

Establishing a Non-Police, Community-Based Crisis Response Team [JJ1] as a Primary Responder in Charlotte:

Stakeholder Feedback and Development Report



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List of Abbreviations[JJ3]

APP Wake EMS Advanced Practice Paramedic
CAHOOTS..... Crisis Assistance Helping Out on the Streets
CFSCalls for Service
CITCrisis Intervention Team
CMPD Charlotte-Mecklenburg Police Department
CPCRT..... Community Policing Crisis Response Team
DBHIDS.....Philadelphia Department of Behavioral Health and Intellectual disAbility Services
DPDDenver Police Department
EMSEmergency Medical Services
EMT Emergency Medical Technician
EPDEugene Police Department
LME/MCO..... Local Management Entity/Managed Care Organization
NC DHHS North Carolina Department of Health and Human Services
RMCP Rocky Mountain Crisis Partners
STARSupport Team Assisted Response



Executive Summary [JJ4]

The current relationship between the community and CMPD, along with an increased number of involuntary commitments in Mecklenburg county, warrant the exploration of how a non-police mobile crisis unit could both decrease the number of non-violent, non-criminal 911 CFS in which police engage, and lower the number of involuntary commitments in Mecklenburg county. The purpose of this report is to provide recommendations in the development of a non-police, community-based crisis assistance unit that responds to non-violent, non-criminal, mental or behavioral health 911 CFS [JJ5][JJ6] in Charlotte. Stakeholders in local and state government, academia, mental and behavioral health services, practicing clinicians, community activists, and law enforcement were interviewed to collect feedback about how a non-police, community-based crisis assistance unit [PN7][JJ8] responding to non-violent, non-criminal, mental or behavioral health 911 CFS could be developed and piloted in Charlotte. Based on stakeholder interviews, the following recommendations are presented regarding establishing such a unit through a pilot program:

1. The city should establish a commission to develop and execute the pilot within an established timeline. The commission should be charged with establishing the policies, infrastructure, and operational guidelines of the pilot. The commission should be comprised of individuals representing the following: city government, county government, county health and human services, CMPD and its communications division, a partnered mental and behavioral health service provider network, mobile crisis services, community members, and peer-specialists or persons with lived experiences [PN9][JJ10] of mental health recovery.
2. The commission should allot 7-12 months dedicated to establishing pilot policy, pilot budget management, emergency communication services, operational organization, personnel recruitment and development, and community awareness protocols before initiating the pilot. Considering the timeline established by the SAFE Charlotte Professional Consulting Services RFP (City of Charlotte, North Carolina, 2020), recommendations from a selected consulting service regarding transitioning certain police duties to a civilian response model are to be reported April 22, 2021. With such a timeline, a pilot such as this could be operational by November 2021.
3. The pilot should run for one full calendar year. The city should evaluate the effectiveness of the pilot six months post-initiation and again at the conclusion of the calendar year.
4. The city must partner with an interdisciplinary network of local, county-supported service providers to ensure that immediate and underlying conditions resulting in a mental health or substance use crises are addressed. This coordinated network should create a social continuum of care that assists individuals with or without health insurance, and provides culturally competent counseling services, outpatient mental health and substance use services, peer support, and assistance for basic needs (i.e., housing, utilities, food, clothing). Should a service like NC Care 360 be utilized to coordinate this interdisciplinary network, it is recommended that local mental health and basic assistance service providers be recruited and registered with NC Care 360 before initiating the pilot.



5. The city should identify a mobile crisis services organization willing to participate with the pilot alongside peer-support personnel and paramedics as a first-response service to mental/behavioral and situational crises. The mobile crisis service should also have the capabilities to be accessed through an independent phoneline.
6. CMPD officials and organizing members of the pilot should work jointly to determine the types of 911 CFS that could best be managed by a non-police, community-based response unit [PN11] addressing mental and behavioral health crises. Ideally, these calls should not involve any type of weaponry or combative criminal activity, and do not involve the execution of written citations in which an individual is ordered to pay a fine or report to court.
7. The city should contribute 911 CFS information and pilot results alongside other RTI Cohort Cities in North Carolina to contribute to the greater body of collaborative work in North Carolina public safety.
8. The city should use a data-driven approach to determine potential pilot locations by assessing 911 CFS data, law enforcement intelligence, and community feedback. Feedback from law enforcement personnel and community members must be considered to ensure that a non-police, community-based crisis assistance pilot could be introduced into the community in a manner that both ensures the safety and supports the operating capabilities of pilot personnel as much as feasible.
9. Considering CMPD's *Management of Subjects with Mental Illness/Extreme Distress* procedures, the piloted unit should be permitted to serve as a first responder to an appropriate 911 CFS should the unit be immediately available. CMPD should have the ability to summon the piloted unit as a primary officer assisted deflection resource. In turn, the unit must also have the capabilities to summon CMPD or EMS assistance should their encounter with an individual exceed their operational capabilities.
10. The piloted unit should not be involved in initial involuntary commitment procedures. This is to ensure that the unit maintains a reputation of civil service in assisting individuals experiencing mental or behavioral health crises, and not that of executing judicial orders involving involuntary restraint.
11. Pilot unit personnel training should include a cultural awareness component facilitated by a local group or organization. Such training should inform unit personnel about racial, economic, or social disparities faced by the individuals with whom they could interact, and how it contributes to mental distress. It should equip unit personnel with an empathetic, communicative skillset practical for the execution of their duties.
12. Pilot unit personnel should undergo paramedic-based, 40-hour CIT training if they have not done so.
13. Pilot unit personnel should be trained in emergency radio communication usage and incorporated into the law enforcement radio network. The unit should acclimate itself into the already developed radio network system.



14. Each pilot unit should consist of a master-level clinician or certified peer-specialist and a paramedic. The unit should dress in attire that is plain and non-assuming in nature yet signifies their association to the unit. Personnel should have individual and system radios that are tuned to the local police network in order to respond to calls within their vicinity and coordinate backup or deflection assistance.
15. Operational procedures used by pilot personnel should include on-site treatment procedures, transportation to service provider procedures, backup request procedures, and support response procedures.
16. The established commission should contract an evaluation partner to assess the safety and effectiveness of the pilot. Considering vicinity, the resources at University of North Carolina at Charlotte Criminal Justice and Criminology Department could serve as a pilot evaluation partner.
17. While a more in-depth financial analysis conducted by the city is needed, the city should expect to invest \$300,000-500,000 in the pilot. These funds should be used for the year-long salaries of pilot personnel, transportation vehicles and maintenance expenses, radio and communication equipment, basic emergency medical supplies, basic needs assistance supplies, emergency communications training materials for 911 operators, electronic equipment, and expenses associated with contracting services partners.

This report was limited by its inability to assess CMPD 911 CFS information and provide a financial analysis to accurately predict the cost of a non-police, community-based response unit in Charlotte.



H.I. Introduction

SAFE Coalition NC and Promise Resource Network, advocating on behalf of the equitable treatment of black, brown, and marginalized communities, and for those living with mental health diagnoses who have courageously overcome the trauma of their lived experiences, are honored to present a shared vision for a city-sponsored, community-based, non-police, crisis response team to respond to non-violent, non-criminal, mental and behavioral 911 CFS in Charlotte. This report is in response to the *SAFE Charlotte* recommendation to develop a civilian response model to address non-violent, non-criminal mental health and homeless 911 CFS. Historically, these issues have frequently resulted in police intervention, incarceration, and/or involuntary hospitalization. Utilizing police intervention to address non-violent, emotional distress overtaxes our local law enforcement. Officers have been required to intervene in situations in which they may not be fully trained to address, resulting in numerous examples of officers who acted in manners that eroded public trust. A community-based, non-police alternative demonstrates a significant shift in how mental health and substance use crises are viewed, and how people experiencing them are understood and treated. It is our hope that this report guides Charlotte's development of a civilian response model that not only addresses mental health intervention and public safety, but also begins to re-establish the bridge of trust between community members and law enforcement sworn to serve and protect them.

H.II. Background [JJ12]

CIT training was introduced in North Carolina in 2005 (NC Department of Health and Human Services, 2015). It is a police-based, pre-booking, jail diversion program that trains law enforcement personnel in how to address and de-escalate encounters involving individuals experiencing a mental or behavioral health crisis. CIT training emphasizes treatment rather than jail time for individuals displaying symptoms of mental illness (NC CIT Advisory Committee, 2009). In order to become CIT-certified, a law enforcement officer or paramedic must complete a 40-hour CIT training course. Based on a progress measurement report conducted by NC DHHS (2015), the highest percentages of CIT-certified law enforcement officers were located in Durham (59%), Cumberland (54%), and Wake (50%) counties. At the time of the survey, Mecklenburg County reported that 29% of their law enforcement officers were CIT certified¹. In 2016, CMPD began conducting mandatory, in-service de-escalation training for all officers, and required CMPD personnel to receive eight hours of Mental Health/First Aid training (2020). In addition, an abbreviated version of CIT training was administered to emergency call-center operators. Eventually, CMPD protocols were established to direct crisis-related 911 CFS to CIT-trained officers, and allowed CIT-trained officers to add themselves onto calls requiring crisis assistance (CMPDvidcast, 2016). CMPD's efforts led to an increase in events utilizing CIT intervention from 2017 to 2019 (Charlotte Mecklenburg Police Department, 2020)².

¹ This percentage does not exclusively reflect CMPD. Police departments surveyed from Mecklenburg county included CMPD, Cornelius Police Department, Davidson College Police Department, Huntersville Police Department, Matthews Police Department, Mecklenburg County Sheriff's Office, Mint Hill Police Department, Pine Hill Police Department, UNC-Charlotte Campus Police Department, and Veteran's Administration Police Department.

² This included citizens' calls for service and officers initially dispatched to an event.



In April, 2019, CMPD partnered with CriSyS, a mobile crisis organization that uses mental health specialists to respond to mental and behavioral health crises, to launch CPCRT. The partnership was a \$3.38 million contract over five years which paired Master's-level clinicians with officers to respond to non-violent, non-criminal, mental and behavioral health-related 911 CFS (Charlotte Mecklenburg Police Department, 2020). While CMPD and CriSyS work together as partners addressing mental health emergencies in Charlotte, the emphasis to decriminalize mental illness may have inadvertently contributed to an increased trend in involuntary-commitments in Mecklenburg County.

Research from Peer Voice NC (2018) found that the involuntary commitment rate in Mecklenburg county increased by 135% from 2009 to 2018 (from 6,103 to 14,328, respectively), with a concentrated spike of 105% between 2014 and 2018 (6,990 to 14,328, respectively). In addition, between 2014 and 2016, Atrium Health experienced a 41% increase in behavioral health volume at their acute care emergency departments and a 7.7% increase in inpatient length of stay at their Charlotte and Davidson hospitals. Since 2017, a community-wide health assessment has ranked mental health as the number one priority for Charlotte residents (Atrium Health; Novant Health; ONE Charlotte Health Alliance, 2019). [JJ13][JJ14]

Complicating CMPD's involvement in addressing mental health has been the nationwide protests for police reform after the deaths of George Floyd in Minneapolis, MN, and Breonna Taylor in Louisville, KY. The relationship between Charlotte residents and CMPD suffered even more after a series of city protests against racially-charged police brutality led to an internal investigation of the department, resulting in the suspension of a sergeant (Bose, 2020; Charlotte-Mecklenburg Police Department, 2020). Statewide efforts have been conducted to assess racial equity in criminal justice in North Carolina, and the same has been done locally in Charlotte (North Carolina Task Force for Racial Equity in Criminal Justice, 2020). Community input collected from the Charlotte Safe Communities' Community Input Group influenced Charlotte City Council to recommend developing a non-police unit to also respond to mental and behavioral health crises. This recommendation was incorporated into the city's *SAFE Charlotte* plan (City of Charlotte, 2020). The current relationship between the community and CMPD, along with an increased number of involuntary commitments in Mecklenburg county, warrant the exploration of how a non-police mobile crisis unit could both decrease the number of non-violent, non-criminal 911 CFS in which police engage, and lower the number of involuntary commitments in Mecklenburg county. Considering such an effort would invoke interdisciplinary healthcare interventions, city officials should also consider how Charlotte residents experiencing mental illness can utilize all available treatment services before being involuntarily committed in accordance to North Carolina G.S. 122C-201 (State of North Carolina, 2020)³.

³ It is state policy to encourage voluntary admissions to mental or behavioral health treatment facilities (State of North Carolina, 2020).



IV.III. Purpose[JJ15]

The purpose of this report is to provide recommendations in the development of a non-police, community-based crisis assistance unit to respond to non-violent, non-criminal, mental or behavioral health 911 CFS [JJ16][JJ17] in Charlotte. Stakeholders in local government, academia, mental and behavioral health services, practicing clinicians, community organizing, and law enforcement were interviewed to collect feedback on how such a unit could be established through a pilot program.

V.IV. Previous Programs[JJ18]

A. Crisis Assistance Helping Out on the Streets (CAHOOTS)

CAHOOTS is a mobile crisis intervention unit in Eugene and Springfield, Oregon, that has operated since 1989. Its units consist of an EMT and a crisis worker having several years of experience in the mental health field, and is dispatched through the police-fire-ambulance communications center in Eugene, and through an independent phoneline in Springfield (White Bird Clinic, 2020). Its services include: crisis counseling, suicide intervention, conflict resolution and mediation, grief and loss counseling, substance abuse intervention, first aid and non-emergency medical care, resource connection and referral, and transportation to services. CAHOOTS operates as a service of the White Bird Clinic, a federally qualified health center in Eugene. The clinic operates 10 health services programs, including 24-hour crisis services, outpatient drug and alcohol treatment, a human services information and referral center, and homeless case management services (White Bird Clinic, 2020).

Emergency dispatchers in Eugene are trained to recognize non-violent 911 CFS involving a behavioral health component and route those calls to CAHOOTS (White Bird Clinic, 2020). According to the Eugene Police Department Crime Analysis Unit (2020), from January 1, 2019 to December 31, 2019, CAHOOTS diverted approximately 5% to 8% of EPD calls for service. CAHOOTS was dispatched as the first responder to 13,581 calls. The bulk of calls in which CAHOOTS was the only unit dispatched included welfare checks (30.5%), public assistance (28.8%), transportation services (23.8%), and suicidal subjects (6.4%) (Eugene Police Department Crime Analysis Unit, 2020). Examples of calls classified as “check welfare” included, “female walking barefoot and not wearing much clothing...” (Eugene Police Department Crime Analysis Unit, 2020, p. 6), and “there is possibly a person sleeping on sidewalk, or possibly items covered by tarp. Hasn’t moved...” (p. 6). An example of a call deemed “assist public” included, “[request] cahoots for counseling and assistance...having suicidal thoughts no plans or means at this time” (p. 6). Further call types addressed by CAHOOTS are described in **Appendix A**.

The percentage of calls in which CAHOOTS was the only unit dispatched then requested backup was 2% (311 backup requests). However, when the nature of calls deviated from the top call-topics which CAHOOTS addressed, such as calls deemed “criminal trespass,” CAHOOTS’ requests for police backup increased. In some occasions, both CAHOOTS and EPD were jointly dispatched to address calls such as suicide intervention and disorderly conduct (Eugene Police Department Crime Analysis Unit, 2020).



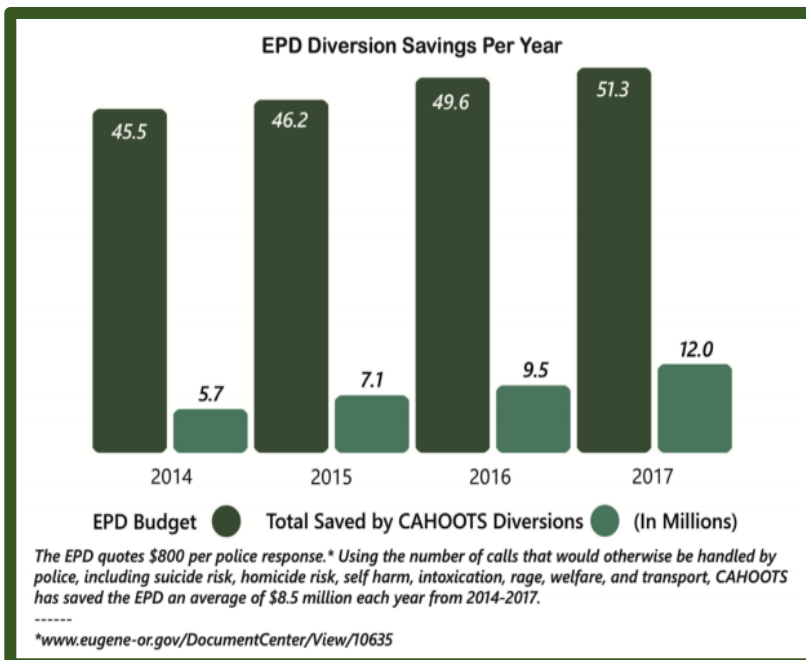


Figure 1. The White Bird Clinic (2020) reported saving the Eugene Police Department \$8.5 million from 2014-2017 (p. 4).

The city of Eugene funded CAHOOTS through EPD contracts. In fiscal year 2018 (July 2017 to June 2018), the contract budget for CAHOOTS was approximately \$798,000, which funded 31 hours of service per day (overlapping coverage), seven days a week (Eugene Police Department, 2020). In fiscal year 2020 the city of Eugene added an additional \$281,000 on a one-time basis for an additional 11 hours of coverage. **Figure 1** demonstrates the relationship between EPD’s investment in CAHOOTS and EPD budget savings from 2014-2017.

While CAHOOTS has been successful in Eugene, there are stark differences in the population and demographic makeup between Charlotte and Eugene. For instance, in 2019 there were 885,708 residents living in Charlotte compared to 172,622 in Eugene. Charlotte reported a racial demographic being 49.5% white compared to Eugene, being 83.3% white (United States Census Bureau, 2020). The population density and racial demographic differences could mean that more organizational and community barriers must be overcome before establishing a similar mental health response unit in Charlotte. While CAHOOTS presents a theoretical and practical framework for using a mobile crisis first-response unit, more research must be done before initiating such a model in Charlotte.

B. Denver Support Team Assisted Response (STAR)

Modeled after CAHOOTS and launched June 2020, Denver STAR is a mobile crisis intervention unit accessible through Denver’s 911 communications center. STAR currently operates as a pilot program within central downtown Denver between 10:00 AM and 6:00 PM (Denver Justice Project, 2020). It is a joint venture between the Denver Police Department, Mental Health Center of Denver, Denver Health Paramedic Division, Rocky Mountain Crisis Partners, and community support and resources (Denver 911 Center, 2020). STAR personnel are staffed by clinicians from Mental Health Center of Denver, paramedics from Denver Health, and peer support specialists from Rocky Mountain Crisis Partners (Denver Justice Project, 2020; Denver 911 Center, 2020). According to STAR stakeholders from the Mental Health Center of Denver (2020), Denver previously established a co-responder program with law enforcement and mental health personnel in 2016, similar to CPCRT. STAR did not replace this program, but instead operates as a supplemental resource. The city of Denver elected to utilize both services noting that not every crisis assistance call needed law enforcement presence.



A STAR unit consists of one mental health clinician and one paramedic who are dispatched to provide free medical care, first aid, or mental health support for non-violent and non-criminal emergencies including: drug overdoses, suicidal individuals, intoxication, indecent exposure, trespass/unwanted person, and syringe disposal (Denver Justice Project, 2020). According STAR personnel (Denver, 2020), the unit operates from one van covering roughly 25 square miles of downtown Denver. The van is equipped with a basic life support kit, an automated external defibrillator, IV equipment, band-aids, clothing, tinfoil blankets, snacks, water, and feminine hygiene products.

From June to November 2020, STAR responded to approximately 717 calls and did not request police backup (Denver, 2020). STAR is also dispatched to support police, fire, or EMS personnel at the scene of an incident (Denver 911 Center, 2020). In the event of encountering a more serious medical emergency or an event that escalates beyond the unit's management capabilities, the unit is also able to quickly coordinate backup assistance with ambulances or police. **Appendix B** presents an emergency communications dispatch flow chart from the *STAR-RMCP Alternate Response Combined Reference Guide* (2020).

To fund STAR, the city of Denver's "Caring 4 Denver Foundation" awarded DPD \$208,141 in two payments contingent on the learnings and continuation of the program. DPD used the funds to employ a full-time paramedic, a full-time mental health clinician, and 16 hours of a peer-specialist. Prior to launching STAR, DPD developed and delivered comprehensive training to twenty-five 911 dispatchers, 6 paramedics, 2 clinicians, and 4 peer-specialists (Caring 4 Denver, 2020). After four months of operation, Denver Mayor Michael Hancock invested an additional \$2.8 million to STAR, and at the request of Denver City Council transitioned STAR from the Department of Public Safety to Denver's Department of Public Health and Environment (Swanson, 2020a, 2020b). Denver's investment into STAR and its scaling parameters created safeguards to minimize financial and safety threats impacting personnel and consumers. While STAR's approach to addressing mental health crises may better fit a metropolitan area like Charlotte, the resources in Charlotte for establishing a continuum for care for consumers must still be taken into account.

C. Philadelphia [JJ19][JJ20] Department of Behavioral Health and Intellectual disAbility Services

The city of Philadelphia has utilized mobile crisis teams for several years, and have since taken a greater investment in mental health reform following the October 2020 shooting death of Walter Wallace, Jr. by law enforcement and the subsequent protests throughout the city that followed (Behavioral Health and Justice, 2020). Upon collecting community feedback and engaging in mental health and criminal justice reform, DBHIDS enacted, and is expanding upon, several public safety measures regarding mental health crises. The measures include further utilizing mobile crisis units composed of clinicians and trained peer-specialists as first responders throughout the city, further utilizing co-responder units which partner behavioral health specialists and Philadelphia Police Department officers, and establishing the Philadelphia Crisis Line for individuals contemplating suicide accessible through 911.

Philadelphia's non-police mobile crisis teams respond to approximately 3,700 crises annually, coming from either a city mental health line or forwarded by 911 dispatchers (Ao,



2020). Mobile crisis team operations rely heavily upon the efforts of trained peer-specialists, distinguishing it from STAR. Representatives of DBHIDS elected to rely on peer-specialists because their intimate knowledge of a crisis in which a person could experience gave them heightened rapport within the mental health consumer community (Behavioral Health and Justice, 2020). An interviewed stakeholder of DBHIDS reported that the city spends approximately \$2 million dollars to operate its mobile crisis services. The stakeholder emphasized that both residents and Philadelphia City Council made mental health and criminal justice reform an immediate priority, thus accelerating intervention efforts in the city.

In addition to dispatching a mobile crisis unit through 911, DBHIDS sponsors a 24/7 mental health delegate line. The line allows residents to request a mobile crisis team, find a nearby crisis center, and request a community response team for anyone experiencing trauma (Department of Behavioral Health and Intellectual disAbility Services, 2021). City officials also engaged residents about their willingness to use the “988” national crisis number authorized by the Federal Communications Commission to receive crisis assistance instead of dialing 911 (Federal Communications Commission, 2020). A majority of Philadelphia residents voiced that they were not going to dial “988,” and instead depended on 911 operators to dispatch the appropriate assistance they needed (Behavioral Health and Justice, 2020). In response, emergency communication operators have been trained to triage 911 CFS regarding mental health and coordinate either a non-police mobile crisis response, or a co-responder response with law enforcement. The city also added mental health clinicians into emergency call centers to act as crisis operators and is in the process of training approximately 250 emergency operator staff in being able to identify 911 CFS needing crisis assistance rather than other emergency services.

Philadelphia’s efficiency in its emergency communications and reliance on trained peer-specialists demonstrates how an emergency crisis assistance framework could be established in a major city. Considering the resources in Charlotte, a similar crisis assistance model could be established within the city.

D. North Carolina Community Paramedicine Pilot Programs [PN21]

From 2016 to 2017, NC DHHS conducted two concurrent pilot programs aimed at reducing emergency department visits and healthcare costs for consumers. The Community Behavioral Health Paramedicine Pilot, which operated in 13 counties, found that up to one-third of consumers experiencing a behavioral health issue could be diverted away from the emergency department and to an alternative treatment site (Kurtz, 2017). The Community Paramedicine Pilot, which operated in 3 counties, found that the number of 911 CFS could be lowered by utilizing a direct line to mobile paramedic services (The North Carolina Department of Health and Human Services, 2017). Both pilots found that alternative treatment measures lowered emergency department crowding.

By introducing the alternative locations as additional EMS transportation options, researchers found that 34% of individuals were able to be either treated on scene or transported



to a location other than the hospital. This supported the idea that crowding in emergency departments could be reduced when treatment options for individuals experiencing mental health crises were included in the array of emergency treatment services. Researchers originally observed that individuals experiencing psychiatric crises were treated in emergency departments when they instead could be treated in alternative, less costly settings. However, while EMS could divert individuals to alternative settings, they were only compensated for taking consumers to the emergency department (Kurtz, 2017). To alleviate this, the Community Behavioral Health Paramedicine Pilot established a reimbursement mechanism for EMS services whenever individuals were transported to crisis intervention alternatives instead of to the local hospital emergency department. To fund the pilot, researchers were appropriated \$225,000 from the North Carolina General Assembly and awarded federal block grants. The funding established partnerships between EMS agencies, local LME/MCOs, and crisis providers in each participating area; covered costs of CIT training to paramedics in 11 counties; standardized clinical guidelines; and established a reimbursement mechanism for EMS services. **Appendix C** presents pilot information detailing the financial implications, treatment types, and consumer demographics.

The Community Paramedicine Pilot successfully reported a reduction in EMS patient transports to the emergency department and estimated reductions in 911 CFS and consumer healthcare costs when community paramedics were used (Fernandez, 2017). Three counties within the state (McDowell, New Hanover, and Wake), representing varying population and geographic statuses, utilized a mobile paramedic program to address a specific targeting focus within their area. Wake county's APP community paramedic program specialized in redirecting patients experiencing a mental health or substance use crisis away from the emergency department and to acute care services. During the course of the pilot, APP evaluated 1,191 mental health and acute substance use patients and diverted 47% of those patients away from the emergency department (The North Carolina Department of Health and Human Services, 2017). **Appendix D** presents statistical information regarding where patients were transported and an explanation of why some patients were still transported to the emergency department. At the time of the study, APP consisted of two supervisors and 14 full-time personnel staffing five units across the county. To fund the pilot, the North Carolina General Assembly appropriated a total of \$350,000, with \$70,000 going to McDowell and Wake counties, and \$210,000 going to New Hanover county.

Both pilots demonstrated that hospital-intervention programs regarding mental health could divert patients to away from emergency departments and to more specialized care facilities. This could perhaps lead to a reduction in involuntary commitments if utilized in Mecklenburg county.



E. Mecklenburg County Criminal Justice Sequential Intercept Mapping Workshop

In July 2016 and again in 2020, the Mecklenburg County Criminal Justice Services Department funded a multi-system, multi-stakeholder planning workshop utilizing the Sequential Intercept Model to assess the available resources, gaps in services, and cross-systems collaboration opportunities regarding mental health and criminal justice (Mecklenburg County Criminal Justice Services Department, 2017). The workshop included stakeholders representing Cardinal Innovations and its contracted providers, National Alliance on Mental Illness, CMPD, Mecklenburg County Criminal Justice Services, both Mecklenburg County Health Department and its Behavioral Health Division, Promise Resource Network, National Alliance on Mental Illness, local hospitals, advocacy groups, and more. The results of the workshop were network maps that illustrated the entities in which individuals with behavioral health needs interacted in both the behavioral healthcare and criminal justice systems. This information can be found in **Appendix E**.

The 2016 workshop had three primary objectives:

1. Develop a comprehensive picture of how people with mental illness and co-occurring disorders flowed through the criminal justice system along five distinct intercept points: (I) Law Enforcement and Emergency Services, (II) Initial Detention and Initial Court Hearings, (III) Jails and Courts, (IV) Reentry, and (V) Community Corrections/Community Support;
2. Identify gaps, resources, and intervention opportunities at each intercept for individuals with mental health and substance use challenges; and
3. Develop priorities for activities designed to improve system and service level responses for and of individuals living with mental illness.

Priority areas that emerged from the workshop included:

- establishing a non-hospital alternative within each intercept of the mental health crisis continuum, primarily in pre-crisis and non-emergency crisis, that serve as a linkage source to and from the existing assistance resources;
- establishing a cross stakeholder advisory group to enhance coordination, planning, communication, troubleshooting, community education, and a System of Care approach for the crisis continuum;
- expanding the prevention service array at Intercept I: Law Enforcement and Emergency Services;
- adding a viable alternative to individuals seeking services from services CriSyS Mobile Crisis Team, with the goal to prevent hospitalization when possible;
- developing alternatives to legal involvement, including incarceration, for Charlotteans with mental health and/or substance use challenges; and
- creating a hospital diversion option that would benefit individuals as well as two local community hospitals (Carolina's Health Care and Novant) that have experienced growth in emergency department and inpatient utilization.



The priority areas from the workshop align with the priority areas of the *SAFE Charlotte* initiative. A community-based, mobile crisis unit could streamline the available array of services and direct individuals to a wholistic network of community-based service providers that not only address mental health crises, but also address the provisions that attribute to positive mental health.

VI.V. Methodology[JJ22]

A search of mobile crisis teams was conducted through a web-based search engine. Mobile crisis units that operated through 911 were identified and evaluated for best practices. Individuals who worked for or oversaw the operations of these units were contacted via e-mail in order to coordinate informational interviews discussing unit logistical and operational components. Stakeholders in local and state government, academia, mental and behavioral health services, practicing clinicians, community activism, and law enforcement were interviewed to collect feedback about how a non-police, community-based crisis assistance unit[PN23][JJ24] responding to non-violent, non-criminal, mental or behavioral health 911 CFS could be developed and piloted in Charlotte. Notes from each interview were coded and assessed to develop recommendations on how such a unit could be developed and operated within Charlotte.

Government officials at the state, county, and city levels, in and outside North Carolina, were contacted regarding how their locality either operated, or planned to operate, mobile crisis teams. At the state level, officials representing NC DHHS and the Governor's Task Force for Racial Equity in Criminal Justice were contacted and interviewed regarding how previous programs were conducted and supported at the state level in North Carolina. Mecklenburg County officials were interviewed regarding how the county could support a mobile crisis team within the area. City officials in Durham and Charlotte were interviewed about how a mobile crisis team pilot program could be funded and operated within its vicinity. Outside of North Carolina, a health director representing the Philadelphia Department of Behavioral Health and Intellectual disAbility Services was interviewed regarding how the city operated community-based crisis response teams in a metropolitan area. STAR and CAHOOTS personnel provided best practice information for pilot operation.

At the community level, feedback was acquired from the Charlotte Safe Communities' Community Input Group and local Charlotte activists. Feedback was also collected from a coalition of minority mental health and behavioral health clinicians and counsellors located in Charlotte. Feedback regarding the fair and equitable treatment of individuals experiencing a mental or behavioral health crisis was collected from Promise Resource Network, a non-profit organization in Charlotte dedicated to utilizing peer experience in the recovery and wellness process of individuals who have faced mental, behavioral, and substance use trauma. Law enforcement feedback was collected from representatives of CMPD's Community Wellness Division and its Crisis Intervention Team partners. Feedback from each interview guided this research's perspective on the development process of a non-police, community-based mobile crisis intervention unit in Charlotte.



VII.VI. Pilot Development

A. Organizing Body

Stakeholder feedback affirmed that city and county governmental relations were important in efficiently organizing and operating a non-police, community-based unit addressing behavioral and mental health crises in the city. A lack thereof could hinder pilot development. Considering this, the city must establish a commission designated to develop and execute the pilot within an established timeline. The commission should be charged with establishing pilot policies, infrastructure, and operational guidelines. Commission duties should be conducted in a transparent manner that can be followed and feedbacked by Charlotte residents. The commission should be comprised of individuals representing the following entities:

- One individual representing the Charlotte City Council Budget Committee or designee
- One individual representing health and human services of Mecklenburg County or designee
- One individual representing the Charlotte Safe Communities Community Input Group or designee
- One individual representing CMPD or designee
- One individual representing the Communications Division of CMPD
- One individual representing a partnering network of mental and behavioral health treatment facilities within Charlotte
- One individual representing a partnering mobile crisis service of the city
- One individual representing the mental and behavioral health community as a peer-specialist or person with lived experiences of mental health recovery.

Legal staff and associated personnel should be available to assist with the needs of the commission.

Following the example of STAR, it is recommended that the commission allot 7-12 months dedicated to establishing pilot policy, pilot budget management, emergency communication services, operational organization, personnel recruitment and development, and community awareness protocols before initiating the pilot. Considering the timeline set forth by the *SAFE Charlotte Professional Consulting Services RFP* (City of Charlotte, North Carolina, 2020), recommendations from a selected consulting service regarding transitioning certain police duties to a civilian response model are to be reported April 22, 2021. With such a timeline, a pilot such as this could be operational by November 2021. The pilot should run for one full calendar year. It is recommended that the city evaluate the effectiveness of the pilot six months post-initiation and again at the conclusion of one full calendar year. Following a six-month evaluation, the commission should address any pilot deficiencies and consider its continuation or cancelation. Following one calendar year, the commission should recommend if the pilot is to be continued, expanded, or terminated.



B. Crisis Assistance Services and Facilities in Charlotte

To establish an effective, non-police, community-based response unit [PN36][JJ37] addressing behavioral and mental health crises, the city of Charlotte must first assess its number of county-supported behavioral health and substance use treatment providers, along with basic assistance providers in the area. Considering [PN38] that Mecklenburg County is in the process of disengaging with its local LME/MCO, Cardinal Innovations (Kuznitz, 2020), Charlotte should look to partner with county-supported services. Mecklenburg County has a long-standing reputation of supporting health services including non-traditional, community-based service providers. In addition, local, community-based service providers typically serve individuals regardless of their insurance and payer type, minimizing barriers to treatment services. Leveraging the county's commitment to local innovation, it is recommended that Charlotte partner with county-supported services in order to create a mechanism for state funding to support the pilot. When a local LME/MCO is determined, service providers participating with the pilot could be incorporated into the new provider network.

Identified service providers should be willing to participate in an interdisciplinary network capable of addressing an individual's immediate and long-term conditions. These services should address [PN39][PN40][JJ41] an individual's mental and emotional wellness through ethical and humane means – limiting the individual's confinement, forced medication, or involuntary commitment unless an immediate physical threat is evident. The behavioral health services must be able to treat the underlying conditions leading to an individual's state of crisis or psychosis – whether through substance use/addiction help, counselling, and/or outpatient care. Lastly, basic assistance service providers should be able to address an individual's environmental conditions by providing employment, utility, shelter, and/or food assistance.

Charlotte is unique in that both clinical and peer-support behavioral health treatment services are located within the city. For example, Atrium Health (2020) [JJ42] offers behavioral health and substance use services for children, teens, and adults with clinic locations across the Charlotte region. Novant Health (2020) offers similar clinical behavioral health services in the Charlotte region, including inpatient, outpatient, and partial hospitalization services. Both entities, along with the Mecklenburg County Health Department, are part of ONE Charlotte Health Alliance, an organization dedicated to supporting and maximizing individuals' health and quality of life through a sustainable, collaborative process (ONE Charlotte Health Alliance, 2020). In regards to peer-support services in Charlotte, Promise Resource Network (2020) offers 14 different recovery-based alternatives for individuals with and without health insurance, including a recovery center, outpatient care guided by peer-specialists, and a voluntary peer respite staffed by trained peer-specialists. Individuals assisted by the piloted unit could have greater confidence that accepting assistance would not be disguised as a covert measure to involuntarily commit them, considering that someone who may have lived through a similar experience is offering them assistance.

The combination of clinical and peer-support services ensure that assisted individuals have structured crisis treatment and recovery options suitable to their needs. Partnering clinical and alternative treatment service providers also increases the number of service provider locations and treatment options for individuals, both critical to successfully establishing a pilot of this nature.



C. Social Continuum of Care

Based on community feedback from resident and community stakeholders, a social continuum of care must be incorporated into the pilot to supplement mental and behavioral healthcare. For instance, a mental health specialist assisting an individual may find that the individual's moment of crisis was triggered by the overwhelming thoughts of unemployment, food insecurity, and/or inability to pay their utilities. Therefore, while the individual may benefit from counseling or de-escalation to address their mental health, the individual may actually need basic assistance support. To establish a social continuum of care, it is recommended that this pilot partner with a health and human services network platform such as NC Care 360.

NC Care 360 is a statewide network that unites healthcare and human services organizations through a technology platform enabling a coordinated, community-oriented approach for assisting an individual (NCCARE360, 2021). The platform is a result of a public-private partnership between NC DHHS and the Foundation for Health Leadership & Innovation, and incorporates the United Way of NC and NC 211. NC Care 360 allows community service providers to electronically connect to individuals with identified needs. It also allows for feedback to be collected and follow ups to be performed to ensure that connected individuals were provided the necessary assistance (NCCARE360, 2021). In theory, pilot personnel assisting an individual could address the individual's immediate crisis, identify environmental factors contributing to the crisis such as homelessness and/or food insecurity, refer and transport the individual to an appropriate service provider, and track the outcome of if the needs of the individual were met using a follow up mechanism. This would create a social continuum of care for which community stakeholders have lobbied.

Despite the capabilities of NC Care 360, state social services stakeholders said that the platform had difficulty attracting service providers in Charlotte. Conversely, local stakeholders representing small and minority-owned mental health service providers along with local social services providers said that they had difficulty being spotlighted by the city for their services. A solution to these issues could be achieved through the partnership of the two groups. If local service providers were to register with the NC Care 360 platform, and the platform was to be utilized by the pilot, individuals assisted through the pilot could be connected to local service providers within their community. State social services stakeholders said that registering with the NC Care 360 network was a low-barrier entry process for organizations. Registration with NC Care 360 does not require any financial obligation, nor does participation (NCCARE360, 2019). It would be recommended that local mental health and basic assistance service providers be recruited and registered with NC Care 360 before initiating the pilot.



D. Mobile Crisis Partners [JJ43][PN44][JJ45] and Personnel

Operating personnel should consist of mental health clinicians with experience in mobile crisis intervention, trained peer-specialists, and paramedics who all adhere to the recommended training for participating personnel described in **Section VI-H** of this report. It is recommended that the city of Charlotte partner with an organization that already provides mobile crisis intervention services within the city or county. This allows the city to streamline mobile crisis services already offered in its vicinity, minimizing duplicated crisis response programming. The selected mobile crisis partner should be willing to participate in the pilot alongside entities across an interdisciplinary health and social service network that includes alternative treatment service providers. The mobile crisis partner should have the capacity to provide a designated number of trained clinicians experienced in crisis intervention to participate in the pilot as mental health first responders. In addition, it should have the capabilities to be reached through an independent hotline existing outside 911 should individuals experiencing a crisis elect to receive assistance outside of the local emergency communications network. Examples of two organizations providing mobile crisis services in Mecklenburg county are CriSyS, LLC, and Daymark Recovery Services, Inc. CriSyS already works closely with CMPD, providing clinicians for CPCRT (Little, 2019). The city of Charlotte should also partner with entities who are able to provide trained peer-specialists and paramedic personnel to participate as operating specialists as a part of this pilot. If necessary, the city should also consider extending the opportunity to participate in the pilot to individual clinicians.

E. Calls to be Addressed [JJ46]

CMPD officials and the established commission overseeing the pilot must work jointly to decide what type of 911 CFS could best be addressed by a non-police unit specializing in behavioral and mental health crisis. Calls to which the unit responds should be non-violent and non-criminal in nature and address the behavioral state and/or environmental condition of the person in need. These calls should not involve any type of weaponry or combative criminal activity, and should not involve the execution of written legal citations in which an individual must pay a fine or report to court. Such environments or actions could heighten the aggressiveness of the individuals being assisted, threatening the safety of pilot personnel.

A WCNC report found that in one week, CMPD received 485 non-emergency 911 CFS, spending 448 hours addressing those calls (Shabad, 2020). Officers spent a majority of their time on traffic accidents (approximately 131 hours), followed by hit-and-runs without injuries (approximately 113 hours), noise complaints (approximately 73 hours), found property (approximately 42 hours), and vandalism (approximately 40 hours). Most of the described calls have not traditionally been handled by mobile crisis units specializing in mental health. Beyond mental or behavioral health crises, STAR addressed welfare checks, intoxicated persons reports, suicide threats, indecent exposure reports, trespass or unwanted person reports, and syringe disposal (Denver Justice Project, 2020). CAHOOTS addressed conflict resolution and mediation, grief and loss counseling, substance abuse, housing crisis, first aid and non-emergency medical care, resource connection and referrals, and transportation to services (White Bird Clinic, 2020). Examples of CAHOOTS and STAR 911 CFS expanding beyond mental or behavioral health crises can be found in **Appendix A** and **Appendix B**, respectively. The established commission should determine which calls outside of mental and behavioral health could be addressed by the piloted unit instead of CMPD officers.



Charlotte is not alone in assessing 911 CFS data in order to develop alternative public safety response models. The cities of Durham, Burlington, Cary, Greensboro, Winston-Salem, Raleigh, and Rock Hill, South Carolina, formed a municipal cohort (referred to as “Cohort Cities”) through RTI International (an independent, nonprofit research institute) to evaluate their own 911 CFS and develop alternative methods to address certain 911 CFS via pilot programs. Each city then planned to share the results of their respective pilots for collective learning purposes (City of Durham, 2020). Charlotte participates with the Cohort Cities as an observer. It is recommended that Charlotte participates alongside the other Cohort Cities to contribute to the greater body of collaborative work in North Carolina regarding public safety.

F. Pilot Placement^[JJ47]

It is recommended that the city of Charlotte use a data-driven approach to establish the placement of the piloted unit by assessing 911 CFS data, law enforcement intelligence, and community feedback. Analyzing 911 CFS data based on call type and geographic location could give pilot facilitators insight into where specific types of 911 CFS are clustered. Law enforcement intelligence of the clustered sites could then give insight into whether the locations are safe enough to introduce a non-police unit to administer crisis assistance. For example, community stakeholders, including the Charlotte Safe Communities’ Community Input Group, recommended piloting the program in the Beatties Ford corridor. The Beatties Ford corridor was designated as a “hot-spot” for criminal activity, including violent crime. While community members within the Beatties Ford corridor may desire the pilot to be located in their community, input from law enforcement personnel must also be considered to ensure that such a pilot could be introduced into the community in a manner that both ensured the safety of pilot personnel and supported their operating capabilities as much as feasible. However, law enforcement feedback alone should not be the determining factor of potential pilot locations.

Community insight should also be taken into consideration when determining pilot placement. For example, while the Charlotte Safe Communities’ Community Input Group recommended implementing a non-police unit into the community as an effort to re-imagine public safety, other community stakeholder feedback suggested that a police-alternative response that lacked insight about the communities in which it served was not desired. Community members feared “clinicians in white vans” entering their neighborhoods and involuntarily committing residents, even if they were not law enforcement officers. Such a program would be rejected by residents if operated in that manner. Instead, community feedback envisioned a unit in which pilot personnel familiarized themselves with the needs of the area, and informed residents about how the piloted services benefited their community. Feedback from the recent Charlotte Community Safety Summit, in which residents were invited based on their zip code to give feedback on city safety initiatives, could give further insight into residents’ willingness to accept a non-police unit in their communities and their expectations of that unit.



G. Law Enforcement/EMS Protocol[JJ48]

Protocols for incorporating the piloted unit as an officer assisted deflection service should be established in accordance with CMPD's *Management of Subjects with Mental Illness/Extreme Distress* (2020) directive. The piloted unit must also have the capabilities to coordinate CMPD or EMS backup support should their encounter with an individual exceed their assistance capabilities and/or threaten their safety. The *Management of Subjects with Mental Illness/Extreme Distress* directive provides officers with information about how to identify subjects either in extreme distress or who may be mentally ill and need assistance. It directs officers regarding how to interact with an individual experiencing mental illness in a manner that minimizes risks to themselves and the individual. It also instructs officers on how to facilitate assistance in a practical fashion. Incorporating procedures in the directive that both directed CMPD to utilize the piloted unit when practical and established CMPD/EMS backup protocols could ensure that the pilot is enacted in a safe and effective fashion.

According to section IV, A-1 of the directive, if an officer establishes that the individual with whom they encounter is unarmed and does not appear to pose an immediate threat to the physical safety of the officers, others, or themselves, the officer must utilize de-escalating tactics until backup arrives. Upon securing the safety of the scene, section IV, G-3.c then directs the officer to contact an on-duty CIT officer and/or the mobile crisis team. Should this occur in a piloted area, the officer could instead contact the piloted unit and deflect the situation to the unit for management. It would still be recommended, however, that the initial officer remain on scene assisting the unit as needed.

In order for the effectiveness of the pilot to be demonstrated, the non-police unit should be permitted to serve as a first responder to an appropriate 911 CFS should it be immediately available. According to CMPD feedback, even with CPCRT in place, no 911 CFS is first addressed by a CPCRT unit considering that non-police personnel are involved. A nearby patrol officer first addresses the scene then decides if CPCRT is necessary. This is done to ensure safety, as there is no guarantee that any 911 CFS is safe for civilians. It is also done to ensure that there is no delay in assistance should a CPCRT unit not be immediately available. However, with proper safety measures the piloted unit could operate in a safe and effective manner. Safety for the unit and individual requiring assistance should be controlled as much as possible by thoroughly applying 911 CFS and pilot location safety parameters and as expressed in **Section VI-E** and **VI-F** of this report. Should the piloted unit respond to an incident that escalates beyond their capabilities, it must have the communication capabilities to request backup from either a nearby CMPD unit or EMS. Such would be the case if the individual the unit assisted became physically combative, or if the unit encountered a medical emergency in which it lacked the means to assist. This is further demonstrated in **Section VII**.

In the case in which a crisis services plan must be executed regarding the lawful involuntary commitment of an individual, it is not recommended that the piloted unit be involved in the initial involuntary commitment procedures. This is to ensure that the unit maintains a reputation of civil service in assisting individuals experiencing mental or behavioral health crises, and not that of executing judicial orders involving involuntary restraint of an individual experiencing crises.



H. Training [JJ49][JJ50][JJ51]

This pilot creates an interdisciplinary unit in which certified mental health specialists and paramedics bring their individual specializations into practice when assisting a person in crisis. A standard baseline of training and operating procedures should exist that allow members of this unit to operate in sync. The piloted unit must have baseline training and education in, but not limited to, crisis intervention, de-escalation, suicide intervention, emotional CPR, local social service resources, and cultural awareness. In addition, pilot personnel should have a mastery of its own operating procedures upon being dispatched. Pilot training elements should ensure that unit personnel can effectively execute its duties in a manner that considers their own safety as well as that of the individual being assisted. Training should direct unit personnel in how to assist an individual in manner that preserves the individual's dignity and constitutional rights.

Following the example of the 2016-2017 Community Paramedicine Pilots conducted by NC DHHS, personnel in the piloted unit should undergo paramedic-based, 40-hour CIT training if they have not done so. According to CMPD stakeholders, courses exist in which paramedics and CMPD train together in order to receive CIT certification. In addition, the unit must be well versed in its own operating procedures, including the proper steps to take if the scenario at which they arrive is beyond their assisting capabilities. This is described in greater detail in **Section VII** of this report.

Unit personnel should be knowledgeable of local social service or basic needs assistance programs in which they can direct individuals facing a situational crisis. For instance, if the unit assists an individual whose behavioral crisis was triggered by food insecurity, it should be able to direct the individual to the proper service which best addresses the individual's circumstance. This is accomplished by educating unit personnel about the services of the partnered programs associated with the pilot. In addition, personnel must be able to utilize the equipment and resources at its immediate disposal to identify service providers within its vicinity to assist individuals in need. This ensures that the unit is able to begin creating the necessary continuum of care for the individuals whom they assist.

Community stakeholders have emphasized that the piloted unit be knowledgeable about the community in which it serves, including racial and cultural awareness. Considering this feedback, it is recommended that unit personnel training include a cultural awareness component facilitated by a local group or organization. Such training should inform unit personnel about racial, economic, or social disparities faced by individuals with whom they could interact, and how this contributes to mental distress. It should equip unit personnel with an empathetic, communicative skillset practical for the execution of their duties.

Emergency communication operators should be educated about what the piloted unit does and how it fits into the emergency communication service framework. However, it is not recommended that drastic changes be made to the operating procedures of emergency communication personnel. Instead, pilot unit personnel should be trained in emergency radio communication usage, acclimating itself into the established system. For example, in the Denver STAR program, even though an adjusted 911 communication tree was introduced to Denver emergency communication operators regarding when to dispatch STAR versus when to dispatch police, STAR personnel acclimated itself to the police radio network to coordinate responses with law enforcement. DPD officers also communicated with STAR through the police radio



network in order to coordinate deflection services (Denver, 2020). By operating as such, emergency communication protocols were not drastically changed to incorporate STAR, but rather STAR adapted itself to the established protocols. This report recommends the same tactic.

I. Infrastructure [JJ52][PN53][JJ54]

Following the successful outcomes of CAHOOTS, STAR, DBHIDS, and the 2016-2017 NC DHHS Community Paramedicine Pilots, it is recommended that pilot unit personnel consist of master-level clinicians, trained peer-specialists having previous crisis intervention experience, and paramedics. Personnel should have baseline training in CIT and operating procedures as described in **Section VI-H**. The unit should dress in attire that is plain and non-assuming in nature yet signifies their association to the piloted unit (see **Figure 2**). Personnel should have individual and system radios that are tuned to the local police radio network in order to respond to calls within their vicinity and coordinate deflection or backup assistance. Each unit should be equipped with a laptop and mobile internet service in order to complete service reports, coordinate care with partnering service providers, and any other pertinent duties.



Figure 2. STAR personnel dressed in work attire in front of operational van (Beaty, 2020).



Figure 3. A CAHOOTS van fitted for transportation and equipped with radio communication, basic medical supplies and basic needs materials (Andrew, 2020).

The unit should be equipped with mobile vans fitted to allow the safe transportation of an individual to an appropriate assistance service provider and stocked with basic medical supplies and needs (see **Figure 3**). Basic medical supplies should include, but not be limited to, the following: small and large bandages, antiseptic solution, eyewash solution, epinephrine auto-injectors, hand sanitizer, face masks, and materials to treat small cuts and abrasions. Basic needs supplies should include, but not be limited to: water, various snacks, shoes, socks, sweatpants, shirts, jackets, blankets, and male and female hygiene

products (see **Figure 4**). The van should also be equipped with Naloxone, an automated external defibrillator and other equipment needed to perform cardiopulmonary resuscitation.



Figure 4. STAR van equipped with water, snacks, and basic medical supplies (Beaty, 2020). STAR vans are also equipped clothing, blankets, and hygiene products (Denver, 2020).

VIII.VII. Operation [JJ55]

The pilot should operate using four mobile crisis vehicles equipped with basic medical equipment and basic needs materials located in four separate areas determined by the pilot placement recommendations described in **Section VI-F**. Each vehicle should be capable of transporting an individual from a designated 911 CFS location to a partnering treatment or social service provider. Each piloted unit should consist of one mental health specialist, being either a clinician or peer-specialist, and one paramedic. Additional staffing should be determined by the established commission. The units should be active during day-time hours, and should not conduct night services nor operate 24/7 while in its piloted phase.

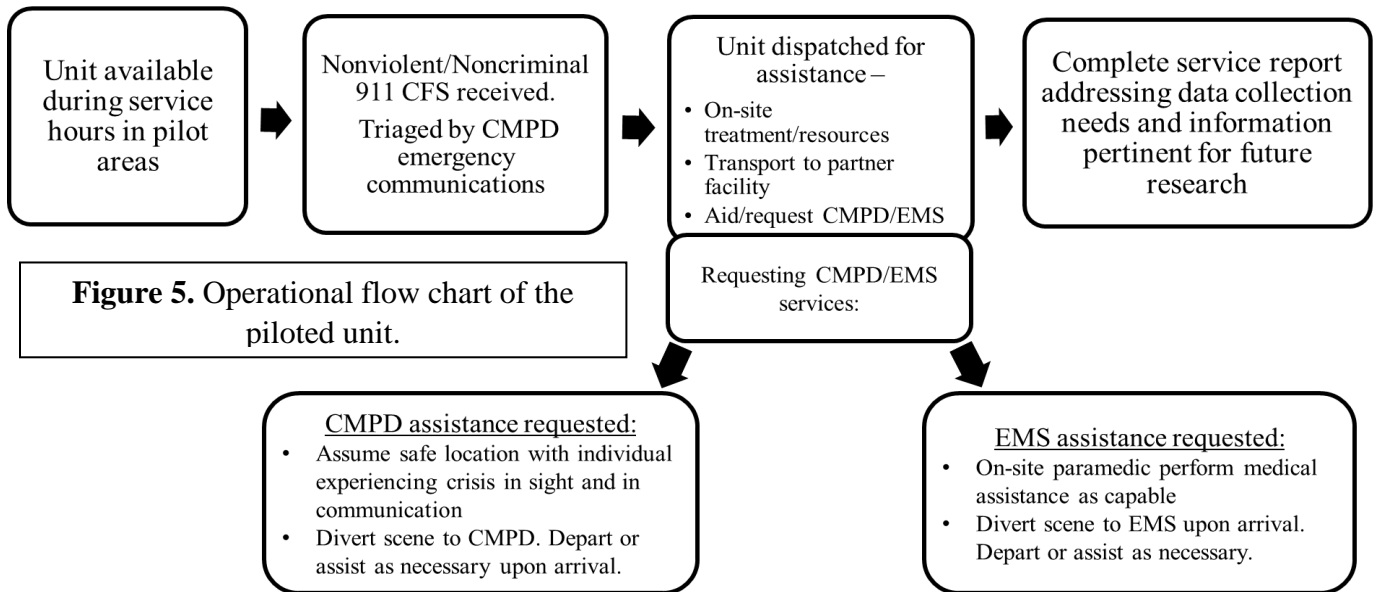


Figure 5. Operational flow chart of the piloted unit.

Figure 5 depicts the operational order that should be followed by the piloted unit. Upon receiving a 911 CFS within its service responsibilities and location, the unit should be dispatched from either a designated location or from patrol and report to the 911 CFS location. Upon arrival, the unit should assess if the incident can be treated on-site, requires transportation to a partnering facility or service, or requires further assistance from CMPD or EMS. If the scene can be treated on-site, the unit should employ its resources and training to address the situation at hand, being either de-escalation techniques, on-site counseling, basic medical assistance, or basic needs assistance provisions. If the CFS requires transportation, the unit should determine which type of assistance would best help the individual (being either assistance at an acute treatment facility or basic assistance service provider), locate the designated site within its vicinity, then coordinate

with the designated facility for the arrival of the individual. The information of the individual transported to the assistance location should then be logged into NC CARE 360 platform by the receiving service provider.

If transporting an individual to a service provider, the unit should always attempt the voluntary compliance of the individual. If the individual being assisted does not want to be transported to a service provider, the unit should utilize its on-site treatment resources to assist the individual as much as feasible. At the conclusion of each 911 CFS, the unit should provide to the individual the contact information of the partnered mobile crisis unit's direct service line, or contact information to basic assistance service providers. Post-service, the unit should complete a service report describing the 911 CFS in which they intervened, the service provided, demographic information of the individual assisted, and any other information deemed pertinent for future research.

Should the unit respond to a CFS in which it determines that an alternate emergency response would be more appropriate, the unit should decide which alternative response is necessary, then use its radio equipment to coordinate its arrival. If the scene requires police intervention, the unit should assume a safe position while keeping the individual being serviced in sight and in communication, if possible. The unit should then wait for CMPD arrival before leaving or assisting in any further intervention efforts. If the scene addressed requires EMS assistance, the paramedic on site should utilize their training while EMS arrival is coordinated. Upon EMS arrival, the unit should forfeit authority of the scene to EMS, assisting as necessary. The unit should then complete a service report at the conclusion of its assistance describing the alternative emergency response requested, its reasoning, and any additional information deemed pertinent for future research.

It is recommended that CMPD officers utilize the piloted unit when it determines that the 911 CFS in which they have responded would be better addressed by the unit's services. Should this occur, the CMPD officer on site should radio the piloted unit in its vicinity for assistance. Upon arrival, the officer should provide an overview of the situation at hand, then support the unit as needed, staying on sight until the situation is either resolved or clearly controlled by the piloted unit. In such a case, the piloted unit would act as the officer-assisted deflection resource now overseeing the 911 CFS.



IX.VIII. Evaluation[JJ56][PN57][JJ58]

The commission should establish an evaluation partner or method to assess the safety and effectiveness of the pilot. Important criteria to be assessed include, but are not limited to:

- race and ethnicity demographic information of unit personnel and of assisted individuals;
- assessment of the frequency of services rendered by the unit;
- frequency of dispatches during service hours;
- frequency of police and EMS backups requested;
- frequency of officer-assisted deflection utilization;
- frequency of CFS types addressed;
- response time from unit dispatch to unit arrival for CFS;
- time spent addressing CFS;
- type of service administered in response to CFS;
- operating costs and financial assessments including money saved by the city or CMPD since pilot operation;
- frequency of complaints filed against piloted unit; and
- consumer satisfaction with unit services.

An assessment of these statistics, including others, should be conducted every two months during the duration of the pilot. Results of the assessments should be presented to Charlotte City Council and Mecklenburg Board of County Commissioners at the 6-month and 12-month conclusion of the pilot. It is recommended that assessment statistics be publicly posted on an easily accessible website for public viewing. At the 12-month conclusion of the pilot, Charlotte City Council should decide if the pilot is to be extended, expanded, or concluded. Following Charlotte City Council's decision, the commission should adjust any protocols or procedures associated with the unit's operation. Considering vicinity, the resources at University of North Carolina at Charlotte Criminal Justice and Criminology Department could serve as a pilot evaluation partner.

X.IX. Pilot Funding[JJ59]

Considering that Charlotte City Council voted to implement this pilot, it should be the city of Charlotte's responsibility to acquire the funding necessary to operate all capacities of the pilot. This report is limited in its ability to conduct a proper financial analysis to assess the operating costs of such a pilot in Charlotte. However, funding for similar pilots have been assessed in North Carolina and the country, guiding the financial recommendation within this report.

Within North Carolina, the Community Behavioral Health Paramedicine Pilot and the Community Paramedicine Pilot were funded by the North Carolina General Assembly. For the Community Behavioral Health Paramedicine Pilot, the North Carolina General Assembly appropriated \$225,000 across 11 counties (Kurtz, 2017). Counties also utilized federal block grants to assist in pilot operations. The North Carolina General Assembly appropriated \$350,000 towards the Community Paramedicine Pilot, with \$70,000 going to McDowell and Wake counties, and \$210,000 going to New Hanover county (The North Carolina Department of Health and Human Services, 2017).



Outside of North Carolina, the contract budget for CAHOOTS was approximately \$798,000 in fiscal year 2018 (July 2017 to June 2018). This funded 31 hours of service per day (overlapping coverage), seven days a week (Eugene Police Department, 2020). In fiscal year 2020 (July 2019 to June 2020), the city of Eugene added an additional \$281,000 on a one-time basis for an additional 11 hours of coverage. The city of Eugene funds CAHOOTS through a contract with the Eugene Police Department (Eugene Police Department, 2020). The city of Denver's Caring 4 Denver Foundation awarded the Denver Police Department a total of \$208,141 awarded in two payments contingent on learnings and its continuation in order to initiate STAR (Caring 4 Denver, 2020). After four months of operation, Denver Mayor Michael Hancock invested an additional \$2.8 million to STAR (Swanson, 2020a; 2020b). Philadelphia's DBHIDS estimated spending \$2 million to operate its mental health crisis services throughout the city (Services, 2020).

While a more in-depth financial analysis conducted by the city of Charlotte is warranted, the city should expect to invest \$300,000-500,000 in the pilot. These funds would be used to cover the salaries of pilot operating personnel for one year, transportation vehicles and maintenance expenses, radio and communication equipment, computer and technology equipment, basic emergency medical supplies, basic assistance supplies, emergency communications training materials, and expenses associated with contracting partnering service providers, and pilot evaluation fees. Expenses could be reduced if the city allotted city-owned equipment towards pilot use, such as vans, communication equipment, and electronic equipment. Expenses could also be reduced by structuring service-in-kind contractual agreements with service partners. Funding could be lobbied for at the state level as state legislators seek to enact measures stemming from recommendations in the North Carolina Task Force for Racial Equity in Criminal Justice's final report (2020). Public safety grant dollars from public and private organizations funding local initiatives that reimagine public safety would also contribute towards establishing this pilot at a lower cost burden to the city.

XI.X. Recommendations^[JJ60]^[JJ61]

1. The city should establish a commission to develop and execute the pilot within an established timeline. The commission should be charged with establishing the policies, infrastructure, and operational guidelines of the pilot. The commission should be comprised of individuals representing the following: city government, county government, county health and human services, CMPD and its communications division, a partnered mental and behavioral health service provider network, mobile crisis services, community members, and peer-specialists or persons with lived ^[PN62]^[JJ63] experiences of mental health recovery.
2. The commission should allot 7-12 months dedicated to establishing pilot policy, pilot budget management, emergency communication services, operational organization, personnel recruitment and development, and community awareness protocols before initiating the pilot. Considering the timeline established by the SAFE Charlotte Professional Consulting Services RFP (City of Charlotte, North Carolina, 2020), recommendations from a selected consulting service regarding transitioning certain police duties to a civilian response model are to be reported April 22, 2021. With such a timeline, a pilot such as this could be operational by November 2021.



3. The pilot should run for one full calendar year. The city should evaluate the effectiveness of the pilot six months post-initiation and again at the conclusion of the calendar year.
4. The city must partner with an interdisciplinary network of local, county-supported service providers to ensure that immediate and underlying conditions resulting in a mental health or substance use crises are addressed. This coordinated network should create a social continuum of care that assists individuals with or without health insurance, and provides culturally competent counseling services, outpatient mental health and substance use services, peer support, and assistance for basic needs (i.e., housing, utilities, food, clothing). Should a service like NC Care 360 be utilized to coordinate this interdisciplinary network, it is recommended that local mental health and basic assistance service providers be recruited and registered with NC Care 360 before initiating the pilot.
5. The city should identify a mobile crisis services organization willing to participate with the pilot alongside peer-support personnel and paramedics as a first-response service to mental/behavioral and situational crises. The mobile crisis service should also have the capabilities to be accessed through an independent phoneline.
6. CMPD officials and organizing members of the pilot should work jointly to determine the types of 911 CFS that could best be managed by a non-police, community-based response unit [PN64]addressing mental and behavioral health crises. Ideally, these calls should not involve any type of weaponry or combative criminal activity, and do not involve the execution of written citations in which an individual is ordered to pay a fine or report to court.
7. The city should contribute 911 CFS information and pilot results alongside other RTI Cohort Cities in North Carolina to contribute to the greater body of collaborative work in North Carolina public safety.
8. The city should use a data-driven approach to determine potential pilot locations by assessing 911 CFS data, law enforcement intelligence, and community feedback. Feedback from law enforcement personnel and community members must be considered to ensure that a non-police, community-based crisis assistance pilot could be introduced into the community in a manner that both ensures the safety and supports the operating capabilities of pilot personnel as much as feasible.
9. Considering CMPD's *Management of Subjects with Mental Illness/Extreme Distress* procedures, the piloted unit should be permitted to serve as a first responder to an appropriate 911 CFS should the unit be immediately available. CMPD should have the ability to summon the piloted unit as a primary officer assisted deflection resource. In turn, the unit must also have the capabilities to summon CMPD or EMS assistance should their encounter with an individual exceed their operational capabilities.
10. The piloted unit should not be involved in initial involuntary commitment procedures. This is to ensure that the unit maintains a reputation of civil service in assisting individuals experiencing mental or behavioral health crises, and not that of executing judicial orders involving involuntary restraint.



11. Pilot unit personnel training should include a cultural awareness component facilitated by a local group or organization. Such training should inform unit personnel about racial, economic, or social disparities faced by the individuals with whom they could interact, and how it contributes to mental distress. It should equip unit personnel with an empathetic, communicative skillset practical for the execution of their duties.
12. Pilot unit personnel should undergo paramedic-based, 40-hour CIT training if they have not done so.
13. Pilot unit personnel should be trained in emergency radio communication usage and incorporated into the law enforcement radio network. The unit should acclimate itself into the already developed radio network system.
14. Each pilot unit should consist of a master-level clinician or certified peer-specialist and a paramedic. The unit should dress in attire that is plain and non-assuming in nature yet signifies their association to the unit. Personnel should have individual and system radios that are tuned to the local police network in order to respond to calls within their vicinity and coordinate backup or deflection assistance.
15. Operational procedures used by pilot personnel should include on-site treatment procedures, transportation to service provider procedures, backup request procedures, and support response procedures.
16. The established commission should contract an evaluation partner to assess the safety and effectiveness of the pilot. Considering vicinity, the resources at University of North Carolina at Charlotte Criminal Justice and Criminology Department could serve as a pilot evaluation partner.
17. While a more in-depth financial analysis conducted by the city is needed, the city should expect to invest \$300,000-500,000 in the pilot. These funds should be used for the year-long salaries of pilot personnel, transportation vehicles and maintenance expenses, radio and communication equipment, basic emergency medical supplies, basic needs assistance supplies, emergency communications training materials for 911 operators, electronic equipment, and expenses associated with contracting services partners.

XII.XI. Limitations[JJ65]

This report was limited by its inability to assess CMPD 911 CFS information and provide a financial analysis to accurately predict the investment cost of a non-police, community-based response unit in Charlotte. While information regarding 911 CFS data and non-police unit operating costs were gathered from secondary resources, a primary analysis of CMPD 911 CFS data and a cost-analysis from the City of Charlotte Strategy and Budget Department is recommended.



~~XIII~~.XII. **Future Research**[JJ66][PN67][PN68]

Emerging themes stemming from the existence of a non-police, community-based crisis assistance unit responding to non-violent, non-criminal, mental or behavioral health 911 CFS include further exploration into 911 CFS which could be diverted from CMPD; the amount of money saved by the city of Charlotte by investing in a civilian response model to mental and behavioral health emergencies; and the impact of a non-police public safety alternative on public trust between residents and CMPD.[JJ69][JJ70]Based on a one-week analysis of CMPD 911 CFS information collected by WCNC (Shabad, 2020), a majority of non-emergency 911 CFS to which CMPD officers responded, such as traffic accidents, hit-and-runs without injuries, and noise complaints could be appropriate for personnel such as CMPD investigative technicians or firefighters rather than CMPD officers. A future exploration of the duties and responsibilities of such non-police personnel could minimize the time CMPD officers spend on non-emergency calls.

As previously stated, EPD saved an average of \$8.5 million each year from 2014-2017 when investing in CAHOOTS (White Bird Clinic, 2020). The city of Charlotte and CMPD could also see cost savings from investing in a police-alternative service to responding non-violent, non-criminal 911 CFS. A financial analysis and case-study could either support or refute this position.

The deaths of George Floyd and Breonna Taylor have served as a catalyst for police reform across the country in 2020 (North Carolina Task Force for Racial Equity in Criminal Justice, 2020). It is important that Charlotte City Council investigate the impact of a police-alternative model on public safety, and how it influences the trust between CMPD and the community in which it serves.

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~~XV~~.XIV. Appendix

A. Explanation of Top Calls Addressed by CAHOOTS and Brief Descriptions. Direct Excerpts taken from the Eugene Police Department Crime Analysis Unit's *CAHOOTS Program Analysis* (2020, pp. 6-7).

EXPLANATION OF CAHOOTS TOP NATURES:

1. CHECK WELFARE (4,615 dispatched): The CAHOOTS Welfare Check nature is generally separate from the EPD Welfare Check. Dispatch makes the determination at the time of the call that the caller does not appear to require a law enforcement response, or the caller specifically requests CAHOOTS. CAHOOTS arrived at 4,220 of the Welfare Checks. They make up 30% of the total call volume CAHOOTS is dispatched to.

2. ASSIST PUBLIC- POLICE (4,448 dispatched): This nature is not considered a traditional police call. It generally involves non-emergency service requests from the public, from counseling, to injury evaluation after a person declined to be evaluated by a medic, to providing general services. CAHOOTS arrived at 3,996 of the Assist Public calls. They make up 29% of the total call volume that CAHOOTS is dispatched to.

3. TRANSPORT (3,712 dispatched): A CAHOOTS transport call generally involves moving an individual, often unhoused and in need, or dealing with mental health issues, from one location to another for non-emergency services. For example: an individual may need to get from a dusk-to dawn site to a hospital for non-emergency issues. CAHOOTS arrived at 3,303 of the Transport calls. Transport calls make up 24% of the total call volume CAHOOTS is dispatched to.

To better understand the natures, the following are random samples from the calls of these natures, which were dispatched to CAHOOTS personnel. These calls are indicative of those in the nature, although not all inclusive.

1. Check Welfare:

• (19283789) LOC/ SOUTH OF THE INTERSECTION, ON THE OVERPASS FEMALE WALKING BAREFOOT AND NOT WEARING MUCH CLOTHING -- REQ CAHOOTS TO GO AND CHECK ON HER LAST SEEN 5 AGO NO WEAPONS OBS

• (19250067) LOC/NE CORNER OF 2ND AND VAN BUREN. C/ADVI THERE IS POSSIBLY A PERSON SLEEPING ON SIDEWALK, OR POSSIBLY ITEMS COVERED BY TARP. HASN'T MOVED IN 5 HOURS. C/IS CONCERNED THE PERSON MAY NEED A WELFARE CHECK



2. Assist Public:

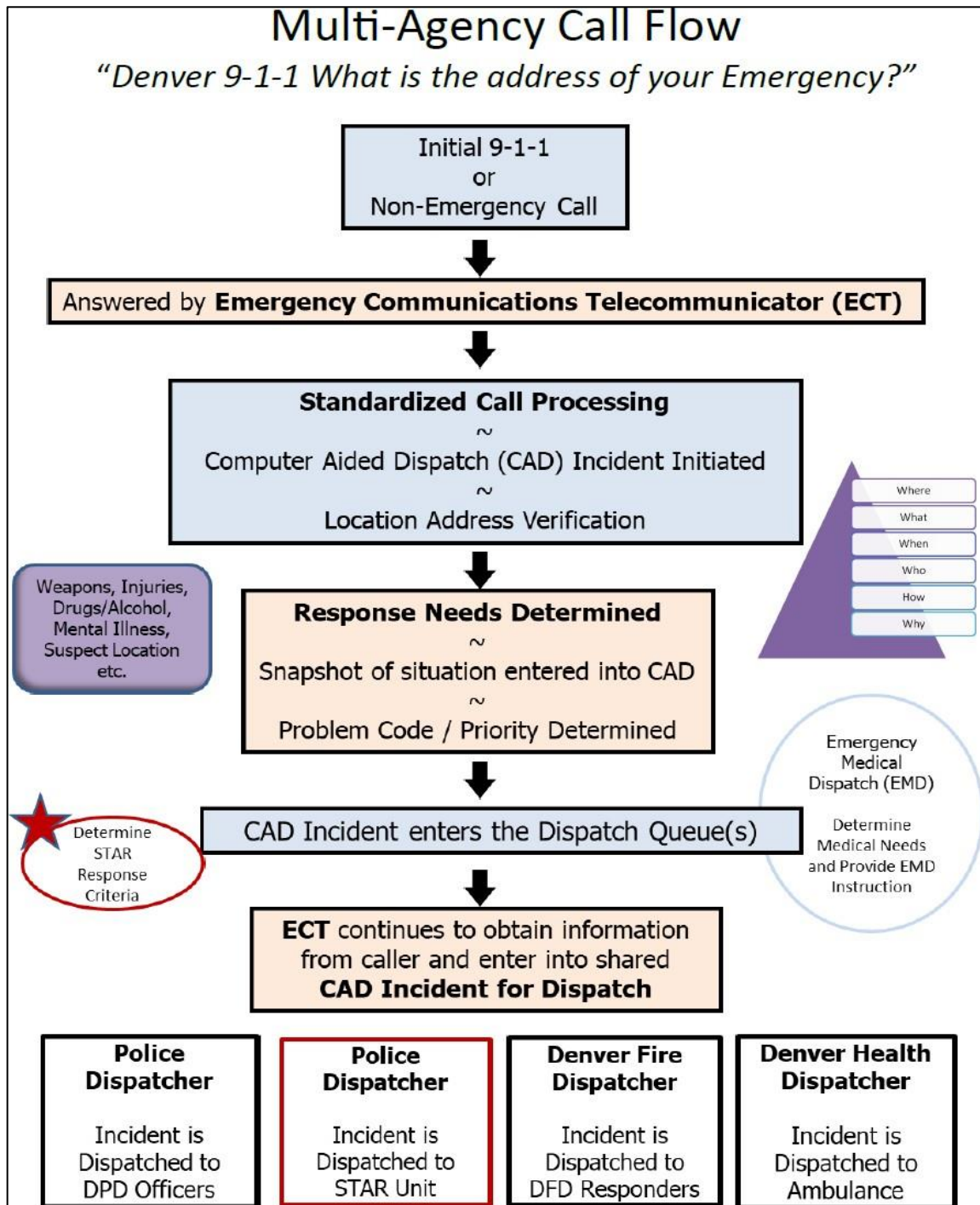
- (19062532) C/ REQ CAHOOTS FOR COUNSELING AND ASSISTANCE C/ HAVING SUICIDAL THOUGHTS NO PLANS OR MEANS AT THIS TIME
- (19310041) C/ REQ TRAN FOR HERSELF AND HER SON TO A MEAL THIS MORNING

3. Transport:

- (19222410) INV/UNK, NAME NEEDS XPORT TO SERVICE STATION - WAITING IN ED LOBBY
- (19080551) LOC/ LOBBY I/ UNK, MARK WM. 57. 600. MED. BALD LSW/ UNK TRAN TO HOURGLASS



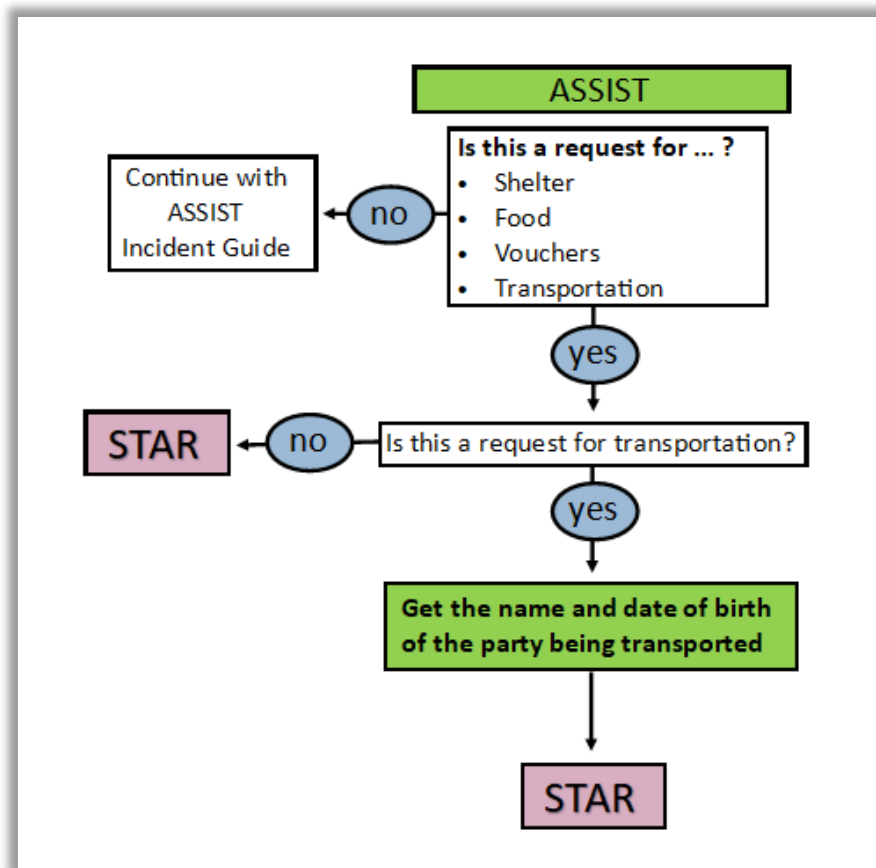
B. STAR-RMCP Emergency Communications Telecommunicator Flow Chart and Examples of 911 Calls Addressed. Direct Excerpt taken from *STAR - RMCP Alternate Response Combined Reference Guide* (2020, pp. 6-13)



Assist

- The caller is requesting assistance for things such as shelter, food, vouchers, or transportation that will indicate an appropriate /STAR response. Note: alternate response is not to be used for vehicle lockouts.
- On requests for transport the ECT will request the name and date of birth of the person requiring transport

Note: STAR will not transport individuals to private residences other than the subject's personal residence. When necessary STAR will transport individuals to staffed, attended facilities or shelters



EXAMPLES:

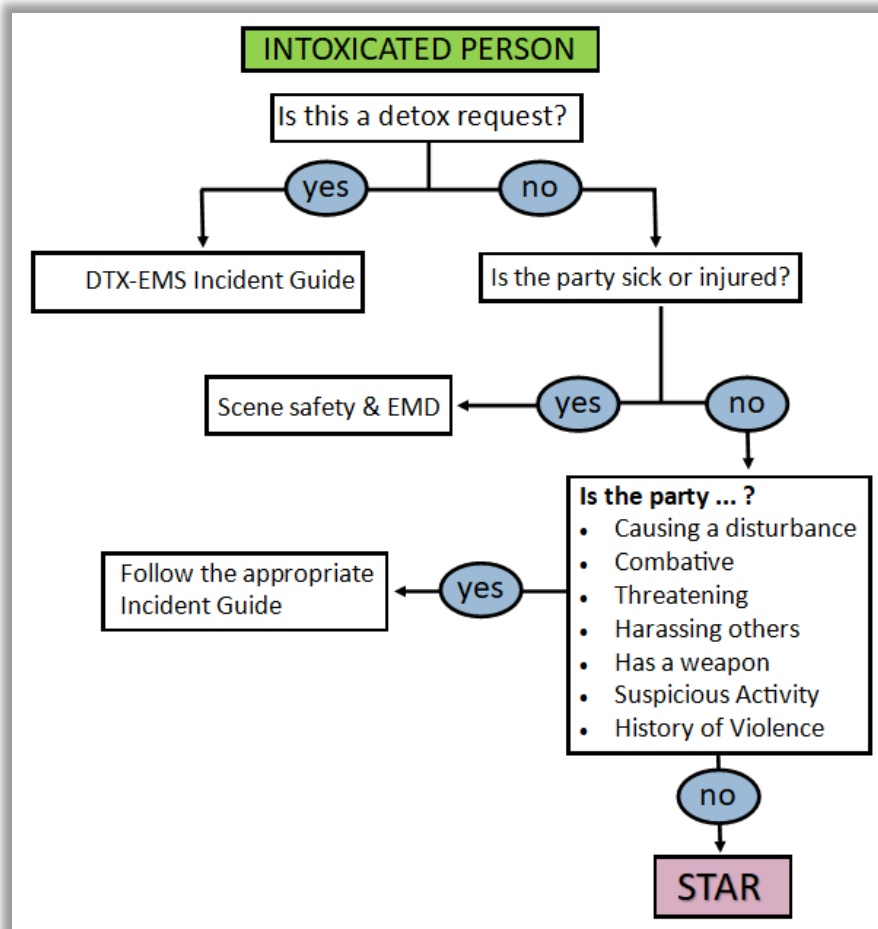
- Caller lost their bus ticket to California and is stranded.
- Mother says she lost her job and the family has no food.
- Father says his 7-year-old son is refusing to get dressed and go to school.
- Male caller says he is homeless and would like a voucher for a hotel.



Intoxicated Person

- The caller sees an intoxicated person stumbling around that needs help and needs a STAR response.
- The subject is not causing a disturbance or other problem.

NOTE: This is NOT someone requesting Detox.



EXAMPLES:

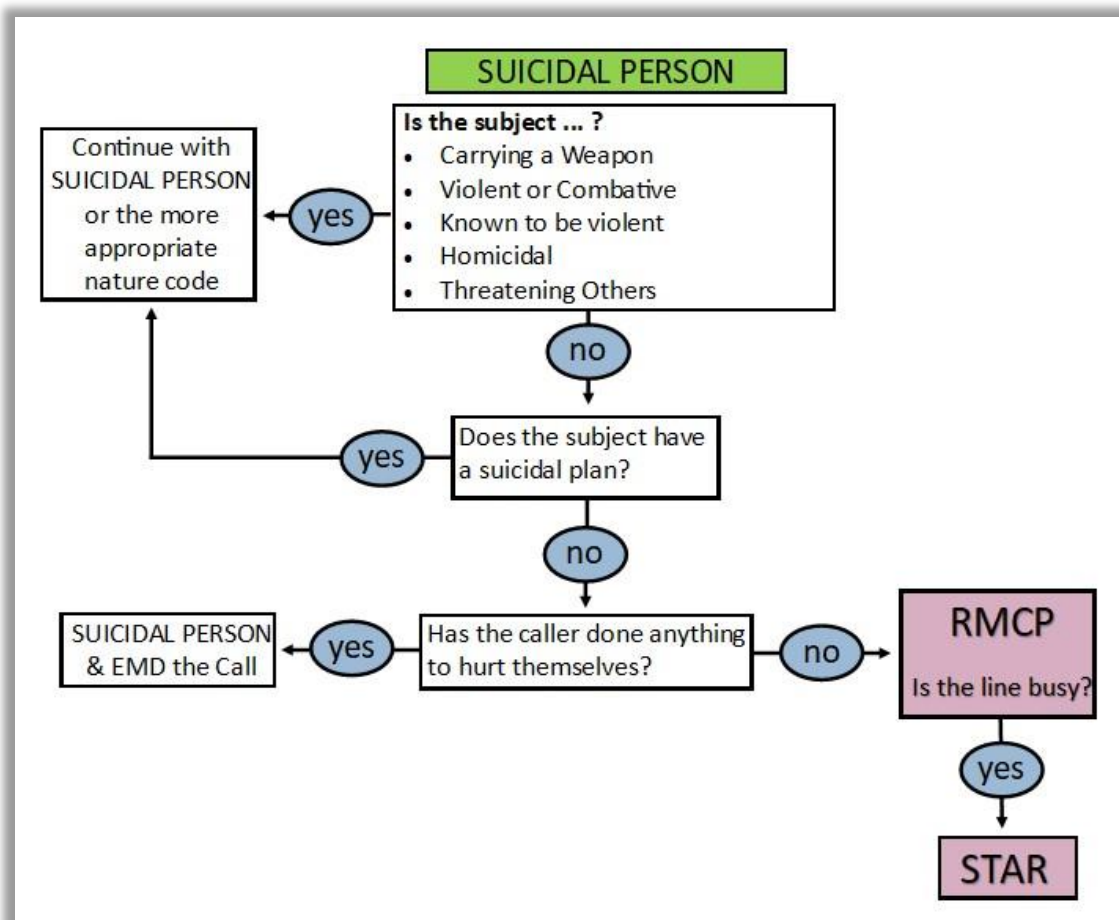
- A bartender calls and advises there is a man who just left the bar who is intoxicated, they are worried about him walking in his condition.
- A bartender calls and advises there is a man who is outside their door who should probably be taken to Detox. The individual is awake and not injured, however the caller is unsure if the person will voluntarily go to Detox or not.
- The clerk at the convenience store reports there is a drunk male who is hanging around the parking lot of his place and when the clerk offered to call him Detox, he refused.



Suicidal Person

- The caller is indicating they are feeling depressed or exhibiting depression but has no active plan, has no weapon, has not done anything to hurt themselves, and is non-combative. This will use the mandatory shorthand command /HL and then be warm transferred to the Crisis Line.
- If the Crisis Line is busy, enter a comment indicating they are busy and then process the call as /STAR for an alternate response. If an alternate response is not available incident will be dispatched for police response.

NOTE: /STAR can be utilized for a second party caller reporting someone else is depressed or exhibiting depression but has voiced no active plan, has no knowledge of a weapon, has not done anything to hurt themselves, and is not known to be combative.



EXAMPLES:

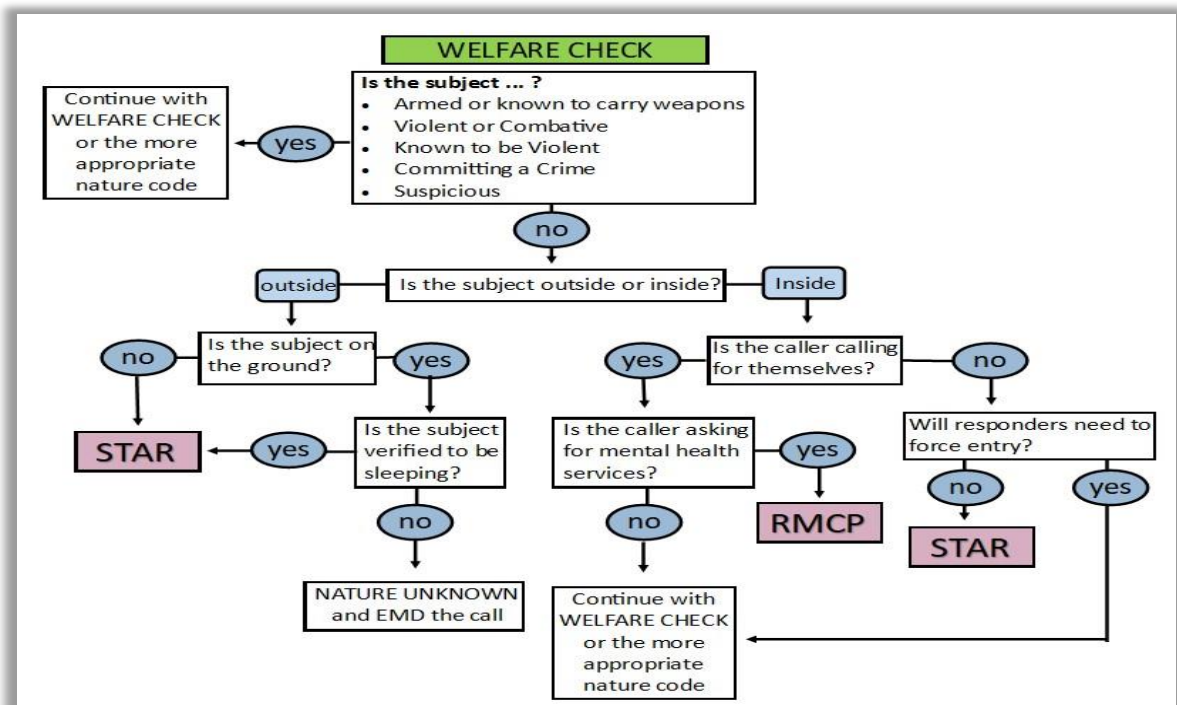
- Caller is feeling depressed and wants to talk to someone.
- Caller has a friend who is very depressed and has mentioned committing suicide or made comments indicating they think about ending it. The caller would like someone to go check on their friend.



Welfare Check

- Someone is sleeping on the sidewalk and the caller is positive the subject is just sleeping and has no medical needs.
- If a caller requests response to check on someone (family member, employee, friend, etc.) who hasn't been seen or heard from, this behavior is out of character, and there are **no** other known or indicated circumstances,
- The caller sees someone acting strange, such as talking to themselves, but isn't doing anything else that would require a police response.
- The subject is known to have mental health issues and no other factors known to warrant a police response.
- If the subject appears to be dazed, lost, is unable to tell the caller their name or engage with the caller, the ECT will not consider an alternative response and will process the incident on the most appropriate medical protocol.

NOTE: Do not use the alternate transfer response to RMCP for a 2nd party caller. Use the decision tree to determine most appropriate DPD response or alternate STAR response.



EXAMPLES:

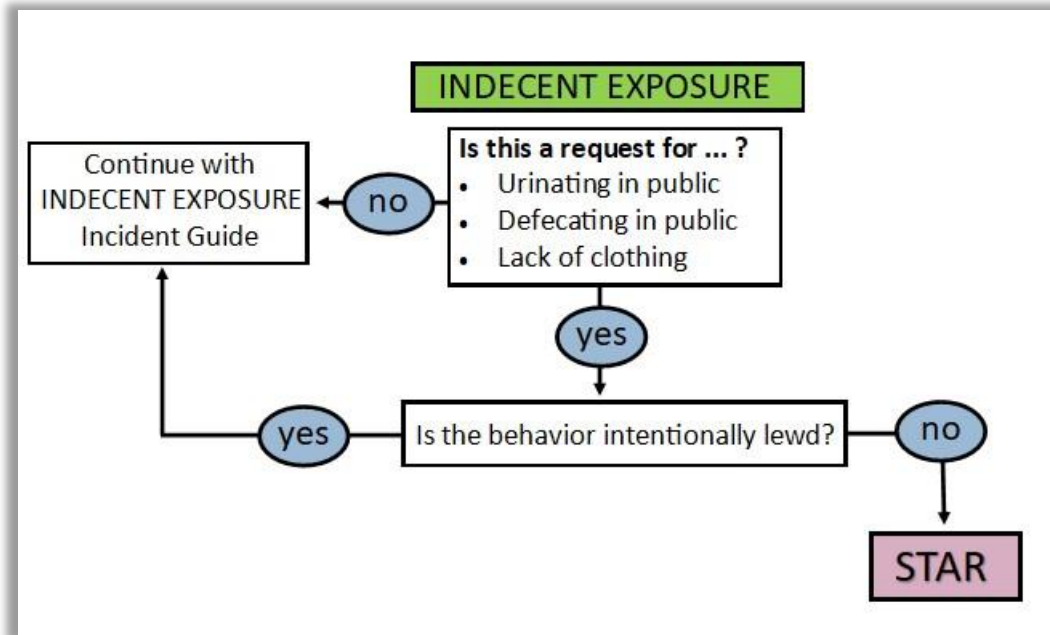
- Caller's little sister is in college and calls home every Friday and didn't call this last weekend.
- Caller says that a teenager is sleeping in their apartment laundry room for the fourth night and she is concerned he is a transient and needs resources.
- The manager of 7-Eleven says there is a man outside the store who is sitting on the curb talking to himself. He appears harmless and dirty.
- There is a report of a woman at the corner who is begging for money and she has a baby with her



Indecent Exposure

- The caller indicates that someone is urinating and/or defecating in public.
- There is no lewd behavior involved.

NOTE: The caller has no knowledge of the subject being violent/combatative or know of any history of violence.

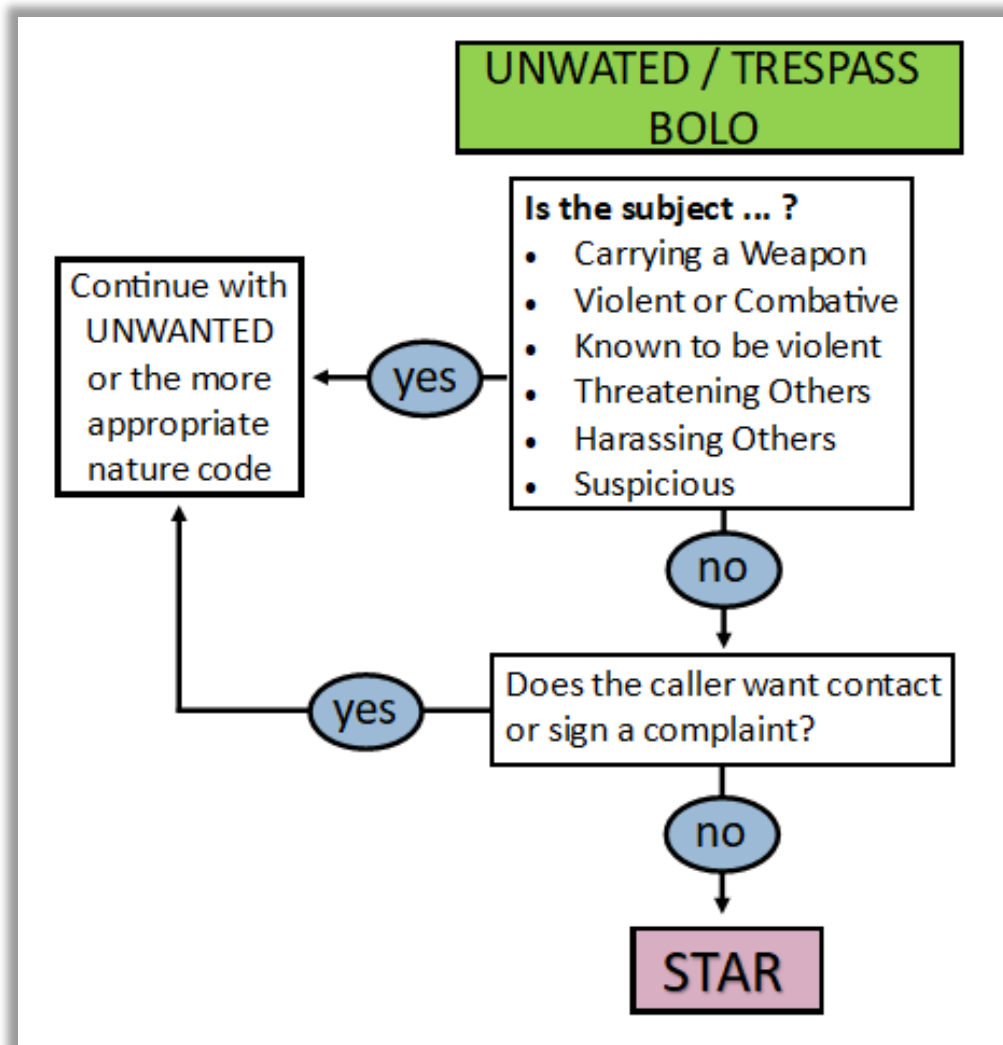


EXAMPLES:

- The caller sees a male urinating in an alley.
- There is a homeless man who is sitting on the sidewalk and his pants are down.

Unwanted / Trespass (also BOLO)

- A STAR response can be used for a report of the caller wanting a transient removed from private or public property.
- The subject may be in need of resources.
- The caller is not requesting police contact and is not wanting to sign a report of trespass.
- The subject is not combative and is not known to be combative or violent.



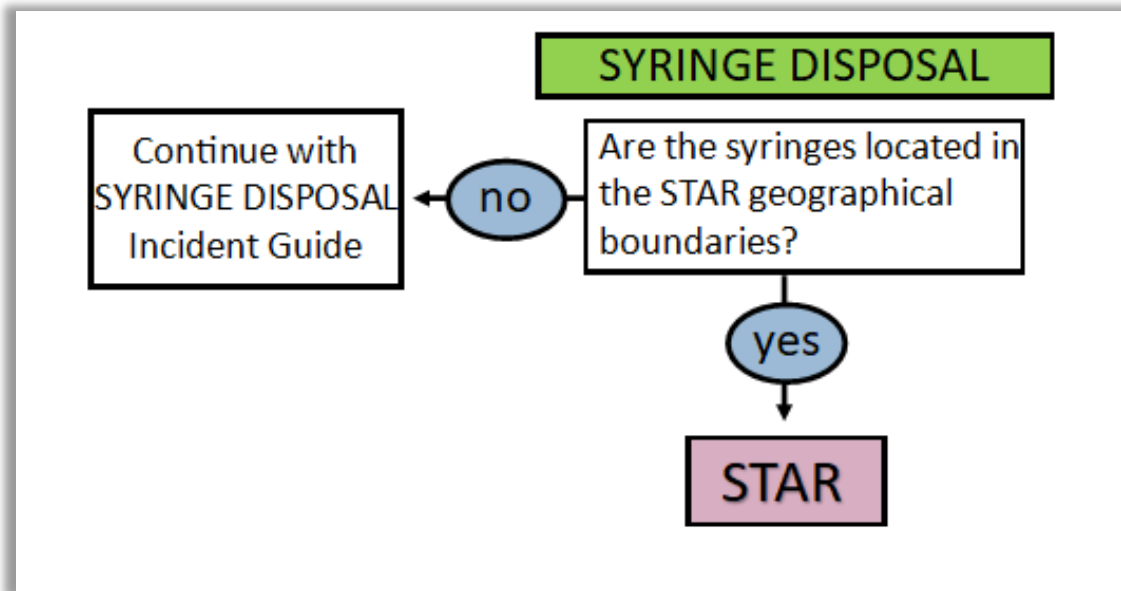
EXAMPLES:

- Panhandler on the street corner asking for money.
- Caller says someone is sleeping inside a vacant house.
- Caller has someone sleeping at a table outside of their business.
- People loitering in an alley and setting up tents.



Syringe Disposal

- If a caller is requesting pick up of used syringes or providing a location of used syringes, the ECT will follow the appropriate Syringe Disposal Incident Guide for processing the call/request.
- If the location of the syringe is in the STAR geographical area, the ECT will add /STAR to the comments of the incident for STAR dispatch and statistical tracking.



EXAMPLES:

- Caller found several syringes laying in an alley within the STAR boundaries.
- Caller says there are used syringes on the bike path along the Platt.

C. Community Behavioral Health Paramedicine Pilot Program Findings – Graph Screenshots Taken from Community Behavioral Health Paramedicine Pilot Program, NC DHHS Presentation (Kurtz, 2017)

1. No transport (treat on scene), transport to alternative location, transportation to emergency department, and transportation to psychiatric hospital pilot findings and value totals.

| Transportation Counts | | | | | | For Svc Events Reported with FY17 Dates | | |
|-----------------------|-------------------------------|-------------------------------------|-------------------|-------------------------------------|--------------|-----------------------------------------|--------------------------|-------------------|
| Count | Transportation Type | | | | | | | |
| EMS Program | No Transport (Treat on Scene) | Transported to Alternative Location | Transported to ED | Transported to Psychiatric Hospital | Grand Total | No Transport Svc Value @\$164 | Alt Loc Svc Value @\$211 | Total Value |
| Durham EMS | 109 | 16 | 335 | | 460 | \$ 17,876 | \$ 3,376 | \$ 21,252 |
| Forsyth EMS | 8 | 6 | 20 | | 34 | \$ 1,312 | \$ 1,266 | \$ 2,578 |
| Halifax EMS | 23 | 2 | 114 | | 139 | \$ 3,772 | \$ 422 | \$ 4,194 |
| Lincoln EMS | 33 | 41 | 177 | | 251 | \$ 5,412 | \$ 8,651 | \$ 14,063 |
| McDowell EMS | 10 | 16 | | 2 | 28 | \$ 1,640 | \$ 3,376 | \$ 5,016 |
| Onslow EMS | 12 | 3 | 54 | | 69 | \$ 1,968 | \$ 633 | \$ 2,601 |
| Stokes EMS | 5 | | 6 | | 11 | \$ 820 | \$ - | \$ 820 |
| Wake EMS | 155 | 139 | 345 | 68 | 707 | \$ 25,420 | \$ 29,329 | \$ 54,749 |
| Grand Total | 355 | 223 | 1,051 | 70 | 1,699 | \$ 58,220 | \$ 47,053 | \$ 105,273 |

First table shows data through Feb. 2017, second table shows data for all of FY 2016

| Transportation Counts | | | | | | For Svc Events Reported with FY16 Dates | | |
|-----------------------|-------------------------------|-------------------------------------|-------------------|-------------------------------------|--------------|-----------------------------------------|--------------------------|-------------------|
| EMS Program | No Transport (Treat on Scene) | Transported to Alternative Location | Transported to ED | Transported to Psychiatric Hospital | Grand Total | No Transport Svc Value @\$164 | Alt Loc Svc Value @\$211 | Total Value |
| Durham EMS | 41 | 9 | 124 | | 174 | \$ 6,724 | \$ 1,899 | \$ 8,623 |
| Forsyth EMS | 2 | | 4 | | 6 | \$ 328 | \$ - | \$ 328 |
| Guilford EMS | | 6 | 6 | 7 | 19 | \$ - | \$ 1,266 | \$ 1,266 |
| Halifax EMS | 3 | 1 | 422 | | 426 | \$ 492 | \$ 211 | \$ 703 |
| Lincoln EMS | 52 | 59 | 263 | | 374 | \$ 8,528 | \$ 12,449 | \$ 20,977 |
| McDowell EMS | 17 | 5 | | | 22 | \$ 2,788 | \$ 1,055 | \$ 3,843 |
| Onslow EMS | 79 | 85 | 348 | | 512 | \$ 12,956 | \$ 17,935 | \$ 30,891 |
| Wake EMS | 272 | 200 | 930 | 75 | 1,477 | \$ 44,608 | \$ 42,200 | \$ 86,808 |
| Grand Total | 466 | 365 | 2,097 | 82 | 3,010 | \$ 76,424 | \$ 77,015 | \$ 153,439 |



2. Diversion to lower level of care findings.

| Count | 51% Diverted to Lower LOC | | | Final Disposition | | | | | | | |
|-------------------------|-----------------------------------------------------------|-----------------------------|---------------------------|----------------------------------------|---------------------------------|--------------------------------------------------|----------------------------------|-------------------------------------|------------------------------------------------------|----------------|----------------|
| | Outpatient/ Community MHDDSA Svcs or Supports | Facility Based Crisis | Non- Hospital Detox | Home pending LOC availability | Transfer to a Hospital ED | Community Psychiatric Inpatient service | State Psychiatric Hospital | Left AMA/Refu sed Services | Transfer to a Tier IV BH Urgent Care Ctr | State ADATC | Grand Total |
| Durham EMS | 9 | | | | 1 | | | 3 | | 1 | 14 |
| Forsyth EMS | 1 | | | | | | | 1 | | 1 | 3 |
| Halifax EMS | | | | 2 | | | | | | | 2 |
| Lincoln EMS | 4 | 5 | 1 | 1 | 1 | | | 3 | | | 15 |
| McDowell EMS | 1 | | | | | 1 | | | | | 2 |
| Onslow EMS | | | | | | | | | 1 | | 1 |
| Wake EMS | 22 | 18 | 19 | | 9 | 47 | 3 | 1 | | 1 | 120 |
| Grand Total | 37 | 23 | 20 | 3 | 11 | 48 | 3 | 8 | 1 | 3 | 157 |
| Percent of Total | 24% | 15% | 13% | 2% | 7% | 31% | 2% | 5% | 1% | 2% | 100% |

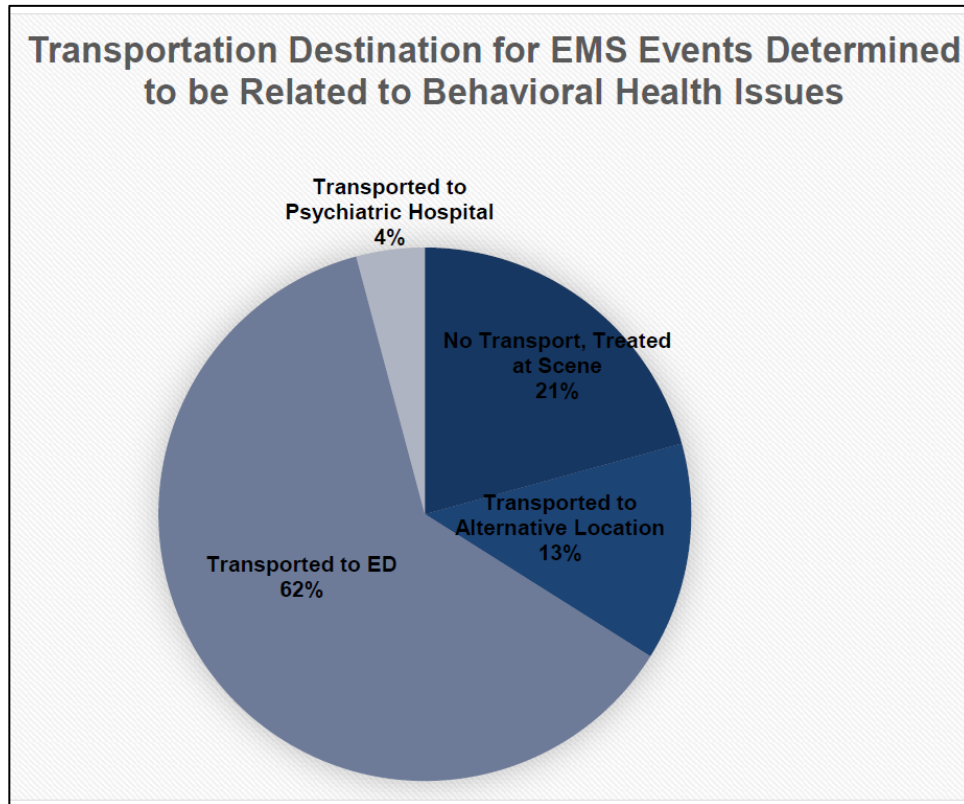
Note: 66 events were missing the Final Destination and are not included in the above table.

First table shows FY 2017 through February, second table shows all of FY 2016

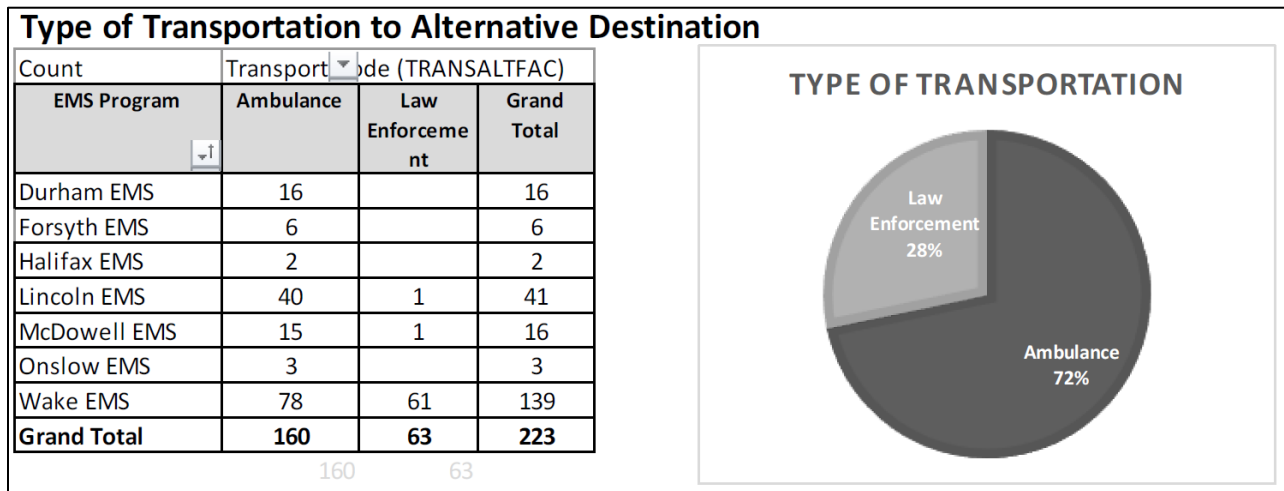
| EMS Program | 48% Diverted to Lower Level of Care | | | Home pending LOC availability | Transfer to a Hospital ED | Community Psychiatric Inpatient service | Jail/Deten tion Center | Psychiatric Residential Treatment Facility | State Psychiatric Hospital | VA Hospital | Left AMA/Refu sed Services | Transfer to a Tier IV BH Urgent Care Ctr | Grand Total |
|-------------------------|-----------------------------------------------------------|-----------------------------|---------------------------|----------------------------------------|---------------------------------|--------------------------------------------------|------------------------------|-----------------------------------------------------|----------------------------------|----------------|-------------------------------------|------------------------------------------------------|----------------|
| | Outpatient/ Community MHDDSA Svcs or Supports | Facility Based Crisis | Non- Hospital Detox | | | | | | | | | | |
| Durham EMS | 3 | 1 | | | | 2 | | | | | 3 | | 9 |
| Halifax EMS | 1 | | | | | | | | | | | | 1 |
| Lincoln EMS | 10 | 25 | | 3 | 8 | 1 | | | | | 8 | | 55 |
| McDowell EMS | 4 | | | | | | | | | | 1 | | 5 |
| Onslow EMS | | | | | | | | | | | | 2 | 2 |
| Wake EMS | 28 | 30 | 28 | 5 | 17 | 73 | 1 | 2 | 4 | 1 | 8 | | 197 |
| Grand Total | 46 | 56 | 28 | 8 | 25 | 76 | 1 | 2 | 4 | 1 | 20 | 2 | 269 |
| Percent of Total | 17% | 21% | 10% | 3% | 9% | 28% | 0% | 1% | 1% | 0% | 7% | 1% | 100% |



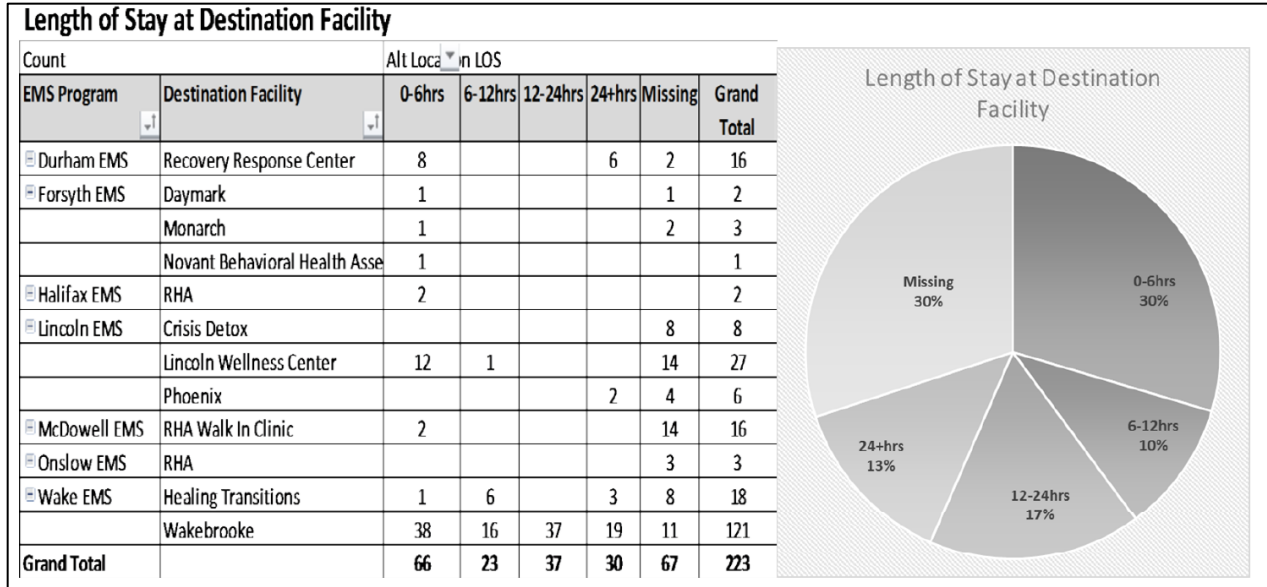
- Transportation Destination for EMS events determined to be related to behavioral health issues.



- Type of transportation to alternative destination findings.



5. Length of stay at destination facility findings.



6. Reason for transportation to the emergency department from an alternative destination.

| If Transported to ED from Altern. Destination, Why? | | | | | |
|-----------------------------------------------------|--|---------------------------------------------|-------------------|---------------------------|-------------|
| Count | | EDReason (Applicable) (TRANSALTFAC/TRANSED) | | | |
| EMS Program | | Medical Clearance | Medical Emergency | Patient Chose to Go to ED | Grand Total |
| Durham EMS | | 1 | | | 1 |
| Lincoln EMS | | | | 1 | 1 |
| Wake EMS | | | 9 | | 9 |
| Grand Total | | 1 | 9 | 1 | 11 |

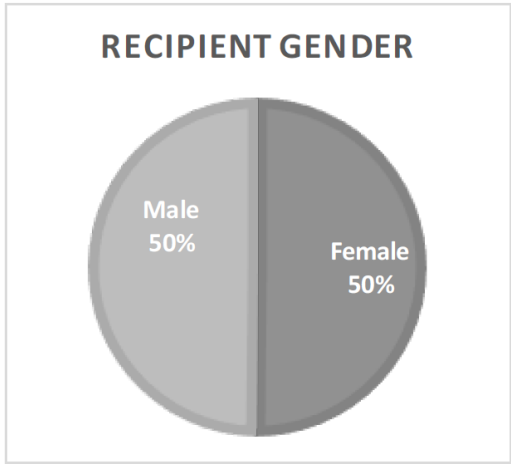


7. Reason for transportation to the emergency department from originating scene.

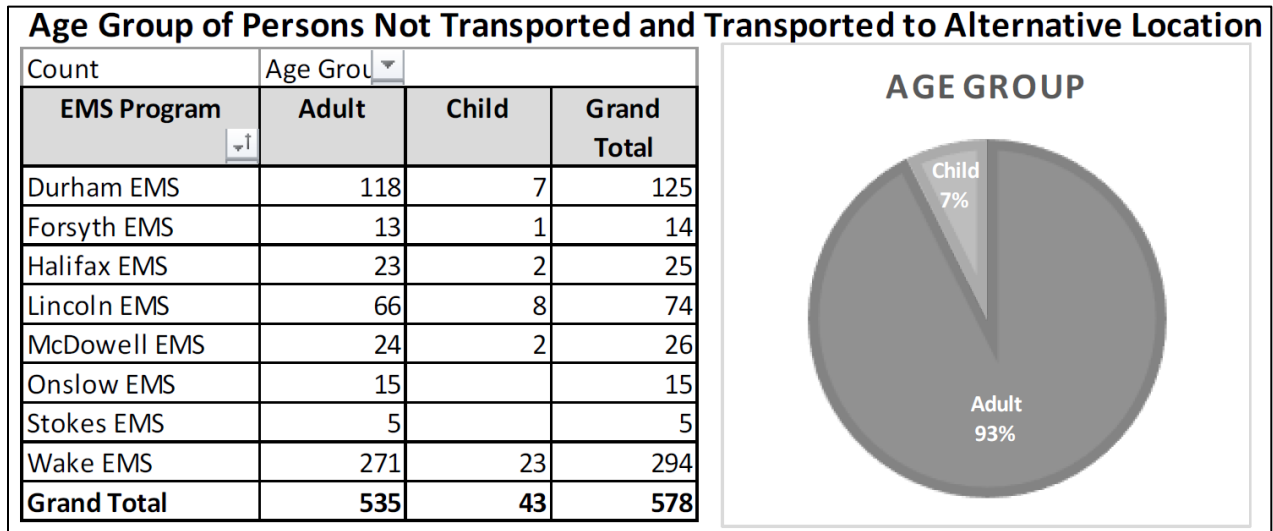
| If Transported to ED from scene, Why? | | | | | | | | |
|---------------------------------------|--------------------------|-------------------|-------------------|---------------------------|--------------------|-----------------------|----------|-------------|
| Count | Reason Transported to ED | | | | | | | |
| EMS Program | Center Capacity | Medical Clearance | Medical Emergency | Patient Chose to Go to ED | Psychiatric Acuity | Tier III Closing Time | Missing | Grand Total |
| Durham EMS | | 252 | 34 | 11 | 38 | | | 335 |
| Forsyth EMS | | 3 | | 6 | 10 | 1 | | 20 |
| Halifax EMS | | 14 | 17 | 1 | 79 | | 3 | 114 |
| Lincoln EMS | 3 | 44 | 66 | 39 | 10 | 15 | | 177 |
| Onslow EMS | | 2 | 1 | 14 | 37 | | | 54 |
| Stokes EMS | | 1 | 2 | 2 | 1 | | | 6 |
| Wake EMS | 17 | 109 | 130 | 73 | 15 | | 1 | 345 |
| Grand Total | 20 | 425 | 250 | 146 | 190 | 16 | 4 | 1051 |

8. Gender of individuals not transported to the emergency department, and transported to an alternative location.

| Gender of Persons Not Transported and Transported to Alternative Location | | | |
|---------------------------------------------------------------------------|------------|------------|-------------|
| Count | PtGender | | |
| EMS Program | Female | Male | Grand Total |
| Durham EMS | 76 | 49 | 125 |
| Forsyth EMS | 7 | 7 | 14 |
| Halifax EMS | 19 | 6 | 25 |
| Lincoln EMS | 40 | 34 | 74 |
| McDowell EMS | 15 | 11 | 26 |
| Onslow EMS | 10 | 5 | 15 |
| Stokes EMS | 5 | | 5 |
| Wake EMS | 118 | 176 | 294 |
| Grand Total | 290 | 288 | 578 |



9. Age of individuals not transported (treated on scene), and transported to an alternative location.



10. Disability of individual not transported (treated on scene), and transported to an alternative location.

Disability of Persons Not Transported and Transported to Alternative Location

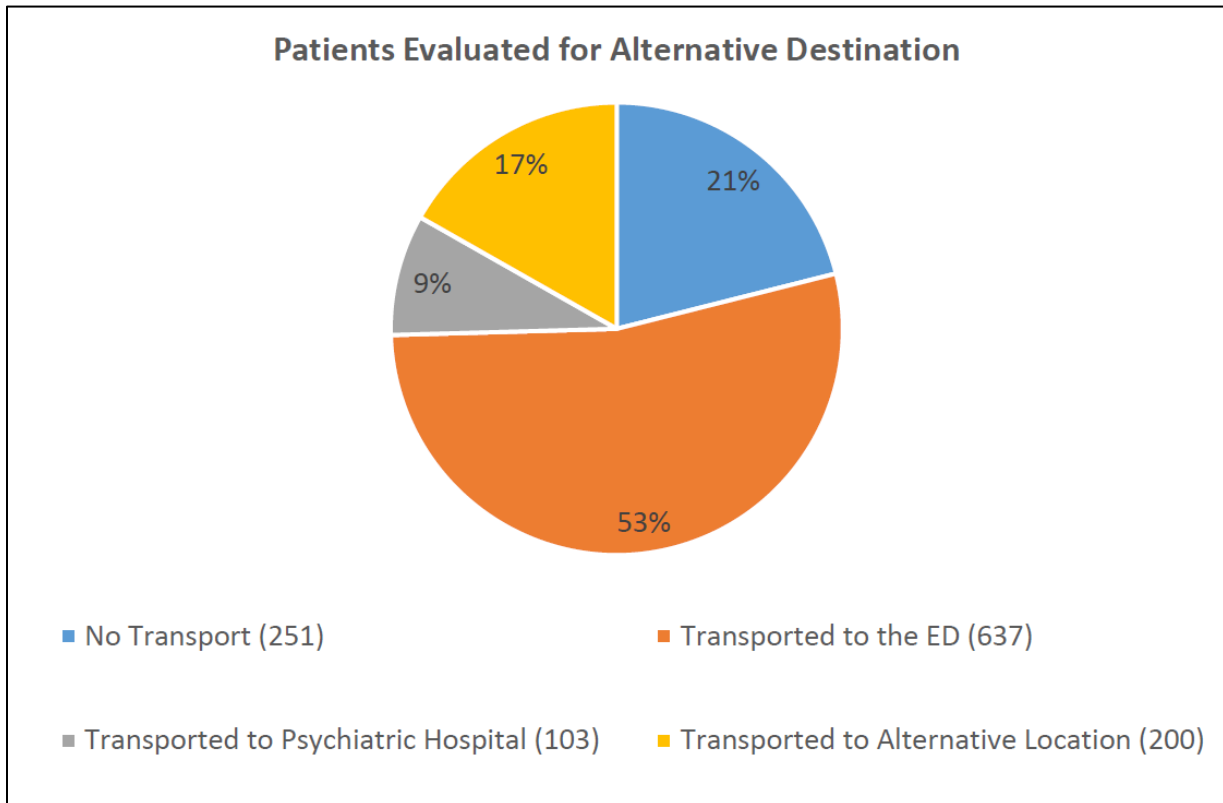
| Count | Behavior Health Disability | | | | | | |
|--------------------|----------------------------|-------------------------------|------------|-------------------------------------------|-----------|------------|-------------|
| EMS Program | Mental Illness (MH) | Substance Used Disorder (SUD) | MH/SUD | Intellectual/Developmental Disorder (IDD) | MH/IDD | MH/SUD/IDD | Grand Total |
| Durham EMS | 99 | 19 | 7 | | | | 125 |
| Forsyth EMS | 8 | 1 | 3 | | 2 | | 14 |
| Halifax EMS | 21 | 1 | 2 | 1 | | | 25 |
| Lincoln EMS | 55 | 10 | 8 | 1 | | | 74 |
| McDowell EMS | 21 | | 5 | | | | 26 |
| Onslow EMS | 9 | 1 | 4 | | | 1 | 15 |
| Stokes EMS | 4 | | 1 | | | | 5 |
| Wake EMS | 143 | 100 | 39 | 4 | 8 | | 294 |
| Grand Total | 360 | 132 | 69 | 6 | 10 | 1 | 578 |
| % of Total | 62% | 23% | 12% | 1% | 2% | 0% | 100% |



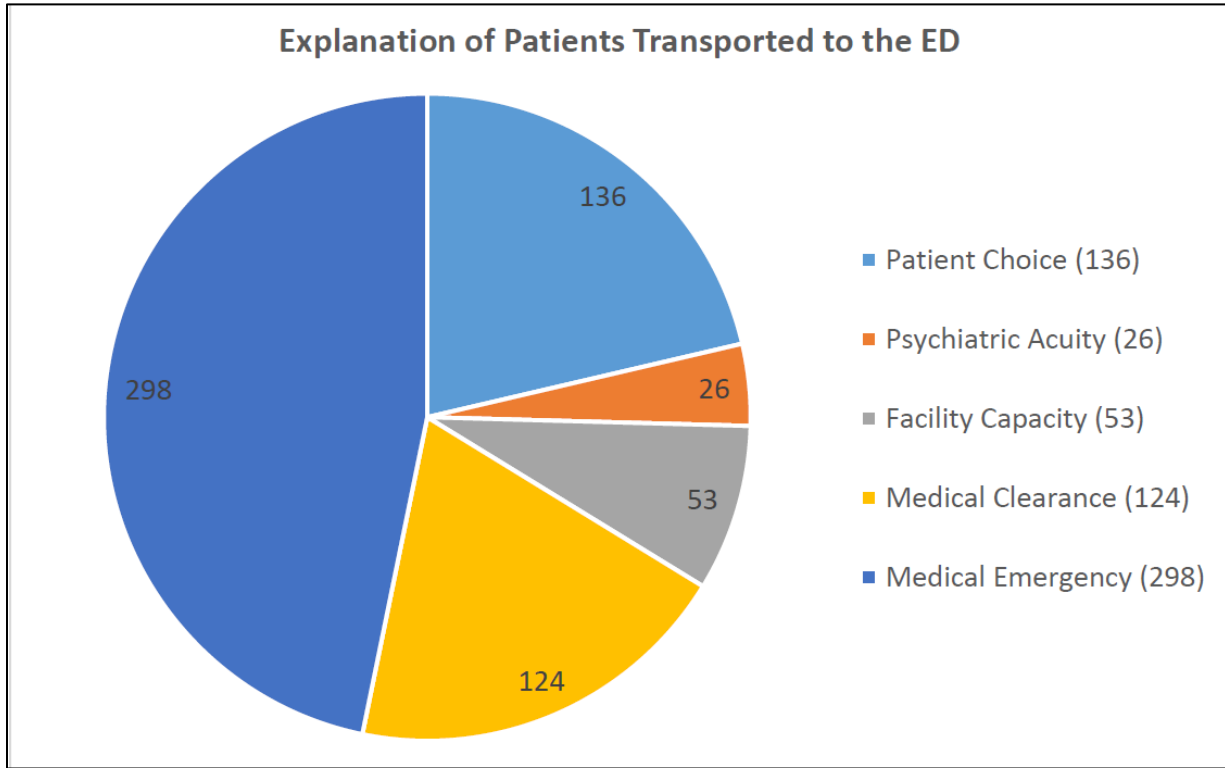
D. Community Paramedicine Pilot Programs – Wake County Patients Evaluated for Alternative Destinations and Explanation of Patients Transported to the Emergency Department (The North Carolina Department of Health and Human Services, 2017, pp. 19-21)

“Wake County EMS evaluated a total of 1,191 mental health and acute substance use patients from January 1, 2016 through November 30, 2016 (p. 19).”

1. Destinations of individuals evaluated by Wake County EMS (p. 20).

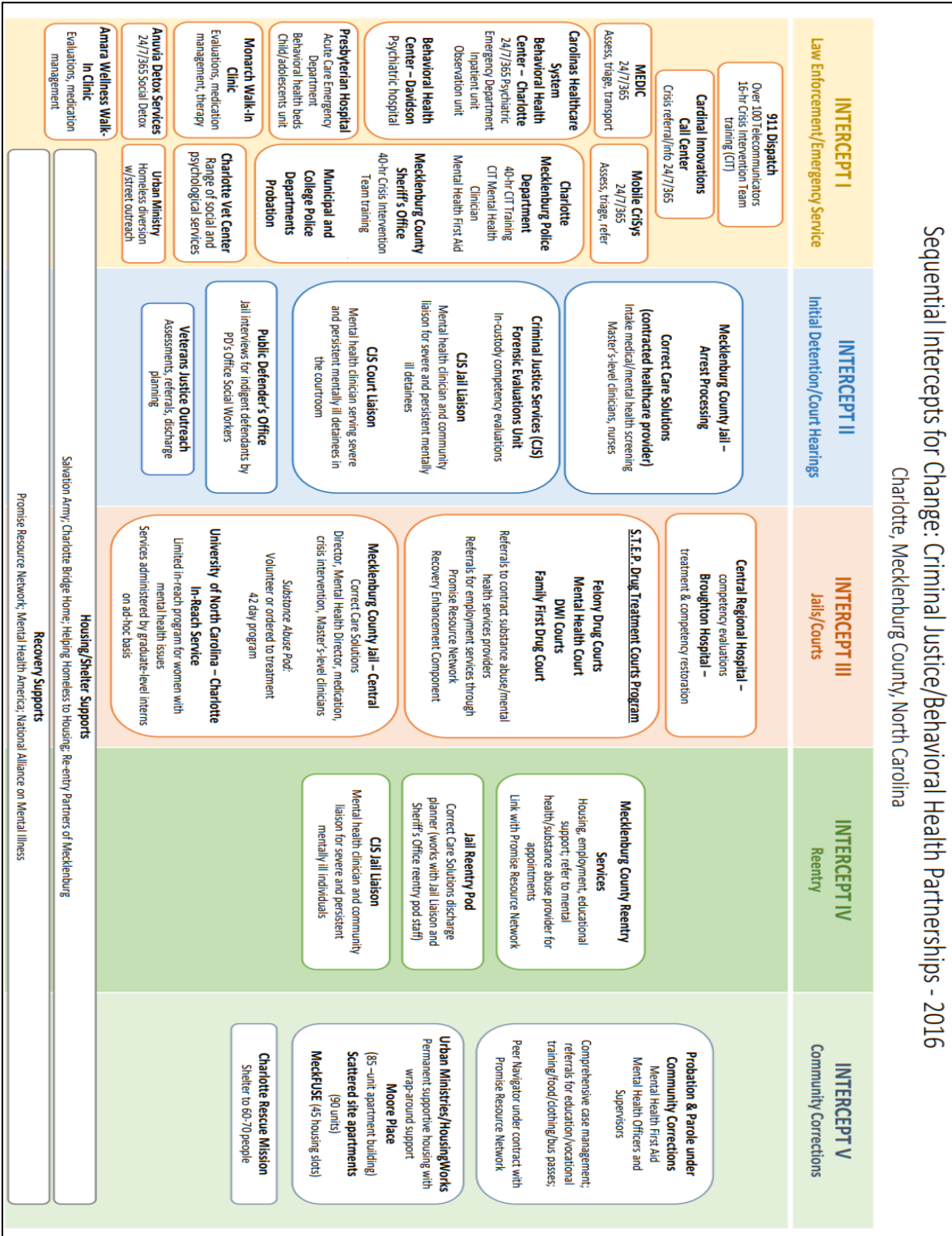


2. Explanation of patients transported to the emergency department who were evaluated by Wake County EMS (p. 21)



E. Mecklenburg County Criminal Justice Department Sequential Intercept Mapping Workshop Findings (Mecklenburg County Criminal Justice Services Department, 2017)

1. Sequential Intercepts for Change: Criminal Justice/Behavioral Health Partnerships – 2016



2. Continuum of Mental Health Services – 2016

