Louisville Metro
Crisis Call Diversion Program
Pilot
Final Evaluation Report

June 2022

COMMONWEALTH
INSTITUTE OF KENTUCKY

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Executive Summary

Background

The prevalence of behavioral health conditions in the United States is high and has increased since the start of the COVID-19 pandemic. In 2020, approximately 21% of adults ages 18 and older reported living with a behavioral health condition. Fifteen percent (15%) of individuals ages 12 and older needed substance use disorder (SUD) treatment.[i] In Kentucky, approximately 746,000 adults live with a behavioral health condition and 189,000 of those individuals report having a serious mental illness.[1] While the need for behavioral health services is extensive, there are few options available and accessible, particularly for those experiencing a crisis.

One strategy to address the growing behavioral health needs and to build a more effective safety net for those with behavioral health conditions is the implementation of alternative responder models. These models deflect responses from law enforcement to specialized response teams that address needs more adequately and appropriately during a behavioral health crisis. Alternative responder models work in tandem with law enforcement to identify individuals who might benefit from crisis intervention and address root causes of an individual situation, rather than transporting the person to jail or a hospital. In many cases, the alternative responders are trained health care or behavioral health providers who help stabilize crises and connect individuals to needed social services. The use of alternative responder models is emerging in communities across the United States. These models vary in structure, design, and funding.

Key Findings

- **There is a clear need for Crisis Call Diversion Program (CCDP) in Louisville, with model design and administrative priorities determining what success looks like.**
- **The CCDP is a promising model and resulted in 119 individuals receiving additional crisis support and referrals in the first 49 days. One hundred (100) hours of LMPD officer time was released between March 21 and May 8, 2022.**
- **CCDP is complex and there is limited knowledge of the model's intricacies. More education is needed to improve operations and build trust and confidence in CCDP, particularly in the community.**
- **The long-term success of CCDP is in its evolution. The model is underutilized due to low volume, and data-driven expansion is needed to make a larger impact.**
- **Long-term investment is needed to allow for program innovation, maturity, evaluation, and provide emergency behavioral health crisis support to the community.**

Overview of the Report

In this report, we provide a detailed description of implementation processes, community and stakeholder perceptions of the pilot and its contribution to public safety, and economic outcomes of the Crisis Call Diversion Program (CCDP) pilot in Louisville Metro's Fourth Division. We also provide recommendations to expand and strengthen the model in Louisville to better serve those in need and reduce the burden on law enforcement. It is important to keep in mind that this evaluation is an assessment of a short (7 week) and small pilot project. CCDP volume is increasing as familiarity and experience sets in, the long-term success of the intervention will be its evolutions.

Overview of the CCDP Pilot

In January 2021, the Commonwealth Institute of Kentucky was funded by Louisville Metro to examine how evidence-based deflection or alternative responder interventions could be applied and adapted to

[1] The National Institute of Mental Health defines a serious mental illness as one or more mental, behavioral, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

meet needs in and goals of Louisville Metro. That process and the outcomes of that work provided a foundation for designing and implementing the Louisville CCDP pilot that launched in March 2022. Building on this work, Louisville Metro contracted directly with Seven Counties Services to serve as the service provider for the CCDP pilot. Planning efforts intentionally considered and incorporated components of and lessons from projects in other cities, specifically the models in Austin, Texas, Albuquerque, New Mexico, and the Eugene, Oregon CHAOOTS program. Planning also incorporated accommodations for internal systems and process at SCS and in the 911 Call Center, as well as input from community members.

The CCDP pilot was launched on March 21, 2022, in the Fourth Division of Louisville Metro, which includes parts or all of Smoketown, Germantown, Churchill Downs, Old Louisville, and South Louisville. MetroSafe, the Metro Government agency responsible for handling all public safety communications, serves as the project lead. Seven Counties Services, a local community mental health center and behavioral health provider, is contracted to provide mobile crisis response services to eligible callers.

Goals of the CCDP pilot are:

1. Provide support to callers in the Fourth Division who are experiencing a behavioral health crisis
2. Deflect non-emergent calls away from Louisville Metro Police Department

Prior to the launch of the CCDP pilot, 911 calls received by MetroSafe were screened and then, if necessary, assigned to either police, fire, and/or emergency medical services (EMS). This process is still in place but, with the implementation of the CCDP pilot in the Fourth Division, MetroSafe call takers have a new pathway to assist eligible callers in need of crisis intervention. The program, even in its pilot phase, is complex.

Table I. CCDP Components

Component of CCDP	What is it?	What does it do?
Crisis Triage Worker (CTW)	These individuals work in the call center alongside MetroSafe call takers to identify caller needs, divert calls, and de-escalate the situation, if necessary.	CTWs can: 1. Resolve caller needs or de-escalate over the phone, 2. Send the caller to the SCS Crisis Information Center for more assistance, 3. Dispatch the MCRT for an in-person response, or 4. Return the call back to MetroSafe call takers for police response when call is found to be ineligible (in cases of violence, active suicide, or medical emergency).
Mobile Crisis Response Team (MCRT)	A two-person team that can provide in-person assistance to a caller in need. The team is mobile, using a van to respond and transport, if needed.	The team uses trauma informed approaches to assist the caller in need, provide de-escalation, and connect the caller to services, if needed. The team can: 1. Make referrals to services, 2. Transport the person to the hospital (e.g. University of Louisville Emergency Psychiatric Services), 3. Transport the person to respite, and/or

		4. Connect the person to friends or family members.
Respite Center	This stabilization space is located at Seven Counties Services Addiction Recovery Center.	The Respite Center provides a space for stabilization, services, and referrals for up to 24 hours. A caller is not required to have a substance use disorder to utilize the respite space. Only individuals dropped off by the MCRT are eligible to use the respite space.

Eligibility Criteria

The CCDP pilot is only available to assist callers located in the Fourth Division of Louisville Metro. At its initial launch on March 21, the eligibility criteria for a mobile crisis response were as follows:

1. Call must be received through 911
2. Must be related to a behavioral/mental health crisis
3. Person in crisis is in the Fourth Division of Louisville Metro
4. The call is received between 2PM and 10PM (only shift alternative responders are available)
5. First-person calls only (caller must be the person in crisis)

The eligibility criteria expanded on March 28 to include the above, and:

- Second-person calls (caller can be someone familiar with the person in crisis who is physically present at the scene)
- Police in the Fourth Division can call for MCRT response if they determine need while on a scene
- Repeat callers from any division
    - Repeat callers from outside the Fourth Division are eligible for CTW-led de-escalation and service referrals, but not for in-person assistance from MCRTs

Repeat 911 callers are defined as individuals who are known to MetroSafe and/or have a documented call history, have called more than once in the last 3 months and are experiencing a mental health crisis. The caller is not considered a repeat caller if they have not called 911 in the last 3 months.

Calls are not eligible for the intervention if the caller:

- Is in physical possession of a firearm, knife, or other weapon
- Is under the influence of alcohol or drugs to the extent requiring medical intervention (e.g., overdose or detox)
- Is in the process of hurting/killing self or threatening to hurt/kill others
- Requires medical attention because of a self-inflicted injury
- Has known violent tendencies or is exhibiting violent behavior
- Another person at the scene has committed a violent crime

On May 15, 2022, the eligibility criteria were further expanded to include the First Division, which includes the Butchertown, Downtown, Phoenix Hill, Portland, and Russell neighborhoods.

In June 2022, the eligibility criteria will be further expanded to allow First and Fourth Division officers to drop individuals off at the respite center.

Evaluation Approach and Methodology

The CCDP pilot evaluation includes both a process and impact evaluation centering on four research questions:

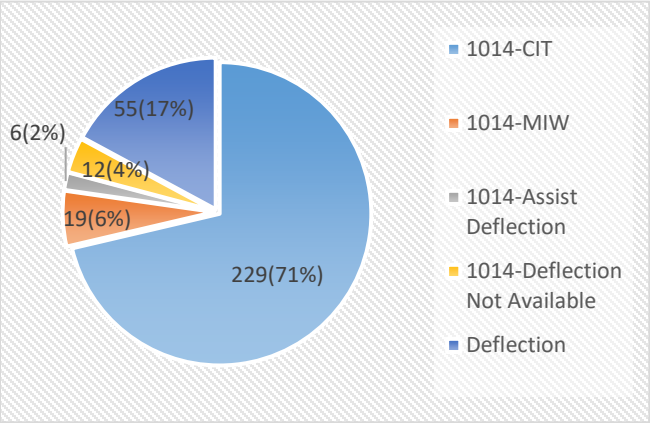
- To what extent was the CCDP implemented as designed and how was it adapted to meet community needs and expectations? (Process)
- To what extent do individuals in crisis receive needed assistance and what type of assistance is provided? (Process)
- How does the CCDP contribute to community safety? (Impact)
- What are the economic implications of the deflection efforts? (Impact)

This mixed-methods evaluation used both quantitative and qualitative data[2] to answer these questions and provide insight into the first seven weeks of the pilot and expansion potential across Louisville Metro. There are limitations of this evaluation, which are described in the full report.

What Happened During the Intervention?

Throughout the pilot period, there were 2,846 behavioral health designated events, making up 5% of all events. Seven percent (7%) of all 911 calls for service were labeled as a behavioral health event. The Fourth Division continues to have the highest number of behavioral health related events, with 888 events between Jan 1 and March 20, 2022, and 670 between March 21 and May 8, 2022. The First Division had the second highest volume at 814 and 452 events, respectively. The most common behavioral health event type was a "1014-CIT", which is designated as a police only behavioral health event that involves violence, a weapon, active suicide, medical emergency, or one of the other Deflection exclusion criteria**.** In the Fourth Division, 76% of all behavioral health events were "1014-CIT", while 8% were designated as "SCS Deflection" and 11% were coded "1014-Deflection Not Available" when looking at all hours of the day.

Figure I. Number and Percent of Fourth Division Behavioral Health Events by Classification (2 p.m. to 10 p.m., Mar 21-May 8)



During the intervention's operating hours, between 2 and 10 p.m., and in the Fourth Division, 55 (17%) events went to SCS Deflection which otherwise would have gone to LMPD. Of the 55 events, 27 went to and were addressed by the CTW, with the CTW and MCRT team responding to the other 28 events. Across all divisions, the SCS Deflection intervention responded to 119 events or 10% of all behavioral health events that occurred between 2 and 10 p.m. during the study period. Frequently provided crisis support from CTWs included crisis de-escalation, identification of coping strategies, and providing supportive crisis counseling. Frequently provided crisis support for MCRTs included motivational interviewing, assessing for risk of self-harm, and connecting individuals to resources.

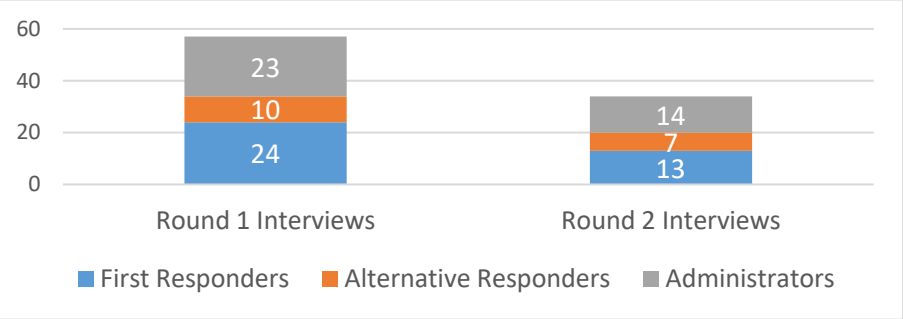
Economic analysis indicates the model freed 100 hours from LMPD officers to respond to other calls. Cost projection analysis reveals that if the CCDP responded to 13.74 calls per day, the CCDP would offset

[2] As qualitative and quantitative studies collect different data, their data collection methods differ considerably. Quantitative studies rely on numerical or measurable data. In contrast, qualitative studies rely on personal accounts or documents that illustrate in detail how people think or respond within society

police resources spent on CIT calls and in effect create additional labor hours available for police to respond to other crime-related calls. The cost analysis, however, does not factor in societal costs and the value of services added by providing the public with acute crisis support by trained behavioral health professionals.

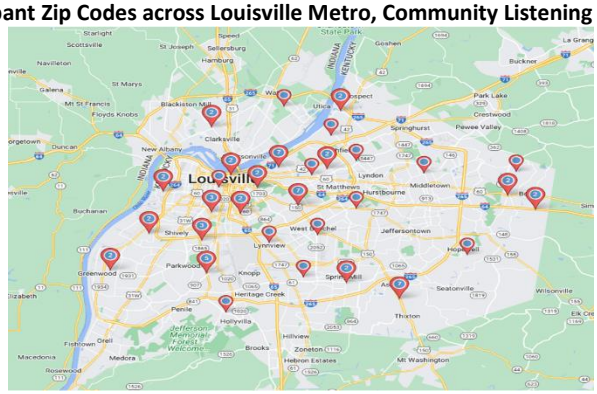
CCDP Responder and Community Perspectives

Figure II. Number of interview Participants by Stakeholder Type



A total of 70 CCDP responder interviews were conducted with 63 unique individuals including first responders (police, dispatchers, call takers), alternative responders (CTWs, MCRTs, respite workers, case managers), and administrators (police, 911 call center, SCS). We conducted two rounds of interviews to compare perceptions before and after the start of the intervention. Round one interviews were completed prior to or within the first week of the start of the intervention and round two interviews were completed one month or more after the start date. In addition, community listening sessions were held with 96 individuals participating in focus groups. Focus group participants were located throughout Jefferson County, with some residents working within the county but living outside.

Figure III. Distribution of Participant Zip Codes across Louisville Metro, Community Listening Sessions



The qualitative analysis revealed eleven thematic findings and with an additional 24 sub-themes. The major takeaways from stakeholder interviews include,

- Model design and administrative priorities will dictate what successes are achievable and ultimately how success is defined.
- Limited knowledge about the CCDP's operations and intricacies leads to uncertainty about what the CTWs and MCRTs are capable of handling and contributes to a first responders' willingness to engage the model.
- Communication structures are vital for building relationships, familiarity, and trust necessary for the CCDP to achieve its goals across responders and the community. Greater community engagement and input will help build trust, identify gaps, and offer innovative solutions.

- Safety concerns, both perceptual and situational, guide model design and exclusion criteria and are a potential barrier to increasing volume and expansion. Only 21% of all Fourth Division behavioral health calls were classified as “Deflection” or “Deflection Not Available” while CCDP is operating, suggesting a combination of eligibility criteria and stakeholders comfort level with CTW/MCRT safety protocols are influencing volume. Increased familiarity with operations and continued policy development that minimizes safety concerns, are key for increasing volume.
- Interviews revealed behavioral health 911 calls present challenges for call-takers and CTWs as the limited information, coupled with model criteria, concerns over safety, and differing views on what is eligible allows deflection-eligible calls to slip through the cracks, with the exact number being difficult to estimate.
- Innovative solutions to staffing are needed as administrators noted staffing was the number one barrier to expansion.
- Stakeholders noted the current respite space is sufficient to get started but is designed for addiction stabilization and will have to evolve to meet the needs of individuals experiencing other forms of behavioral health crisis.
- The long-term success of the CCDP is in its evolution. CCDP is a complex intervention requiring collaboration and coordination amongst multiple agencies. While volume and staffing are important, the evaluation reveals that building relationships is vital to expansion. Building better communication structures and increasing knowledge will alleviate safety concerns and increase responder and community support. Expansion should consider the range of needs and successes identified by respondents. Forming a multi-stakeholder workgroup is recommended to study and plan expansion.

Phasing Considerations and Recommendations

We used the results of this evaluation, as well as national best practices and evidence-based research, to identify a timeline for next phases and key recommendations for improving and expanding the pilot. The recommendations reflect the complexity of the CCDP and were crafted to acknowledge community needs, funding, staffing, organizational turnover, among others. The proposed phasing should be viewed as goals and not hard-set targets. We also provide a detailed cost analysis for consideration when making decisions regarding phasing and expansion. We recommend that final decisions for phasing come from the formation of a workgroup as well as continued evaluation to ensure data-driven decision-making.

Phasing Plan and Timeline

Phase 1: Ends June 30, 2022

- Alternative Responders operate 2 p.m. to 10 p.m.
- Callers in First and Fourth division are eligible for CCDP, and frequent callers from all divisions are eligible for CTWs, but not mobile response.
- MCRT and First and Fourth Division officers can drop off at respite care

Phase 2: July 1, 2022, to June 30, 2023

Phase 2 Goals:

1. Increase awareness of and familiarity with the CCDP both internally and externally
2. Expand the reach of CCDP

Key Steps for Phase 2:

1. Create a workgroup to provide guidance on the expansion of CCDP and advise on issues such as safety concerns, staffing, etc.
2. Increase awareness of the CCDP
3. Expand access to, and use of, the CCDP
4. Develop an independent respite space
5. Develop educational material for responders and community resource providers to raise awareness of the existence of CCDP and its benefits
6. Develop public information campaign to raise awareness and increase reach

Phase 3: July 1, 2023, to June 30, 2024

Phase 3 Goals:

1. Expand access to CCDP
2. Provide in-service cross training for Deflection, police, and 911 communication specialists, as well as Mental Health First Aid training
3. Integrate community behavioral health professionals and community members to assist in education and awareness

Recommendations

Seven core recommendations are made with a total of 28 sub-recommendations related to future research, improving data processes, and CCDP expansion. The core recommendations are presented below.

R1: Continue with process and outcome evaluation to drive data-informed decision-making related to implementation and expansion.
R2: Improve CCDP data collection in MetroSafe, LMPD, and Seven Counties Services.
R3: Strengthen Infrastructure for Expansion.
R4: Improve CCDP education and awareness by developing education material for responders and a public education campaign.
R5: Secure long-term funding.
R6: Expand respite space and services to meet a broader range of behavioral health needs.
R7: Develop and standardize training specific to CCDP.

Conclusions

On March 21, 2022, the Crisis Call Diversion Program (CCDP) launched in Louisville, Kentucky in Louisville Metro Police Department's Fourth Division after several months of planning and development. The CCDP is led by Louisville Metro Emergency Management Agency who contracted with Seven Counties Services to provide the behavioral health response. These agencies, in collaboration with other stakeholders, spent countless hours designing, implementing, and training personnel to provide needed services in Louisville by providing acute crisis support for individuals experiencing non-violent behavioral health crisis. The CCDP follows best practice responding to behavioral health crisis by providing "someone to talk to," "someone to respond," and "a place to go." As the CCDP is new to Louisville, stakeholders designed the intervention to start small with intentions to grow the intervention as familiarity and opportunities presented it, with three model expansions occurring since launch date. During the study period, March 21 to May 8, 2022, the CCDP responded to 119 individuals in behavioral health crisis providing professional crisis support and referrals and in process, freeing up 100 hours of LMPD officer hours to respond to other calls. The beginning weeks of the model show promise and interviews with administrators, first responder, alternative responders, and community members expressed widespread need and support for such an intervention.

As expected with a new intervention, CCDP experienced challenges along the way, with administrators maintaining close monitoring of operations and addressing many challenges with additional trainings, clarifications, or making changes to the program as required. Unfamiliarity, safety, and uncertainty defined the pilot study for administrators, first responders, alternative responders, and community.

Sending non-police to behavioral health via 911 is new to Louisville, the community, and the organizations responsible for responding to these events. Designing, implementing, and staffing this intervention is new and safety is at the forefront of decision-making, wanting to ensure the individual in need and responders are safe. The lack of experience in this space leads to more cautious decision-making that can be overcome with familiarity and experience. However, a third factor hangs over the project and that is uncertainty related to if the CCDP will continue. Stakeholders acknowledged throughout the study that new interventions typically have a short shelf-life in Louisville. Concerns over long-term funding create hesitation in making the bold and innovative moves necessary to develop an intervention that meets the full range of needs and successes identified in the study. The long-term success of the CCPD is in its evolution. An evolution that requires long-term commitment and resources to create a model that provides acute professional help for people in behavioral health crises, deflects calls from police and frees up their time to address serious crime, and keeps people out of jail and hospitals by providing appropriate levels of care in community respite space. The takeaway from this report is MetroSafe and SCS have laid the foundation to provide non-police responses to behavioral health crisis. The decision to start small along with gaps in the intervention have led to low volume in the early weeks, something that is not sustainable for the long-term future. However, the foundations laid have created meaningful paths forward to contribute to public safety in Louisville.

It is important to reiterate that this intervention is designed for acute behavioral health crisis response through a 911 deflection design and is insufficient alone to address chronic behavioral health needs. Greater investment in behavioral health services, housing, and other social determinants of health are required to address chronic challenges. However, a well-designed CCDP may contribute to preventing others from developing chronic behavioral health through early intervention and support provisions.

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Acknowledgements

We want to acknowledge Louisville Metro Government and Louisville Metro Council for providing funding and allowing us to evaluate the Crisis Call Diversion Program pilot. We also want to thank Louisville Metro Emergency Management Agency, Seven Counties Services, and Louisville Metro Police Department for sharing data and participating in interviews. We also want to thank our community members who participated in our research. To all of those who gave their time to help us understand and evaluate this intervention, we are indebted.

We also want to recognize the research team who spent countless hours planning, collecting, analyzing, and writing this report. In alphabetical order: Ashley Barnette, Craig Blakely, Amira Bryant, Sara Choate, Khalilah Collins, Liza Creel, Melissa Eggen, McKeeya Faulkner, Jacelyn Grimes, Seyed Karimi, Hannah Kay, Tanisha Howard Lewis, Brian Schaefer, Katherine Yewell, and Tony Zipple. Special thanks to Noèmi Stanev, Erin Nunn, Glen Reid, and Sam Fowler who provided administrative support throughout the project and CJ Swift for data assistance.

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Background

The prevalence of behavioral health conditions in the United States is high and has increased since the start of the COVID-19 pandemic. In 2020, approximately 21% of adults ages 18 and older reported living with a behavioral health condition. Fifteen percent (15%) of individuals ages 12 and older needed substance use disorder (SUD) treatment.[ii] In Kentucky, approximately 746,000 adults live with a behavioral health condition and 189,000 of those individuals report having a serious mental illness (SMI). While the need for behavioral health services is extensive, there are few options available and accessible, particularly for those experiencing a crisis. In 2020, 232,000 Kentuckians with behavioral health conditions did not receive any acute or routine care related to their specific needs.[iii]

Nationally, 10% of all law enforcement responses are related to a behavioral health crisis. Police officers across the country, and in Louisville, have expressed that they are asked to do too much given their training and expertise, particularly when assisting a person in a behavioral health crisis. It is well documented that individuals with a behavioral health condition are disproportionately impacted by the criminal legal system. Up to 28% of people living with a behavioral health condition have been arrested, compared to 7-10% of individuals without a diagnosis.[iv] Individuals with disabilities, both psychiatric and otherwise, account for one-third to one-half of all people killed by law enforcement officers.[v] In Kentucky, about 25% of adults with an SMI have been arrested by the police at some point in their lives, resulting in over 2 million annual jail bookings of people with SMI.[vi] Negative encounters between the police and those living with behavioral health conditions can be attributed to the lack of resources available to police to handle mental health crises, stigma and disdain for psychopathological behaviors, and the barriers limiting real access to needed healthcare and behavioral health systems.[vii,viii]

In 2015, the President's Task Force on 21st Century Policing recommended that law enforcement implement "least harm resolutions" and partner with community agencies outside of law enforcement.[ix] An intent of this recommendation is to shift police response from "warrior" to "guardian" and build much needed trust between law enforcement and community, particularly among communities of color who have been disproportionately impacted by police violence.

One strategy to address the growing need around behavioral health and build a more effective safety net for those with behavioral health conditions is the implementation of alternative responder models. These models deflect responses from law enforcement to address needs more adequately and appropriately during a behavioral health crisis. There are several models of alternative response, all with a goal of decreasing the likelihood that individuals in a behavioral health crisis enter the criminal legal system.[x] A national poll indicates that 70% of likely voters support alternatives to law enforcement responses for 911 calls that involve behavioral health crises and 68% like the idea of creating non-police emergency response programs.[xi]

Alternative responder models work in tandem with law enforcement to identify individuals who might benefit from crisis intervention and address root causes of the situation, rather than transporting the person to jail or a hospital. In many cases, the alternative responders are health care or behavioral health providers with training and expertise who help stabilize crises and connect individuals to needed social services. The use of alternative responder models is emerging in communities across the United States. These models vary in structure, design, and funding. Many of them require years of formative adaptation to fit into, or fundamentally change, existing structures and processes to accommodate the inherent innovation in the model. Cities such as Austin, Texas and Denver, Colorado have implemented small-scale alternative responder models as pilot projects, then adapted and expanded them as

institutional and operational challenges and barriers have surfaced. One of the most well-known programs is the Crisis Assistance Helping Out On the Streets (CAHOOTS) program in Eugene, Oregon. Appendix 1 includes more details on models across the country.

Overview of the Report

In February 2021, the Commonwealth Institute of Kentucky (CIK) at the University of Louisville (UofL) was funded by Louisville Metro Government to examine how evidence-based alternative responder models could be applied and adapted to meet the unique needs of Louisville Metro. In addition to reviewing existing alternative responder models, CIK and a steering committee gathered input from behavioral health providers, individuals in agencies throughout Louisville Metro Government, and the community to inform a proposed model for Louisville.[xii] In March 2022, CIK was contracted to study implementation and short-term outcomes of an alternative responder pilot funded by Louisville Metro Government in a contract to Seven Counties Services.

In this report we evaluate Louisville Metro's Crisis Call Diversion Program (CCDP) and Mobile Crisis Response Team (MCRT), the designated names of Louisville Metro's alternative response approach. Throughout the report we refer to the intervention as CCDP for short. In this report, we provide a detailed description of implementation processes, community and stakeholder perceptions of the pilot and its contribution to public safety, and economic outcomes of the CCDP pilot in Louisville Metro's Fourth Division. The report also models potential implications based on three expansion scenarios, informed by historical data and observations from the pilot. We also provide recommendations to expand and strengthen the model in Louisville to better serve those in need and reduce the burden on law enforcement.

Overview of the Crisis Call Diversion Program Pilot

Planning

Implementing the Crisis Call Diversion Program (CCDP) pilot required extensive planning, which Louisville Metro Government supported for over one year before the pilot officially launched. In January 2021, the Commonwealth Institute of Kentucky was funded by Louisville Metro to examine how evidence-based deflection or alternative responder interventions could be applied and adapted to meet needs in and goals of Louisville Metro. That process and the outcomes of that work provided a foundation for designing and implementing the Louisville CCDP pilot that launched in March 2022. A full description and results of that planning phase are documented elsewhere.[xiii]

Building on this work, Louisville Metro contracted directly with Seven Counties Services to serve as the service provider for the CCDP pilot. Though the contract was executed in January 2022, both SCS and Louisville Metro undertook joint planning efforts prior to the pilot launch. An in-depth inquiry into planning processes as part of this evaluation is summarized below.

Planning efforts intentionally considered and incorporated components of and lessons from projects in other cities, specifically the models in Austin, Texas, Albuquerque, New Mexico, and the Eugene, Oregon CHAOOTS program. Planning also incorporated accommodations for internal systems and process at SCS and in the 911 Call Center, as well as input from community members. As an example of the latter, community input gathered from the initial planning phase, and input from the steering committee that oversaw that work, indicated that some community members without typical formal behavioral health training could serve as key members of a mobile crisis response team, given their practical experience and connections in the local community.[xiv] As such, SCS modified their job descriptions and pay scales to

both allow applications from individuals who may not meet the usual recruitment criteria and support salaries that would attract such community leaders.

SCS and MetroSafe were the primary leads and decision-makers during the pilot planning process. The approach to planning included some formal, routine meetings and some more informal interactions as questions arose. As needed, they would request input from others external to SCS or MetroSafe (e.g. members of the original planning team, other agencies within Louisville Metro Government). LMPD was not part of the formal, routine planning processes in the months leading up to launch. Rather, LMPD's Chief was provided updates and LMPD's CIT coordinator was consulted as needed.

Decision-making responsibilities lie entirely between SCS and MetroSafe. Day-to-day process decisions or those specific to internal operations were made by SCS. CCDP pilot-specific policy decisions, such as eligibility criteria, were made together with MetroSafe leadership. People involved in planning reported a collaborative approach to decision-making, usually happening during weekly meetings.

The goal in the planning phase was to start small with a focus on 911 deflection that included elements of "someone to talk to," "someone to respond," and "a place to go." The CCDP's form was new to MetroSafe and Seven Counties Services, and as such administrators designed the implementation plan to start small, giving both organizations time to build new infrastructures and gain familiarity, before expanding. As a 911 deflection program, the intervention was designed to start with a 911 call and proceed from there. The Fourth Division was selected for the pilot phase based on recommendations made in the planning report, as the Fourth Division has the highest volume of 911 behavioral health calls. Similarly, the 2 p.m. to 10 p.m. time frame was selected as it is the period with the highest volume of calls. Finally, inclusion/exclusion criteria were selected with a focus on safety and starting with low volume. Full explanations of the factors that guide decision making are presented on in CCDP Responders and Community Perceptions section. The following section describes how the model works and reflect the decisions made in the planning phase.

How it Works

This section of the report provides an overview of the CCDP, including a description of decisions related to the model and the implementation of it. The CCDP pilot was launched on March 21, 2022, in the Fourth division of Louisville Metro, which includes parts or all of Smoketown, Germantown, Churchill Downs, Old Louisville, and South Louisville. MetroSafe, the Metro Government agency responsible for handling all public safety communications, serves as the project lead. Seven Counties Services, a local community mental health center and behavioral health provider, is contracted to provide mobile crisis response services to eligible callers.

Goals of the CCDP pilot are:

1. Provide support to callers in the Fourth Division who are experiencing a behavioral health crisis
2. Deflect non-emergent calls away from Louisville Metro Police Department

Prior to the launch of the CCDP pilot, 911 calls received by MetroSafe were screened and then, if necessary, assigned to either police, fire, and/or emergency medical services (EMS). This process is still in place but, with the implementation of the CCDP pilot in Division 4, MetroSafe call takers have a new pathway to assist eligible callers in need of crisis intervention. If MetroSafe receives an eligible 911 call, call takers have the option to assign the call to a newly established Behavioral Health Hub which consists of Crisis Triage Workers (CTW) and is located within the 911 call center. The CTWs assess caller needs and make determinations about next steps. The program, even in its pilot phase, is complex. Table I

below summarizes three primary components of the CCDP pilot – CTWs, the Mobile Crisis Response Team (MCRT), and Respite.

Table 1. CCDP Components

Component of CCDP	What is it?	What does it do?
Crisis Triage Worker (CTW)	These individuals work in the call center alongside MetroSafe call takers to identify caller needs, divert calls, and de-escalate the situation, if necessary.	CTWs can: 1. Resolve caller needs or de-escalate over the phone, 2. Send the caller to the SCS Crisis Information Center for more assistance, 3. Dispatch the MCRT for an in-person response, or 4. Return the call back to MetroSafe call takers for police response when call is found to be ineligible (in cases of violence, active suicide, or medical emergency).
Mobile Crisis Response Team (MCRT)	This two-person team provides in-person assistance to a caller in a need. The team is mobile, using a van to respond and transport, if needed.	The team uses trauma informed approaches to assist the caller in need, provide de-escalation, and connect the caller to services, if needed. The team can: 1. Make referrals to services, 2. Transport the person to the hospital (e.g. University of Louisville Emergency Psychiatric Services), 3. Transport the person to respite, and/or 4. Connect the person to friends or family members.
Respite Center	This stabilization space is located at Seven Counties Services Addiction Recovery Center.[3]	The Respite Center provides a space for stabilization, services, and referrals for up to 23 hours. A caller is not required to have a substance use disorder to utilize the respite space. Only individuals dropped off by the MCRT are eligible to use the respite space.

Eligibility Criteria

As noted, the planning phase was guided by an intention to start small and build infrastructure, before expanding. The CCDP pilot is only available to assist callers located in the Fourth Division of Louisville Metro. At its initial launch on March 21, the eligibility criteria for a mobile crisis response were as follows:

1. Call must be received through 911
2. Must be related to a behavioral/mental health crisis
3. Person in crisis is in the Fourth Division of Louisville Metro
4. The call is received between 2PM and 10PM (the only shift MCRTs are available)
5. First-person calls only (caller must be the person in crisis)

The eligibility criteria expanded on March 28 to include the above, and:

[3] An additional factor for using existing SCS space was the space is already licensed by the State and allows for Medicaid billing for any services that would fit.

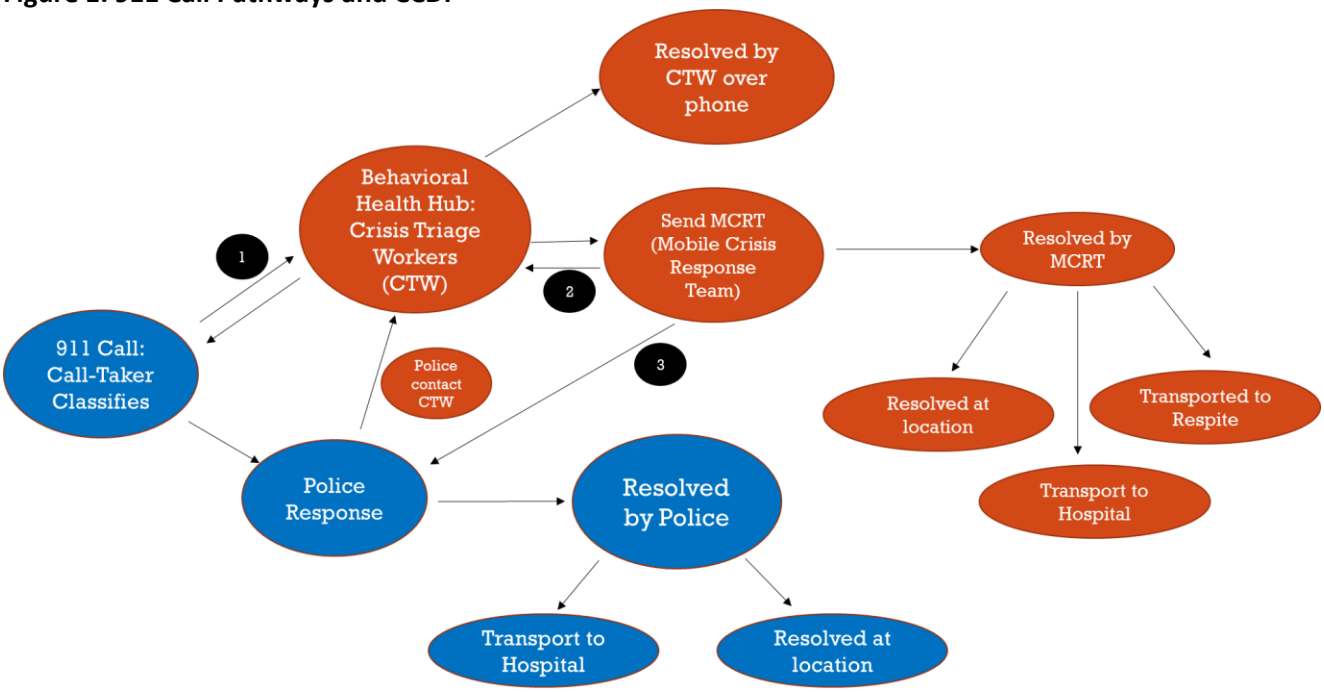
- Second-person calls (caller can be someone familiar with the person in crisis who is physically present at the scene)
- Police in the Fourth Division can call for MCRT response if they determine need while on a scene
- Repeat callers from any division
    - Repeat callers from outside the Fourth Division are eligible for CTW-led de-escalation and service referrals, but not for in-person assistance from MCRTs

Repeat 911 callers are defined as individuals who are known to MetroSafe and/or have a documented call history, have called more than once in the last 3 months and are experiencing a mental health crisis. The caller is not considered a repeat caller if they have not called 911 in the last 3 months.

Calls are not eligible for the intervention if the caller:

- Is in physical possession of a firearm, knife, or other weapon
- Is under the influence of alcohol or drugs to the extent requiring medical intervention (e.g., overdose or detox)
- Is in the process of hurting/killing self or threatening to hurt/kill others
- Requires medical attention because of a self-inflicted injury
- Has known violent tendencies or is exhibiting violent behavior
- Another person at the scene has committed a violent crime

Figure 1. 911 Call Pathways and CCDP[4]



[4] Figure 1 contains three numbers connected to different pathways which indicate, (1) The CTW may send a call back to the call-taker if someone hangs up or if during crisis support the individual provides information that would meet the ineligibility criteria such as stating a medical emergency. (2) The MCRT team may also send a call back to MetroSafe if an event requires police or EMS support, such as an individual demands to speak to the police or needs medical attention, in which MCRTs will notify CTWs who will then notify a call-taker. (3) If the MCRTs experience a safety-related emergency, they are able to use their radio and press the emergency alert button and communicate with dispatch on the mutual aid channel to request immediate assistance, this channel is monitored and available to all emergency responders, so immediate emergency assistant can be sent.

On May 15, 2022, the eligibility criteria were further expanded to include the First Division, which includes the Butchertown, Downtown, Phoenix Hill, Portland, and Russell neighborhoods. Appendix 2 presents the CCDP protocols in effective on May 15th, 2022.

As implemented, the CCDP pilot has several pathways through which a caller can flow. Figure 1 shows these pathways and visualizes the intervention.

The previous paragraphs describe the criteria for CCDP exclusion and inclusion; however, the intervention is complex entailing multiple pathways and outcomes. As such, the following section uses a single case study with four variations to illuminate how the inclusion/exclusion criteria influence processes. The case studies are based on a real 911 call with details altered to obscure identities and to display the multiple pathways. The following case study is set in the Fourth Division and is therefore potentially eligible for the CCDP; however, four factors vary in the case study to change the processes, these factors are: time of day, the presence of violence threats towards others, requirement of an in-person response, and willingness to go to respite. The following scenario is set to the eligibility requirements that occurred during the study period, meaning the March 21 and March 28 criteria are used to guide decision processes. For instance, in these scenarios the police are unable to drop someone off at respite as that did not occur until June 2022

Scenario 1

On May 1, 2022, a 911 call comes into MetroSafe and is answered by a call-taker. The call-taker asks a series of questions beginning with a caller's current address, name, and telephone number. The address is in LMPD's Fourth Division, and the call-taker identifies themselves as David. **The time is 1:20 p.m. (Decision Point 1)** David informs the call-taker that someone came into his house and took his keys and then follows-up by saying there are ghosts in his house and explains that **he believes the ghosts killed his neighbor (Decision Point 2.1)/he believe the ghosts have possessed him and he is going to kill his neighbor with his knife (Decision Point 2.2).**

> **Decision point 1:** Because the call occurred at 1:20, the CCDP is not operating and therefore the call is not eligible to be sent to the CTWs and will therefore be sent to a dispatcher who will mobilize two police officers to respond to the call.
>
> **Decision point 2.1:** The second decision-point is how the call-taker will classify the event and is contingent on what detail the caller provides. In the first scenario (ghosts killed his neighbor), the call-taker is likely to classify the event as a 1014-Deflection Not Available, indicating the event would be appropriate for the alternative responders if they were operating, as no exclusion criteria are present.
>
> **Decision point 2.2:** In the second scenario, the caller indicates an intent and means to cause harm to his neighbor and the call-taker is likely to classify this as a 1014-CIT, which indicates that a police response is necessary regardless of if the intervention was operating.

Moving forward with Decision 2.1: The caller states there are ghosts, they killed his neighbor, and they **want to talk to someone (Decision point 3.1)/wants an in-person response (Decision 3.2).**

Decision point 3.1: When CCDP is not operating, the call-taker has limited options for providing over-the-phone assistance. One option could be to connect to the Crisis & Information line; however, this is unlikely since David is not expressing thoughts of suicide or self-harm.

Decision point 3.2: When the CCDP is not operating, the call-taker's only option for an in-person response is to send the police.

Moving forward with Decision 3.2: Since the call took place at 1:20 p.m., the only option for the individual is to have police respond. As a result, the call-taker sends the run to a dispatcher so they can dispatch a police officer and two officers go enroute to the location. When the officers arrive on scene, they conduct a safety check and determine there is no safety risk to the individual or others.
They are able to locate the individual and engage him to determine his needs. During the conversation, the individual indicates **he volunteers to be transported to respite;** however, officers inform him that they are unable to drop-off at respite but are willing to transport to UofL or OLOP. Donald accepts and the individual is transported.

The above case study follows the traditional behavioral health response identified by the "blue" boxes in Figure 1. The following section uses the same case study and accounts for decision-making processes when the CCDP is operating.

Scenario 2

On May 1, 2022, a 911 call comes into MetroSafe and is answered by a call-taker. The call-taker asks a series of questions beginning with the caller's current address, name, and telephone number. The address is in LMPD's Fourth Division, and the call-taker identifies themselves as David. **The time is 2:20 p.m.** David informs the call-taker that someone came into his house and took his keys and then follows-up by saying there are ghosts in his house and explains that **he believes the ghosts killed his neighbor/he believe the ghosts have possessed him and he is going to kill his neighbor with his knife.**

Decision Point 1: The call took place at 2:20 p.m. in the Fourth Division, meaning the alternative responders are operating and the call may be eligible for CTW intervention, contingent on whether or not the call meets the eligibility criteria.

Decision Point 2.1: If David indicates that **he believes ghosts killed his neighbor,** then a call-taker will likely classify this as a "Deflection" classification meaning it will be sent to CTW.

Decision Point 2.2: If David indicates that he **believes the ghosts have possessed him and he is going to kill his neighborhood with his knife,** then a call-taker will likely classify this as a 1014-CIT due to potential violence and will send it to dispatchers to dispatch the police.

CCDP provides another resource for police. If Decision Point 2.2 was the condition, then police would be dispatched and would follow the same procedures outlined in the first case study, where two officers would respond and conduct a safety check and then engage the individual to identify their needs. In this scenario, if officers arrive and determine there is **no safety concern**, officers can determine if they are going to attempt to provide support to the individual or they can contact MetroSafe and be connected to the CTW. If they handle the event themselves, then the options noted in the previous case study apply. If they contact MetroSafe and are connected to the CTW,

they will inform the CTW of the situation and then the CTW can either contact the individual via phone and/or dispatch the MCRT. Officers are then able to decide whether they will clear the scene or wait for the CTW and/or MCRT to make connection. **If** the police make the connection to the CTW, then next sequence of events follows in the next paragraph.

Moving forward with Decision Point 2.1: The call-taker determines the call is eligible for CCDP and informs David that he will be transferred to the CTW. A warm hand-off occurs between the call-taker and CTW to build rapport and ensure the caller stays on the line. Once the CTW takes over the call the CTW asks a series of questions, including whether or not the individual is a current client of SCS, which the individual indicated they were. During the discussion the individual was animated in verbal discussion of current situation and the CTW is able to ascertain that the individual was upset about missing keys and connected the situation with neighborhood conspiracies and a haunted living space. During the conversation the CTW helped the individual identify their emotional state and de-escalate from a state of agitation, while developing a safety plan with the individual that includes family and mental health professionals as part of his support structure. During the conversation the CTW confirmed that the individual had no thoughts of hurting himself or others, nor any weapons. CTW asked if an individual would like MCRT dispatched, and David indicated **he just wants to talk/requests in-person response.**

Decision Point 3.1: If the caller indicates they do not want a MCRT response and only wants to talk, the CTW will then stay on the line with the caller and continue to offer the caller needed support until they feel stabilized and wish to end the phone call.

Decision Point 3.2: If the caller indicates they do want an in-person response, then the CTW is able to dispatch the MCRT team.

Moving forward with Decision Point 3.2. David indicated he wished to have the MCRT dispatched. While MCRT was enroute, the CTW continues the conversation and continues to stabilize the individual by modeling slower speech and breathing to assist further de-escalation. Once the MCRT team arrives, the CTW is able to inform David of their arrival and requests he meets them at the front door. The MCRT team meets the individual at the front door and completes a warm hand-off with the CTW. While the MCRT team was enroute they were able to review what services were being provided to the individual and be aware of crisis support provided by the CTW. As a result, MCRT is able to continue engagement with David regarding their safety plan and provide additional resources. During the conversation, MCRT asks David if they can connect him with family or friends or take him to respite and he indicates that he **wants to go to respite/does not want to go to respite.**

Decision Point 4.1: The MCRT can drop individuals off at the respite care space which is located at SCS Addiction Recovery Center. The CCDP includes a “a place to go” and the MCRT team is able to take someone to respite and it is not required the individual has addiction-related issue.

Decision Point 4.2: If David does not want to go to respite, the MCRT team will continue to use trauma-informed care to develop a plan to ensure David feels safe and secure. This may include stabilizing David on site, transporting David to a friend or family member, or transporting David to a hospital if that is what he needs.

Moving forward with Decision point 4.1. MCRT acknowledges his request and contacts respite to inform them of an individual who wishes to come to respite and coordinates drop-off. MCRTs voluntarily transport David to the respite space and once they arrive, they meet a respite care worker in the lobby to conduct a warm hand-off and the respite care worker is then able to take David inside for assessment and then taken to the respite space that includes gentle lighting, snacks, games and television, and a clean bed. David is able to stay at respite for up to 24 hours and is able to leave any time he wishes. The MCRT is then able to leave the location and becomes available for the next call.

In summary, the previous two scenarios display the multiple decision-points involved in the CCPD. In effect, call-takers are the primary gatekeepers to accessing the CCDP. However, the police, CTWs, MCRTs, and respite space also serve as gatekeepers as they use their knowledge and expertise to determine the appropriate support and resources David needs. The case studies provide a general overview, and it should be noted that there is greater nuance, for instance, a call may be sent to the CTWs and during the CTW's intervention an individual indicates they have the means and intent to harm themselves, in that scenario the CTW will send it back to a call-taker so emergency responders can be dispatched. The purpose of this report is to examine model processes and outcomes during the CCDP's first seven weeks.

Staffing and Hiring

SCS and MetroSafe identified multiple positions needed to establish and staff the pilot program. Table 2 below summarizes the staffing model and recruitment to date.

Table 2. CCDP Positions

Position	Agency	Budgeted Positions	Positions Hired	Current Positions Filled
Program Manager	MetroSafe	1	1	1
Project Manager	SCS	1	1	1
Supervisor	SCS	3	1	1
Crisis Triage Worker	SCS	9	2	2
Case Manager	SCS	3	4	3
Mobile Crisis Response Specialist	SCS	9	2	2
Mobile Crisis Response Worker	SCS	9	4	3
Mobile Response Direct Care Counselors[1]	SCS	4	0	0
Mobile Response Senior Clinician[1]	SCS	3	0	0

[1] Positions are covered with existing employees; however, no full-time dedicated people have been hired.

During the pilot phase both agencies have hired their project manager, with SCS being in place throughout the planning period and MetroSafe's project manager coming on board in May 2022.[5] To date, Seven Counties Services has been able to hire 13 individuals to fill roles, however, two employees have left, leaving them with 11 current employees dedicated CCDP, plus the project manager. Positions for mobile response direct care counselors and mobile response senior clinicians are being filled with existing employees. Prior to and during the pilot, a total of 85 applications were submitted for SCS

[5] In Fiscal Year 2023, MetroSafe intends to hire 10 additional call-takers to assist with CCDP and nurse triage call volume. The hiring will be contingent on filling existing posted positions.

deflection positions, with 73 unique individuals. 31 individuals were interviewed for positions and 15 offers made.[6]

To attract the best possible candidates, and under encouragement from members of the original planning team, SCS increased the baseline wage rate for employees in the wage category for which mobile crisis response staff were being hired. Additionally, SCS modified position requirements in official job postings to accommodate prior practical experience that may not be reflected in degree requirements alone. The qualifications for each of SCS's positions are as follows:

1. **Crisis Triage Worker** are required to have at least 1 year of human services experience and a bachelor's degree.
2. **Mobile Crisis Response Workers** (Mobile Crisis Responders) are required to have at least 1 year of lived experience with GED/high school diploma and National Peer Support Specialist (NPSS)/Kentucky Peer Specialist (KPS) certification required within twelve months of hire or minimum of 3 years of experience in human services.
3. **Mobile Crisis Response Specialists** (Mobile Crisis Responders) are required to have at least a bachelor's degree and a minimum of 2 years social service/human service experience; one year may be substituted if holding a master's degree.
4. **Mobile Response Senior Clinicians** (Mobile Response Sr. Social Worker/Mobile Response Sr. Therapist) is required to have a master's degree in a behavioral health field, state certification or licensure in their discipline, and a minimum of 2 years' experience, post master's degree.
5. **Mobile Response Program Supervisor** is required to have a bachelor's degree in a human service field with three to four years' experience with case management/service coordination services including some supervisory experience and program development/oversight experience.
6. **SCS Project Manager** will be required to have a master's degree in a human service field with three to four years' experience with case management/service coordination services including supervisory experience and program development/oversight experience.
7. **Mobile Response Case Managers** are required to have a bachelor's degree in a human service field and a minimum of one year experience post bachelor's working in a human service setting, or with relevant master's degree, no experience.
8. **Mobile Response Direct Care Counselors** for the respite center are required to have a bachelor's degree with minimum one year of social service or related field experience.

All applications were phone screened for minimum criteria, then a team from SCS and a member of the community engagement team identified and invited applicants for interviews. Interviews began in February 2022 and are ongoing has applications are received. Interviews have taken place over Zoom.

Training

The SCS contract with MetroSafe states that each member of the mobile crisis response team (CTWs, mobile crisis response specialists, and mobile crisis response workers will get 80 hours of training in mobile crisis response, de-escalation, risk assessment and response, safety, emergency planning, and other areas. The original planning team authored a training document that was primarily followed by SCS during the CCDP pilot. Official training is presented in Table 3; status is noted as completed or

[6] Three individuals refused an offer. Two accepted positions elsewhere and one cited the hours available as the reason to decline the offer.

ongoing. The ongoing training noted below reflects training activities that not all employees have completed to date. For some activities such as shadowing and field trips, the training is ongoing as new opportunities emerge. For training on Trauma Resilient Communities, employees are waiting for their scheduled training time.

Table 3. Alternative Responder Completed and Ongoing Training[7]

Training Activity	Personnel Trained	Status
Shadowing and Field Trips: SCS Homeless Outreach Team, SCS Adult Services Engagement Team, SCS ACT/I-ACE, SCS Adult Crisis Team, SCS Recovery Zone, SCS Peer Fit, SCS Adult Outpatient Services, MetroSafe, LMPD Headquarters, UofL Hospital EPS, SCS Addiction Recovery Center/Respite Center, St. Mary and Elizabeth's, UofL Peace Hospital, Men's Healing Place, Hope Village, Louisville Recovery Community Connection, Falls City Community Bikeworks, Wellspring CSU, neighborhoods in Fourth Division	CTWs, MCR Specialists, MCR Workers, Case Managers	Ongoing
SCS Crisis and Information Center Coaching/Training	CTWs	Ongoing
Trauma Resilient Communities Training (24-credit hours, see more details here: https://louisvilleky.gov/government/office-safe-healthy-neighborhoods/samhsa-trauma-resilient-community-project)	CTWs, MCR Specialists, MCR Workers, Case Managers	Ongoing
Role Playing using deidentified 911 call examples from the Fourth Division (4-5 hour sessions)	CTWs, MCR Specialists, MCR Workers, Case Managers, CIC staff	Completed
On the job coaching with 911 call takers (call takers helping CTWs work through real calls)	CTWs	Ongoing
On the job consultation with SCS CCDP Leadership Team (check-ins with SCS supervisor and project manager on next steps before final call disposition and prior to all referrals)	CTWs, MCR Specialists, MCR Workers, Case Managers	Ongoing
Written Training Binder	CTWs, MCR Specialists, MCR Workers, Case Managers	At hire, Completed

Evaluation Approach and Methodology

The CCDP pilot evaluation includes both a process and impact evaluation centering on four research questions:

- To what extent was the CCDP implemented as designed, and how was it adapted to meet community needs and expectations? (Process)
- To what extent do individuals in crisis receive needed assistance and what type of assistance is provided? (Process)
- How does the CCDP contribute to community safety? (Impact)
- What are the economic implications of the deflection efforts? (Impact)

[7] Descriptions of class-room and online training curriculum can be provided upon request.

This mixed-methods evaluation used both quantitative and qualitative data to answer these questions and provide insight into the first seven weeks of the pilot and expansion potential across Louisville Metro. Table 4 below summarizes the methodological approaches used in each research question. Following the table, we include a detailed description of each component of the evaluation.

Table 4. Research Questions and Methods

Research Questions		Research Methods
To what extent was the alternative responder model implemented as designed? How was it adapted to meet community needs and expectations?	Process	• One-on-one qualitative interviews with responders and administrators • Community focus groups and listening sessions • Descriptive quantitative data analysis
To what extent do individuals in crisis receive needed assistance and what type of assistance is provided?		
How does the alternative responder model contribute to community safety?	Impact	• One-on-one qualitative interviews with responders and administrators • Community focus groups and listening sessions • Descriptive quantitative data analysis • Cost-benefit analysis
What are the economic implications of the deflection efforts?		

Quantitative Methodology

Data Sources

Quantitative data included data from Louisville Metro Emergency Management Services (MetroSafe) 911 Computer Aided Dispatch (CAD) system, Seven Counties Services Deflection Electronic Health Records, and Louisville Metro Police Department (LMPD) Crisis Intervention (CIT) Reports. The MetroSafe CAD data for LMPD events and LMPD CIT reports contain data from June 1, 2019, to May 8, 2022. The MetroSafe CAD and Seven Counties Services CCDP data range from March 21, 2022, to May 8, 2022.

Data Analysis

All data were cleaned and coded using Stata 13. The data were then summarized for each of the following questions:

- What percentage of calls were deflected to the mobile crisis responders?
- What were the types of CIT calls deflected to the mobile crisis responders?
- Of the identified calls for deflection, what percentage required a mobile response?
- What percentage of CIT calls received LMPD response?
- What percentage of LMPD dispatches could have been diverted?
- What percentage of mobile crisis responders' responses resulted in a subsequent call to emergency responders for additional support?
- What were the trends in calls overall, and those deflected to mobile crisis responders, by time/day/month?
- What was the average time per call referred to the Behavioral Health Hub?

- What was the timeframe for a mobile crisis responder response?
- What was the number of citations and arrests for CIT dispatches?
- Of the calls identified for deflection, what percentage received a mobile response?
- What services do the mobile crisis responders provide?
- What percentage of individuals who received a mobile crisis response required transportation away from the scene of crisis?
- How did individuals utilize the Respite Center?
- To what resources were individuals linked following CCDP?
- How has the frequency of calls from 911 familiar callers changed?

Qualitative Methodology

There are two separate components of the qualitative methodology, including:

1. Interviews with administrators, first responders, and alternative responders
2. Community listening sessions

A detailed description of participant recruitment, data collection, and data analysis related to the qualitative methods are provided below.

Participant Recruitment

Interviews with Administrators, First Responders, and Alternative Responders

These interviews involved three sets of stakeholders: (1) *First Responders* (e.g., police, dispatchers, call takers); (2) *Alternative Responders* (Crisis Triage Workers, Mobile Crisis Response Team workers, Respite workers, and Case Managers); and (3) *Administrators* (police, 911 call center, Seven Counties Services). Two rounds of interviews were conducted to capture people's perceptions prior to or within the first week of the intervention. The second round of interviews took place 1 month or later into the intervention to examine how perceptions and experiences operating within the intervention had changed.

Given that the intervention design touches multiple agencies and responder types, researchers used purposive sampling to target administrators from Louisville Metro Emergency Services, Louisville Metro Police Department, and Seven Counties Services. Throughout the report, anyone with supervisory capacity was identified as an administrator, and researchers did not identify the rank or specific role of any administrator to ensure participant confidentiality in accordance with ethical research standards. Researchers also used purposive sampling to recruit call-takers dispatchers, officers, crisis triage workers, mobile crisis response team members, respite workers, and case managers. In the subsequent sections the analyses groups call-takers, dispatchers, and police officers as first responders and crisis triage workers, mobile crisis response team members, respite workers, and case managers as alternative responders. This approach was taken as there are too few alternative responders to identify their roles without revealing their identities.

Community Listening Sessions

Community listening sessions were conducted in April and May 2022. The purpose of these sessions was:

1. To provide community members with information about the model and implementation progress.
2. To collect community feedback on the model to inform potential expansion and sustainability.

Participation was solicited through personal invitation with existing networks, social media posts and outreach, and in partnership with community organizations that agreed to disseminate information about the listening sessions on behalf of the evaluation team. Organizations that helped with recruitment include:

- Louisville Metro Public Health and Wellness Department (various programs)
- Seven Counties Services
- 490 Project
- Feed Louisville
- Hope Village
- Kentucky Alliance Against Racist and Political Repression
- Louisville Political Education for Liberation
- Louisville Standing Up for Racial Justice
- Spalding University
- University of Louisville
- The Bail Project

Data Collection

Interviews with Administrators, First Responders, and Alternative Responders

The Consolidated Framework for Implementation Research (CFIR) was used as a guide for studying implementation of the CCDP, as the CFIR is designed to help capture the multiple dimensions of implementing a new intervention. The CFIR informed two interview guides, one for interviews with administrators and a second for interviews with alternative responders and first responders. There was considerable overlap for administrator questionnaires versus alternative responders and first responder questionnaires, the difference being the volume of questions related to hiring decisions, planning, and other administrative roles. Both questionnaires asked respondents about the relative advantage, communication, knowledge and awareness, evaluation, training, compatibility, and adaptability of the intervention. The use of CFIR ensured the interviews were addressing key issues from the points of view of administrators, first responders, and alternative responders, allowing for triangulation of perspectives, comparing and contrasting how each group defines the need for the intervention, perceptions of success, knowledge, and their safety concerns, among other issues.

All interview, focus group, and listening session data was recorded and transcribed for analysis.

Community Listening Sessions

Phase 1: Community Listening Session

The research team purposely selected community members to participate in community listening sessions. The purpose of the community listening sessions was to qualitatively explore the knowledge, attitudes, beliefs, and perceptions of the alternative responder model. Researchers used the in-depth qualitative focus group guide to engage with participants, and all focus groups were recorded and transcribed upon completion. Data was collected until “theoretical saturation” occurred. At each community listening session, participants were asked to complete a survey. The survey assessed sociodemographic characteristics (i.e., age, race, ethnicity, gender, and socioeconomic status).

Phase 2: Member Checking Focus Group

To increase the credibility of the first set of analyses, a member checking focus group was conducted.[xv] Participants were selected through systematic invitation.[xvi] A list of all survey participants was developed and focus group participants were randomly drawn from the list.[xvii]

Peer Debriefing- This research study utilized peer debriefing techniques during the data analysis process. During coding, all members of the research team discussed any disagreements through peer debriefing until the group came to a consensus on the analysis. The data was coded into themes. Discussion of the themes and the selection of supporting quotations ensued until all researchers reached a consensus.

All focus group and listening session data was recorded and transcribed for analysis.

Data Analysis

Interviews with Administrators, First Responders, and Alternative Responders

Interviews were recorded, transcribed, and the transcriptions were cleaned to remove identifying information. Once the transcript was cleaned, copies of the recording and original transcript were deleted and only deidentified records were kept to protect responders' identities. Researchers used Atlas.Ti qualitative analysis software to analyze interview data and MetroSafe 911 narrative information. The analysis itself was conducted using the tradition of grounded theory[xviii] This tradition uses an inductive research design at the beginning of the research to discover any latent, non-apriori patterns that might emerge from the data.[xix] Themes and subthemes were identified using open and axial coding. To ensure these themes existed, comparison among data, concepts, and themes were regularly made during the overall iterative coding process. Findings regarding themes were validated after being compared with new findings generated from different subsets of the data. Inter-coder reliability was checked for all themes and subthemes, with a 97.3% agreement rate. Where disagreements occurred, researchers discussed the findings until agreement could be reached, with the project PI making final decisions on codes when agreement could not be reached.

Community Listening Sessions

A constructivist analytic approach grounded the analysis using Dedoose software as an organizational tool.[xx] Researchers trained in qualitative data analysis and who have experience with constructivist grounded theory conducted the analysis.[xxi] The research team, including several individuals who had conducted interviews, conducted open (line by line) coding independently on three listening session transcripts. The research team grouped initial codes by topic and developed a codebook consisting of focused codes. The team utilized the most frequently recurring and substantive focused codes to develop a codebook. After focused coding was complete, the coders identified relationships among the codes and reached a consensus on initial themes. This iterative process served to identify segments in which codes did not agree, so that coders could address and edit the code segments and move forward with accurately coded material.[xxii]

Cost Benefit Methodology

Data Sources

The cost analyses relied on secondary data from MetroSafe and LMPD as well as data reported and analyzed under RQs 1-3. Researchers used these data sources to construct a cost-effectiveness model to compare costs of the alternative responder model with those that would have existed in its absence based on estimated costs of traditional LMPD response.

Internal data was also used on the costs of the deflection program in terms of salaries, benefits, and other overhead costs associated with CIT, as well as the costs of any care the Respite Center provided.

Data Analysis

A combination of cost-effectiveness analysis (CEA) and cost-benefit analysis (CBA) were conducted. The distinction is that CBA is used when the effect is measured in dollars, while CEA is used when the effect is not translated into dollar values (e.g., police time released).

Incremental costs were calculated and incremental effects of the CCDP model with respect to the current practice. The analyses also projected and then compared how the findings would differ under several alternative scenarios, where one or more of the underlying variables were changed in the model to estimate the effects. This created projected costs or benefits associated with potential responses that could be implemented in the future.

Limitations of the Evaluation

This evaluation has several limitations.

1. The timeframe in which the pilot has been implemented is short, a total of just seven weeks. This short implementation period limits any measurement of client health outcomes or any causal inference about the effects of the CCDP. Further, this phase of implementation included a cautious roll-out and several adjustments and adaptations. At this point in our evaluation, the data are simply too limited to draw any final conclusions.
    a. Recognizing the need for measuring longer term outcomes, the evaluation team has been involved in conversations about strategies for measuring health and systemic impacts, should the evaluation be extended.
2. Relatedly, the short timeframe of the evaluation limited more extensive community outreach and input. This type of intensive community outreach relies on relationship building and partnerships, many of which were established during the evaluation. However, the time constraints prevented any sessions focused specifically on future planning specific to CCDP.
3. The short timeframe also limited the ability of researchers to interview or survey individuals who have interacted with CCDP, which could provide valuable insight for improving processes and ensuring responses are meeting people's needs.
4. The cost analyses and scenario development in consideration of future expansions rely extensively on assumptions that may or may not end up being true. To the extent possible, this element of the evaluation used real, historical data to establish assumptions. However, any changes in future implementation could substantially alter the cost projections.
5. The types of crisis support, treatment, and/or referrals made for individuals brought into respite were not obtained by researchers, as these data were not in Seven Counties Services "deflection" data. As a result, researchers could not show if respite provided additional services, although the small number of individuals taken to respite would have restricted our ability to draw conclusions.
6. Researchers were unable to validate behavioral health call classification patterns. Attempts were made to analyze all 911 behavioral health calls for inclusion/exclusion criteria to determine the reliability and validity of properly coding calls as deflection or deflection not available. The inability is related to third-party callers being ineligible for deflection and CAD not

indicating caller-type. Thus, researchers cannot determine if a call stating that "Joe is wandering around talking to ghosts" and classified as 1014-CIT, not eligible for deflection, is an incorrect classification or the caller was third-party and therefore an accurate classification.

7. The economic analysis reflects metro government's perspective, not that of society. From a societal perspective, the deflection efforts may improve other community outcomes such as a potential decrease in numbers of arrests, hospitalizations, and deaths, or an increase in community trust in police and equality. The timeframe allocated for the intervention was too short for researchers to capture these benefits; future work could quantify them in greater detail and incorporate them into the analysis of program benefits. As a result, to the extent that these other benefits exist, our current measure of benefits in terms of resources saved will understate potential societal benefits of the program.

What Happened During the Intervention?

Crisis Call Diversion Program Pilot Implementation, by the Numbers

How Many Calls Come into MetroSafe 911 Center?

This analysis begins by looking at the historical trends in LMPD 911 events, as LMPD has been the default behavioral health response for 911 calls prior to the intervention launching. The data includes events created involving LMPD alone or in combination with Fire and/or EMS or events created and sent to CCDP. Events where other law enforcement agencies in Jefferson County were the lead agency were not included in the study. It is also important to note, this report uses events and dispatches interchangeably to refer to the volume of calls-for-service and self-initiated activity by LMPD. These historical trends help demonstrate how many behavioral health calls are sent to LMPD historically, and if and how they have shifted during the intervention period.

It is important to state the limitations of the data. The CIT event is designated by the call-taker using what is known at the time of the call and information is not consistently updated in internal MetroSafe data systems. Therefore, some events designated by call-takers with one code (e.g., missing persons) may turn out to be CIT and some events designated CIT may not actually result in a person in crisis. MetroSafe does not keep records of the initial and final 10-code designation, so it is not possible to determine the number of CIT events with perfect accuracy. In this study, we use all 1032-Trouble/CIT run designated events to estimate the volume of CIT events for Louisville Metro Police Department from June 1, 2019, to March 20, 2022, and all 1014 mental health designated events and "Deflection" events from March 21, 2022 to May 8, 2022. Table 5 provides a list of behavioral health call type designations, a brief description of the event type and the timeframe the designation was in use for LMPD and Seven Counties Services. As shown in Table 5, LMPD event type "1014-deflection not available" and Seven Counties Services event type "Deflection" have the same classification criteria, therefore, "1014-deflection not available" counts indicate responses that could go to "Deflection" if they were operating 24/7 and in all divisions.

Table 5. MetroSafe Behavioral Health Event Designations for LMPD and SCS Deflection

LMPD Event Designation	Description	Time Frame
1032-Trouble: CIT	1032-CIT was a subcode of 1032 Trouble and included events that met one or more of the following situations: Assist EMS with a Mental Patient, Mental Inquest Warrants, Attempted/Threatening Suicides, confirmed information of a history of mental illness, complain of unusual or abnormal behavior, and known abuse and or overdose of drugs or alcohol.	June 1, 2019-March 20, 2022
1014-Mental Health: MIW	Used for serving a Mental Inquest Warrant including self-initiation by officers.	March 21, 2022-present
1014-Mental Health: Assist Deflection	Used if the Mobile Response Team needs police assistance non-emergency.	March 21, 2022-present
1014-Mental Health: CIT	Used for all CIT's that do not meet deflection criteria i.e., weapons in possession.	
1014-Mental Health: Deflection Not Available	**Call fits the deflection criteria** but is refused by the caller, the CTW is not available, the call is not in the Fourth Division, or the call is transferred back to a 911 operator from the CTW.	March 21, 2022-present
SCS Deflection		
Deflection	**Call fits the deflection criteria** including 1st or 2nd party callers, repeat callers in any division	March 21, 2022-present

Table 6 presents the number of events that were sent to LMPD between June 1, 2019 and March 20, 2022, and the number of events that went to LMPD or SCS Deflection between March 21 to May 8, 2022. CIT events include all behavioral health designations including the 1032-CIT, 1014-mental health sub codes, and SCS Deflection events. The "Other" event types include all other LMPD events including shootings, general trouble runs, missing persons, traffic accidents, and various self-initiated activities.

During the entire period there were 60,936 behavioral health designated events, making up 5% of all events across the period.

The period from January 1 to March 20, 2022, saw the highest percentage of CIT calls compared to overall events, but this was due to an abnormally low event volume for LMPD. The intervention period between March 21 to May 8, 2022, was 5% and comparable to other periods and the overall totals since 2019.

Table 6. LMPD and Deflection Event Type by Year*

	2019- June 1 to Dec 31	2020	2021	2022-Jan 1 to Mar 20	2022-Mar 21 to May 8	Total
CIT	12,362 (4%)	20,149 (4.6%)	20,816 (4.6%)	4,882 (11.8%)	2,846 (5%)	60,936 (5%)
Other	293,072 (96%)	416,513 (95.4%)	435,322 (95.2%)	36,495 (88.2%)	53,069 (95%)	1,234,471 (95%)
Total	306,540	436,662	456,138	41,377	55,915	1,295,407

*Data is from MetroSafe CAD data for all LMPD CAD events and SCS Deflection CAD Events

As noted above, Table 6 presents all event types including those where people call 911 and ask for assistance and events where police officers self-initiate activity. LMPD designates directed patrol and officer-initiated activities as "self-initiated" activity, meaning the officer-initiated contact with MetroSafe regarding an issue they witnessed or notifying dispatch of a directed patrol activity.[8] Events generated by the public are referred to as "calls-for-service" (CFS). This report uses CFS when referring to public generated calls (e.g., calling 911) and self-initiated when referring to officer-generated activity.[9] Table 7 indicates that across the timeframe, 31% of events are self-initiated and 69% are calls-for-service.

Table 7. LMPD and Deflection Events by Self-Initiated versus Calls for Service by Year

	2019-June 1 to Dec 31	2020	2021	2022-Jan 1 to Mar 20	2022-March 21 to May 8	Total
Self-Initiated	87,330 (29%)	130,122 (30%)	159,056 (35%)	12,797 (31%)	16,588 (30%)	405,893 (31%)
CFS	218,104 (71%)	306,540 (70%)	297,082 (65%)	28,580 (69%)	39,208 (70%)	889,514 (69%)
Total	306,540	436,662	456,138	41,377	55,796	1,296,513

Since a substantial portion of events are self-initiated, examining behavioral health events in the context of all events distorts the percentage of 911 calls where people require assistance for a behavioral health event. Table 8 presents the number of behavioral health events that originated as calls-for-service and compares it to all other calls-for-service.

Across the timeframe and in the intervention period, 7% of all 911 calls for service were labeled as a behavioral health event.

Table 8. LMPD and Deflection Calls for Service for Behavioral Health Events by Year

	2019-June 1 to Dec 31	2020	2021	2022-Jan 1 to Mar 20	2022-March 21 to May 8	Total
CFS-CIT	11,719 (6%)	19,164 (7%)	19,722 (7%)	4,641 (18%)	2,469 (7%)	57,715 (7%)
CFS-Other	187,202 (94%)	259,269 (93%)	247,774 (93%)	21,356 (82%)	32,746 (93%)	525,347 (93%)
Total	198,921	278,433	267,496	25,997	35,215	806,062

[8] LMPD defines self-initiated activity as "Any duties performed by patrol officers that are proactive in nature. Self-initiated activity includes detecting and deterring crime, providing a visible presence of law enforcement in the community, and assistant the public as needed or as appropriate. Self-initiated does not include general patrol, administrative duties, or personal business (e.g., getting gas, eating meals, etc.)" (LMPD Standard Operating Procedure 1.11.1).

[9] MetroSafe CAD data did not include an indicator that separates CFS from self-initiated activity. To calculate the number of self-initiated calls, researchers designated all LMPD event types 1011 (directed patrol) and 1054 (field interrogations) as self-initiated activities and any event where the police were dispatched and arrived in under 30 seconds as self-initiated activity. As such, the measures for self-initiated is a conservative estimate that likely undercounts self-initiated activity and over counts calls for service.

Table 9 presents the breakdown in behavioral health events in 2022 by LMPD division. The data indicates relative stability in the number of events before and after the intervention started.

The Fourth Division continues to have the highest number of behavioral health related events, with 888 events between Jan 1 and March 20, 2022, and 670 between March 21 and May 8, 2022. The First Division had the second highest volume with 814 and 452 events, respectively.

These data reinforce the decision to pilot the CCDP in the Fourth Division and partially explain why the intervention expanded to the First Division.

Table 9. Frequency of LMPD and Deflection Events by Type in 2022 by LMPD Division[10]

	2022- Jan 1 to Mar 20			2022- Mar 21 to May 8		
	CIT	Other	Total	CIT	Other	Total
First (%)	814 (7%)	10,579 (93%)	11,393	452 (6%)	7,166 (94%)	7,618
Second (%)	464 (13%)	3,209 (87%)	3673	313 (5%)	6,454 (95%)	6,767
Third (%)	619 (13%)	4,179 (77%)	4798	355 (6%)	5,510 (94%)	5,865
Fourth (%)	888 (17%)	4,380 (83%)	5268	670 (7%)	8,328 (93%)	8,998
Fifth (%)	284 (11%)	2,358 (89%)	2642	257 (7%)	3,703 (93%)	3,960
Sixth (%)	453 (12%)	3,331 (88%)	3784	307 (5%)	5,622 (95%)	5,929
Seventh (%)	395 (10%)	3,729 (90%)	4124	213 (3%)	6,606 (97%)	6,819
Eighth (%)	730 (20%)	2,889 (80%)	3619	263 (5%)	4,851 (95%)	5,114
Total (%)	4,882 (12%)	36,495 (88%)	41,377	2,846 (5%)	53,069 (95%)	55,915

Summary. The data to this point shows the total number of MetroSafe CAD generated events for LMPD and SCS Deflection between June 1, 2019 and May 8, 2022.

- During the entire period there were 60,936 behavioral health designated events, making up 5% of all events across the period.
- Across the timeframe and in the intervention period, 7% of all 911 calls for service were labeled as a behavioral health event.
- The Fourth Division continues to have the highest number of behavioral health related events, with 888 events between Jan 1 and March 20, 2022, and 670 between March 21 and May 8, 2022. The First Division had the second highest volume at 814 and 452 events, respectively.

Understanding Behavioral Health Events During the Intervention

This section focuses on the intervention period which began on March 21, 2022. The following section uses data from March 21 to May 8, 2022, from MetroSafe's 911 CAD system for LMPD and SCS Deflection and SCS Deflection Electronic Health Records. The following tables compare the Fourth Division to the First Division, Fifth Division, and All Divisions combined. The First and Fifth were chosen

[10] The analysis uses LMPD patrol divisions as the primary geographic variable. LMPD's Fourth Division was selected as the pilot location due to it having the highest volume of behavioral health events. The continued use of LMPD's patrol divisions is also advantageous for MetroSafe 911 communication specialists as once they enter an address it automatically designates the patrol division, both letting the communication specialist know if the call is eligible for the intervention and recording the division in which the event is occurring. As a result, the evaluation team examines LMPD activities and SCS Deflection activities by LMPD patrol division.

as reference divisions due to the recent expansion to the First Division and the Fifth Division having the second highest SCS Deflection event volume.

Table 6 displays the type of behavioral health event between March 21 to May 8, 2022, for all shifts and the Fourth, First, Fifth, and All Divisions. The most common behavioral health event type was a 1014-CIT, which is designated as a police only behavioral health event that involves violence, a weapon, active suicide, medical emergency, or one of the other Deflection exclusion criteria**.** In the Fourth Division, 76% of all behavioral health events were "1014-CIT", while 8% were designated as "SCS Deflection" and 11% were coded "1014-Deflection Not Available". "Deflection" and "1014-Defleciton Not Available" use the same classification criteria. However, the "1014-Deflection Not Available" are sent to LMPD while "Deflection" are sent to SCS alternative responders. "1014-Deflection Not Available" is available for all divisions and is sent to the police for response. If SCS Deflection was operating 24/7 in the Fourth Division during this period, there were 125 events eligible for deflection (55 Deflection + 70 Deflection Not Available) or 19% of all CIT events eligible.

The First and Fifth Division also had 11% of their CIT events coded as "1014-Deflection Not Available", and examining All Divisions, 12% of events were "Deflection Not Available". The data indicate that if the intervention was operating 24/7 across all divisions a total of 361 events (342 "Deflection Not Available" and 119 "Deflection") could have been eligible for SCS Deflection. However, this analysis looks at all shifts and the intervention were only operating between 2 p.m. and 10 p.m., so these data show what could have happened if operating 24/7 and across all divisions.

16% of all behavioral health 911 calls were classified as "Deflection" or "1014 Deflection Not Available" meaning they were eligible for deflection.

Table 10. Number of Behavioral Health Events by Event Designation and Selection Divisions, March 21 to May 8, 2022.

	Fourth Division (%)	First Division (%)	Fifth Division (%)	All Divisions (%)
1014-CIT	496 (76%)	369 (82%)	197 (77%)	2,190 (78%)
1014-MIW	38 (6%)	29 (6%)	9 (4%)	161 (6%)
1014-Assist Deflection	7 (1%)	0	1 (0.4%)	10 (0.4%)
1014-Deflection Not Available	70 (11%)	49 (11%)	24 (9%)	342 (12%)
Deflection	55 (8%)	3 (1%)	24 (9%)	119 (4%)
Total Unique Mental Health Events	651	452	257	2,820

Table 11 describes how behavioral health events were designated during the intervention time period and when the intervention was operating (between 2 p.m. and 10 p.m). This table begins to show how the intervention is operating, starting with the event designations. During the operational hours of the intervention in the Fourth Division:

17% of behavioral health events were designated "Deflection", meaning that during the intervention SCS alternative responders responded to 55 events. Another 12 events (4%) were coded "1014 Deflection Not Available," meaning they were eligible for deflection.

The Fifth Division had six "1014-Deflection Not Available" events and twenty-four "Deflection" events, while the First Division had sixteen "1014-Deflection Not Available" events and three "Deflection" events. Only events involving an identified frequent caller were eligible to be sent to the CTWs if outside the Fourth Division. As such, all "Deflection" designated events outside the Fourth Division were frequent callers.

During the pilot period (days and time-of-day), there were 119 Deflection events across all divisions, with 55 or 46% of all Deflection events occurring in the Fourth Division.

In the Fourth Division 21% of all behavioral health calls are classified as deflection-eligible; that number drops to 16% for all divisions.

Table 11. Number of Behavioral Health Events by Event Designation and Selection Divisions, between 2 p.m. and 10 p.m., March 21 to May 8, 2022.

	Fourth Division	First Division	Fifth Division	All Divisions
1014-CIT	229 (71%)	164 (85%)	94 (72%)	957 (77%)
1014-MIW	19 (6%)	11 (6%)	5 (4%)	74 (6%)
1014-Assist Deflection	6 (2%)	0 (0%)	1 (1%)	7 (1%)
1014-Deflection Not Available	12 (4%)	16 (8%)	6 (5%)	92 (7%)
Deflection	55 (17%)	3 (2%)	24 (18%)	119 (10%)
Total Behavioral Health Events	321	194	130	1,249

As this is a new intervention one would expect that time will improve processes which will in turn increase the volume of behavioral health calls being transferred to alternative responders. Figure 2 displays the type of behavioral health events for the Fourth Division during the 2 p.m. to 10 p.m. time frame March 21 to May 8. The green line represents Deflection designated calls and shows an overall steady increase in the number of calls transferred to the alternative responders.

Figure 2. Frequency of Behavioral Health Events by Week, Fourth Division.

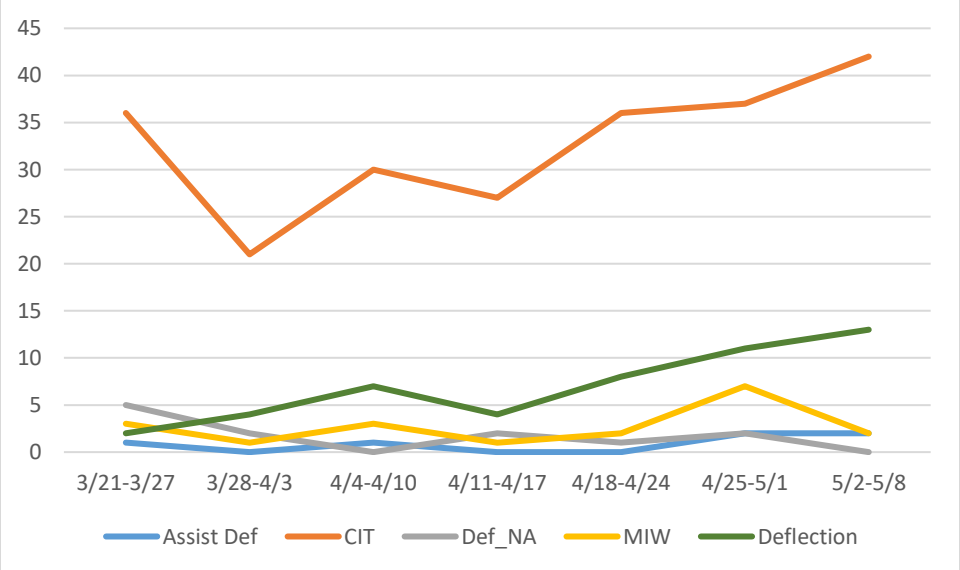


Table 12 focuses on who is responding to the events to illustrate how the pilot operates in the context of the various behavioral health designations. In this table we collapse "1014-CIT", "1014-MIW", and "1014-Assist Deflection" into "1014-Other", while keeping "1014-Deflection Not Available" and "Deflection" as separate categories. This allows for easier comparison between event types potentially eligible for SCS Deflection.

Table 12 includes data breakdowns for Fourth Division only, the other seven LMPD divisions, and all divisions. The data is only during the intervention period and operating hours, March 21 to May 8, 2022, and 2 p.m. to 10 p.m.

As the intervention is currently designed, any event coded "1014-CIT", "1014-MIW", "1014-Assist Deflection", and "1014-Deflection Not Available" are responded to by LMPD, with only the "1014-Deflection Not Available" being eligible for the SCS Deflection Intervention.

During the intervention's operating hours in the Fourth Division, 55 (17%) events went to alternative responders which otherwise would have gone to LMPD.[11] Of these events, 27 went to and were addressed by the Crisis Triage Workers (CTW) only, meaning the Mobile Crisis Response Team (MCRT) was not required. Twenty-eight (28) events received an intervention from both the CTWs and MCRT.

The alternative responders responded to 64 events in other divisions, all of them involving an identified frequent caller. All 64 events were resolved by the CTW, as MCRT were not available to respond outside of the Fourth Division.

Across all divisions, alternative responders responded to 9% of all behavioral health events during the pilot phase between March 21 and May 8, 2022.

Table 12. Type of Response by Behavioral Health Event Designation. March 21 to May 8, 2 p.m. to 10 p.m.

Fourth	Police	CTW Only	CTW+MCRT	Total	Avg Per Day (49 days)
1014-Other	254	n/a	n/a	254	5.2
1014-Def_NA	12	n/a	n/a	12	0.2
Deflection	n/a	27	28	55	1.1
Total (%)	266 (83%)	27 (8%)	28 (9%)	321	6.6
Other Divisions					
1014-Other	738	n/a	n/a	738	15.1
1014-Def_NA	80	n/a	n/a	80	1.6
Deflection	n/a	64	0	64	1.3
Total (%)	864 (93%)	64 (7%)	0	928	18.9
All Divisions					
1014-Other	1038	n/a	n/a	1038	21.2
1014-Def_NA	92	n/a	n/a	92	1.9
Deflection	n/a	91	28	119	2.4

[11] It is important to note that this is 17% of CIT events and not all events. The 55 events make up only 1.5% of all LMPD events in the Fourth Division between March 21 to May 8, 2022, between 2 p.m. and 10 p.m.

Total (%)	1130 (90%)	91 (7%)	28 (2%)	1,249	25.6

This section provides a breakdown on the volume of Deflection events in comparison to other behavioral health classifications. Call-takers are responsible for designating events based on the information provided by the caller and the policies and protocols that govern their job. The key takeaways for events that occurred during the intervention period, March 21 to May 8, 2022, and between 2 p.m. and 10 p.m. include,

1. In the Fourth Division, 55 (17%) behavioral health events were designated SCS Deflection, with another 4 events labeled 1014 "Deflection Not Available", meaning that during the intervention SCS Deflection responded to 55 events, with another 12 events eligible.
2. During the intervention's operating hours in the Fourth Division, 55 (17%) events went to SCS Deflection which otherwise would have gone to LMPD.
3. Of the 55 events, 27 went to and were addressed by the CTW only, meaning the MCRT was not required.
4. 28 events received an intervention from both the CTWs and MCRT.
5. Across all divisions, the SCS Deflection intervention responded to 119 events or 10% of all behavioral health events during the pilot phase between March 21 and May 8, 2022.

Response Resources

The previous section focused on the volume of events that went to LMPD versus SCS Deflection by behavioral health event type. Another factor to consider is the resource allocation attached to each event. There are numerous ways to measure resources related to behavioral health events; however, the available data sources are limiting. For this report, the research team examined resources using six metrics: the average number of personnel responding (including police and SCS deflection), the total personnel (labor) hours used on the event, the average length of time from the start (units dispatched) to end of event (units cleared from run), the average length of time to respond to an event (dispatch to arrival), and average length of time on scene (arrival to clear).

A starting point in this analysis is to understand the average out-of-service time per CIT event. Table 13 shows behavioral health events for police only, CTW only, and CTW+MCRT only by event type in the Fourth Division, Other Divisions, and All Divisions. Deflection is not eligible to respond to other 1014 event types such as CIT or MIWs and the "1014-Def NA" is entered when they are not available and therefore did not respond. Similarly, the police will not respond to a Deflection designated event, as that is used only for SCS. For police responses, the average out-of-service time, dispatch to clear, is 9 minutes longer for "1014-Other" events compared to "1014-Deflection Not Available" events in the Fourth Division, and when looking at all divisions the differences is over 3 minutes. The primary comparison point, however, is between average out-of-service time for police responses to "1014-Deflection Not Available" events versus SCS Deflection average out-of-service times.

In the Fourth Division, for events where the CCDP was implemented and only the CTW responded, the average time of the event was just under 17 minutes (16:57), meaning on average when only the CTW responded, they spent almost 9 minutes less on the event compared to similar events for LMPD.

When examining events where the CTW and MCRTs both responded, the average out-of-service time was just over 39 minutes (39:03), which was 12 minutes longer than police.

Table 13. Average Length of Intervention Time by Responder Type

	Police Only	CTW Only	CTW + MCRT
Fourth Div.	N=266	N=27	N=28
1014-Other	36:27	---*	---
1014-Def_NA	27:10	---	---
Deflection	---	16:57	39:03
Total	0:30:19 (266)	16:57	39:03
Other Divisions	N=864	N=64	
1014-Other	29:45	---	---
1014-Def_NA	34:17	---	---
Deflection	---	17:09	---
Total	34:44 (549)	17:09	---
All Divisions	N=1,130	N=91	N=28
1014-Other	35:57	---	---
1014-Def_NA	32:21	---	---
Deflection	---	15:02	39:03
Total	35:58 (815)[12]	15:02	39:03

*Intervention's operations do not allow for a type of response to occur

Given the model design, one should anticipate the combined CTW and MCRT intervention will have a longer out-of-service time.

When looking at all other divisions, the average out-of-service time for police responses to "1014-Deflection Not Available" events was over 34 minutes (34:17) which is almost double the out-of-service time for a CTW response (17:09).

Finally, when looking at all divisions, the average out-of-service time for CTW only events (15:02) was half the length of time compared to a police response for a "1014 Deflection Not Available" event (32:21), but a deflection response involving CTW and MCRT response was over 6 minutes longer in time. It is important to consider the out-of-service times for CTW only events versus CTW and MCRT events when considering expansion and required capacity to do so.

There is a fourth type of response that can occur in the intervention. When the police are dispatched to an event and determine that an individual would benefit from the Deflection intervention, the officers can contact MetroSafe 911 center and request the CTW. During the intervention period there have been five events where the police called the CTW for assistance.

Table 14 presents the average out-of-service time for each response component for the four events that have complete data. One case was missing data. There were two events where the police and CTW responded and the average time for the police and CTW response was 22 minutes. There were two events where the police, CTW, and MCRT responded, and the combined average time was 1 hour 51

[12] This number is calculated from when an officer is dispatched to the time they "clear" the run, indicating they are available for the next run. This measure gives the most direct indicator for the length of an event from start to finish and a more accurate estimate of office's labor time. However, the total length of time from when a call comes into 911 and an event is created to clear is 1:02:22, meaning that on average it takes 26 minutes and 44 seconds before an officer is available to send on a run, a considerable delay for someone experiencing a behavioral health crisis.

minutes. Given that there are only four events, one should not draw any conclusions about these times. Interview data from first responders and behavioral health responders, indicated an unfamiliarity with this process and extra layer of caution for staying on scene until they gain a better understanding of the model.

Table 14. Average Length of Intervention Time for Police event sent to Alternative Responders

	Police average time dispatch-clear	CTW average time start-finish	MCRT average time start-finish	Total- combined average time Police, CTW, + MCRT
Fourth Division				
Police & CTW (n=2)	0:09:04	0:5:30	---	0:22:36
Police, CTW, & MCRT (n=2)	0:33:00	0:29:00	0:49:00	1:51:00

The above tables display the average out-of-service time for each event, which is beneficial for understanding the potential volume the alternative responders could handle. However, the average out-of-service time only tells a partial story for understanding resource consumption. Table 15 provides a further breakdown in response times and personnel for police responses in the Fourth Division, other divisions, and all divisions between March 21 and May 8, 2022, from 2 p.m. to 10 p.m. Within the Fourth Division, 254 "1014-Other" events were sent to LMPD. Fifty-two received no response, meaning an event was created but an officer was not dispatched. This was often due to a frequent caller who had already received a police response earlier in the day with no resolution. Only one "1014-Deflection Not Available" event received no response. The average response time for the first officer to arrive on scene is over six minutes for "1014-Other" events and under six minutes for "Deflection Not Available" events.

Officers spend more time on scene for "1014-CIT events" (34:22) compared to "1014-Deflection Not Available" (22:12), and both events average two personnel.

LMPD policy requires that two officers respond to all CIT events. The average length of out-of-service time for "1014-Other" events is 9 minutes longer compared to "1014-Deflection Not Available" events. Similar patterns emerge when examining other divisions and examining all divisions together. These numbers are important as they form the comparisons points for deflection response, especially when conducting cost-benefit analyses.

Table 15. Out-of-Service Times for Police by Event Type, 2 p.m. to 10 p.m. March 21 to May 8, 2022

	No Response	Avg. Police Response Time Dispatch-Arrive	Avg. Police Intervention Time Arrive-Clear	Avg. # of LMPD personnel (LMPD Officers +Supervisors)	Avg. Total Intervention Time Dispatch-Clear Time
Fourth Division					
1014-Other	52	0:06:25	0:34:27	2.08	36:10
1014-Def_NA	1	0:05:39	0:22:12	2.05	27:10
Other Divisions					
1014-Other	128	0:09:24	0:29:12	2.04	40:57
1014-Def_NA	21	0:08:46	0:22:32	1.68	33:52
All Divisions					
1014-Other	180	0:08:46	0:29:06	2.0	35:37
1014-Def_NA	22	0:08:15	0:33:56	1.74	32:21

Table 16 presents the same data for Deflection response in the Fourth Division, other divisions, and for all divisions. What is unique to the Deflection intervention, compared to police intervention, is individuals may receive two interventions, from both the CTW and MCRT. Therefore, Table 16 provides the average intervention time for CTWs and MCRTs separately.

In the Fourth Division, the average CTW intervention time was over 15 minutes (15:33) and includes CTW only events and those events where the CTW sent the MCRT team. On average, the MCRT took almost 14 minutes (13:52) to arrive on scene, which is double the time of a police response.

Given there is only one MCRT team for an entire division, the longer response time is not surprising, and it becomes an important measure for expansion. The MCRTs average total intervention time is over 44 minutes, which is also longer than the average police response. Although the MCRTs were more likely to transport than the police, which would increase the overall intervention time (see Table 17 for outcomes), Deflection events use more personnel, on average, compared to police responses. But there is an important caveat to events using both CTW and MCRTs, as the CTWs will eventually transition off the event and leave the MCRT to complete the intervention. Finally, the data show the deflection events have similar out-of-service times to police when comparing deflection and 1014-Deflection Not Available Events.

Table 16. Out-of-service Times for Deflection by Event Type, 2 p.m. to 10 p.m. March 21 to May 8, 2022

	Overall Deflection Response				
	Avg. CTW Intervention Time (Start-Clear)	Avg. MCRT Travel Time (Dispatch-Arrival)	Avg. MCRT Intervention Time (Arrival-Clear)	Average # of Personnel, CTW + MCRT	Total Intervention Time CTW+MCRT (Start of CTW to Clear)
Fourth Division	15:33	13:52	44:22	3.01	27:19
Other Division	17:09	---	---	2	17:09
All Divisions	14:50	13:52	44:22	2.5	19:47

This section examined the average out-of-service times, average number of personnel, average intervention time, and average response time for police and deflection responses across behavioral event types between March 21 to May 8, 2022, between 2 p.m. and 10 p.m. Of particular importance is a comparison between police responses to "1014-Deflection Not Available" events and SCS Deflection response to Deflection events, as these event types share similar characteristics. The key findings are:

1. Officers spend more time on scene for "1014-CIT" events (34:22) compared to "1014-Deflection Not Available" (22:12), and both events average two personnel.
2. In the Fourth Division, for events where only the CTW responded, the average time of the event was just under 17 minutes (16:57), meaning on average when only the CTW responded, they spent almost 9 minutes less on the event compared to similar events for LMPD.
3. In the Fourth Division, when examining events where the CTW and MCRTs both responded, the average out-of-service time was just over 39 minutes (39:03), which was 12 minutes longer than police.
4. In the Fourth Division, a Deflection event averaged 3.01 personnel and 2.5 personnel for all divisions, which are higher than police responses. However, the involvement of personnel are sequential for CTW and MCRT responses as CTW hands over events to MCRT intervention.
5. When looking at all other divisions, the average out-of-service time for police responses to 1014-Deflection Not Available events was over 34 minutes (34:17) which is almost double the out-of-service time for a CTW response (17:09).
6. Finally, when looking at all divisions, the average out-of-service time for CTW only events (15:02) was half the length of time compared to a police response for a 1014 Deflection Not Available event (32:21), but a deflection response involving CTW and MCRT response was over 6 minutes longer in time.
7. On average, the MCRT took almost 14 minutes (13:52) to arrive on scene, which is double the time of a police response.
8. Finally, the data shows the deflection events have similar out-of-service times to police when comparing deflection and "1014-Deflection Not Available" Events.

Outcomes

Table 17 below provides the outcomes associated with all behavioral health events by LMPD and alternative responders in the Fourth Division during the intervention period. The data come from LMPD CIT Reports and SCS Deflection Electronic Health Records.

In the 59 events with a completed CIT report, 12 individuals were stabilized on scene, 27 resulted in voluntary hospitalization and 18 in involuntary hospitalization. One event resulted in someone going to jail. 17% of events resulted in a transportation and hospitalization.

The second column provides the breakdown for CTW and MCRT events. Out of the 55 Deflection events in the Fourth Division, 21 were resolved by the CTW, 6 were sent back to MetroSafe call-takers, and 28 were sent to the MCRT team. Of the 28 MCRT responses, 5 were resolved at the location, 9 were transported voluntarily to the hospital, 9 were transported to another location, and 5 were transported to respite. The data indicate 23 MCRT responses resulted in transportation. Table 17 provides important estimates for what happens during Deflection responses and what to expect moving forward.

Of the 55 responses in the Fourth Division, over 50% resulted in a MCRT response. MCRT response resulted in 82% needing transportation, with five transports to respite (18%).

During the study period, the police had 266 CIT-related events and 207 of those events resulted in no CIT report being completed. Of the 207 events with no documentation, 53 had no officer response due to a supervisor cancellation for a frequent caller. The resolution of the remaining 154 events is unknown**.**

Table 17. Outcomes Intervention Time Period. Fourth Division 2 p.m. to 10 p.m.

	March 21 to May 8, 2022		
	Police (%)	CTW (%)	MCRT (%)
No Resolution Documented*	207 (78%)	0	0
Stabilized	12 (5%)	21 (78%)	5 (18%)
Sent back to MetroSafe	---	6 (22%)	0
Sent to MCRT	---	28 (51%)	---
Jail	1 (.4%)	---	---
Voluntary Hospitalization	27 (10%)	---	9 (32%)
Involuntary Hospitalization	18 (7%)	---	---
Other Outcome	1 (.4%)	---	9 (32%)
Respite	---	---	5 (18%)
Total	266	55	28

The outcomes associated with the CCDP go beyond deflecting calls from police or hospitals. The CCDP intervention is also designed as a service added, deploying trained behavioral health workers to support individuals calling 911 in a behavioral health crisis. As designed, this provides people with access to trained professionals whose primary job is to provide behavioral health care and possess knowledge of available local services and supports.

Table 18 provides a breakdown of the types of services provided by the alternative responders during the pilot period. This analysis uses SCS Deflection Electronic Health Records to examine the crisis support and referrals made for each of the alternative response or "Deflection" components, CTWs, MCRT, and Case Managers. The CTWs created records for 119 deflection responses, with 28 of those responses including the MCRTs. There were seven additional records created by case managers related to previous responses. For CTWs, 93 (80%) of events resulted in crisis support being provided, the responses without crisis support were due to a call being sent back to MetroSafe, an individual hanging up before the crisis support could be provided, or missing data. The MCRT team provided crisis support in all their responses. Table 18 provides a breakdown of the most common crisis supports provided and Appendix 3 provides a complete list and frequency of all supports provided. Case managers are available to all individuals served through the CCPD. Case managers follow-up with individuals who request case management services and case managers attempt to connect individuals to additional resources. In SCS Deflection Electronic Health Records crisis support such as de-escalation and crisis counseling are not marked in the database, rather data only includes referrals made. Another component to the model is that CTWs, MCRTs, and case managers can provide referrals to individuals to meet their needs. For CTWs, there were 17 responses where no resources or referrals were given, 2 responses for MCRTs, and one response for case managers.

Table 18. Frequency of Crisis Support and Referrals by Alternative Responders, All Divisions, 2 p.m. to 10 p.m., March 21 to May 8, 2022.

	CTW	MCRT	Case Manager
Events	119	28	7
Crisis Support	93	28	---
Referrals	14	40	15
No Resources or Referrals Given	17	2	1

Table 19 shows the most common types of crisis support performed by the CTW (73) and MCRT (22) teams, with both teams validating feelings as one of the primary forms of crisis support. Validating feelings is an important component of trauma informed care, which is the primary framework identified by the Deflection team in interviews.

For CTWs, providing crisis de-escalation, identifying coping strategies, and providing supportive crisis counseling were also common crisis support tools. For MCRTs their most frequent crisis support was motivational interviewing, assessing for risk of self-harm, and connecting to various resources.

Table 19. Frequency of Type of Crisis Support Provided for CTW and MCRT, All Divisions, 2 p.m. to 10 p.m., March 21 to May 8, 2022

Type of Crisis Support	CTW N=93	MCRT N=28
Validate Feelings	73	22
Provide Crisis De-escalation	58	17
Identify Coping Strategies	53	6
Provide Supportive Crisis Counseling	51	3
Motivational Interviewing	49	26
Assess for Risk of Self Harm	37	20
Develop a Safety Plan	34	1
Encourage Counseling/Treatment Resources	34	23
Encourage use of Community Support Agencies	31	19
Generate Hope/Reason for Living	24	7
Offer Deflection Mobile Response	19	---
Include Natural Supports/Family Members in Safety Plan	18	3
Offer Resource Referral	13	10
Offer Case Management Resource Linkage	11	17
Provide Crisis Phone/Text/Chat information	9	19

In addition to providing immediate crisis support to stabilize an individual in crisis, they are also able to provide referrals related to an individual's needs. The case managers also make referrals to provide individuals with additional assistance. In Seven Counties Services Deflection Electronic Health Records they group referrals by the type of assistance needed. Table 20 presents the referral types which include connecting individuals to resources for benefits (e.g., Social Security), other community services providers, additional crisis resources, legal resources, other Seven Counties Services departments, referrals to shelters, and treatment providers. Between March 21 and May 8, 2022, the CTWs made 14 referrals with two Benefit referrals and 12 referrals to other Seven Counties Service departments. The MCRT team made 40 referrals, for benefits (1), other community service providers (4), Seven Counties Services (27), shelters (4), and treatment providers (4). Case managers made referrals to benefits (2), other community service providers (3), legal services (1), Seven Counties Services (4), shelters (2), and treatment (3). Appendix 3 provides a complete list of referral options CTWs, MCRTs, and case managers have available, along with the frequency of referrals by the specific types.

Table 20. Frequency of Referrals by Alternative Responders, All Divisions, 2 p.m. to 10 p.m., March 21 to May 8, 2022.

	CTW	MCRT	Case Manager
Type of Referral	Events=93	Events=28	Events=7
Benefits	2	1	2
Community Agency	0	4	3
Crisis	0	0	0
Legal	0	0	1
Seven Counties Services	12	27	4
Shelter	0	4	2
Treatment	0	4	3

This section began by analyzing the outcomes associated with the behavioral health events for LMPD and alternative responders, before analyzing the types of crisis support and referrals made by the alternative responders. The key findings from this section include,

1. For police responses to behavioral health events, 59 resulted in a CIT report where 12 individuals were stabilized on scene, 27 events resulted in a voluntary hospitalization and 18 in an involuntary hospitalization, and one event resulted in someone going to jail. The remaining 207 events provide no indication what services were provided.
2. For police, 45/266 (17%) of events resulted in a transportation to a hospital.
3. Out of the 55 alternative responses in the Fourth Division, 49% were resolved by CTWs and 51% were sent to MCRT for a response.
4. Out of the 28 MCRT responses, 82% resulted in a transportation with 5 transportations to respite and 9 transportations to a hospital.
5. During the intervention period alternative responders deflected 55 events from police and took 5 individuals to respite instead of hospitals.
6. The CTWs and MCRTs completed a combined 121 forms of crisis support, across 93 individuals.
7. Validating feelings, providing crisis-de-escalation, identifying coping strategies, and providing supportive crisis counseling were the most common forms of crisis support for CTWs.
8. For MCRT's their most frequent crisis support tool was motivating interviewing, assessing for risk of self-harm, and connecting to various resources.
9. For CTWs, MCRTs, and case managers 81 referrals were made with referrals to other SCS department being the most common type.

Frequent Callers

Frequent callers are a known challenge for 911 call centers[xxiii] and the topic was raised several times during interviews as both a planning consideration and a challenge for call-takers, dispatchers, and police officers**.** The Seven Counties Services Deflection Electronic Health Records used for these analyses contain a unique identifier for each known caller and uses a pseudo-client for individuals who do not provide their information. This unique identifier was generated for research purposes and the researchers do not know who is connected to each ID. Within the 119 Deflection events, there were 42 verified unique callers. Of these 42 callers, 10 were repeat callers collectively accounting for 65 Deflection events, with the number of repeat calls ranging from 2 to 27. In other words, 65 out of the 119 events were for frequent callers and the number of calls ranged from having 2 to 27, 911 calls. The

pseudo-client ID had 22 events and it is possible this contains a frequent caller who refuses to identify themselves to a CTW.

When examining the frequent callers use of the intervention, three individuals called the CTW more than 10 times and all three were outside of the Fourth Division, meaning none were eligible to have a MCRT response and could only have telephone interactions with the CTW. When looking within the Fourth Division, three individuals had 2 MCRT responses and all other MCRT responses were to unique individuals.

One intended purpose of the CCDP pilot is to allow frequent callers to be connected to the CTW regardless of division, to deflect those calls from LMPD, and to connect those individuals to behavioral health specialists who can provide crisis support and make referrals. To this end, the data suggest there are frequent callers who are willing to utilize the CTW, with one individual calling 27 times, essentially deflecting those events from the police.

While Seven Counties Services data can tell us the percentage of frequent callers utilizing the intervention, the other data provided to the evaluation team do not have unique identifiers that allow accurately identifying frequent callers. As a result, our ability to estimate how many frequent callers still went to LMPD during the intervention period is limited. In an attempt to provide a low-end estimate for frequent callers, we used the XY coordinates for all LMPD behavioral health events to identify events generating from the same location. Locations associated with shelters or other service providers were removed as it is unknown whether the calls are for the same individual. The results show that three locations had 10 or more events, totaling 51 events, between the 2 p.m. to 10 p.m. time frame from March 21 to May 8, 2022. However, it should be noted that frequent callers are not limited to calling 911 during 2 p.m. to 10 p.m. When examining other time frames (10 p.m. to 2 p.m.), there are eight addresses that have 10 or more behavioral health events, totaling 200 events, which are sent to LMPD for response.

As the intervention continues, the utilization by frequent callers needs to be monitored. However, there are challenges to do this, as there are no formal definitions of what constitutes a frequent caller.[13] There are known individuals by call-takers, dispatchers, and police who they believe are frequent callers, but a perception of who those individuals are may not align with the reality of how many times they call. A further challenge with identifying frequent callers is that call-takers or dispatchers may lump together multiple calls into a single event and using an event-level analyses will undercount the number of times a single person calls. If a frequent caller designation is created, then it will be possible to identify the events where multiple calls are grouped together and develop a more accurate count.

Having a consistent definition of frequent caller and accurate counts, will provide administrators with better data to adjust the intervention and develop strategies to deflect frequent callers from police responses. The data will also help inform SCS Deflection to know the potential volume, staffing needs, and develop more intensive strategies to meet the frequent caller's behavioral health needs, while not overwhelming the model with repeat callers.

[13] MetroSafe defines a repeat caller as someone with a CIT history in CAD or known to the Call Taker, who has called more than once in the past 3 months and is experiencing a Mental Health crisis and NOT actively attempting suicide or physically violent toward themselves or others. If it has been more than 3 months ago, they are not considered a repeat CIT caller.

Economic Evaluation

The following sections present data and analyses for Research Question 4, which asks:

RQ4: What are the economic implications of the deflection efforts? (Impact)

This research seeks to understand the costs of the deflection program, compared with potential benefits/outcomes. In particular, the *costs* of the deflection program entail salaries, personnel benefits, and other overhead costs associated with the behavioral health hub (or, the triage center), the mobile response team, and the respite care provided.

The *benefits* of the program will primarily be measured in terms of savings on resources and expenditures by LMPD from comparing those in typical responses to CIT calls. The deflection will save response time, effort, and transportation time for LMPD officers, which we will translate into dollars saved.

This analysis will be conducted from *metro government's perspective*, not from the societal perspective. As a result, to the extent that the deflection efforts improve other community outcomes (e.g., a potential decrease in numbers of arrests, hospitalizations, and deaths, or an increase in community trust in police and equality), this measure of benefits in terms of resources saved will understate the true benefits of the program.

Context and Existing Research

Different versions of alternative response models to the traditional practice of police officers responding to behavioral crisis calls have been implemented in the United States and other countries, and their effects have been examined by various researchers. In 2019, a comprehensive review of studies from 1998-2018 was conducted on a variety of police-based and other first response models.[xxiv] Relevant to this study, they discuss how the co-responder team approach is implemented with significant variation and is increasing in prevalence in the US, with the earliest US co-response occurring in Los Angeles, CA. The authors summarize that stakeholder view the co-response model favorably, and that it can have important benefits such as reducing unnecessary ED visits and reducing the number of repeated calls for service. This review also references mobile crisis team (MCT) models which are reported to have high rates of consumer and provider satisfaction, increase community-based service use, reduce use of EDs, and connect people to care. The authors also state that the current MCT studies are old and that more updated research is needed.

Cost-effectiveness evaluation of alternative models is rarely conducted. A 2019 systematic review of the literature on prearrest diversion studies identified ten studies (covering only five independent economic evaluations) that address the economics of these models.[xxv] These studies suggested that prearrest diversion into community health services can lead to overall cost savings, with most of the cost savings being realized up to 2 years after initial diversion. They note that more work is needed to understand the full costs and benefits of such programs

In the context of Louisville, a previous analysis of a Police Crisis Intervention Team (CIT) program that was implemented, which required police officers to be trained by mental health professionals with information and tools on how to identify psychiatric symptoms and communicate clearly to verbally

deescalate the situation.[14,xxvi] The study was retrospective in nature, with access to data from many sources since they studied the program 9 years after it was implemented. The costs of the program were approximated to be about $2.5 million for 1 year, comprised of costs associated with officer training, emergency psychiatric evaluations, hospitalizations of patients transported by CIT, and arrests. The savings of the program were estimated to be around $3.5 million for 1 year, made up of deferred hospitalizations, reduced jail inmates with severe mental illness, and fewer arrests. Thus, the net savings were calculated at about $1 million. It bears repeating that unlike the aforementioned study, this analysis is from the government's perspective and does not currently take into account the potential benefits in terms of other community outcomes (e.g., a potential decrease in numbers of arrests, hospitalizations, and deaths, or an increase in community trust in police and equality), which means that any measure of benefits in terms of resources saved will be less than they found and will understate the benefits of the program relative to their study.

Findings

Pattern of CIT Calls in LMPD Divisions in Recent Years

We start by exploring descriptive patterns of CIT events in Louisville, especially focusing on how they change over time and how they differ across the 8 LMPD divisions. LMPD CAD data allows us to quantify the number of CIT calls in each division over time, which we converted to an average per day (by dividing by the number of days in the relevant period) and are presented in Table 21.

Figure 1 shows the average CIT calls per day across all the years of study, broken down by LMPD divisions. Figure 2 shows the division-level daily average CIT calls as a proportion of the overall CIT volume across all divisions over time.

Note that the 2019 data begins on June 1 and therefore entails 214 days of data. In all divisions, there were 12,362 CIT calls over those 214 days, for an average of 57.8 calls per day. Division 4 comprised the highest volume of CIT calls during that time, with 12.7 average CIT calls per day (Figure 3) or almost 22% of the overall call volume per day on average (Figure 4). The next highest was division 1, with an average of 9.5 CIT calls per day, or about 16% of the overall volume. Next was division 3, with an average of 8.5 CIT calls per day, entailing 15% of the overall volume on average.

The patterns remained the same in 2020, which had 366 days of data (leap year), and in 2021, which had 365 days of data. In 2020 in all divisions, there were 20,149 CIT calls throughout the year, for an average of 55 calls per day. Division 4 again had the highest volume with about 11.1 CIT calls per day, comprising about 20% of the overall LMPD volume of 55 CIT calls per day on average. In 2021 in all divisions, there were 20,816 CIT calls throughout the year, for an average of 57 calls per day. Division 4 again had the highest volume with about 11.3 CIT calls per day, comprising 20% of the overall LMPD volume of about 57 CIT calls per day on average. Divisions 1 and 3 again had the second and third highest average daily volume, respectively, in both 2020 and 2021.

For the year 2022, we broke the data down by pre-intervention (January 1 – March 20, total of 79 days) and post-intervention (March 21 – May 8, the last day of data collection, total of 49 days).[15] To the

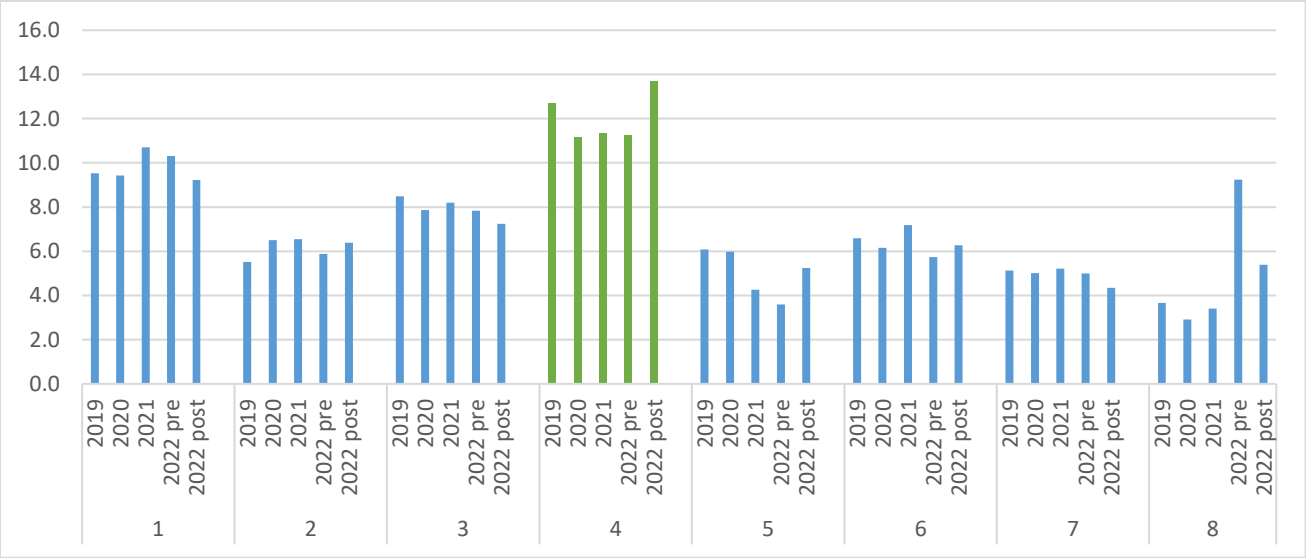
[14] Note that the intervention studied in El-Mallakh et al. (2014) focused on a police-response only intervention through training, thus cost comparisons between his study and this evaluation are limited.

[15] Note that in this discussion, for the post-intervention time period, we will count *both* CIT events that went to LMPD, *as well as* CIT events that went to Seven Counties Services for deflection. This allows us to accurately capture total CIT deflection eligible events in the post-intervention period.

extent that there may be seasonal variation in the number of CIT events per day, these numbers may be slightly less comparable to the data collected for other years. In the pre-intervention period of 2022, there were a total of 4,882 CIT events across all divisions, for an average of 61.8 per day. In the post-intervention period of 2022, there were a total of 2,846 CIT events across all divisions, for an average of 58.1 per day. [16] Once again, division 4 had the highest average daily volume of CIT events, with an average of 11.2 per day (18% of overall) in the pre-intervention period, and 13.7 per day (24% of overall) in the post-intervention period.

These patterns, while descriptive, are useful to show (1) the high volume of CIT events in the division that was chosen for treatment under the intervention; and (2) the volume of CIT events in other divisions that may be chosen for an intervention in the future. It is apparent that across all time periods, division 4 has the highest volume of CIT events and is therefore a well-chosen division for the intervention. If CIT volume remains a primary concern in future expansions of the intervention, then divisions 1 and 3 may be the next locations to target.

Figure 3: **Average CIT Calls per day across years and LMPD divisions**



[16] Note that post-intervention counts in this section include LMPD 1014-mental health events and Seven Counties Services "Deflection" events. See Table 5 for an explanation on how behavioral health events are classified.

Figure 4: Proportion of Overall Average CIT Calls per day across years and LMPD divisions

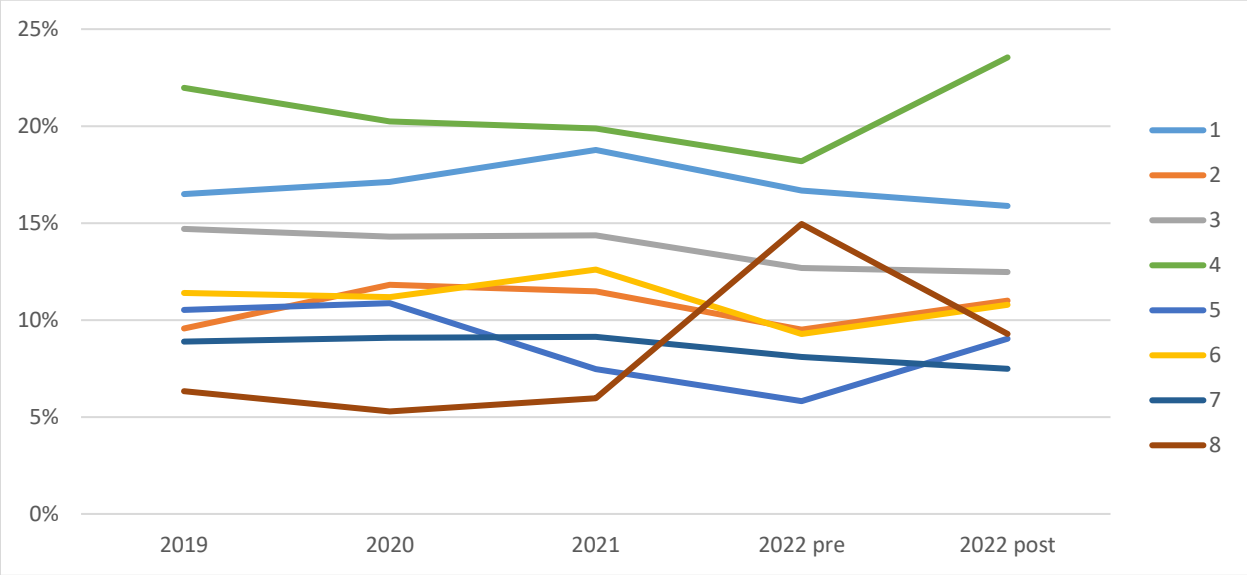


Table 21: Average CIT Calls per Day across years and LMPD divisions

Division and Time Period	Average CIT Calls per Day	Proportion of Overall Average Across All Divisions
Division 1		
2019	9.5	16%
2020	9.4	17%
2021	10.7	19%
2022 pre-intervention	10.3	17%
2022 post-intervention	9.2	16%
Division 2		
2019	5.5	10%
2020	6.5	12%
2021	6.5	11%
2022 pre-intervention	5.9	10%
2022 post-intervention	6.4	11%
Division 3		
2019	8.5	15%
2020	7.9	14%
2021	8.2	14%
2022 pre-intervention	7.8	13%
2022 post-intervention	7.2	12%
Division 4		
2019	12.7	22%
2020	11.1	20%
2021	11.3	20%
2022 pre-intervention	11.2	18%

2022 post-intervention	13.7	24%
Division 5		
2019	6.1	11%
2020	6.0	11%
2021	4.3	7%
2022 pre-intervention	3.6	6%
2022 post-intervention	5.2	9%
Division 6		
2019	6.6	11%
2020	6.2	11%
2021	7.2	13%
2022 pre-intervention	5.7	9%
2022 post-intervention	6.3	11%
Division 7		
2019	5.1	9%
2020	5.0	9%
2021	5.2	9%
2022 pre-intervention	5.0	8%
2022 post-intervention	4.3	7%
Division 8		
2019	3.7	6%
2020	2.9	5%
2021	3.4	6%
2022 pre-intervention	9.2	15%
2022 post-intervention	5.4	9%
Total All Divisions		
2019	57.8	-
2020	55.1	-
2021	57.0	-
2022 pre-intervention	61.8	-
2022 post-intervention	58.1	-

Cost of Police Handling of CIT Calls

Now we turn to examine how LMPD handles CIT events, and the associated costs. Throughout the discussion, please reference table 22 which presents a summary of variables and their values, as well as details on either their calculations or their source, where appropriate.

For simplicity, we will first focus on the time period of March 21 – May 8, 2022, the same 49 days during which the intervention occurred. During that time, there were 1,130 CIT events that occurred during the mid-day shift, to which police responded rather than deflection. In the same period, a CIT event response involved an average of 0.11 LMPD supervisors, 1.87 LMPD officers, and 0.02 other officers per event (Table 22, rows 3, 9, 15). The time spent by each was on average 2 minutes 58 seconds for the LMPD supervisors, 54 minutes 33 seconds for the LMPD officers, and 20 seconds for other officers per

event (Table 22, rows 4, 10, 16). Given the current estimated hourly pay of each and the average time spent on each event, a CIT event costs on average $3 of LMPD supervisor time per LMPD supervisor that responds, $41 of LMPD officer hour time, and $0.25 of other officer time for officers that respond (Table 22, rows 8, 14, 20). Incorporating the average number of responders per event, as well as overhead costs associated with police time[xxvii], the average total cost of a police response to a CIT event is around $74 total per event (Table 22, row 24). Given the average time spent per event, that also means a police response to a CIT event costs an average of approximately $76 per hour, or just over $1.27 per minute (Table 22, rows 25 and 26). We can also calculate the average daily cost of police response to CIT events, which is approximately $1,695 (Table 22, row 28).

These calculations are useful as a baseline to examine how costly police response is in terms of time and resources, and begin thinking about the potential volume and costs that could be decreased if deflection becomes more common.

Table 22. Summary of Variables Related to Police CIT Responses

Row	Variable	Value[a]	Details
1	Number of days of deflection activities under consideration	49	March 21-May 8, 2022
2	Total number of CIT events responded by police (shift 2), March 21 – May 8, 2022	1,130	Source: LMPD CAD data (across all divisions)
3	Average number of LMPD supervisors on CIT events (shift 2)	0.11	Source: *ibid*
4	Average time spent by LMPD supervisors on CIT events (shift 2), mm:ss	0:02:58	Source: *ibid*
5	Average time spent by LMPD supervisors on CIT events (shift 2), decimal hours	0.05	Row 4 converted to decimal hours
6	Average hourly pay to a LMPD supervisor	$54	Source: LMPD administrative data
7	Total cost of LMPD supervisors' time, March 21 – May 8, 2022	$3,051	Row 2 x Row 5 x Row 6
8	A LMPD supervisor cost per CIT events	$3	Row 5 x Row 6
9	Average number of LMPD officers on CIT events (shift 2)	1.87	Source: LMPD CAD data
10	Average time spent by LMPD officers on CIT events (shift 2), mm:ss	0:54:33	Source: *ibid*
11	Average time spent by LMPD officers on CIT events (shift 2), decimal hours	0.91	Row 10 converted to decimal hours
12	Hourly pay to a LMPD officer	$45	Source: LMPD administrative data
13	Total cost of LMPD officers' time, March 21 – May 8, 2022	$46,274	Row 2 x Row 11 x Row 12
14	A LMPD officer cost per CIT event	$41	Row 11 x Row 12
15	Average number of other officers on CIT events (shift 2)	0.02	Source: LMPD CAD data
16	Average time spent by other officers on CIT events (shift 2), mm:ss	0:00:20	Source: *ibid*
17	Average time spent by other officers on CIT events (shift 2), decimal hours	0.01	Row 16 converted to decimal hours

18	Hourly pay to other officer	$45	Assumed to be the same as in row 12
19	Total cost of other officers' time, March 21 – May 8, 2022	$509	Row 2 x Row 17 x Row 18
20	Another officer cost per CIT event	$1	Row 17 x Row 12
21	Total police hours, decimal hours	1,089.5	Row 2 x (Row 5 + Row 11 + Row 17)
22	Total police personnel cost, March 21 – May 8, 2022	$49,834	Row 7 + Row 13 + Row 19
23	Total estimated police cost (including overhead), March 21 – May 8, 2022	$83,057	Row 22/0.6, assuming that personnel costs are approximately 60% of overall costs
24	Cost of police per CIT event, March 21 – May 8, 2022	$74	Row 23 / Row 2
25	Cost of police per personnel hour of CIT response, March 21 – May 8, 2022	$76	Row 23 / Row 21
26	Cost of police per personnel minute of CIT response, March 21 – May 8, 2022	$1.27	Row 25 / 60
27	Total estimated police personnel cost per day for CIT response, March 21 – May 8, 2022	$1,017	Row 22 / Row 1
28	Total estimated police cost (including overhead) per day for CIT response, March 21 – May 8, 2022	$1,695	Row 23 / Row 1

[a] Note that dollar values are rounded to the whole dollar

Analysis of Deflection Efforts Thus Far

Next, we examine how the deflection program has worked so far, and the impact it has had on LMPD time and resources. Throughout the discussion, please reference table 23 which presents a summary of variables and their values, as well as details on either their calculations or their source, where appropriate.

The intervention under consideration started on March 21, 2022. For this report, we collected data through May 8. As a result, there are 49 days of deflection activity (table 23, row 1). During that period, there were 119 events sent to the Behavioral Health Hub for the Crisis Triage Workers (CTW) and Mobile Response Crisis Team (MCRT) to handle. That means the CTW-MCRT team handled an average of 2.4 deflection events per day (table 23, row 3).

Given that the average time spent by the deflection team per event is around 19 minutes 47 seconds (source: Table 16), that means each event only takes about 0.33 hours on average. Note that this time is across *all* divisions, and therefore also includes several CTW-only responses that were not in the 4th division, which have a shorter response time on average than calls that also require MCRT intervention (in a moment we will consider an alternate interpretation in which we use the longer response times associated with MCRT). Given the average daily number of deflection events and the average time spent on each event, this means that the deflection team only spent about 0.8 hours on deflection events on average per 8-hour shift. Clearly, they are operating well below capacity. This average daily hours on deflection events is useful to examine potential capacity under expansion (e.g. 8/0.8=10 times the number of hours on events they are taking may be possible), which we will investigate below.

Now consider the cost of the deflection efforts. SCS billings are used to determine the year-to-date billed expenses up to April 30, 2022, which were $162,674 (table 23, row 7). Because the intervention report period went through May 8, but that billing was not yet available, we projected what approximate expenses would be for 8 additional days of operation at around $20,294 (table 23, row 8). This is based on converting the 30 days of invoice activity from April to a daily rate and multiplying it by 8 to account for the 8 additional days of operation under consideration in May. Adding these two numbers, the approximate total cost of the deflection activity up to May 8, 2022, was $182,968.

Given that the deflection activities under consideration lasted 49 days so far, the average cost of deflection per day of operation was $3,734 (table 23, row 10). Given the total number of deflection events during the period under consideration, the average cost per deflected call was about $1,538 (table 23, row 11). Finally, we considered the total time spent by the deflection team and found that the average cost per hour was approximately $4,663 (table 23, row 12), or approximately $78 per minute (table 23, row 13). Comparing these costs to the police only response, the deflection program has been more costly across all measures in its rollout so far.

The preceding analysis relied on the average total intervention time of deflection across all divisions of 19 minutes and 47 seconds (0.33 hours). However, any deflection events occurring outside of the Fourth Division did not involve an MCRT intervention, which takes more than twice as long to clear (source: Table 16). If the average total intervention time in the 4th division only is considered, the new time would be 27 minutes and 19 seconds on average (source: Table 16), because this includes responses that were handled by CTW only, as well as events where both CTW and MCRT responded. In that case, an average deflection event is resolved in 0.46 hours, meaning that 1.11 total hours are occupied by the deflection team per 8-hour shift (0.46 x 2.4). The total hours spent by the deflection team across all days is then 54.18 hours (119 x 0.46), so the overall average cost of deflection per hour of response is now $3,377, or $56 per minute. Again, this scenario reveals that the capacity could be expanded, potentially by more than 7 times the number of hours on calls they are currently taking (8/1.11 = 7.21).

If the analysis focuses on the MCRT only intervention time, that took about 58 minutes 14 seconds to clear on average during the intervention in the 4th division (source; Table 16).[17] In this case, an average deflection event is resolved in 0.97 hours, meaning that 2.33 total hours are occupied by the deflection team per 8-hour shift (0.97 x 2.4). The total hours spent by the deflection team across all days is then 115.50 hours (119 x 0.97), so the overall average cost of deflection per hour of response is now $1,584, or $26.40 per minute. Again, this scenario reveals that the capacity could be expanded, potentially by more than 4 times the number of hours on calls they are currently taking (8/.97=8.2), although down-time would need to be factored into any volume.

The alternate assumptions of response times described above reveal a range of cost per time spent on response, as well as a range of total time *not* spent on deflection that could aid in discussions of expansion. Any expansion efforts that hold deflection resources fixed will necessarily decrease the cost per deflection call as well as the average cost per time spent on deflection.

[17] Note: this average time to clear is comprised of 44 minutes 22 seconds of intervention time, as well as 13 minutes 52 seconds of travel time. It is important to incorporate travel time in this case, because that combination represents their total out of service time that would also be required if it had been a police-only response.

Table 23. Summary of Variables Related to Deflection Team's Response from March 21 – May 8, 2022

Row	Variable	Value[a]	Details
1	Number of days of deflection activities under consideration	49	March 21-May 8, 2022
2	Number of deflection calls, March 21 – May 8, 2022	119	Source: SCS EHR
3	Average number of deflection calls per day (8-hour shift), March 21 – May 8, 2022	2.4	Row 2 ÷ Row 1
4	Average time spent by the deflection team per call, decimal hours	0.33	19 minutes 47 seconds Source: Table 12 in Quantitative overview
5	Average hours spent on a deflection call per 8-hour shift, decimal hours	0.80	Row 3 × Row 4
6	Total time spent by the deflection team on deflection calls, decimal hours	39.24	Row 5 x Row 2
7	SCS Year to date billed expenses, period ending 04/30/2022	$162,674	Source: SCS Invoice, April 2022
8	Estimated SCS expenses for the period covering 05/01/22 – 05/08/22	$20,294	Approximate expense for 8 days of operation, based on per day calculation from April invoice. Source: *ibid*
9	Approximate total cost of deflection up to 05/08/22	$182,968	Row 7 + Row 8
10	Average cost of deflection program per day	$3,734	Row 9 ÷ Row 1
11	Average cost of deflection program per event	$1,538	Row 9 ÷ Row 2
12	Average cost of deflection per hour of response	$4,663	Row 11 ÷ Row 6
13	Average cost of deflection per *minute* of response	$78	Row 12 ÷ 60

[a] Note that dollar values are rounded to the whole dollar

Next the analysis applies the number of deflection events to consider the police resources released due to the intervention. Taking into account the average number of police supervisors and officers that respond to a CIT call (Table 22, rows 3, 9, 15), and adjusting for 15 deflected calls where police officers were subsequently called to the scene, approximately 207 officers were released from responding to CIT calls from the 104 (119-15) deflection only calls (104 x (0.11+1.87+0.02)). Next, given the average time of police responses to a CIT call (Table 22, rows 4, 10, 16), we calculated that approximately 100 police hours were released during the intervention (104 x (0.05+0.91+0.01)).

The CCDP resulted in approximately 207 officers being released from low-level behavioral health calls equating to almost 100 hours of time released in the first 49 days.

This translates to approximately $4,586 in police salary costs averted as a result of the intervention so far (104 calls x ((0.05 supervisor hours per call x $54 supervisor pay per hour) + (0.91 officer hours per call x $45 officer pay per hour) + (0.01 other officer hours per call x $45 other officer pay per hour))), or approximately $7,643 in overall police costs ($4,586/0.6 to account for overhead costs as well). This

means that the CCDP program has saved about $156 of LMPD operating costs per day while in effect ($7,643/49).[18]

These calculations reflect the 49 days of operation for the deflection efforts under consideration so far. While the deflection program has not been proven to be cost effective to date, it may be in the future. We can use the data we have to calculate cost savings for various scenarios about how the program could be expanded in the future. These scenarios are presented later in the report when discussing next phases. It is also important to reiterate that these models only look at the financial costs associated with the intervention. One non-monetary benefit is the CCDP may improve responses times for behavioral health crisis. Due to current call demand and staffing, there is on average a 27 minute delay in responding to behavioral health calls. The CCDP should reduce the 27-minute delay by having an alternative response available and freeing up police resources. Continued evaluation is needed to monitor these potential effects.

The avenue for cost-benefit and cost-effectiveness for CCDP is multi-faceted. First, the economies of scale will drive the average cost per event down for alternative responders to provide acute behavioral health crisis support. Second, by averaging 13.744 events per shift, the CCDP releases enough police time to become cost-effective and in-effect give them additional labor hours to focus on other criminal matters. There are other costs not captured in this evaluation due to the short evaluation period; however, future evaluation will look at reductions in hospitalizations and jail,[19] and respite admissions along with their associated costs. A longer study period will allow for causal examination on impacts of call volume and repeat utilization and the associated costs. It should be noted that the cost analysis of long-term health outcomes for individuals will be limited by an individual's willingness to gain consent from individuals to track their use of referrals.

[18] These cost savings are marginal as the CCDP has not replaced any officers.

[19] CCDP is unlikely to have a major impact on jail diversion, as the eligibility criteria are limited, and the police are responding to the majority of behavioral health calls.

CCDP Responders and Community Perspectives

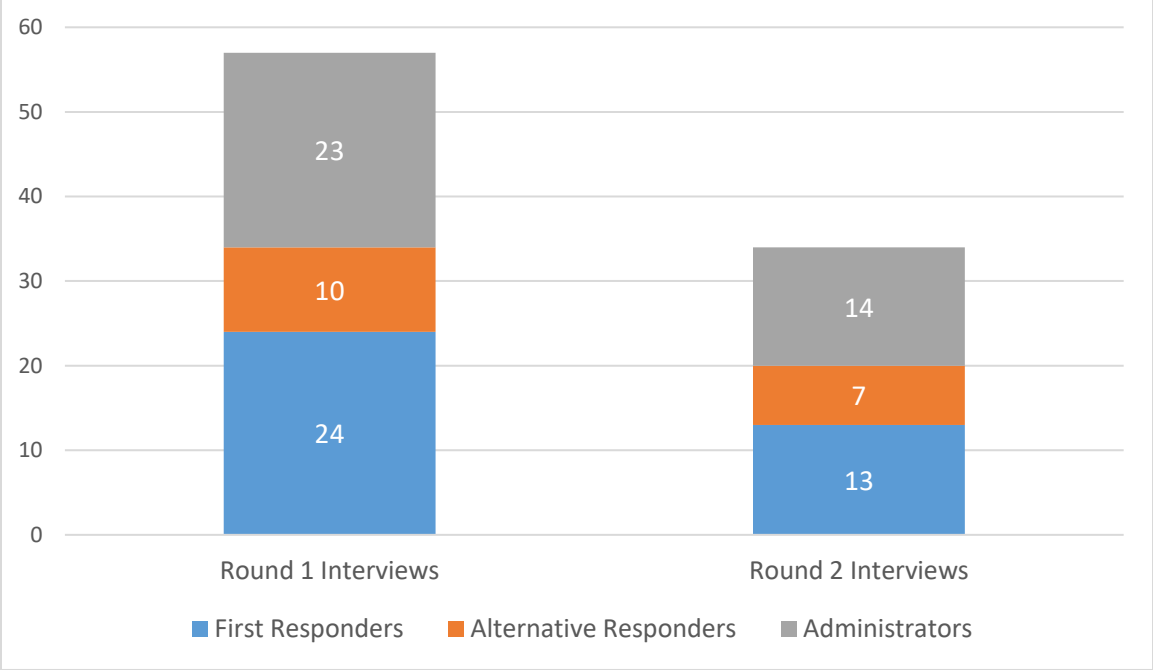
Respondent Sample

Interviews with Administrators, First Responders, and Alternative Responders

We conducted a total of 70 stakeholder interviews totaling 93 first responders (police, dispatchers, call takers), alternative responders (CTWs, MCRTs, respite workers, case managers), and administrators (police, 911 call center, SCS). 63 respondents were unique, with 30 respondents participating in more than one interview. We heard many valuable perspectives and thoughts during the interview process but could not include all the quotes in this report. For this section, we selected quotes that best illustrate the themes that emerged during the interviews or provide a contrast to a common theme. The quotes in this report reproduce what was shared in the interviews.

We conducted two rounds of interviews to compare perceptions before and after the start of the intervention. Round one interviews were completed prior to or within the first week of the start of the intervention and round two interviews were completed one month or more after the start date. Figure 5 provides a breakdown of the number of interviews completed with each stakeholder by round.

Figure 5. Number of interview Participants by Stakeholder Type



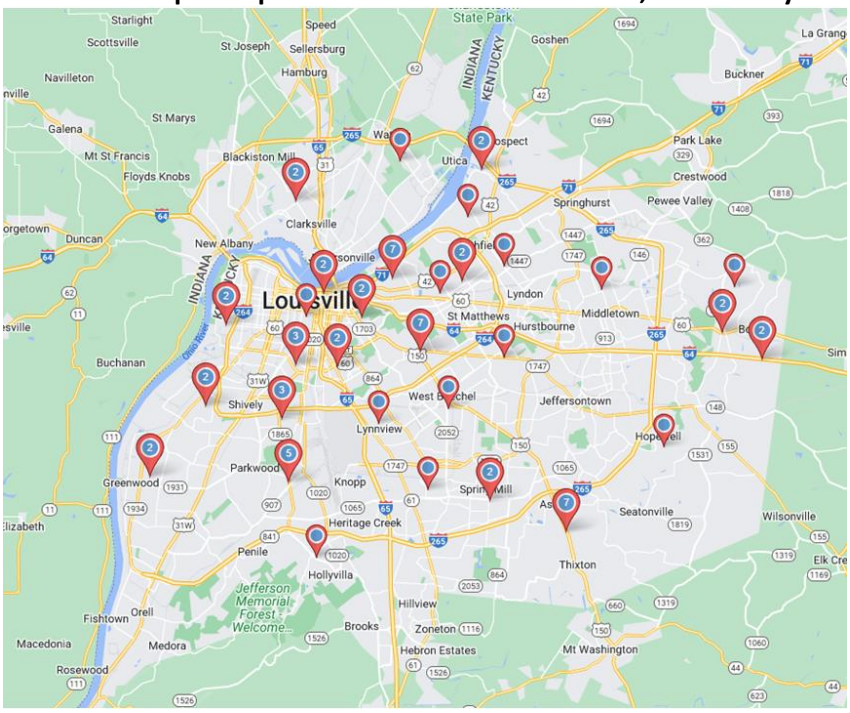
The intervention involves multiple agencies and stakeholders from Louisville Metro Emergency Services, LMPD, and SCS. Throughout this section of the report, we refer to individuals with supervisory capacity as “administrators”. To maintain anonymity, we do not identify the rank or specific role of any administrator.

There were 96 participants across all listening sessions. Among those, we have demographic information on 72 individuals. There was diversity in race, ethnicity, age, educational background, and geography. A summary of the study sample for whom we have these data is provided below.

Table 24. Participant Characteristics, Community Listening Sessions (n=72, others missing)

	Sample Size	Percent
Age		
19-25	12	17%
25-35	27	38%
36-45	19	26%
46-55	5	7%
56-65	6	8%
66-75	3	4%
Race/Ethnicity		
White	36	50%
Latino/Hispanic	4	6%
Black or African-American	28	39%
American Indian or Alaska Native	1	1%
Asian	1	1%
Black of African-American, White	1	1%
Black of African-American, Other	1	1%
Gender		
Woman	43	60%
Man	24	33%
Non-binary/Non-conforming	3	4%
Other or Prefer not to answer	1	1%
Highest Educational Attainment		
High school graduate (or equivalent)	2	3%
Associate's degree (including occupational or academic degrees)	7	10%
Some college (1-4 years, no degree)	18	25%
Bachelor's degree	27	38%
Master's degree	12	17%
Professional school degree	5	7%

Figure 6. Distribution of Participant Zip Codes across Louisville Metro, Community Listening Sessions



Participants were also able to self-identify their occupation. Participants had diverse professional and employment backgrounds, including social workers, judicial candidates, community activists, students, health care providers, teachers, and engineers, among others.

Key Findings

The following section is organized thematically and describes major findings that emerged under each theme during the stakeholder interviews. Where possible, we use direct quotes from stakeholder participants. "Stakeholder" refers to all participants including community members, first responders, alternative responders, and administrators. Some findings were not expressed by all stakeholders and in instances where first responders, alternative responders, and administrators gave responses we use CCDP responders. It is important to reiterate that these findings occurred in the CCDP's first seven weeks, as such perceptions may evolve over time with greater familiarity and experience with the intervention.

Finding 1: Stakeholders agree there is a need for the intervention.

We asked, "Do you see a strong need for this intervention?" to assess perceptions of the intervention across stakeholder groups. There was considerable alignment among community members, administrators, alternative responders, and first responders related to the need to free up officer time and, in doing so, relieve frustration. We heard three specific needs, each of them detailed below.

1.1 Deflecting calls from emergency responders

The need to deflect behavioral health calls away from emergency responders to deflect calls from police was frequently mentioned across all stakeholders. One community member explained this intervention as moving away from the over-reliance on police stating,

"Socially we depend on the police for things that we don't necessarily need them for, and so our behavior socially, collectively is more of a pattern of calling the police because there haven't been other alternatives. So hopefully this shifts the paradigm status quo so that people don't feel like they need to call the police. There are other alternatives."

This sentiment is echoed by one administrator shared that police resources are more appropriate for dealing with safety concerns and criminal activity as opposed to non-criminal activity.

"The police spend a lot of time doing things that have nothing to do with criminal activity. However, at the point it creates conflict or that it reduces their ability to do the things that they are actually, technically, supposed to be doing in keeping people safe."

While stakeholders overall responded strongly about the need for the CCDP, there were some stakeholders who expressed different views. One first responder shared doubts that the pilot would deflect calls and stated,

"Honestly, no. Some of them, unfortunately we end up sending the police on anyway, and I feel like it's kind of a... I don't know how to say it. It's kind of a waste of resources."

First responders and alternative responders had similar perspectives on the need to deflect calls to reduce frustration among emergency responders, including police and call takers. This frustration may manifest as escalation of behavioral health crises when an emergency responder is called to the scene.

One first responder stated,

"It's going to lessen the burden on the police department because they're shorthanded already. It's going to lessen the burden on us because we're not having to process those calls on the dispatcher side. They're going straight to the deflection team [alternative responders] and they're not coming across dispatcher's desks. So, it decreases our workload a little bit also."

The perspective that stakeholders shared about the need to deflect calls from emergency responders is not surprising given the purpose of the intervention. However, the interviews revealed greater nuance to this theme by clarifying the need to free up resources and alleviate frustration among emergency responders by providing access to a behavioral health specialist. There was also a need expressed to divert behavioral health related calls to a more appropriate pathway (i.e. a trained specialist).

Stakeholders noted another dimension to deflecting calls from police, recognizing that there are members of the public who will not call 911 due to past traumas from emergency response and/or distrust with emergency responders. As one first responder notes,

"I want the community to feel safe and feel like they can rely on that individual or that group of people because I think if we have the turmoil in the community of people not feeling safe or against first responders of any type."

One community member expressed the need for connecting to services as allowing the next generation to view 911 as a resource instead of a potential threat, explaining

"…I can call 911. If someone I care about is in crisis, I can call this number and I will be helped.

I'm not going to be in danger of something happening because the police are going to come. I'm only going to be helped and just seeing it as a resource rather than a potential threat that should only be used if there's something really, really bad happening."

Thus, one related need to deflecting calls from police is providing an option for marginalized populations who otherwise do not call 911, although building the trust will not come easy, as a community member noted, "I would have to see data about this program before I trusted to call personally," referencing their unwillingness to call 911 for a behavioral health crisis if it meant a police response.

1.2 Deflecting calls to ensure individuals are not institutionalized unnecessarily

A common theme across all stakeholder groups was the need to deflect calls to prevent individuals in a behavioral health crisis from being unnecessarily institutionalized at jails and hospitals. Stakeholders agreed that deflecting calls from police to behavioral health specialists may reduce escalation in crisis situations and reduce occurrences of institutionalization.

One community member described the CCDP as "a really beautiful step towards just people thriving" and another referenced recent LMDC deaths stating,

"And so yes, it is a deflection program in the sense of keeping the police from arriving on the scene. But it also is a potentially life saving program in that it will keep people who have actual medical needs out of LMDC at the same time."

One administrator shared their professional history dealing with behavioral health crises and recognizing that previous options for addressing crises were limited,

"You really had two choices in most of my career; put somebody in jail to make it stop to make them go away to make it stop…. I just think there's a huge need."

There was agreement among stakeholders that the intervention provides an additional pathway for responders to assist individuals in a behavioral health crisis. One alternative responder described an event that occurred that did not require additional services.

"I mean, we have on runs that we've done, granted, some of them have been, "Nope, can't do anything before me, but thanks for coming to talk to me." Granted, we've had some of those, but there have been other runs with clients that we have connected to mental health services, to medication services, to temporary housing, to programs that are out there to help get into more permanence is not the word I'm looking for, more stable housing. There's definitely been successes of being able to connect people to the things that they need, which is what we're here for."

While stakeholders tended to agree about the need to deflect calls to ensure individuals experiencing a behavioral health crisis are appropriately cared for, there was some disagreement about the anticipated short and long-term impacts of the intervention. One first responder shared,

"I think it would be beneficial couple of years down the road. But there's so little that everybody, general public and us included, know about mental health. We don't know any resources other than, "Send them down to UofL. They have an [Emergency Psychiatric Services] send them down there. Send them to Norton's."

First responders shared that few options exist for dealing with individuals experiencing a behavioral health crisis and, while jail and hospitalization are not the best use of resources, these are often the only options available.

1.3 Provide help and connect individuals in need to services

Stakeholders frequently mentioned the key role the intervention plays in providing individuals in crisis a linkage to trained behavioral health specialists who can connect them to needed services. Administrators and first responders acknowledged that, while traditional response attempts to provide the best care possible, training and resources often fall short of meeting the need. One first responder shared,

> *"We're going to the same people and they need help. And it's help beyond, the most help that I can give them is someone who's going to listen and transport to the hospital."*

Community members expressed similar views, indicating the importance of sending out trained professionals, explaining,

> "…There's somebody going out there, that's listening to them understanding them and respecting them as a person for who they are and trying to deal with the situation, the best they can, and giving them options. And now it's up to them to take those options and do something with it."

Administrators note that the intervention provides increased opportunities to connect individuals in crisis to services and receive assistance that they otherwise did not have access to or were unaware of prior to the intervention. One administrator stated,

> *"There are lots of ways they can get connected to services, but that hadn't existed through calls that are flowing through 911. People could call the crisis center, but there's still a portion of folks that either don't know about that option or feel safe even reaching out for any kind of mental health support. But everybody knows 911."*

In addition to expanding awareness of resources, the intervention is also viewed as providing options to individuals who otherwise would not seek help via 911.

> *"I think there's a whole group of people that historically have not typically sought help or been able to seek help because of the situations they're in, and that this will give us the opportunity to help more of those people, regardless of their situation…..I think it will allow more people to have access to care, and I think that's a huge thing."*

Alternative responders expressed the advantage of connecting people to services and, generally, more awareness of available services. One needed service is transportation for emergent needs that may not have otherwise been available,

> *"I think a huge thing that I didn't really realize before starting this is transportation. I think a lot of people have called 911 and said like, "I'm at the end of my rope. I need to get to the hospital." Or people who are schizophrenic and self-aware that they're falling into an episode and they're like, "I need to get to a hospital, but I have a no transportation. Someone help me before it goes*

further." And that's something that unless someone is actively harming themselves, the cops probably aren't going to respond to, but that's something we can do".

One advantage of the intervention as noted by alternative responders is being able to meet people where they are both physically and figuratively. The ability to send a MCRT to a location to engage in de-escalation or provide services for individuals in need allows them to get help they otherwise may not be able to access.

First responders were more likely than other stakeholders to note their limited training and efforts to deal with individuals in a behavioral health crisis. Further, first responders were aware that individuals in crisis may prefer a non-police response for behavioral health assistance.

Overall, there was recognition from all stakeholders that a pathway for more effectively addressing the needs of individuals in a behavioral health crisis is needed. The Crisis Call Diversion Model provides a pathway for first responders to route individuals in need to services and assistance that may reduce the strain on LMPD and other resources.

Finding 2: There is general excitement about the intervention though some are more uncertain that others.

We inquired about the receptivity of the intervention among CCDP stakeholders to gain a better understanding of where challenges and opportunities may have existed during implementation. In Round 1 interviews, overall responses were positive among 55 stakeholders while four expressed doubts. One alternative responder said,

"Everybody's excited about this project, even the police department. We went to the Fourth Division, I think, last week and got to meet some of the police officers. They introduced us as to what we're going to be doing. And they're like, thank you. They're looking forward to us taking a lot of these calls for them because it frees them up to do whatever else they need to be doing."

It is important to note that feelings of excitement were not universal. One first responder shared,

"I think it's a good effort. I think there is definitely people that could benefit from something like this, but there's already a crisis line. There's already people that they can talk to over the phone, and whether or not they would send people out, offhand, I'm not sure. I think it's a good effort to try to take some burden off the officers, but we need more officers. We need more call takers and dispatchers. We just need more people."

These initials reactions were anticipatory as they occurred during Round 1 interviews which were conducted prior to the start of the intervention. In Round 2 interviews, we asked stakeholders whether the intervention was meeting their definitions of success. In this round of interviews, more indicators of cynicism emerged. One first responder said,

"I don't think it changes it a whole lot…..It doesn't really change your day to day, especially if you don't know what they're taking. Cause you're still, now that we can see the CIT change to 1014, we can see those now--at first we couldn't--but it's just like another run in the queue. I've never seen 1014 with deflection, not available. It's just the 1014. And they send it to me. I've never seen deflection available."

A similar sentiment was expressed by another first responder,

> *"I don't want to speak for the amount of work that they have or the amount of calls that they get. I think they probably can handle more. I don't think on a shift they're taking that many calls, and right now I'm sitting directly behind them.... Once they talk to somebody, what paperwork they have to do or what things that they have to do to log all the data and all the information in their system. So, I mean, I don't know once they take that call, once they release it, how long it takes them to process that."*

There is acknowledgment that new interventions can take time to start working and, as the intervention is currently structured, benefits are limited. One first responder shared,

> *"Programs like this take a long time. If there's not any movement forward in a year then, what's the point? But also for us, if it stays at 10:00PM…..this is useless to us just cause they're not here long enough to really make a difference for us."*

It is important to consider these quotes in the appropriate context. This intervention is in its early stages of development and is rapidly evolving as learnings emerge. It is important to keep in mind, however, that long-term receptivity of the intervention will likely facilitate its effectiveness.

Finding 3: Stakeholders generally agree about the evidence they need to see to consider the intervention a success though there are some key differences by stakeholder type.

Stakeholders were asked to describe their perception of success in the context of the intervention and identify the evidence they would need to consider it an effective intervention.

Takeaway: Findings 1-3 reveal widespread support for CCDP based on three general needs: deflect calls from police, deflect individuals from unnecessary institutionalization, and provide support and services to those in behavioral health crisis. Stakeholders also noted several indicators of success, which creates a challenge for administrators. It is possible for the CCDP to succeed on one front while failing to achieve on others**. Model design and administrative priorities will dictate what successes are achievable and ultimately how success is defined.**

3.1 Perspectives on Indicators of Success

When asked to identify the evidence needed to consider the intervention successful, we heard the following across all stakeholder types:

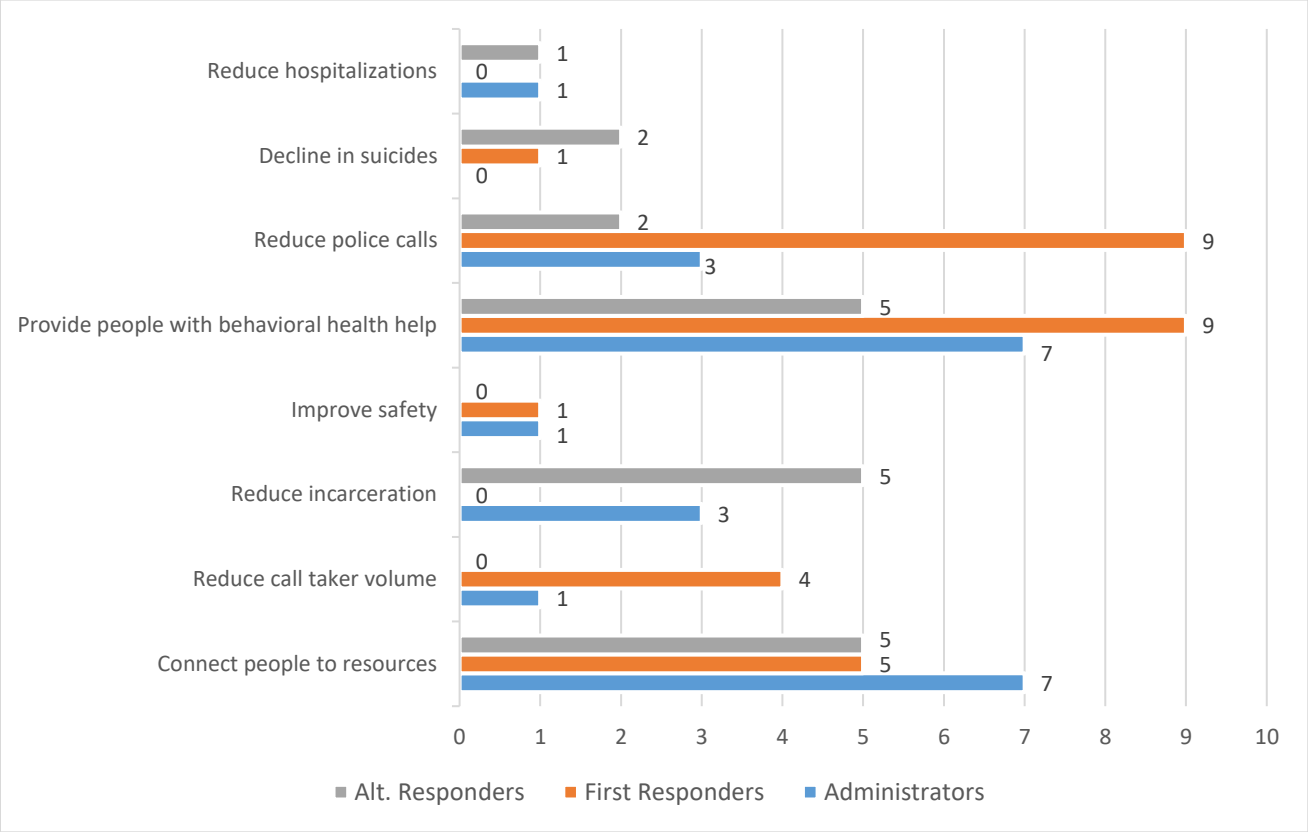
a. The number of people connected to resources
b. Reduce call taker volume
c. People with behavioral health needs receive help
d. Reduction in incarceration
e. Improve community safety
f. Reduce police calls

These indicators of success have considerable overlap with the need for the intervention as identified by stakeholders. In addition to the above, first responders identified two indicators of success that reflect their daily experience as responders:

a. Decrease in suicide
b. Reduce frequent 911 callers

First responders were also more likely than administrators to mention a reduction in hospitalizations as an indicator of success, though this indicator was only mentioned once.

Figure 7. Evidence Needed to Determine Success by Administrators, First Responders, and Alternative Responders (Round 1 Interviews)



Finding 4: Stakeholders generally feel prepared for the intervention but express additional training needs, especially related to expansion of the intervention.

This section describes stakeholder perceptions of training, including how well it prepared them for the job, perceived gaps, and, for alternative responders, information regarding the most important training they received.

4.1 Training and Sense of Preparedness

The first theme that emerged was whether training prepared people to carry out their job in relation to the intervention. Administrators tended to focus on the preparedness of responders and, overall, believed training was sufficient to get the project launched. There was agreement among administrators that more time for training prior to the launch of the intervention would have been beneficial. One administrator said,

> *"I feel like we're in a pretty good place to start as small as we are. There's tons more that they could have and will have but feel pretty good about where we are starting. And I feel like a lot of it is going to, once we finally start, we'll learn a lot more about where to go next and we can prioritize some of those things."*

Administrators and first responders expressed a desire for additional time for training but also emphasized that they are quick to adapt. There was, however, frustration expressed among

administrators regarding the lack of clear policies at the start of the intervention that made it difficult to create comprehensive training protocols. One administrator said,

> *"The good thing with our organization is we are very good at dealing with less than ideal circumstances…..we're adaptable. We orient towards whatever crisis there is and figure out a way to deal with it. I mean, the ideal way to do this would have been to have extensive meetings between the involved personnel. I think in both fields, you can't underestimate the value and importance of trust."*

On the other hand, there was recognition among administrators that no amount of training could account for every possible scenario that responders might encounter. An administrator said,

> *"I feel like we did a pretty good job of doing an overview of all the different things that they might encounter knowing that what they encounter is enormous and it's going to be different for every run. We could truly train people for a year and still not have been prepared for everything."*

First responders reported that the intervention made only small changes to their day-to-day work. While their training was limited due to time, they reported feeling prepared for their role. Often, first responders leaned on their previous experience with behavioral health crisis work as a rationale for feeling prepared. Though many felt prepared, there was recognition that a new intervention would take time to fully embrace.

Because the alternative responder role is new, these stakeholders experienced some nervousness about their role. One alternative responder shared,

> *"I do feel prepared. I feel nervous, but I have a certain level of preparedness through training, through learning the systems that we're working with. It felt like a work in progress for the past four weeks that I've been involved because that's really what it is. It's starting something from the ground up."*

There was acknowledgment that experience in the field would be complementary to training and, in some way, more preparatory.

> *"I don't think the training's missing. Now we're missing the clientele. You can have all the training in the world, but this is a field and experience things and you have to get out there and interact and you have to make mistakes and learn what not to do or what to do because everybody's different. So, the training is good but it's specific. It's just a training."*

4.2 Training Needs

Stakeholders had the following suggestions for additional training opportunities.

1. Admins
    a. Managing co-occurring disorders
    b. Safety training
    c. Alternative responder protocols
2. First Responders
    a. Safety training
    b. Behavioral health training/mental health first aid
    c. Intervention components and roles of MCRTs and CTWs
3. Alternative Responders
    a. First aid
    b. Harm reduction
    c. Naloxone training
    d. Behavioral health resource availability
    e. Training to enhance skills on the job (e.g. techniques for calming individuals down during a behavioral health crisis)
4. Community
    a. Call-takers screening behavioral health calls
    b. MCRT's environmental safety awareness
    c. Mental health first aid

> *"One of the things that has crossed my mind is potentially teaching the MCRT team some type of way to take care of themselves, whether it's self-defense, maybe getting somebody to come in and teach them…..not an offensive type of thing, but a defensive type of thing if somebody attacks them."*
>
> *Administrator*

Frequently mentioned was the need for additional training to support call takers.

> *"I think…..how to communicate with people that are having a crisis on the phone and just…more coaching, on like what to exactly ask them or say to them…..So these calls are being handled appropriately."*

> *"I think our call takers…..sometimes it's, "Oh, this person's rambling, they're crazy. I'm over it." And they stop listening. And I get that. I was there for three and a half years. I just think that a lot of our call takers are burnt out right now and they're on their 300th call, they're just like, "Ugh, great, it's a crazy person." And they just want to be done with it."*

Similarly, the need to better understand the resources available to call takers and alternative responders to assist individuals in a behavioral health crisis was mentioned several times.

Finding 5: There are varying degrees of knowledge of the intervention among stakeholders.

In this section, knowledge and awareness of the intervention among CCDP stakeholders is discussed, including how it works, and what components are missing. Communication channels and information sharing between individuals and organizations as it relates to the intervention is also explored.

Overall, administrators expressed a clear understanding of the intervention's purpose and how it works. Most understood that the intervention begins with a call to 911. There was less understanding of specific components of the intervention, however, such as roles and responsibilities of the CTWs, MCRT, and the Respite Center. Few administrators lacked complete awareness of the function of the CTWs,

MCRTs, and respite care though there was less overall awareness of the function and purpose of the Respite Center. One administrator said,

> *"I don't know anything about the respite space, and I don't know much about their MCRT, and honestly, this is one of the, I guess heartburns I have over the project…"*

Limited awareness of the individual components may be related to challenges related to communication and information sharing. One administrator said,

> *"… we've asked [for documentation]….all the policies and procedures I've had to develop myself with the help of [name] or [name], but mainly me from the stuff that we got."*

Takeaway: CCDP stakeholders felt training prepared them to carry out their duties. All stakeholders indicate training needs they believed alternative responders needed. The desired training needs were, in part, a product of respondents knowledge about the intervention. CCDP stakeholders had general awareness of how the intervention operated, but the general public expressed little knowledge. Few respondents outside of the alternative responders, could explain what the CTWs and MCRTs do and the services they provide. Even fewer knew that respite existed. **Limited knowledge of CCDP's operations and intricacies leads to uncertainty about what the CTWs and MCRTs are capable of handling and contributes to a first responders' willingness to engage the model.**

There was more variation in understanding of the intervention among first and alternative responders. Many did not understand how each component operated outside of their specific job duties and were not aware of updates to the intervention, including changes to eligibility criteria that took place after the launch. First responders were mostly clear about the role of the CTWs but were almost entirely unaware of the purpose of the MCRT and the Respite Center. As it relates to the Respite Center, administrators and first responders were, overall, not familiar with the purpose of it or how it fit into the intervention. Alternative responders expressed a clearer understanding of the role of the Respite Center, likely because of their first-hand experience with transporting individuals in crisis to the Center. One alternative responder stated,

> *"We've been up there a couple of times. We've handed some clients off there….it's a nice, quiet spot for them to calm down and then where the caseworkers can usually get there the next day and figure out what's next because it's just a 23-hour stay."*

Finally, some alternative responders perceived the Respite Center as a strategy for keeping individuals in a behavioral health crisis from jail. One responder stated the following regarding the role of respite:

> *"10 out of 10 essential. I mean, it's potentially making the difference between somebody ending up in a cell and somebody ending up in respite where then they can transfer into any number of different recovery programs and better themselves instead of ending up in jail, abused, and alone. It's a difference of night and day."*

Finding 6. A variety of challenges emerged during implementation that should be addressed in upcoming phases to ensure success.

This section presents challenges to the intervention that occurred in the first seven weeks of implementation. Understanding these early challenges can support proactive discussion to ensure that unaddressed needs and challenges to the intervention are dealt with early on.

6.1 Communication Challenges

Perhaps not surprisingly, given the complexity, reach, and multi-organizational nature of the intervention, communication challenges were frequently mentioned by stakeholders as a barrier to success. When asked about inter-agency information sharing, administrators and first responders generally shared the view that not sharing protocols and data have been a challenge. As mentioned before, there was confusion and frustration across stakeholder groups about protocols for the intervention and roles (e.g. MCRT, CTW). Administrators stated that information was being shared between organizations at high levels, but it is unclear, based on the interviews, whether the information was shared with other levels of staff within the organization. Administrators also shared that they had received general policies related to the intervention but had not been provided with a detailed protocol of all components. This level of information sharing is critical for ensuring that all staff are aware and engaged so they can activate all components of the intervention when necessary. It can also support administrators and staff in process improvements. All stakeholders expressed frustration that they were not given the full extent of policies and procedures related to the intervention though many suggested the rapid pace of the intervention may have been a barrier. One first responder suggested a flow-chart could help improve their understanding of the intervention as a whole and their role within it.

> *"At a certain point, before you do something to another agency or for another agency….that agency has to know about it."*
>
> Administrator

There was additional frustration expressed likely related to gaps in communication across agencies. One first responder shared frustration about uncertainty regarding MCRT availability (deflection) related to calls:

> *"Maybe I am one of those salty, jaded vets already, I don't know, but I feel like when it says, 'Deflection not available,' my first question is why? I haven't seen you available for anything, why? Why are you not available? Or, why can't you take this? Or, why does this not qualify for you? I don't mean to sound rude or disrespectful, I don't, but that's where it comes down to brass tacks for us is. We have to see a difference."*

Gaps in communication also impacted staff's ability to provide appropriate services to individuals in need, in some instances. One alternative responder noted that they were not informed of an individual being transported to respite care so they were not able to provide a warm hand-off. Another noted that breaks in communication has resulted in individuals in crisis not receiving appropriate levels of care.

Stakeholders suggested creating internal processes to facilitate communication and feedback regarding the intervention. Ideas included creating a dedicated email for the intervention, monitored by supervisors, peers, and upper-level administrators to address needs as they emerge. Another idea was to create daily action reports that could be used for quality control and identification of training needs.

There was a desire to engage in more frequent sharing of data related to call volume, specifically how many calls the CTWs were taking and the outcomes of those calls. This information can help each agency better understand how the intervention is unfolding. One first responder said,

> *"I would love to know what their solution to our problems are because that's the whole point of this partnership, is we see areas of need that they can meet better than we can. And until I see evidence of that happening, it feels like nothing's happening."*

Some stakeholders wanted to know the number of CIT calls, how many deflections occurred, and the outcomes of those calls. There was also a desire to better understand caller patterns to identify frequent callers and better identify needs to provide appropriate referrals. Finally, some responders requested feedback related to their handling of calls so they could improve in the future. One responder said,

> *"I would like, at least for maybe the first few months, if they could listen to some of the 1014 calls, the CIT calls and just let us know, okay, did we parse it out properly? Or should we have sent this to the CTW?"*

The use of volume, outcomes, and performance feedback can be used to provide immediate training on how the intervention is working and has the benefit of creating familiarity and confidence in the intervention.

6.2 Lack of structure for the intervention

There was some frustration expressed regarding the lack of structure of the intervention. Given that this is a pilot project, designed to start small and then adapt based upon learnings, it is not surprising that the implementation process has felt loose. However, for some, this has been an uncomfortable process, as shared by a first responder,

> *"We need a strict framework by which to operate from because it's like a piano player, they can't learn to play these great classical pieces until they learn the fundamentals. So if you have a framework by which to build those fundamentals, then you can use the ambiguity of different runs to actually inform how you handle those….I think that experiential learning mixed with a solid framework or an SOP…really gives you the ability to be able to actually implement this tool."*

Alternative responders and administrators also expressed frustration with unclear protocols and procedures or the information not being shared between or within agencies. The perceived lack of protocols and procedures created a sense of frustration and sowed doubts that the intervention was thought out.

6.3 Lack of Community Awareness and Education

The decision was made by agencies and stakeholders to not engage in strategic or extensive community outreach about the intervention so as to avoid overburdening the implementation at the start. While the rationale behind this decision was generally supported, there was acknowledgement that community outreach is needed in future phases to ensure success of the intervention and reduce confusion in the community.

Community members noted their knowledge of the CCDP primarily came from their own social networks, word of mouth, or community engagement sessions, with one community member suggesting more engagemenet sessions would benefit outreach stating,

> *"I think having these sessions like on multiple different opprotunities to attend, multiple different times, just actively seeking a response form the commuinty has been amazing."*

There was broad acknowledgement of the need to engage in strategic and thoughtful community engagement though some stakeholders were interested in doing so sooner rather than later. One administrator shared,

> *"I would like to see more education and more information put out to the public, more utilization of media in that way. I think that people need to know more about what's out there. There's not enough information on what this... And I know it's been on the news and so forth, but there's a of people who don't watch the news, a lot of people who don't watch television. They do connect to social media, though. I know people who would just love it, because they have issues that they don't want to call 911 for because there are mental health stuff going on."*

Increasing community engagement is likely to increase utilization as the public becomes aware of the intervention. Responders expressed variation in how much the public knows about it and noted several instances where the public were excited for the intervention. One alternative responder said,

> *"The public at large that I've interacted with has been insanely positive about it. Every single person that I've talked about with has been excited about it, and I have been shocked at how many people have heard about it."*

Communicating to the community is seen as two-fold. First, there is the need to make the community aware of the intervention, but there is also the need to educate them on available resources and on utilizing 911 for mental health crisis. Developing effective public awareness and education materials will be vital to providing services to those in need.

6.4 Community wants more relationship building

Another dimension to the communication challenges is the community expressed frustration that greater efforts were not made to include community in decision-making or building relationships with community providers. One community member noted that relationship building is at the center of supporting people and wanted to build relationships between the response teams and community partners, noting

> *"I understand the way, like you were saying, this is a pilot. This is starting up, new, small, given the circumstances, so it makes sense, but I would hope, in the future, there would be talks about expanding that criteria to include, not just [name removed], but the Mobile Outreach Teams that are always out in the field, who do have relationships with the people that might need help. I think about some of our outreach people who know ... We go out on the street, they know them by name. They know their whole backstory. They have almost a friendly relationship, so that might be a blurry area right now that might be good to know more about in the future."*

Community members believed that greater community input can provide the administrators with their experiences with past and current responses and inform them of gaps in current systems that could inform future expansion. As currently constructed, community members had doubts that the CCDP would be effective because of restrictive criteria, with one participant explaining their desire for input and whether the intervention would be effective,

> *"…if it continues as it's rolled out, no. If there is any opportunity for growth and change, maybe, but that has to be a fluid process that allows for continuous community input that says, okay,*

well, we're doing it this way, but that really isn't working for us over here because I have this son who's 45 and he's taller than my husband and I together. And I can't control him or whatever my situation is. Or I have a 15 year old or whatever I have, but if they're not continuing getting our feedback and saying what's working and what's not, then we already know that they didn't roll it out in a healthy way."

The community wanting more input reinforces that the CCPD can be successful in deflecting calls, but if the purpose is to provide acute crisis support for the community, then engagement with the community to understand their needs is paramount to achieving success on this dimension.

Finding 7. Some facilitators of success are emerging.

CCDP stakeholders did indicate positive communication channels that were contributing to successful processes.

7.1. CCDP Stakeholders felt heard in the planning and decision-making process.

First and alternative responders frequently mentioned that their voices were included in planning and ongoing decision-making. The use of staff meetings to provide opportunities for alternative responders to discuss challenges and identify areas of need were beneficial. During these sessions, responders noted the ability to work through various hypothetics and provide feedback on people's comfort levels, Simliar approaches were noted in other organizations in efforts to involve front-line personnel in decision-making and the development of processes.

Takeaway: Stakeholders identified several gaps in communication, with a lack of information sharing being a primary concern. Stakehodlers want feedback on the volume of calls alternative responders took and exchanging of policies, protocols, and training guides as needed. Community members also noted the lack of community education, leaving them unaware of what the CCDP is and how it operates. CCDP stakeholders did note that internal communication structures were positive as they received good support from supervisors and were involved in the decision-making process. **Communication structures are vital for building relationships, familiarity, and trust necessary for the CCDP to achieve its goals across responders and community. Greater community engagement and input will help build trust, identify gaps, and offer innovative solutions.**

7.2 Supervisors have been available and responsive to stakeholder needs.

Stakeholders noted that their supervisors were responsive to their needs as the intervention launched and adaptations have occurred. Noting that the opportunities to having a voice resulted in quick responses and solutions, as one alternative responder noted,

"We've been doing team meetings weekly...and actually I was very pleasantly surprised that within three hours of having mentioned that in the staff meeting we had already sourced the blankets and figured out their delivery on Monday next week. That felt great."

Individuals who believed supervisors were responsive and supportive were also more likely to have positive perceptions of the intervention and/or were more willing to give the intervention an opportunity to develop. Not everyone, however, had positive experiences with supervisors. Several respondents expressed frustration that when they had asked questions, they were told by leadership that they would get back to them with answers, but no follow-up occurred. Another responder mentioned the limited interactions they've had with their supervisor and the barriers this created for their success.

Finding 8. Safety concerns limits expansion and trust.

Stakeholders had similar responses when asked about their primary safety concerns prior to and after the start of the intervention.

8.1 The unpredictable nature of emergency response.

Stakeholders' primary safety concerns were related to the unpredictable nature of responding to behavioral health calls. First responders, in particular, noted their experiences with calls where an individual started off calm but escalated in behavior and how those experiences create concerns for MCRTs responding to calls. As one first responder explained,

> "*I think the biggest concern in the room is the safety for the mobile responders because you just don't know what's going to happen to somebody. They might be fine one second, and then the next they're trying to hurt somebody…Mainly making sure that they're not put into a situation that they don't need to be in. That's my personal biggest concern.*"

The safety concerns extend to the potential presence of a weapon or someone grabbing a weapon during the interaction, changes in a consumer's behavior while transporting them, or sending a call to the CTW and MCRTs that result in getting them hurt. Administrators also noted safety was a central focus in planning and developing protocols, with one administrator noting "safety was and is my biggest concern, I do not want anyone to get hurt."

Stakeholders were primarily focused on the safety of responders rather than the consumer, with only 14 respondents making explicit references to maintain consumer safety. Community members, however, were more likely to note safety concerns for the individual in crisis and concerns that the police may escalate a situation by their presence or actions, a sentiment shared by other stakeholders as well.

8.2 Differing views on MCRT's safety preparedness.

While there was universal recognition that behavioral health events can be unpredictable, there were differing views on alternative responder's safety preparedness. First responders expressed doubts about their inexperience in relation to the experience of police officers, with one first responder stating,

> *"That's one thing with the officers. The officers have become familiar with these people. They see these people every day. So, they know if it's a person that they see out there all the time, and they're just being their self because of their disability."*

This individual later says,

> *"Where I don't feel like these CTWs, initially in the beginning anyways, are going to know enough about these people."*

First responders and community members also expressed concern about whether alternative responders would maintain distance, be aware of potential danger, and have spatial awareness to know escape routes, if needed.

This view contrasts with alternative responders who expressed comfort in their safety protocols based on their work history and using teamwork to maintain safety. As one alternative responder noted,

"I've worked with plenty of adults in crises, in the community, clients that I had that weren't violent and didn't dream of being violent. There's such low co-occurrence of mental health and violence. It is possible, it does happen. It happens constantly, but it is not evenly represented in the numbers and the headlines and the things that are seen. That's the fear of the people around me."

The differing views in safety preparedness are driven by differing occupational views on behavioral health and violence. It should be noted there is little evidence to suggest individuals with mental illness are more likely to be violent than the general public.[xxviii] Further, individuals with mental health challenges are more likely to be victims than perpetrators.[xxix]

8.3 There are avenues for alleviating safety concerns.

Stakeholders noted several avenues for alleviating safety concerns, with the biggest element is gaining familiarity with what the alternative responders do and their approaches to safety. Community members expressed the importance of alleviating their safety concerns by building relationships with alternative responders, as one community member explains,

"At the end of the day, safety is rooted in relationships. And so if you are a member of the community, you are invested in the safety of your neighbors, of your community. You want to see them healthy… Safety is rooted in relationships."

Increasing information sharing about the alternative responders will also allow first responders to be able to identify them in the field, as one officer explained the problems of not knowing how MCRTs are dressed,

"When I go on scene, I need to know which person I am going to help. Which person am I going to protect first? And if I don't know the difference between who's who and everybody around, then that can be bad."

A related avenue is being able to view MCRTs' events to know their location and notes associated with the run in real-time, with a first responder noting,

"…if the police officers can't see the calls for service, they can't see that they're out on this…Right now, officers can't see that. They're unable to do that for the mobile units."

First responders expressed a greater sense of ease if they are able to view MCRT runs and be able to provide immediate emergency response if a safety situation arose. First responders also expressed support for MCRTs to walk away from any situation they are uncomfortable with and call the police to assist, with one first responder responding to this scenario by stating, *"Absolutely, we do the same thing… I have no problem with it."*

Stakeholders also noted increase training, including cross-training with alternative and first responders to increase familiarity and define response protocols and for alternative responders to receive some basic defense training. Clearly defined protocols were of particular importance for alternative responders to ensure unnecessary escalation and create safety concerns for the individual.

Takeaway: Safety and volume were the primary factors that guided model design and the creation of the inclusion/exclusion criteria. Stakeholders note the uncertainty of behavioral health calls and do not want responders or consumers to get hurt. Safety concerns derive from experience and a lack of knowledge about CTW and MCRT training, with alternative responders feeling confident about their safety training and other stakeholders expressing doubts. Stakeholders identified avenues for alleviating safety concerns, with first responders noting they will always have some concerns. **Safety concerns, perceptual and situational, guide model design and exclusion criteria and are a potential barrier to increasing volume and expansion. Only 21% of all Fourth Division behavoiral health calls were classified as "Deflection" or "Deflection Not Available" while CCDP is operating, suggesting a combination of eligibility criteria and stakeholders comfort level with CTW/MCRT safety protocols are influencing volume. Increased familiarity with operations and continued policy development that minimizes safety concerns, are key for increasing volume.**

8.4 Safety is a barrier to volume and expansion.

An overarching theme related to safety is that the safety concerns generate hesitancy in sending 911 calls to the CTWs due to uncertainty or for the police to contact the CTW as they do not know if they are capable of handling an event. Some of these concerns will be alleviated with time and experience, however, this process is slowed by unaddressed safety concerns. As one first responder explains, "we need to trust that you're going to come there and not screw it up to the point where we have to come and fix it. And it's become a fiasco. You need to trust that when you need help, we are going to be there immediately and make sure that you stay safe. And we all need to trust that at the end of the day, we have that consumer's best interest and the community's best address in mind." This mindset is also extended to call-takers who do not want to send a call to the CTWs and MCRTs, that could get someone hurt, instead preferring to err on the side of caution and send the police.

Stakeholders also express safety concerns when discussing expansion. The hesitancy to allow direct access to the CTWs, expand to third party callers, or expand to other call types are heavily influenced by safety concerns. Similarly, the desire to expand to co-response, allow police to review MCRT runs, and provide radio communication are guided by the belief that these elements would improve safety.

Finding 9. Widespread uncertainty about CCDP's volume.

Throughout interviews the issue of CCDP volume arose in relation to evidence, communication, and knowledge and awareness. The following section focuses on data seeking to increasing volume and following protocols.

Finding 9.1. A desire to increase CCDP volume.

Within the first week of the intervention first responders and alternative responders expressed the need to increase volume. Collectively, everyone recognized the benefits of starting small so people could get familiar with new processes, as one first responder notes,

> *"So before that, I think it was very specific. I see the good and the bad in it. It was good because it was able to get our staff exposed to just saying these words, saying the word, "deflection," saying the word, "mental health," just getting that exposure to it, right? I think it was good in that sense."*

While starting small was viewed as positive, stakeholders expressed a desire to expand the criteria to allow greater volume, with widespread belief among respondents that alternative responders could handle more calls. One alternative responder provides a succinct summary of the desire to increase volume,

"I think where we're at right now with staffing and training, maybe it's good, but we could definitely use a little bit more. I do think that opening up to different districts might be useful. We did this week, just start opening up to second party callers, which we anticipate really increasing the call volume. But it's hard to watch a call come in that would've been perfect, but it's a couple of blocks away from where we're servicing."

"As soon as we can get people in. I mean, that's the glaring challenge that everybody has, is getting candidates for positions." Administrator

Increasing volume leads to the logical outcomes of respondents' needs for the CCDP including deflecting calls and providing help to those in need. In turn, low volume leads to frustrations that the CCDP is failing to meet individuals needs and may harm buy-in, with respondents giving varoius time ranges for when doubt seeps in, with one first responder noting, *"At least another month or so, maybe, I'd say two months max,"* whereas other first responders were willing to give it six months to a year.

Finding 9.2. Questions arose as to the proper utilization of protocols and procedures and its impact on volume.

Takeaway: There is widespread recognition that volume needs to increase, especially for first responders who are noticing a reduction in calls. Stakeholders recognize the complex nature of behavioral health 911 calls but note that call-takers play a key role as gatekeepers to the intervention, with call-takers noting they are not behavioral health experts. **Behavioral health 911 calls present challenges for call-takers and CTWs as the limited information, coupled with model criteria, concerns over safety, and differing views on what is eligible allows deflection-eligible calls to slip through the cracks, with the exact number being difficult to estimate.**

Stakeholders noted the subjective nature of identifying 911 behavioral health calls and determinations of appropriate response, with several respondents suggesting additional training for call-takers to improve their recognition of behavioral health conditions. For first responders, they indicated that call takers are the gatekeepers to how calls are distributed, and as one call-taker noted when asked about whether people have different views, they noted *"Oh yes. You can have 20 people in there and they'll all have 20 different opinions."*

As noted in the finding 4.2, first responders indicated their limited training on behavioral health and this training extends to recognizing someone in behavioral health crisis. If communicaiton specialists primarily rely on statements and tone to determine behavioral health crisis, this has considerable implications for accuratley coding calls, especially if there are co-occurring issues noted in the call. However, first responders also noted frustration of calls that they were sent to CTWs, but the CTWs sent back to call-takers believing they were not eligible.

Behavioral health 911 calls present challenges for call-takers as the limited information, coupled with model restrictions, concerns over safety, and differing views on what is eligible resulting in many eligible calls not being sent to deflection and this number is difficult to estimate,

"I mean you can, I don't you put a number on, I don't think so. It's just, I mean, cause you, the call taker is just getting a little information that you get sometimes. Cause a lot of times its callers call in and they hang up, before they get all the information."

Another challenge for volume, is that CTWs have to dispatch MCRTs. Currently, if only one CTW is working, another SCS deflection staff member will provide support who can assist with dispatching and communcating with the MCRTs. However, if the CTW is providing crisis support to an individual over the

phone and a second eligible call comes in the second caller will be put on hold since the CTW is engaged. If there are alternative avenues for dispatching MCRTs, than the second-caller might be served by the MCRTs. As the model operates now, the MCRT is rendered stationary if the CTWs are otherwise occupied.

Finding 10. Staffing concerns create barriers to expansion.

CCDP stakeholders identified staffing levels as a challenge within their own organizations and as a barrier to expansion.

Finding 10.1. Staffing shortages are impacting intervention expansion.

One of the reoccurring themes that emerged throughout the interviews are staffing levels and how they impact the intervention. During the interviews labor shortages were mentioned in the context of organizational challenges and challenges specific to the intervention. Administrators overwhelmingly cited issues related to a limited work pool as effecting their ability to hire and retain personnel and this is true across all organizations. One administrator evoked the "great resignation" in reference to hiring challenges. The issues related to hiring were not limited to behavioral health as first responders also noted challenges in filling positions with one administrator noting there were over 50 vacancies in their organization. It is common to hear about labor shortages impacting organizations.

The primary limiting factor to expanding CCDP is staffing shortages. Although leadership felt favorable about the prospects of expansion, most participants were hesitant of this prospect as the staffing issues were (1) too great currently and (2) many felt like the staffing issues would persist for the foreseeable future. As one administrator noted when discussing their desire to expand operating hours to 24/7, "I can't do that until I get to the minimum…."

Takeaway: Staffing was identified as the biggest challenge facing administrators. **Innovative solutions to staffing are needed as adminsitrators noted staffing was the number one barrier to expansion.**

Another administrator also noted the desire to expand and referenced the labor shortage as being a challenge in achieving that goal. The interviews indicate that one of the major hurdles for the intervention moving forward is also for first responders, as an administrator explains, *"Unfortunately, our shifts are really…we're short staffed too."*

There was universal recognition that staffing levels need to increase across the board for significant expansion to occur and this issue occurred in the context of expanded hours, expanded divisions, or other avenues for increasing volume including in respite space.

Finding 10.2. Qualifications as a potential hurdle to staffing.

Several respondents discussed that they felt the requirements for each job were sufficient but did note that the qualifications might pose challenges hiring behavioral health workers. Administrators noted that the qualifications for the deflection team were sufficient, with one administrator noting in respond to whether they think the qualifications are sufficient,

> *"I do. We added some things to it. We wanted somebody that was…especially at a CTW, we wanted somebody that had a degree, either a bachelor's degree or master's degree".*

Another element to the qualifications is being able to meet state and federal requirements for working in 911 communication centers or accessing computer aided dispatch systems, not all candidates would have met their standards, as one administrator explained,

"So, I don't know their qualifications. We did tell them things that they…So some of the MCRT people probably, we wouldn't have hired… because of our strict policies with the states, CJIS requirements, we probably couldn't have hired them."

The requirements to work within 911 communication centers also creates challenges for hiring call-takers and dispatchers.

Finding 10.3. Difficulty and uncertainty with recruitment strategies.

Administrators noted the challenges with recruitment for behavioral health positions, noting they've had success in some areas getting applicants, while acknowledging that attracting applicants isn't enough as they do not always follow-up,

"Just recruiting in general. I think there's a lot of jobs and not as many candidates. But again, like I said, we're very lucky that when we posted this, I think at one point we had a total of 30 applicants. But the same thing we see in other positions, sometimes people apply and they never call us back, or they set up an interview and they don't show, or after the interview they say, 'you know what? This isn't what I thought it was going to be.' We had one person who in the interview just kind of said, 'I thought this was a defund the police.' This wasn't what I thought it was. I'm not interested.'"

Administrators note recruitment challenges are not limited to the CCDP but exist in other behavioral health positions and similar challenges were reported for filling first responder positions. Despite widespread challenges, questions arose as to what recruitment strategies were being used to attract candidates, while others noted perceived instances where qualified people applied and were never contacted. The challenges surrounding staffing have direct organizational impacts and also point to issues related to communication and sharing information across organizations. In turn, the lack of communication clouds decision-making processes as shown in the next section.

Finding 10.4. Innovative solutions are needed to increase staffing.

Stakeholders identified two possible solutions to address staffing shortfall. One solution is to use existing employees to fill in gaps and allow the intervention to expand, which administrators are already doing, as one notes, *"We've only had one applicant so far, so we're actually going to borrow existing staff to work toward this project."*

Using existing employees to fill gaps was the primary avenue for expanding the intervention, but one administrator raised another challenge related to staffing the intervention, which raises another possible avenue for attracting applicants. One administrator relayed concern related to the difficulty staffing midwatch shift and how that can create staffing challenges,

"As the program becomes more involved, more and more runs over more and more divisions, I can just see a limited CTW staff in order to handle the amount of calls coming in, keeping that positions staffed…during that 14 to 22 or 20 hours because that's a very difficult schedule to maintain employees during those hours…."

One possibility to increase an applicant pool might be to move to 12-hour shifts where alternative responders, especially CTW, MCRT, and case managers have more days and weekends off. The move to 12-hour shifts also allows for expanded hours which has several benefits to the intervention. While the

use of existing employees can help the intervention in the short term it may create long-term problems with turnover. Forcing many existing employees were to absorb the other job duties and responsibilities of vacancies and lead to burnout and turnover, which could exacerbate the already prominent staffing issues.

Finding 11. Respite space is limited and idiosyncratic for behavioral health crisis.

Stakeholders had limited knowledge of the CCDP's respite component and used the Living Room as a reference point. Stakeholders described the current respite space as a different form of crisis stabilization.

Finding 11.1 Setting is institutional, barriers to entry, and limited capacity.

Stakeholders noted the current respite space is a good starting point, but not a long-term solution to serve the CCDP, as one administrator noted,

> *"I feel like it's good for where we are right now. When we look at best practice models and things like that, like the one that's in North Carolina that is purely peer run is very much a home setting and things like that, that is true respite and, and peer led and things like that. That's a someday kind of thing. For what we have, I think it is good because it's already a 24/7 facility, it's already linked in with seven counties."*

One administrator acknowledged that the current space is not designed as a "drop-in" facility and goes on to describe their knowledge of other places, "And I've heard lots of presentations from other cities. And one component that we don't have is like the living room or that model of a center where we hub out of and can bring people to."

Alternative responders indicated unfamiliarity with who should go to respite and what to do with individuals once they arrive, as one alternative responder explains in reference to the confusion,

> *"And so I need us to really understand everybody, all the players at the table that are involved to understand the procedure so that we are serving clients to the best of our ability."*

During interviews the specific inclusion/exclusion criteria were not articulated and researchers did not receive protocols describing those, thus it is uncertain what the guidelines are for determining if an individual "meets" the criteria and will be accepted.

Finally, stakeholders indicated the current respite space is limited and is designed to accommodate seven clients at a time, four in one room and three in another connected room. This capacity was for individuals brought by MCRT and others brought in for addiction stabilization. Staffing difficulties limited operations to a single room of 4 beds, and two are designated for the CORE program (see finding 10.2 for more information on CORE).

Finding 11.2 Services are limited and designed for addiction

Another factor related to using existing space for respite, is that the processes and services are not designed specific to behavioral health crises. For instance, the current respite space is also unable to prescribe or administer medication, a serious limitation given the nature of common client needs.

The services that are available are primarily focused on addiction and staff's training is focused in that area, as an alternative responder note explaining training gaps, "… introduce if it's strictly mental health

disorder that you're coming across in symptoms and what are some techniques and interventions that kind of fit. But otherwise, as far as like how to do trauma informed care searches and de-escalation and those things, they get lots of training for those stuff." The alternative responder further indicates that training on motivational interviewing within the respite center would also be beneficial.

The biggest challenge noted is the majority of their clientele comes from the CORE program which is through the emergency room. As one administrator explains, " It's people that are specifically acutely intoxicated. The ER will call us, we'll have a peer support go out and meet them and bring them to our respite center." The administrator notes that CORE clients and existing processes may not apply to individuals coming to respite via CCDP, describing a situation where MCRT brought an individual to respite and the differences in needs,

> *"They need to sleep. They might just... So for example, we had somebody that was sitting down in our eval department, and it's a several hour process because you're meeting with nurses, clinicians, nurse practitioners. And finally, the person was just like, I just want to lay down. Can I just go lay down? And that was really all they were needing, but our staff is not accustomed to that."*

Due to the nature of the location, there are a range of rules imposed on clients in the respite center. For example, cell phones are not allowed because the cell phone may be passed to another client. Research observations from the space also note there are on restrooms adjacent to the space and staff must escort residents through locked doors to access the restroom. These restrictions vary from national best practices (CITE) for low-barrier behavioral health respite space, as one administrator explains,

> *"I think it's just confusing because if the model is truly to be more of a let's hang out and chill and rest and we're very driven here to help and refer and treat. And that's what they're seeing when they come in. That's what the process is for anybody else that's in the room. And so it is a little maddening, if that makes sense."*

Collectively, administrators and alternative responders note that the dual purpose of the space creates challenges for entry, service availability, and the ability of staff to provide needed support, although they indicate that they will adjust with more time.

Finding 11.3 Respite is not fully integrated.

As noted in finding 5, few stakeholders could describe how respite space was integrated into CCDP and several first responders were not aware of respite or knew what it was. The lack of knowledge related respite space indicates that respite was not a core element of CCDP in its early stages. There were also noted gaps in communication and feedback between respite and other CCDP components, that created frustration. For instance, one individual indicated they were given minimal notice that this was coming and noted, "I wasn't told the specifics of it."

In part, the limited integration is due to the low volume going to respite, as only five people were taken during this study period. The low volume has captured the attention of some stakeholders and a desire to start utilizing it more suggesting changes to the model where "officers can actually take CIT individuals there and drop them off like they used to do at The Living Room. So maybe there is an issue or the MCRT team is not available.

The police can take them there, drop them off, and then they can get back into service." While this change may bring in more volume, it may create additional challenges if clear protocols are not established as one administrator expressed when talking about potentially allowing police to drop-off,

Takeaway: SCS addiction stabiliztaion unit is being used as respite space for the CCDP, providing up to 24 hour stabliizaiton for individuals in behavioral health crisis. Few first responders were aware that respite existed and several adminsitrators had limited knowledge of how it operated and respite was not fully integrated into the larger intervention. During the study period, only 5 individuals were taken to repsite by MCRTs. **Stakeholders noted the current respite space is sufficient to get started but is designed for addiction stabilization and will have to rapidly evolve to meet the needs of individuals experiencing other forms of behavioral health crisis**.

"I feel like if everybody worked together and trained that it's a very good possibility, but I feel like the police need to be trained on when to contact respite. When is it appropriate? When do we need them? That's what it would take is everybody knowing when the next person needs to step in. You have to get that clear understanding. And then after that clear understanding, it would be great, but they need to know what items specified them going here versus somewhere else? Just like a list of generalized. You would send this here and this here instead."

There appears to be an underutilization of respite space, but it is also idiosyncratic and not designed specific to the behavioral health needs. While adjustments can be made over time to smooth processes and add additional services, creating designated space may be a more prudent option.

Expanding the CCDP—Phasing and Timeline

As previously described, stakeholders discussed the need for and benefits of the intervention. While there is a clear need to deflect calls from law enforcement and provide support and resources to individuals in a behavioral health crisis, there were adaptations suggested to increase the impact of the intervention.

Figure 8. Frequently Mentioned Expansion Ideas

- **Expanded hours.** This was frequently mentioned as a way to expand reach and increase buy-in, particularly among late shift police officers who may not otherwise be exposed to the intervention. A few disagreed, citing wasted resources if calls are slow or ineligible for the intervention, especially in the early morning hours. Additionally, more staffing would be required to expand hours. An alternative suggestion is expanding the intervention to 16-18 hours a day.
- **Expanded geography.** There was an interest in expanding the intervention to all LMPD divisions and, for some, this took priority over expanded hours. Again, increased staffing needs were raised as a potential concern with this expansion. Some expressed expanding the intervention to the county, especially to reach rural areas where a need for the intervention has been observed and expressed.
- **Expanded access.** Some stakeholders were interested in the intervention being accessible outside of a 911 call. Many had an interest in individuals accessing the intervention upon calling 988, the National Suicide Prevention Lifeline. Some disagreed out of concern about "muddying the waters" between 911 and 988. Notably, 988 has not yet launched and many were unaware of it. Respondents were also interested in allowing MCRTs to self-initiate a response by, for instance, coming up on an individual who appears to be in a behavioral health crisis and responding to the individual without the need for a 911 call. Respondents believed that MCRTs should still notify MetroSafe for approval; however, some disagree with self-initiation citing safety concerns for responders and challenges that may result from a lack of communication between MCRT and MetroSafe.

> *"One of the biggest barriers to people getting assistance is people aren't necessarily going to come to you. They don't know where to go. They don't know who to talk to. They don't know who to ask. If we can go to them, all the better."*
> *Alternative Responder*

- **Increase use of CTW Expertise.** Several requested more access to the CTWs, perhaps through a direct line, for police or others to request CTW services and expertise for their response. Some disagreed out of concern for safety, citing that direct access may lead to by-passing the police when they are needed. Others were concerned about direct access to CTWs leading to unmanagemeable call volumes as a result of lack of effective triaging.
- **Police observations of alternative responder runs.** First responders were particularly interested in this idea, citing a desire to know more about what is occurring at the scence of a mobile response. It was suggested police observations could reduce the amount of communication back and forth between police and alternative responders related to a situation though some thought police presence may lead to escalation. Some disagreed with police observations, citing the additional work this would add to law enforcement, particularly since the intervention was designed to reduce workload for police.
- **Add radio communication.** Alternative responders currently communicate via phone but expressed interested in a dedicated radio channel. This would increase communication among the larger team and, overall, improve lines of communication and could increase safety.
- **Co-response.** The MCRT currently responds to eligible events alone but there was interest in co-response with police, fire, and EMS. Ideas included sending police and mobile responders on a run together, having mobile responders standby at a scene until it is cleared "safe" by police before responding, or police arriving on scene and then mobilizing MCRT if appropriate. Again, escalation was expressed as a potential concern if police are present.
- **Third party callers.** There were mixed views about allowing those not present with an individual in crisis to access the intervention via a 911 call. This idea was thought to expand call volume

and reach though there were concerns about uncertainty related to a situation where a caller is not on the scene.

- **Beyond Behavioral Health.** There was general support for expanding the CCDP to include non-behavioral health call types such as trespassing, suspicious persons, disorderly conduct, substance abuse, houseless outreach, and juvenile disturbances; however, this support was heavily contingent on safety concerns and crime, with many respondents noting the existence of co-response would help alleviate those concerns. There were also mixed views as to whether CCDP should focus solely on behavioral health events or expand to include other non-criminal or low-level events that do not require police intervention.
- **More respite care/Living Room.** Overall, there were fewer ideas related to respite care but this could be due to the lack of awareness of its role within the intervention. Several mentioned needing a place to send individuals in crisis outside of a hospital. Some stakeholders noted the current respite space is a good start but could be improved in terms of feel (e.g. more home-like setting), having multiple locations for respite, and allowing police to drop off individuals at respite, if appropriate. Police drop offs were seen as potentially problematic, particularly if no protocol or process is established regarding who can be dropped off and for what reason. Walk-ins were also suggested though there was hesitation expressed due to potential safety concerns and overburdening the respite space. Some were concerned about the availability of funding to improve respite care in the future.

Deciding to Expand

The decisions to expand are a complex interplay between organizational capacity, funding, and political willpower. The current administration structures of the model lie with Louisville Metro Government, MetroSafe, and Seven Counties Services with minimal input from Louisville Metro Police Department and funding and oversight provided by Louisville Metro Council. These factors create a lot of complexity in making collective decisions about where and how to expand. As one administrator noted in reference to the planning process,

> *"A lot of it's streamlining and just that it's so much to do. I feel like, because it's a brand-new program and there's so many people involved in making sure that everybody that need to be updated is updated on what's going on, that we're getting input from everybody. I mean, it's just a lot to do and there are only so many hours of the day."*

Within the two primary organizations leading the development, the decision-making dynamics are unclear where both entities identified ownership over pieces of the intervention and at times these ownership claims conflicted. MetroSafe noted overall ownership of the intervention as they hold the contract and have ultimate responsibility for this intervention working, while noting that they have full control over the 911 communication center and the processes involving call-takers and dispatchers. It was also noted that Seven Counties Services are contracts and do not directly work for Metro. The overarching working dynamic was one of collaboration where they felt comfortable bringing ideas, needs, or issues to Seven Counties Services and working towards an agreement. This process was framed as a collaboration and not as forcing Seven Counties Services to engage in any activity. Similarly, Seven Counties Services representatives expressed collaborations as well, noting that they felt comfortable taking information to MetroSafe and working together to come up with a solution. However, Seven Counties Services continually expressed that they had control over deflection operational matters, meaning decisions on how the CTWs, MCRTs, or respite operated. Collectively, the interviews did not provide consistent insight into who had final operational control, although it was

clear that both parties were operating through a collaborative process. Outside of MetroSafe and Seven Counties Services, there were no other organizations involved in decision-making processes, rather other organizations, were notified of pending changes by email or phone, but were not actively involved in decision-making.

Volume is guiding change

During the pilot phase MetroSafe and Seven Counties Services have been collecting and analyzing call volume sent to deflection. There was considerable emphasis on data collection, reviewing data, and ensuring data was being entered correctly. Several administrators indicated they would use this data to make operational decisions,

> **Takeaway:** There is universal support for expansion, but variation in what, how, and when the intervention should expand. Volume is the primary factor used to determine where and how to expand; however, staffing is the primary barrier to expansion. The process for determining expansion is collaborative between SCS and MetroSafe, yet it is unclear who is final say as such a need has not played out. **The long-term success of the intervention is in its evolution. CCDP is a complex intervention requiring collaboration and coordination amongst multiple agencies. While volume and staffing are important, the evaluation reveals that building relationships is vital to expansion. Building better communication structures and increasing knowledge will alleviate safety concerns and increase responder and community support. Expansion should consider the range of needs and successes identified by stakeholders. Forming a multi-stakeholder workgroup is recommended to study and plan expansion.**

"But the data we're going to use is going to be the sheer volume of calls…But, I mean, at the end of the day, it's how fast can you keep pace with the demand? That's going to drive how much we can do because we may want to do a lot we're just not capable of doing right now…The data is going to take us right where we want to go. And I think it's going to be 99% data driven and 1% qualitative to talk about it."

The data related to volume led to change within the first week, as the initial inclusion and exclusion criteria was limited to first person calls and did not include frequent callers from other locations. Administrators recognized the calls for service by first-person consumers were extremely limited, so they opened it to second-person consumers quickly thereafter:

"It did require Metro because it changed the criteria in which the calls that they would transfer over. So, that first week, we were already having discussions of, 'okay, we're going to have to open this up.' Because after a couple days, like, 'Wow, there's not as many first-person callers as we thought."

The willingness to make early adjustments is a signal that administrators are willing to make rapid adjustments to improve the intervention. The bigger challenge is how these changes will be made. During administrator interviews eight different ideas of expansion were exchanged between organizations from March 21 to May 8, with three of the suggestions being implemented within the first week by adding 2nd party callers, allowing Fourth Division officers to contact the CTW if they believe an individual can benefit from the intervention, and sending frequent callers to the CTW city-wide. A fourth change was made on May 15th, which expanded the full intervention to the First Division. Additional changes will allow officers in the First and Fourth division to drop individuals off at respite. As noted above these discussions were a collaborative process; however, there were apparent differences in willingness to expand between MetroSafe and Seven Counties, with MetroSafe being more willing to increase volume. What did not emerge in the interviews were clear metrics from administrators about what constitutes acceptable volume and what the intervention's capacity is.

It also important to note that the changes noted above are the major changes to the intervention, but do not capture the numerous examples of administrators making changes in real-time via emails, one-on-one counseling, and staff meetings. The additional trainings, policy tweaks, reviewing data entry protocols, and consultations are occurring on a daily basis designed to improve processes and increase familiarity.

A key next step in the intervention's development is identifying CTW and MCRTs response capacity, as this is dictating one's willingness to expand. A similar issue exists for Respite, how many people can respite space handle? If the capacity of each is known, then the information needs to be shared among organizations as part of improved communication and coordinated efforts to expand. As noted previously in this report's analyses, volume alone is insufficient to make expansion decisions. Administrators will also need to factor in the number of calls that end with the CTW versus require a MCRT response, the response time for MCRT, the average intervention time, and the number of transportations. As these parameters form the basis for intervention capacity, staffing considerations, and expansion.

Summary

It is important to reiterate that these findings occurred in the CCDP's first seven weeks, as such perceptions may evolve over time with greater familiarity and experience with the intervention. There is a clear need for CCDP.

- Model design and administrative priorities will dictate what successes are achievable and ultimately how success is defined.
- Limited knowledge of CCDP's operations and intricacies leads to uncertainty about what the CTWs and MCRTs are capable of handling and contributes to a first responders' willingness to engage the model.
- Communication structures are vital for building relationships, familiarity, and trust necessary for the CCDP to achieve its goals across responders and the community . Greater community engagement and input will help build trust, identify gaps, and offer innovative solutions.
- Safety concerns, both perceptual and situational, guide model design and exclusion criteriaand are a potential barrier to increasing volume and expansion.Only 21% of all Fourth Division behavioral health calls were classified as "Deflection" or "Deflection Not Available" while CCDP is operating, suggesting a combination of eligibility criteria and stakeholders comfort level with CTW/MCRT safety protocols are influencing volume. Increased familiarity with operations and continued policy development that minimizes safety concerns, are key for increasing volume.
- Interviews revealed behavioral health 911 calls present challenges for call-takers and CTWs as the limited information, coupled with model criteria, concerns over safety, and differing views on what is eligible allows deflection-eligible calls to slip through the cracks, with the exact number being difficult to estimate.
- Innovative solutions to staffing are needed as administrators noted staffing was the number one barrier to expansion.
- Stakeholders noted the current respite space is sufficient to get started but is designed for addiction stabilization and will have to evolve to meet the needs of individuals experiencing other forms of behavioral health crisis.

- The long-term success of the intervention is in its evolution. CCDP is a complex intervention requiring collaboration and coordination amongst multiple agencies. While volume and staffing are important, the evaluation reveals that building relationships is vital to expansion. Building better communication structures and increasing knowledge will alleviate safety concerns and increase responder and community support. Expansion should consider the range of needs and successes identified by stakeholders. Forming a multi-stakeholder workgroup is recommended to study and plan expansion.

Phasing Considerations

In addition to this evaluation report, we were asked to provide a proposal for next phases of the CCDP pilot. We used the results of this evaluation, as well as national best practices and evidence-based research, to identify a timeline for next phases and key recommendations for improving and expanding the pilot. The recommendations reflect the complexity of the CCDP and were crafted to acknowledge community needs, funding, staffing, organizational turnover, among others. The proposed phasing should be viewed as goals and not hard-set targets. We provide below a detailed cost analysis for consideration when making decisions regarding phasing and expansion. We recommend that final decisions for phasing come from the formation of a workgroup as well as continued evaluation to ensure data-driven decision-making.

Phasing Plan and Timeline

Phase 1: Ends June 30, 2022

- Alternative Responders operate 2 p.m. to 10 p.m.
- Callers in First and Fourth division are eligible for CCDP, and frequent callers from all divisions are eligible for CTWs, but not mobile response.
- MCRT and First and Fourth Division officers can drop off at respite care

Phase 2: July 1, 2022, to June 30, 2023

Phase 2 Goals:

1. Increase awareness of and familiarity with the CCDP both internally and externally
2. Expand the reach of CCDP

Key Steps for Phase 2:

1. Create a workgroup to provide guidance on the expansion of CCDP and advise on issues such as safety concerns, staffing, etc.
2. Increase awareness of the CCDP
3. Expand access to, and use of, the CCDP by:
    a. Allowing third-party callers to access CCDP
    b. Adding co-response for non-eligible CCDP behavioral health calls
    c. Moving CTWs and MCRTs to 12-hour shifts
    d. Allowing police to view alternative responder runs
    e. Allowing for direct connection to CTW/MCRT without dialing 911
    f. Revising inclusion criteria to increase eligibility for behavioral health calls
4. Develop an independent respite space
5. Develop educational material for responders and community resource providers to raise awareness of the existence of CCDP and its benefits
6. Develop public information campaign to raise awareness and increase reach

Phase 3: July 1, 2023, to June 30, 2024

Phase 3 expansion is contingent on workgroup and evaluation findings in FY 2023 (Phase 2), as well as the completion of Phase 2. We do not provide recommendations for FY 2024 expansion, as FY 2023 expansion will likely change the operational context needed to make evidence-based recommendations.

Phase 3 Goals:

1. Expand access to CCDP
    a. Integrate CCDP to include calls to 988
    b. Expand operational hours to 16 hours a day
    c. Expand to all LMPD Divisions
    d. Begin expansion to other county agencies
    e. Allow other call types (outside of behavioral health)
2. Provide in-service cross training for Deflection, police, and 911 communication specialists
3. Integrate community behavioral health ambassadors to assist in education and awareness

Phasing and Thinking About Costs

One component of phasing is projecting the conditions in which the CCDP becomes cost-neutral or saves the city money. In order to estimate future costs, counterfactual scenarios were created using data previously discussed in Table 24 in the cost-benefit analysis. The table is replicated below for ease. This data is used to inform some calculations for alternative projections under various assumptions. *It is important to remember that these projections are based on a given set of assumptions, and that changes to CCDP will impact these assumptions.*

Recall, this research seeks to understand the costs of the deflection program, entailing salaries, personnel benefits, and other overhead costs associated with the behavioral health hub (or, the triage center), the mobile crisis response team, and the respite care provided. This is in comparison to the typical costs of LMPD response to CIT calls, in order to understand how the deflection program may save resources or expenditures. We have focused on how deflection could save response time, effort, and transportation time for LMPD officers, translated into dollars saved.

Table 25. Summary of Variables Related to Deflection Team's Response from March 21 – May 8, 2022

Row	Variable	Value[a]	Details
1	Number of days of deflection activities under consideration	49	March 21-May 8, 2022
2	Number of deflection calls, March 21 – May 8, 2022	119	Source:
3	Average number of deflection calls per day (8-hour shift), March 21 – May 8, 2022	2.4	Row 2 ÷ Row 1
4	Average time spent by the deflection team per call, decimal hours	0.33	19 minutes 47 seconds Source: Table 12 in Quantitative overview
5	Average hours spent on a deflection call per 8-hour shift, decimal hours	0.80	Row 3 × Row 4
6	Total time spent by the deflection team on deflection calls, decimal hours	39.24	Row 5 x Row 2
7	SCS Year to date billed expenses, period ending 04/30/2022	$162,674	Source: SCS Invoice, April 2022

8	Estimated SCS expenses for the period covering 05/01/22 – 05/08/22	$20,294	Approximate expense for 8 days of operation, based on per day calculation from April invoice. Source: *ibid*
9	Approximate total cost of deflection up to 05/08/22	$182,968	Row 7 + Row 8
10	Average cost of deflection program per day	$3,734	Row 9 ÷ Row 1
11	Average cost of deflection program per call	$1,538	Row 9 ÷ Row 2
12	Average cost of deflection per hour of response	$4,663	Row 11 ÷ Row 6
13	Average cost of deflection per *minute* of response	$78	Row 12 ÷ 60

[a] Note that dollar values are rounded to the whole dollar

Option 1: Expand number of CCDP events per shift with current resources.

In this section, we examine a counterfactual scenario where there are no changes to the current CCDP other than an increase in average daily volume. Given that the current program is operating under capacity, we wanted to see what would happen if it were operating as efficiently as possible with the current resources. In this scenario, we will assume that the costs of the CCDP do not change, since the number of workers and the number of operating hours does not change. We will also assume that the out of service times associated with each CCDP event are held constant. Under this scenario we assume a change in eligibility criteria that allows a greater volume of calls to be diverted to alternative responders.

We defined full capacity as an average of 8 hours of CCDP response per day (since they work an 8-hour shift). Now, the total time spent on CCDP would be 392 hours (49 days x 8 hours in a shift per day). That means the average cost of CCDP per hour of response is approximately $467 ($182,968/392), or the cost per minute is $8 (467/60).

To project what the potential volume is under full capacity, we compared the average total hours spent by alternative responders per event (0.33 – 0.97, depending on out of service time measure; see Table 23) and the average number of events responded to per shift (2.4) to calculate the total hours spent on deflection events per shift (0.80 = 0.33x2.4, or 2.33 = 0.97x2.4, respectively). Then, since each shift is 8 hours total, that means the deflection team should be able to handle approximately 8.2—24.3 events per day (8 hours/0.97 hours per call, or 8 hours/0.33 hours per call). If the deflection program had operated at this projected full capacity for the entire 49 days of operation from March 21 – May 8, that would have meant they responded to somewhere between 403 and 1,189 events in total. Note that LMPD responded to 1,130 CIT events during the intervention period (see Table 21), when 119 events were deflected, so the total potential call volume across Louisville would have been 1,249 over those 49 days. Thus, our estimate is within the bounds of Louisville's supply of about 58.1 deflection eligible events per day across all divisions (Table 21).[20]

[20] We note that handling all deflection-eligible events across *all* divisions in Louisville would lose some efficiency due to longer travel times across the city, and that this reality is not currently reflected by our model. We would suggest that a reasonable response would still be to handle events in geographically close divisions, such as the 1st, 2nd, 4th, and 5th divisions. As Table 21 and figures 3 and 4 show, this would still cover a large proportion of the overall volume of CIT events in the city, freeing up additional police resources that could be allocated elsewhere.

If we apply the same costs as above (recall, we assumed there is no change in resources, only that we are using the resources to their full capacity), this implies that the average deflection call costs approximately $154-454 ($182,968/1,189 or $182,968/403). Clearly, increasing the average daily deflected volume, without altering the resources allocated to CCDP, improves the cost outlook.

One potential way to expand the deflection volume is by expanding eligibility. As Table 21 shows, the average daily CIT volume in the 4th division, where the intervention is focused, was about 13.7 events per day. For an 8-hour shift to be able to handle this many events would imply that about 0.58 hours are spent per event, which is reasonable considering that not all the events will need an MCRT response which takes longer.

Option 2: Expand number of calls taken with more resources and/or more shifts and/or more eligible divisions

Another option is to expand the number of CIT events deflected by increasing the number of shifts covered and/or expanding the program to other divisions. We note that this will most likely take additional resources invested in SCS but expect there to be economies of scale such that the increase in the volume of CIT calls that can be handled under full, efficient capacity outweighs the additional costs and decreases the average cost per deflected CIT event.

Consider the average daily CIT events across divisions in the most recent time period under consideration (Table 21, post-intervention). In division 4 only, there were about 13.7 calls per day, about 5.7 times more than the average daily deflection amount (13.7/2.4 = 5.7). For any 8-hour shift to handle this many calls, that would imply about 0.59 hours spent per call, which is within the range of times discussed earlier. If the 1st and 2nd division were added, the expected average daily calls would be around 29.3, or 12.2 times the current volume, or about 2.1 times the volume in the 4th division alone. Given the geographic proximity to the 4th division, these are natural divisions in which to expand, and we don't expect that travel times will play a prohibitive role in increasing the volume that MCRT could handle, although it is recommended that stakeholders monitor changes to the average intervention times with geographic expansion.

Again, we note that in addition to increasing call volume, this will also take additional resources. To calculate costs in this scenario, we would have to make some assumptions about how costs will increase. For now, we assume that economies of scale would exist such that the average cost per call would be decreasing. This is reasonable because, for example, if personnel or shifts were doubled to handle this increase in volume, we expect that costs will not double since personnel represent a variable cost while other costs (such as overhead) are fixed and have already been paid.

Breakeven Scenario

Next, we wanted to describe characteristics of a scenario in which the resources used to run the deflection intervention exactly offset the resources that are saved for police officers. One perspective for this calculation is to compare current resource usage by LMPD to the potential resource savings that the deflection effort can provide. Recall, with current average response times, response personnel involved, and hourly wages, the total estimated police cost per CIT call is about $74 (Table 22, row 24), and the average daily cost is about $1,695 (table 22, row 27).

That means that, in order to break even, the daily police resources released due to the intervention should be close to that number. Applying the same calculations above, we can translate a hypothetical number of deflection calls taken and compare that to the police resources released. See table 25 below for a calculation of the daily cost savings under the assumption of various levels of average daily deflected calls. You can see in the table that the current daily LMPD cost of $1,695 spent on CIT calls would be saved if about 13.744 calls were deflected per day. This is well within the range we calculated above of potential expansion and is also in line with the average daily call volume experienced in the 4th division during the post-intervention time period (table 21).[21]

The scenarios listed in Table 26 also provide the estimated time released for LMPD officers. Referring to Table 22, there are approximately two officers per CIT call and total intervention time lasts approximately 54 minutes. Thus, if five call per day are deflected, this would equate to just under 10 hours of officer time released to focus on other calls for service up to 18 hours released if 20 calls per day were deflected.

Table 26. Hypothetical police resources released with different daily deflection volumes

Average Daily Number of Deflected Calls	LMPD personnel cost savings ($) [average daily deflected calls x $74 personnel cost per call]	Daily total LMPD cost released, including overhead ($) [personnel cost / 0.6 to approximate total cost]	Daily Cost Savings ($) [Total cost released-$1,659]	Potential cost savings over 49 days of deflection activity ($) [daily cost savings x 49]
5	$370	$617	-$1,078	-$52,838
10	$740	$1,233	-$462	-$22,622
11	$814	$1,357	-$338	-$16,578
12	$888	$1,480	-$215	-$10,535
13	$962	$1,603	-$92	-$4,492
13.2	$976.8	$1,628	-$67	-$3,283
13.4	$991.6	$1,653	-$42	-$2,074
13.6	$1,006.4	$1,677	-$18	-$866
13.744	$1,017.1	$1,695	$0	$5
13.8	$1,021.2	$1,702	$7	$343
13.9	$1,028.6	$1,714	$19	$947
14	$1,036	$1,727	$32	$1,552
15	$1,110	$1,850	$155	$7,595
16	1184	1,973	278	13,638
17	1258	2,097	402	19,682
18	1332	2,220	525	25,725
19	1406	2,343	648	31,768

[21] Note that this approach does not take into account the overhead costs of running the deflection program, only how to save the LMPD police resources on CIT calls.

20	1480	2,467	772	37,812

The avenue for cost-benefit and cost-effectiveness for CCDP is multi-faceted. First, the economies of scale will drive the average cost per event down for alternative responders to provide acute behavioral health crisis support. Second, by averaging 13.744 events per shift, the CCDP releases enough police time to become cost-effective and in-effect give them additional labor hours to focus on other criminal matters. There are other costs not captured in this evaluation due to the short evaluation period; however, future evaluation will look at reductions in hospitalizations and jail, and respite admissions along with their associated costs. A longer study period will allow for causal examination on impacts of call volume and repeat utilization and the associated costs. It should be noted that the cost analysis of long-term health outcomes for individuals will be limited by an individual's willingness to gain consent from individuals to track their use of referrals.

Recommendations

The following recommendations are designed to offer guideposts rather than detailed "how-to" manual. This approach was selected in recognition that the CCDP is complex and contingent on model design. A change to CCDP eligibility criteria or expansion, may render some recommendations moot and creating confusion as to why a certain recommendation was or was not followed. An overarching recommendation is that stakeholders meet with researchers where questions arise, or additional guidance is required.

Recommendation 1: Continue with process and outcome evaluation to drive data-informed decision- making related to implementation and expansion.

This report focuses on what happened in the first seven weeks of the CCDP pilot and provides a baseline for understanding efficacy moving forward. It is important to note that seven weeks is a short timeline on which to base long-term decisions. The data collected in this short period allows for data-driven decisions to be made in the next phase and has provided a better understanding of data and research needs for the future. Continuing to support the pilot with evaluation will enable stakeholders to further understand the processes and outcomes associated with CCDP, as well as gain a better understanding of costs and benefits. In addition to continuing the current design, we recommend expanding the evaluation to include:

Recommendation 1.1: Review random sample of "1032-General Trouble" and "1014-Mental Health" 911 call recordings to evaluate reliability and validity of call-taker classifications and, if necessary, develop training modules to improve processes.

Research establishes the important role call-takers play in determining the type of response provided. Because the CCPD starts with a call-taker, efforts should be made to provide them with support to improve processes. First responders expressed the need for additional behavioral health training, recognizing that they confront a wide range of scenarios in their daily work. It is recommended that future research analyzes a random sample of "1032-General Trouble" and "1014-Mental Health" 911 call recordings to evaluate the accuracy of call-taker classifications. The research should involve trained behavioral health researchers to review the calls and determine the accuracy of classification using both tone and language as indicators. The research process should also involve identifying additional questions that call-takers could ask to clarify if a situation involves a behavioral health indicator. This research has the potential to provide call-takers with new questions to ask callers as well as audio examples of overlooked behavioral health indicators that would provide call-takers with additional resources to improve call classification.

Recommendation 1.2: Track individuals beyond CCDP to better understand service and referral utilization and outcomes.

It is important to understand if the alternative responders' efforts resulted in the caller utilizing referral services to know whether the CCDP is meeting one of its primary goals. To better examine patterns of referral utilization and individuals' experiences with CCDP, we propose interviewing and/or surveying individuals who have interacted with the CCDP (e.g., received assistance from CTWs, MCRTs, respite, etc.) to understand how to better meet their needs. Interviews or surveys with individuals who have refused to engage the CCDP is also important, as it identifies existing gaps in the intervention. It is important to note that someone not following through on a referral is not a failure, but an empirical reality of individuals seeking change.

Recommendation 1.3: Analyze behavioral health related hospitalizations via walk-ins, police drop-offs, EMS drop-offs, and MCRT drop-offs.

A better understanding of why people are going to the hospital for behavioral health crises can help stakeholders identify individuals who may be more appropriate for a CCDP intervention. This understanding can also ensure that CCDP processes are meeting individuals' behavioral health needs. This information will be valuable to ensure respite space(s) are deflecting hospitalizations. Knowing who is utilizing hospitals for behavioral health needs can also inform effective targeting of public education campaigns. There are important cost considerations related to deflecting behavioral health crises from unnecessary hospitalizations. Analysis of hospitalization data will also allow researchers to understand if the CCDP is resulting in fewer behavioral health hospitalizations.

Recommendation 1.4: Examine the scope of EMS and Fire responses and the impact of the nurse triage program on behavioral health related calls for service.

This report indicates that one area of expansion for behavioral health events is co-response with EMS and Fire. One classification of interest is "person down—unknown reason" which is often a houseless individual sleeping or passed out and does not usually require immediate medical attention or transportation. As a result, these runs may be an opportunity for co-response with MCRTs to connect individuals to services. However, the nature of the classification "person down—*unknown reasons*" provides limited information that complicates the decision to send EMS or Fire and the MCRT team. Further research is needed to analyze EMS and Fire data to identify estimates for the volume of calls and develop recommendations around co-response procedures.

Recommendation 1.5: Evaluate the impact of public education and awareness building and 988 on CCDP call volume.

Recommendation 4.2 proposes a public awareness campaign to increase visibility of the CCDP, community behavioral health resources, and provide information about how to use 911 for behavioral health emergencies. One concern related to public education in Phase 1 was the potential for call volume to overwhelm the CCDP in its early stages. There were also concerns and frustrations related to individuals who needed CCDP services but were located outside of the service area. If a public awareness campaign is implemented, it will be valuable to assess call patterns and how calls have been impacted by the campaign.

Recommendation 2: Improve CCDP data collection in MetroSafe, LMPD, and Seven Counties Services.

CCDP's design required several changes to existing 911 communication center practices, including changes to how behavioral health events are coded, what is entered into CAD, and how to send events to the CTWs. For LMPD, the CCDP resulted in changes to filling out CIT Reports when the police transfer an event to the CTW. Finally, CCDP resulted in the creation of a new CAD agency, Deflection, for the alternative responders and specifically for CTWs to enter in data related to their runs. During the first seven weeks of the intervention, stakeholders monitored data entry and sent out training documents to improve practices. One example is the inconsistent use of "1014-Assist Deflection", which was being used to indicate instances where the police requested CTWs, but also times where CTWs sent a call back to MetroSafe because a caller hung up. Neither situation met the definition of a "1014-Assist Deflection." This was an issue that was identified by administrators in the interview process. It is recommended that stakeholders and researchers meet to discuss identified data gaps and recommendations for improved data collection. The following sub-recommendations build on these monitoring practices and point out recommended areas for improving data quality.

Recommendation 2.1: Build in needed variables into MetroSafe's new CAD system.

In January 2023, MetroSafe anticipates rolling out a new computer aided dispatch (CAD) system, which provides a unique opportunity to add needed measures on the front-end. One existing data limitation is the lack of identification within the current CAD system to denote if the caller was a 1st, 2nd, or 3rd party. Since 3rd party callers are not currently eligible for CCDP, we are not able to estimate how many calls would become eligible if 3rd party callers were included. A straightforward solution is to ensure the new CAD system has a checkbox that call-takers can click indicating the caller type. Being able to easily analyze the type of caller can assist with internal and external evaluation processes and improvements.

A second limitation is the lack of inclusion of initial and final classification type within the current CAD system. First responders noted in interviews that what is entered into CAD does not always align with the situation on the street. This could mean that a call starts off as a "1032-General Trouble" run but then becomes a "1014-Mental Health" call or conversely, a call identified as a "1014-Mental Health" event could actually be a domestic. By having a start and end classification, internal and external evaluations can have a better understanding of the range of potential calls eligible for CCDP and adjust practices accordingly. This would require training call-takers, dispatchers, and police to provide and enter the changes to the event classification.

A third limitation to the current CAD system is LMPD is unable to see current runs for the alternative responders, especially MCRTs. LMPD patrol officers have an MDT that includes access to CAD and allows them to see where all officers are in their division, which is noted as an important safety tool. In the case of an emergency where an officer needs assistance, officers want to be able to quickly see where that officer is without having to rely on potentially hectic radio traffic. Officers expressed a similar desire to see MCRT runs in the case of an emergency, to know where they are located and improve response. There was widespread support for this expansion, however, administrators noted that making this change might crash the CAD system and blind officers to all runs. This concern was realized on the CCDP's first day, when the CIT code changed from a "1032-CIT" to "1014-Mental Health." This caused a system glitch where officers were not able to see others' locations for "1014-Mental Health" events, causing frustration and safety concerns. It should be noted the issue was fixed the next day. If an immediate solution to allowing LMPD to view MCRT events is not feasible due to technological

limitations, then the solution should be embedded in the new CAD system from the start. This has important implications for alleviating safety concerns, building trust, and expanding to co-response and third-party callers.

A final limitation in the current CAD system is that it only captures behavioral health events that are coded as "1014-Mental Health" classification. This is a narrower criterion, which underestimates the role of behavioral health in other call types. Someone who calls in about a houseless individual wandering down an alley could result in a "1036-Suspicious Persons" classification and, as a result, there is no record that this is a potential behavioral health issue. Inserting one or more checkbox options for call-takers to indicate if there is a behavioral health issue present, and preferably the specific type of behavioral health event present, would improve data accuracy and have implications for co-response volume. With the introduction of co-response, call-takers might shift their classification from "Trespassing" to "1014-Mental Health" knowing that it might trigger a co-response, a behavioral change that would be difficult to measure within current data systems.

Recommendation 2.2: Maintain data records with shift to new system to maximize continuity in evaluation data.

Prior to the launch of the new CAD system, it is recommended that MetroSafe save at least the previous two years of data for all agencies. This will be important for future research considerations and for continuity checks in measures and operations. Currently, CAD data is saved on a rolling two-year time frame, which means the shift to a new CAD system might eliminate all historical data. Switches to new data systems always come with unforeseen challenges and having historical data to compare classifications, response times, or other needed comparisons for accuracy is critical. The data will also be important for future research across CAD systems. For instance, if this evaluation continues, we want to ensure that measurements from the new CAD system align with the previous system and then develop a new set of syntax for analyzing future data.

Recommendation 2.3: Develop consistent frequent caller definitions and designations

Administrators and first responders anticipated the CCDP would reduce the frequency of calls, deflect calls from call-takers, and connect individuals to needed services. While the CCDP is unlikely to eliminate frequent callers, there is the potential to decrease overall call volume and stress for call-takers and police officers. To fully understand CCDP's impact on frequent callers, a clear definition for "frequent callers" needs to be decided upon. For this report, we used proxy measures to identify frequent callers, but we acknowledge that this approach fails to capture the full picture. A consistently applied definition could better show if the frequency of calls decreases, using survival analysis to understand if CTW intervention increases the length of time to next call compared to a call-taker only or police response. The workgroup (see recommendation 3.1) should use empirical research and best practices to develop a definition that uses frequency of calls and familiarity. The workgroup should also monitor the use of this definition to ensure a frequent caller designation does not result in unintended consequences, such as lower response priority due to overuse.

Recommendation 2.4: MetroSafe continues to monitor data entry to ensure consistent data entry and quality to effectively evaluate inputs and outcomes.

Administrators noted numerous instances and efforts to improve data entry in CCDP's first weeks. The CCDP resulted in new behavioral health classification codes and recognized that it would take time for call-takers to adjust patterns. Data entry monitoring should continue to identify challenges and additional entry needs for internal monitoring. It is recommended that standardized and consistent language are used to indicate when a call is sent to a CTW, merge events when the police contact CTW,

explain why a call was sent back from CTW, and indicate the type of third-party caller would improve the ability of administrators to monitor the intervention.

Recommendation 2.5: SCS continues to monitor data entry to ensure consistent data entry and quality to effectively evaluate outcomes.

Seven Counties Services faced the steepest learning curve related to data entry, as alternative responders had to learn both SCS EHR and MetroSafe's CAD system in a short period of time. As the report notes, data entry improved during the first seven weeks. It is important for evaluation purposes that data is entered consistently into CAD and SCS EHR. The two data systems contain different information and serve different purposes, but it is possible for the two datasets to be linked via the CAD event number. SCS added the CAD number to the EHR during the first seven weeks, but there were over 40 events that did not contain CAD data. This limited our ability to connect an event to a geographic location or to police events. One advantage of low call volume is the opportunity provided to ensure data entry is consistent as responders are not pressed to jump quickly from call to call. It is important that regular data quality checks are conducted, and entry is corrected for accurate measures.

Recommendation 2.6: SCS should add additional measures in EHR that align with MetroSafe data.

Throughout the pilot phase, SCS took steps to add variables into their system to improve data collection. As noted in the previous sub-recommendation, SCS EHR and MetroSafe CAD data provide different information, but a second challenge is they are owned by two different organizations. As a result, SCS is not able to conduct internal analyses without obtaining MetroSafe CAD data. While the organizations are collaborating and willing to share data, it creates additional time and analytical steps that are not necessary if certain variables are added to SCS EHR. First, it is recommended that CTWs record the police division for each call in the EHR. The police division is automatically generated in CAD and can easily be entered into SCS EHR, this will allow SCS to know the volume of runs that are occurring in divisions where the full intervention is operating versus those only available to frequent callers. Second, it is recommended that SCS record the same time variables that CAD records for police responses to allow for more accurate internal and external analyses. For CTW, the times should include when their call started, when they dispatched MCRT, and when the call ended. For MCRT, the times should include when they went enroute, when they arrived, when they started a transportation, when they ended a transportation, and when the event ended. Having each of these times becomes important when call volume increases and the CTWs and MCRTs begin to move from call-to-call. Consistent guidelines on when to enter these times is also important, for instance, MCRTs should be told if an enroute time begin when they head to their car or if it begins when they start to drive. Third, SCS should record when the event was created in CAD, as a call-taker might create a "Deflection" event but CTWs may be on an existing call and thus the initial response is delayed. Having these variables will allow SCS to conduct internal evaluations without having to wait for MetroSafe data. The inclusion of data in two datasets can also be used for accuracy checks. There are additional measures that SCS is recommended to add to improve internal monitoring that align with stated goals for the CCDP. It is recommended that SCS add a box for CTWs and case managers to indicate if they attempted/completed a call back.

Recommendation 2.7: SCS should connect respite data as part of deflection model.

SCS EHR data is organized around different organizational components such as child services or adult services, with "Deflection" existing as its own category. The current EHR "Deflection" data structure includes activities by CTWs, MCRTs, and case managers but does not include respite activity specific to the CCDP. Instead, the crisis supports and referrals for individuals brought to respite via MCRTs is in a different data silo than the rest of the alternative responder components. It is recommended that

respite activity specific to individuals brought in via the CCDP should be connected to the "Deflection" data structure. This would include also include individuals brought to respite by the police, as this expansion was developed as a direct result of CCDP. Connecting the data is important for three reasons. First it is important to know what services and referrals are being made at this stage in the process. Second, connecting the data will also allow internal and external evaluators to understand why someone is utilizing respite space and thus operational adjustments can be made to ensure respite space is providing needed services. Third, it will allow for comparison between individuals brought in by MCRT versus police to know if there are differences in an individual's behavioral health crisis and needs. This data can also be used to identify needed trainings to improve processes, awareness, and drop-off protocols. Finally, this data is needed to model cost-benefit analysis and cost-effectiveness analysis, which should be included in future research.

Recommendation 2.8: LMPD should improve data entry for updating run classification and recording CIT reports.

The CCDP design has minimal impact on current LMPD data processes, but two gaps emerged in the analyses. First, it is recommended that LMPD improve data entry related to updating the event classification related to behavioral health events. This includes events that were not sent as 1014-mental health but ended up being so and calls that were classified as 1014-mental health but were not. This will improve data consistency. Second, when filling out a CIT report officers should ensure the CAD number is included in all reports so they can be tied to the CAD run and any potential incident reports. The inclusion of the CAD number is particularly important for runs where the police contact the CTW for assistance, having the CAD number will allow internal and external evaluators to match the CIT report to LMPD CAD data and "Deflection" CAD data.

Recommendation 3: Strengthen Infrastructure for Expansion.

The third recommendation is to strengthen infrastructure needed to expand the intervention moving forward. As noted in the report, this a complex intervention that respondents want to fill multiple needs and meet different versions of success. To maximize the CCDP's impact on behavioral health in Louisville, stakeholders will need to determine the appropriate expansion given a range of criteria. Determining what the criteria are and who is involved in those decisions moving forward will be factors for CCDP's long-term growth.

Recommendation 3.1: Form workgroup of individuals with decision-making capacity and appropriate time allocations to identify and execute expansion.

MetroSafe and SCS committed considerable resources to launch CCDP with an emphasis on starting small, using a narrow set of inclusion criteria, and a focus on getting processes ironed out. The current decision-making processes have existed largely at the upper levels of each agency, which has worked for a narrow intervention. As the intervention expands, it will become increasingly difficult for upper-level administrators to be in the weeds on all facets of the intervention and expansion. Upper-level administrators will continue to play an important role in setting the CCDP's long-term vision but should form a workgroup to translate those visions into goals, inputs, outputs, and outcomes that drive expansion. It is recommended the workgroup be task focused and consist of individuals with decision-making capacity to use data to design intervention protocols, policies, training, and/or education strategies. Administrators will need to determine if task development resides with them, with the workgroup, or a combination. It is recommended at minimum the workgroup include supervisors and front-line personnel from MetroSafe, SCS, LMPD and outside behavioral health providers and community members. It is recommended that LMPD is included as several of the expansion requires

changes to LMPD operations or the development of protocols. The inclusion of outside behavioral health providers and community members is to ensure that CCDP expansion centers the needs of individuals in behavioral health crisis along with operational considerations. The workgroup needs to be carefully crafted and include individuals who possess the time, knowledge, and decision-making authority to recommend and design expansion. If the workgroup only includes low-level supervisors, then it will slow progress as a recommendation might require multiple layers of review. It will be important for administrators to give clear instruction and guidelines for the workgroup to operate to ensure efficient and effective work. The workgroup should also incorporate real-time research findings into the decision-making process.

Recommendation 3.2: Develop specific data-driven criteria for expansion and integrate research findings into the decision-making process.

As outlined in the expansion section respondents have many different views on how the CCDP should expand. In addition, the research shows there are unclear criteria driving expansion considerations. It is recommended that administrators and/or the workgroup develop data-driven criteria for expansion, while recognizing that the criteria may change depending on the need. Thus, it is imperative that the criteria are clear at the forefront and applied consistently throughout expansion. For instance, expansion should not be limited to only increasing volume. Other factors such as knowledge, trust, safety concerns, communication, technology, and/or staffing may also be a factor. The integration of research, both from the evaluation and external published research, should be used to help inform expansion.

Recommendation 3.3: Increase staffing to support expansion

Staffing was regularly mentioned as a potential barrier for expansion. It is recommended stakeholders increase staffing to support expansion. Researchers acknowledge pay limitations, so it is up to stakeholders to identify opportunities, innovations, and solutions to filling staffing gaps. This may include promoting opportunities within university programs to engage students, using more diverse hiring platforms, initiating public education campaigns that can include recruitment, using part-time employees, or including other service providers.

Recommendation 3.4: Develop infrastructure to increase volume by adding co-response and expanding deflection-only criteria by adding third-party callers.

The quantitative and qualitative data suggest the two best avenues for increasing alternatives responders' volume is to introduce a co-response option and expanding deflection-only criteria to include third-party callers, among other suggestions. Appendix 4 provides an overview of expansion ideas which includes the pros and cons of co-response and third-party calls. Co-response and third-party callers encapsulate the connections between processes, volume, costs, and stakeholders' perceptions regarding need, safety, training, knowledge, communication, volume, staffing, and expansion. The impacts of co-response and third party are highly contingent on how they are designed and deployed, limiting researchers' ability to provide fully fleshed recommendations on how to move forward with these two. It is recommended that the workgroup focus their attention on co-response and third-party calls as their first efforts. Researchers have provided a list of considerations in Appendix 5 that lays out the range of factors to be considered before co-response could be deployed.

Recommendation 4: Improve CCDP education and awareness by developing education material for responders and a public education campaign.

A reoccurring theme in the analyses was the lack of knowledge and awareness of the CCDP from responders and the community. The lack of knowledge and awareness of the intervention and limited communication about how the CCDP is operating, contributes to many of the barriers noted in previous sections. For instance, first responders are safety conscious and not knowing the MCRTs training or processes, does little to alleviate their safety concerns towards MCRTs getting hurt. In a different vein, community members regularly noted they were unfamiliar with CCDP which decreases the likelihood they would use it and impacts volume. As the CCDP continues, it is recommended stakeholders develop education strategies for responders and community.

Recommendation 4.1: Improve education processes for CCDP responders including call takers, dispatchers, alternative responders, and police.

As noted in the report, the primary means for educating responders about the intervention were through emails, roll-call trainings, and whatever interactions occurred. These processes left considerable gaps in knowledge about who the alternative responders are, how they provide crisis support, and their protocols and policies related to safety. Further, responders indicated a desire to receive feedback about the number of calls going to alternative responders as a way of seeing the impact it is or is not having on their day-to-day work. It is recommended that stakeholders develop education material describing who the CTWs and MCRTs are (e.g., their qualifications and training) and what types of crisis support they are able to provide. This material should be in multiple forms including resources cards, short videos explaining what CTWs and MCRTs do, and through face-to-face interactions. All three avenues will provide first responders with additional information that can be used to communicate the CCDP's purpose with callers and improve their own decision-making by understanding what the alternative responders can and cannot handle. A key element of this education campaign is to communicate the protocols and procedures for interactions between responders such as call-takers and CTWs or police and MCRTs to ensure everyone is aware of appropriate interactions and responses. It is recommended that these education documents are developed by the workgroup to ensure the material are meetings the needs of each responder.

Recommendation 4.2: Develop a multi-faceted behavioral health public awareness campaign.

Community members expressed a lack of knowledge and awareness about the CCDP. The lack of public awareness campaigns was intentional by administrators out of concerns related to over-burdening the alternative responders in the early weeks. However, administrators did acknowledge that a public awareness campaign was something that needed to be done as the CCDP developed. It is recommended that stakeholders develop a multi-faceted public awareness campaign that focuses on three areas: increasing awareness of available mental health resources; inform the public about how to use most effectively 911 for behavioral health crisis; and promote the CCDP and increase awareness of its purpose. Each is necessary to help connect public to available resources and limit the potential for overburdening the CCDP with non-emergent calls.

To increase awareness of available mental health resources, stakeholders should form a workgroup to create an asset map of available behavioral health resources in the community along with basic information about the services provided, operating hours, if they are available for walk-ins, and contact information. The asset map could be included in subsequent education material and shared with 311 to facilitate connection to non-emergency services.

Stakeholders should create flyers that can be distributed at medical offices and via social media describing the do's and do not's for using 911 for behavioral health crises. The outreach should specify conditions in which 911 is an appropriate resource, such as when someone is using a weapon versus situations where there are other options, such as calling the Crisis & Information Center.

Finally, it is recommended that a public awareness campaign be launched describing the CCDP and its purpose. The awareness campaign should include links to the asset map and 911 dos and don'ts to reinforce the overall messaging around available services. The public awareness campaign should start by targeting neighborhoods in the First and Fourth division where the CCDP is fully operating. To alleviate concerns related to over-burdening the system, it is recommended that the campaign starts in two neighborhoods and call volume from those neighborhoods is monitored to examine whether call volume does increase and adjust protocols accordingly. The public awareness campaign should expand to include newspaper articles, news station and radio stories, and social media posts describing how the CCDP works and where it is operating. The public awareness campaign should provide simplified messages about what the CCDP is and is not, and a broad overview of how CCDP operates. It is recommended a video describing CCDP's operations is developed to create a simple and visually appealing overview that is transferrable to multiple mediums. As part of the public awareness campaign, it is recommended that community volunteers are recruited and trained to provide public outreach in the communities being served by the CCDP and be able to answer questions.

Recommendation 5: Secure long-term funding.

One of the underlying themes for administrators was concerns with continued funding for the CCDP and hesitancy in expanding too quickly, where long-term resources may not be available. Providing a budgetary structure that provides long-term funds, even if contingent on meeting thresholds, may increase the willingness of organizations to expand and achieve the outcomes sought by the community and their representatives. It is therefore recommended that Louisville Metro Government and Louisville Metro Council develop budget structures that support CCDP's long-term development and expansion. External funding through federal agencies or non-profits should also be pursued to supplement, not replace, public funds.

Recommendation 6: Expand respite space and services to meet a broader range of behavioral health needs.

The CCDP includes a 23-hour crisis respite program. The program is operated by Seven Counties Services and is housed in two rooms within a large addictions treatment and detox center located in Louisville's downtown medical district. During the study period between March 21st and May 8th only MCRTs operating in the Fourth Division take individuals to the respite space as part of the CCDP. On May 15th the CCDP expanded to the First Division and on June 1st First and Fourth Division officers were allowed to drop-off at respite. The short study period and limited use of respite makes it difficult to provide a quantitative assessment of the respite space; however, qualitative findings provide insight into the current operations and barriers associated with respite. The following sub-recommendations provide guidance on next steps for expanding respite, increasing utilization, and decreasing unnecessary hospitalizations.

Recommendation 6.1: Low barriers to entry.

A respite crisis space should be available 24 hours a day and have few eligibility criteria, with only two exclusionary criteria: (1) Medical concerns beyond the scope of the program's ability to serve them and

(2) Behavioral issues that pose a significant and immediate risk to the individual or other people the crisis. It is recommended the respite space allow walk-ins, MCRT drop-offs when operating, and 24/7 drop-offs for police.

Recommendation 6.2: Intake is quick and easy.

It is recommended the intake process has clearly defined protocols that are shared and communicated with police and MCRT to ensure efficient and appropriate intake, that includes a warm hand-off. The develop of clear protocols will build effective working relationships and ensure people are able to get in the door quickly and predictable. This is particularly important for police officers and MCRTs who want to be able to transfer someone to the program and return rapidly to their responsibilities on the street. It is recommended that an individual is accepted without extensive and time-consuming intake processes, and paperwork is completed after the person is accepted into the program. Intake should include assessing Medicaid eligibility. If the individual is eligible for Medicaid but not enrolled, the program can enrollment assistance. This is helpful to client and increases third-party reimbursement for the program.

Recommendation 6.3: Rapid clinical and social welfare assessment.

It is recommended the respite space include rapid and practical assessments of individual circumstances, conditions, and needs of clients. This includes a brief clinical assessment, assessment of social welfare needs, and developing an understanding of the client's personal values and goals. Because the assessment includes a high level of clinical judgment, this function is usually conducted by a licensed and experienced behavioral health clinician. The goal assessment is to rapidly decide on supports and services needed by the client and developing a short-term service plan to meet those needs.

Recommendation 6.4: Provide supportive services, referrals to services, and case management.

Respite spaces are not designed to engage in intensive therapy; however, it is recommended that the space provides supportive, therapy-like intervention designed to engage clients. Many individuals with serious behavioral health conditions also have significant needs for social services and basic supports like food, protection from the elements, a safe and comfortable place to rest, and companionship. While the respite space is not a residential action, it is equipped to help with these needs. Developing an understanding of the individual's longer-term service needs is in important element of the initial assessment. Given the short-term nature of the CRS, referrals to essential services are an important part of the program. This includes referrals to behavioral health and medical providers for physical health, psychiatric, and addictions treatment services. It also includes referrals to social welfare organizations to assist with entitlements, food security, shelter, and so on. Identifying needs, providing immediate support, and making referrals are helpful services but they are seldom sufficient to meet the needs of clients and reduce risk of future encounters with law enforcement. It Is important for the respite space to refer clients to additional service providers and facilitate the actual use of the services. This can involve accompanying the individual to service, contacting the service to ensure that the client has arrived and has received the service, or contacting the client to see if the services meeting their needs.

Recommendation 6.5: Medication and medical services.

Many clients served will have immediate needs for medication and or medical services. This does not mean that programs must have full-time prescribers and medical personnel. It does mean that they need the ability to rapidly bring the services on-site to meet the needs of clients. This can be organized as on-call psychiatric and medical service. The services could be provided by some combination of on-call physicians, nurses, physician assistants, or medical technicians. If immediate complex intervention is

required, transportation to medical or behavioral health facilities can be arranged. Minor first-aid intervention may be provided by nonmedical staff.

Recommendation 6.6: Relocate respite space to a non-institutional environment.

While the current location has the advantage of easy access to addictions treatment services, there are disadvantages to existing in an institutional space. It is difficult to make the current setting warm, welcoming, and attractive to clients who may be reluctant to engage in services. Relocating to a more spacious and inviting location would improve the program's ability to engage clients. As noted earlier, this is a voluntary service. Many individuals who need respite space services have had adverse experiences in institutional settings and may resist crisis services that look and feel like an institutional setting. Engagement and willingness to accept services depends on creating an atmosphere that is comfortable, attractive, warm, and welcoming. Providing an alternative that is attractive and comfortable is important to efforts to engage people. Furniture and decor are comfortable and home-like. The environment is warm, comfortable, and welcoming. Attention to the principles of trauma informed designed are important. Centers want to be seen as safe and comfortable places to relax and receive support. Images of these non-institutional settings are available on the Internet.

Recommendation 6.7: Identifying community needs and increasing capacity.

The program was designed to accommodate up to seven clients at a time, four in one room and three in another. Staffing difficulties have limited operations to a single room of 4 beds. While this may be adequate for an initial demonstration, the program size needs to be increased to meet community needs. To determine what capacity is required to meet community needs, it is recommended that a workgroup develops operational parameters for respite space using available data to estimate capacity.

Recommendation 6.8: Fully fund and staff respite space to meet community needs and capacity.

Louisville's previous experience with the "Living Room" was short lived, as the pilot was well liked but not cost effective for the services it was provided. It is important key lessons are learned and ensure that funding levels include appropriate setting(s) and provide services that the community needs, such as referrals and prescribing medicine. An analyses of behavioral health hospitalizations and survey of mental health providers, analyses of CCDP drop-offs, and police drop-offs would provide a strong estimate for respite volume and associated needs, creating a data-driven design and funding allocation. It is also recommended that stakeholders consult with other locations with robust community crisis receiving and stabilization facilities, such as Austin, TX, Dutchess (Poughkeepsie County), NY, or Denver, CO which has two crisis centers that accept referrals only from the STAR*D mobile team or police officers.

Recommendation 7: Develop and standardize training specific to CCDP.

Stakeholders indicated that existing training prepared them to carry out their duties, while noting that training was ongoing and new needs were being identified. The new training needs were expressed by alternative responders wanting specific training as well as administrators, first responders, and community members suggesting training needs.

Recommendation 7.1: SCS standardize training protocols.

The list of training completed shows there is a training core that all employees must complete. However, the trainings completed also shows some idiosyncrasies in receiving training, especially as it relates to ongoing training. This is expected due to the newness of the intervention for SCS and new insights are

learned through each call. It is recommended that SCS reviews the completed training and develops a training sequence that ensures all employees receive the same type of training, exposure to other agencies, and on-the-job consultation/coaching. It is particularly important that recurring consultation/coaching inform new training scenarios to alleviate reliance on supervisors.

Recommendation 7.2: Develop cross-training for alternative responders and first responders. Stakeholders noted the importance of building trust and familiarity between first responders and alternative responders. As such, it is recommended for MetroSafe, LMPD, and SCS to develop in-service training for call-takers, dispatchers, and police where the CCDP can be explained, protocols and policies articulated, and alternative and first responders can engage in role-playing scenarios using standardized actors. In the healthcare field, simulations with standardized actors allow medical students to practice skills in high fidelity simulated scenarios with actors trained to respond differently based on how students treat them during an interaction. Coupled with traditional classroom training, this method of simulation has proven successful at improving medical students' ability to show more empathy toward patients, deliver prognoses in a more compassionate manner, and provide more detail regarding patient care options.[xxx]. Thus, it is recommended that training using standardized actor simulations coupled with instruction on trauma-informed and person-centered responses be developed. Multiple scenarios that account for variations in diagnoses, previous traumas with behavioral health response, and cultural needs should be created to provide a range of experiences for learners before entering the field.

Conclusions

On March 21, 2022, the Crisis Call Diversion Program (CCDP) launched in Louisville, Kentucky in Louisville Metro Police Department's Fourth Division after several months of planning and development. The CCDP is led by Louisville Metro Emergency Management Agency who contracted with Seven Counties Services to provide the behavioral health response. These agencies, in collaboration with other stakeholders, spent countless hours designing, implementing, and training personnel to provide needed services in Louisville by providing acute crisis support for individuals experiencing non-violent behavioral health crisis. The CCDP follows best practice responding to behavioral health crisis by providing "someone to talk to," "someone to respond," and "a place to go." As the CCDP is new to Louisville, stakeholders designed the intervention to start small with intentions to grow the intervention as familiarity and opportunities presented it, with three model expansions occurring since launch date. During the study period, March 21 to May 8, 2022, the CCDP responded to 119 individuals in behavioral health crisis providing professional crisis support and referrals and in process, freeing up 100 hours of LMPD officer hours to respond to other calls. The beginning weeks of the model show promise and interviews with administrators, first responder, alternative responders, and community members expressed widespread need and support for such an intervention.

As expected with a new intervention, CCDP experienced challenges along the way, with administrators maintaining close monitoring of operations and addressing many challenges with additional trainings, clarifications, or making changes to the program as required. Unfamiliarity, safety, and uncertainty defined the pilot study for administrators, first responders, alternative responders, and community. Sending non-police to behavioral health via 911 is new to Louisville, the community, and the organizations responsible for responding to these events. Designing, implementing, and staffing this intervention is new and safety is at the forefront of decision-making, wanting to ensure the individual in need and responders are safe. The lack of experience in this space leads to more cautious decision-making that can be overcome with familiarity and experience. However, a third factor hangs over the project and that is uncertainty related to if the CCDP will continue. Stakeholders acknowledged

throughout the study that new interventions typically have a short shelf-life in Louisville. Concerns over long-term funding has resulted in hesitation to make bold and innovative strides necessary to develop an intervention that meets the full range of needs and successes identified in the study. The long-term success of the CCPD is in its evolution, one that requires long-term commitment and resources to develop a model that provides acute professional help for people in behavioral health crises, deflects calls from police and frees up their time to address serious crime, and keeps people out of jail and hospitals by providing appropriate levels of care in community respite spaces. MetroSafe and SCS have laid the foundation to provide non-police responses to behavioral health crisis. The decision to start small, coupled with gaps in the intervention, have initially resulted in low volume, which is not sustainable for the long-term future. However, these efforts have created early successes and revealed meaningful paths forward to contribute to a comprehensive realization of public safety in Louisville.

This intervention is designed for acute behavioral health crisis response and is insufficient alone to address chronic behavioral health needs. Greater investment in behavioral health services, housing, and other social determinants of health is required to address chronic challenges. However, a well-designed CCDP may contribute to preventing others from developing chronic behavioral health through early intervention and support provisions.

Key Findings

1. There is a clear need for CCDP in Louisville, with model design and administrative priorities determining what success looks like.
2. The CCDP is a promising model and resulted in 119 individuals receiving additional crisis support and referrals in the first 49 days. One hundred (100) hours of LMPD officer time was released between March 21 and May 8, 2022.
3. CCDP is complex and there is limited knowledge of the model's intricacies. More education is needed to improve operations and build trust and confidence in CCDP, particularly in the community.
4. The long-term success of CCDP is in its evolution. The model is underutilized due to low call volume and data-driven expansion is needed to make a larger impact.
5. Long-term investment is needed to allow for program innovation, maturity, evaluation, and provide emergency behavioral health crisis support to the community.

Appendix 1: Sample of National Models

Table 1: Alternative Responder Models		
Model	**Description**	**Example**
Call Diversion	911 call-takers divert non-emergent, non-life-threatening calls to specially trained crisis professionals for immediate de-escalation and crisis stabilization.	Houston, TX Pima County, AZ
Civilian Responder	Multidisciplinary crisis response teams work independently from the emergency response system, using their own crisis line for intake of calls that would benefit from onsite support.	Portland, OR Salt Lake City, UT Rochester, NY
Community Responder	Integration of a response team into the emergency response system to respond to 911 calls. Consisting of some combination of social workers, clinicians, crisis intervention specialists, paramedics, and peer outreach workers, the team functions distinctly from other emergency responders and provides onsite crisis management and follow-up services to connect individuals to resources.	Eugene, OR Denver, CO
Police Department Social Workers	Social workers integrated as a full-time member of the Police Department. Provides crisis intervention, short-term counseling, advocacy, community outreach, education and other social service assistance to the Police Department. Not first responders. Follow up with people after interactions with police or respond to call after police have cleared the scene.	Alexandria, KY Durham, NC
Co-responder	Behavioral health specialists paired with uniformed officers to respond to 911 callers in crisis and offer on-scene stabilization and a resource needs assessment.	Oakland, CA Sacramento, CA
Fire Department	Non-law enforcement mobile crisis team, embedded in the Fire Department, includes pairs of behavioral health clinicians and paramedics.	Albuquerque, NM Madison, WI
Police-Centered Diversion	Police department leads crisis response, with options for pre-booking diversion, as designed with Crisis Intervention Team (CIT) officers and Homeless Outreach Teams.	Tucson, AZ Wichita, KS

Appendix 2: Crisis Call Diversion Program Protocols

Gregory E. Fischer
Mayor

Edward J. Meiman III
Executive Director

TO: All Communications Personnel

FROM: Angela Downes
MetroSafe Assistant Director

DATE: ~~March 28, 2022~~ (Revised May 10, 2022)

RE: Crisis Call Deflection Program
Emergency Services MetroSafe GM 22-005

Effective May 15, 2022, the program will expand the LMPD's 1st division.

Purpose: Define 911 Operator responsibilities in the **C**risis **C**all **D**eflection Program

Background: CCD focuses on diverting non-emergent mental health related calls away from LMPD and to a **B**ehavioral **H**ealth **H**ub located in the 911 center. **C**risis **T**riage **W**orkers will be available in MetroSafe from 1400-2200 7 days a week and can receive eligible calls transferred directly from 911 Operators.

CTW 1 - sits at Position 32
CTW 2 - sits at Position 33

Crisis Triage Workers Core Functions:

1. Call Diversion
2. Call Consult
3. Call De-escalation

Calls Not Eligible for CTW Intervention:

- An individual in ***physical possession*** of firearms, knives, or any other weapons (i.e., simply having a weapon in the home is not a disqualifier)

- An individual under the influence of alcohol or drugs to the extent requiring medical intervention (overdose or detox)
- An individual ***in the process of*** hurting/killing self or threatening to hurt/kill others with the means and intent
- An individual requiring medical attention because of a self-inflected injury
- An individual with known violent tendencies (i.e., dangerous location indicator) or exhibiting violent behavior
- When the individual in crisis or another person on scene has committed a violent crime (e.g., family violence)

Calls Eligible for CTW Intervention:

- 1st party CIT callers in LMPD's 4th or 1st Division, experiencing a Mental Health (MH) crisis and **NOT** actively attempting suicide or physically violent toward themselves or others
- 2nd party caller (person with the CIT subject) in LMPD's 4th or 1st Division, who is with the subject experiencing a Mental Health (MH) crisis who is NOT actively attempting suicide or physically violent toward themselves or others.
- Repeat CIT callers in <u>any</u> LMPD Division, experiencing a Mental Health crisis and NOT actively attempting suicide or physically violent toward themselves or others.
    - "Repeat CIT Caller" is defined as a caller with a CIT history in CAD or known to the Call Taker, who has called more than once in the last 3 months and is experiencing a Mental Health crisis and NOT actively attempting suicide or physically violent toward themselves or others.
        - If it has been more than 3 months ago, they are not considered a "repeat CIT caller".
        - If it is outside the 3 months and they are not in the 4th division it would be sent as a 1014 Deflection not available, or 1014 CIT if the caller doesn't meet deflection criteria.

Calls <u>from LMPD</u> Eligible for CTW Intervention:

- LMPD 4th or 1st Division responds or self-initiations on a CIT subject, secures the scene, and believes intervention from the CTW or MCRT will be beneficial.
    - The officer will call MetroSafe, provide the MetroSafe call taker with the location, and ask to be transferred to the Behavioral Health Hub/CTW.
        - The 911 call taker will find the event and copy it to the CTW (if available) using "Deflection" and transfer the officer to the Behavior Health Hub to speak to the CTW.

CTW Responsibilities:

- CTW's will triage the call circumstances for safety following safety guidelines
- If there is no serious threat, de-escalate and problem solve with the caller over the phone. If the situation requires face to face intervention and no safety threat has emerged, the <u>Mobile Crisis Response Team</u> (MCRT) may be dispatched by the CTW
- If there IS a threat, CTW's will transfer the call back to the 911 operator.

911 Operator Process:

Answering the initial call:

- **Operators may ask the following questions in addition to normal call triage to help determine if DEFLECTION is appropriate.**
  - **Are you experiencing a mental health crisis?**
  - **Do you have any weapons in your possession right now, or anything you want to harm yourself with?**
  - **Have you been drinking or taken any drugs requiring medical assistance?**
  - **Have you harmed yourself, if so how?**

Transferring a call to the CTW:

- **When a call meets the criteria listed above and the CTW is available:**
  - **See if the CTW is available in the phone system.**
  - **The 911 operator will use the event type "DEFLECTION" to send the call for service to the CTW. They will then transfer the caller to the CTW if they are not on another call.**
  - **If the CTW is on another phone call, the 911 operator can ask the caller if the Crisis Triage Worker can call them back.**
  - **If the caller agrees you will send the call for service up in CAD using "DEFLECTION" and put a note in the narrative that says to call the complaint back.**
  - **CTW's will monitor calls in their pending queue and will make call backs as soon as they are available.**

- **If the caller doesn't want to wait for the CTW to call them back:**
  - **Change the event type to 10-14 Mental Health (CIT Deflection not available) and put a note in the call for service on why it needs to be dispatched (i.e., CTW on another call and caller refused call back).**

- **If the CTW isn't available: i.e., not working, caller refuses call back, or the call for service is in another division other than the 4th but meets all other criteria.**
  - **Send the call for service up as a 10-14 Mental Health (CIT Deflection not available).**
    - **The SGT's do have the ability to cancel the run out like they do now, but we will be able to track for future expansion and staffing.**

- **When the CTW is handling a call and it needs to be sent to police:**
  - **The CTW will transfer the call back to a call taker and advise them of the situation.**
  - **The Call Taker will copy the event to Police using one of the following subtypes under 10-14 Mental Health**
    - **CIT**
      - ***used for all CIT's that do not meet deflection criteria i.e. 3rd party calls, weapons in possession***
    - **CIT Deflection not available**

- *call fits the deflection criteria but is refused by the caller*
- *call fits the deflection criteria but the CTW isn't available*
- *call fits deflection criteria but isn't in the 4th division*
- *call is transferred back to a 911 Operator from the CTW*

▪ **Assist Deflection**
- *used if the Mobile Response Team needs police assistance non-emergency- CTW should contact call taker/dispatcher to request this event type be sent*

▪ **MIW**
- *used for serving an MIW including self-initiation by officers*

o **The CTW will then close the event using a disposition code**
Cancelled
Duplicate Event
Handled by Deflection
Test
Transferred to Metro

- **There has been an additional option under 10-30 Responder in Trouble to include "DEFLECTION". This will be used if the MCRT comes up on Mutual Aid needing emergency assistance.**

Appendix 3: CCDP Crisis Support and Referrals

Crisis Triage Workers

Tables A1-A9 present the types of crises support and referrals made by Crisis Triage Workers for their 119 deflection events between March 21 and May 8, 2022. Please note that a CTW can provide multiple forms of crisis support and/or referrals during a single intervention.

Table A1: Number and Type of Crisis Support Provided by the Crisis Triage Worker, March 21 to May 8, 2022.

Triage Intervention	Frequency
Arrange phone check - ins with CIC	1
Assess for risk of self harm / SI / HI	37
Consult with co-worker / team	46
Counsel on access to lethal means	14
Develop Safety Plan with caller	34
Encourage community support agencies	31
Encourage counseling / treatment resources	34
Generate hope / reasons for living	24
Identify coping strategies	53
Include natural supports / family members in Safety Plan	18
Motivational Interviewing	49
Offer Case Management resource linkage	11
Offer Deflection Mobile Response	19
Offer resources / referral information	13
Other	9
Provide crisis de-escalation	58
Provide crisis phone / text / chat information	9
Provide education on addictions treatment process	1
Provide education on mental and behavioral treatment process	7
Provide supportive crisis counselling	51
Stay on the phone with the caller until team arrives	8
Validate Feelings	73

Table A2: Number of Benefit Referrals Provided by the Crisis Triage Worker, March 21 to May 8, 2022

Triage Benefits	Frequency
Food Stamps / SNAP resources	0
KYNECT Benefits resource	0
Medicaid / Managed Care Organizations	1
Medicare	1
Social Security (SSI / SSDI)	0
Other	0

Table A3: Number of Community Agency Referrals by the Crisis Triage Worker, March 21 to May 8, 2022.

Triage Community Agency	Frequency
Americana World Community Center	0
Cabbage Patch Settlement House	0
Catholic Charities of Louisville	0
Center for Accessible Living	0
Central Louisville Community Ministries	0
Dare to Care Food Bank	0
Depression and Bipolar Support Alliance	0
ElderServe	0
Family Scholar House	0
Feed Louisville	0
Goodwill general info	0
Goodwill Works / Career Center	0
Highlands Community Ministries	0
Jewish Family and Career Services	0
Kentuckians Voice for Crime Victims	0
La Casita	0
LouieCONNECT	0
Louisville Metro Department of Resilience and Community Service	0
Louisville Metro Housing Authority (Section 8)	0
Mandala House	0
Metro311	0
NAMI Louisville	0
Neighborhood Place	0
Other	0
PFLAG	0
Restorative Justice	0
South Louisville Community Ministries	0
TARC	0
TRIAD	0
West Louisville Community Ministries	0

Table A4: Number of Crisis Phone Line Referrals by Crisis Triage Worker, March 21 to May 8, 2022.

Triage Crisis	Frequency
Crisis LGBTQ Trevor Project Call / Chat / Text	1
Crisis Suicide Prevention National Lifeline Call / Chat	0
Crisis Text Line 741741	0
Survivors of Suicide	0
Other	0

Table A5: Number of Legal Resource Referrals by Crisis Triage Worker, March 21 to May 8, 2022.

Triage Legal	Frequency
Adult Guardianship process / CHFS	0
Adult Protective Services (APS)	0
Casey's Law Information	0
Child Protective Services (CPS)	0
EPO / DVO Domestic Violence Intake Center (Hall of Justice)	0
Legal Aid Society	0
Louisville Metro Police	0
MIW Process / Hall of Justice	0
Probation and Parole	0
Victims Advocacy Office	0
VINE - KY Dept of Corrections	0
Tim's Law Information	0
Other	0

Table A6: Number of Seven Counties Services Resource Referrals by Crisis Triage Worker, March 21 to May 8, 2022.

Triage SCS	Frequency
Crisis and Information Center / SCS Crisis Line	4
EPS / Emergency Psych Services UofL Hospital	3
Respite Center / ARC ASU	3
SCS ACCESS (first time appointment scheduling)	3
SCS Addiction Recovery Center (ARC)	1
SCS Adult Crisis Team	0
SCS Adult Services	0
SCS Child Crisis Team	0
SCS Child Services	0
SCS DSD Crisis Team	2
SCS DSD Services	0
SCS Rural Site	0
TAYLRD	0
Other	0

Table A7: Number of Shelter Referrals by Crisis Triage Worker, March 21 to May 8, 2022.

Triage Shelters	Frequency
Franciscan Shelter House	0
Hope Village	0
Salvation Army Center of Hope	0
Shelter Bed Reservation Line (Coalition for the Homeless) / Street Tips Guide	0
St. John Center (day shelter)	0
St. Vincent De Paul	0
Sweet Evening Breeze LGBTQ Youth Shelter	0
Wayside Emergency Shelter - Men Women or Families	0
Wayside Low Barrier Shelter	0
YMCA Safe Place	0
Other	0

Table A8: Number of Treatment Option Referrals by Crisis Triage Worker, March 21 to May 8, 2022.

Triage Treatment	Frequency
12 Step - AA / NA	0
12 Step - Al-Anon / Alateen / Family Resources	0
12 Step - Gambling / Sex / Food	0
Baptist Health Louisville	0
Bridgehaven Mental Health Services	0
Center for Women and Families	0
Family and Children's Place	0
Family Health Centers	0
Healing Place	0
Home of the Innocents	0
Hosparus Health	0
Insurance company - call for benefit and in-network provider	0
Louisville Metro Health Department	0
Morton Center	0
North Audubon Hospital	0
Norton Children's Hospital (E Chestnut Street)	0
Norton Hospital (E Chestnut Street)	0
Norton Hospital - Other	0
Norton Women's and Children's Hospital (Dutchmans Lane)	0
Nursing or Personal Care Home	0
Other	0
Park DuValle Community Health Center	0
Phoenix Health Center	0
Private Physician / Therapist	0
The Brook Dupont	0
The Brook KMI	0
The Couch	0
UofL Health - Mary and Elizabeth Hospital	0
UofL Health - Other Hospital	0
UofL Health - Outpatient Psychiaty	0
UofL Health - Peace Hospital (formerly OLOP)	0
UofL Health - UofL Hospital (Jackson Street)	0
Veterans Affairs - Outpatient Services	0
Veterans Affairs - VA Hospital	0
Volunteers of America (VOA) Addiction Services	0
Volunteers of America (VOA) Housing Services	0
Wellspring CSU (Crisis Stabilization Unit)	0
Wellspring Supportive Employment	0
Wellspring Supportive Housing	0

Table A9: Number of Events in Which Crisis Triage Worker Did Not Utilize Resources or Referrals, March 21 to May 8, 2022.

Triage No Resource	Frequency
No Resources or Referrals Made	17

Mobile Crisis Response Team

Tables A10-A18 present the types of crises support and referrals made by the Mobile Crisis Response Team for their 28 deflection events between March 21 and May 8, 2022. Please note that a MCRT can provide multiple forms of crisis support and/or referrals during a single intervention.

Table A10: Number and Type of Crisis Support Provided by the Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Intervention	Frequency
Assess for risk of self harm / SI / HI	20
Basic First Aid	1
Consult with co-worker / team	18
Counsel on access to lethal means	3
Develop Safety Plan with parties	1
Encourage community support agencies	19
Encourage counseling/treatment resources	23
Generate hope/reasons for living	7
Identify coping strategies	6
Include natural supports / family members in Safety Plan	0
Motivational Interviewing	26
Offer Case Management resource linkage	17
Offer resources / referral information	10
Other	0
Provide crisis de-escalation	17
Provide crisis phone / text / chat information	19
Provide education on addictions treatment process	0
Provide education on mental and behavioral treatment process	3
Provide supportive crisis counseling	3
Transportation	12
Validate Feelings	22

Table A11: Number of Benefit Referrals by the Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Benefits	Frequency
Food Stamps/SNAP resources	1
KYNECT Benefits resource	0
Medicaid/Managed Care Organizations	0
Medicare	0
Social Security (SSI / SSDI)	0
Other	0

Table A12: Number of Community Agency Referrals by the Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Community Analysis	Frequency
Americana World Community Center	0
Cabbage Patch Settlement House	0
Catholic Charities of Louisville	0
Center for Accessible Living	0
Central Louisville Community Ministries	0
Dare to Care Food Bank	0
Depression and Bipolar Support Alliance	0
ElderServe	0
Family Scholar House	0
Feed Louisville	0
Goodwill general info	0
Goodwill Works/Career Center	0
Highlands Community Ministries	0
Jewish Family and Career Services	0
Kentuckians Voice for Crime Victims	0
La Casita	0
LouieCONNECT	0
Louisville Metro Department of Resilience and Community Service	0
Louisville Metro Housing Authority (Section 8)	1
Mandala House	0
Metro311	0
NAMI Louisville	0
Neighborhood Place	0
Other	2
PFLAG	0
Restorative Justice	0
South Louisville Community Ministries	0
TARC	1
TRIAD	0
West Louisville Community Ministries	0

Table A13: Number of Crisis Phone Line Referrals by Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Crisis	Frequency
Crisis LGBTQ Trevor Project Call / Chat / Text	0
Crisis Suicide Prevention National Lifeline Call / Chat	0
Crisis Text Line 741741	0
Survivors of Suicide	0
Other	0

Table A14: Number of Legal Resource Referrals by Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Legal	Frequency
Adult Guardianship process / CHFS	0
Adult Protective Services (APS)	0
Casey's Law Information	0
Child Protective Services (CPS)	0
EPO / DVO Domestic Violence Intake Center (Hall of Justice)	0
Legal Aid Society	0
Louisville Metro Police	0
MIW Process / Hall of Justice	0
Probation and Parole	0
Victims Advocacy Office	0
VINE - KY Dept of Corrections	0
Tim's Law Information	0
Other	0

Table A15: Number of Seven Counties Services Referrals by Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT SCS	Frequency
Crisis and Information Center/SCS Crisis Line	22
EPS/Emergency Psych Services UofL Hospital	8
Respite Center/ARC ASU	7
SCS ACCESS (first time appointment scheduling)	3
SCS Addiction Recovery Center (ARC)	0
SCS Adult Crisis Team	0
SCS Adult Services	0
SCS Child Crisis Team	0
SCS Child Services	0
SCS DSD Crisis Team	0
SCS DSD Services	0
SCS Rural Site	0
TAYLRD	0
Other	0

Table A16: Number of Shelter Referrals by Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Shelter	Frequency
Franciscan Shelter House	0
Hope Village	0
Salvation Army Center of Hope	2
Shelter Bed Reservation Line (Coalition for the Homeless) / Street Tips Guide	1
St. John Center (day shelter)	0
St. Vincent De Paul	1
Sweet Evening Breeze LGBTQ Youth Shelter	0
Wayside Emergency Shelter - Men Women or Families	0
Wayside Low Barrier Shelter	0
YMCA Safe Place	0
Other	0

Table A17: Number of Treatment Option Referrals by Mobile Crisis Response Team, March 21 to May 8, 2022.

MCRT Treatment	Frequency
12 Step - AA / NA	0
12 Step - Al-Anon / Alateen / Family Resources	0
12 Step - Gambling / Sex / Food	0
Baptist Health Louisville	0
Bridgehaven Mental Health Services	0
Center for Women and Families	0
Family and Childrens Place	0
Family Health Centers	0
Healing Place	0
Home of the Innocents	0
Hosparus Health	0
Insurance company - call for benefit and in-network provider	0
Louisville Metro Health Department	0
Morton Center	0
North Audubon Hospital	0
Norton Children's Hospital (E Chestnut Street)	0
Norton Hospital (E Chestnut Street)	0
Norton Hospital - Other	0
Norton Women's and Children's Hospital (Dutchmans Lane)	0
Nursing or Personal Care Home	0
Other	0
Park DuValle Community Health Center	0
Phoenix Health Center	0
Private Physician / Therapist	0
The Brook Dupont	1
The Brook KMI	0
The Couch	0
UofL Health - Mary and Elizabeth Hospital	1
UofL Health - Other Hospital	0
UofL Health - Outpatient Psychiatry	0
UofL Health - Peace Hospital (formerly OLOP)	3
UofL Health - UofL Hospital (Jackson Street)	0
Veterans Affairs - Outpatient Services	0
Veterans Affairs - VA Hospital	0
Volunteers of America (VOA) Addiction Services	0
Volunteers of America (VOA) Housing Services	0
Wellspring CSU (Crisis Stabilization Unit)	1
Wellspring Supportive Employment	0
Wellspring Supportive Housing	0

Table A18: Number of Events in Which Mobile Crisis Response Team Did Not Utilize Resources or Referrals, March 21 to May 8, 2022.

MCRT No Response	Frequency
No Resources or Referrals Made	2

Case Manager

Tables A19-A26 present the types and frequencies of referrals for case managers. Between March 21 and May 8, 2022, seven individuals agreed to CCDP case management. Please note that a case manager can provide multiple forms of referrals.

Table A19: Number of Benefit Referrals by the Case Manager, March 21 to May 8, 2022.

Case Manager Benefits	Frequency
Food Stamps / SNAP resources	0
KYNECT Benefits resource	0
Medicaid / Managed Care Organizations	1
Medicare	1
Social Security (SSI / SSDI)	1
Other	0

Table A20: Number of Legal Resource Referrals by Case Manager, March 21 to May 8, 2022.

Case Manager Legal	Frequency
Adult Guardianship process/CHFS	0
Adult Protective Services (APS)	0
Casey's Law Information	0
Child Protective Services (CPS)	0
EPO/DVO Domestic Violence Intake Center (Hall of Justice)	0
Legal Aid Society	1
Louisville Metro Police	0
MIW Process/Hall of Justice	0
Probation and Parole	0
Victims Advocacy Office	0
VINE - KY Dept of Corrections	0
Tim's Law Information	0
Other	0

Table A21: Number of Community Agency Referrals by the Case Manager, March 21 to May 8, 2022.

Case Manager Community Agency	Frequency
Americana World Community Center	0
Cabbage Patch Settlement House	0
Catholic Charities of Louisville	0
Center for Accessible Living	2
Central Louisville Community Ministries	1
Dare to Care Food Bank	1
Depression and Bipolar Support Alliance	0
ElderServe	1
Family Scholar House	0
Feed Louisville	0
Goodwill general info	1
Goodwill Works/Career Center	0
Highlands Community Ministries	0
Jewish Family and Career Services	0
Kentuckians Voice for Crime Victims	0
La Casita	0
LouieCONNECT	0
Louisville Metro Department of Resilience and Community Service	0
Louisville Metro Housing Authority (Section 8)	1
Mandala House	0
Metro311	0
NAMI Louisville	0
Neighborhood Place	1
Other	1
PFLAG	0
Restorative Justice	0
South Louisville Community Ministries	0
TARC	1
TRIAD	0
West Louisville Community Ministries	0

Table A22: Number of Crisis Phone Line Referrals by Case Manager, March 21 to May 8, 2022.

Case Manager Crisis	Frequency
Crisis LGBTQ Trevor Project Call / Chat / Text	0
Crisis Suicide Prevention National Lifeline Call / Chat	0
Crisis Text Line 741741	0
Survivors of Suicide	0
Other	0

Table A23: Number of Seven Counties Service Referrals by Case Manager, March 21 to May 8, 2022.

Case Manager SCS	Frequency
Crisis and Information Center/SCS Crisis Line	4
EPS/Emergency Psych Services UofL Hospital	2
Respite Center/ARC ASU	0
SCS ACCESS (first time appointment scheduling)	1
SCS Addiction Recovery Center (ARC)	0
SCS Adult Crisis Team	0
SCS Adult Services	2
SCS Child Crisis Team	0
SCS Child Services	0
SCS DSD Crisis Team	0
SCS DSD Services	0
SCS Rural Site	0
TAYLRD	0
Other	0

Table A24: Number of Shelter Referrals by Case Manager, March 21 to May 8, 2022.

Case Manager Shelter	Frequency
Franciscan Shelter House	0
Hope Village	0
Salvation Army Center of Hope	1
Shelter Bed Reservation Line (Coalition for the Homeless)/Street Tips Guide	0
St. John Center (day shelter)	0
St. Vincent De Paul	0
Sweet Evening Breeze LGBTQ Youth Shelter	0
Wayside Emergency Shelter - Men Women or Families	2
Wayside Low Barrier Shelter	0
YMCA Safe Place	0
Other	0

Table A25: Number of Treatment Option Referrals by Case Manager, March 21 to May 8, 2022.

Case Manager Treatment	Frequency
12 Step - AA / NA	0
12 Step - Al-Anon / Alateen / Family Resources	0
12 Step - Gambling / Sex / Food	0
Baptist Health Louisville	0
Bridgehaven Mental Health Services	0
Center for Women and Families	1
Family and Childrens Place	0
Family Health Centers	1
Healing Place	1
Home of the Innocents	0
Hosparus Health	0
Insurance company - call for benefit and in-network provider	0
Louisville Metro Health Department	0
Morton Center	0
North Audubon Hospital	0
Norton Children's Hospital (E Chestnut Street)	0
Norton Hospital (E Chestnut Street)	0
Norton Hospital - Other	0
Norton Women's and Children's Hospital (Dutchmans Lane)	0
Nursing or Personal Care Home	0
Other	1
Park DuValle Community Health Center	0
Phoenix Health Center	0
Private Physician / Therapist	0
The Brook Dupont	0
The Brook KMI	0
The Couch	0
UofL Health - Mary and Elizabeth Hospital	0
UofL Health - Other Hospital	0
UofL Health - Outpatient Psychiaty	0
UofL Health - Peace Hospital (formerly OLOP)	0
UofL Health - UofL Hospital (Jackson Street)	0
Veterans Affairs - Outpatient Services	0
Veterans Affairs - VA Hospital	0
Volunteers of America (VOA) Addiction Services	0
Volunteers of America (VOA) Housing Services	0
Wellspring CSU (Crisis Stabilization Unit)	0
Wellspring Supportive Employment	0
Wellspring Supportive Housing	0

A26. Number of Events in Which Case Manager Did Not Utilize Resources or Referrals, March 21 to May 8, 2022.

Case Manager No Resources	Frequency
No Resources or Referrals Made	1

Appendix 4: Full Stakeholders Views on Expansion

CCDP Respondents Views on Expansion

This appendix provides the full qualitative analyses related to expansion and uses all 70 interviews and responses from the 93 first responders, alternative responders, and administrators. The community listening sessions did not systematically ask questions about expansion and therefore, community data is not included. If the evaluation continues, researchers will propose to use community based participatory research principles to hold visioning sessions to gather community insight into these expansion ideas.

At the beginning of the qualitative analyses, respondents noted a widespread need for the intervention and saw multiple benefits of this type of intervention. Yet, respondents also noted several areas where they thought the intervention could adapt to better fit the needs of the community, responders or systems. The following data presents the ideas for expansion and adaptability responders identified during the interviews. As researchers were presented with new ideas about expansion, researchers would add those ideas to the interview guide and ask subsequent responders their perspectives on the matter. As a result, not all expansion ideas have the same number of responses. Descriptions for all ideas are presented along with counts for how many administrators, first responders, and alternative responders indicated yes, no, or maybe. The analysis also provides select quotes that capture the needs or concerns for the expansion area.

Operations

The first set of expansion ideas were related to operational considerations and were focused on expanding hours and/or geography.

Expanded Hours. A total of 30 respondents indicated that the intervention should be expanded to 24 hours a day, 7 days a week, with administrators (5), first responders (16), and alternative responders (9) all showing positive support for the expansion. As one administrator noted,

> Sure, I would say that'd probably be a good idea, especially it seems there's more CIT calls at night. Seems like we get a lot more people that are either under the influence of something, or have mental crises. (Administrator)

Not all responders were supportive of the shift to 24/7, with one administrator, three first responders, and two alternative responders indicating a maybe and two first responders and one alternative responder indicating no. For the responders indicating maybe and no, there concerns were related to whether there was a need for a 24/7-time frame, instead suggesting 16-18 hours a day. As one first responder explained,

> I feel like that would be difficult. I don't know. That would have to be look at the data on that one. I feel like as I asked about 24/7, but I know that someone said that someone tried a 24/7 model and it didn't necessarily work very well. They ended up wasting more money on the third shift, necessarily the first and second. But maybe extending second shift out to like midnight. Nothing good happens after two AM anyway". (First Responder)

Several responders indicated that expanding hours to 16-18 hours shift would either be a better or alternative approach to going 24/7. Three administrators, one alternative responder, and four first responders, agreed on expanded hours outside of the 2pm to 10pm range, one administrator saying,

> I think the 2:00 PM to 10:00 PM is good, but I do think that it would be more effective if it were able to run both earlier and later. I guess, theoretically, that would be earlier though, if it's after midnight. But for example, the case managers, we had a client who didn't want any SUD services, but still had a lot of medical issues, still had housing issues, so they needed case management. The adult team, the deflection team has case managers for that. But it's 2:00 PM before they can come, meet with the person. And we had it timed out with them, so that literally at 2:05, they're walking through our door to speak with this client. (Administrator)

The increase in hours will provide greater opportunities for the intervention to deflect calls and provide services to those in need. Expanded hours also have benefits for buy-in. As the model is operating now, late shift police officers have limited opportunity to interact with the CTWs or MCRTs and do not get to experience the benefits of not going to as many behavioral health calls because the operations end at 2 p.m. A big point of emphasis for first responder buy-in is having fewer calls and since their shifts exist outside the 2 p.m. to 10 p.m. time frame there are still a large number of interactions. The challenge with expanded hours is needing additional staffing which is noted in previous sections.

Expanded Geography. A second prominent want was to expand the CCDP to all LMPD divisions, with 50 respondents supporting LMPD-wide expansion, which included 10 administrators, 15 alternative responders, and 25 first responders. A first responder stated the need to expand to other divisions as a way of increasing call volume and noted that geographic expansion was a bigger priority than expanded hours,

> If you're going to limit it to eight hours a day and 2:00 in the afternoon to 10:00 at night, you've got to increase the divisions. You're not getting any call volume. You have nothing to base it on or to tweak or critique. There's no calls. So, if you want to do baby steps, then divisions and then times or whatever, however you want to do that, but. (First Responder)

While perceptions of expansion to other divisions is ultimately positive, there are limitations. A first responder again referenced concerns with staffing as being able to expand to other areas,

> Because I really want this to expand and to be through the whole community. We don't just have CIT people in the fourth division or the fifth division. We need to be mobile. I would love to see it in here 24/7, and in all the divisions. I would love to be able to say, "Hey, Middletown's got this guy. They've been out on him four times. Can we go?" I want to be able to interact with that. I want it all to be cohesive, if that makes sense. Funding, staffing. Just the actual availability of it. Louisville Metro is a big city. Having that availability, you're not going to be able to go from the eighth division down on US Highway 42 to the third division out on Cameron Road any time. We need areas where they could be. And I just don't know that we have that kind of resource to us that, like I said, for especially the funding and the staffing, those are the major things. (First Responder)

Countywide expansion is another option that would involve accessibility to the intervention across the entire county, including in small cities such as Jeffersontown, St. Matthews, Shively, or other communities with their own police department. Of five respondents, three indicated the intervention should expand county-wide, two alternative responders and one first responder. One alternative responder noted,

> I think even past the city is the rural areas. I think there's a need for that in the rural... and they've expressed a need for it. So even if we didn't do that all the time, maybe one or two days a week, send a team out there and do that as well. (Alternative Responder)

Two administrators indicated maybe to county-wide expansion, one claimed,

> That's tricky. Only because we are not ... So, there's certain agencies that have their own police agency. They have their own mayors, so that is tricky. (Administrator)

There was widespread desire to expand to other divisions and in the first two months of the intervention, there were two expansions. First, on March 28th the inclusion criteria expanded to allow familiar callers from all LMPD divisions to access the CTWs and on May 15th the full intervention expanded to the First Division, allowing access to the CTWs, MCRT, and respite.

Expanding Access

Another noted expansion want was increasing access to the intervention outside of having to call 911 to access the alternative responders**.** There were several different ideas about expanding access

988

A total of 13 respondents affirmed the need to expand access to the intervention using the 988 number. 988 is a new dialing code that would route callers to the National Suicide Prevention Lifeline. If someone calls 988, they could be connected to the intervention. Three administrators, six alternative responders, and four first responders indicated yes to expansion using 988. An alternative responder stated,

> I definitely think there should be some way that if someone wants to directly talk to us that they can. And I know that there might be the situation of like, "Okay, what's the difference between you guys and the CIC?" But I think that if we made it very well defined when you call this number, what you'll get versus if you call all this number where you'll get. (Alternative Responder)

One first responder indicated no to expansion using 988, and noted,

> From what I know it sounds so similar just for me learning stuff. It just sounds so similar. So, I think they should probably integrate or somehow join. (First Responder)

Two administrators and one first responder indicated maybe using 988, one of the largest barriers given by an administrator,

> Muddy in the waters of 988 because it's so new. I think it needs to get some experience before we muddy the waters with that. 988 can be answered in about any state, right? Like if you don't pick up here and you're from Louisville, if Louisville doesn't get to the phone, it can be answered in Texas or whatever. (Administrator)

988 has yet to launch which presents opportunities and challenges for expansion. Since it is new, the intervention could be integrated into the system on the front end, but this would require long-term commitment to CCDP. On the downside, several respondents did not know what 988 was and as was noted in previous sections a lack of knowledge about a component is unlikely to result in utilization.

Direct Access to CTW

Several respondents wanted to expand access by having a direct line to the CTWs or at minimum, be able to specifically request the CTW and/or MCRT for their response**.**

There were different variations of a direct line mentioned, the first being access for anyone wishing to access the intervention. 3 administrators, 5 alternative responders, and 4 first responders indicated yes for this option. A first responder stated,

> I think it would be at the discretion of the CTW to say, "Here's my direct line. I'm here at this time. Or you can talk to Joe or John or whoever." But I think it would be, yes, I think they need a line. I think they need a direct line. However, I don't think we need to be the ones to give it to them, or give it to the people. I think they need to establish their clients and their rapport and their trust bond and then give them the number. (First Responder)

Direct access to the intervention for everyone was indicated as maybe by one administrator and six first responders. Most concerns were raised about safety. One administrator claimed,

> We thought about that, but I think it's better if it comes through 9-1-1. Now, if somebody... Eventually, maybe we get to a suicide type hotline or something like that, but I think there's so much unknown about somebody having a weapon and things like that, for it to go straight to the CTW. I think the 9-1-1 callers it's still... because that way they can send it to the police and it doesn't take time to backtrack it. (Administrator)

Two administrators, two alternative responders, and four first responders indicated no for direct access by all to the intervention. The primary concern of a direct line for everyone is an unmanageable call volume with no gatekeeper screening and triaging calls. One first responder noted,

> I think you're taking away from the ... Well, I'm not sure on that one, how I feel about that one, honestly. I feel like it's supposed to be a program that helps to keep the police from having to go, and if you're doing that, you're setting yourself up to be another crisis center. (First Responder)

The second option to expand access to the intervention is providing a direct line only to familiar callers. Familiar callers are individuals who frequently call 911. Of four respondents, two first responders indicated yes to providing a direct line to frequent callers. One first responder stated,

> That would be marvelous for our call takers. Our call takers would worship you if you did that. (First Responder)

One administrator and one first responder indicated no to providing a direct line to frequent callers. An administrator claimed,

> Well, I don't think they would do that because they like calling 9-1-1. That's their thing is they call 9-1-1. So, what we don't want to happen is frequent callers to bombard [the CTW], and [the CTW] be so busy with them that they can't take care of the business that they need to. I think triaging them through 9-1-1 and sending it over to them, so they can interact with them is better. (Administrator)

The last option for expanding direct access to the CTW involves providing a direct line for people who do not call 911. Of five respondents, two administrators and two first responders indicated yes to a direct line for people who do not call 911. One administrator and one first responder indicated maybe, both indicating safety as the primary barrier. The first responder stated,

> Well I think if they get word out, I think it can still be the same way. Because again, the call takers are getting the information about the location, if there's weapons involved and all that stuff. Whereas a CTW may go right into negotiating and deescalating and not realize to ask all those call taker questions. (First Responder)

Police can directly contact CTW and MCRT

Another avenue for expanding access to the intervention is to allow police officers to contact CTWs and MCRTs for assistance. On March 28th the intervention protocols changed to allow Fourth Division officers to contact CTWs if there was an appropriate case and this is now available to First Division officers. Therefore, the following focuses on their desire to be able to directly contact MCRTs. Four administrators, eight alternative responders, and 13 first responders indicated this was a needed expansion.

One administrator and three first responders indicated maybe and one first responder said no.

Police view Alternative Responder runs

Respondents also indicated a desire to allow police to view the MCRTs runs, with two administrator, one alternative responder, and eight first responders indicating this is something they wanted. First responders in particular voiced the desire to know what MCRTs were doing as they are used to knowing what is going on,

> Normally on our runs, we know all the moving parts, even though we might not be in control of them because dispatch handles a lot of our stuff. But the thing is, either manual, type information as you see the updates, or it has the units that are responding, we know all that, we know when they arrive, when they're on route, all that. And with deflection, it's kind like a guessing game. And then we know we keep reverting back to the EMS thing. EMS, hey, can you go make sure the scene is safe? Yeah, we go there. And a lot of times for me, especially if it's kind of a weird situation, I'll just hang out until EMS says they're good. Same with fire, we go with fire too. And so with deflection be the same thing, we get there, even though we say, hey, it's good, y'all come in. They come in. We'll hang out until one of the deflection people is like, hey, we think we're good, you all can go, thanks for being here. I'm like, cool. And then with that, if they wouldn't have called her, we wouldn't have known. And so if we would've got called like, hey, we need assistance back at this address. We'd be like, for what? It was two people and one was packing to leave. (First Responder)

Knowing what runs the alternative responders are taking, also allows them to know what they are taking which has the added benefit of knowing their workload is shifting as one first responder noted,

> I don't think it changes it a whole lot. I mean, at least that we've noticed because just because we don't and again, we don't know exactly who they take or what they take every night, but it just, you still do for us still do the same thing. It doesn't really change your day to day. Especially

> if you don't know what they're taking. Cause you're still, now that we can see the CIT change to 1014, we can see those now at first we couldn't, but you still it's just like another run in the queue. So I don't think it changes a whole lot. (First Responder)

There was some hesitancy mentioned, primarily from two alternative responders saying maybe, but also one first responder. Two alternative responders also said no. An alternative responder explained their hesitancy,

> Might be 1% game for it, but I mean the one caveat I'll say is like, the one thing I've really realized is how overworked police are to begin with. So I don't want to put another thing on their lap, another mandatory piece of training, but if it's something that they would be willing to look into, I think we should be crystal clear. (Alternative Responder)

One concern was related to police already being overworked, but there was also concern about escalating situations, as one alternative responder explained,

> Do not like. We've had a couple of different times where police have shown up after the fact while we're deescalating. The one time it happened, I thought they were about to get attacked, or they were about to get us attacked. In a way that is hard to overstate. We were interacting with a client, and we were talking ... Again, superheroes, everybody loves Marvel. We were talking about our favorite superheroes, whatever, just getting into it. And had established good rapport. He had told us several times how much he appreciated us being there, how glad he was to see us, how he thought we were really cool folks, and he loved the program. I tried to explain to clients what the program's about some other time at least. I'd explained to him and he thought it was fantastic. Just a really warm rapport. And then a police officer showed up, and the gentleman immediately started growling at the officer and us and assumed a very aggressive pose. (Alternative Responder)

The primary explanation for why this was not in place was concerns that the change might crash the officer's computer systems, which would raise considerable safety concerns as officers would not be able to see each other's current runs and the location.

Co-Response with Police

Currently the Mobile Response Crisis Team responds alone to events that fit the inclusion/exclusion criteria. CIT events excluded from MCRT criteria, including CIT runs that fall outside of the 2 to 10pm hours and runs outside of Divisions 1 or 4, get police response. One option of expansion involves sending the police and mobile responders on a run together. This takes multiple variations, one including both teams showing up simultaneously. Another option for co-response involves mobile responders staging nearby to the scene and police responding first, clearing the scene for safety before the MCRTs arrive on scene. A final option involves police arriving on scene and having the ability to mobilize the MCRT team if LMPD deems the event appropriate for mobile response.

Of the 28 respondents that indicated yes for co-response with police, 6 were administrators, 11 were alternative responders, and 11 were first responders. One administrator provided an example of co-response involving staging,

> If you've got an individual that's got a baseball bat, swinging a baseball bat, something like that, where the police can get there, they take the baseball bat away from them. They figure out that it's a CIT individual, they can... And the MCRT team may be standing by a block away, down the

> road, as we do with EMS now, when the situation, it would mirror our EMS response to say a shooting or something like that, where EMS get there, the police get there first, they diffuse the project or the problem, and then they call EMS up to the location. So they get there, they make sure that the scene's safe, however they need to do that, make sure they don't have any weapons on them and then they can call the MCRT team on up. (Administrator)

An alternative responder provided an example of LMPD mobilizing the MCRT team,

> So we have discussed second-party calls and being able to respond to those. One caveat is, or I guess sort of one hangup, is our ability to ensure that the team's safe is a priority in situations. And that I think a lot of times, as the processor shakes out, it's going to include like a co-response and a referral through LMPD or other first responders, that like, "Hey, the person, they don't have a weapon on them, they're in mental, emotional distress, and they're experiencing a crisis. Can we get CIT or the mobile response team out here? And me as a LMPD officer, I can now leave and go chase a bad guy," or whatever. (Alternative Responder)

There are still concerns of assuring safety to the best of one's ability, with 4 administrators, 6 alternative responders, and 10 first responders indicating maybe for co-response with police. As an administrator stated,

> As long as we know all the situation that they're getting in. I mean, you can't know anything, but everything, is what I mean. You can't know everything, but if they got the information they need to go into the situation prepared, then by all means. Because some things can be diffused if you just take somebody that's hyper and holds a gun at the situation. (Administrator)

One alternative responder indicated no to co-response, the major concern being police presence escalating the person in crisis. The responder stated,

> I worry about being misconstrued as the police or any sort of law enforcement related entity. To that end, uniforms are extremely concerning to me. Doing ACT training it was made very clear that to a point, the more you look like your clients, the better off you were. It's easier to relate to somebody that's not worried about you being in a business casual outfit…Or similarly wearing a vest or a uniform polo or something. You don't want people in crisis to be worried about any sort of preconceived notions because most of their interactions with authority have probably not been positive. So the less you can resemble somebody from one of those prior interactions, the better off you are. (Alternative Responder)

Co-Response with EMS

Frequent callers of 911 often ask for EMS when there is no medical emergency. This may be due to the fact the patient is CIT. Expansion could involve EMS co-responding with the MCRT team similar to police co-response in that EMS assesses the situation and determines if a medical emergency exists. With inclusion/exclusion criteria, EMS would be able to mobilize the MCRT team or arrive on a frequent caller scene simultaneously with the MCRT team.

17 respondents indicated yes to co-response with EMS, 5 administrators, 7 alternative responders, and 5 first responders. One administrator noted,

> Well, so normally, if it's a EMS run, the police are going, if it's something mental health wise overdose, anything. So they're already with the police anyway. So yes, it would be pretty much the same. (Administrator)

Some concerns arise considering the low volume of CIT EMS runs in addition to being able to distinguish a medical complaint from a CIT complaint. Two administrators, one alternative responder, and five first responders indicated maybe to co-response with EMS. One first responder stated,

> EMS typically doesn't respond to mental crisis calls unless they have an actual medical complaint. They may be short of air or something like that, but in that circumstance, they would end up going to the hospital to be treated for their medical condition first. (First Responder)

Two first responders indicated no to co-response with EMS. One claimed,

> EMS doesn't go on a lot of behavioral, mental health crisis calls for service on their own. There usually has to be a medical complaint, that they've actively done something to themselves. They've cut themselves, hung themselves, taking the medications. If it's just someone complaining of, "I feel suicidal," EMS doesn't response. (First Responder)

Co-Response with Fire

The Fire Department is often the first responder to arrive on the scene and they have the ability to call for backup from police and EMS. Expansion could include Fire mobilizing the MCRT team for co-response if they deem the run appropriate for the mobile responders. 14 respondents indicated yes to co-response with fire, five administrators, five alternative responders, and four first responders. One alternative responder justified co-response with Fire stating,

> And the reason why I say that this would be so helpful in those situations is because not only is there the first responder that helps the individual that is having the crisis or physical difficulty or is hurt or whatever, but then having a counselor or someone from our team dispatch could also be there to help people who have witnessed this event or family members who are just confused or don't know what's going on and they can help explain like, "Hey, we are here with the police right because there is a weapon involved." Or, "We are here right now with the EMS because there is a potential of someone overdosing right now." And basically kind of help people understand what they're experiencing. So secondary trauma is also kind of addressed. (Alternative Responder)

Because of their ability to arrive first on the scene, some argued Fire would be a good gatekeeper able to assess the situation and sometimes call for MCRT mobilization. Eight respondents indicated maybe to co-response with fire, two administrators, two alternative responders, and four first responders. One administrator stated,

> Fire is kind of the oddball out there because they respond to a certain criteria of runs, because they can, a lot of times get there before EMS. So where it will help the fire department is your man down runs, because it requires a police fire and EMS. So maybe it becomes an MCRT response, instead of any of the three, depending on the type of call that comes in. So it would eliminate probably some of their calls. (Administrator)

Two respondents indicated no to co-response with fire, both first responders. Both respondents addressed the issue of when co-response would be appropriate, in which neither thought the scenario existed. “But I think that just sending an MCRT and fire department, no.” (First Responder)

MCRTs Self-Initiate

Currently the MCRTs can only respond if they are dispatched by the CTW and the dispatched is approved by the supervisor. However, several respondents indicated that allowing MCRTs to self-initiate could be a positive. Self-initiation would involve the mobile response team coming upon an individual who appears to be having a behavioral health crisis and responding to the individual. 10 respondents indicated yes for self-initiation, five alternative responders and five first responders.

> Because I know CAHOOTS does that where they actually are out in the community, finding people that need assistance. And that's one of the biggest barriers to people getting assistance is people aren't necessarily going to come to you. They don't know where to go. They don't know who to talk to. They don't know who to ask. If we can go to them, all the better. (Alternative Responder)

Eight respondents indicated maybe for self-initiation, four administrators, two alternative responders, and eight first responders. One of the primary concerns for self-initiation is lack of direct communication between the mobile response team and MetroSafe,

> If your people can handle that radio traffic, I'm all for it, all for it. Right now, I think, and don't hear this the way it's going to sound. They're going to get in the way. Mobile three to radio pulled me out at this. I've got a subject that's walking around, yelling and screaming. It'd be great if they could handle that and we didn't have to send the police. But do you know how to call it on the radio? Do you know, I guess radio etiquette? Do you know what to tell me without me having to ask kind of thing? Yes, I think that would be a good thing down the road, like way down the road, because it would eliminate police response. If they can handle it, I don't need to send the police out. (First Responder)

The other main concern deals with the lack of knowledge of scene safety. One first responder stated,

> That is tricky because what are they seeing? I would say no, because I'm thinking of safety issues. Like what if they have a pocketknife and they don't have it where it can be seen. I don't think that would be good. (First Responder)

Some indicate the solution to safety would be a co-response, with a first responder noting “I think that would end up stage co response.”

Six respondents indicated no to self-initiation, one administrator and five first responders. The main concern continues being safety with a first responder noting,

> With the self-initiation would be like, they're popping out on someone. Like they see someone that might be in crisis that hop out. Cause I see that being a horrible idea. In my opinion. Cause they don't know what's going on. And a lot of people, they don't like us approaching, especially random people in civilian clothes. I'm sure they know what they're doing, but, still, I just see that being a poor idea. (First Responder)

Communication via Radios

As the intervention is currently designed the alternative responders do not have their own radio channel, rather their communication between each other occurs over the phone. The MCRTs do possess a radio but only have access to mutual aid in the case of an emergency. Several respondents noted issues related to alternative responders not being on a police channel or at least their own channel. One administrator, nine first responders, and ten alternative responders indicated that communication via radios would be a positive. As one alternative responder noted, the ability to have a radio would improve lines of communication,

> I like that. I feel like that gives them direct access. It's just like when I worked in the ER, we had a red phone. So if it was an emergency, EMS could only call the red phone. It was directly connected to Louisville Metro EMS. And so if it was something a gunshot wound or somebody was coding that phone wrong so we knew to be looking for them. So I feel like that's a nice resource to have the walkie that they can talk to them directly.

A second alternative responders noted another advantage of being on a radio channel in the sense of allowing officers more direct communication,

> I think that would be helpful 100% because, and I feel like that too may increase the amount of officer calls for us because if they can just get on the radio and be like, "Yo, this is a call for deflection." As opposed to having to call us and go through the whole process. I feel like whatever is easier for them is going to be more beneficial for us as far as getting calls. (Alternative Responder)

First responders shared the same sentiment, in wanting the ability to switch channels and request their assistance, especially for calls that are labeled as something other than behavioral health, but they know the individual is CIT. First responders also expressed advantages of having deflection on the radio as it relates to easier notifications if there were any safety issues and ensuring that someone in the call center would hear the call for help, as the mutual aid channeled is monitored by a supervisor and not a dedicated dispatcher.

Administrators (4) and first responders (12) were more likely to have conditions on having the alternative responders on a radio channel, noting staffing issues and required training. Generally, the sentiment was to have alternative responders on their own channel to avoid having too much chatter on already busy police radios as one first responder explains,

> I think their own channel would be better just because you're going to run into, if they're on police channel, you're either one not going to be able to get on it or you're going to get on it. And obviously they'd have training and stuff, but it's just different. A lot to talk on the radio. And something maybe that we can switch to, or they can, are able to switch to our channel because the only time they're going to need to talk to us is if they need us. Be my guess that's y'all are agreement with that is the only reason why they need to be on our channel is if they need us there. So they need to be able, at least have access to our channels. (First Responder)

The overall preference was to allow officers to switch to the alternative responders' channels when they were needed, a process officers are familiar with when they have to switch to traffic or specialty units' channels. There are complications that arise from providing a radio channel in the form of staffing, as

one first responder noted concerns over increased responsibility and workload associated with monitoring another channel,

> I would be opposed to the dispatchers being responsible for them, but having more information about where they are and what they're doing would be beneficial to us. It's just kind of the way, we have the ability to see what other agencies in Louisville Metro are doing. Such as Shively Police or St. Matthews or whatever. Those responders are monitoring on another channel, but we can always look and see what it is that they're doing and see their active run because it's important for us to know what is going on with another agency, should there be a critical incident. Just the time that it takes to put a run in. (First Responder)

Putting alternative responders on a radio channel would require another dispatcher to monitor the channel, which again is limited by noted staffing challenges and security clearances required to possess a police radio, especially with Louisville Metro shifting to encrypted channels. An administrator explains the range of complexities associated with the alternative responders having their own channel voicing cautionary support,

> Yes, but we don't have the current staffing to be able to do that. If we had additional ... Actually, there aren't enough people to staff on a normal basis. But if we had additional staffing, the only flip side to that is we have to be really careful with what channels they have access to, because of the CJIS stuff, because we don't ... If these people on the street have backgrounds that are on the MCRT team, they listen to police channels. But if they had additional staffing, we would have no problem whatsoever giving them a radio channel for their deflection, and saying, "You all use this." (Administrator)

Respondents are supportive of giving alternative responders a radio channel if staffing allows but noted too many hurdles to giving them access to police channels. Access to a radio channel would improve communication and ease respondents' safety concerns, as they expressed discomfort in not being able to communicate with alternative responders if something goes wrong.

Increase use of CTWs expertise in the call center

Respondents also raised the desire to increase the use of CTWs expertise in the call center, particularly as it relates to assisting call-takers with individuals who are in active crisis, but a police response is required and to allow CTWs to review incoming calls to identify additional calls that might be eligible for alternative responders. Six administrators, two alternative responder, and four first responders expressed interest in allowing CTWs to conference call with call-takers for certain events. The most common scenario mentioned was if someone was actively considering suicide, such as discussing jumping off a bridge, an event that is currently ineligible for alternative responders. In situations where the individual contemplating suicide was on the phone, the call-taker could conference call with the CTW and have the CTW use their training to attempt to deescalate and provide crisis counseling while emergency responders were in route. One first responder explained this type of story,

> Yeah. So I've been on the phone with the person who's been sitting on the bridge getting ready to jump. So I really like the fact that there's somebody that's trained and educated to talk to them, because I'm not that... I mean, I'm a mother and I'm older. So I mean, I have a little bit of experience with that. And kind of to think on my feet, but I'm not trained to have that conversation with somebody. So I appreciate the fact that there's going to be somebody there that I can conference the call in. And a lot of times, once you start talking to that person, you

> have created a relationship and they don't want to talk to anybody else. So transferring that call absolutely has to be a conference and you have to make the person that's there comfortable with talking to the CTW. I think they're really good at what they do and have the right verbiage. (First Responder)

To an extent a conference call already occurs between call takers and CTWs when they transfer a call over to the behavioral health hub, but going beyond current practices had mixed reactions. One administrator, four deflection, and six first responders said maybe. One alternative responder was concerned that conference calls could “ruin the rapport that was already built with that person, granted I know they're on the phone, but I don't want to... I know my partners would not want to restart the whole incident in motion again.” Indicating that too many parties involved can create unnecessary complexities. Further there were concerns with conference calls over-burdening call takers and CTWs and that was the reason for why three first responders said no,

> I think it should be brief because of the amount of call volume they have. I think it's necessary. That's what they've sent out as a reminder is that you need to keep your caller on the line. What we do is a soft transfer. So we put them in limbo. They connect with the CTW and say, "Hey, this is what I have. This is what's going on." And they're like, "Okay, yeah, we'll take it." And then they send them through kind of thing. I don't think it should be any longer than that because of other calls for service that would be in pending. If you have a conference call going on that takes a call taker offline in addition to a call taker that's already on a lunch break, in addition to another call taker that's following up another call for service now, and then you've only got two call takers available to take calls for service in your prime time of the day. (First Responder)

The concerns related to over-burdening staff were also noted when respondents discussed allowing CTWs to review pending calls and notify call-takers or dispatchers that the run would be appropriate. However, there was support for allowing CTWs to review calls as a way of pulling in greater volume with two administrators and nine first responders indicating their support. One administrator indicated the ability to be on the radio and review calls would increase the likelihood the appropriate call type classification was entered,

> Well, they should be able to do it for ... Like I said, I thought they should be on radio. I think they should be able to do it for the police. Just because someone's labeled a CIT, the call taker should have already handled whether it was a police issue or an issue for the CTW. So I think that the dispatcher just doing it because they see that someone wrote that someone CIT in the call, I think that should be addressed at the call taker level. (Administrator)

Respondents expressed acceptance provided CTWs followed the criteria as on first responder expressed concern that the CTWs might take calls that are outside the intervention parameters,

> ... Should they have access to those? I mean, I don't see a problem with it as long as it's the criteria. I guess if it's in a different division and it's not one they're openly taking yet, but if it's somebody that's being aggressive, I mean, I don't know if they would be able to help, but again, I don't know exactly what they do either and what resources that they have. (First Responder)

A second first responder expressed similar sentiment, but their concern was greater which led them to say CTWs should not review pending calls,

> No. And only because I think that would still limit so many unknowns. I think it should still go through the call taker process to establish to go to them. So you're saying that the CTW would like sit there and look at every run that comes in or... So that's a big thing is I don't know if they would have that much time. (First Responder)

Throughout discussions of expansion a sense of familiarity and concerns over safety guide one's willingness to expand or not.

Third Party Callers

Third party caller refers to an individual who is calling for someone else but are not physical present. The caller may or may not know the individual. For instance, someone might be concerned about a friend but live in a different city or might drive past a park and see someone talking to themselves and call 911. Another possibility is that a therapist may call about concerns for a client. Third party calls are currently not eligible for the intervention and there were mixed views on whether they should be included in the future. One administrator, one alternative responder, and two first responders said yes. The main reason for supporting the inclusion of third-party callers is volume as one alternative responder explains,

> I think down the line, I would really like to be able to respond to people that call 911 on another person, those third-party callers, because I feel like that's the majority of 911 calls when people are going through a crisis or distress publicly, is that people instantly call the police. Whenever we can start taking on third party calls, I see our responses doubling or tripling, because it seems to me and my perception is that's what the majority of calls are when people are in crisis, is someone else calling. I could be wrong, it could be mainly first party callers and people calling on themselves. (Alternative Responder)

A first responder shared similar sentiments about expanding to third party calls for the purposes of increasing volume,

> Yeah, definitely. Because, like I said, a lot of times it's not first party callers that are making the calls. A lot of times, it is a second third party, saying, "I'm seeing this," or, "Someone's called me," or, "I've seen this on social media." So, yeah, no expanded to second, third party would definitely... (First Responder)

There were noted hesitations with the expansion to third party calls expressed by four administrators, two alternative responders, and five first responders who said maybe. One administrator suggests the expansion but thought it would be best operated as a co-response,

> I think we can add those. A third-party call in my opinion will become more of a co-response. Because if somebody drives by and they see somebody naked hollering at the moon in the middle of an intersection, and they call 9-1-1, but they drive by those questions to make sure that that person doesn't have a weapon, isn't going to be able to be answered. So that would be where a co-response would go, police would go, defuse the problem, make sure they don't have any weapons. And then the CTW or the MCAT team can be sitting a block away, and they come in and they take possession of the person. (Administrator)

The overarching concerns with third party calls it the unknowns associated with the event and often times the lack of detail provided by the callers. As one first responder explains "Well, at third party, I

think that I don't know about third party. They're not there. They're getting someone else's opinion." Even with the safety concerns several responders were still willing to expand if it was done correctly. However, one administrator and three first responders were opposed due to the unknowns,

> I think it's too unknown for them to go because I mean, that's not a, you don't know what you're like, you literally have no idea what's happening. Because third party callers that they can be anything. That's what I, you don't. It could be absolutely nothing. Which majority of time it is. Or it could be just like said a nightmare. (Administrator)

Safety concerns are again noted in respondent's hesitancies to expand.

Call Types

Events that currently get called into the call center that are considered appropriate for this intervention are the 1014 CIT runs. Expansion takes into consideration other call types that may overlap with CIT runs and would therefore be appropriate for the MCRT team, or for other non-criminal runs that could deflect additional calls from the police. There were several call types noted during interviews.

Welfare Check

One call type that was mentioned by respondents and actively discussed by administrators was welfare checks. Two administrators, two alternative responders, and four first responders supported the idea of sending welfare checks to the alternative responders.

> Yes, but I don't think it'd be a whole lot of them. There's a lot of times check the welfare for type runs are more like we haven't been able to get in touch with somebody, you know, they're not answering their calls, or what have you. I don't necessarily know if that would be specifically a mental health. You know, we get a lot of them that aren't mental health issues, it's just, "Hey, this person has these health problems and we haven't heard from them in a couple days." (First Responder)

Three administrators, three alternative responders, and nine first responders were willing to send them to welfare checks in certain conditions.

> In some situations a wellness check could be a drain on staff resources. And in some situations, it could definitely be a positive plus thing. In other situations, like if a person is deceased when we arrived, then what does the process then look like? Do we have to be present the entire time of that process? And that could take several hours. At what point are we clear to leave, and just, someone else take over. Those sorts of things. (Alternative Responder)

Whereas two alternative responders and two first responders said no, with one first responder explaining,

> That's interesting. Most of my welfare checks have been because the relative or the friend or whomever hasn't heard from this person in a week or two. So I'm not real sure that leads me into a CIT situation immediately. (First Responder)

Disorderly Conduct

Disorderly conduct calls were another call type noted as a possibility for alternative responders. A disorderly conduct is an event in which an individual may be acting in a disruptive or unusual manner,

such as yelling at a passersby, a business needing help with an individual in crisis inside/outside the business, or someone loitering. There were four respondents that indicated yes to the MCRT team responding to disorderly conduct runs, one administrator, two alternative responders, and one first responder.

Hesitation around disorderly conduct call types mostly involved safety concerns. 14 respondents indicated maybe to disorderly conduct runs, five administrators, four alternative responders, and five first responders. One possible solution to safety concerns involves co-response. As one administrator stated,

> Yeah. Depends on what kind of disorderly it is. Yeah, somebody's got to assess whether it's a mental health issue, or not. And I don't think it's safe for a mental health person to go out there and do that assessment alone. That's where co-respondent, I think would be good. Okay. If it's... So okay, it's probably the same person. Somebody either calls about that person or you see that person, right? So it's coming through that 911 center and it's going to get assessed, right? (Administrator)

Another administrator concurred, by saying "Definitely have to go with police." There were 6 respondents that indicated no to disorderly conduct runs, five first responders and one alternative responder. One first responder simply stating "It's police," with no elaboration; however, the same first responder previously explained their concern with safety and any matter that was criminal should be "handled by police."

Indecent Exposure call types involve a form of public nudity and can sometimes involve CIT individuals that may undresses in the street or in a park because they are having a behavioral health crisis. Two respondents indicated yes to the MCRT team responding to indecent exposure calls. As one administrator succinctly noted, "That's got potential, I think," although did not offer elaboration. The primary focus on indecent exposure was the type, noting that exposing oneself to kids should never go to the alternative responders. Safety concerns also emerged, with two first responders indicating no by explaining "Usually if there's no clothes on somebody, there's something usually they're a little agitated," and another explained "Yeah most of the time it's not just mental health. It's absolutely intoxication. Of something."

Juvenile Disturbances involve parents calling 911 for behavioral issues they are having with their children. An example may include a child refusing to go to school. Five respondents indicated yes for MCRT responding to juvenile disturbances. Most indicated maybe, depending on the situation, with three administrators, two alternative responders, and six first responders. A lot of hesitation comes from the age and size of the child and the situation. One first responder stated,

> I'm still going to say it depends. I mean, if you're talking about a three-year-old throwing a fit, I mean, I'm thinking nobody needs to respond unless Mom's hitting him more than ... or hitting him, or he's hitting other people or something like that. Then that's a little more than that. But a three-year-old ... If it's a 10- or 12-year-old and they're throwing a fit like that, there's a potential for violent behavior. It just depends. Like I said, a lot of this stuff is gray area. (First Responder)

Seven first responders indicated no to MCRTs responding to juvenile disturbances, the main issue being responder safety. One first responder claimed,

> That's a domestic situation and a lot of our officers, I'm sure you've heard there's many times that a lot of our officers have been hurt seriously or killed from domestic situations. And it can be as little as something like that. Again, I don't think that's something that someone who is unarmed like them, should walk into. No, domestics, no. Any type of domestic, no. (First Responder)

There were three other call types related to potential low-level criminal activity that respondents mentioned which were noise complaints, suspicious persons, and trespassing. Similar to the call types above, respondents views were largely contingent on the specific scenario at hand, whether there as a safety concern, or whether they believed the call type had anything to do with behavioral health. To prevent further repetition, the counts for each type are presented,

Noise complaints

Yes: 4 administrators, 1 deflection, 2 first responders.
Maybe: 2 deflection, 2 first responders.
No: 4 administrators, 2 alternative responders, 10 first responders.

Suspicious Persons

Yes: 1 deflection, 2 first responders.
Maybe: 2 administrators, 2 alternative responders.
No: 2 deflection, 13 first responders.

Trespassing

Yes: 3 admin, 3 deflection, and 3 first responders.
Maybe: 1 admin, 2 fist responders, 3 deflection.
No: 1 admin, 3 deflection, 5 first responders.

Living Room Needed

Compared to some of the other expansion ideas, there were not as many mentions of the need for respite. The data would suggest that one reason for this was the lack of knowledge of respite as a component of the intervention and the lack of information shared about its role in the intervention. While there are not as many responses for respite, the responses were more adamant about the need and value of the space for their respective roles. Four administrators, seven alternative responders, and eleven first responders indicated yes while three administrators and one alternative responder indicated maybe. For several respondents they had positive experiences with the Living Room and wanted greater access to respite space as one first responder explained,

> It was great. I want to go to the Living Room. They don't feel trapped. They know they can leave anytime they want to leave. Checked them out, throw them in the car, and run on down… I mean, some of them just don't want that stigma of the hospital. But, if they're going receive services and still they go get those services and they feel like they don't want to be there anymore, they can just leave. (First Responder)

A second first responder shared similar perspective on the living room,

> It Was nice. Cause it was another option. A better option. Yeah. People didn't want to go to the hospital or, cause you run into a lot of people that I don't want to go to the hospital and you don't have enough to involve them, but there's going to be issues if they don't leave where they're at, that was a good place because you can offer that. It's like, Hey, they will help you here. If you have something going on, but it's also another place to go where you're not going to

be here. And then arguments, aren't going to, whatever the situation may be. Just another resource. (First Responder)

Additional support was found by administrators and alternative responders, but their support was limited to concerns related to available space as one administrator explains,

> I don't think that's a bad idea. I guess my question would be, how would you provide individuals to help with the program? Where would you house them? Yeah. So I think this is more of an intermediate. So it's not the same necessarily as somebody who required medical treatment or detox, it would be somebody who just another place to go that's not a hospital, that's not jail, so more like you can get a snack, you could hang out, you can stay warm, but it's kind of the intermediate step. It's not somebody who requires any kind of medical treatment. (Administrator)

A related issue to the need for a living room is whether the current respite is the right space. This issue only came up for administrators and alternative responders, with 1 administrator and four alternative responders saying yes and five administrators and two alternative responders saying maybe. One administrator noted that the current space is a good start for where they are right now,

> I feel like it's good for where we are right now. When we look at best practice models and things like that, like the one that's in North Carolina that is purely peer run is very much a home setting and things like that, that is true respite and, and peer led and things like that. That's a someday kind of thing. For what we have, I think it is good because it's already a 24/7 facility, it's already linked in with seven counties. So, we're able to collaborate in ways that it would be more difficult if it was with a different agency. Not to say that we couldn't do that. It's perfectly fine but it's nice to be able to have the EHR that's shared and we're able to look at all the different things and we're able to collaborate in that way. So, that is helpful. And just having another option for people that's not jail and not the hospital. I feel like it's a great start button, for sure. (Administrator)

This sentiment was shared by other administrators that the respite space was a good start in the context of a quick start, but there is room for improvement,

> I think it's an adequate setting for respite. It's not a home-like setting, but their living room was not a home-like setting either, but, in an ideal world, you would have multiple respite centers out in the community, and they would be very much home-like settings, but resource-wise, that's not where we're at. So, what we have has been more than adequate. Well, the short answer is probably yes, but the long answer is, I don't necessarily see the city wanting to fund that. So, and there's a lot of questions about Medicaid sustainability and Medicaid billing, and of course, respite is not a Medicaid billable service. So, and even though we explain that over and over again, there's a lot of still continued questions about it. (Administrator)

The administrator notes the need for expanded respite space, including multiple locations, but uncertainty around available funding to provide the type of respite services required. While the current space is viewed as a good start, alternative responder indicated concerns about space noting “They’re pretty limited on our space. Like, I don't know that we would have any other space that would allow for it to get bigger. If they did, they moved it to the basement or whatever and made it bigger, that would be fun. But again, it goes back to client and staff ratio and what you're dealing with and also case

manager possibly, if the deflection team's not going to have their case manager out here on a regular basis, then we need one of our own here." The alternative responder once again evokes staffing realities being a component of broader expansion considerations.

There was widespread support for increasing access to respite spaces with a desire to allow police to drop-off and to allow walk-ins. For police drop-offs, two administrators, one alternative responder, and seven alternative responders said yes to allowing police to drop off at the respite space as one administrator articulates,

> Yes. And I say that only because I saw Austin's model, and we actually visited. It was a very nice place… It was new. So I understand what was nice, but they actually had a space around back that officers could come and drop somebody off. They showed us the little triage area. The officer comes in, drops them, and the officer leaves. But that way, they're not getting seen in front by a police car getting dropped off. That would be amazing, because I know that the officers would love to have a resource like that. (Administrator)

Allowing police officers to drop off is seen as a benefit to providing individuals with care and deflect further calls from police or higher levels of care, as another administrator explains,

> Yeah, I think that's necessary because I expect them to respond to a run that could be deflected or the MCRT team could take over. And so if they can contact them directly and say, "Hey, send one of your people out here," I think that'd be fine. (Administrator)

The hesitations to allowing police to drop off at the respite space were related to following proper protocols, where five alternative responders and one first responder said maybe, whereas one alternative responder and one first responder said no. As one first responder voices support for police drop-offs it is contingent on criteria being met,

> Yeah. I don't know what type of process has to be gone through to accept somebody into that, but as long as they're willing to go through that process, like the mobile response unit or whoever. I think there should be probably criteria that needs to be met: nonviolent, people that don't need to potentially have to be restrained or things of that nature. But if they meet certain criteria, I don't see any issues with the police taking them there. (First Responder)

If a process where police are to drop-off at respite comes into play, then it becomes important that everyone is trained on what the drop-of processes are, as an alternative responder explains,

> I feel like if everybody worked together and trained that it's a very good possibility, but I feel like the police need to be trained on when to contact respite. When is it appropriate? When do we need them? That's what it would take is everybody knowing when the next person needs to step in. You have to get that clear understanding. And then after that clear understanding, it would be great, but they need to know what items specified them going here versus somewhere else? Just like a list of generalized. You would send this here and this here instead. (Alternative Responder)

So one component of needed training would to make sure you are dropping off people who fit the criteria and also making sure those drop-offs are made to staff as one alternative responder noted that it could work "as long as where they dropped off was staffed," reflecting on frustration in times where

police had dropped someone off for other services and did not inform staff. Related to training and protocols, one first responder said no to allowing police to drop off “Because they all also don't have the education that the MCRT team does.”

Generally respondents viewed dropping off at respite to be a good thing as long as criteria were met and similar sentiments were expressed for allowing walk-ins where one administrator, three alternative responders, and five first responders said yes. One alternative responder succinctly indicated “I feel like you if you feel like you need help, it needs to be available to do it.” The hesitancy for allowing walk-ins was related staffing and safety concerns. Two deflection and first responders said maybe, and one alternative responder and two first responders said no. One first responder expressed their concerns with walk-ins,

> Okay. Then I would say that I don't necessarily agree with walk-ins just because of the potential for violence. What about the other people that are there? I think that they would need to be triaged ... well, unless ... I mean, if they just walk in and they haven't even been through triage yet, there's still a potential. If things aren't locked down, there's still a potential for it to become violent in there, which I guess there could be at any doctor's office, too. I mean, and the grocery store and anywhere else. But, at the same time, when you're trying to be a place of healing, I think that's ... Yeah. I think that I would say not just a walk-in. I think that some type of referral, someone who's trained and has referred them. Of course, you'll probably still have walk-ins, or people trying to walk in. But even the people that try to walk in, if they could be referred to make the call and get triaged that way prior, that could be an opportunity, also. (First Responder)

A second concern related to allowing walk-ins was overburdening the space. A alternative responder explains, “I don't think that, I think that would be a good idea eventually. The only concern I have with that is that that could possibly bog down that respite space. And then it's going to lead to having more strict criteria as to who qualifies to be there, and who doesn't.” Similarly, a first responder also stated “I think they're going to get overcrowded with just homeless people.” These concerns again evoke the need for respite space to have a clear purpose that guides the design of the space, services provided, drop-off criteria, and protocols.

Beyond Behavioral Health

One of the broader themes that emerged through expansion discussions is whether or not this intervention should stay focused on behavioral health issues long-term or if it can expand to address other non-criminal 911 calls or provide crisis responses to a broader range of people. Five administrators, five alternative responders, and four first responders believed that the intervention should expand beyond behavioral health in the long-term, but the immediate focus has been on CIT as one administrator explains, “I think it can expand. We've been concentrating so hard on the CIT. I don't know really what's out there totally, but I guarantee it can expand.” For alternative and first responders, their day-to-day interactions guide their belief the intervention is needed beyond behavioral health, as an alternative responder notes,

> Oh yeah. I think that would be great. And I see that stuff is just flowing across the screen all day. And it would be nice to have somebody who's not police that is calm and you're not in trouble. But, "Hey, what's going on buddy?" I think that would be good. (Alternative Responder)

Like other ideas for expansion, there is some caution and one of the biggest issues expressed is that it is too early to know if the intervention should expand beyond behavioral health. Two administrators, three alternative responders, and six first responders said maybe. The overall knowledge and awareness of the how the intervention works contributes to the hesitancy, as one administrator notes, “I think it's too early to know. I don't know. I think so, but I don't know yet. I think the sentiment seems to be there for the group, the folks that we're working with. Yes. I think the sentiment's there. I do.” Respondents, for the most part, can see various evolutions moving forward, but three first responders said no to expanding beyond behavioral health noting, “I don't think so, CIT is fine. No I don't think we should expand any further. Because when you're getting outside of that realm, I mean there's already safety issue involved in mental health anyway, in behavioral health. And if you start expanding to outside of that realm, you're getting into more safety issues, concerns.” Another first responder expanded more,

> I don't like that one. But I don't think that's a good idea on that one, but I mean the problem with expanding could it sure it absolutely could. Do we have other people in this community who need resources and help? Yes. As long as it doesn't take away from the mentally ill people who always get crapped on. And also that all depends on your resources. Like how many people is it going to take that hire to expand to that? And, something tells me that with society and the way that the jobs are and everything else that is well, well, well down the line, when you get a lot of grants and a lot of money and a lot of care, but as long as you don't lose focus, cause now you have all this, now they're concentrating on their own epidemic. And so what's happened is our mentally ill people are the same way they're not getting cared for. (First Responder)

This last point reiterates one of the greatest complexities associated with this intervention. The responder double-downs that the purpose of this intervention is to serve individuals with behavioral health issues and expansion might result in those individuals not receiving the services they need.

This is a very important point, if the purpose of the intervention is to only serve individuals with behavioral health crisis and raises some of the most important questions moving forward:

1. What is the purpose of this intervention?
2. Who is this intervention supposed to serve?

As noted in the beginning of this analyses, respondents identified multiple needs and versions of success associated with this intervention and these perspectives vary within and across organizations and roles, so getting a clear answer is not easy. The ideas respondents had about expansion for the most part reflects their perceptions of why this intervention is needed and what success looks like. If you take the ideas for evolution together, we can create a long-term vision for what alternative response looks like in Louisville.

Achieving this vision is no easy task. It will require a clear purpose, innovative strategies, consistent funding, and evidence it is achieving its goals. It starts with a clear understanding of what will drive change and what those steps look like.

Appendix 5: Considerations for Co-Response Expansion

As noted in the report's expansion section and in more detail in Appendix 4 CCDP stakeholders viewed co-response as a needed expansion. The primary rationale for respondents was to alleviate safety concerns related to behavioral health calls and to increase volume. Co-response has clear implications for volume, as noted in the main report between March 21 and May 8, 2022, there were 2,820 behavioral health calls for LMPD and/or the CCDP, with only 461 (16%) deemed deflection-eligible, leaving LMPD to respond to 84% of behavioral health events. A similar pattern emerged when looking only at the 2 p.m. to 10 p.m. time frame, where there were 1,249 total behavioral health events and only 17% being classified as deflection eligible. Depending on design, co-response could substantially increase volume. However, we cannot automatically assume all the behavioral health calls would result in a co-response, as some calls such as MIWs or those with active violence would be handled by police only. Using LMPD CIT Reports we can estimate the volume of police-only behavioral health events by assuming that any event resulting in an involuntary hospitalization or a charge, would be police only. In 2022, approximately 6% of all behavioral health events resulted in an involuntary hospitalization or charge and therefore it is unlikely the MCRTs would participate in the run. Therefore, we can estimate that an additional 250 events would be eligible for deflection in the Fourth Division between 2 and 10 p.m. with co-response as an option.

The increase in volume is beneficial, but another key factor in co-response is that it alleviates many of the safety concerns indicated by CCDP stakeholders. CCDP responders regularly mentioned the unknowns associated with behavioral health calls and even other call types. As responders noted that co-response would allow police to check for safety and then leave if their presence was not required, an idea supported by officers as shown in Appendix 4.

The benefits of co-response for volume and CCPD responders' safety concerns are clear; however, stakeholders did indicate caution with co-response related to volume and safety, which should be factored in. Some CCDP responders were reluctant to advocate for co-response as they did not want officers to go on all calls, as noted in Appendix 4. Therefore, it is important that any co-response model have a deflection-only option and it is recommended that stakeholders should expand deflection-eligibility criteria to increase the number of deflection-only calls.

Expanding eligibility criteria was an important factor noted for stakeholders, as many first and alternative responders felt there were unnecessary calls being sent to the police. Another advantage to expanding eligibility criteria is getting greater community buy-in and providing a model that the community trusts and is willing to use. Community members noted that they were unwilling to call 911 for behavioral health crisis out of fear the police would respond yet recognizing that current eligibility criteria would exclude them from CCDP. Providing greater or direct access to CCDP for those who do not want a police response should be considered. One unintended consequence of a co-response models is that without proper public education campaigns explaining when a co-response occurs, community members may not engage with CCDP at all due to not wanting a police response**.** As co-response is designed, it is important to get community input to identify gaps and develop a model that will serve their needs. It is, therefore, important to consider the classification of deflection only, co-response, and policy only scenarios.

Challenges

While co-response has advantages for increasing volume, alleviating safety concerns, and expanding deflection-only eligibility criteria the process is not without challenges, many of which align with findings in this report. We present the immediate challenges below:

Designing a model that meets community and organizational needs

The biggest challenge is building collaboration and consensus on how the co-response model should operate. There are several considerations to be made, such as:

1. Will co-response create two or three response categories? A two-response category would include deflection-only and co-response. A three-response category would include deflection-only, co-response, and police-only response. Part of the considerations for how many response categories will be safety considerations and the workgroup will need to design inclusion/exclusion criteria for these that are operationally clear.
2. A second factor for determining two- or three-response category co-response is who is best positioned to serve as gatekeeper, determining whether police and co-responders are needed? The CCDP is designed around a call-taker making the initial determination and that process would still be in place; however, in a two-response category co-response, the call taker's decision is straightforward. In a three-category response, the eligibility criteria may create challenges for determining if a deflection-only, co-response, or police only response is required with limited information. One option is that in the three-response category, the call-taker determines if it is deflection-only or co-response and then an officer would serve as the de facto gatekeeper, as once they get on scene for co-response they could determine if the MCRTs are needed or not. Either approach has advantages and disadvantages and thinking through the intended and unintended consequences is needed.
3. Another factor is what does a co-response look like? Do police officers and MCRTs approach the individual together? Or is co-response designed using existing "assist EMS" run protocols, where EMS stages one-block away and allows LMPD to clear the scene and then notify EMS when the scene is safe. The majority of stakeholders believed MCRTs staging would be the best approach.
4. Who engages first? If the co-response scenario is designed to have officers arrive first and check for safety, what happens once a scene is deemed safe? Will officers begin to deescalate and build rapport with the individual in crisis or will they buy time to wait for the MCRTs to pull up and start engaging. Several responders noted that the staging approach might create challenges in gaining rapport. For instance, offices may arrive on scene and start building rapport with an individual and the arrival of the MCRTs could unsettle the individual or would require them to start over building rapport. A policy cannot be developed to account for every possible scenario, so what type of guidelines will be provided and how will communication structures be put in place for feedback and addressing any conflicts that emerge between police and alternative responders?
5. What happens if the individual refuses to engage with police or MCRTs? Policy and protocols will need to be developed in situations where a caller refuses to interact with one or the other. The report notes that there are individuals who do not want to interact with the police and also individuals who demand to speak to the police. Clearl guidance on what should happen in those situations need to be written.

The creation of a well-designed workgroup can work through these challenges, but for co-response to be effective communication challenges noted in the report, particularly the sharing of protocols and data, are important to building trust and confidence in each other's operations. This process is also time

consuming, as one administrator noted developing a co-response policy would take a month and that is "on the fast track."

Staffing

Once co-response criteria are determined, the workgroup will then need to use those criteria to estimate potential call volume. As noted throughout the report, staffing issues are a challenge and too great of call volume may overwhelm alternative responders and result in police-only responses as a default.

A second staffing consideration is related to how MCRTs will be dispatched for co-response. The current operational design requires the CTWs to dispatch MCRTs. An outstanding question is whether CTWs will continue to provide crisis support in co-response models or dispatch only. In the latter scenario, will CTWs be able to keep up with co-response volume or will a separate "dispatcher"[22] be required to send MCRTs for co-response.

Another factor with staffing is the report revealed that the average time between a behavioral health event being created and an officer becoming available to dispatch is over 26 minutes. Meaning that an officer might not be available for an immediate co-response. If a MCRT team is available to respond, will they be required to wait until an officer arrives? Policies will need to be put in place to guide what occurs when a MCRT team responds, and an officer is not available.

Training

Once protocols and policies are finalized, there are numerous training considerations to address. Adding co-response is far more involved than minor changes to eligibility criteria (e.g., adding second party callers). Because police and MCRTs will be working in close proximity to each other, cross-training will need to occur, so each entity is familiar with how they operate. This is particularly important in scenarios where police and MCRTs are working together to deescalate, and an individual becomes violent. Further, training must explore differing perceptions of violence across CCDP responders, such as mobile crisis response teams, police officers, and 911 telecommunicators. Clear operational guidelines and familiarity with who takes control needs to be established. There are safety concerns, but also implications for the working relationship, as first and alternative responders referenced the need for professional respect. Identifying training needs then designing and providing the training can take another couple of months. Training alone does not breed familiarity, there will need to be a period of piloting co-response to work out any unidentified gaps and allow officers and MCRTs to build a working relationship. This period needs to align with intensive monitoring, feedback loops, and data analysis to help the workgroup make data-driven decisions.

Needs and Opportunities for Simultaneous Expansions

Interviews with stakeholders suggest there are other expansions that need to occur before or simultaneously with co-response. The move to co-response also presents opportunities to consider other expansions, as co-response may alleviate safety concerns that give stakeholders pause with certain expansion.

[22] Dispatcher here is used in the context of someone to dispatch MCRT to a run, and not the common term for a certified 911 communication specialist. Certified dispatchers require one-year of training and due to staffing shortages, it is unlikely a certified dispatcher would be available to handle co-response calls, without significant changes to model design.

Probable Needs: Radio Communication and Viewing MCRT Runs. First responders consistently noted their desire for alternative responders to have their own radio channel so first responders and alternative responders can more easily communicate with each other. This will be important for co-response as communication is paramount for each responder type to know what is going on. A related need is for police to be able to view MCRTs pending runs, which again will allow officers to know when MCRTs are en route and have arrived. As noted in the report, technology limitations will not allow the police to view MCRTs runs until the new CAD system comes online, likely pushing co-response timeline to 2023.

Potential Opportunities: Third party callers and other call types. As noted in Appendix 4, respondents offered several wants to for expansion, with one of the central ideas being adding third-party callers to the eligibility criteria. The hesitation for adding third-party callers is there is often little information provided creating safety concerns for MCRTs. With the introduction of co-response, third-party call concerns are alleviated as officers can arrive and make sure the scene is safe. Similarly, respondents noted the feasibility of expanding to other low-level or non-criminal call types but expressed hesitance due to safety, an issue now potentially alleviated. Adding call types or third-party callers will impact volume and revert back to staffing challenges, so potential expansion should include estimating volume.

Summary

Moving to a co-response model has clear benefits for the model, but the transition to co-response is not without challenges and will take time to design, train, and launch. The research suggests that co-response will improve familiarity and build trust among responders. This familiarity will play an important role in how responders view each other's capacity and willingness to expand inclusion/exclusion criteria. It is doubtful a co-response is needed for almost 80% of behavioral health events and the workgroup should identify ways to expand the deflection-only criteria to free up greater police time. Having better communication structures in place and better familiarity as a result of co-response, is likely to expand eligibility criteria for CCDP, such as including third-party callers, as stakeholders know better safety protocols are in place. Changing the number of deflection-eligible calls would greatly improve cost outcomes as it would free officer time from those events. There are technological changes that are required, and staffing will still guide what is happening. It is recommended that if CCDP expands to co-response it is piloted within the larger intervention for at least 3 months to ensure appropriate protocols are in place, fill knowledge gaps, and monitor volume levels. Given estimated timelines for protocols, training, technological changes, and a monitoring period, co-response may not be fully operational until Spring 2023. A final benefit of co-response is that it has clear economic benefits, especially if the number of deflection-only calls increases. The following section explores the CCDP costs *if* co-response was in place during the intervention period. The following section is hypothetical, and the cost-benefit analysis will need to be updated to reflect a final co-response design, if created.

Co-Response Scenario

A fourth economic model was estimated to consider the financial outlay under the conditions that co-response was operating during the study period, March 21 to May 8, 2022. The co-response model assumes a three-response category, with deflection-only, co-response with police and MCRTs, and a policy-only response. The model assumes the eligibility criteria for deflection-only events stayed the same and 16% of all behavioral health calls would be classified as deflection only. The deflection-only calls would follow existing protocols. We estimated that the remaining 84% of behavioral health calls would be eligible for co-response or police only. Estimating the volume of "police only" calls is not

possible with provided data, so researchers calculate the number of behavioral health events that resulted in involuntary hospitalization or jail, two outcomes only the police can make. The data indicated that approximately 6% of all LMPD behavioral health events resulted in an involuntary hospitalization or jail. Thus, 6% becomes the estimate for police-only calls and the remaining 78% of calls are eligible for a co-response scenario that would involve LMPD officers and MCRTs, with the assumption that a co-response model would reduce officer-time on scene. The economic model calculates the number of officers required for call and the time release, capturing the potential net benefits in terms of the dollar values of police time released in relation to the time spent by alternative responders.
We assumed the co-response model would be applied to LMPD Fourth Division during the second shift (2 pm to 10 pm) and time frame (March 21 to May 8) that this evaluation occurred. Therefore, the application of the co-response model to the division and shift can be considered as an expansion of the intervention to a familiar environment and building on existing experiences. We also assumed a hypothetical situation in which the co-response model was implemented during the intervention time to improve comparability in terms of timing and location.

Benefits: Police's Time and Cost Savings

The model assumes two police personnel would be involved in the co-response, as this is reflected in the analyses and LMPD policy requiring two officers per CIT run. The assumption corresponds to the data collected during the intervention. The analysis indicated the average number of LMPD officers, LMPD supervisors, and non-Louisville (other) police departments' officers in co-response-eligible calls during the period were 1.87, 0.11, and 0.02, respectively, in Division 4, Shift 2. We assumed the same average numbers for the involvement of LMPD officers, LMPD supervisors, and other officers in co-response.
We also calculated police personnel's average time spent (travel time plus the time spent with a client) on the calls, 54:33 for LMPD officers, 02:58 for LMPD supervisors, and 00:20 for other police departments' officers. One purpose behind co-response is for officers to provide a safety check and be able to quickly leave the scene, thus experiencing a significant time reduction related to behavioral health calls. In this model we considered four reduction scenarios: 0%, 25%, 50%, and 75%.
In addition, similarly to the early economic analyses, we used $45.46, $54.14, and $45.46 as hourly pay rates for LMPD officers, LMPD supervisors, and other officers, respectively. The pay rates include both wages and benefits. We used the LMPD sergeants' pay rate for LMPD supervisors and LMPD officers' pay rate for other officers. The information on pay rates was provided to us by the LMPD. The co-response model's assumptions for police personnel are summarized in Table A5:1.

Table A5:1. **The co-response model's assumptions for police personnel's involvement in co-response-eligible CIT calls (estimated to be 78% of CIT calls)**

	Average Number of Police Personnel per Event	Average Police Personnel Time per Event (hh:mm:ss)	Average Police Personnel Time per Event (Decimal Hours)	Police Personnel Pay Rate, Hourly
LMPD Officers	1.87	0:54:33	0.91	$45.46
LMPD Supervisors	0.11	0:02:58	0.05	$54.14
Other Officers	0.02	0:00:20	0.01	$45.46

Given the assumptions described above, we calculated the hours of police personnel time released and the potential wage and benefit dollars saved under the four scenarios of police time reduction for co-response CIT calls. In **Table A5:1**, the calculations are presented for a typical co-response-eligible CIT call

and for two levels of total CIT call volumes, 5,000 and 10,000. The increased volumes can be used to approximate the time and dollar release in the event of the application of the co-response model to the entire year instead of the 03/21/2022−05/08/2022 intervention period. Obviously, no police time and money would be released if the presence of an MCRT team would not lead to any police time reductions. However, a presumed 25%-time reduction would release 25':35'' (0.4264 decimal hours) of total police time per call, 51:10 (0.8528 decimal hours) if police time would reduce by 50%, 1:16:45 (1.2793 decimal hours) if police time would decrease by 75%. The police time reductions would translate into $19, $39, and $58 cost savings per co-response-eligible CIT call, respectively. With a total of 5000 CIT calls, 1,663, 3,326, and 4,989 hours of police time and $75,648, $151,297, and $226,945 of police costs would be released due to co-responses that reduce police time on co-response-eligible CIT calls to by 25%, 50%, and 75%, respectively.

Table A5:2. Hours of police personnel time released and the potential wage and benefit dollars saved under the fours scenarios of police time reduction in co-response CIT calls,

Presumed Police Personnel Time Reduction	per CIT Call		per 5,000 CIT Calls		per 10,000 CIT Calls	
	Hours of Police Time Released	Potential Police Dollars Saved	Hours of Police Time Released	Potential Police Dollars Saved	Hours of Police Time Released	Potential Police Dollars Saved
LMPD Officer						
The Same Time as Before	0.0000	$0	0	$0	0	$0
25% Less Time than Before	0.4250	$19	1,658	$75,356	3,315	$150,712
50% Less Time than Before	0.8501	$39	3,315	$150,712	6,631	$301,425
75% Less Time than Before	1.2751	$58	4,973	$226,069	9,946	$452,137
LMPD Supervisor						
The Same Time as Before	0.0000	$0	0	$0	0	$0
25% Less Time than Before	0.0014	~$0	5	$287	11	$574
50% Less Time than Before	0.0027	~$0	11	$574	21	$1,148
75% Less Time than Before	0.0041	~$0	16	$861	32	$1,723
Other Agencies' Officer						
The Same Time as Before	0.0000	$0	0	$0	0	$0
25% Less Time than Before	0.0000	~$0	~0	$5	~0	$10
50% Less Time than Before	0.0001	~$0	~0	$10	~0	$20
75% Less Time than Before	0.0001	~$0	~0	$15	1	$30
Totals						
The Same Time as Before	0.0000	$0	0	$0	0	$0
25% Less Time than Before	0.4264	$19	1,663	$75,648	3,326	$151,297
50% Less Time than Before	0.8528	$39	3,326	$151,297	6,652	$302,593
75% Less Time than Before	1.2793	$58	4,989	$226,945	9,978	$453,890

Costs: Spending on the Deflection Team

We assumed three deflection team members would be involved in any co-response: one crisis triage worker who would engage with the client over the phone and two MCRT members who would travel to the scene with the responding police personnel. We assumed the average time spent by a CTW on a co-

response-eligible call would be 5 minutes and considered two scenarios for the time spent by the two MCRT team members. In one, the MCRT team would spend the same amount of time on a co-response eligible call as they spent on deflection-only calls during the 03/21/2022–05/08/2022 intervention period in Division 4, Shift 2: 58':14". In the other scenario, the team would spend 25% less time than 58':14". The 25% reduction can be attributed to potential improvements due to learning by doing. Using the intervention's budget, we calculated an hourly pay rate of $33.90 (including wage and benefits) for CTW and MCRT members. Table A5:3 summarizes the co-response model's assumption for deflection team members participating in co-response.

We assumed the cost of other deflection team members not directly involved in co-response as administration cost. In addition, we assumed that the share of administration costs per co-response is the same for police and deflection personnel.

Table A5:3. The co-response model's assumptions for the deflection team's involvement in co-response-eligible CIT calls (estimated to be 78% of CIT calls)

	Number of Deflection Team Personnel per Event	Average Deflection Team Time per Event (hh:mm:ss)	Average Deflection Team Time per Event (Decimal Hours)	Deflection Team Pay Rate, Hourly Equivalent
CTW	1.00	00:05:00	0.08	$33.90
MCRT Member	2.00	00:58:14	0.97	$33.90
Travel Time	2.00	00:13:52	0.23	
Intervention Time	2.00	00:44:22	0.74	

Under the assumptions described above, we calculated the deflection team's variable costs per co-response call also for scenarios of totals of 5,000 and 10,000 CIT calls (Table A5:4). The average time spent by the deflection team on a co-response CIT call would be 2.02 hours if the MCRT spent the same time as it spent on deflection-only calls during the intervention, and 1.54 hours if the MCRT spent 25% less time. Given the pay rates, the cost for deflection personnel directly involved in co-response would be $69 and $52 per call, respectively. For a total of 5,000 CIT calls, co-response would require 7,895 hours of personnel time and cost $267,688 if the MCRT would spend the same time as it spent on deflection-only calls during the intervention. If the MCRT would spend 25% less time than before, 6,003 hours of deflection team personnel time would be needed, costing $203,521.

Table A5:4. Hours of deflection team personnel time and wage and benefit dollars spent under the two scenarios of MCRT time spent co-response CIT calls

	per CIT Call			per 5,000 CIT Calls			per 10,000 CIT Calls	
	Hours of Deflection Personnel Time Spent	Potential Deflection Personnel Dollars Spent		Hours of Deflection Personnel Time Spent	Potential Deflection Personnel Dollars Spent		Hours of Deflection Personnel Time Spent	Potential Deflection Personnel Dollars Spent
Crisis Triage Worker	0.08	$3		325	$11,019		650	$22,038
Mobile Response Crisis Workers' Time:								
Equal to the Time during the Intervention	1.94	$66		7,570	$256,669		15,141	$513,339
25% Less than the Time during the Intervention	1.46	$49		5,678	$192,502		11,356	$385,004
Totals								
Equal to the Time during the Intervention	2.02	$69		7,895	$267,688		15,791	$535,377
25% Less than the Time during the Intervention	1.54	$52		6,003	$203,521		12,006	$407,042

Benefits versus Costs

In Table A5:5, we put together cost savings in terms of hours of police personnel time released from Table A5:4 with new costs in terms of hours of deflection team personnel purchased from Table A5:4. In Table A5:6, we presented costs in terms of the number of personnel saved or hired. In both Tables A5:5 and A5:6, we calculated the net dollars saved, equal to the value of the LMPD personnel time released minus the value of deflection team time spent.

The co-response model will result in a significant release of police time, which can be spent on other, perhaps more urgent calls. The amount of police time release depends on the total number of CIT calls and the magnitude of police time reduction on co-response-eligible calls. With a total of 5,000 CIT calls (among which we assume 78% would be co-response-eligible) and police time reduction of 25%, 50%, and 75% due to the presence of the deflection team, 1,663, 3,326, and 4,989 hours of police time would be released, respectively. If the total of CIT calls is 10,000 and the police spends 25%, 50%, and 75% less time than when the deflection team is absent, 3,326, 6,652, and 9,978 hours of police time would be released, respectively (Table A5:5). Considering a job with 130 hours of work in a month as a full-time job, we calculated the corresponding number of personnel saved over a year (Table A5:6).

As the police time is decreased on co-response-eligible CIT calls, deflection personnel time is increased on those calls. The calculated net dollars saved associated with the introduction of the described co-response model were negative unless co-response resulted in a remarkable reduction in the police time spent on co-response-eligible CIT calls. If the deflection team's time spent on co-response remains equal to the time they spent on deflection-only calls during the intervention, the co-response model does not become cost-effective even if it reduces police time by 75% (Tables A5:5 and A5:6). The breakeven point for police's time reduction is 88.5%. In other words, if the deflection team's time spent on co-response remains equal to the time they spent on deflection-only calls during the intervention, the co-response model would become cost-effective if it reduces police time by 88.5%.

If the deflection team's time spent on co-response turned out to be 25% less than the time they spent on deflection-only calls during the intervention, the co-response model would become cost-effective if it reduces police time by 75% (Tables A5:5 and A5:6). Under this scenario, the breakeven point for police's time reduction is 67.3%.

The economic evaluation of the co-response model needs to be interpreted carefully as it merely takes the time released from police and spent by the deflection personnel and their dollars values. This evaluation does not account for the contribution of the police's released time and the hours spent by the deflection team to the health and welfare of Louisville residents. If the police's released time gets spent on calls that did not receive a response before or on events with safety concerns and leads to disabilities avoided or lives saved, this extra value-added is not included in our calculations. Also, if the effort and expertise of the deflection team lead to a reduction in the number of escalated cases at CIT events and fewer involuntary hospitalizations, these contributions are not quantified in our calculations. Therefore, the economic evaluations provided here underestimate the real value of a co-response to the community.

Table A5:5. Savings versus new (deflection) costs in terms of hours of personnel time and dollars.

	per 5,000 CIT Calls				per 10,000 CIT Calls		
	Hours of Police Personnel Time Released	Hours of Deflection Personnel Time Spent	Potential Net Dollars Saved		Hours of Police Personnel Time Released	Hours of Deflection Personnel Time Spent	Potential Net Dollars Saved
No Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	0	7,895	-$267,688		0	15,791	-$535,377
(2) MCRT Time 25% Less than the Time during the Intervention	0	6,003	-$203,521		0	12,006	-$407,042
25% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	1,663	7,895	-$192,040		3,326	15,791	-$384,080
(2) MCRT Time 25% Less than the Time during the Intervention	1,663	6,003	-$127,873		3,326	12,006	-$255,746
50% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	3,326	7,895	-$116,392		6,652	15,791	-$232,784
(2) MCRT Time 25% Less than the Time during the Intervention	3,326	6,003	-$52,225		6,652	12,006	-$104,449
75% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	4,989	7,895	-$40,744		9,978	15,791	-$81,487
(2) MCRT Time 25% Less than the Time during the Intervention	4,989	6,003	$23,424		9,978	12,006	$46,847

Table A5:6. Savings versus new (deflection) costs in terms of numbers of personnel and dollars.

	per 5,000 CIT Calls				per 10,000 CIT Calls		
	Number of Police Personnel Time Saved	Number of Deflection Personnel Time Spent	Potential Net Dollars Saved		Number of Police Personnel Time Saved	Number of Deflection Personnel Time Spent	Potential Net Dollars Saved
No Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	0.0	5.1	-$267,688		0.0	10.1	-$535,377
(2) MCRT Time 25% Less than the Time during the Intervention	0.0	3.8	-$203,521		0.0	7.7	-$407,042
25% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	1.1	5.1	-$192,040		2.1	10.1	-$384,080
(2) MCRT Time 25% Less than the Time during the Intervention	1.1	3.8	-$127,873		2.1	7.7	-$255,746
50% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	2.1	5.1	-$116,392		4.3	10.1	-$232,784
(2) MCRT Time 25% Less than the Time during the Intervention	2.1	3.8	-$52,225		4.3	7.7	-$104,449
75% Time Saving for Police Personnel and:							
(1) MCRT Time Equal to the Time during the Intervention	3.2	5.1	-$40,744		6.4	10.1	-$81,487
(2) MCRT Time 25% Less than the Time during the Intervention	3.2	3.8	$23,424		6.4	7.7	$46,847

The avenue for cost-benefit and cost-effectiveness for CCDP is multi-faceted. First, the economies of scale will drive the average cost per event down for alternative responders to provide acute behavioral health crisis support. Second, by averaging 13.744 events per shift, the CCDP releases enough police time to become cost-effective and in-effect give them additional labor hours to focus on other criminal matters. The introduction of co-response would easily achieve the needed 13.744 events per shift. In general, co-response will play a significant role in developing the economies of scale and freeing up officer labor time. There are other costs not captured in this evaluation due to the short evaluation period; however, future evaluation will look at reductions in hospitalizations and jail, and respite admissions along with their associated costs. A longer study period will allow for causal examination on impacts of call volume and repeat utilization and the associated

costs. It should be noted that the cost analysis of long-term health outcomes for individuals will be limited by an individual's willingness to gain consent from individuals to track their use of referrals.

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