Examining Alternative Response: A Landscape Analysis of Nine Community Responder Teams

Insights into Model Variation and Performance

November 2025

Harvard Kennedy School Government Performance Lab (GPL)

Authors: Marianna Yamamoto, Ana Obiora, Gabriela Solis Torres
Contributors: Nya Anthony, Benjamin Appleton

HARVARD Kennedy School
Government Performance Lab

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Executive Summary

Jurisdictions across the country are incorporating innovative approaches to respond to quality of life, mental health, and behavioral health related 911 incidents. These approaches often include sending out teams of unarmed, trained professionals to respond to some 911 incidents; these teams are commonly called community responder teams (CRTs).[1] However, publicly available information about the range of alternative response programs is limited to individual case studies on technical assistance provider websites, news articles, and jurisdiction-specific data dashboards. This information gap limits the field's ability to track and support new developments in alternative response while putting the burden on local governments to conduct individual research about program models amidst public calls for swift, effective program development.

This report seeks to centralize research efforts on emerging trends by analyzing and summarizing the results of our landscape analysis of nine alternative response programs[2] operating CRTs across the country[3] that send out unarmed responder teams providing in-person responses to 911 incidents.[4]

The Government Performance Lab (GPL) intends these findings on active programs to support replication, scale, and additional research on CRTs and their impact on government systems and individuals they serve.

An Analysis of 2024 CRT Program Data

This report uses 2024 CRT program data of nine distinct programs to answer **five key field-level questions** about the emerging characteristics of CRTs, including what variation exists and when jurisdictions are converging around models, as well as early indications of team performance.

Key field-level questions:

1. What do we know about where and in what contexts CRTs are currently operating?
2. What type of variation exists in how CRTs are structured and deployed?

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[1] Approximately half of the 50 largest U.S. cities have already launched or piloted community responder teams as part of alternative response programs. At the federal level, policies mandating the rollout of the 988 behavioral crisis line and investments in crisis intervention have encouraged local innovation on alternative response.

[2] This analysis is based on a small and non-representative sample of jurisdictions that are currently operating community responder teams (CRTs) nationally. See methodology section in the appendix for information on the selection criteria for programs included in the sample.

[3] Two programs included in the sample operate in the same jurisdiction. The teams operate out of different departments and respond to different types of 911 incidents.

[4] The focus of this analysis is community responder teams (CRTs), one model of alternative response programs that provide in-person response to 911 incidents. See Appendix 2 for more information on terminology used in this report.

3. What role do CRTs play in the emergency services system and in relation to other first responder teams?
4. What indication do we have that CRTs are responding to 911 incidents as expected?
5. What happens once CRTs respond to a 911 incident?

This quantitative analysis produced four findings on emerging trends in program model variation and seven findings on early insights into CRT performance, outlined below in two sections.

Section One: Emerging Trends in Program Model Variation

1. Jurisdictions determine how CRTs are managed based on local agency and contracted provider capacity and expertise.
2. Jurisdictions staff CRTs using interdisciplinary teams of unarmed professionals with backgrounds in mental health, behavioral health, crisis care, and medical care, as well as people with lived experience.
3. CRTs have grown to operate multiple teams seven days a week, with plans to iterate and expand program hours.
4. CRTs are designed to respond to a range of non-violent 911 incidents beyond mental and behavioral health, including trespassing, welfare checks, and addressing social service needs.

Section Two: Early Insights into CRT Performance

1. The majority of incidents CRTs respond to come directly from 911 dispatch.
2. The majority of 911 incidents CRTs respond to are handled alone, without additional responder teams on scene.
3. The majority of 911 incidents CRTs respond to fall into one of five common call categories with incidents related to mental health and welfare checks comprising the largest percentage of incidents.
4. When dispatched to 911 incidents as primary response, CRTs are responding to, and resolving, 95 percent of incidents on scene.
5. When dispatched to 911 incidents, CRTs provide immediate on-scene response.
6. CRTs rarely request back up while resolving 911 incidents as a primary response.
7. CRTs provide connections to voluntary services including case management and care coordination, shelter/housing resources, and medical services.

Discussion and Areas for Future Exploration

This analysis provides a point-in-time investigation into CRT models, performance, and implementation insights. The alternative response field needs future research to better understand the actual impact of these programs on individual and system outcomes beyond these performance measures. To assess the actual impact of these programs, programs need to establish a counterfactual to evaluate what would have happened to a 911 incident in the absence of a CRT response and need access to individual-level data across systems, such as jails, hospitals, and community mental health providers. Additionally, the field needs more research on the performance and cost effectiveness of CRTs compared to other first responders to contextualize emergency system improvements and CRT performance.

About the GPL's Alternative 911 Emergency Response Initiative Landscape Analysis

Over the past five years, the Harvard Kennedy School Government Performance Lab (GPL) Alternative 911 Emergency Response Initiative has supported 35 cities and counties as they implemented 24 CRT programs. The GPL selected programs included in this landscape analysis based on current or past participation in the GPL's implementation cohort and according to the following criteria:

- **Program maturity**: CRTs that have been in operation for a minimum of ten months.
- **Size and scale**: CRTs respond to a minimum of 100 incidents per month.
- **Data quality and access**: Programs with the capacity to collect and share CRT and 911 data with the GPL based on active technical assistance agreements.

Ten of the 24 programs met the maturity, size, and data quality criteria. Of those, the GPL included nine programs that were able to share data. See Appendix 1 for more details on research methodology.

Project Findings

An Analysis of CRT Program Data

→ *Section One: Emerging Trends in Program Model Variation*

Key Questions:

- What do we know about where and in what contexts CRTs are currently operating?
- What type of variation exists in how CRTs are structured and deployed?

Why this matters:

Given how new the field of alternative response is, these learnings and insights are intended to provide clarity on the design and purpose of CRTs. The field can use this information to further compare CRTs to other types of crisis response resources, such as traditional police, fire, and emergency medical services, as well as mobile crisis teams.

Primary findings from this sample of nine programs include:

1. **Jurisdictions determine how CRTs are managed based on local agency and contracted provider capacity and expertise.**

Jurisdictions use one of three models to operate their teams: (1) staffing CRTs in-house, hiring responder team staff within existing or newly created government departments; (2) contracting with a non-profit or for-profit entity to staff CRTs; or (3) using a hybrid model in which some CRT staff are hired by government departments and others are hired by a contracted provider (Table 1).

Table 1. CRT Program Models

Program	In-House	Contracted Provider	Hybrid
A	✓		
B	✓		
C		✓	
D			✓
E		✓	
F		✓	
G	✓		
H		✓	
I	✓		

To inform this decision of which model to use, jurisdictions described weighing factors including:

- ***Government department experience**:* Jurisdictions with departments experienced in delivering or managing other direct services may opt to incorporate CRTs within existing program divisions to leverage shared resources and promote coordination. For example, CRTs placed within a public health department's community violence prevention division may be able to leverage existing connections with local resources and service providers.
- ***Jurisdiction leadership and political preferences:*** Leaders may be interested in establishing new, dedicated departments to showcase the importance of CRTs as an equal branch of the jurisdiction's public safety strategy or instead in contracting with non-profit organizations to demonstrate community collaboration.
- ***Contract management and procurement capacity**:* Jurisdictions with high-functioning procurement offices are often better positioned to expedite contracting to quickly stand-up teams that are managed by external contracts. Similarly, in jurisdictions with more experienced provider organizations there may be more capacity to bid on and handle reporting requirements of government contracts.
- ***Cost*:** Jurisdictions may weigh the relative cost of hiring government employees versus contracted staff given the size of their program budget. Governments might weigh differences in up-front and longer-term program costs when determining the program model. Costs may also vary depending on whether jurisdictions are experimenting with piloting CRT as opposed to hiring permanent staff for a long-term program. For example, a contracted provider may have an existing training program that could be adapted for the CRTs saving on training costs, or government departments may have open office space to house the program saving on office rental costs.
- ***Contracted provider availability and expertise***: Jurisdictions with robust service provider ecosystems may have multiple providers available to quickly stand up a program due to their experience hiring staff with behavioral health training and their ability to leverage existing clinical supervision supports from other programs.

CRTs are currently housed in a range of departments including Fire, Public Health, Human Services, Community Safety, city executive offices, 911 call centers and public safety branches. After a year or more in operation, several jurisdictions in this sample and the GPL's implementation cohort are now engaging in long-term planning to assess where to continue housing CRTs to sustainably support program expansion, for example embedding the program in a department with more programmatic bandwidth or creating new standalone departments.

2. Jurisdictions staff CRTs using interdisciplinary teams of unarmed professionals with backgrounds in mental health, behavioral health, crisis care, and medical care, as well as people with lived experience.

Jurisdictions staff CRTs with 2-3 responders per team, including behavioral health professionals, paramedics, EMTs, and peer support specialists (Table 2). When determining the CRT team staffing composition, jurisdictions often consider the community's needs, the eligible 911 call types, existing staff within the agency, hiring constraints, funding, and learnings from other programs to ensure that staff have the necessary training and skills to respond to 911 incidents.

Most programs in this sample (7/9) staff teams with trained behavioral health professionals who are not required to be licensed mental health clinicians. These professionals have experience in field-based programs and crisis services and possess the ability to apply on-scene skills not exclusive to licensure, such as de-escalation, service navigation, and rapport building. For example, one jurisdiction staffs their teams with a community mental health responder (i.e., behavioral health professional, license not required) and a community paramedic. When hiring, they seek individuals with experience working with people with mental illness and in the behavioral health field, like community-based mental health and substance use. In addition, they seek individuals with strong commitments to the "principles of recovery" and cultural diversity and inclusion with strong communication skills and the ability to work in an interdisciplinary team.

Seven programs leverage licensed behavioral health professionals to serve in leadership or managerial roles to provide clinical supervision and consult with responders on incidents when needed. For example, if a response team decides that a person in crisis at the scene of a call needs further evaluation before deciding that an involuntary hold is needed, they may call a licensed behavioral health supervisor to come on scene and provide a second opinion.

Programs in this sample also include EMTs (4/9) or peer support specialists (4/9) on the teams.

On CRTs, EMTs assess individuals for urgent medical needs, provide pre-hospital emergency medical care, help identify underlying medical needs that may have led to the 911 call, and maintain the medical equipment on the vans.

When responding to 911 incidents, peer support specialists are staff who have direct personal experience with the mental or behavioral health system and can provide culturally competent services to, advocate for, and build rapport with the person on scene. Peer support specialists may have a certificate in mental health, peer support specialist, or a similar certificate program.

CRTs in this sample also invest significant amounts of time training new hires during their onboarding period. Training type varies by program, but covers topics such as on-scene safety,

911 technology, radio usage, de-escalation, and working with special populations, such as the unhoused, elderly, or people with disabilities.

Table 2. CRT Team Staffing

Program	Responders per Team	Behavioral Health Professional, No Clinical License Required *(includes Crisis Workers)*	Licensed Behavioral Health Professional	EMT	Paramedic *(includes Community Paramedic)*	Peer Support Specialist	Community Health Worker
A	3		✓	✓		✓	
B	2	✓		✓			
C	2					✓	
D	2	✓			✓		
E	2	✓					
F	2	✓	(✓)				
G	2	✓		✓		(✓)	(✓)
H	2					✓	
I	3			✓	✓	✓	

(✓) – Indicates staff who may serve as substitute responders when the standard staff are unavailable or if specialized skills are needed

3. CRTs have grown to operate multiple teams seven days a week, with plans to iterate and expand program hours.

Typically, when programs launch, they operate with one to two teams during limited hours and in a small geographic area of the jurisdiction. This initial stage typically lasts for 6 months to 1 year as programs refine their operations. During this stage, jurisdictions are troubleshooting operations, strengthening relationships across partner agencies, refining data collection and performance tracking practices, and iterating on call triage protocols.

In this sample, most programs have been in operation for more than a year (8/9) and are now operating jurisdiction-wide (7/9), seven days a week (9/9) (Table 3). While many programs have plans to operate at all times of day, fewer than half (4/9) operated 24/7 at the time of this analysis. All programs in the sample expanded their operations in at least one way since launching, such as increasing the number of teams in operation at a given time, adding hours of operation, increasing the number of days in the week service is available, or expanding team geographic reach within and around the jurisdiction. To inform program operations and expansion planning, jurisdictions are analyzing 911 call data by geography, time of day, priority level, and call type to identify the level of demand for their teams, leveraging programmatic data like response times, services, outcomes, and demographic information to improve service delivery, and responding to community interest.

Table 2. CRT Operating Geography and Hours

Program	Population Size[1]	Jurisdiction Land Area[2] (sq miles)	Operating Geography		Hours of Operation		
			Jurisdiction-wide	Subsection of the Jurisdiction	7 Days	24 Hour Operation	Part Time Operation[3]
A	250,000-499,999	100-299	✓		✓		✓
B	1+ million	Over 1,000		✓	✓		✓
C	1+ million	300-499		✓	✓	✓	
D	250,000-499,999	50-99	✓		✓		✓
E	250,000-499,999	50-99	✓		✓	✓	
F	250,000-499,999	100-299	✓		✓	✓	
G	500,000-999,999	100-299	✓		✓		✓
H	500,000-999,999	<50	✓		✓		✓
I	500,000-999,999	<50	✓		✓	✓	

[1] United States Census Bureau Quick Facts, 2024
[2] United States Census Bureau Quick Facts, 2020
[3] Part time is defined as a program operating for less than 24 hours a day. Hours of operation in this sample ranges from 8 to 16 hours per day

4. CRTs are designed to respond to a range of non-violent 911 incidents beyond mental and behavioral health, including trespassing, welfare checks, and addressing social service needs.

A common misconception about CRTs is that they duplicate services provided by mobile crisis teams, whose primary purpose is to seek out and provide non-urgent mental health care in the community. Both in policy and practice, jurisdictions in this sample follow two models to describe the types of 911 incidents, also known as calls for service, to which CRTs are deployed to respond and handle. The first model consists of CRTs that focus on mental and behavioral health incidents, and the second model is where CRTs respond to 911 incidents that extend beyond mental and behavioral health incidents to include other social service and quality of life-type needs. For both models, 911 centers rely on trained call takers to screen incoming 911 calls for CRT response using specific exclusionary criteria, such as weapons or violence, to help ensure calls are safe and appropriate for CRTs.

Table 4 showcases the eligible call types for each program. In this sample, it is observed that CRTs respond to a range of 911 call types, including those that are explicitly related to mental or behavioral health (e.g. mental health, suicide, and substance use) and others that are not (e.g. welfare check, dispute or disturbances, or unwanted persons). However, 911 centers typically only assign one call type that best represents the primary complaint of the caller to the 911 incident. Call takers may document other needs or complaints from the caller in the written comments[5] in the CAD system. These comments may describe instances of unmet mental and behavioral health needs not captured by the call type assigned to the call that also inform the determination of eligibility for CRT response.

[5] Written comments documented in the CAD were not included in this analysis.

Table 3. CRT Program Scope and Eligible Call Types

Program	Focus Beyond Mental and Behavioral Health	Mental Health	Welfare Check	Substance Use	Suicide	Dispute or Disturbance	Homelessness	Unwanted Person	Indecent Exposure	General Assist	Other
A	✓	✓	✓	✓	✓	✓		✓	✓	✓	
B	✓	✓					✓			✓	
C	✓	✓	✓	✓		✓			✓		
D		✓*	✓*	✓*	✓*	✓*		✓*		✓*	✓*
E		✓*	✓*								
F		✓			✓						
G		✓*	✓*	✓*	✓*						
H	✓		✓			✓	✓	✓			✓
I		✓	✓	✓	✓		✓				

✓* – These programs use a dedicated call type to indicate eligibility for the CRT (e.g. "CRT"). 911 staff identify eligible incidents for CRTs using traditional first response 911 call type codes and assign the dedicated CRT call type to the incident instead of using traditional first response 911 type codes. The traditional first response 911 type codes that may be eligible for CRT response are denoted with a "✓*"

Program stakeholders often decide eligible 911 call scenarios and exclusionary criteria for CRT response in the design process. While call types like suicide or substance use are behavioral health related, stakeholders often exclude them from CRT response as programs choose to start with a small subset of call types that stakeholders perceive to be less risky. Four programs in this sample have expanded their operations since launch to respond to more call types to capture more CRT eligible incidents, while other programs maintain a limited scope of call types, possibly limiting the impact that these teams can have.

5. CRTs serve as primary responders on 911 incidents rather than as a secondary or self-dispatched mobile response.

All nine programs in this sample receive 911 incidents directly from their primary public safety answering point (PSAP) 911 call centers, with one program in the sample also taking calls from a 311 line. Jurisdictions in this sample fully integrate CRTs as a response option within 911, equipped to receive calls from 911 dispatchers without requiring an additional level of screening from other first responder agencies. Furthermore, jurisdictions are investing in CRTs as a primary response, rather than as a deployable resource after police, fire, or emergency medical services (EMS) are already on the scene. These efforts speak to the potential of CRTs to divert 911 calls that would have otherwise gone to a different first responder team, decreasing the likelihood of a person interacting with police or emergency medical systems.

→ *Section Two: Early Insights into CRT Performance*

Key Questions:

- What role do CRTs play in the emergency services system and in relation to other first responder teams?
- What indication do we have that CRTs are responding to 911 incidents as expected?
- What happens once CRTs respond to a 911 incident?

Why this matters:

There are an estimated 240 million calls made to 911 each year in the United States.[6] Jurisdictions facing a high volume of 911 calls seek to reduce the burden on understaffed and expensive traditional first responder teams (police, fire, and EMS), reduce unnecessary contact with the criminal justice system, and improve a person's outcomes by identifying ways to divert 911 incidents to alternative resources, including CRTs. To achieve this goal, CRTs need to be able to directly respond to 911 incidents alone without requiring joint support or backup resources. High rates of primary and direct dispatch of CRTs with low rates of calls for backup indicate that CRTs are functioning as an alternative to traditional first response, as opposed to a supplemental resource for traditional first responders. A low backup rate could also suggest that these incidents are safe and appropriate for unarmed responders to manage independently, and that the CRT 911 screening procedures and responder staff hiring and training are working as intended. Further, sending a CRT to a call can also better address the needs of the caller, as teams are equipped with the training and tools to address a range of behavioral health needs and can connect people in crisis to local service providers able to provide longer-term care.

Primary findings from this sample of nine programs include eight findings across three categories:

- Impact on 911 and Traditional Emergency Response
- Incident Response
- Incident Resolution

[6] Estimate provided by NENA, the 9-1-1 Association. https://www.nena.org/page/911Statistics

Impact on 911 and Traditional Emergency Response

1. The majority of incidents CRTs respond to come directly from 911 dispatch.

In 2024, CRTs in our sample provided a response[7] on a total of 85,300 incidents, 74 percent of which originated from 911 (i.e., 911 incidents). One program in the sample also takes calls from 311, accounting for 15 percent of total incidents. If we remove this program from the sample (n=67,300), 89 percent of incidents to CRTs originated from 911 and 11 percent were "self-initiated." This indicates the extent to which CRTs are operating as intended, to respond to incidents coming through 911 with a relatively small proportion (11 percent) of incidents being "self-initiated," meaning they were started by the teams themselves in the field. This finding confirms that CRTs are not just another community-based response, like homeless outreach teams or ambassadors serving the business district of a jurisdiction that provides outreach or is self-directed to community members. Instead, the percentage of incidents that comes from 911 shows that a new model is being tested that takes 911 incidents and sends them directly to a CRT.

2. The majority of 911 incidents CRTs respond to are handled alone, without additional responder teams on scene.

CRTs in this sample were the primary and only responder team managing the scene in 79 percent of the 911 incidents dispatched. This distinguishes the role of CRTs as unique from co-response and secondary dispatch options, in which CRTs would appear on scene as a supplement, rather than a substitute, to traditional police, fire, or EMS teams. If this trend continues and CRTs divert more 911 incidents across all public safety branches, they could provide a first response with skills that better match the individual's needs in the moment and reduce 911 system strain by conserving more traditional responder team resources for other emergencies. Researchers conclude that the field could benefit from an additional evaluation of the longer-term impacts of CRTs on an individual to further understand the utility of this new model.

3. The majority of 911 incidents CRTs respond to fall into one of five common call categories,[8] with incidents related to mental health and welfare checks comprising the largest percentage of incidents.

Despite variation across jurisdictions and models in the sample, 91 percent of the total 911 incidents CRTs responded to as primary response (n=47,115) fall within one of five categories: mental health, welfare check, unwanted persons, dispute/disturbance, and medical.[9] Mental

[7] Includes primary, joint, or secondary responses by CRTs

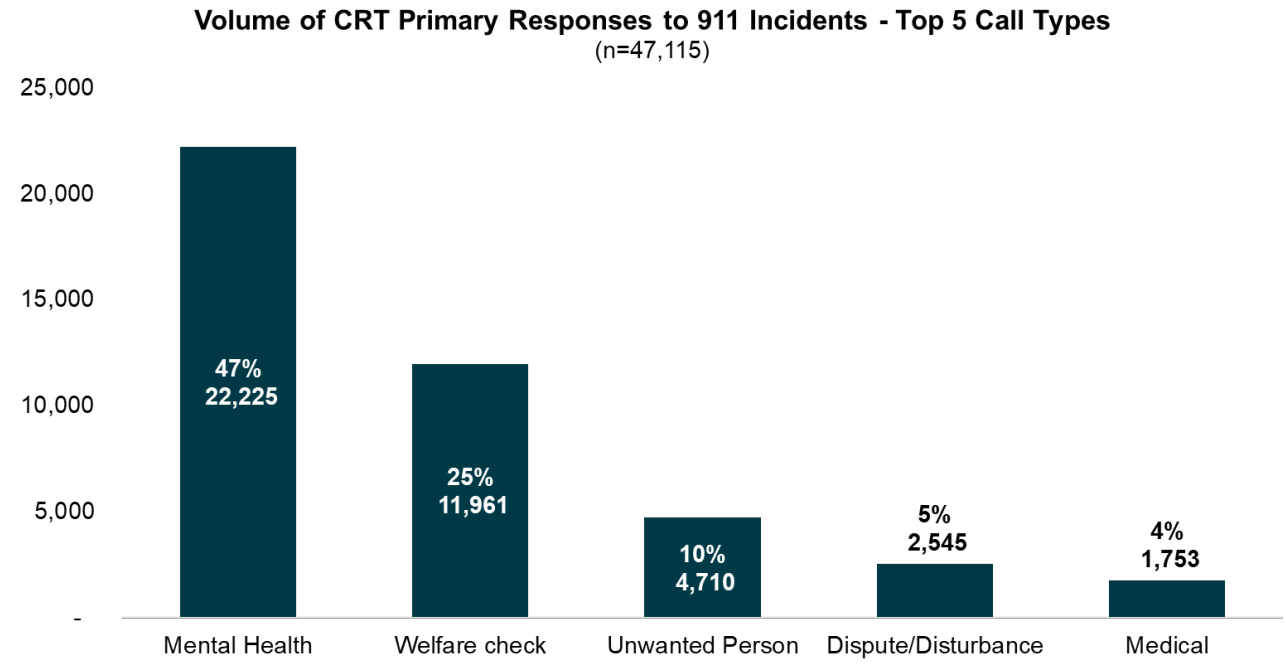
[8] The call categories used in this analysis are defined in Appendix 2.

[9] The first three categories (mental health, welfare check, and unwanted persons) represent the most common call types for the majority of programs in the sample, comprising 82 percent of incidents managed by CRTs. The remaining two categories are primarily driven by individual programs in the sample that specialize in certain types of services,

health and welfare check incidents can encompass a wide variety of scenarios, such as helping a family connect to mental health resources for their son or assisting an unhoused person to prepare for an extreme weather event. An unwanted person incident can include scenarios like checking on a person who is asleep at a bus stop or a local business owner calling about a person with mental health needs in their store. CRTs responding to these calls can help with crisis de-escalation and connections to resources.

As jurisdictions across the field seek to expand the number of incidents diverted to CRTs, maximize their impact on individual outcomes and the emergency response system, and establish themselves as a new branch of emergency response, there is opportunity for programs to respond to more incidents that involve unwanted persons, dispute/disturbances, and low acuity medical incidents, as well as add additional call types for 911 incidents similar to those they already respond to. Both strategies would allow CRTs to increase the number of incidents diverted without needing to develop new capabilities.

Figure 1. Volume of CRT Primary Responses to 911 Incidents - Top 5 Call Types



N=8 Programs reported in this sample

for example CRT programs that have a medic on staff and are run by a fire department with EMS tend to handle more medical incidents. The program that responds to dispute/disturbance-type incidents was explicit in including these types of incidents in their program scope during design discussions to be responsive to community needs.

Table 4. CRT Primary Responses to 911 Incidents by Call Type

Call Type	Total Distinct Incidents (n=47,115)	%	# Programs Reporting this Call Type (N=8)
Mental Health	22225	47%	7
Welfare check	11961	25%	6
Unwanted Person	4710	10%	4
Dispute/disturbance	2545	5%	3
Medical	1753	4%	3
Homelessness	956	2%	1
General Assist	859	2%	3
Substance use	625	1%	2
Indecent exposure	530	1%	3
Suicide Threat	282	1%	1
Unknown	247	1%	2
Other	238	1%	3
Domestic Dispute	41	0.1%	3
Police	35	0.1%	1
Follow up	29	0.1%	1
Traffic	26	0.1%	2
Agency Assist	23	0.1%	1
Mental health with violence/weapons	11	0%	1
Crime	9	0%	2
Assault	7	0%	1
Overdose	2	0%	1
Suicide	1	0%	1

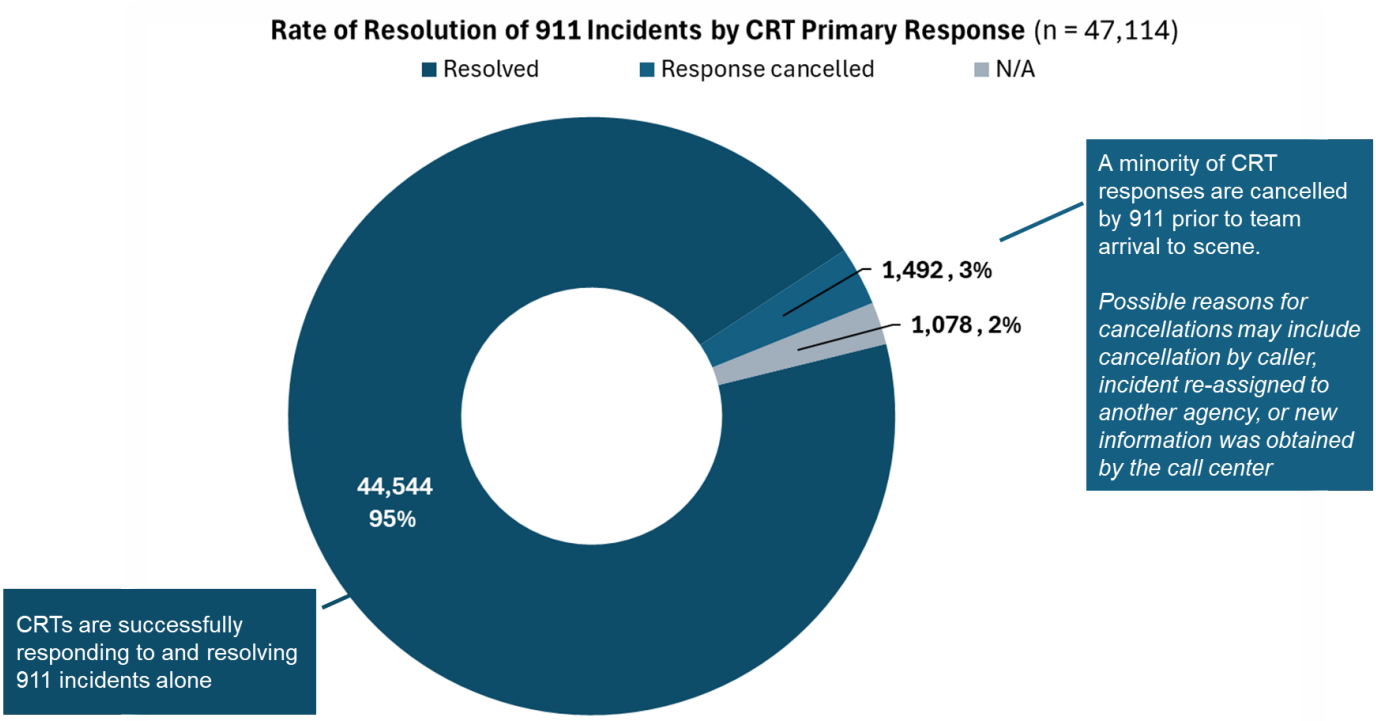
N=8 programs reported in this sample

Incident Response

4. When dispatched to 911 incidents as primary response, CRTs are responding to, and resolving, 95 percent of incidents on scene.

Typically, dispatch considers 911 incident "resolved" when the first responder completes their response by following their protocols and procedures. Most teams consider a 911 incident resolved if the CRT responds to the scene and closes the incident in the Computer Aided Dispatch (CAD) system, regardless of whether the team made contact with a person. On a small minority of incidents, responses were cancelled prior to CRT arrival to scene by the 911 Center.[10] The reasons for response cancellation were not consistently reported across programs, as it is likely that this data point is captured in the 911 CAD rather than the CRT reporting systems.

Figure 2. Rate of Resolution of 911 Incidents by CRT Primary Response



[10] The cancellation rate between programs ranged from <0% to nearly 7%. Two programs had higher cancellation rates at around 6%, while all other programs in this sample reported cancellation rates of 1% or less. The variation in cancellation rates between programs may be due to differences in PSAP policy on maximum CRT response times, queuing calls for CRT, or the caller's ability to request to "cancel" a first response.

Of the resolved 911 incidents, a CRT encounter may result in one of three outcomes – (1) engaged and services offered where a CRT makes contact with an individual and engages people using techniques such as de-escalation, mediation, rapport building, safety planning, as well as distribution of basic resources and offering connections to services; (2) Declined engagement where CRTs make contact with an individual and the person on scene chooses not to engage with the CRT; and (3) no contact made where the CRT arrives to the scene and the person is not found.

Among the resolved 911 incidents where CRTs responded as primary response, CRTs in this sample made contact with a person on scene in 61% of 911 incidents. The person on scene declined to engage with the CRT in just 5% of 911 incidents. This suggests that when they can make contact, CRTs are effectively engaging individuals to provide on-scene support. Teams made "no contact" on 39% of resolved incidents, where the team arrived on scene but did not find anyone to engage, common for incidents related to someone who is transient or unhoused. Further, the reasons for resolution do not vary significantly by the most common call types.

Table 5. Outcomes of 911 Incidents Resolved by CRTs as Primary Response

Encounter Outcome	All 911 Incidents (n=44,544)	Mental Health Incidents (n=21,077)	Welfare Check Incidents (n=10,962)	Unwanted Person Incidents (n=4,542)
Engaged and services offered	56%	57%	49%	57%
Declined engagement	5%	5%	9%	3%
No contact made	39%	39%	42%	40%

5. When dispatched to 911 incidents, CRTs provide immediate on-scene response.

Following 911 dispatch, CRTs in this sample take between 14 to 40 minutes to arrive and spend an average of 24 minutes on scene resolving incidents, an indication of their ability to operate as a timely response, even without lights and sirens. At a time when many 911 call centers report struggling to dispatch traditional responders to a high volume of 911 incidents, CRTs are well positioned to provide a timely response to incidents that may have taken hours to receive a response or gone unanswered all together due to system capacity constraints. While some jurisdictions have set target response times to less than 30 minutes as part of their program goals, others are still determining how to assess what constitutes a timely response on incidents that do not involve a medical, fire, or police related emergency.

Future analyses could assess CRT availability further by studying how quickly 911 is able to dispatch CRTs to incidents and calculating what percentage of CRT-eligible 911 incidents receive a response within the team's operating days and hours.[11] This data was either not requested or unavailable from jurisdictions for this analysis.

Incident Resolution

6. CRTs rarely request back up while resolving 911 incidents as a primary response.

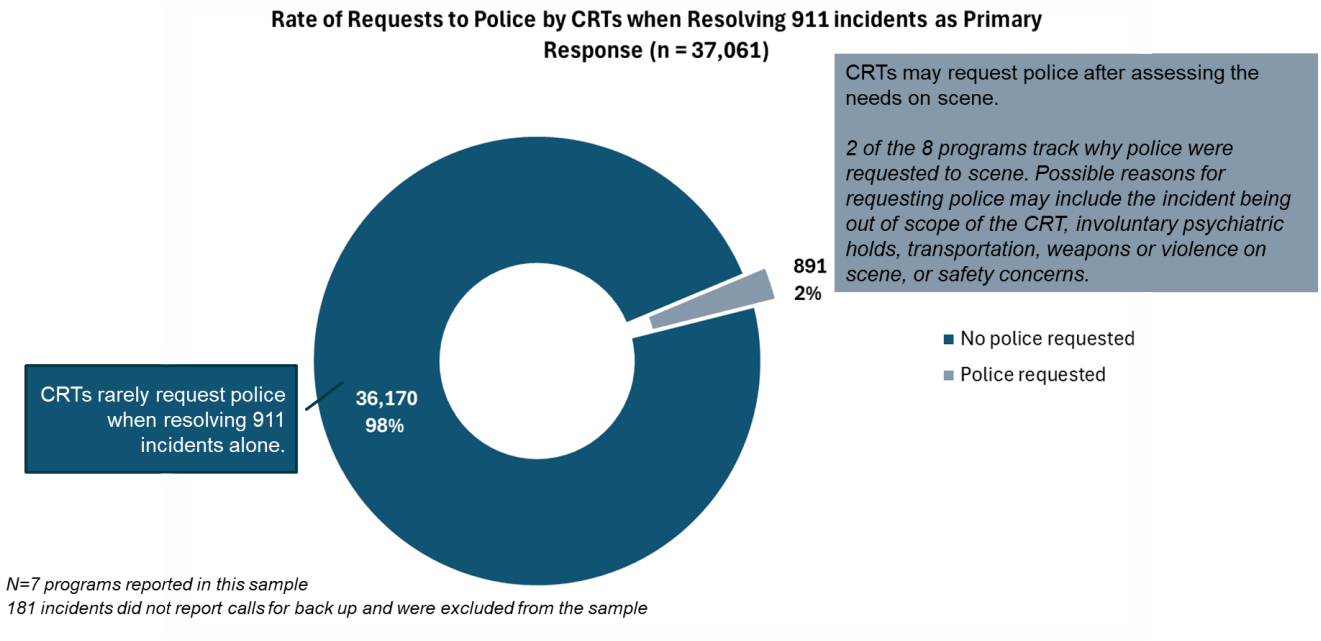
CRTs in this sample requested back up from police two percent of the time and EMS four percent of the time when responding to 911 incidents where they were dispatched, indicating that the types of incidents dispatched to CRTs are safe and appropriate for unarmed response. This finding also suggests that rather than simply delaying an individual's interaction with law enforcement or emergency medical teams, CRTs are effectively disrupting what could have otherwise resulted in a harmful and costly system interaction. Tracking subsequent incidents to 911 involving individuals served by CRTs could serve to identify long-term impacts on criminal justice and emergency medical system outcomes.

Two of the nine programs in the sample collect data on why CRTs call for backup from police and reported reasons such as that an incident was out of the CRT scope (e.g., weapon on scene or emergent medical need), specific transportation was needed, the request required police, or there were safety concerns for the responder or person on scene. One program is actively updating their data collection processes to capture data on reasons for calls for back up. Other programs may capture reasons for requiring back up in the responder notes or narratives submitted to the case management system that researchers did not include in this analysis.

Accurately capturing reasons for calls for back up requires a dedicated question in the CRT case management system or additional CRT outcome codes options in CAD. Further, programs may not track this data because changes to an existing data management system can be costly, staff see additional data collection as burdensome, or they may not prioritize recording the reason for calling back up as a metric since it is not typically collected by other first responder agencies.

[11] To conduct this analysis, 911 Call Centers must be able to reliably and consistently track and report CRT-eligible 911 incidents, regardless of the responding agency, which requires technological changes or staff adaptations, further discussed below. Many 911 Call Centers find this difficult to accomplish due to internal staffing, technological constraints, and lack of publicly available guidance for how to set this up.

Figure 3. Rate of Requests to Police by CRTs when Resolving 911 Incidents as Primary Response



7. CRTs provide connections to voluntary services including case management and care coordination, shelter/housing resources, and medical services.

When engaging a person on scene, CRTs work to be responsive to the person's needs. Two common strategies deployed by CRTs on scene include providing referrals to resources or services in the community or voluntary transportation, among other strategies. CRTs may offer referrals or transportation, or both, after assessing the needs and determining the most appropriate services.

CRTs in this sample provided service referrals in 21 percent of incidents in which they successfully engaged the person on scene. Referrals to services could include providing information about a service or providing a warm hand-off. For example, CRTs may help a person identify the closest food pantry in their community or call a local mental health clinic and help make an intake appointment with the person in crisis.

Another way in which CRTs meet the needs of individuals they respond to is by providing voluntary transportation to a service, resource, or residence. CRTs in this sample provided transportation in 17 percent of incidents in which they successfully engaged the person on scene. The transportation destinations included hospitals, private residences, mental health resources, or other community resources.

Discussion and Areas for Future Exploration

As the field of alternative 911 emergency response and CRT programs develops, practitioners and researchers have an opportunity to promote shared learning and evidence generation on current program performance and potential for growth. Over the course of this landscape analysis, the GPL has captured priority implementation learnings and areas for additional research, summarized below.

→ *Data Quality*

Even among governments selected to have program data collection practices in place, the GPL regularly observed 911 and program staff struggle to consistently generate quality program data and report on meaningful metrics. This appears to be, in part, due to structural challenges in 911 data tracking generally that government and program staff are still figuring out how to overcome.

Researchers found it challenging to compare basic information between jurisdictions due to significant variation in data collection that exists within and across local 911 call centers, such as how they categorize 911 incidents and what constitutes a response-eligible 911 incident. In addition, some jurisdictions use different call data systems between public safety branches, with Fire and Police tracking the same incidents using different systems, which makes it additionally complicated to integrate CRTs and establish which incidents they can and do take. Two of the metrics the GPL initially discussed with program leaders to be included in this analysis—responder staff feelings of safety on scene and the number of 911 telephone incidents that received an in-person response —proved too difficult to track with the level of data CRTs currently collect.

To address these challenges, jurisdictions are eager for standardized language and metrics to guide data collection practices and to explore inter-agency data sharing agreements and technology solutions to link information between systems. In addition, programs are seeking to hire and train staff to better manage and analyze data to be able to track program progress.

See Appendix 4 for additional observations on CRT date collection, reporting capacity, and metrics used in this study.

→ *Opportunities for Program Growth and Expansion*

In most communities across the country, when someone calls 911 for any non-fire or medical emergency, the default response is to dispatch police even though the vast majority of 911 incidents are not for serious crime or violent incidents.[12] Jurisdictions in this sample, the GPL's implementation cohort, and the GPL's national community of practice have described strategies they are exploring to increase call diversion rates through their CRT and broader alternative response programs. These include:

- Refreshing 911 dispatcher training on CRT-eligible incidents to ensure call takers are not inadvertently screening out eligible incidents.
- Expanding the geographic areas or number of hours CRTs operate within the jurisdiction.
- Increasing the range of call types deemed eligible for CRTs.
- Embedding behavioral health professionals in 911 call centers to manage low acuity incidents via phone to prevent the need for in-person response.
- Increasing the number of CRTs that operate within the jurisdiction to meet demand.

Additionally, the 35 jurisdictions the GPL has worked with are evaluating an array of strategies to better address the needs of 911 callers, reducing the emergency response system's costs, and improving outcomes for their communities. Some of these strategies include implementing responses that allow a 911 incident to be resolved over the phone, such as by a clinician, or using online reporting for some police matters, such as reporting crimes not in progress or traffic incidents with no injuries. We call this array "alternative responses." CRTs are just one type of alternative response available to jurisdictions to implement.

As jurisdictions refine their CRT models to absorb additional 911 incidents, it is important for the field to recognize that CRTs are not the only resource available to jurisdictions, nor are they always necessary. Due to CRT's program costs and in-person response model, jurisdictions should be carefully examining the right types of incidents they deploy their teams to —911 incidents where CRT will most decrease the chance of negative interactions with police, reduce costs, and improve outcomes for the person in crisis. Jurisdictions need to invest in an array of alternative response resources and correctly target their CRTs.

[12] Can We Really Defund the Police? A Nine-Agency Study of Police Response to Calls for Service Cynthia Lum, Christopher S. Koper, and Xiaoyun Wu *Police Quarterly* 2022 25:3, 255-280

→ *Additional Areas for Exploration and Recommendations for the Field*

This analysis provides a point in time snapshot of nine alternative response programs to capture current variation and trends in CRT models and early indicators of team performance. To assess the actual impact of these programs on individual and system outcomes beyond these performance measures, programs need to be able to establish a counterfactual to evaluate what would have happened to a comparable 911 incident in the absence of a CRT response. To date, there are a limited number of published evaluations of alternative response teams, the majority of which focus on well-established programs in predominantly liberal and white cities, such as Denver and Portland. Although promising, the results of these evaluations hold less relevance for the new CRTs that are in early phases of implementation or located in more geographically and racially diverse communities. Investments in future research should focus on building a jurisdiction's internal data management capacity and connecting jurisdictions to researchers who can provide impact evaluation support.

Appendix

Appendix 1 - Methodology

Quantitative Analysis Methodology

Jurisdiction Selection

The GPL invited nine community responder programs from eight jurisdictions to participate in the landscape analysis. Programs considered for the project had existing relationships with the GPL through its Alternative 911 Emergency Response Initiative. Among these, programs were selected to participate based on (1) program maturity to prioritize programs operating for at least 10 months,[13] (2) scale to prioritize programs with a response rate of upwards of 100 incidents per month,[14] and (3) data quality to prioritize programs with high quality data collection and reporting capacity. Participating programs had active technical assistance agreements with the GPL at the time of the analysis.

Participating Programs

Table 6. Participating Programs

Jurisdiction	Program	Launch Date	Time in Operation (as of Jan 2025)
Durham, NC	Holistic Empathetic Assistance Response Team (HEART)	July 2022	2-3 years
Harris County, TX	Holistic Assistance Response Team (HART)	March 2022	2-3 years
Los Angeles, CA	Unarmed Model of Crisis Response (UMCR)	March 2024	10 months
Madison, WI	Community Alternative Response Emergency Services (CARES)	September 2021	3-4 years
Minneapolis, MN	Behavioral Crisis Response (BCR)	December 2021	3-4 years
New Orleans, LA	Mobile Crisis Intervention Unit (MCIU)	June 2023	1-2 years
Portland, OR	Portland Street Response (PSR)	February 2021	3-4 years
San Francisco, CA	Homeless Engagement Assistance Response Team (HEART)	May 2023	1-2 years
	Street Crisis Response Team (SCRT)	November 2020	5+ years

See Appendix 3 for additional information on the participating programs.

[13] Apart from one program that had been operating for nearly 10 months at the time of this analysis.
[14] The scale for calls per month was determined using publicly available data on CRT response volume from small, mid-sized, and large cities. For mid-sized and large cities, a response volume of 100 to 499 was considered medium scale and over 500 calls per month was considered large scale.

Data Sources

Participating programs provided 1 year[15] of de-identified programmatic data and 911 summary data for inclusion in the analysis. The data submitted reflected operations between January 1 and December 31, 2024. Data was provided as a CSV or Excel spreadsheet and transferred using the jurisdiction's preferred secured data transfer method. No sensitive or personally identifiable information was shared with the GPL or included in the analysis.

Programmatic data – This analysis reports on thirteen metrics captured and reported by CRTs.

1. **Case ID** - The unique identifier assigned to the individual call for service when the call is received and input into the Computer Aided Dispatch (CAD) system.
2. **Date** - Date the call for service was received by Public Safety Answering Point (PSAP)
3. **Time assigned** - Time the call for service was received by PSAP.
4. **Call origin** - Source of the call for service for the CRT. This includes calls for service originating from sources like 911, 988, 311, or responder initiated.
5. **Response type** – Indication of whether the CRT was dispatched to the scene alone as the primary responders, with another agency as a joint response, or upon request of another agency as a secondary response.
6. **Call type** – The label assigned to the call for service by the PSAP upon dispatch that describes the primary need or nature of the incident based on the information provided by the caller. Also known as nature codes or type codes
7. **Time to scene** – Minutes elapsed from the dispatch of the first response team to the team's arrival to scene.
8. **Time on scene** – Minutes elapsed from the first response team's arrival to scene to closing the call for service.
9. **Outcome** – The code describing the ultimate result of the CRT response to the call for service. The outcome is typically assigned or reported by the CRT when clearing or closing the call for service from CAD.
10. **Requests for back up** – Whether the CRT requested back up from another first responder agency during their engagement. When possible, programs report on the agency from which support was requested.
11. **Referrals made** – Whether the CRT provided a referral to the individual(s) engaged. Referrals can include distributing information and warm hand-offs. When possible, programs report on referral locations.
12. **Transportation provided** – Whether the CRT provided voluntary transportation to the individual(s) engaged. If possible, programs reported the transportation locations.

[15] Apart from one program that provided 10 months of programmatic data because they were operating for nearly 10 months.

13. **Safety on scene** – CRT responder reported feelings of safety while responding to the call for service.

911 data – This analysis reports on three metrics of summary 911 data.

1. Total 911 telephone calls received and triaged by the 911 center for all agencies, including CRTs.
2. Total CAD incidents generated in the CAD system by call for service origin.
3. Among CAD incidents originating from a telephone line, the number of CAD incidents that received a response.

Data Analysis

GPL researchers cleaned submitted datasets to ensure consistency in format in preparation for analysis. If participating governments did not report metrics or there were inconsistencies in data collection, like inconsistent reporting of CRT response type, that impacted data quality, researchers omitted the calls for service entries from the analysis for that metric.

Each program uses a distinct data system and approach to data collection and reporting. To allow for cross-program analysis, researchers developed master categories for call type, dispatch type, response type, transportation locations, and referral locations. Researchers re-coded metrics using the master categories in the analysis. The definitions for the master categories are in Appendix 2.

In addition to creating master categories for selecting metrics, researchers developed five binary variables for request for back up by police, request for back up by emergency medical services, request for back up by any resource, referral provided, and transportation provided.

Four datasets included duplicate entries due to program data collection policies. Researchers attributed duplicates to either more than one person engaged on scene, or multiple teams responding to the same 911 incidents. Datasets were deduplicated to only reflect one entry per call for service. If the duplicates contained different data, researchers prioritized the entries of the team that arrived first, reported contact with an individual, indicated a request for back up, or reported a referral or transportation.

Researchers excluded outliers for the response times and on-scene times from the analysis. Researchers labeled values that fell outside of three standard deviations from the mean for the individual program as outliers and excluded from the analysis of response times and on-scene times.

Researchers divided the number of CRT responses to 911 incidents as primary response by the number of 911 incidents that originated from a telephone call to 911 to calculate the percentage

of CRT responses to 911 incidents. Researchers asked the 911 centers of the programs included in this sample to report the number of CAD incidents that originated from a telephone call to omit self-initiated incidents by police, fire, EMS, and CRTs.

Researchers conducted analyses conducted using Excel and Power BI.

Appendix 2 – Definitions

General

- **Community Response Teams (CRTs)** – Teams of trained unarmed responders that can be dispatched to respond to 911 incidents alone.
- **Computer Aided Dispatch (CAD)** - The software system used by 911 centers to record 911 incidents, track responders in the field, and dispatch first responders.
- **911 incident** – The call for service or entry into the 911 Computer Aided Dispatch (CAD) system to which a first response team is dispatched. Incidents can originate from a telephone call or be self-initiated where they are created by a responder or 911 staff.
- **Self-initiated incident** – A call for service or entry into the 911 CAD system that was created by a responder or 911 staff rather than originating from a telephone call. Also known as a responder-initiated incident

CRT Response Types

- **Primary response** - CRTs dispatched as the only responder to the 911 incident.
- **Joint response** - CRTs dispatched simultaneously with another first response agency to the 911 incident.
- **Secondary response** - CRTs dispatched after or upon request of a team from another first response agency to the 911 incident.
- **Other** - CRTs provided another response, such consulting with another first responder agency.

Incident Resolutions

- **Resolved** – The team responded to the incident and closes the incident in CAD. A resolved incident includes a range of encounter outcomes of no contact made, declined engagement, and engagement with services offered. A resolved incident can include requesting support from another agency.
- **Response cancelled** – The team was dispatched, and the incident was cancelled prior to the team's arrival to the scene by 911. Reasons for response cancellations may include the incident being re-assigned to another agency, new information was obtained by the 911 staff that changes the eligibility, or the caller requested the response to be cancelled.
- **N/A** – The outcome or disposition code for the call for service was not reported or unknown.

Encounter Outcomes

Among resolved incidents, CRT encounters on scene can result in one of three outcomes – no contact made, declined engagement, and engaged and services offered.

- **No contact made** – CRTs arrived and did not engage with anyone on scene. Also known as "unable to locate" or "gone on arrival."
- **Declined engagement** - CRTs made contact with the individual(s) on scene, and the person declined further engagement.
- **Engaged and services offered** - CRTs engaged with the individual(s) on scene. CRTs offered or delivered services, which includes providing referrals, transportation, or requesting support from another agency. A person may decline to receive the services offered by CRTs.

CRT Interventions

- **Referral** – CRTs provided a referral to a service or resource that matches the needs of the individual(s) on scene. Referrals can include a warm handoff to the resource, sharing of information, or submitting an official referral.
- **Transportation** – CRTs provided voluntary transportation to the individual(s) on scene. Possible transportation destinations can include private residences, community resources, medical services, city, or county resources.
- **Request for back up** – CRTs request another resource to scene based on the assessment of the scene and needs of the individual(s). Other resources requested can include police, fire, EMS, and other jurisdiction resources.

Call Types

Table 7. Master Call Type Definitions

Master Call Type	Definition	# Original Jurisdiction Call Types	# Programs Reporting this Call Type (N=9)
Agency Assist	Incidents related to assisting or standing by for another first responder agency. Example call types include "assist EMS" and "stage for PD"	7	2
Assault	Incidents related to assault, likely physical. Example call types include assault, sexual assault, and stabbing	15	3
Crime	Incidents related to property crime, violent crime, and other crimes. Example call types include burglary, motor vehicle theft,	38	3

Master Call Type	Definition	# Original Jurisdiction Call Types	# Programs Reporting this Call Type (N=9)
	larceny-theft, aggravated assault, stabbing, sexual assault, robbery, aggravated assault, stabbing, sexual assault, robbery		
Dispute or Disturbance	Incidents related to interpersonal conflict between one or more people, likely non-physical, or disturbance of the peace. Example call types include juvenile disturbance, neighbor dispute, harassment or threat, fight, neighborhood check, loud noise, group disturbance	33	4
Domestic Dispute	Incidents related to domestic disputes or domestic violence. Example call types include family disturbance, domestic violence, family dispute	7	3
Fire	Incidents related to active fires or the dispatch of a fire engine. Example call types include dispatch engine, fire	8	2
Follow Up	Incidents related to follow up engagements with individuals. Example call types include follow up, care navigation	2	2
General Assist	Incidents related to informational engagements or non-specific engagement with an individual. Example call types include information call, meet the citizen, assist person, encounter	10	3
Homelessness	Incidents related to homelessness. Example call types include encampment, homeless complaint, person experiencing homelessness	5	2
Indecent exposure	Incidents related to indecent exposure. Example call types include indecent exposure, indecency, or prostitution	9	4
Medical	Incidents related to emergency medical services or medical needs. Example call types include accidental injury, unknown medical emergency, fall, unconscious, sick	110	3
Mental Health	Incidents related to mental health and non-violent mental or behavioral health needs. Includes general program-specific call types assigned when a call is eligible for CRT response. Example call types include mental health call, indication of mental illness, involuntary commitment, psych	40	8

Master Call Type	Definition	# Original Jurisdiction Call Types	# Programs Reporting this Call Type (N=9)
Mental Health - Violent/Weapons	Incidents related to mental health with known violence or weapons on scene. Example call types include crisis with violent subject, psych – violent/weapon	9	2
Other	Incidents in all other categories. Includes incidents related to animals, death on scene, hang ups, physical hazards, missing persons, rescues, and more	57	4
Overdose	Incidents related to overdose. Example call types include overdose, drug OD possession	19	3
Police	Incidents related to police matters. Example call types include direct patrol, unknown police problem, citizen arrest, shot spotter, person down	12	2
Substance Use	Incidents related to substance use other than overdose. Example call types includes intoxication, drugs, nuisance or intoxicated	10	3
Suicide	Incidents related to active or attempted suicide. Example call types include suicide, attempted suicide, psych suicidal	11	3
Suicide Threat	Incidents related to threats of suicide. Example call types include suicide threat, jumper (threat)	3	2
Traffic	Incidents related to traffic matters, including traffic accidents. Example call types include flooded roadways, abandoned vehicle, traffic hazard, traffic stop, auto pedestrian, hit and run, MVC person trapped or pinned, injury accident	28	3
Unknown	Incidents with unknown nature.	7	3
Unwanted Person	Incidents related to an unwanted person. Example call types include suspicious person, trespassing, panhandling or nuisance, solicitors, prowler	24	5
Welfare Check	Incidents related to checking the welfare of an individual. Example call types include welfare check, wellbeing check	10	7

Appendix 3 – Additional Program Information

Figure 4. CRT Dispatch and Response Process Chart

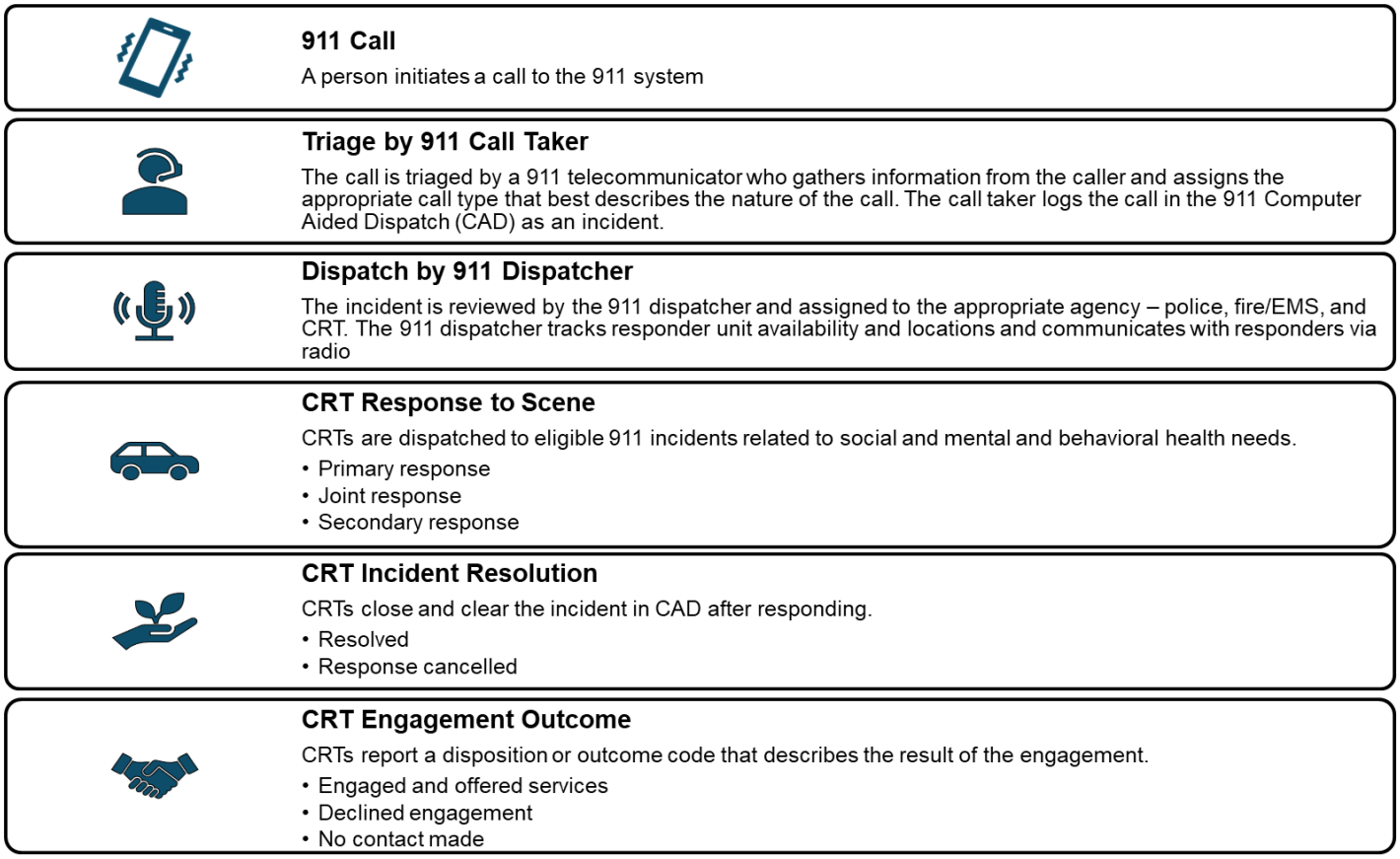


Table 8. Other Resources Available in the Jurisdiction

Program	Co-Response	Mobile Crisis	Homeless Outreach	Substance Use/Overdose	Embedded Behavioral Health Staff at 911	Care Navigation	Other	Coordination with 988
A	✓	✓			✓	✓		Plans to
B	✓	✓		✓			✓	
C	✓	✓	✓	✓				Plans to
D	✓	✓			(✓)			Plans to
E								
F								Limited
G	✓	✓	✓	✓		✓	✓	
H				✓				(✓)
I				✓				

(✓) – In development and not yet in operation

Table 9. CRT Program Information

Program	Agency Housing CRT	Annual Funding (millions)	# Teams Operating at a Given Time
A	Community Safety	$1-4	4
B	Public Health	$5-9	10
C	Executive Office	$5-9	6
D	Fire	$1-4	3
E	Fire	$5-9	5
F	Public Health	$1-4	2
G	Public Safety	$5-9	2
H	911	$1-4	2-3
I	Fire	$15+	10

Table 10. Jurisdiction 911 Call Center Information

Program	Agency Housing 911	2024 911 Call Volume	2024 911 Calls for Service
A	Consolidated PSAP[1]	508,400	399,400
B	Law Enforcement PSAP[2]	Not reported	Not reported
C	Law Enforcement PSAP	3,770,000	711,000
D	Consolidated PSAP	379,500	283,500
E	Consolidated PSAP	630,100	544,100
F	Consolidated PSAP	768,400	509,700
G	Consolidated PSAP	522,800	491,900
H	Consolidated PSAP	1,071,000	870,400
I	Consolidated PSAP	1,071,000	870,400

[1] Consolidated PSAP – A jurisdiction that merged multiple PSAPs into a single, unified communications center that operates as an independent public safety agency. This can include triaging and dispatching calls for multiple first response agencies, like police, fire, and EMS, or for multiple jurisdictions, like a County

[2] Law Enforcement PSAP – The PSAP is operated by the local law enforcement agency. If the PSAP does not dispatch for fire or EMS, appropriate calls are transferred to a secondary PSAP for further screening and dispatch

Appendix 4 – Additional Observations and Insights on Data Collection

CRT Data Collection and Reporting Capacity Observations

This analysis required several rounds of requesting CRT programmatic data and working closely with data analysts from the CRTs and 911 center. The following insights were developed on CRT data quality and reporting capacity.

- ***Variation in approaches to data collection*** – Key metrics for CRTs are consistently being collected across programs. However, the data shows considerable variations in how teams capture metrics and in the level of detail, making it difficult to easily compare outcomes across programs. As a result, researchers dedicated significant time to understanding and interpreting individual program data and producing master categories to analyze data across programs.
    - → For example, the level of reporting CRT response type varied from simply stating that the CRT responded with another agency (i.e., "joint response") to detailing the co-responding or requesting agency (e.g., "EMS requested alt response").
- ***Data collected across multiple systems*** – Teams may collect and store key metrics on CRTs across multiple data sources, such as 911 CAD systems and case management systems, depending on how CRT designs the program. Other data sources, like those of local social service systems, are necessary to track person- or population-level outcomes. For jurisdictions to fully understand the full impact of their programs across data systems, they need to invest staff time, complete data sharing agreements, and develop data sharing practices across agencies to be able to link various data sources for analysis.
- ***Staff capacity to extract, analyze, and report data is critical*** – Programs in this sample had designated data staff—either data staff dedicated to the program or shared within the agency—who could extract the data. Data staff were critical for this project and for internal efforts to leverage data to inform program and performance management decisions, be responsive to internal and external requests for metrics, and for program leaders to be able to share about their work.

Metrics

The data collection and reporting capacity of CRT programs and 911 impacts the ability to confidently and accurately analyze data to understand the initial impact and reach of CRTs. Given differences in policies and data collection processes across programs, future researchers should consider how certain metrics are more effective and informative when analyzed by program versus at a field-level when planning their methodologies.

Metrics most insightful when analyzed on the program level:

- ***The 911 diversion rate to CRTs*** is best tracked on the program-level because of differences across 911 Centers in how incoming 911 incidents and calls for service are tracked. Each 911 Center has unique protocols on (1) whether all or only incidents that are "response-eligible" by a first response agency are logged as a call for service in the CAD system; and (2) how, if at all, CRT-eligible incidents are tracked to understand demand. Without industry-wide standards, the variation in approach across 911 Centers makes it challenging to calculate a field-level diversion rate. Calculating diversion rates on the jurisdiction level would likely result in a more accurate calculation that can consider the specific 911 Center practices.
- ***CRT response times from dispatch to arrival to scene*** is best tracked at the program level. Response times may be impacted by program design, such as where CRTs are stationed across a jurisdiction and operating geography, and jurisdiction qualities, such as traffic patterns and land area. Given these factors, response times are more meaningfully reported and tracked on the program level to identify opportunities to adjust operations to ensure timeliness of response.
- ***Referrals*** provided on scene by CRTs is most appropriate to track on the program level due to differences in each jurisdiction's service landscape that impacts what services, if any, a person can be referred to and the available resources may not match the person's needs. Furthermore, researchers often found variation in how teams defined referrals, ranges from distributing information (e.g., a flyer) to facilitating a warm handoff to a service. Lastly, programs can have varying scopes, some programs include follow ups after an initial CRT engagement to provide additional resources and facilitate service connections, while other programs do not provide follow up engagements.
- ***CRT requests for back up of other first responder agencies*** like police, EMS, and fire is best tracked on the program level given difference in policy on when CRTs must request support from other first responders. Furthermore, the requests for back up may also be informed by the team staff composition and the staff training and certifications, creating different constraints on what services CRTs may be able to deliver when responding to an incident.

Metrics most insightful when analyzed on the field level:

- ***The number of responses by CRTs by call types, response type, and incident source*** can be tracked across jurisdictions with standard definitions for response types. This metric can be used to understand the reach of CRTs collectively and the common pathways to reach CRTs. This metric could also be used to understand the volume of 911 incidents where the skill possessed by a CRT was deemed necessary to resolve an incident.

- ***CRT encounter outcomes*** tracked on the field level can provide insights on the initial impact of CRTs when responding to a 911 incident. A field level understanding of how often CRTs do not contact an individual, an individual declines engagement, or an individual engages with services offered, could be used as a proxy for how well CRTs are helping connect people to services. These outcomes could be compared across other first responders to understand differences in engagement success. Standardization of CRT disposition codes across programs would strengthen the interpretation and clarity of the outcomes.
- ***On scene time*** can provide insights on the amount of time CRTs are dedicating to responding to and resolving 911 incidents. This can be used to understand the capacity CRTs are providing for the 911 system and the potential impact on individual outcomes. With other data sources, on scene time can be used to determine the time saved of other first responders with CRT responses.