City of Alexandria Co-Response Program (ACORP)

12-Month Evaluation Report

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12-Month Evaluation Report

Submitted to:

City of Alexandria

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Acknowledgments

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

This report presents data collected through the City of Alexandria Co-Response Program (ACORP) from the first 12 months of implementation (October 2021-September 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 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 de-emphasize law enforcement as the only response to persons in need of mental health assistance.

This report reflects on the first year of ACORP implementation by examining program operations, challenges encountered along the way, and program adaptations made in year 1 of implementation. Additionally, the report explores the achievement of the following program goals:

1. Improve system responses to individuals experiencing behavioral health crises in the community.
2. Providing equitable access to services.
3. Improve experiences and outcomes for all parties involved in behavioral health calls.

Key Findings

- ✓ **2,387** Total behavioral health calls were received by DECC (911) between Oct. 2021 – Sep. 2022.
- ✓ Of these, **354** were responded to by the ACORP team.
  - **47%** of these were for unusual behavior or threats/ harm to self.
  - Many of the calls resulted in a resource or referral to a community service **(62%)**
  - Only **2%** of 911 calls that ACORP responded to resulted in arrest.
  - Only **17%** of 911 calls that ACORP responded to resulted in nonvoluntary transport to the hospital.
  - Of the 20 calls ACORP responded to that met criteria for arrest, **70%** were diverted away from arrest.
- ✓ Call trends show that there is a greater community need than can be met fully by the ACORP team, justifying the active expansion of the team.
- ✓ Collaboration Partners agree that ACORP is reaching its intended goals and that there is a strong sense of collaboration between participating agencies.
- ✓ Partners reported the need for ongoing sustainability efforts and behavioral health-related training to enhance ACORP's effectiveness.

ACORP History & Other City Services

In 2009, City staff began implementing an array of services to identify, assist, and divert 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 (CIT). CIT officers learn how to identify persons experiencing a behavioral health crisis, de-escalate situations, and connect these persons safely and appropriately with treatment resources.

Other examples of initiatives that 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 CSB mental health professionals and probation agencies to support those with serious mental illness and substance misuse)

Initiatives have been created and implemented for many years, largely with State grant funding. These initiatives 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. Additionally, they requested 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 was initially comprised of a single unit pair – Dr. Megan Hencinski (clinician) and Officer Thomas Evans (officer). During the pilot phase, the unit operated 40 hours a week, Monday-Thursday. Beginning January 2023, ACORP will have an additional two teams actively training and beginning fieldwork, allowing the program to be available seven days a week.

Evaluation Approach

In the early stages of the partnership between OMNI and the City of Alexandria, the teams collaboratively developed program goals and a corresponding evaluation plan to serve as the roadmap for subsequent evaluation efforts. This collaboration involved a series of meetings between OMNI and ACORP collaboration partners, who reviewed existing program materials, available data systems, and the broader best practices in the field. The review ensured that evaluation activities conducted in this project were feasible and aligned with the field at large. Over the past 12 months, OMNI has worked closely with OPA to review, refine, and audit ACORP data collection protocols and reporting approaches that meet the immediate and longer-term needs of the Program.

In collaboration with ACORP, OMNI generated a six-month report in April of 2022, representing a first look at the data collected around ACORP implementation, including documentation of initial successes and challenges associated with the early stages of program launch. This 12-month report highlights important data indicators around program efforts and outcomes. It continues to explore program successes, challenges, and opportunities, but it also examines noteworthy differences between the first six months and the latter six months of program implementation. In addition, feedback gathered from key partners (called Collaboration Partners in this report) is also incorporated into further contextual ACORP efforts. Information contained within this report reflects upon the first year of ACORP implementation and continues to highlight important lessons learned and ongoing opportunities for program growth and adaptation.

The primary data sources for this report were collected through the clinician's documentation in DCHS's Electronic Health Record and the CAD and related documentation maintained by APD and the **Department of Emergency and Customer Communications (DECC)**. For this report, datasets from each source were extracted and cleaned individually by OPA. Key indicators include call outcomes, required data auditing, and manual data entry/coding. These datasets were merged across unique IDs (where available), de-identified, 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 year of implementation.[1]

Additionally, OMNI developed and administered a *Collaboration Survey* to measure perceptions of program implementation across key Collaboration Partners (Appendix A). OMNI used the *Collaboration Survey* data to 1) assess the degree to which partners collaborate effectively, 2) examine perceived program effectiveness, and 3) identify program successes, challenges, and opportunities for improvement.

Evaluation Results

This report examines the prevalence, characteristics, response types, and outcomes for all behavioral health calls received by the DECC call takers. It organizes key data indicators under the three main goals articulated for ACORP, as specified under *ACORP Overview*. Results from the *Collaboration Survey* are integrated where appropriate.

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 designated as behavioral health call type in the **Computer Aided Dispatch system (CAD)**

911 dispatcher identified call as behavioral health related **using a powerline command**

The responding **police officer answered "yes" to a mandatory question** asking whether mental health was a primary factor in the call

[1] If you have any questions or want to learn more about the methodology, 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.).

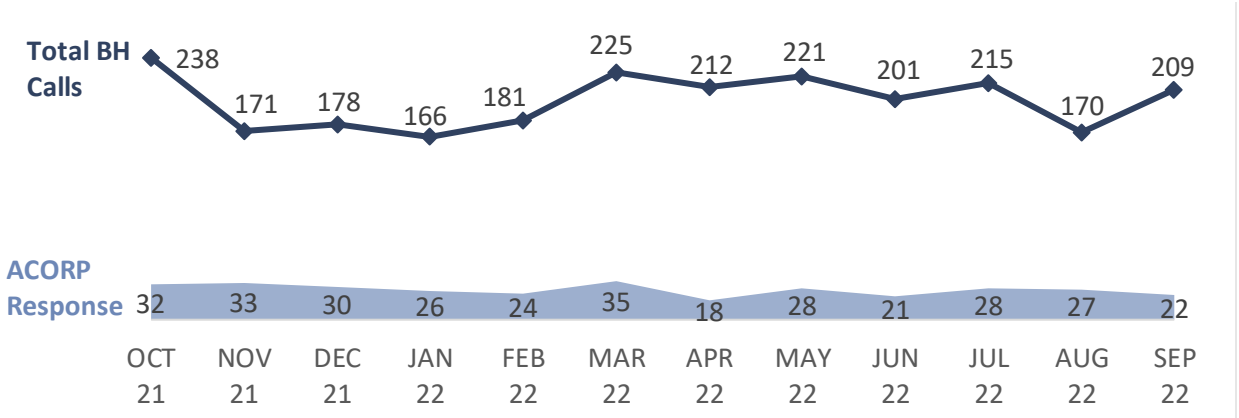
Goal 1: Improve system responses to individuals experiencing behavioral health crises in the community.

A primary goal of co-response programs broadly, and ACORP specifically, is to improve the handling of incidents involving persons experiencing a behavioral health crisis in the community. Co-response programs aim to leverage the expertise offered by mental health clinicians to intervene in behavioral health-related incidents while also ensuring public safety with the accompanying presence of law enforcement. This report assesses the goal of improving system responses by examining the proportion of behavioral health calls that ACORP or Crisis Intervention Trained (CIT) officers responded to, the nature of ACORP calls, and the day and time distributions of those calls to fully understand ACORP workload and operations. As ACORP moves toward expansion, it is critically important to examine all distributions to determine appropriate shift assignments.

Behavioral Health Call Prevalence

When DECC call takers receive a 911 call, behavioral health calls are assigned based on the above criteria. The figure below illustrates the behavioral health call trends received through DECC throughout ACORP implementation and the distribution of those calls responded to by ACORP.

ACORP responded to 324 (14%) of 2,387 total behavioral health-related calls from Oct 2021 through Sept 2022.



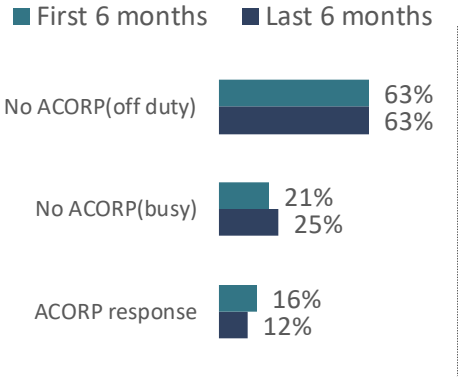
Behavioral health call data are reported under three categories[3] :

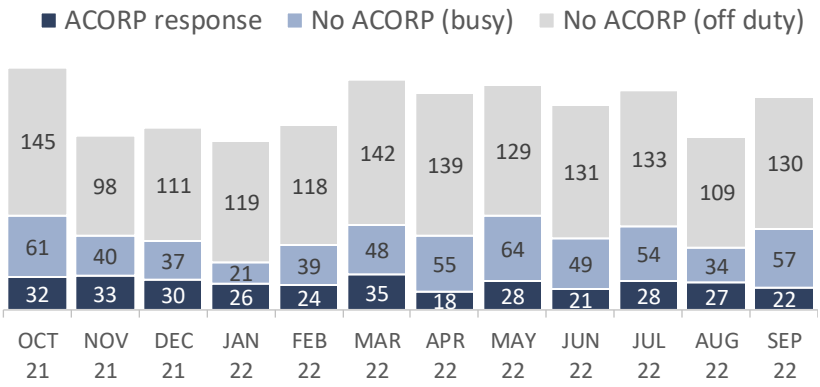
1. **ACORP Response:** ACORP responded to the call.
2. **No ACORP (busy)**: ACORP was busy responding to a different call and did not respond.
3. **No ACORP (off Duty):** ACORP was not on duty and unable to respond.

[3] All cases where ACORP responded are counted as an ACORP response, regardless of ACORP's status. In most cases where ACORP responds to a call (90%), ACORP is on duty and available. In the remaining cases, ACORP responds even though they are busy or off duty (e.g., call response will be held so that ACORP can join).

Below, behavioral health calls are broken down by prevalence and response type. Many behavioral health-related calls are received while ACORP is off duty.

It is worth noting that calls falling into the "No ACORP (busy)" category not only consist of calls that came in while ACORP was responding to another call but also incidents they may not have been originally flagged as Mental Health by DECC but were later identified as such by officers on the scene (many of whom are CIT trained) who may have felt confident handling the call without ACORP assistance.





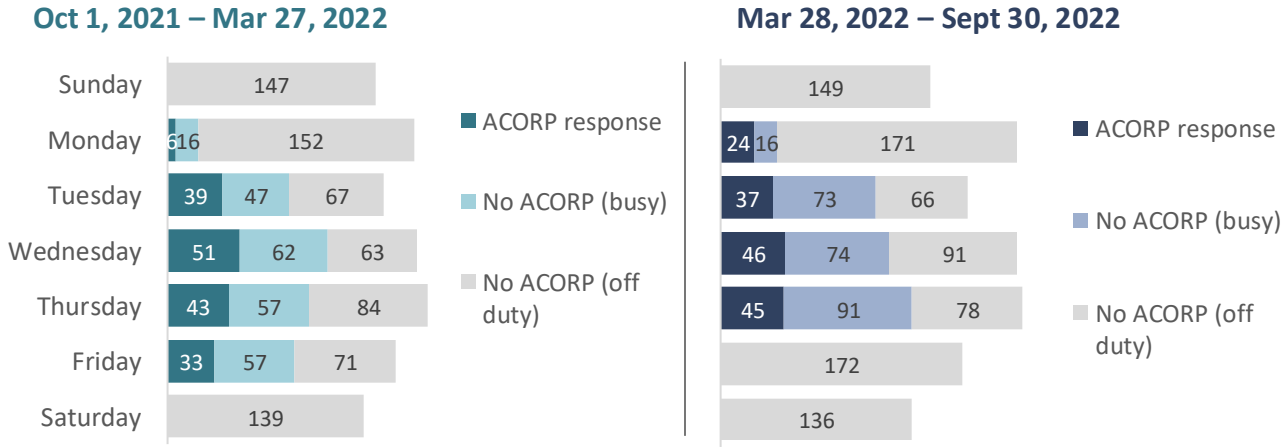
Response Times

Officers can receive behavioral health-related calls at any time. To be responsive to trends in calls received, ACORP has modified shifts over time to better ensure services are available during the highest-demand periods. More specifically, the schedule was changed from Tues-Fri to Mon-Thurs because there was a need for coverage on Mondays that was outweighing the need for coverage on Fridays at the time. ACORP consistently reviewed call data to determine how best to meet the community needs within the scope of what we were able to do as one team. Throughout the pilot phase, the ACORP team has been able to learn and collect data that will continue to guide program expansion and coverage needs.

Operating hours during the first year of implementation were as follows:

- **October 1, 2021 – November 15, 2021**: Monday to Friday from 12:00 pm to 8:00 pm
- **November 15, 2021 – March 27, 2022**: Tuesday to Friday from 12:00 pm to 10:00 pm
- **March 28, 2022 – September 30, 2022**: Monday to Thursday from 12:00 pm to 10:00 pm

The trend in behavioral health calls is relatively consistent throughout the week.

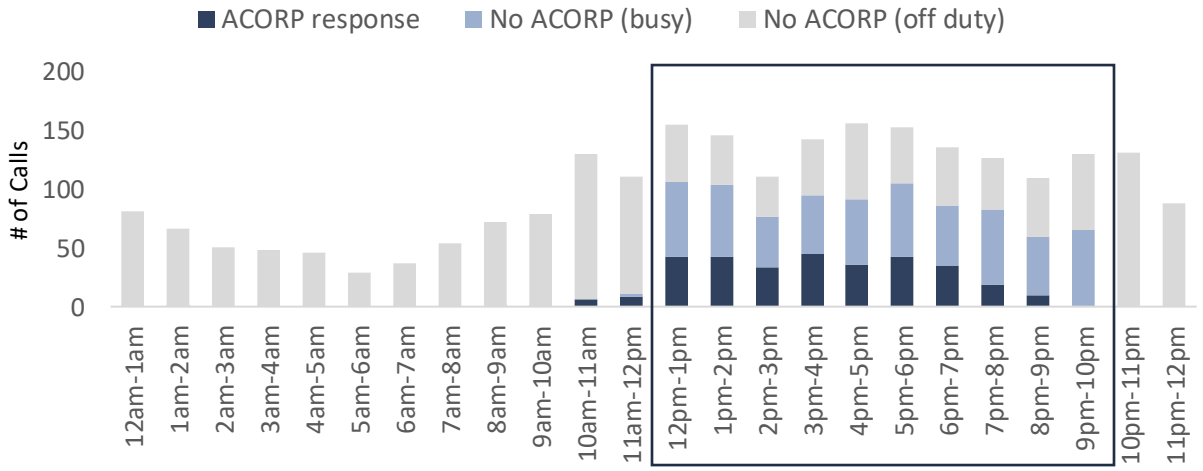


As indicated earlier in the report, ACORP responded to fewer calls in the latter six months of program implementation than in the first six months. The latter six months involved the ACORP team being more heavily involved in hiring and onboarding new staff, as well as working to streamline administrative processes, which has contributed to the reduced number of calls. In addition, **the figure above suggests that this reduction may also be partially attributable to the shift change**, most notably to the shift from availability on Fridays to availability on Mondays. Both days had high call volumes and with only one team on board throughout the pilot period the team shifted to be responsive to trends found in the first 6 months of the report. Similarly, the data presented below around the distribution of behavioral health calls by time of day indicates potentially expanding coverage to slightly earlier and slightly later in the day may allow ACORP to improve service capacity to meet the community's needs. As the team expands, these are important data points to consider when deciding on shift assignments.

Below is a heat mapping of behavioral health call volumes across the day of the 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
Sunday	13	6	10	8	5	8	4	10	11	7	9	13	16	16	12	14	21	16	14	13	18	22	20	10
Monday	9	6	10	9	6	2	9	2	15	13	26	12	24	19	16	20	31	26	21	21	19	19	19	15
Tuesday	11	8	5	5	4	1	5	5	6	11	21	16	19	21	15	21	20	28	18	19	14	19	21	16
Wednesday	16	11	7	5	4	4	2	7	11	16	19	19	28	29	19	26	21	22	31	20	18	17	22	13
Thursday	13	10	8	4	6	3	8	14	17	12	21	22	30	27	17	27	28	23	20	27	20	18	12	11
Friday	8	11	4	9	15	3	4	10	6	11	24	16	23	20	22	16	18	23	14	15	13	19	17	12
Saturday	11	14	6	8	6	8	5	6	6	9	10	13	15	14	10	18	17	15	18	12	7	16	20	11

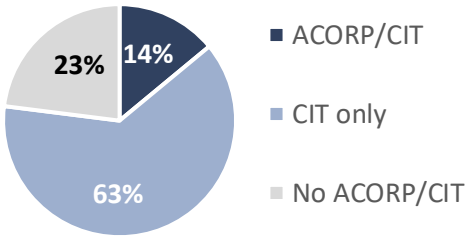
Behavioral Health Calls were generally concentrated during the times of day that ACORP is on duty.



Breakdown of Response Teams

When examining responses to behavioral health-related calls in the City of Alexandria, it is important to recognize that many police officers in Alexandria have received specialized behavioral health training (Crisis Intervention Team-CIT training). Even in the absence of ACORP response, individuals in crisis may still receive a response from officers that have been well-trained to identify and address mental health crises. The figure below shows the distribution of calls responded to by ACORP (a clinician and a CIT-trained officer), CIT officer(s) only, or neither the ACORP team nor a CIT officer to illustrate the overall proportion of behavioral calls receiving a response from a trained officer and/or clinician.

76% of behavioral health-related calls had a responding officer with CIT training (including calls responded to by ACORP) between October 2021 and September 2022

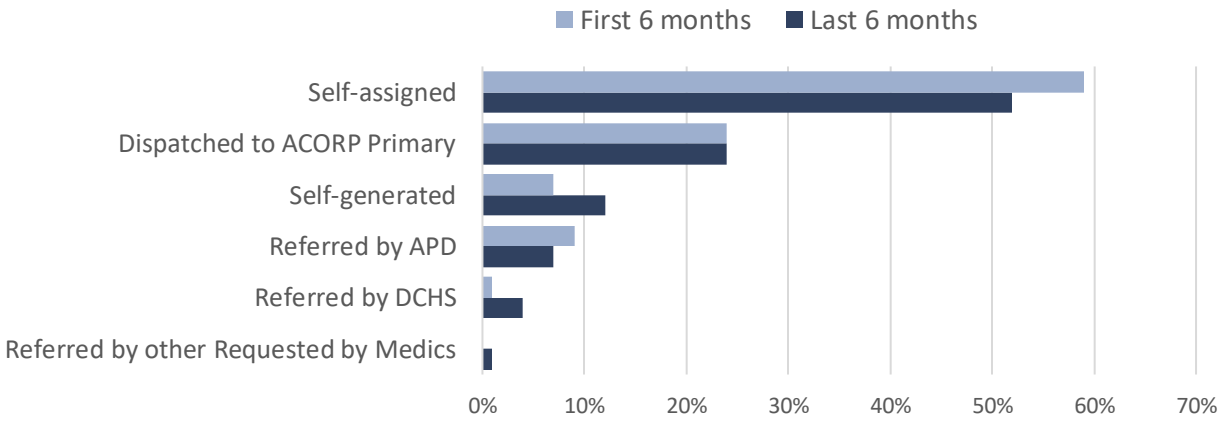


Crisis Intervention Team (CIT) Training is the course of instruction associated with the CIT approach to responding to people with mental illness. The course emphasizes understanding of mental illness and incorporates the development of communication skills, practical experience, and role-playing.

Nature of ACORP Encounters

An important challenge encountered by co-responders around the country, and ACORP specifically, is making sure that calls appropriate for co-response get flagged as such by dispatchers so that teams like ACORP can respond in a timely manner. For this reason, it is important to examine how the ACORP team is being assigned to calls to determine if there are opportunities for improved partnerships between dispatch, law enforcement, and ACORP to improve access to services for those in crisis. Across the first year of implementation, with very little difference between the first six months and the latter six months, less than a quarter of ACORP encounters stem from a direct dispatch of ACORP, indicating a need to strengthen communication in this area.

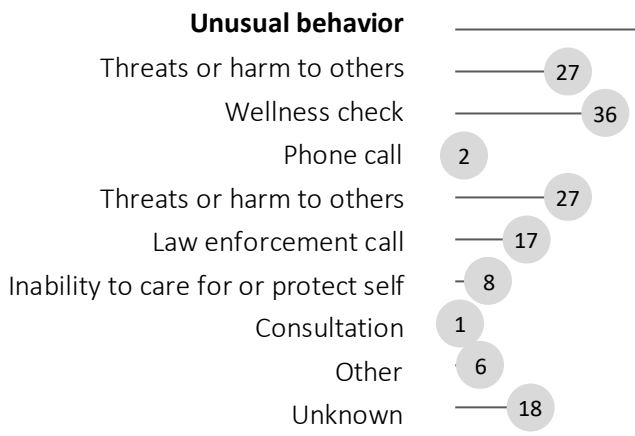
Most calls are self-assigned, meaning ACORP was not dispatched to the original call for service. ACORP added themselves after the fact.[4]



Examining the nature of a call or why ACORP was requested to respond can help the City of Alexandria understand the community's needs and how ACORP can best support these needs. The nature of these calls will likely evolve and expand as ACORP continues to grow. The figure below highlights the types of calls that ACORP responded to in the first 12 months of implementation.

[4] "Self-generated" is separate from "self-assigned" and indicates ACORP requested that dispatch create a mental health call for service.

Almost half (47%) of encounters ACORP responded to were for unusual behavior.[5]



Unusual behavior, which represented almost half of all responses, is defined as behavior(s) that deviate from societal norms. Examples include delusional ideation, public indecency, hyperverbal to self or others, or not dressed in clothes appropriate to the weather.

Cross-System Collaboration

The collaboration and partnership between law enforcement and behavioral health organizations is a key component of improving the system response to persons experiencing a behavioral health crisis in the community. This collaboration facilitates timely information-sharing and integrated responses needed to appropriately identify and address the behavioral health needs of persons in the community. The evaluation team developed and administered a ***Collaboration Survey*** to explore cross-system collaboration within the partner agencies involved in ACORP. OMNI administered the *Collaboration Survey* to representatives of partner departments and key stakeholders involved in the Program in August 2022 to understand the following:

(1) the degree to which the ACORP pilot is achieving its program goals, and

(2) to gather partner feedback about the Initiative's successes and challenges. The information gathered through the *Collaboration Survey* helps to tell the story of the Initiative from the perspective of the internal partners after one full year of implementation.

14 surveys were distributed, and **10 surveys were completed.**

Key stakeholders representing the entities that are central to the program were asked to complete the survey, including the City of Alexandra, Alexandria Police Department, Department of Community and Human Services, and Department of Emergency and Customer Communications.

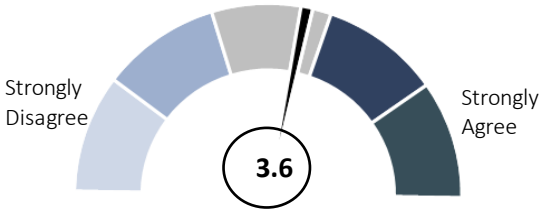
Specific elements of **cross-system collaboration** were assessed and feedback around **successes, challenges, and sustainability** were gathered.

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

OMNI researched community collaboration and pre-existing assessment tools to develop the *Collaboration Survey* used on ACORP partners. OMNI designed the assessment tool to address ACORP's specific program needs. The survey directed collaboration partners to indicate the degree to which they felt ACORP has achieved the outcomes outlined in the *Evaluation Plan* (see Appendix B), share their perceptions around program sustainability, and identify opportunities for the Program moving forward.

Collaboration partners rated their agreement with collaboration-related questions based on their experiences with ACORP from *1 = Strongly Disagree to 5 = Strongly agree.*

Across all questions combined, partners averaged an agreement level rating of 3.6 out of 5.



Collaboration Strengths

90% to 80% Agree or Strongly Agree

- ✓ **There is a shared understanding** of program objectives and goals.
- ✓ **A system exists to monitor and report** the activities and services of our program.
- ✓ **Members trust one another** sufficiently to share information, perceptions, and feedback honestly and accurately.
- ✓ **Our policies and procedures** support our program goals.
- ✓ The process we are engaged in is likely to **have a sustainable impact on the problem** (e.g., serving persons in crisis in the community).
- ✓ **Our program has access to credible information** that supports problem solving and decision-making.
- ✓ **Our group is effective in obtaining the resources** it needs to accomplish its objectives.
- ✓ People in this collaborative group have a **clear sense of their roles and responsibilities**.
- ✓ The partners involved in our pilot program **invest the right amount of time in our efforts.**

Collaboration Opportunities

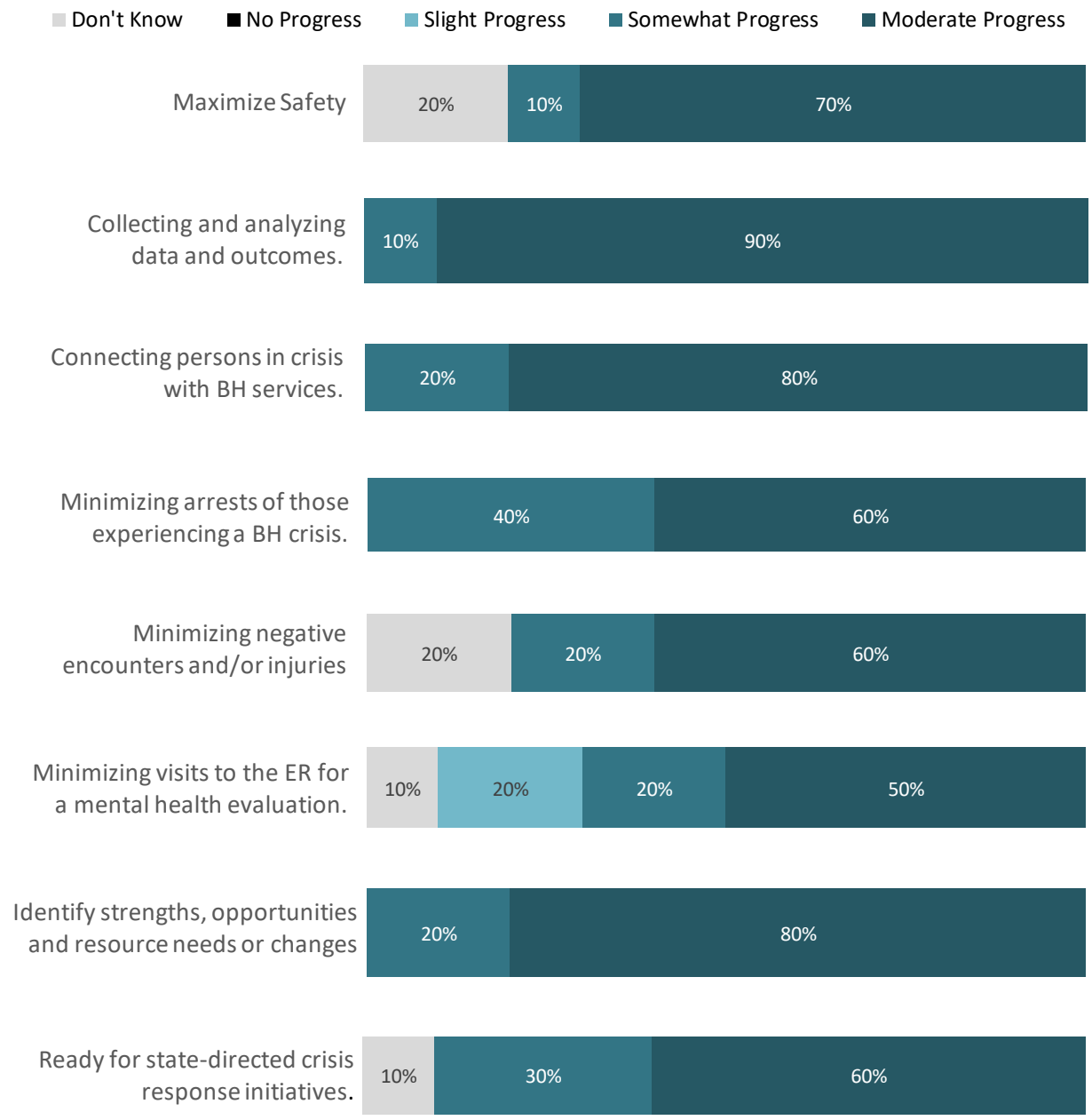
50% to 40% Agree or Strongly Agree

- ‹ **We are engaged in a streamlined process** that is informed by research and used to inform decision-making.
- ‹ Our collaborative group **engages other stakeholders, outside of the group**, as much as we should.

Next, the survey directed participants to rate the degree to which ACORP has made progress toward achieving program-related goals. Below is the distribution of responses amongst survey respondents across ACORP goals. As indicated, participants responded mostly favorably across ACORP goals, indicating that ACORP is making notable progress.

One program area showing less progress was around minimizing emergency department visits strictly for a mental health evaluation. Additionally, respondents indicated they were unaware of the progress related to several goals, which could stem from a lack of direct communication or available data around those specific goals. But, overall, community respondents recognized ACORP's continued progress and commitment to its current program goals.

Overall, respondents reported moderate progress across ACORP goals.



The last section of the *Collaboration Survey* had partners comment on ACORP's strengths, opportunities for growth, areas for improvement, and barriers that could hinder the achievement of program goals. Below highlights the common themes across these four domains.

Successes and Opportunities

Strengths:

- ✓ Positive community outcomes
- ✓ Strong agency collaboration
- ✓ Effective and adaptable programming
- ✓ Strong communication
- ✓ Established trust

Opportunities:

- ✓ Generating buy-in
- ✓ Community awareness
- ✓ Data collection and evaluation
- ✓ Program expansion

"Megan and Tommy work well together; Meghan seems to have earned the trust of APD staff. The program is well-regarded by City Council and is getting great press. The ability for the team to adjust their work in real time (adjust program hours, for example) is awesome. "

Challenges and Areas for Improvement

Challenges:

- ‹ Funding to support the sustainability of the program
- ‹ Ongoing training and support for DECC staff on ACORP and behavioral health
- ‹ Clarity on ACORP's role related to crisis response vs outreach

Areas for Improvement:

- ‹ Additional units and staff to cover a 24/7 schedule
- ‹ Expanding and updating data collection efforts

"I really hope we can develop the partnership with DECC such that remembering ACORP becomes routine rather than something new staff need to remember."

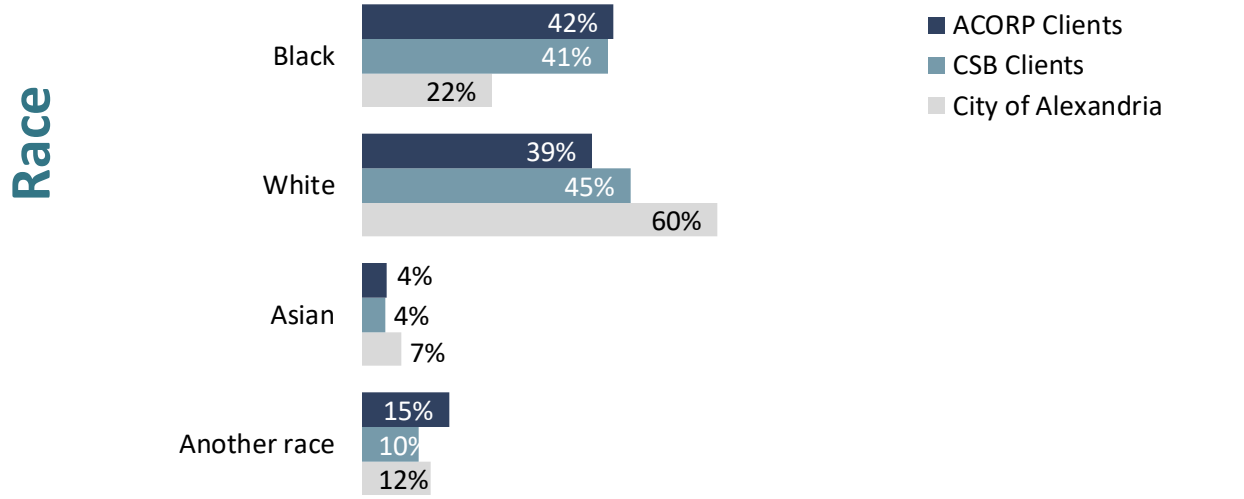
"One area of improvement would be more staffing to have 24-7 coverage. The barrier is always financial."

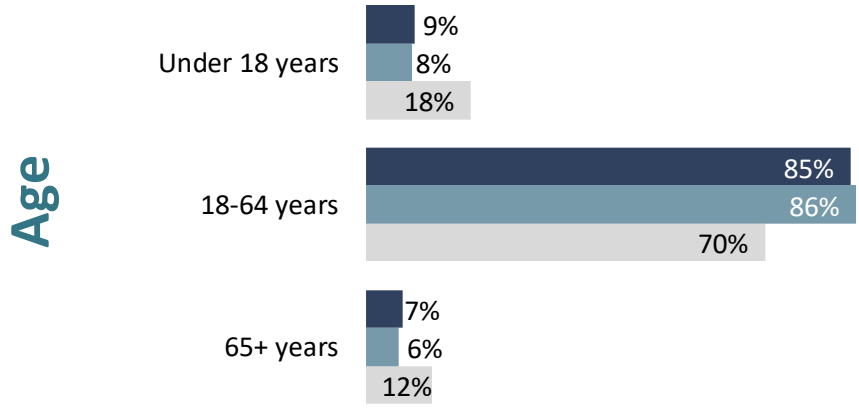
Goal 2: Providing equitable access to services

A core goal of ACORP is to provide equitable services to the Alexandria community and to identify and address potential health barriers for clients effectively. A client survey has been developed and is in the field to better understand the health barriers ACORP clients face. This report assesses equitable service delivery by comparing the profile of ACORP clients to that of the City of Alexandria and Community Services Board (CSB) clients.

Demographics Comparisons

The graphs presented below compare the demographics of ACORP clients to census data and CSB client data to help determine the degree to which ACORP clients are representative of their community.[6,7,8] This comparison indicates that the ACORP client population is similar to the CSB client population. However, compared to the broader Alexandria community, **White clients are under-represented, and Black clients are over-represented in the ACORP client population**. In addition, **ACORP clients are disproportionately older than the Alexandria community**. Within the 18-64 age range, over half (54%) of ACORP clients are between the ages of 25-44.

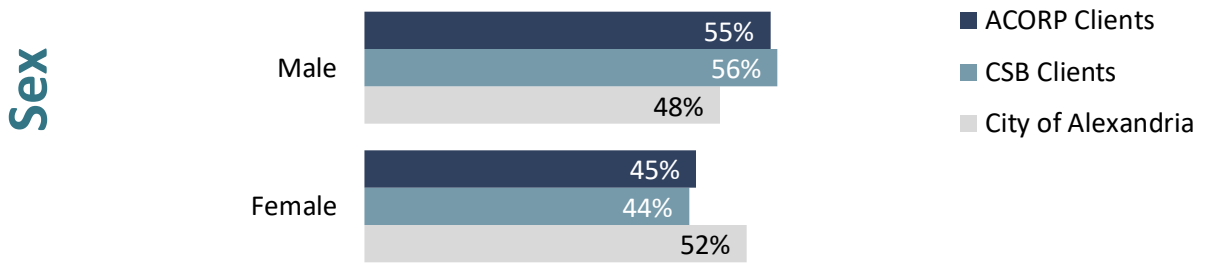


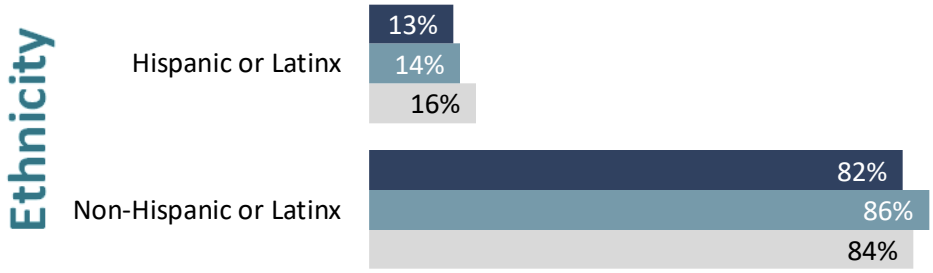


[6] ACORP data divided race into four categories: 'Black', 'White', 'Asian', and 'Another race'. 'Another race' is not clearly defined, and the limited racial categories in the data likely exclude other racial minorities and do not fully capture multi-racial identities. Collecting more robust and inclusive 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.

[7] CSB data covers clients served from 10/1/2021 – 9/30/2022 (the same timeframe as ACORP data). City of Alexandria data is from the 2020 census.

[8] ACORP and CSB demographic data provided represent the population for whom demographic information was collected (demographic information was collected for >95% of ACORP clients and >99% of CSB clients).

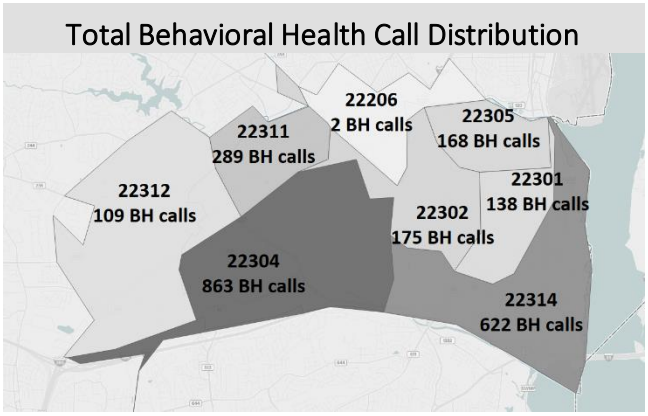


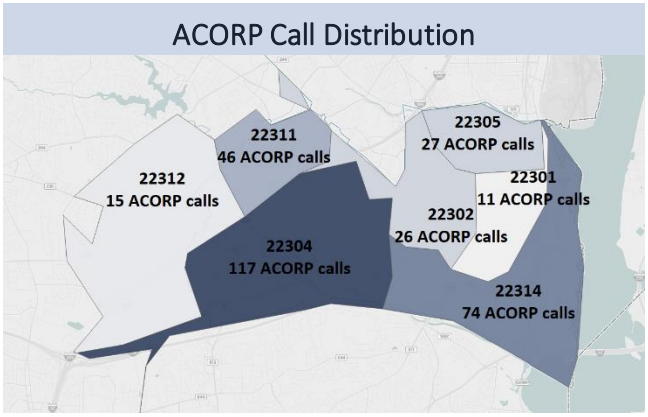


Geographic Distribution of Behavioral Health Calls

Below compares the Geographic (zip code) distribution of behavioral health calls and ACORP-response calls. Examining calls for service by zip code provides insight into where the client's need is concentrated within the City and potentially where to focus attention and allocation of additional resources. In addition, exploring the geographic concentration of calls may highlight potential gaps in service and mental health disparities in various regions. As illustrated below, the greatest concentration of these behavioral health calls (and ACORP-response calls) was observed in **zip codes 22304 and 22314**.

The distribution of total behavioral health calls by zip code was similar to that of ACORP response calls by zip code.





Client Experience Survey

To understand the degree to which ACORP is meeting the needs of clients and supporting clients with their unique health barriers, OMNI partnered with the ACORP team to develop a *Client Experience Survey*. This survey is intended to be administered to all individuals receiving ACORP services for which contact information was gathered. The main elements of the survey include:

- **The reason for the ACORP encounter**
- **The impact of the encounter and types of supports offered**
- **Whether the service delivery was equitable and culturally responsive**
- **Service engagement following the encounter, including barriers to care**
- **Comfort re-engaging with the police if needed**

The *Client Experience Survey* was piloted in June 2022 and has undergone several administration adjustments to address ongoing challenges with data collection. Initially, ACORP members shared a business card with information about the survey and the survey link with individuals directly following their encounter. Unfortunately, that approach did not result in many survey responses. As a result, OMNI and ACORP decided to pivot and have OMNI text individuals who have engaged with the ACORP team within 3-6 months following the encounter to share the survey link. This method has also been largely unsuccessful due to challenges inherent in surveying people following crisis situations. Looking ahead, the ACORP team is exploring other opportunities for more direct outreach following the initial encounters to improve response rates and data collection sustainability. Client survey efforts are intended to continue into early 2023.

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

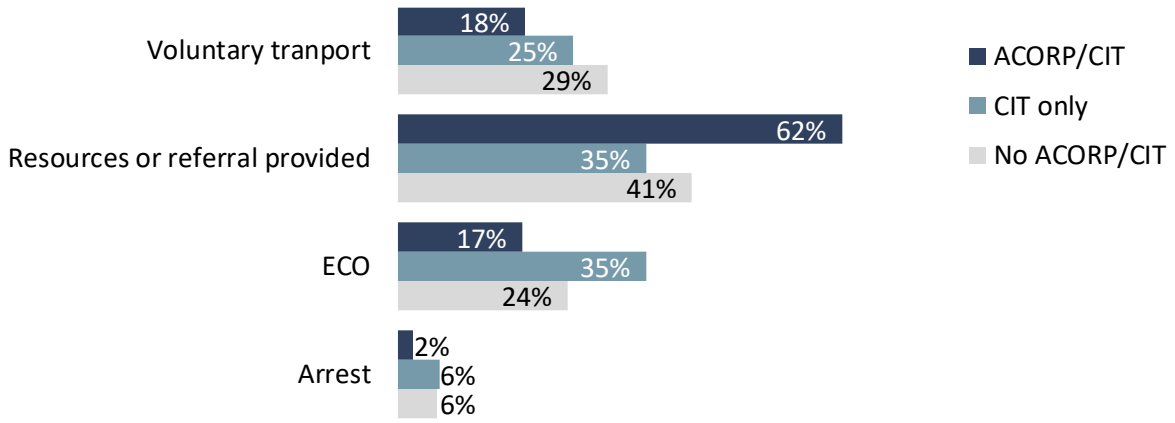
Diverting individuals with behavioral health concerns away from jails and toward appropriate treatment is a primary impetus of co-response programs. Therefore, improving the experiences and outcomes for all parties involved in mental health calls—police officers, co-responders, bystanders, and clients—is a core objective of these programs. While the broader evaluation plan incorporates indicators to examine the use of force and injuries on calls, this report explores the outcomes of ACORP calls versus calls not involving ACORP to understand the effects of ACORP on clients served.

Behavioral Health Call Outcomes

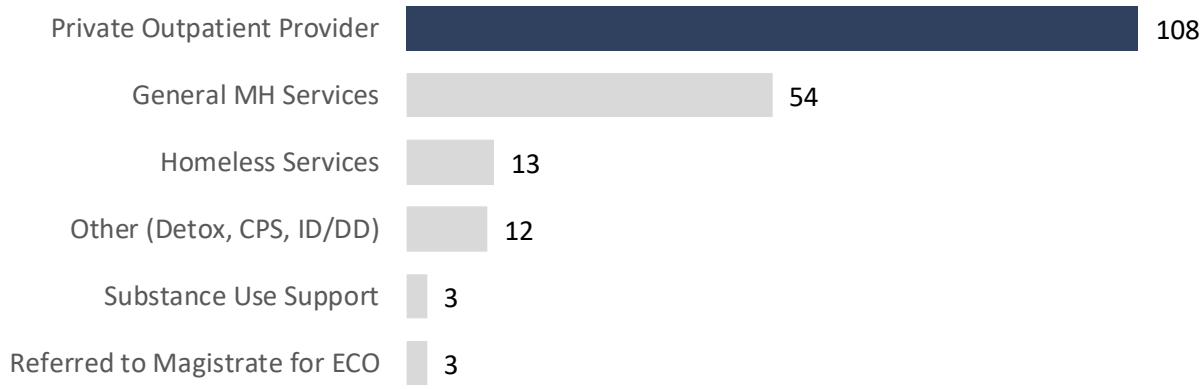
The ACORP team tracks outcome data from each encounter and highlights the most common outcomes based on the ACORP response below. **Call outcome data were unavailable for 67% of CIT-only calls and 33% of No ACORP or CIT calls.** Below only presents the proportion of outcomes for calls for which outcome data are available.[9] However, CIT-only or No ACORP or CIT calls for which outcome data are available likely parallel ACORP calls in terms of severity, as more severe calls require a higher 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.

[9] Based on ACORPs current practices, policies, and procedures, Alexandria police 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 outcome data for all 911 calls. One ACORP call had an outcome of "outreach" which is not included in the outcomes chart.

For encounters related to mental health and the clients were present, ACORP calls were more likely to have resources provided than other response groups.

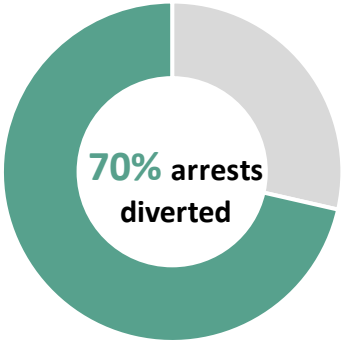


Of the 193 encounters that provided resources and referrals, over half (56%) were referred to a private outpatient provider.



Legal System Diversion

Co-response presence on the scene to support de-escalation and provide mental health referrals can often divert an encounter from legal system involvement. Diversion can be challenging to assess because determining whether an arrest would have happened without a co-responder is subjective. ACORP has worked with field officers to identify cases where an individual met arresting criteria but was not arrested due to ACORP's support.



When examining the 20 encounters where an arrest could have been made in 911 calls, 14 encounters (70%) were diverted away from arrest by the ACORP team.

ACORP Success Stories

The ACORP team outlined the success stories they encountered in the first year of pilot implementation to shed light on the Program's impact on community members and add depth to the program's quantitative outcomes.

Cross-System Collaboration

ACORP and APD responded to a call at an individual's place of employment, where the individual had barricaded themself in an empty office after engaging in self-harm. ACORP was able to collaborate with APD officers on scene and identify the person at risk based on the call details. Due to the imminent nature of the call, ACORP shared information with APD regarding verbal approaches that had worked well with this individual in the past. After APD gained access to the individual, ACORP accompanied the individual to the hospital where they continued to receive the care needed. ACORP's ability to collaborate with other agencies in this case allowed APD and ACORP to safely locate and provide services needed to an individual in life-threatening circumstances.

Building Community Rapport

ACORP generated a call for service after an individual's Assertive Community Treatment (ACT) case manager was unable to make contact. The case manager reported that the individual was reluctant and had been decompensating in the weeks prior. ACORP and the ACT case manager successfully collaborated to meet with this individual to perform a welfare check. The individual continued to decline to engage with the case manager but cooperated with ACORP. The individual had wanted to go to the hospital but was unable to get there themselves, so ACORP was able to facilitate voluntary transport to the emergency room where medical and psychiatric aid could be provided. In this case, ACORP's prior rapport building with this individual assisted ACORP in rendering aid when needed, as the individual knew and trusted ACORP from their prior experience.

Resource Provision

ACORP and APD responded to a call regarding a potential sex offense in progress. Several calls for service had indicated an individual was exposing themselves. Officers arrived on scene to discover that the individual's pants were too large and did not fit, likely resulting in the individual unintentionally exposing themselves. The individual's presentation also indicated potential mental health concerns and/or an intellectual or developmental disorder (IDD) that could help explain their situation. ACORP and the officers were able to refer the individual to services that could provide an appropriate level of support for their mental health and intellectual/developmental disability needs. Through this outcome, ACORP reduced future calls from the community due to concerns about the individual's behavior and directed an individual in need of support to appropriate resources.

Key Takeaways & Next Steps

ACORP has been in operation for over a year, during which the team has demonstrated agility in adapting processes and overcoming barriers to best meet the community's needs. In addition, the team has effectively made progress toward achieving the intended program goals. Findings contained in the six-month report provided a solid baseline for ACORP and highlighted early successes and challenges. Since that report was released, these results have been used to inform ongoing programmatic discussions and refinements. The 12-month report expands upon that initial report by incorporating the additional six months of data, running some comparisons between the first six months and the latter six months, and building in additional data points for further contextualization. Below presents the key takeaways from the 12-month report.

Key Takeaways

Encounter-Level Takeaways

- **The program continues to operate as intended,** responding to behavioral health calls for dispatch while on duty. With the program's limited capacity, there is ample opportunity for expansion and growth to respond to increasing calls over time.
- **ACORP is self-dispatching to most of their calls** rather than having DECC dispatch them directly. This represents an increasing need for ongoing training and support to ensure calls can be flagged and dispatched to ACORP appropriately.
- **The prevalence and timing (day of the week/time of day are relatively consistent over time,** with a fair share of calls coming in when ACORP is off duty. This data provides valuable insights into targeting ongoing expansion efforts regarding on-duty assignments.
- **ACORP mostly responds to calls for unusual (including delusional behavior in the community.** ACORP encounters many delusional individuals and utilizes this information to inform CIT training with officers on how to engage with this population. There are also noticeable service gaps for this population since they aren't at risk of harming themselves or others and can care for themselves, but they are clearly in distress and constantly call 911.
- ACORP client demographics are very similar to CSB and City of Alexandria demographics, highlighting that **ACORP provides relatively equal access to services across tracked populations.**
- **Most ACORP calls result in providing individuals with resources or service referrals,** mostly for outpatient treatment, as opposed to jail transport or other negative outcomes, which is a core focus of ACORP.
- Most individuals transported following an ACORP call are voluntary, suggesting an **increased ability to de-escalate and gain compliance from individuals in crisis.**
- Very few ACORP calls result in arrest even when arresting criteria are present, highlighting that **ACORP successfully diverts most individuals in crisis from arrest.**

System-Level Takeaways

- **Key partners have a strong sense of trust and collaboration**, which is the foundation for an effective co-response program.

- **Partners have a shared understanding of program goals** and agree that ACORP has made considerable progress toward these goals throughout the year.
- As the Program continues to grow, there are further **opportunities to increase community awareness** about ACORP services and **generate more buy-in for program sustainability.**
- ACORP is unique in its **ability to adapt and evolve based on community needs**. This ability plays out across ACORP scheduling, data collection, and education and training.
- There is still **room for clarity on the role ACORP has in the community and the services they provide**. ACORP services will likely continue to grow and adapt, and it would be helpful for ACORP to share any changes across internal and external collaboration partners.
- **Key partners would like to expand their collaboration** to include more direct and indirect external partners.
- An area noted for improvement included **expanding the program to meet better the community's needs,** which ACORP is actively engaging in as they train new team members.
- The ability of ACORP to collect data and evaluate the Program was a noted strength among collaboration partners. However, there are **still data collection protocols and efforts that need improvement.**

Next Steps

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

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

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

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

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

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

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

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

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

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

Conclusion & Next Steps

Through this evaluation, the ACORP pilot has demonstrated effectiveness toward accomplishing intended program goals, including providing equitable access to services and improved outcomes for individuals in

crisis and the broader community. While the program has achieved many meaningful successes, as with any pilot program, there are still areas of ongoing growth and refinement, specifically in cross-agency collaboration, call-taker training, and ongoing data collection.

A key next step for ACORP is focusing on effective and streamlined program expansion and measuring the impact of that increased capacity. Expanding the ACORP team is beneficial in terms of increasing the hours and days they can offer services and increasing collaboration with other agencies (e.g., Fire/EMS). Although the expansion will allow ACORP to be better positioned to meet the needs of the community, continuing to focus on refining program practices, data collection, training, and protocols will be important. Expanding the ACORP team is anticipated to increase administrative and managerial support to meet these additional needs.

The ACORP pilot has positioned Alexandra to support 988 and Marcus Alert initiatives developing in the coming years. Additional work includes fine-tuning and identifying levels of crises and dispatching to match community needs with appropriate resources. The City closely examines how ACORP collects and tracks data relevant to behavioral health across different systems and approaches. This work is evolving and underway, but ACORP has given the City a strong understanding and foundation of these data. Additionally, the success of this pilot program paved the way for the City to continue to grow and expand its efforts to meet the community's behavioral health needs effectively.

Appendices

Appendix A. Collaboration Survey

ACORP Collaboration Survey

You are being asked to take this brief survey because you are a critical stakeholder in ACORP, and we value your input. This survey is designed to assess the cross-system collaboration components of the Program and gather your feedback around successes and challenges encountered since the launch of the pilot program. This survey should take no more than 5-10 minutes to complete. This survey is anonymous, and results will be aggregated for interpretation. Consent is implied when you begin the survey.

Perceptions of Cross-System Collaboration

This section contains questions related to different aspects of collaboration. Please indicate your response to the following questions based on your experiences with the ACORP Pilot.

1. Since the start of the pilot, the frequency of meetings, calls, and other planning/decision-making events for the Initiative were:
    a) Not enough to accomplish our goals
    b) Just right to accomplish our goals
    c) More than we need to accomplish our goals

Please indicate your response to the following questions based on your experiences with the ACORP Pilot	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
There is a shared understanding of program goals and objectives across collaborators.					
A system exists to monitor and report the activities and services of our Program					
Our Program has access to credible information that supports problem solving and decision-making.					
We are engaged in a streamlined process that is informed by research and used to inform decision-making.					
Our group is effective in obtaining the resources it needs to accomplish its objectives.					
Members trust one another sufficiently to share information, perceptions, and feedback honestly and accurately.					

Our collaborative group engages other stakeholders, outside of the group, as much as we should.					
Our policies and procedures support our program goals.					
People in this collaborative group have a clear sense of their roles and responsibilities.					
The process we are engaged in is likely to have a sustainable impact on the problem. (e.g., serving persons in crisis in the community)					
The partners involved in our pilot program invest the right amount of time in our efforts.					

2. What has gone well with ACORP collaborative efforts?
3. What are existing challenges with ACORP collaborative efforts?

Perceptions of Program Goal Progression

This section contains questions related to progress towards achieving program-related goals. Please indicate your response to the following questions based on your experiences with the ACORP Pilot

to what degree you think ACORP has been effective in	No Progress	Slight Progress	Somewhat Progress	Moderate Progress	Don't Know
Maximize safety for all involved					
Collecting and analyzing data and outcomes					
Connecting persons in crisis with behavioral health services					
Minimizing arrests of individuals experiencing a behavioral health crisis					
Minimizing potentially negative encounters and/or injuries for persons experiencing a behavioral health crisis					
Minimizing visits to the Inova Alexandria Hospital Emergency Department for the sole purpose of a mental health evaluation					

Identify strengths, opportunities and resource needs or changes for future programming					
Positioning City services for the eventual implementation of State-directed crisis response initiatives					

High-Level SWOT

SWOT (Strength, Weakness, Opportunities, and Threats) questions can help you to analyze what your Program does best now, and to devise a successful strategy for the future. SWOT analysis assesses internal and external factors, as well as current and future potential. Below we will ask you a set of question that will help to evaluate these factors.

Internal to ACORP

1. What is ACORP doing well? What are program strengths?
2. What are areas ACORP needs to improve on? What are program barriers?

External to ACORP

3. What opportunities exist for program growth (ex. Services, partnerships)?
4. What barriers exist that could limit or hinder program goals? (ex. legislation, public attitudes, political climate).

Thank you for completing the survey! The information provided will be compiled and analyzed, and OMNI will provide the team with an overview of the results to inform work for 2021. Thank you again for your participation.

Appendix B. Evaluation Plan

Goal	Objective	Measures	Data Collection Tools	Deliverables
Improving experiences & outcomes for all parties involved	Reduce police use of excessive force and maximize safety for all involved	Proportion/# of ACORP calls resulting in injuries vs. non-ACORP BH calls	WebRMS, Credible	Quarterly Reports
	Connect persons in crisis with behavioral health services	#/type of referrals made; # of BH calls received by dispatch.; proportion of BH calls responded to by ACORP	Credible	Quarterly Reports
	Minimize arrest of individuals experiencing a behavioral health crisis	Proportion/# of ACORP calls that met arrest criteria but did not result in arrest; # of arrests among ACORP calls vs. non-ACORP BH calls	WebRMS, Credible	Quarterly Reports
	Minimize visits to the Inova Alexandria Hospital Emergency Department for the sole purpose of a mental health evaluation	Proportion/# of ACORP calls transported to CITAC; Proportion/# of ACORP calls resulting in ECO, ER Transports vs. non-ACORP BH calls	WebRMS, Credible	Quarterly Reports
	Reduce stigma around law enforcement	ACORP client experiences/perceptions with LE	Client Follow-Up Survey	Annual Report Only
	Improve law enforcement understanding of behavioral health issues & services	Officer perceptions/knowledge/attidues of MI	Collaboration Survey	Annual Report Only
Improving system responses to individuals experiencing mental health crises in the community	Identify strengths, opportunities and resource needs or changes for future programming	#/Type of referrals made; Distribution of ACORP call outcomes; Day/time trends for BH calls; Distribution of nature of the call; Client self-reported needs; proportion of BH calls responded to by ACORP	CAD, Credible, Client Follow-Up Survey, Credible	Quarterly Reports; Annual Report
	Position City services for the eventual implementation of State-directed crisis response initiatives	Summary of ACORP efforts	All Data Sources	Annual Report Only
	Enhance coordination and collaboration between LE and BH providers	Perceptions of collaboration/strengths/challenges of ACORP from stakeholders/partners	Collaboration Survey	Annual Report Only

Identify and Address Health Barriers and Inequities for ACORP clients	Ensure equitable access to ACORP services.	Demographics of those served by ACORP compared to non-ACORP BH calls and overall city demographics; Geographical distribution of ACORP calls vs non-ACORP BH calls	Credible; Census, Client Follow-Up Survey	Quarterly Reports; Annual Report
	Identify and address health disparities & inequities for ACORP clients.	On-scene resolution by demographics; Self-reported barriers to accessing services; ACORP team perspective of barriers; Client perceptions of encounters	Credible; Client Follow-Up Survey	Quarterly Reports; Annual Report