City of Alexandria Co-Response Program (ACORP)

Initial Evaluation Report

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City of Alexandria

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City of Alexandria Co-Response Program (ACORP)
Executive Summary

This report presents data collected through the City of Alexandria Co-Response Program (ACORP) from the first five months of implementation (October 2021-February 2022). This report contains relevant process and performance measures for ACORP analyzed and compiled by OMNI Institute in collaboration with the City of Alexandria's Office of Performance Analytics (OPA).

ACORP Program Overview

The City of Alexandria's Co-Response Program (ACORP) pairs a specially trained law enforcement officer and a licensed, behavioral health clinician to respond in tandem to calls for persons experiencing a behavioral health crisis. The Alexandria Co-Response Program (ACORP) is a collaborative effort between the Alexandria Police Department (APD) and the Department of Community and Human Services (DCHS).

The team utilizes best-practices and trauma-informed approaches to maximize helpful and safe outcomes for persons served, decrease the stigma associated with behavioral health calls for service, promote opportunities for racial sensitivity and equity, divert individuals from unnecessary incarceration or involuntary hospitalization, and deliver services in ways that deemphasize law enforcement as the sole response to persons in need of mental health assistance.

This report represents a first look at ACORP efforts, focusing on the following **program goals** which are grounded in the existing literature and best practice in the field:

1. Improve system responses to individuals experiencing behavioral health crises in the community.

2. Identify and address health barriers and inequities for ACORP clients.

3. Improve experiences and outcomes for all parties involved in behavioral health calls.

Key Findings

- ✓ **958** Total behavioral health calls were received by DECC (911) between Oct. 2021 – Feb. 2022.
  - Of these, **145** were responded to by the ACORP team.
  - **52%** of these were for unusual behavior or threats/ harm to self.
  - Many of the calls were resolved on-scene **(45%)**, by ACORP providing a resource or referral to a community service **(20%)**, or resulted in a voluntary transport to another community service like a hospital or shelter **(16%)**.
  - Only **13%** of calls that ACORP responded to resulted in involuntary transport to the hospital.
  - Of calls that could have resulted in arrest, **71%** were diverted away from arrest.
- ✓ The ACORP team has facilitated a strong collaboration between behavioral health, law enforcement, and other community partners to better serve persons in crisis in the community. This strong collaboration positions the City well as it moves forward with redesigning the behavioral health crisis system as required by Virginia's Marcus Alert Legislation.
- ✓ Call trends show that there is a greater community need than can be met fully by the ACORP team in its current capacity.

ACORP History & Other City Services

In 2009, City staff began implementing an array of services aimed at identifying, assisting, and diverting persons with behavioral health challenges away from the criminal justice system and into the treatment system. In addition to the 24/7 crisis response work conducted by DCHS Emergency Services staff, hundreds of police officers and other first responders have been trained in crisis intervention, learning how to identify persons experiencing a behavioral health crisis, how to de-escalate situations, and how to connect these persons safely and appropriately with treatment resources. In addition, services have been developed to proactively reach out to persons not in crisis but who are high utilizers of emergency services, including 911 and the Inova Alexandria Hospital Emergency Department, to connect them with community treatment services that decrease their need for reactive, crisis-based interventions.

Other initiatives which promote compassion, prevention, and treatment services to persons in crisis and/or already involved in the criminal justice system include the Alexandria Treatment Court, Forensic Discharge Planning and Reentry services from the Adult Detention Center, the Commonwealth Attorney's Office Mental Health Initiative, Community Release planning through the Magistrate's Office, the CORE program which partners mental health staff and probation staff, response and outreach to survivors of an overdose, and many others. Initiatives have been created and implemented for many years, largely with State grant funding, that focus on prevention, intervention, treatment, and follow-up at every intersection point between behavioral health and criminal justice, all aimed at helping persons lead healthy, productive, law-abiding lives in the community; Alexandria has long been recognized as a leader in the State with these efforts.

In June 2020, the Alexandria City Council requested information on alternative approaches that prioritize non-law enforcement responses to homelessness, public gatherings, after-hours construction, noise, and other quality of life complaints; and the creation of a mobile crisis unit trained in crisis prevention and management such as suicide prevention and intervention, domestic disputes, substance use, and other mental wellness calls. In response to this request, staff presented a review of current services that target these challenges during the October 27, 2020, Council meeting. As a result of that presentation, staff were directed to craft a proposal for a co-response program.

The program pilot soft-launched on September 1, 2021, with an official evaluation start date a month later on October 1, 2021. ACORP is currently comprised of a single unit pair – Dr. Megan Hencinski (clinician) and Officer Thomas Evans (officer), with possible program expansion under consideration.

Evaluation Approach

In the early stages of the partnership between OMNI and the City of Alexandria, program goals and a corresponding evaluation plan were collaboratively developed to serve as the roadmap for subsequent evaluation efforts. This involved a series of meetings between OMNI and ACORP program stakeholders during which existing program materials and available data systems were reviewed along with the broader best practices in the field to ensure that evaluation activities conducted in this project were not only feasible but aligned with the field at large. Over the course of the past six months, OMNI has worked closely with OPA to review, refine, and audit ACORP data collection protocols and reporting templates that meet the immediate and longer-term needs of the program. With the program in operation for over six months, it is an appropriate time to take a comprehensive look at program operations and performance, with the caveat that it is still in the early stages of implementation. This report not only highlights important data indicators around program efforts and outcomes, but also begins to explore some of the challenges and successes the program has encountered in its infancy. These early lessons

learned pave the way for future program refinement, as evaluation is intended to be an iterative and dynamic process.

The data sources utilized for this report are collected through the clinician's documentation in DCHS's Electronic Health Record and from the CAD and related documentation maintained by APD and the Department of Emergency and Customer Communications (DECC). For this report, datasets from each of these sources were extracted and cleaned individually by OPA, with some data auditing and manual data entry/coding required for key indicators, such as call outcomes. These datasets were then merged across unique IDs (where available), deidentified, and shared with OMNI for analysis. OMNI, OPA, and the ACORP team worked closely to establish agreed upon data indicators to be included in this report that accurately reflect ACORP's efforts during the first five months of implementation.[1]

Initial Evaluation Results

This report examines the prevalence, characteristics, response types, and outcomes for all behavioral health calls received by the DECC call takers and organizes key data indicators under the three main goals articulated for the ACORP program, as specified on page 1 of this report.

For the purposes of this evaluation, a behavioral health call is defined as a call that meets any of the following three criteria:[2]

- Call is designated with a behavioral health call type in the **Computer Aided Dispatch system (CAD)**
- A 911 dispatcher identified the call as behavioral health related **using a powerline command**
- A responding police **officer answered "yes" to a mandatory question** asking them whether mental health was a primary factor in the call

Goal 1: Improve system responses to individuals experiencing behavioral health crises in the community.

A primary goal of co-response programs broadly, and ACORP specifically, involves improving the manner in which incidents involving persons experiencing a behavioral health crisis in the community are handled. Co-response programs and similarly situated programs are intended to leverage the expertise offered by mental health clinicians to intervene in these situations, while also ensuring public safety with the accompanying presence of law enforcement. To assess how ACORP is achieving this goal, this report examines the proportion of behavioral health calls responded to by ACORP and/or Crisis Intervention-trained (CIT) officers, as well as the nature of ACORP calls and day/time distribution of calls. This section of the report not only illustrates the number and types of calls ACORP is responding to (e.g., improved system response), but also when and how ACORP is responding to better understand ACORP workload and operations.

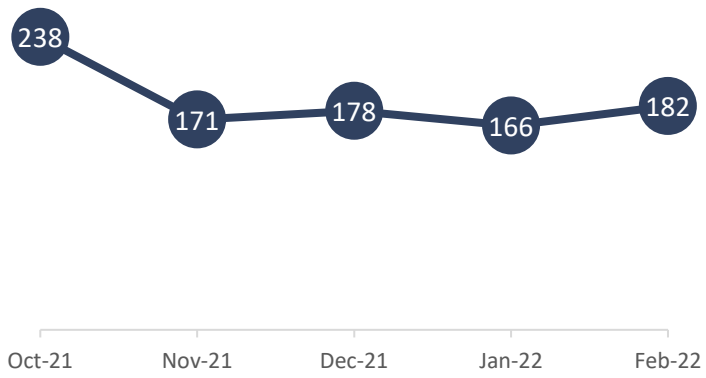
[1] If you have any questions or want to learn more about the methodology information, please reach out to performance@alexandriava.gov.

[2] CAD now requires officers to specify whether mental health was a primary factor in the call, allowing OPA and OMNI to capture mental health calls that may not be immediately identified as such (i.e. instances of trespassing, someone with a weapon, etc.).

Behavioral Health Call Prevalence

When dispatch receives a call, it may be assigned as a behavioral health call based on the criteria outlined on page 5. Below, this data is further broken down by whether ACORP was able to respond to the call, and if not, if ACORP was unable to respond due to preoccupation with another call or because they were off duty.

From Oct 2021 through Feb 2022, dispatch received 935 behavioral health calls.[3]

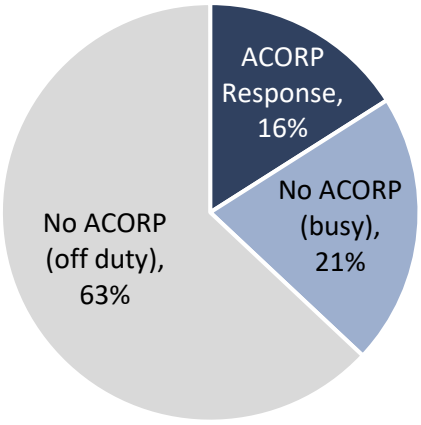


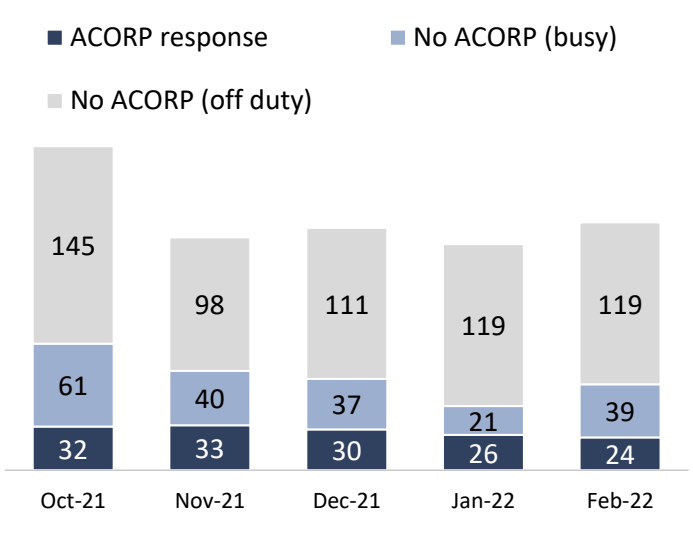
ACORP responded to 145 (16%) of 935 total behavioral health-related calls.

Behavioral health call data are reported under three categories:

1. **ACORP Response**: ACORP was on duty and responded to the call.
2. **No ACORP (busy)**: ACORP was busy responding to a different call and did not respond.
3. **No ACORP (off Duty):** ACORP was not on duty and unable to respond.

Below, behavioral health calls are broken down by prevalence and response type.



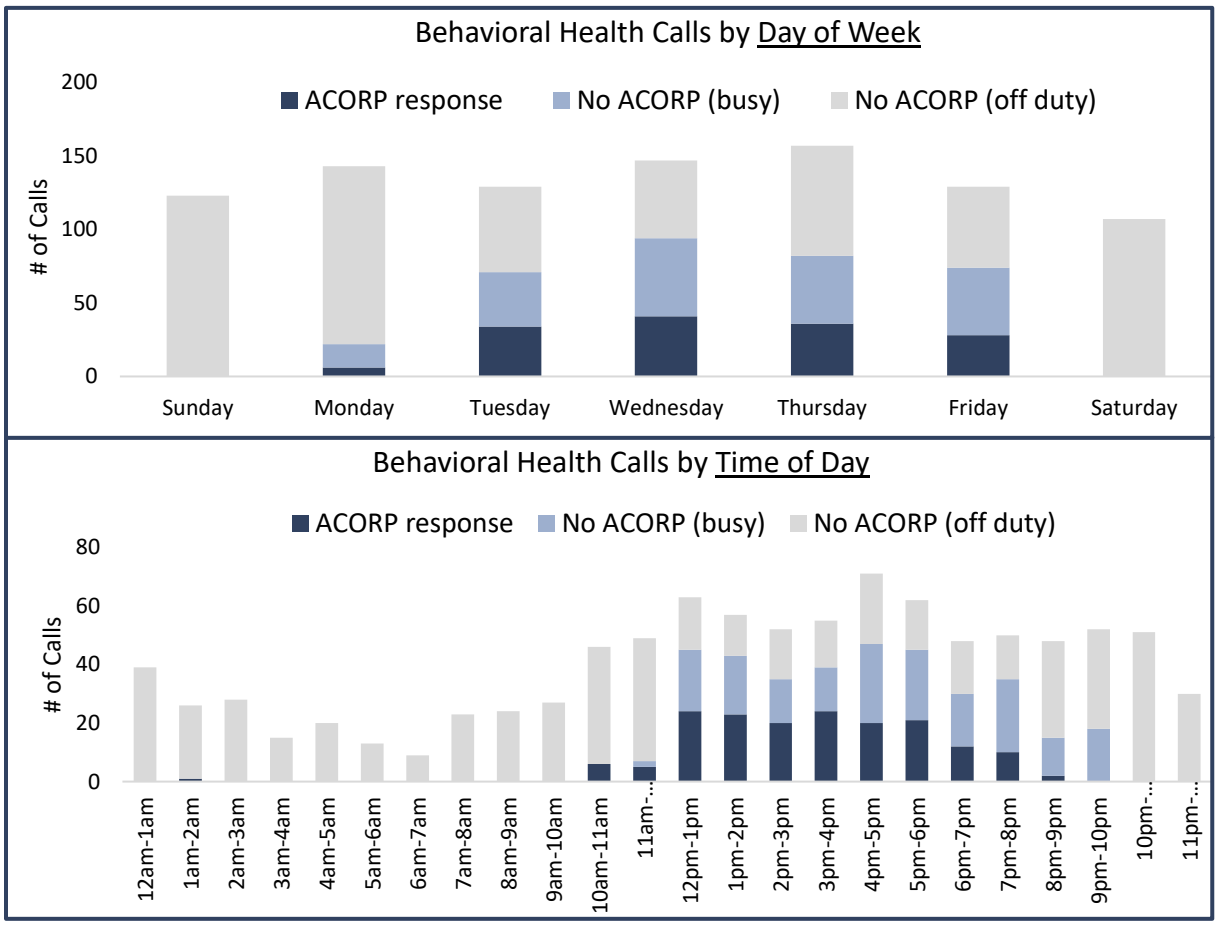


[3] Some calls were excluded from this count (i.e., domestic violence calls, ECO/TDO paperwork calls, and calls where the call notes did not actually indicate any mental health factor).

Response Times

Behavioral health-related calls may be received at any time. ACORP is consistently modifying shift times to ensure the operating hours occur during peak times that behavioral health calls are received by 911. The program previously operated on Monday – Friday, 12 - 8pm before shifting to a Tuesday – Friday, 12 -10 pm schedule. ACORP operated on the Tuesday – Friday, 12 -10 pm schedule throughout most of the time period covered in this report (Oct. 2021 – Feb. 2022). **More recently, the ACORP team shifted to a Monday – Thursday, 12 - 10pm** schedule to better address the high number of calls consistently coming in on Mondays.

The trend in behavioral health calls is relatively consistent throughout the week, and generally concentrated in the times of day that ACORP is on duty.

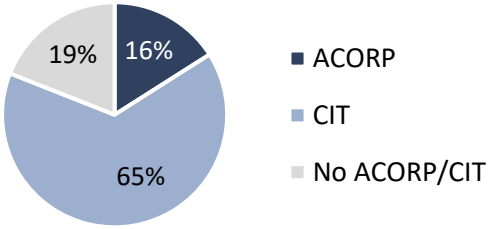


Below is a heat mapping of behavioral health call volumes across day of week and time of day.

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	7	4	6	4	1	4		4	3	3	4	4	6	4	8	5	7	6	6	3	11	9	10	4
Mon	3	3	4	4	3	1	2	2	6	4	6	2	7	6	4	12	11	12	7	10	10	12	6	6
Tue	4	4	3	3	3		2	2	2	4	10	8	6	6	7	4	11	14	6	5	3	8	9	5
Wed	7	3	3	1	2	1	1	5	4	2	6	11	11	13	5	14	11	8	10	11	6	4	7	1
Thu	9	4	7	2	4	1	2	4	7	5	8	8	10	9	10	6	11	7	8	11	9	7	4	4
Fri	3	6	2	1	3	2	2	3		2	9	8	8	8	13	8	9	10	5	6	5	7	6	3
Sat	6	2	3		4	4		3	2	7	3	7	7	7	4	3	9	4	5	2	4	5	9	7

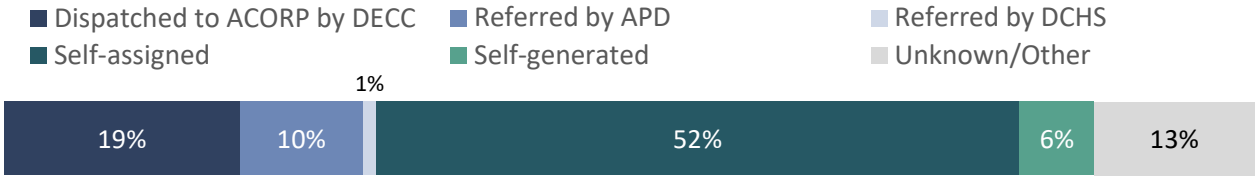
Breakdown of Response Teams

Crisis Intervention Team (CIT) training is offered to police officers to better understand mental health issues and de-escalation techniques, and can be critical in supporting community members in crisis.[4] The City has trained hundreds of officers through this program since its inception. To assess the degree to which the calls coming in through dispatch are receiving a response by a specially-trained CIT officer, the figure below shows the proportion of calls that were responded to by ACORP (a clinician and a CIT trained officer), CIT officer(s) only, or neither the ACORP team nor a CIT officer.



81% of behavioral health-related calls had a responding officer with CIT training (including calls responded to by ACORP) between October 2021 and February 2022.

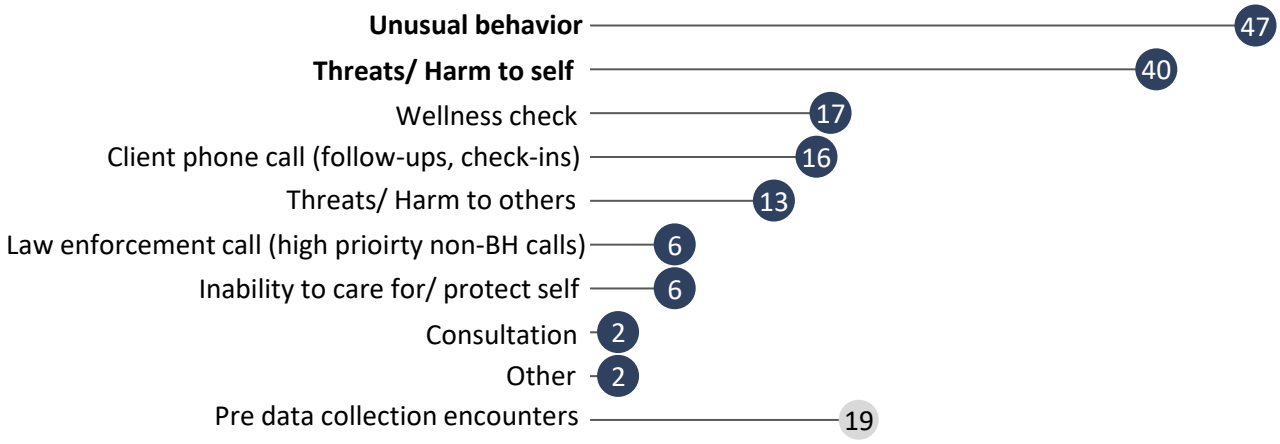
Over half (52%) of calls ACORP responds to are "self-assigned" by the ACORP team.



Nature of ACORP Encounters

Examining the nature of a call, or why ACORP is requested to respond, can help Alexandria understand what the needs of the community are and how ACORP can best support these needs. These call types will likely evolve and expand as the ACORP program continues to grow. The figure below highlights the different types of calls that ACORP responded to in the first 5 months of implementation.

Over half (52%) of encounters ACORP responded to were for unusual behavior or threats/ harm to self.[5]



[4] Currently, the CAD cannot attach CIT officers to specific behavioral health-related calls, but over 60% of officers are CIT trained and all CIT officers are now noted in the CAD so that the officers can more easily be assigned to behavioral health calls.

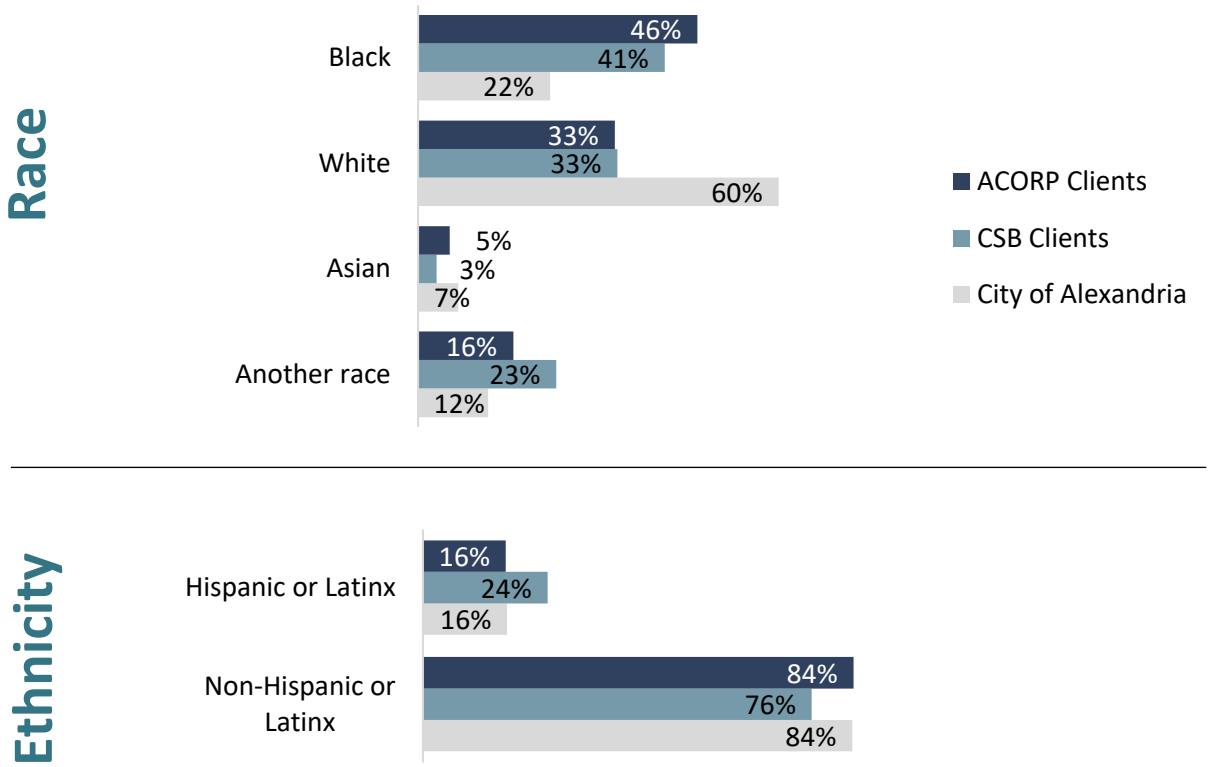
[5] Prior to 11/30/21, ACORP did not collect data on encounters that did not result in full clinical assessment. A shorter form was developed to capture data from non-assessment encounters.

Goal 2: Identify and address health barriers and inequities for ACORP clients.

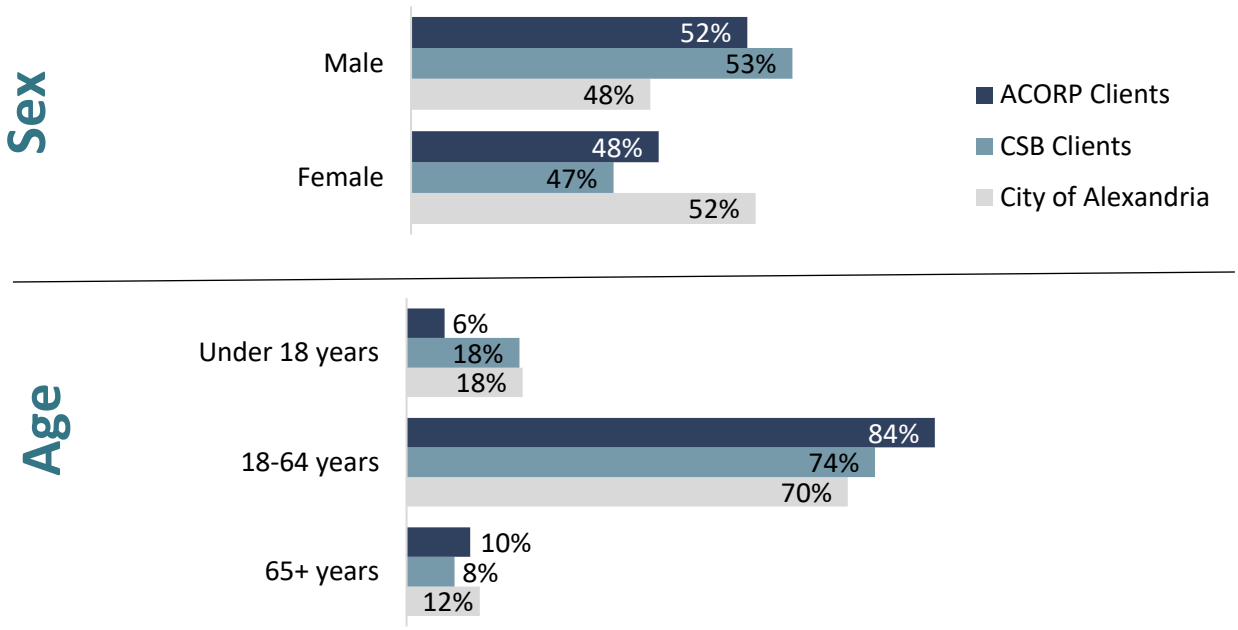
A second goal of the ACORP program is to provide equitable services to clients and identify and address health barriers that may exist among ACORP clients. While a client survey is planned to better capture health barriers for ACORP clients, this report examines the representation of ACORP clients in relation to the broader City of Alexandria and Community Services Board (CSB) client demographics to assess equitable service delivery.

Demographics Comparisons

To help determine the degree to which ACORP clients represent Community Service Board (CSB) clients and the broader City of Alexandria and to assess for any over or under-representations, demographics of ACORP clients are compared to census data and CSB client data.[6] The results of this comparison indicate that overall, ACORP clients generally represent CSB clients. However, among ACORP clients, there appears to be a disproportionate under-representation of White clients and an over-representation of Black clients when compared to the broader Alexandria community. In addition, ACORP clients are disproportionately older than the City of Alexandria. Within the 18-64 age range, **nearly 60% of ACORP clients are between the ages of 25-44.**



[6] ACORP data divided race into four categories: 'Black', 'White', 'Asian', and 'Another race'. 'Another race' is not clearly defined, and the limited racial categories in the data likely exclude other racial minorities. Collecting more robust and inclusive race data in the future may allow for improved, nuanced reporting. For this report, racial categories in ACORP data were mapped to census data and CSB data based on shared categories. For more information about the categorization, please contact OMNI directly

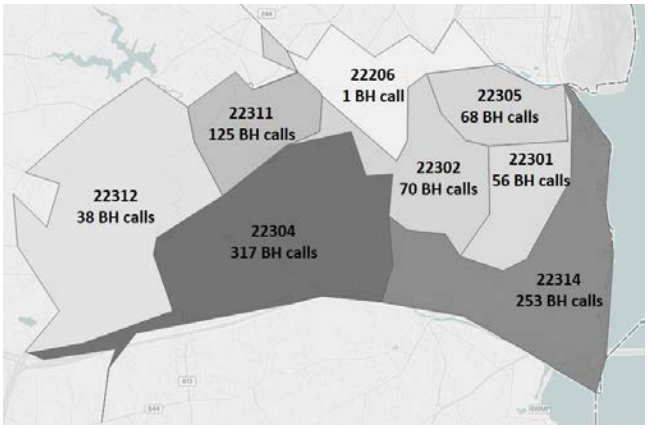


Geographical Distribution of Behavioral Health Calls

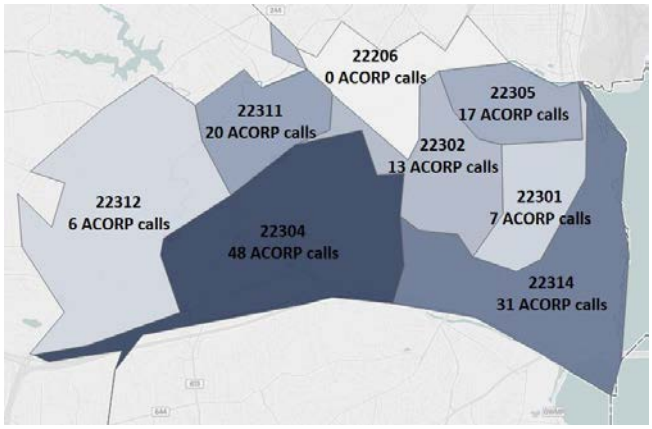
Geographic (zip code) distribution of behavioral health calls and ACORP-response calls are provided below. Examining calls for service by geographical area provides insight into where client need is concentrated and potentially where to focus attention and allocation of additional resources. In addition, exploring geographical concentration of calls may highlight potential gaps in service and disparities in various regions. As illustrated below, the greatest concentration of these behavior health calls (and ACORP-response calls) is observed in zip codes 22304 and 22314.

The distribution of total behavioral health calls by zip code are similar to the distribution of ACORP response calls by zip code.

Total Behavioral Health Call Distribution



ACORP Call Distribution



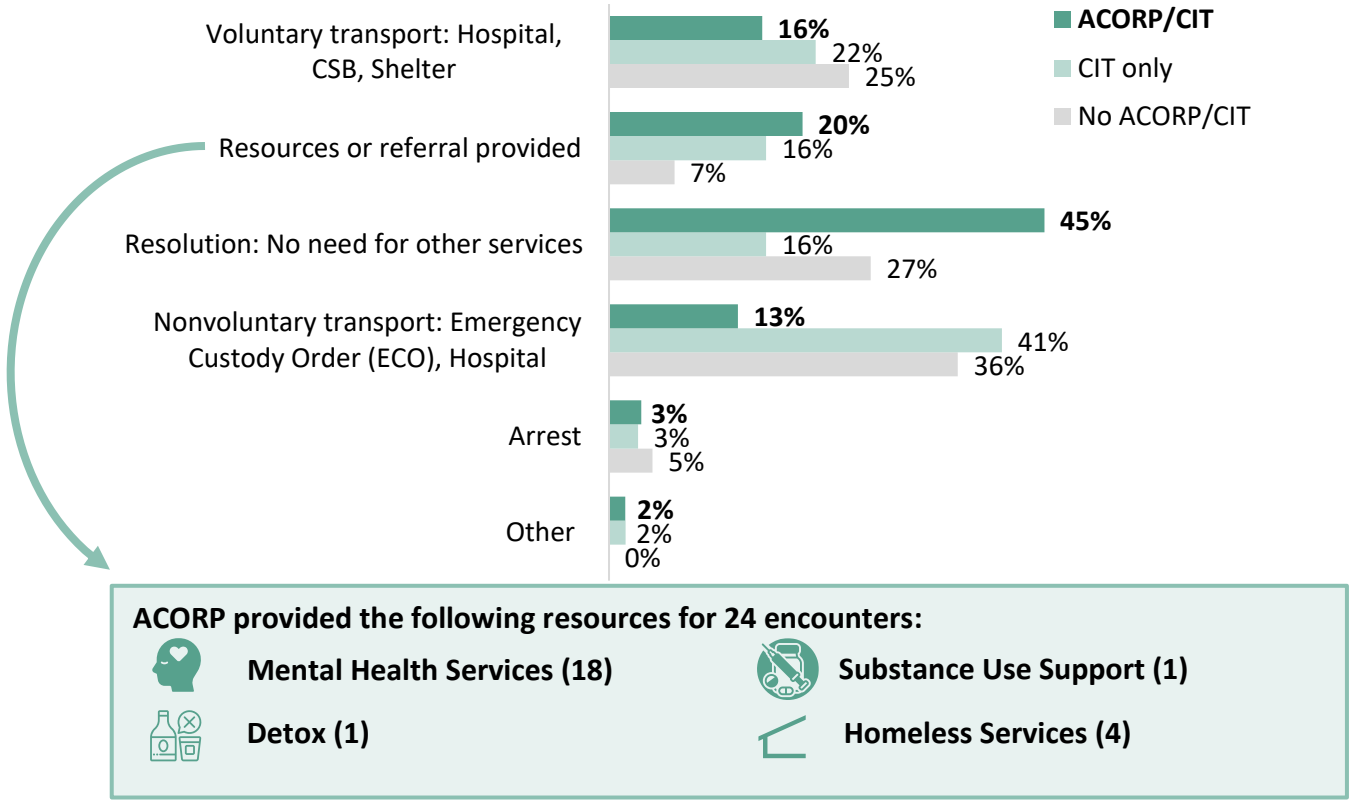
Goal 3: Improve experiences and outcomes for all parties involved in behavioral health calls.

The primary impetus of co-response programs is to divert individuals with behavioral health concerns away from jails and toward appropriate treatment and community resources. Therefore, improving the experiences and outcomes for all parties involved in mental health calls is a core objective of these programs. While the broader evaluation plan incorporates indicators to examine use of force and injuries, this initial report focuses on exploring the outcomes of ACORP calls for services in relation to calls not involving ACORP. Service referrals are also included here.

Behavioral Health Call Outcomes

With the support of the ACORP team, who has tracked encounter outcome data, the most common dispositions and outcomes based on the type of response are highlighted below. Please note that call outcome data were not available for nearly 50% of CIT-only calls and over 66% of No ACORP or CIT calls.[7] However, CIT-only or No ACORP or CIT calls for which outcome data are available likely parallel ACORP calls in terms of severity, given that more severe calls require a certain level of outcome documentation. Therefore, despite limitations in the availability of call outcome data, comparing call outcomes among ACORP, CIT only, and No ACORP or CIT calls remains pertinent.

For encounters where the clients were present and action was taken, ACORP calls were much more likely to be resolved on scene or have resources provided than other response groups.[8]

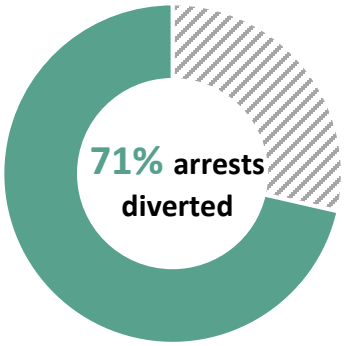


[7] Based on City current practices, policies, and procedures, officers are not required to document call outcomes to this evaluation's degree of specificity. OMNI and OPA are in the process of exploring other opportunities to gather data.

[8] 125 calls where clients were not present (i.e., no action was taken) are not included in the call outcome graph.

Legal System Diversion

Co-response presence on scene to support de-escalation and provide behavioral health and community support referrals can often divert an encounter from legal system involvement. Diversion can be a challenging outcome to assess because determining whether an arrest would have happened in the absence of a co-responder is subjective, so ACORP has worked with the field officers to identify when an individual met arresting criteria, but were not arrested due to ACORP's on-scene support.



When examining the 14 encounters where an arrest could have been made, 10 encounters (71%) were diverted away from arrest by the ACORP team.

ACORP Success Stories

While quantitative data can provide strong insights into the operations and performance of a program, incorporating qualitative data, where available, adds depth and breadth to the story. As such, the evaluation team asked the ACORP team to outline some of the success stories they have encountered in these first five months of pilot implementation. **The stories below shed light on the program's impact on community members**.

On-Scene De-Escalation

ACORP was dispatched to a scene involving a person engaging in suicidal behavior, with a knife in his hand, who had been cutting himself. Several units jointly responded to the call since there was a weapon involved, so there was a heavy police presence on the scene. As the ACORP team was trying to engage with the individual, they were surrounded by police officers (due to the imminent danger). The individual shared that he did not trust the police due to previous negative encounters and threatened to harm anyone coming close to him physically. He did say that he would talk to the ACORP co-responder (Megan) alone, but given that he was still a threat, the co-responding officer stayed in the room, and the other law enforcement officers were asked to slowly, one-by-one, step outside briefly. At that time, the ACORP team was successfully able to de-escalate this individual, get him to hand over the weapon, and voluntarily go with them to the hospital for further assessment and treatment. The individual got the help that he needed. This situation also increased trust between law enforcement and the co-response team and between the individual and law enforcement.

Community Connections

The ACORP team responded to a scene involving an individual in distress following a domestic dispute in the early Fall of 2021. The ACORP team successfully de-escalated this individual on-scene and referred them for additional services. A few months later, after not hearing from this man, ACORP responded to a call for service involving a different person who was heavily intoxicated and experiencing suicidal ideation. They arrived on scene, assessed the situation, and stepped into the hallway to discuss a strategy. While in the hallway, the man ACORP served months prior appeared and shared how grateful he was to the ACORP team for helping him get connected with services and as a result, leave a tumultuous relationship and achieve a better quality of life. This man heard the individual in distress behind the door, whom he knew. He was able to speak with his neighbor in distress and share how much he himself had been helped by the ACORP team. This first-hand experience helped the distressed man trust the ACORP team, agree to speak with them, and ultimately get connected to the services he needed.

Cross-System Information-Sharing

One benefit that has been realized by the partners involved in the ACORP pilot is streamlined information-sharing between agencies. For example, ACORP responded to a scene involving an individual seen with a firearm outside of an apartment building. Seeing the police arrive, this individual went back into the building and refused to engage with the police. Instead, he called his father, who subsequently reached out to the dispatchers to tell them that it was his son and there had been a misunderstanding. The father provided identification information, so the co-responder (Megan) was able to identify the man and contact his DCHS therapist. From this connection, she learned that he had not been taking his medications, decompensating, and becoming more aggressive. With this information, the ACORP team was able to speak with him and convince him to come out of his apartment, at which time he was safely transported to the hospital for treatment and not arrested for brandishing a firearm.

Key Takeaways & Next Steps

When a pilot program launches, there will always be pain points with implementation and, hopefully, early successes that guide policies and practices. The benefit of having an evaluation engaged at the launch of a pilot program is that these opportunities to learn, pivot, and grow can be documented, studied, and utilized to guide decision-making and future program adaptations. In the first five months of implementation, ACORP has experienced a number of successes and also, some challenges and opportunities. These are outlined below.

Early Successes

There are several key areas where ACORP has demonstrated success in the first five months of implementation:

Increased collaboration and engagement between law enforcement, behavioral health, and other community agencies (Fire, EMS, schools, etc.). These agencies have been working even more closely together since the launch of ACORP to collaboratively respond to behavioral health calls for service.

Established partner and community buy-in. APD has fully embraced ACORP and has adapted their approach to responding to behavioral health calls to support ACORP on-scene. In addition, the community is starting to gain awareness and support for ACORP, especially those who have received support or services from them directly.

More appropriate responses and resource allocation for calls for service involving persons experiencing a behavioral health crisis. By more heavily relying on the behavioral health expertise of the ACORP team, the City of Alexandria is not only improving on-scene outcomes but also optimizing resource allocation.

Groundwork for implementing the Marcus Alert Legislation has been laid and all key departments needed to fully implement Marcus are now engaged. Co-response programs are one component of Marcus and having ACORP up and running has given the city a head-start on full Marcus implementation, including data collection procedures.

Improved outcomes for ACORP clients. The data presented here indicates that behavioral health calls for service involving an ACORP response are more likely to be resolved on-scene, while also diverting individuals from arrest and connecting them to necessary services.

Streamlined information-sharing between behavioral health and justice agencies. By partnering a clinician with access to behavioral health records to a law enforcement officer with access to justice systems, ACORP can leverage information from both systems to better serve individuals in crisis. This can reduce the risk of harm to the ACORP team, other officers/responding agencies, and the community at-large.

Ongoing Challenges & Opportunities

Along with successes, there are several areas of opportunity that ACORP has encountered during these first few months of operation:

Need for further collaboration and training with DECC call-takers to appropriately categorize behavioral health calls and flag for ACORP assignment. Since the beginning of the program, there has been uncertainty with dispatchers around when to dispatch the ACORP team, which inhibits ACORP response efforts. This requires the ACORP team to either self-dispatch or rely on officers to call for assistance after arriving on-scene— both scenarios can lead to delayed response times and less successful outcomes for individuals in crisis and the responding agencies. All DECC call-takers have received initial CIT training and ongoing support, but further training and support is necessary to fully support ACORP efforts.

- Currently CAD technology is not in place, scripted or configured regarding specific ACORP dispatch responses. Configuration changes have been identified and currently work is in progress to provide the focused and CAD recommended dispatches immediately.

Limited opportunities for cross-training and guidance around best practices. Prior to the launch of ACORP, the team consulted with several nearby jurisdictions to better understand the co-response model. Much of what they learned from these consultations was that most co-response programs operate in a "learn as you go" manner, in that there is not a prominent training model in the field to guide law enforcement or clinicians as to how to engage in this partnership successfully. As such, the ACORP team to-date has grown and learned together in the field. The team is planning to attend the National Co-Responder Conference in May where they hope to gather additional training and resource materials. In addition, the current ACORP team is developing scenario-based training internally that will be used to onboard any new ACORP team members.

Bridging the gap between behavioral health and law enforcement cultures. Law enforcement and behavioral health professionals have different backgrounds, training, roles, and experiences that guide the way they approach a situation. In the context of a crisis situation, law enforcement is primarily focused on public safety while behavioral health clinicians are primarily focused on the mental well-being of the person in crisis. These differences are valid and expected and are prompting conversations and further training in both departments.

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

Data limitations. While the data systems used for tracking ACORP efforts are great resources for most City functions, there are some limitations when it comes to utilizing them in the ACORP evaluation. Presently, the various data systems utilized in this pilot program do not communicate with one another, requiring manual input and matching of encounters. This introduces the possibility of human error and incomplete data collection. Additionally, the CAD currently does not allow for the required level of specificity in call outcomes. This results in hand coding call outcomes based on officer documentation (which only exist in about 50% of cases). Recognizing that changes to these systems are costly and time prohibitive, the evaluation team in partnership with OPA operates within the parameters of the available data contained within these systems which does have limitations such as those outlined here. OPA and the evaluation team are committed to working within these systems in the most rigorous way possible---and is also committed to being transparent about limitations of the data and margins of error that likely exist.

- The OPA and the evaluation team are currently trying to refine the data required by police officers so that more comprehensive outcomes can be collected related to behavioral health calls. Additionally, they are working to reconfigure the CAD to incorporate the Marcus Alert framework and severity levels, and allow prioritization to match appropriate responses from that classification (e.g., police may not need to go to calls of lower severity level).

Conclusion & Next Steps

In the first five months of implementation, ACORP has demonstrated its initial impact, navigated implementation challenges, realized healthy and productive outcomes for persons served, and continues to adapt (and potentially expand) based on learnings that are being captured and reflected upon routinely by the ACORP team. Many successful outcomes have been realized by the persons served, including helping many access treatment and other community resources that are helping to improve their lives. As the program moves forward, the ACORP team will continue to review data together, utilizing the monthly reporting infrastructure that was developed in partnership with OMNI and OPA. Refinements to data collection processes will continue to be considered by OMNI and OPA, in coordination with the ACORP team. Also, additional data will be collected through the evaluation that will further contextualize the results presented in this report and the broader impact of the ACORP program. This will include qualitative feedback from clients, the ACORP team, and key stakeholders via a client survey and process evaluation. This information will be integrated with the data indicators presented in this report to produce a final evaluation report to be shared with the City of Alexandria at the end of 2022.