them, not only those in law enforcement and other first responders, but also healthcare and social service workers, hospitals, treatment facilities, and others. Community responder teams are different because, especially in systems where police and involuntary treatment teams already exist, they can choose to provide strictly consensual, peer-driven care. Rather than using coercion, force, or control, CRTs rely on relationship building, mutuality, and time. Adding this voluntary, "upstream," pre-crisis option to the spectrum of responses available allows communities to intervene earlier in situations and increases the likelihood that a person will receive the care they need when they need it.

NATIONAL PROLIFERATION OF COMMUNITY RESPONDER PROGRAMS

Community responder teams have sprung up around the country, most within the last five years, in response to a growing demand for alternatives to police for mental health calls. At least 100 U.S cities have an alternative crisis response program.[121] The models vary in the number and professional qualifications of the team members, the program hours and geographic coverage, funding, whether staff are public or private employees, the types of calls sent to the team, and dispatch procedures. Some teams are part of municipal fire or police departments, some are part of county health departments, some are operated by non-profits under contract with local governments, and many are a combination of these options. A few teams are part of brand-new community safety departments that operate as distinct branches of local government.

COMMUNITY RESPONDER TEAMS OPERATING IN 2024

Below is a list of community responder teams operating in 2024. New teams are developing rapidly, so this list is not comprehensive. However, all the teams meet the criteria to be considered community responders: teams of health professionals and/or peers responding independently to low-risk health and safety calls as a fourth arm of first response through the existing 911 system. *

*Note: Atlanta PAD is an exception in that it responds to non-crisis calls only and is dispatched through 311, not 911.

In addition, pilot programs are in development in Boston, Washington D.C., Jersey City, Miami, Nashville, and Charlotte.[122]

PROGRAM NAME	LOCATION	YEAR EST.	TEAM COMPOSITION	ORGANIZATIONAL MAKEUP	ANNUAL BUDGET
CITY LEVEL PROGRAMS					
Albuquerque Community Safety	Albuquerque, NM	2021	2 behavioral health responders	Freestanding city dept.	$7.7 million
Holistic Empathetic Assistance Response Teams (HEART)	Durham, NC	2021	Medic, clinician & peer	Freestanding city dept.	$4.7 million
Crisis and Incident Response Through Community-Led Engagement (CIRCLE)	Los Angeles, CA	2021	Clinician & peer	Freestanding city dept.	$1.5 million in 2022
B-Heard	New York, NY	2021	2 medics & 1 clinician	Several city depts.	$43 million
Mobile Assistance Community Responders of Oakland (MACRO)	Oakland, CA	2022	EMT & community intervention specialist	City fire dept.	$10 million
Portland Street Response	Portland, OR	2021	Medic, clinician, crisis worker & case manager	City fire dept.	$12.6 million
Community Assisted Response and Engagement - Health One	Seattle, WA	2019	EMT & case manager	City fire dept.	$575,000 per team (3 teams)
Behavioral Evaluation and Response (BEAR)	Winston-Salem, NC	2023	Two clinicians	City fire dept.	$700,000
Project LIGHT	Las Cruces, NM	2023	EMT & Clinician	City fire dept.	$592,000
Community Health Access Team (CHAT)	Salt Lake City, UT	2023	EMT & clinician	City fire dept.	$466,000
Crisis Outreach Response and Engagement (CORE)	Honolulu, HI	2021	EMT & community health worker	City EMS dept.	$3.5 million
Crisis Assistance Response and Engagement (CARE)	Chicago, IL	2021	Medic & clinician	City fire & health depts.	$3.5 million
Alternative Response to Crisis (ARC)	Cincinnati, OH	2022	EMT& clinician	City fire & health depts.	$615,000
AR-3	Philadelphia, PA	2023	EMT & clinician	City fire & health depts.	$1.4 million
Crisis Response Unit (CRU)	Olympia, WA	2017	1-2 trained crisis workers	City police dept.	$2 million

PROGRAM NAME	LOCATION	YEAR EST.	TEAM COMPOSITION	ORGANIZATIONAL MAKEUP	ANNUAL BUDGET
PUBLIC-PRIVATE PARTNERSHIP PROGRAMS					
Denver Support Team Assisted Response (STAR)	Denver, CO	2020	EMT & clinician	City EMS & non-profits	$3.9 million
Crisis Assistance Helping Out on the Streets (CAHOOTS)	Eugene, OR	1989	Medic & crisis worker	City fire & non-profit	$2 million
Street Crisis Response Team (SCRT)	San Francisco, CA	2020	Medic, clinician & peer	City fire dept., other city depts, & non-profits	$13.5 million
Alternative Response Team	Tulsa, OK	2023	EMT & clinician	City fire dept & non-profit	$250,000
Community Assistance and Life Liasion (CALL)	St. Petersburg, FL	2021	Clinician & care navigator	Police dept. & non-profit	$1.3 million
Crisis Call Diversion program	Louisville, KY	2021	Two-person team	Local government & non-profit	$4.5 million
Specialized Care Unit	Berkley, CA	2023	EMT, Clinician & Peer	Non-profit with city funds	$5.5 million
Behavioral Crisis Response	Minneanapolis, MN	2021	Two clinicians	Non-profit funded by city	$1.45 million
Aurora Mobile Response Team	Aurora, CO	2021	EMT & Clinician	Private ambulance company & nonprofit, receives city funds	$804,501
COUNTY LEVEL PROGRAMS					
Albany County Crisis Officials Responding and Diverting (ACCORD)	Albany County, NY	2021	Clinician & EMT	County health & sheriff depts (EMTs only)	$300,000
Holistic Assistance Response Teams (HART)	Harris County, TX	2022	County health department staff	County public health dept.	$7.6 million
Mobile Crisis Response Teams	San Diego County, CA	2019	Clinician, case manager, peer	County behavioral health dept & non-profits	$20 million+

EXAMPLES OF COMMUNITY RESPONDERS IN ACTION

The assistance community responders provide is flexible and dynamic by nature. Here are a few stories from several community responder programs across the country.

From Health One in Seattle, Washington:
"The Johnsons are an older couple experiencing homelessness and living in their vehicle. They were originally located when Health One was looking for an unrelated client in late 2020. The crew provided the couple with snacks and water and learned that the couple had been unable to find housing together. Health One case managers recognized that the husband, "Charles," was a veteran and would be eligible for housing through the VA. The couple was provided with a disposable phone and assisted with the process of obtaining documentation. Health One later transported the couple to a VA housing open house and case manager Donna Andrews stayed with the couple throughout the day to ensure smooth processing. Case manager Andrews provided support in getting an updated social

security card for the wife, "Daisy" and coordinated registering Charles with the King County Veteran's Program. The team continued coordination with medical and service appointments over the next several weeks when the housing application was approved. A VA social worker provided transport for the couple to their new apartment, and Case manager Andrews assisted with the move-in. After 17 years of living on the streets, the couple is finally housed."[123]

After 17 years of living on the streets, the couple **is finally housed.**

From Community Assistance and Life Liaison (CALL) in St. Petersburg, Florida:
"Eve," a woman experiencing delusions, called 911 about 10 times in one day—and dozens of times in the few months prior. The first time the CALL community responder, Nina, met her, Eve had driven her car through her family's garage door because she thought she was being chased. Nina worked with Eve to schedule an appointment with a psychiatrist and even offered to accompany her and her family there. Eventually, they created a plan together: every morning, Eve would take her medication in front of her mom. Nina followed up with both her and her mom over the next few weeks, and they said things were going well. 'I told her to call me instead of 911, and she hasn't called me in three weeks,' Nina said. "That's a good thing, because it means she's been taking her medication."[124]

From Holistic Assistance Response Teams (HART) in Harris County, Texas:
A concerned store owner recently called 911 for help with a woman who was acting erratically inside the building. Rather than police responding, a team of professionals trained in mental health and social work arrived at the scene and reunited the woman – a mother with early onset dementia – with her daughter, who was searching for her.[125]

A H.E.A.R.T. responder assists a family in Durham, NC. Source: H.E.A.R.T website. https://heartforthis.org/watch/

From Holistic Empathetic Assistance Response Teams (HEART) in Durham, North Carolina, responding to a trespassing call:
Over the course of several weeks, HEART was dispatched to 911 calls about a neighbor sleeping in a parking garage stairwell. Some of the callers expressed that the neighbor exhibited mean and aggressive behavior. When HEART arrived, the responders approached the neighbor from a safe spot, careful not to overwhelm the neighbor, who was sleeping. They were able to engage and let him know of the need to relocate. However, since it was not HEART's job at that moment to require him to leave, they would come back for several days in a row to check in and help the neighbor keep in mind the need to find a better place to stay. The HEART clinician reflected, "Once I said, 'It sounds like you need a place to stay where people aren't bothering you,' something clicked in how he engaged with us." The next time HEART came by the neighbor let them know that he had found a new location to move to and was able to do so without further support from HEART.[126]

From Street Crisis Response Team (SCRT) in San Francisco, California, responding to a call about a man yelling and blocking traffic:

One of the responders, a paramedic from the Fire Department, lifted her radio and considered requesting police backup, worried he might hurt himself. But then she hesitated, not wanting to involve cops who might escalate things. Maybe, she hoped, her colleagues could calm him down on their own. So, she let them work. The behavioral health clinician made eye contact with the man, "Tom," and gently motioned him toward the sidewalk, where the peer support counselor handed him a water bottle and a snack. Within half a minute, Tom had relaxed. SCRT staff, dressed in civilian clothes, stayed with him, holding his belongings while he bent down to tie his shoes. "Then he started engaging with us," the clinician recalls. "It just looked like he wanted to get a lot off his chest."

After they calmed Tom down, the paramedic invited him to move out of the sun and into the shade, where she gently asked to take his vitals. He agreed and continued to ramble quietly, jumping from topic to topic. "I was just discussing my grandfather's death," he said at one point, kneeling while she examined his blood pressure and temperature. The behavioral health clinician offered to help him get a new blanket. "When was the last time you had something to eat?" the EMT inquired after asking for permission to check his blood sugar. Tom mentioned the snack that had just been shared with him and asked what might be considered a high or low blood sugar level.

He said he couldn't remember his age or his birthday. The team hoped to connect him with a shelter or drug detox clinic. But he wasn't interested. They made a note to follow up with him later through the Office of Coordinated Care, whose outreach workers scour the city on foot, by public transport, or with their own cars to find people after an initial interaction with crisis responders. Even though Tom didn't want to go to a detox clinic, he seemed relaxed by the time he said goodbye to the crisis responders, a far cry from when they first encountered him next to the SUV. The peer counselor asked whether he planned to go look for a bag that he said he'd lost. He nodded. "God bless you all," Tom said quietly as he walked away.[127]

From Community Health Access Team (CHAT) in Salt Lake City, Utah:

"Bob," a soft-spoken man in his sixties, tried going for a short walk in the baking sun in July and fell down, prompting a visit from an ambulance. He was OK — just dehydrated, but he asked for resources to help him quit drinking. The paramedics who had responded called for CHAT. Community responders arrived and sat down in Bob's dimly lit living room and started listening. "I'm lonely," Bob explained. He'd watched

San Francisco Street Crisis Response Team members. Photo by Amy Osborne. Source: Mother Jones. https://www.motherjones.com/criminal-justice/2022/06/mental-health-san-francisco-street-crisis-response-team-cahoots-police-violence/

He seemed **relaxed** by the time he said goodbye to the crisis responders, a far cry from when they first encountered him next to the SUV.

every movie on Netflix. Getting outside was tricky with a disability. He used to love fishing and spending time in the mountains. He wanted to stop drinking, but he struggled to do it on his own. The responders looked at his medications, asked about his insurance, and talked about different groups he might join to make friends. One told him about Utah Support Advocates for Recovery Awareness and gave him the number for the organization. She also sent an email to the organization when she returned to the office and asked them to call him.[128]

Measuring success: outcomes of successful programs

Besides a strong theoretical framework and positive stories, data from community responder programs demonstrate great strides in providing an effective, safe alternative to police for some 911 calls. However, the data that is collected by programs varies. Some of the metrics that have been tracked are the number of injuries, arrests, the percentage of calls dispatched to the team instead of police, how the calls are resolved, the percentage of calls requiring backup, response times, cost savings, and in one case, community-wide benefits. Several programs regularly publish data on their websites for transparency and accountability, such as the interactive data dashboard from HEART in Durham and monthly updated reports from MACRO in Oakland and SCRT in San Francisco.[129] Transparency is often lacking in traditional first-response agencies, and jurisdictions have an opportunity to correct this when creating a new type of first response.

Data from community responder programs demonstrate great strides in providing an **effective, safe alternative** to police for some 911 calls.

SAFETY

A primary driver of the momentum for community responders is the danger that results when police are the default response to every community need. Therefore, community responder programs must demonstrate effectiveness in keeping community members and first responders safe. The most basic metric programs should track is the number of injuries and deaths. Fortunately, this outcome has been straightforward and uniformly positive: to date, no community responder program operating in any of the municipalities studied has reported any deaths or serious injuries to responders or community members. For example, the CALL program in St. Petersburg, Florida has responded to over 9,000 calls without a single injury.[130] CAHOOTS in Eugene, Oregon has operated for 35 years without any deaths or serious injuries.[131]

A 2020 study analyzing 33 community responder teams found that none of the programs reported a single death, and minor injuries (including, for example, a responder being spit on, or closing the van door on their finger) occurred in less than 1% of all calls.[132] HEART responders in Durham report feeling safe in 99% of encounters.[133] Put simply, community

responder programs are safe. By matching the right calls to the right response, and by utilizing a trauma-informed approach, situations can be resolved calmly and safely without force or violence. For more on how community responders improve public safety, see Appendix C.

By matching the right calls to the right response, and by utilizing a trauma-informed approach, situations can be resolved **calmly and safely without force or violence.**

CALL VOLUME

The primary goal of community responder teams is to provide an effective alternative to police response for appropriate calls. If a community responder team exists, but police are still being routinely sent to eligible calls instead of or alongside the team, something is wrong. As an initial priority, localities should focus on making sure teams are responding to all or nearly all the calls in their purview. Call volume should be tracked by recording the number of calls sent to the team and the total number of eligible calls.[134] Given that most teams do not begin by operating 24 hours a day and that some calls will still be dispatched to traditional responders, this data collection allows for a comparison between the eligible call volume and the team's current capacity, which is essential for informing discussions around expansion. For example, in its first year, SCRT responded to 41% of eligible calls but by August 2023, after expanding the number of teams and their hours, it was dispatched independently to 96% of eligible calls.[135]

If a team is responding to a low percentage of eligible calls, leaders should work quickly to find out why and remedy it. If a program is touted to be an alternative to police, but police are still sent to most eligible calls anyway, programs can quickly lose support. An example is the B-Heard program in New York City. When it was launched, former mayor Bill DeBlasio stated that the B-Heard program would answer 70% of mental health calls, then later changed that number to 60%, then 50%. In reality, the team responded to 20% of calls at the beginning, and after expanding, this percentage decreased over time to 16%.[136] By overpromising and under-delivering, many community members lost faith in the program.[137]

A low percentage can be a result of a lack of resources (an inadequate number of teams for a high volume of calls), a dispatch problem, or a lack of real commitment to the goals of community response. CAHOOTS teams have dealt with several of these obstacles in their history. At the outset, police dispatchers were wary of sending calls to the teams.[138] However, over time as the teams proved themselves capable, more and more calls were diverted, so much so that by 2022, the teams received so many calls that response times were becoming slow, leading to a "why bother calling" perception in the community.[139] As a result, the city is in the process of creating more alternative teams to relieve some of the burden on CAHOOTS.[140]

A second important data point is the percentage of total 911 calls sent to the team, to gauge its impact on the public safety system at large. This data point varies greatly depending on the total call volume and call types in the locality, and the call types handled by the team. A CRT with a broad scope of eligible calls can divert a significant burden from other first responders. For example, in its first nine months of operation, the CALL team in St. Petersburg, Florida responded to over 50% of all noncriminal 911 calls in the city.[141] CAHOOTS has a similarly broad scope and estimates that it diverts up to 8% of all 911 calls from police in Eugene while responding to about 17% of all calls (sometimes as co-responders).[142] Other teams, if they are underutilized by 911 dispatch, might be very active in the community but divert few calls from police. In Oakland, the MACRO team is much more likely to initiate services through "on-views" (driving through neighborhoods and stopping as needed) or by fielding calls directly from community members rather than through 911 diversion.[143] As of March 2023, about 91% of calls were "on-views."[144] In a way, this approach is positive because it allows the CRT to respond spontaneously, and be very responsive to community needs. People can reach the team easily without going through 911 and risking a police response. But, while the services provided may be necessary and appreciated, this approach does not change the underlying problems of sending police by default when 911 is called and therefore it has faced critique from Oakland residents.[145]

For these reasons, teams should be accessible by calling 911, 988, 311, 211, the local non-emergency number or crisis hotline, and a direct phone number. Any number that people are accustomed to calling for immediate assistance should be connected to the CRT. This allows CRTs to be integrated into the main public safety systems and utilized appropriately and often, while at the same time allowing community members to avoid calling 911 if they choose and decreasing the overreliance on 911 for needs that are not truly life-threatening emergencies.

Teams should be **accessible** by calling 911, 988, 311, 211, the local non-emergency number or crisis hotline, and a direct phone number.

While having access to the team through all these mechanisms is ideal, few existing programs have managed to incorporate every entry point. The Community Safety Department in Albuquerque, New Mexico comes close by having CRTs available through 911, 988, and 311, but no direct line.[146] Similarly, programs in Dayton, Denver, San Diego County, and others have CRTs connected to direct lines and 911 dispatch but are not linked with 988 or 311.[147] Several programs that are subsets of fire or police departments are linked with 911 only.[148] An indicator of community trust in CRTs is if call volume increases over time, which is another reason to have a direct phone number, so as not to overburden 911 with increasing calls for the new CRT. In Eugene, Oregon community members know to call 911 to reach CAHOOTS, which inflates the call volume.[149]

RESPONSE TIMES

Response times for CRTs should be at least equivalent to other first responders, if not faster. One reason that people may call 911, rather than an alternative hotline or phone number, is because they believe a 911 call will result in an immediate in-person response.[150] The average response time for SCRT (San Francisco) and B-Heard (New York City) teams is 16 minutes.[151] CARE teams in Chicago have an average response time of 12 minutes, while HEART responders in Durham are on the scene in under 6 minutes.[152] To balance the CRT between being underutilized and overwhelmed, municipalities must carefully scale programs over time. Most pilots start with limited hours, a limited geographic area, and limited call types, and expand hours and reach over time as data demonstrates positive outcomes and support grows. Quality is more important than quantity at the beginning, and one aspect of a quality first response is building community trust with a short response time.

Quality is more important than quantity at the beginning, and one aspect of a quality first response is building community trust with a **short response time.**

CALL RESOLUTION

High-performing community responder programs can resolve a high number of calls without backup. Call resolution can be tracked by collecting data on the number of calls resolved on site, transported to hospitals, or transported to other services, the number of calls requiring backup, and the number of calls resulting in arrest (which should be zero, or close to it). For example, SCRT in San Francisco reported that fewer than 7% of clients required urgent medical attention entailing transport to the hospital and that 68% of all contacts were able to remain safely in the community without transport anywhere.[153] The STAR program in Denver has responded to over 10,000 calls over 3 years and has never called for backup and never had a call result in an arrest.[154] Long-operating CAHOOTS requests police backup in 2% of all calls, and even then most are not emergencies. In 2019, only 0.2% of calls (25 calls total) necessitated an immediate "lights and sirens" call for police backup.[155]

STAR team members assisting a woman in Denver, CO. Photo by STAR program. Source: CBS News. https://www.cbsnews.com/colorado/news/star-program-mental-health-paramedic-police/?utm_source=dlvr.it&utm_medium=twitter

COMMUNITY-WIDE BENEFITS

In theory, any response that earns community trust and leads to people calling for and receiving appropriate help is going to have community-wide benefits, such as stronger feelings of community connectedness and peace of mind in public spaces. Today, many community needs are overlooked or ignored when bystanders don't have access to a resource like a CRT. Yet, so far, just one study has looked at the community-wide benefits of community responder teams. A June 2022 peer-reviewed study of the Denver STAR program examined the effect on crime rates in the program's target areas. The study found a 34% reduction in low-level crimes (such as trespassing, public order, and similar), which translated to nearly 1,400 prevented crimes. There was no effect on serious crimes. The crime reduction effect took place even during the hours when the program

wasn't operating (at night), which indicates that crime reduction occurred due to STAR team interventions having a meaningful effect on underlying causes of individuals' behavior, which in turn reduced recidivism.

COST SAVINGS

If a program is tracking the number of calls diverted from police, it can estimate the number of hours of saved police time and cost savings. CAHOOTS found that it saves the city of Eugene $2.2 million per year in officer wages and $14 million per year in avoided emergency room costs.[156] Similarly, in the 6-month pilot phase of the Denver STAR program, researchers found that a STAR response cost, on average, $278 per response, compared to an average of $646 in justice system costs (prosecuting and detaining) for a police response to the same offenses.[157] This represents an average savings of $368 per response, or $275,264 total for the pilot period. Considering that the pilot was funded with $208,141, the money saved in reduced legal system costs outweighed the upfront costs of the pilot after only six months.[158]

CAHOOTS found that it saves the city of Eugene **$2.2 million** per year in officer wages and **$14 million** per year in avoided emergency room costs.

Another way community responders save municipalities money is by reducing liability. Actions by police are one of the largest sources of lawsuits against a city, and when a lawsuit is successful, the city pays, not the individual officer.[159] Community responders reduce the likelihood that a 911 call will result in a lawsuit against the municipality in five ways:

1. By reducing the number of police encounters with the public overall.
2. By sending unarmed responders who do not use force, the likelihood of the responder harming the public is lower.[160]
3. By sending a responder with more training in behavioral health and de-escalation, the chances of the responder administering appropriate support increases.[161]
4. By sending a community responder to eligible calls, the municipality abides by the Americans with Disabilities Act and is less likely to run afoul of federal civil rights claims.
5. By diverting individuals away from jail and into community-based services, the municipality further reduces the risk of lawsuits arising from transporting or incarcerating individuals

Municipalities are more likely to be found liable for harm caused by a responder than for failing to prevent harm by a third party.[162] This means that sending a police officer who causes harm is riskier for a municipality than sending a community responder, even if that community responder gets injured or fails to prevent someone from harming someone else. Though call-takers, dispatchers, and other stakeholders may be initially wary of not sending police due to liability concerns, sending community responders instead of police poses less liability risk than continuing to send

police.[163] Considering that recent lawsuits against police and jail deputies in Buffalo and Erie County have topped $95 million, if community responders can prevent even one lawsuit the cost savings could cover program expenses many times over.[164]

RESPONSE QUALITY

Much of the community responder model philosophy rests on the premise that healthcare workers, including peers, are better equipped to resolve health and social needs effectively and compassionately than law enforcement. However, it is a mistake to assume that just because a person has a certain qualification, their response will necessarily be high quality, culturally sensitive, or trauma informed. Programs should routinely collect feedback to gauge community members' satisfaction with the services provided, publicly report this data, and continuously improve service delivery. Methods for feedback should be incorporated into every interaction, such as having teams leave behind a card with their contact information and instructions on how to make a complaint or suggestion. Feedback can also be gathered through formal surveys. Evaluators of Portland Street Response (PSR) interviewed unhoused community members in Portland, Oregon, who had received services from the team, and these participants rated PSR services 4.8 out of 5. However, only about half of those surveyed had heard of the program, and 42% reported feeling unsafe calling 911, which pointed to the need for more outreach and an alternative to 911 dispatch to reach the team.[165]

Programs should **routinely collect feedback** to gauge community members' satisfaction with the services provided, publicly report this data, and **continuously improve service delivery.**

Programs should know how well individuals in their care are satisfied with the response received and make changes accordingly. Family members and community members should also have ways to provide ongoing feedback about their impressions of the team. Programs can also achieve community accountability through a formalized community oversight or advisory board, which participates in ongoing decision-making about the CRT and actively collects personal stories and public opinions on the program.[166]

LONG-TERM OUTCOMES

Many community responder programs publish anonymized stories from the field, which demonstrate effectiveness in connecting individuals with needed services. A community member served by SCRT said, "A clinician - she helped me out exponentially. She changed my life. Everything that I needed, she did for me. She pointed me in a proper direction and [I got] a long-term case worker and he got me an ID and got me housed. I'm about to move into an apartment because of him."[167]

A staff member in the same program reported, "We have gotten the person who's been number one on San Francisco's housing list, we got him housed. We advocated for him to have a case manager that he connected

with. He's doing a lot better. And we got somebody who'd been in the streets for 27 years - refused to get off the street - she's in her own house. And we had to work really hard with a lot of different agencies to make that happen. That only comes with trust and time."[168]

In addition to recording and publishing these individual narratives, programs should collect data on the number of people housed, enrolled in benefits, admitted to treatment programs, and similar outcomes to demonstrate impact. Here is one example from Portland Street Response:

"PSR community health workers and peer support specialists worked with a total of 75 clients who were referred to them from the PSR first responders. They completed 651 visits with PSR clients and made 107 referrals to service, including 51 housing applications and referrals, 15 shelter referrals, 12 medical referrals, and a variety of other referrals. During this evaluation period, 5 clients obtained permanent housing, 17 were connected to primary healthcare providers, and 15 were enrolled in healthcare coverage as a result of their work with PSR."[169]

Programs that can demonstrate long-term positive outcomes will be in a stronger position to advocate for continued funding and political support, especially under challenging or competitive circumstances.

COMMUNITY TRUST

Community trust is the most impactful long-term outcome for programs. CRTs are a new initiative in a field rife with trauma. Community responders must prove they are different. CRTs must not be used as "soft" policing but must operate from a fundamentally different approach than law enforcement. While law enforcement is responsible for public order, CRTs are focused on the well-being of the individuals involved. When these missions are confused, CRTs can be misapplied as a kinder approach to enforcing public order, which undermines its true goals. In Portland, for example, the mayor began sending PSR teams along with police to clear homeless encampments.[170] This jeopardized the mission of the PSR teams by aligning them with the city and law enforcement against the people they were attempting to build trust with. By contrast, in Atlanta, the Police Alternatives Division (PAD) works to establish a public understanding of the harm reduction model and make it clear that their services are voluntary and that they will not remove or detain people without their consent.[171]

Occasionally this distinction can become blurred when a CRT attempt to build rapport isn't working. CAHOOTS offers one example. When a business owner wanted a woman to leave the premises, CAHOOTS responded and tried to convince her to come with them. After several attempts failed, CAHOOTS staff told the woman that if she chose not to

"And we got somebody who'd been **in the streets for 27 years - refused to get off the street - she's in her own house.** And we had to work really hard with a lot of different agencies to make that happen. That only comes with trust and time."

come with them, the business owner would probably call the police. That worked, and the woman rode with the team to another location.[172] The key difference in community responder models is that rather than being an agent of the state and using force or coercion to compel someone against their will, CRTs collaborate with individuals and respect their choices as much as possible. In the small number of scenarios where that doesn't work, CRTs give truthful advice to the person about what is likely to happen. If police or mobile crisis teams become involved, and if a person is arrested or transported against their will, in many cases, the CRT can maintain the relationship with the person by virtue of their separation from those outcomes. Establishing a person-centered response in a CRT and creating boundaries between the CRT and other types of responses helps community members know what to expect and helps preserve the trust that is built by CRTs.

After trust is earned, safe, supportive, and productive interventions can follow. Outside of community surveys, trust is difficult to quantify and measure. The following reports from San Francisco's SCRT underscore the importance of building trust to advance any longer-term goals: "We had three or four calls with him, and eventually they trusted us enough and we set a date and time to meet … and we got them into the shelter, and it was the longest time that they'd ever stayed inside in a shelter." Another worker stated, "For me, a success story would be going to somebody that we see all the time that's in crisis, [but] we could actually talk to him. He knows who we are, and we are able to help him. Initially, he would refuse, but now when we go, we say, 'Hey, sir. Let's get you off the street tonight.' That's a success story. That took weeks and weeks, to get to that point. What I want the community to know is that these things take time. These individuals have been unhoused for months and years. We need to be patient with their process, and there's no quick fix to this."[173]

Policing Alternatives & Diversion Initiative staff in Atlanta, GA.
Source: PAD website. https://www.atlantapad.org/join-us

The key difference in community responder models is that **rather than being an agent of the state and using force or coercion** to compel someone against their will, CRTs **collaborate with individuals** and respect their choices as much as possible.

Program Design Considerations

How can programs achieve these positive outcomes? Successful programs start with a clear understanding of the community needs they are aiming to meet and work backward to design a program to best meet these needs. They fund the program with enough resources to meet these goals, hire the right people, train them well, and value their work. Staff have what they need to perform well and become fully integrated into local networks of first responders and health and social service providers. High-functioning programs collect good data, rigorously evaluate it, and make improvements quickly while being transparent and accountable. Finally, essentially, successful programs have enduring community and political support based on a solid public understanding and commitment to the community responder model.

High-functioning programs **collect good data,** rigorously evaluate it, and **make improvements quickly** while being transparent and accountable.

DATA COLLECTION

New programs should determine their desired outcomes first, and then work backward to meet those goals, based on best practices drawn from evaluations of existing programs.[174] For example, if one impetus to form a CRT is to more effectively meet the needs of people experiencing homelessness, program designers should, along with looking at other data, collect and analyze data on 911 calls most often related to homelessness (trespassing, loitering, etc.), map them to see what neighborhoods are the most affected, and make decisions about program hours, location, and staff accordingly. Another best practice is to collect data from areas outside the target area and outside program hours to assess the need for future expansion.[175] Programs should track the number of total eligible calls during all hours, even when the program is not operating, and the number of responses to show how the program can grow.

Programs that have invited evaluators to join the planning process have been able to design programs and collect quality data from the beginning, which saves time and effort later. Evaluators can recommend ways to best structure a program to meet certain outcomes, build in data collection tools, collect stories, and analyze data through the pilot phase to have meaningful results that can be communicated to the public as soon as the pilot concludes. If evaluators are left out of the planning process, it can be difficult for evaluators to get the data they need after the fact, because important information might have never been collected, or the CRT might waste their time collecting lots of data that isn't useful for drawing meaningful conclusions. In a worst-case scenario, failing to incorporate program evaluation might mean the program is never evaluated, and opportunities for quality improvement and public storytelling are lost. Without meaningful data, including stories, a program cannot demonstrate any outcomes, and without public results, programs lose support.

FUNDING

Programs should start at the right scale, with enough resources to be successful in meeting the identified needs. Smaller, city-level programs often start with just one or two teams fielding a limited set of call codes, during daytime hours, in a few neighborhoods to test out the program, ensure quality, and adjust before expanding to other areas or all hours. However, other programs, with enough planning, have started on a larger scale, such as the county-run programs in San Diego County, California. The program began with a soft launch in a small area in January 2021, but by May 2022 had 16 teams up and running, covering the whole county 24 hours a day.[176] Pilot programs can adjust their approach for different areas that may have diverse needs, for example, SCRT in San Francisco has neighborhood-based teams. While the teams can respond to calls from anywhere in the city, they focus their outreach and specialize their approach for their coverage area.[177] Given that pilots begin at vastly different scales, their start-up costs vary widely. Pilots can cost anywhere from $208,141 for Denver's 6-month pilot, to $2.4 million to launch the Albuquerque Community Safety Department.[178] Some pilots utilize grants to cover start-up costs. Following a pilot phase, many programs have expanded rapidly and secured more permanent funding.

Programs should **start at the right scale, with enough resources** to be successful in meeting the identified needs.

Many programs are funded by local operating budgets, some using new city taxes. For example, the Crisis Response Unit (CRU) program in Olympia, Washington is funded by a public safety levy on property taxes approved by voters in 2017.[179] In Denver, a 2018 ballot initiative created a special $35 million fund for mental health and substance use programs by raising sales tax by 0.25%, some of which goes to STAR.[180] At the state level, most states collect fees added to phone bills to fund 911 services.[181] In Virginia, this fee was increased by 12 cents a month to supply a Crisis Call Center Fund, which can be spent on services across the crisis response continuum, including call centers, mobile response teams, and crisis stabilization centers.[182] Several programs utilize state and federal mental health or justice grants.[183] As part of the American Rescue Plan, states can opt-in to an 85% federal match to fund non-police crisis response teams that have a clinician and peer.[184] To date, six states have taken advantage of Medicaid funding for mobile crisis response teams, and 20 have received planning grants.[185]

When considering funding, planners must make decisions about team size and qualifications. Team members with advanced degrees typically have higher salary requirements, but including licensed professionals such as clinicians means that teams can bill Medicaid for reimbursement and qualify for federal programs.[186] To reach their full potential, community responders should be equal partners in the first responder system, with pay and benefits in keeping with other first responders. To offer less sends the message that the work of the CRT is somehow less important or valuable.

All first responders should receive ongoing mentoring and coaching from supervisors, generous time off, and regular emotional and mental health support to prevent secondary trauma and avoid burnout.

STAFFING

A good community responder has the requisite skills and personality for the job. It's essential that each member of the team understands trauma, practices cultural sensitivity, and shares the values of the community responder approach. Responders who come to the job from other settings based on a narrow "medical model" view of mental health or law-enforcement-dominated first responder settings may bring technical skills, but if they lack a more holistic perspective, programs risk replicating the same problems pervading these traditional approaches. Therefore, programs must balance hiring decisions to account for skill and technical expertise along with personal experiences and philosophy, community ties, and other personal qualities such as temperament and demeanor that are important in de-escalation.

TEAM COMPOSITION

CRTs usually respond with two to three staff in a van and have some combination of the following: a medical professional, a mental health clinician or trained crisis worker, a peer, and/or a case manager. Sometimes, the same person will fill multiple roles, such as a clinician providing case management. There are pros and cons to including professionals with degrees and licenses versus well-trained community members with the right skills and perspectives.

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MEDICS

Many CRTs employ a paramedic or EMT for physical health assessments and non-emergency medical interventions. In many scenarios, the underlying cause of a person's distress or the degree of their impairment may be unclear. Distress that may initially appear to be mental or emotional can have a physical cause or component. For example, community responders have arrived at calls for mental health crises only to find that the person's behavior was due to problems with their insulin level, or a cognitive impairment like dementia.[187] Substance use is another example of a bio-psycho-social condition. To intervene effectively and safely when a person is under the influence of alcohol or drugs, a person with medical training and skills can be essential, especially when assessing if a higher level of care is necessary. Finally, employing medics is often an efficient choice, as many EMTs are already employed by fire departments, are trained in dispatch procedures, and are trained to drive emergency vehicles, which solves some of the logistical challenges to getting CRT programs up and running.

MENTAL HEALTH CLINICIANS AND CRISIS WORKERS

Licensed mental health clinicians, such as social workers or mental health counselors, are common choices for CRTs. They have detailed knowledge of mental health conditions, can assess the severity of symptoms, and provide interventions. Clinicians should have relevant field experience to augment classroom training. Teams that include clinicians can bill health insurance for services, which can create revenue for the program.[188] However, experienced clinicians have higher salary requirements and are currently in great demand, making hiring difficult. In addition, academic training is no substitute for person-centered care. Clinicians who have a "medical model" perspective may be more inclined to recommend hospitalization or involuntary treatment or may be risk-averse compared to a peer, which is why SAMHSA recommends a two-person peer-clinician team as a best practice for mobile crisis teams.[189]

Some programs, including CAHOOTS and PSR in Oregon, CALL in Florida, PAD in Georgia, and CRU in Washington, utilize trained crisis workers, harm reduction specialists, and community health workers instead of or in addition to licensed clinicians. These workers often have some experience or training in human services but are largely trained on the job and are hired because they have the necessary motivation and personal attributes to be successful.[190] The benefits of this approach are a wider and more diverse pool of applicants to choose from, lower salary requirements, and the potential to add new perspectives to the work.[191]

PEERS

On a CRT, a peer is someone in recovery from addiction or a mental health condition who has personal experience surviving crisis situations. A peer can refer to a certified peer specialist, or simply someone with the training and skills required to provide quality peer support. Programs that hire trained crisis workers or harm reduction specialists, instead of requiring staff to have a certain degree, are better positioned to hire community residents and peers who are of and from the community being served. Teams that reflect the neighborhood and the population they serve often operate from a shared understanding and communicate better with the people they encounter, which builds trust and leads to better outcomes.

CASE MANAGERS

Most community responder programs include methods for following up with people after a call. A few programs (Portland Street Response, CALL, Care Link, and MCRT) do this by including a case manager or community health worker in the CRT van or as one of several people who may be sent on calls, depending on availability. In San Francisco, a new city department, the Office of Coordinated Care, was created to provide follow-up services. This office acts as a central hub for coordinating

Teams that include clinicians **can bill health insurance for services,** which can create revenue for the program. However, experienced clinicians have higher salary requirements and are currently in great demand, making hiring difficult.

services across various providers in the area.[192] However, most teams provide follow-up care by having the clinician, crisis worker, or peer attempt to reconnect with individuals for a period following a call or by linking individuals to case managers who are not going out on calls as first responders.

ENSURING SAFETY

It's not an accident that existing CRT programs have a stellar safety record. Leaders must ensure they are providing extensive, quality training in the field before sending new staff on calls. CAHOOTS staff complete 40 hours of class time and 500-600 hours of in-field training before graduating to their own team.[193] Most programs include training in facts about mental health and substance use, de-escalation and crisis intervention, working with specific populations, equity and diversity, clinical skills (such as motivational interviewing, trauma-informed care, and professional boundaries), situational awareness and personal safety, basic medical training, community resources, relevant legal issues (such as privacy laws and laws about involuntary commitment), logistics such as vehicle and radio use, and other procedures.[194]

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Community responder programs are intentional to match responders to the right calls. No programs send CRTs when violence, weapons, serious crimes, or life-threatening medical needs are reported, and this filter may account for much of the safety record of the teams. However, the calculus of which calls are sent to CRTs is slightly different depending on the municipality, and where teams field a high number of calls, the likelihood of encountering more volatile situations increases accordingly. Even for programs that dispatch teams more conservatively, there are gray areas. What is considered dangerous can be subjective, and two callers might report the same scenario differently. Or a situation may change between when a call is made, when the team arrives, or while a team is on scene. Therefore, responders must be prepared to handle riskier situations when they arise. Here is one example from CAHOOTS in 2020:

"By the time CAHOOTS arrived, the man was lying on the grass with a small burning pile of latex gloves next to his head. When Swift (CAHOOTS staff) jumped out of the van, alarmed, he sat halfway up and poked at the fire with a kitchen knife, then lay back down. Had the cops been called again, the incident might have played out differently, and landed in the next day's paper: 'A young man setting objects on fire was shot after brandishing a knife.' But that's not how it went. Swift grabbed the knife, threw it well out of reach, and began talking to him."[195]

With proper training, CRTs have been able to de-escalate situations that fall outside their usual scope of practice or, when needed, have called for backup while maintaining their safety. Safety for all involved is of

paramount importance, and programs have prioritized it with great success.

COMMUNITY & POLITICAL SUPPORT

Public opinion strongly supports community responders. Eighty-five percent of National Alliance on Mental Illness survey respondents in June 2023 agreed that when someone is in a mental health or suicide crisis, they should receive a mental health response rather than a police response.[196] A separate poll found that 75% of voters, including majorities of both Republicans and Democrats, support their city creating an independent and co-equal Community Safety Department.[197] Eighty-nine percent (89%) of respondents to the same poll, including 94% of Democrats and 85% of Republicans, support a unit within such a department responding to mental health crises.[198] A third poll found that 73% of voters support local and state governments using public funds for additional approaches to police for 911 calls.[199]

Police departments in municipalities with community responders support the idea too. "We think (CAHOOTS) is great. They provide a different avenue than just handcuffs," Sgt. Rick Lewis from Springfield, Oregon police department said. "We have limited resources…so to have this different group, CAHOOTS, come in and have the additional time to spend with these folks to try to get resources and services to them, it's beneficial most importantly to the person, but also to the department and the city as a whole. So we love them."[200]

In March 2023, the Los Angeles police union proposed sending alternative responders to 28 types of calls, to focus officer time on more important issues. "Police officers are not psychologists... We are not social workers, doctors, nurses, or waste management experts," Debbie Thomas, one of the union's directors, said during a news conference. "I do believe that many people think we should be all those things, but we are not. We should be focused on responding to emergencies, saving lives (and) property, and of course, engaging in community policing."[201]

Local programs must have the support of their community to succeed. In Atlanta, the Police Alternatives Division (PAD) accomplished this by analyzing 3.5 years of 911 call data, surveying nearly 600 residents, holding three listening sessions with nearly 200 participants, and convening six stakeholder working groups with 40 participants. From this data, program designers knew what situations community members wanted alternative responders to take on, and how.[202] For example, residents were more likely to call 311 for people using drugs in a public place but were more likely to call 911 when drugs were being sold.[203] Knowing this, PAD designed its program to send teams of harm reduction specialists to 311 calls.[204] Through the same process, PAD used each opportunity to

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educate the public on its harm reduction model, how its approach differs from a traditional response, and what residents could expect to happen when a PAD team responded.[205] Extensive community outreach and collaboration before, during, and after program launch is key to success. Equally important is hiring staff that is reflective of the community being served, collecting and reporting data on an ongoing basis, and establishing a community oversight board or similar mechanism for public input and accountability.

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Pitfalls to avoid

UNREALISTIC EXPECTATIONS

Consistent, empathetic responses by CRTs create trust among the individuals they serve, but it's important that public officials and the community also maintain realistic expectations of what CRTs can do. CRTs, just like other helping professionals, operate within the confines of under-resourced social safety nets and are often frustrated by systemic failures in mental health and drug treatment, a lack of shelter beds, unaffordable housing, and other policy problems. Even established programs like CAHOOTS struggle with these system deficiencies. "Though CAHOOTS' resources extend to people experiencing a housing crisis, workers are unable to provide shelter for unhoused people," says Chelsea Swift, CAHOOTS agency outreach manager, who says she often breaks down in tears when she gets home after a shift. "My job is hard not because of who we work with, but because so often we have nothing to give."[206] A community responder can build a relationship with someone experiencing homelessness, which can lead to that person being housed, but that can only happen when an apartment is available. It is incumbent on leaders to clearly communicate the realistic aims of individual programs, and temper expectations that a CRT alone will "solve" systemic issues of mental health, drug use, homelessness, or poverty.[207]

UNDER-RESOURCING TEAMS

If expectations are high and funding is low, even the best staff can burn out quickly. Staff who are asked to handle emotionally distressing, sometimes traumatic situations without adequate support from supervisors, time off, pay, or other benefits will provide worsening services and will ultimately leave. As recently as 2022, CAHOOTS staff were working multiple jobs to make a living because CAHOOTS paid only $18 per hour, leading to turnover. "The CAHOOTS program is sorely underfunded. We really are encouraging these other programs to prioritize paying their first responders a living wage," said Abbey Carlstrom, with CAHOOTS. "I want to reiterate for (other programs), please don't use our numbers as a template," Carlstrom said. "Please, please, please do differently than that."[208]

Even with proper compensation in place, spreading teams too thin by overwhelming them with too many calls can lead to slow response times and sow community distrust. Community responder programs must be scaled up carefully and intentionally to maintain quality services and should be upfront about program limitations. For example, when Health One in Seattle had two teams in 2021, over a six-month period, they received 1000-1200 calls but were only able to handle about two-thirds of them.[209] Health One's model is an in-depth case management model, where social workers will spend multiple weeks and dozens of hours helping some clients. By contrast, CAHOOTS handles 60 calls a day with only two vans and is unable to provide comparable long-term follow-up services.[210] New programs should be clear on the goals of their model, and what outcomes are realistic based on those goals and the resources they have.

It may be tempting for political leaders to establish CRTs to score political points without committing to the model and the paradigm shift it represents, or to oversell what a program will do. Perhaps the most egregious example is in Washington, D.C., where the CRT was so under-resourced it answered less than 1% of mental health calls, took hours to arrive, and often didn't answer the phone.[211]

New programs should be **clear on the goals** of their model, and what outcomes are realistic based on those goals and the resources they have.

The gold standards

In summary, there are several benchmarks of success for community responder programs. While no existing program meets all these standards yet, many successful programs meet at least some of these criteria:

- Incorporate peers
- Reached by calling 911, 988, 311, 211, and a direct phone number
- Respond to and resolve a high number of calls that would otherwise be dispatched to police, without calling for backup
- Available 24/7, 365 days a year
- Respond in 30 minutes or less
- Funded by sustainable, permanent sources
- Ongoing, transparent data collection and reporting, continuous quality improvement, and clear mechanisms for community complaints and feedback
- Diverse, competent, mission-driven staff who are well-compensated and supported
- Reflective of, supported by, and accountable to the communities served

Program Administration Considerations

Community responder programs across the country achieve these goals even when they are operated and administered very differently. There are four options for program administration: a municipal program, a county-wide program, a privately operated program, or a combination. Each approach has pros and cons and is more or less effective depending on the specific needs of a jurisdiction, the individual decision-makers, and the current first response landscape in that municipality. It is far more important for programs to achieve positive outcomes than to subscribe to a particular operational structure, but choosing the right structure for the local context can significantly influence a program's success.

CITY-LEVEL PROGRAM

Many existing community responder programs are initiatives of local governments and are administered by local fire or police departments. A major benefit of the CRT being staffed by full-time city employees is that it can be quickly and seamlessly integrated into existing first response infrastructure. By housing the CRT in the fire department, for example, and employing EMTs of that department, the team has ready access to vehicles, radios, dispatch procedures, and all the existing experience, training, insurance, policies, and procedures of that EMT and fire department. Adding clinicians, peers, crisis workers, or other staff to the team as employees of that department means they are likely to have at least equal benefits to other fire department employees, whereas non-profits very often have lower pay and benefits. In addition, fully incorporating the team into an existing fire department may lend legitimacy to a new initiative in the eyes of other first responders and the public. This is because community-based providers may be seen as outsiders rather than a fully equal new branch of first response. As an arm of a permanent city department with permanent city employees, the team is more likely to receive steady city funding, compared to grants that often fund new contracts. Finally, as a city program, the teams would be subject to all governmental transparency laws including Freedom of Information requests, which would give the public more tools for transparency.

On the downside, fully city-operated programs might be less reflective of the community if there are civil service tests or other requirements that become barriers to employment. The people who might be the best community responders because of their life experience (peers, people with criminal records, multilingual individuals, etc.) may be screened out of the candidate pool if city hiring practices are too rigid. The culture of the city department can be a problem if there are entrenched negative attitudes toward the people being served by community responders, the community

It is far more important for programs to achieve positive outcomes than to subscribe to a particular operational structure, but choosing the **right structure for the local context** can significantly influence a program's success.

responder model, or the responders themselves.[212]

If the program is inside a police department rather than a fire department, the risk of the police overly influencing the program could be very real, even if the team is operating independently, the community may have that perception. CAHOOTS and the CALL program in St. Petersburg have been based in police departments with good results, but as of 2023 CAHOOTS moved to the Eugene Fire Department to further associate its work with healthcare rather than law enforcement.[213]

Finally, any initiative of government is at risk of being influenced by politics, including who is appointed to run the program, who is hired, what information is and isn't made public, and how accountable a department is to the public.

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COMMUNITY SAFETY DEPARTMENTS

A few cities have added new city-level departments to house all emerging community safety programs. Called Community Safety Departments, the departments typically coordinate several initiatives, including behavioral health CRTs, mediation or violence intervention teams, community service officers, and similar initiatives.[214] Rather than make alternative response teams a subset of an existing department, Community Safety Departments position these programs as a co-equal branch of first response, with dedicated administrative staff, vehicles, dispatch procedures, and other infrastructure. This removes the risk that a new initiative will take on the old culture or practices in an existing department and establishes the department as a permanent city service. Albuquerque, New Mexico, established its Community Safety Department in 2021 and has four types of community responders, one co-responder program, and a violence intervention program.[215] Durham, North Carolina established its Community Safety Department in 2022 and has a crisis call diversion program, community responders, co-responders, and care navigators, and works in coordination with a non-profit community violence intervention program.[216]

COUNTY-LEVEL PROGRAM

Some municipalities operate CRTs at the county level. Harris County, Texas operates the Holistic Assistance Response Teams (HART) program through the county public health department, while Albany County, New York, and San Diego County, California, operate programs through their county mental health departments.[217] In Albany, the county sheriff's office employs EMTs who are sent with a clinician from the county mental health department.[218] In San Diego, the mental health department operates a crisis line and contracts with non-profit organizations to be the first responders.[219]

A county-wide approach has several advantages. Operating a centralized program means there is less variability in the services provided compared to a town-by-town approach. When each municipality is responsible for developing its own program without centralized coordination, there can be confusion about what services are available where, and discrepancies in the quality of the services provided. Rather than spending time, money, and energy for each town to design and implement its own unique CRT, the planning, funding, and administration required to start up the program could be done once and would likely have access to greater funding resources as a result. Counties have larger budgets than municipalities and often are more likely to apply for state and federal grants than smaller towns. Additionally, in Erie County, much of the human services work that is done in the community is managed and funded at the county, not the local, level. Most of the public policy and governance of local health systems is done within the county mental health and public health departments, and these departments are responsible for administering and coordinating services among the dozens of direct service providers in the community. Finally, the geographic coverage of the CRT could be much larger if the county was responsible for it. Even if a pilot program didn't start as county-wide, or with 24-hour services, a county-run pilot would likely start at a larger scale compared to a local pilot, and the program could eventually cover the whole county at all hours.

The downsides of a county-run program are like those of a city-operated one. The barriers to civil service positions might prevent the best candidates from being hired. Administering the program through the government risks the program being too rigid and bureaucratic which could mean it lacks community representation. There is an even greater risk that a fully county-operated program would lack racial and economic diversity than a city-operated program because Erie County as a whole is whiter and wealthier than the cities within it. Finally, a challenge of operating at the county level compared to the city level is that, outside of the Sheriff's patrol deputies and a recently established supplementary ambulance service, Erie County is not accustomed to providing first responder services, and incorporating county-employed community responders into the established network of local first responders may be logistically challenging.

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PRIVATE CONTRACTORS

At least four CRTs in operation are managed by non-profit organizations that receive public funds. One example is the Aurora Mobile Response Team in Aurora, Colorado, which is a partnership between a private ambulance company that employs the team EMT and a non-profit mental health organization that employs the team clinician. The city contracts with these partners to respond to 911 calls and funds the initiative through the city budget.[220]

The advantages of contracting with outside organizations are that they tend to be more flexible, diverse, and responsive than public services, which can be bureaucratic, slow, and conservative. If a city partners with a community organization to provide services, that organization is typically better equipped to hire people with diverse backgrounds because of more flexible hiring procedures, and overall be nimbler with making changes when needed. The organization also brings its reputation to the work, and if that reputation is good, community members may be more likely to trust the team. The organization may bring a plethora of other resources to the table: clinical supervisors, medical care infrastructure, case management services, the ability to bill health insurance, an understanding of trauma-informed care and harm reduction, and an organizational culture aligned with the values of community responders. Depending on the existing first response infrastructure, contracting might be a quicker way to get a CRT off the ground compared to starting a new governmental department or division. This is especially true if the organization already has the required employees doing similar work in the community, or, as is the case with ambulance services in Buffalo and many Erie County towns, the organization is already under contract with the municipality for similar services. If the organization is a non-profit, it can receive grants that governmental agencies cannot, which opens an avenue for funding.

There are drawbacks to contracting with private agencies. One reason community organizations can be more flexible is that they are less likely to be unionized than public departments, which can mean workers are overworked and underpaid. As a result, lower personnel costs might tempt municipalities to choose this option, even if it's not the optimal design otherwise. Similarly, contracting out a new program might contribute to a perception that the CRT is less valuable, less competent, or temporary compared to traditional first responders. This "othering" is especially a risk if the CRT is demographically different from traditional first responders, who tend to be disproportionately white and male. A major concern is that dispatchers won't send many calls to the CRT because they are worried about being held liable if something goes wrong, and any factors that increase distrust between dispatchers and CRTs can worsen this problem.[221] Fully incorporating an outside organization into the first response system (with dispatch procedures, radios, vehicles, etc.) can be logistically complicated. Private organizations aren't subject to FOIL requests, so there is a risk that data will not be transparent, and private organizations, by definition, aren't subject to any formal public oversight or accountability. Finally, contracts come and go, whereas city departments typically have staying power and sustained funding. A major risk of operating the CRT through private contracts is that when times get tough, or leadership changes, the municipality might drop the whole thing.

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A COMBINED APPROACH

Many municipalities have combined several of these approaches to maximize the benefits and mitigate the challenges. A common city-level approach is to pair a fire department EMT with a contracted social worker and/or peer from a local non-profit organization. With this model, the team is incorporated into the existing fire department infrastructure but also has access to the community-based resources of the non-profit.

In San Diego, the county funds and operates a crisis call line, but sends out CRTs (a clinician, peer, and case manager) employed by non-profits.[222] Recently, all police departments in San Diego County coordinated with the county to have some calls diverted to this line, which connected the missing link between 911 and the crisis line.[223] Public-private partnerships can take advantage of a variety of funding sources. County government can act as a convener, funder, and supporter of local CRT initiatives by facilitating conversations between stakeholders, setting aside funds, and establishing minimum standards that municipal grantees must meet to receive funding. Counties can also facilitate shared grant proposals for several municipalities to apply for federal funds together.[224]

Regardless of the administrative approach, municipalities have seen successful outcomes when the stakeholders have demonstrated a strong commitment to the community responder model and values (including community engagement and involvement) and have dedicated the time, energy, and resources required to build a solid program.

Bringing Community Responders to Erie County

Erie County and its municipalities have much in common with the localities that have launched successful community responder programs. Like many places, Erie County is no stranger to police violence and in-custody jail deaths of people with mental health and substance needs. And, like many places, Erie County has several initiatives in place such as police co-responders and mobile crisis teams to attempt to better address some mental health crises. Yet, like all places without CRTs, police still respond to almost all calls involving health and social needs, even when there is no crime or risk of violence reported. Erie County is not unique in its needs or attempts at reform, which means that many of the lessons learned by pioneering CRTs can be applied here.

Erie County and its municipalities **have much in common** with the localities that have launched successful community responder programs.

First and foremost, a CRT in Erie County must be different from the existing responses (police, co-responders, and mobile crisis teams). A CRT in Erie County must go beyond sending clinicians to perform mental health assessments and giving the person in crisis a referral or sending them to the hospital. Erie County lacks peer-driven, community-based first responses, and has a dire need for a CRT that can respond immediately to a wide range of health and social needs, especially for situations that don't rise

to the narrow definition of a mental health crisis. A CRT in Erie County should be equipped to meet basic needs, provide non-emergency medical care on-site, and provide transportation to a variety of care facilities without relying on ambulances or police vehicles. The CRT should be flexible to accommodate a wide range of crisis and non-crisis situations, not just those that involve a known mental health concern. The CRT should be utilized in many scenarios where there is no emergency medical need, crime in progress, or violence reported. Eventually, all Erie County residents should have access to a CRT, 24 hours a day, wherever they live, for an in-person response in less than 30 minutes for all non-violent health and social needs. In this vision, the CRT would be linked with 911, 988, 311, 211, and a direct phone number ensuring all eligible calls are sent to the team and would be fully and permanently funded by public funds.

Recommendations

A pilot community responder program should be launched in Erie County as soon as possible. Because model CRT programs vary, and because Erie County is a large and diverse county, there are likely many options for CRTs here that could be successful. For example, if a fire department in the Southtowns piloted a municipally operated program at the same time a non-profit launched a privately run pilot on the West Side of Buffalo, each program might look very different but be equally transformational. It's unlikely a one-size-fits-all, top-down approach would be comparable in quality to approaches that begin small and community-based.

A pilot community responder program should be launched in Erie County **as soon as possible.**

Governments can support the development of these community-based pilots by providing vocal public support and funding, and by using their platform, power, and connections to facilitate the planning and implementation process. One such example at the state level is Daniel's Law, which, if passed, would direct local governments to establish a planning council of 51% peers to develop community-based crisis first responder teams of EMTs and peers who would respond to mental health and substance use crises, without police in most circumstances.[225] In 2023, the state established the Daniel's Law Task Force which is charged with identifying system needs, recommending model programs, and identifying potential funding sources for expanding mental health, alcohol use, and substance use crisis response.[226] In 2024, the New York State budget included $1.5 million in funding for pilot programs that would establish crisis response teams as described in Daniel's Law.[227]

Daniel's Day Town Hall event hosted by the Community Responders for Erie County Coalition, 9/20/2022. Photo by Unai Reglero.

Local governments can follow the state by committing support for the community responder model, allocating funding, and bringing together stakeholders, especially peers, to support the development of community responder pilots.

Conclusion

A growing chorus of voices, from survivors and activists to police officers and the federal government, recognize that sending police by default to every call for help is dangerous, unnecessary, costly, and inefficient. Community responders offer a better approach to low-risk health and social needs by meeting nonviolent calls for help with empathetic, immediate, consent-based care. As programs spread across the country, their undeniable success has created a mandate for other localities to follow their lead. Erie County and local municipalities must follow the advice and best practices of existing programs to establish community responder teams without delay.

Appendices

APPENDIX A: METHODOLOGY FOR ANALYZING BPD 911 CALL DATA

The data was analyzed using the programming language R. First, the dataset was cleaned to fix missing or unrealistic data entries. In the dataset, each 911 call to the Buffalo police has basic information that is recorded, with each row describing a 911 call and each column representing a different piece of information. Statistics were calculated to summarize many columns. For example, a list of all priority levels can be obtained, along with count information (number of calls for each priority level) and percentages.

All 911 calls were categorized into the following nine categories: alarms, ambulance, crime, general assistance, health and welfare, social disturbance, trouble or dispute, vehicles and traffic, and other. In the dataset, a new column was created to code each 911 call. Statistics were then calculated.

The call codes included in each category are shown in the table below. Note: the dataset did not include final dispatch codes. A small percentage of calls may have changed between initial and final dispatch. For example, a caller reporting a prowler trying to enter their house may have later realized it was a family member who was locked out. Therefore, the data is more reflective of the general nature of the calls as they come in to 911, rather than a reflection of the actual event that occurred.

CALL TYPE	PRIORITY LEVELS	CALL DESCRIPTIONS
Alarms	2, 3	Alarm, Alarm Bank
Ambulance	7	Ambulance
Crime	1, 2, 3, 4, 5, 6	Arrest Need Cd, Arson, Assault, Assault In Progress, Attempted Kidnapping, Bomb Scare, Burglary, Burglary In Progress, Child Neglect, Criminal Mischief, Fight, Fraud, Gangs, Garage Burglary, Hit And Run W/Injury, Home Invasion, Hostage, Kidnapping, Larceny/Theft, License Investigation, Person With Gun, Possible Gunshots Detected, Prowler, Purse Snatch, Rape, Robbery, School Threat Of Weapon, School With Weapon, Sexual Offense, Shooting, Shoplifting, Shots Fired, Stabbing, Subject With Knife, Threats (In Progress), Threats/Harassment, Verbal Threat At School, Violent Domestic, Violent Family Dispute, Warrant Suspect
General Assistance	5, 7	311 Complaint, Animal Bite, Animal Loose, Dumping Trash, Fireworks, Found Property, Gambling, Lost Property, Loud Noise, Miscellaneous, Utility Company Needed
Health and Welfare	3, 4, 5	Assist Citizen, Behavioral Health Follow Up, Check Welfare, Drunk, Injury Non–Criminal, Mental Health Crisis, Narcotics, Person Down, Suicide (Threats)
Other	1, 2, 3, 4, 5, 7	911 Hang Up, Assist Other Agency, Crisis Services Assist, Dead Body, Directed Patrol, Explosion, Fire, Juvenile Found, Missing Person, Missing Person Under 12, Missing Vulnerable Person, Officer In Trouble, Officer Transport, Order To Vacate, Overdose, Rescue, School Other, Suicide Attempt, Suspicious Incident, Suspicious Person, Suspicious Vehicle, Testing Crisis Services, Water Rescue
Social Disturbance	3, 4, 5	Indecent Exposure, Loitering, Person Screaming, Person Soliciting, Prostitution, Trespassing
Trouble or Dispute	3, 4	Custody Dispute, Customer Trouble, Domestic Trouble, Family Dispute, Juvenile Trouble, Labor Dispute, Landlord Trouble, Neighbor Trouble, Property Dispute, Unknown Trouble, Unwelcome Guest
Vehicles and Traffic	2, 3, 4, 5, 6, 7	Abandoned Vehicle, Accident Skyway/Kensington, Accident/ No Injury, Accident/Injury, Crossing Guard, Hit/Run Property Dam Only, Illegal Parking, Motorist Stranded, Reckless Operation, Recovered Uuv, Road Closure, Road Rage Ip, Signal Out, Speeding, Tow Truck, Traffic Control, Traffic Hazard, Traffic Pursuit, Traffic Stop, Unauthorized Use/Veh

TOP TEN 911 CALLS TO BUFFALO POLICE

The most common individual call code to Buffalo police, by far, is “ambulance.” This call code alone accounts for 15% of the BPD’s annual calls. As a policy, the BPD doesn’t usually respond to routine ambulance calls.[228] Instead, those calls go to other responders—the fire department and/or EMS. However, if a 911 dispatcher is concerned for responders’ safety, or if they think a crime has happened, they may send BPD along with the other responders.

After “ambulance,” the top ten most common individual call codes include “domestic trouble” (a separate code from “violent domestic”), “traffic stop,” “alarm,” “check welfare,” “larceny/theft,” “threats in progress,” “accident/no injury” (there are separate codes for accidents with injury, accidents on the Skyway/198/33, and accidents with property damage), “loud noise”, and “directed patrol,” which is a police-initiated patrol of an area, usually following a shooting or other incident.

TOP 10 CALLS TO BPD	PERCENT OF ALL CALLS
Ambulance	15%
Domestic trouble	5%
Traffic stop	5%
Alarm	5%
Check welfare	3%
Larceny/Theft	3%
Threats (in progress)	3%
Accident (no injury)	3%
Loud noise	3%
Directed patrol	2%

APPENDIX B: HOW POLICE BECAME THE DEFAULT

Police are now the default response to nearly any 911 call by design, spurred by the scale of federal investment in police forces over the last 50 years. While police, fire, and EMS services are largely funded by local dollars, federal action (or inaction) has had a significant impact. Protest movements in the 1960s for civil rights and against the Vietnam War simultaneously exposed police brutality and triggered massive federal spending on policing in reaction to social unrest and rising crime rates.[229] In 1968, following President Johnson's declaration of a "War on Crime" and amid then-candidate Nixon's "law and order" campaign messaging, the Omnibus Crime Control and Safe Streets Act funneled $400 million to local police departments. The same year, 911 was adopted as a centralized emergency number to shorten police response times and increase arrests.[230] Some early municipal adopters of 911 used it only for contacting police, while Buffalo was one of the first in the nation to use the number for both police and fire.[231]

Critics warned at the outset that many calls to 911 would not be crime-related emergencies, and indeed when New York City adopted 911 on July 1, 1968, calls for police increased by 40%.[232] Before 911, someone in an emergency situation would have to remember and dial a seven-digit number for the specific resource they needed in that locality, whether that was fire, police, poison control, etc. (ambulance services were scant until 1973, and to this day are weakly supported by block grants).[233] Local jurisdictions often overlapped, so knowing the correct number to call required a good memory. In Washington, DC, for example, there were 45 emergency numbers to remember.[234] Once 911 became an option, dialing it in any emergency became an easy way to get help, no matter the nature of the situation.

In addition, funding for law enforcement got additional boosts in 1986 with Reagan's "War on Drugs" and the Anti-Drug Abuse Act, and again under Clinton with the 1994 crime bill.[235] Between 1968 and 1999, when 911 was expanded and universalized, soaring crime rates dominated political discourse, and policing (and incarceration) was offered as the solution.[236] Violent crime peaked in 1991 and has since declined dramatically, but the legacy of these investments remains today.

In contrast, other emergency services were and are funded by piecemeal grants and never reached anything near the scale of local police departments.[237] To this day, in most localities, ambulances and EMS personnel are a subset of local fire departments or are contracted out to private companies, as is the case in Buffalo, Cheektowaga, and other municipalities in Erie County which have contracts with American Medical Response (AMR). Similarly, though fire departments receive some federal grants, over 70% of fire departments in the U.S are volunteer.[238]

Today there is a cycle: community members call 911 for an in-person response to a problem. Because the police are the most ubiquitous, police are sent to respond. Because the police are responding to so many calls, they are often stretched thin, and response times are slow or inadequate. This tends to generate calls for more funding for police, which then increases the size and personnel of the police department. And the cycle continues.[239]

APPENDIX C: SAFETY OF FIRST RESPONDERS

Historically, public discourse has widely equated policing with public safety. Arguments for increasing police forces center on preventing crime, removing violent actors, and protecting communities. However, over the past several years, body camera and cell phone footage have exposed heinous acts by individual police officers to public view and underscored what many Black residents have been saying for years: that in some circumstances, a police presence can make people less safe.

There is a fundamental and irreconcilable mismatch in police culture and training to what is required when interacting with people experiencing an altered mental state. Police are trained to exert authority over chaotic and tense situations to establish control quickly. They are taught to anticipate danger and react immediately and forcefully to perceived threats. In situations where violence is imminent, this approach can be effective. However, when a person is experiencing an altered mental state, brought on by a traumatic event, a medical condition, substance use, a mental health disorder, or any reason, often the experience is frightening and intense. Heightening the intensity of the experience by using commands, force, or attempting to control the person only makes the person feel more afraid. This is especially true if the person has previously experienced traumatic police encounters.

Instead, a responder must remain calm and provide person-centered, trauma-informed care. The six principles of trauma-informed care are safety, trustworthiness, peer support, choice, collaboration, and cultural humility.[240] People who have experienced trauma must feel that they are safe, that the person providing the care is trustworthy and understands them, that they have autonomy, that they are an active participant in their own care, and that their identity is valued and respected. When care is given in this way, it is often accepted and beneficial. When “care” is coercive, forceful, patronizing, exploitative, or generally unwanted, it often harms more than it helps. The nature of policing is to compel people to take certain actions and, if they don’t cooperate, to take away that person’s freedom, using force if necessary. It’s an approach that should be reserved for only the most extreme, high-risk scenarios, and it is the exact opposite of what is needed when providing quality health care. It’s impossible for police to inhabit both roles, and unfair to expect them to try.

When a person feels safe, they are more cooperative. Community responders use a variety of tools to build relationships and trust, which allows them to understand a person’s situation and their needs more fully. This, in turn, allows them to adapt their response to meet those needs, which builds more trust and reciprocity, keeping both responder and community member safe. This approach works so well, that out of the community responder programs studied, there has not been a single death or serious injury. The CAHOOTS program in Eugene, Oregon is the longest-running example, they respond to over 16,000 calls per year and in 33 years have not had a single death or serious injury. A study analyzed results from 33 community responder teams and found that only minor injuries occurred, and even those were rare: just 1 out of every 25,958 calls, less than 1%.[241] Relying on reciprocity rather than force or coercion is foundational to the community responder model. Inherent in this core tenet is a rejection of long-standing stigmas about people with mental health needs and people who use drugs.

It is a myth that people with mental illness are especially dangerous, but this myth persists in discussions about first responders and safety. Here are the facts:

People with mental health conditions are far more likely to be victims of violence than to perpetrate it.[242]

Only 3-5% of violent acts are committed by someone with mental illness.[243]

Other factors besides mental illness are much stronger predictors of violent behavior, for example, being a victim of violence, or substance use.[244]

Most people (90%) with psychotic disorders are not violent, and of those who are, there is almost always a co-occurring substance use disorder.[245]

This evidence suggests there is a 'chicken-and-egg' dilemma that clouds the public perception of mental illness and violence. If a person who commits a violent act is a victim of violence, uses drugs, and has a mental illness, too often, their mental health is blamed when the other two factors are much more likely to be the cause. The underlying causes for many violent acts are the same, regardless of the person's mental health. However, because 1 in 5 adults will seek treatment for a mental health condition in their lifetime, mental health often becomes the scapegoat.

Knowing this, it's time the emergency response system reckons with its complicity with this pervasive stigma. Too often in discussions about first response and safety, the primary question is: "Who will best protect the community from this (stigmatized) individual?" This question is based on the premise that the person being responded to is a danger to the responder, when many times the reverse is true.

The central question must become: "What can be done to make sure the community, the first responder, and the individual are safe?" The answer must consider and balance the real risks and benefits inherent to any first response to a crisis. Though stigma has unfairly colored public perception of mental health crises, every 911 call contains some risk. Any experienced first responder will tell you that the description of the call is not always what is going on at the scene – callers often have incomplete information, situations change over time, and events can escalate quickly. A key aspect of community responders' success is matching them to the calls they are best suited for to the extent possible.

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