Evaluating a Mental Health Co-Responder Program in Burlington, North Carolina

Final Report

October 2025

Hannah Turner, Senior Project Manager, Criminal Justice Innovation Lab, UNC School of Government

Jamie Vaske, Senior Research Associate, Criminal Justice Innovation Lab, UNC School of Government

Anna Marion, Graduate Research Assistant, Criminal Justice Innovation Lab, UNC School of Government

Contents

Executive Summary

There is growing interest nationally and in North Carolina in alternative responder programs to better promote public safety, effectively connect people with needed services, and reduce reliance on the justice system to address social issues. While individual police departments and other community organizations have begun implementing alternative responder programs, research on these programs remains limited—especially in smaller communities.

Executed in partnership with the North Carolina Association of Chiefs of Police, the Burlington Police Department, and RHA Health Services, Inc., this project evaluates Burlington, North Carolina's Law Enforcement Crisis Counselor (LECC) program. Since 2015, the Burlington Police Department has had a mental health counselor embedded in the department to co-respond to calls involving behavioral health crises and follow up with individuals referred by officers to provide a connection to social services.

The evaluation measures the impact of the program on the Burlington Police Department, the clients served, and the broader community.

Key Evaluation Takeaways

- **Proportionally, a relatively small number of calls for service are eligible for crisis counselor intervention.** From 2013 to 2024, 4.74% (25,774) of all calls for service received by the Burlington Police Department were potentially eligible for LECC intervention, meaning they included a behavioral health component that fell within the scope of the program.
- **A minority of clients have repeat interactions.** On average, the crisis counselor served over 300 unique individuals per year. 17.88% of clients across all years had a repeat interaction with the crisis counselor.
- **Officers value the option to submit after-the-fact referrals to the crisis counselor.** Most clients are not initially connected to the crisis counselor as the result of a co-response during a call for service. Instead, Burlington police officers frequently refer clients to the crisis counselor after an interaction if they believe the person could benefit from additional services, even if the individual is not currently in active crisis. From 2021 to 2024, officers made an average of 253 post-incident referrals per year compared to an average of 78 on-scene co-responses per year. In interviews, officers frequently described the referral option as one of the most beneficial aspects of the program.
- **Calls for service with a co-response almost never end in arrest.** Since 2021, only one call involving an on-scene co-response ended in arrest. Most calls with a co-response are resolved at the scene.
- **Calls for service with a co-response are less likely to result in transport to the emergency room.** Behavioral health calls that do not have a crisis counselor co-response are more likely to result in emergency room transport (26.2%) versus behavioral health calls that have a co-response (18.75%).
- **Engaging a crisis counselor does not save officer time on-scene, but time savings may be reflected in other ways.** On average, calls with a co-response took 21 minutes longer than other behavioral health calls and 47 minutes longer than non-behavioral health calls. This finding shows that co-responses do not save officers time directly at the scene of a call, but time savings from co-responses may be reflected in other ways like reducing the amount of time officers spend waiting

with clients at the hospital. Some officers reported that they strongly believed the LECC program saved them time, while others disagreed.

- **The crisis counselor intervention is seemingly not enough to divert clients from future involvement in the criminal justice system.** Criminal justice outcomes show that a minority of LECC clients have any history of criminal court involvement (28.9%) or incarceration in the local jail (16.4%). However, those clients that do have a history of justice system involvement continue to have future interactions with the justice system even after their interaction with the LECC. These findings suggest that the LECC intervention alone is not enough to interrupt a cycle of justice involvement.
- **Stakeholders across the board are highly satisfied with the program.** Based on survey and interview data, the police department, community partners, and clients are all highly satisfied with the LECC program.

The last section of this report also includes recommendations related to data collection and evaluation for other agencies that may be interested in conducting similar evaluations of alternative responder programs.

Introduction

Social issues like homelessness, substance use, and mental health crises frequently land at the doorstep of the criminal justice system. As first responders, law enforcement officers are tasked with addressing these issues, often with limited training or support. There is growing interest nationally and in North Carolina in alternative responder programs to better promote public safety, effectively connect people with needed services, and reduce reliance on the justice system to address social issues. While individual police departments and other community organizations have begun implementing alternative responder programs, research on these programs remains relatively limited—especially in smaller communities.

In 2021, the University of North Carolina at Chapel Hill School of Government Criminal Justice Innovation Lab (the Lab) began a partnership with the North Carolina Association of Chiefs of Police (NCACP) to help address this knowledge gap. At that time, we conducted a survey, interviews, and case studies to provide a landscape scan of existing and planned-for alternative responder programs in North Carolina.

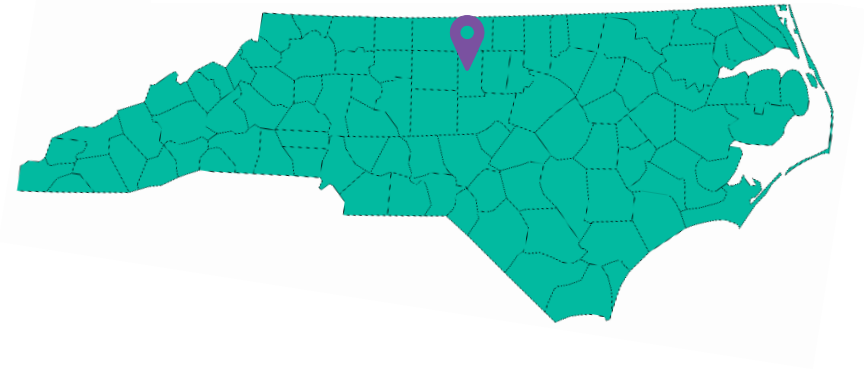
Through this first phase of work, we learned that mental health co-responder programs were of particular interest to police departments. Mental health co-responder programs involve mental health professionals responding with police to calls for service, either arriving with officers or being called to the scene later. With continued support from the NCACP, we sought to evaluate the impact of a mental health co-responder program to inform the expansion of the practice.

In 2023, we partnered with the Burlington Police Department to evaluate their Law Enforcement Crisis Counselor (LECC) Program. This report shares the findings from that evaluation.

About the Program

The City of Burlington is located in Alamance County, North Carolina (Figure 1). While much of Alamance County is rural, the City of Burlington itself is suburban and has approximately 60,000 residents.[1]

Figure 1. Map Showing Burlington, North Carolina



The Burlington Police Department (BPD) has 145 sworn officers, which is considered a midsized department by the International Association of Chiefs of Police.[2]

The BPD established the LECC program in collaboration with the City of Burlington and RHA Health Services—a regional provider of behavioral health, disability, and substance use services. The program

[1] U.S. Census Bureau. (2025). *Burlington city, North Carolina.* https://data.census.gov/all?q=Burlington+city,+North+Carolina.
[2] International Association of Chiefs of Police. (2025). *Midsize Agencies Division.* https://www.theiacp.org/working-group/division/midsize-agencies-division.

began as a pilot in 2015 and was made permanent in 2016. Since then, a clinical mental health counselor has been embedded in the police department to assist with behavioral health calls. The crisis counselor works out of the police department, attends daily line-ups with officers, and is highly integrated in day-to-day operations. For short periods of time in 2022, 2023, and 2024, there were two crisis counselor positions (day shift and night shift). There was also a specific youth crisis counselor (YCC) position in 2021 and 2022. However, across the program's history, it has primarily operated with one crisis counselor working from 8:00 AM to 5:00 PM, Monday through Friday.

The crisis counselor has three primary functions within the police department:

1. **Co-responding on scene to calls related to behavioral health crises and other social issues.** After responding to a call, determining that an individual is in crisis, and securing the scene, an officer may request the crisis counselor co-respond to the call. Once on the scene, the counselor conducts a risk assessment, determines whether the individual needs immediate services or if future follow-up is possible, and makes a direct referral for services as necessary. Crisis counselors also monitor calls for service as they come in and sometimes proactively reach out to officers to ask if they should co-respond.

2. **Providing real-time consultation to officers remotely.** The crisis counselor may be called upon to assist officers remotely if the situation does not require an in-person co-response. For example, an officer might call for consultation if they are interacting with someone they know is currently connected with the crisis counselor or has been in the past.

3. **Connecting individuals to services in response to referrals from officers or community organizations.** Officers often make after-the-fact referrals to the crisis counselor if they interact with an individual who they believe could use additional supportive services, even if the person was not in crisis at the time of the interaction. Officers can make referrals to the crisis counselor by email, text, or radio. Referrals from community organizations are less common, but occasionally a service provider or school principal will refer clients to the crisis counselor. Once the crisis counselor receives a referral, they will follow up with that individual and work to connect them to a variety of services, like behavioral health treatment, housing, and food assistance.

Although the crisis counselor is embedded in the police department, they are employed by RHA Health Services. This relationship with RHA facilitates a direct connection between clients and behavioral health services. Additionally, RHA has provided consistent financial support for the primary position, though the department has received other funding to support the second shift and youth positions in the past.

About the Evaluation

The evaluation of the LECC program began in 2023 with a goal of measuring the impact of the program on the Burlington Police Department, the clients served, and the broader community. Our analyses use data from the following sources:

- **Computer-Aided Dispatch (CAD) Data:** CAD data are primarily the information generated by telecommunicators as they answer 911 calls and dispatch resources. Officers and other department employees can also enter data into the CAD system as they respond to calls. CAD data

include information about when a call for service occurred, who responded, and the nature of the call. CAD data are critical to understanding how many calls are related to behavioral health crises and which calls receive an alternative response. We received CAD data for every call dispatched to the Burlington Police Department between January 1, 2013, and November 1, 2024.

- **LECC Case Management Data:** In the early years of the LECC program, the crisis counselors did not maintain separate case management records about the clients they served. While they did document information in RHA's electronic health record system, that data is HIPPA protected and not directly accessible to the police department. In 2021, the crisis counselors began keeping records in separate spreadsheets, including client demographics, how the client was referred to the counselor, details about follow up contacts, and more. Because CAD data do contain specific identifiers about the subject of the call, these case management data are our only source of information about individual people served by the program. We received case management data from January 1, 2021, to November 30, 2024.

- **Statewide Criminal Court Records Data:** The Lab has compiled statewide criminal court records from January 1, 2014, to December 31, 2023. These data are used in the criminal justice outcomes section of this report, in which we analyze the court system history of LECC clients.

- **Local Jail Data:** Jail booking data from the Alamance County Detention Center are also used in the criminal justice outcomes section to explore the incarceration history of LECC clients. We received jail data from January 1, 2014, to November 1, 2024.

- **Survey Data:** To measure client satisfaction, we used data from RHA's existing Quality Call Back program, where they randomly call clients who have been served by mobile crisis responders, including the LECC. Between April 2024 and February 2025, we asked RHA to focus their call backs to Burlington LECC clients. We received data from sixty-eight people, including sixty-four clients (94.1%), three family members of clients (4.4%), and one group home staff member (1.5%). In September 2024, we also administered surveys to Burlington Police Department leadership and patrol officers to measure satisfaction with the LECC program. The leadership survey was distributed to seven people, and we received six responses (85% response rate). The patrol survey was sent to fifty-five people, and we received twenty-six responses (47% response rate).

- **Interview Data:** Throughout the evaluation, we conducted supplementary interviews with officers and community service providers to learn more about the LECC program, particularly in its early years when quantitative data are limited. We interviewed thirteen patrol officers, all of whom had at least five years of service with the department, to discuss changes in the LECC program over time. We interviewed two local service providers to learn more about community perception of the LECC program.

Findings

The findings below are broken down into four sections: program scope, program outcomes, criminal justice outcomes, and program satisfaction.

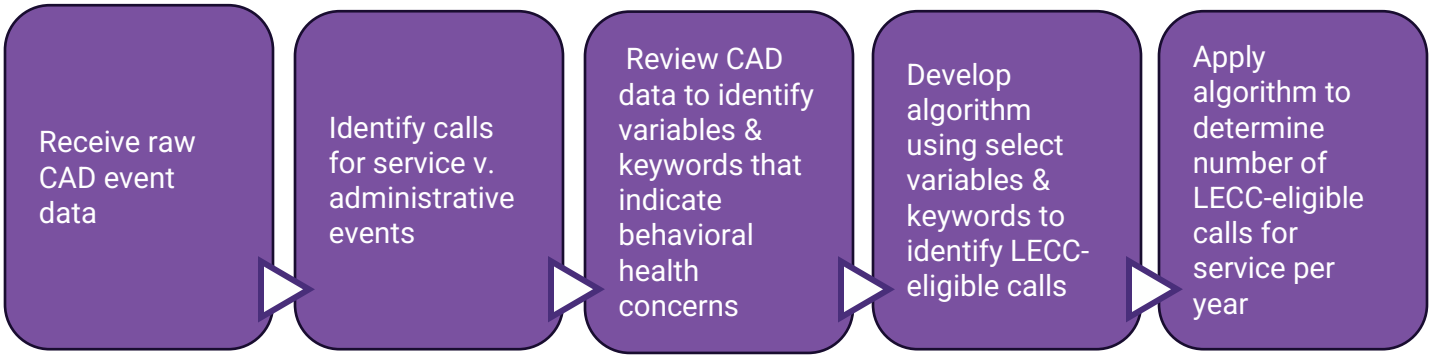
Program Scope

When discussing the overall scope of the LECC program, the first step is to determine the total number of calls for service that are potentially eligible for LECC intervention. After consultation with the department and the existing crisis counselor at the time, we broadly defined calls as "LECC-eligible" if the call was directly related to a behavioral health concern or the subject of the call was exhibiting behaviors that seemed to indicate a behavioral health concern.

However, we learned from the crisis counselor that not all calls that might fall under a "behavioral health" umbrella are appropriate for the LECC. For example, the counselor rarely responded to overdose calls or calls where unhoused individuals were trespassed from private property. We took these program-specific considerations into account when designing our analyses. The department does not have a written policy describing exact parameters that make a call LECC-eligible.

Identifying LECC-eligible calls involved a complex, multi-step process. Our goal was to first identify calls for service as opposed to other administrative notes in the CAD data and, second, identify calls that were related to a behavioral health concern. This process is outlined in Figure 2 and described in detail below.

Figure 2. Process to Identify LECC-Eligible Calls for Service



Identifying Calls for Service

Not every entry in the CAD data is directly related to a call for service from the public. The CAD data also include administrative notes and other events that are self-initiated by officers or the crisis counselor. For example, if officers are driving by a certain location daily for investigative purposes, each day there may be a new entry in CAD to document that drive-by. Or, if the crisis counselor is leaving the department to follow up with a client, they may enter a note in CAD so that dispatchers know where they are in case of an emergency.

For the purposes of this evaluation, we wanted to focus as closely as possible on calls for service. As such, we removed CAD events that we could identify as administrative notes or errors, including entries with the nature codes like "DUPLICATE," "ADMIN," "MESSAGE" and calls with notes under seventy-five characters.

Additional information about our process to narrow down the raw CAD data to represent calls for service can be found in the Methodological Appendix.

Identifying Calls for Service with a Behavioral Health Component

After identifying all calls for service, we then had to narrow down the subset of calls that had an LECC-eligible behavioral health component. Some calls that are related to behavioral health are clearly labeled as such in the CAD data. Telecommunicators attach nature codes to calls for service to help identify the basic purpose of the call, and some nature codes—particularly "MENTAL" and "MENTAL COMMITMENT"—are easily connected to behavioral health issues.

However, many other pertinent calls are not labeled in a way that immediately suggests a behavioral health concern. For example, a call may come into 911 about a person acting strangely and trespassing on private property. The dispatcher, with limited information and limited time to decide which resource to send, dispatches the call as a standard trespassing incident. However, when the officer arrives, it might become clear that the person trespassing is experiencing a behavioral health crisis and is unsure where they are. Therefore, the best way to parse out every call that may be appropriate for the LECC program involves looking at the CAD notes field, which is a free text field where dispatchers, officers, and the LECC all enter notes about the call.

To systematically review the CAD notes, we developed an algorithm that identified more than 100 keywords and keyword combinations related to behavioral health concerns. We chose this list of keywords based on consultation with the department and extensive manual review of samples to determine which words reliably indicated that the call was behavioral health related. For more information on the methodology behind the algorithm and a list of the included keywords, please see the Methodological Appendix.

From 2013 to 2024, 4.74% of calls for service were LECC-eligible

After narrowing down calls for service and identifying behavioral health calls, we are left with the results in Table 1 below. **Across all years, 4.74% of calls for service have a behavioral health component and, as such, are potentially eligible for LECC intervention.** That proportion is higher when looking at more recent years. From 2020 onwards, between 5.6% and 6.07% of calls have been LECC-eligible, translating to an average of about 2,600 calls per year.

Table 1. Number and Proportion of CAD Calls Eligible for LECC Involvement, By Year and Overall

Year	Total Number of CAD Calls for Service	Number of LECC-Eligible CAD Calls for Service	Proportion of LECC-Eligible CAD Calls for Service
2013	46,522	1,647	3.54%
2014	46,292	1,499	3.24%
2015	44,736	1,804	4.03%
2016	44,708	1,798	4.02%
2017	44,036	1,693	3.84%
2018	44,893	1,975	4.40%
2019	46,409	2,386	5.14%
2020	46,127	2,800	6.07%
2021	47,410	2,730	5.76%
2022	45,510	2,574	5.66%
2023	45,981	2,586	5.62%
2024 (Jan – Oct)	40,728	2,282	5.60%
All Years	**543,352**	**25,774**	**4.74%**

Client Demographics

Table 2 shows the breakdown of the number of unique clients that the LECC served in each year for which we have case management data. Additionally, the table shows the number of individuals who were repeat clients, both within each calendar year and across all years. Across all years, 17.88% of LECC clients were repeat clients.

17.88% of clients had repeat interactions with the crisis counselor

Table 2. Number and Proportion of Unique v. Repeat LECC Clients, by Year and Total

Year	Number of Unique Clients	Number of Repeat Clients	Proportion of Repeat Clients
2021	321	55	17.13%
2022	361	33	9.14%
2023	368	48	13.04%
2024 (Jan – Oct)	317	34	10.72%
All Years	**1225**	**219****	**17.88%**

**Table Note: The total number of repeat clients does not equal the sum of the repeat client counts in each year. This is because a client might repeat once within a certain year but multiple times across years.

Figure 3 shows the racial and ethnic breakdown of LECC clients. Most clients are either identified as Black (41%) or White (40%). For comparison, according to the U.S. Census Bureau, the City of Burlington is 44.7% White, 30.3% Black, and 18.5% Latino.[3]

[3] U.S. Census Bureau. (2024). *Quick Facts: Burlington, North Carolina.* https://www.census.gov/quickfacts/fact/table/burlingtoncitynorthcarolina/PST045224

Figure 3. Racial and Ethnic Breakdown of LECC Clients, Jan 2021 – Oct 2024

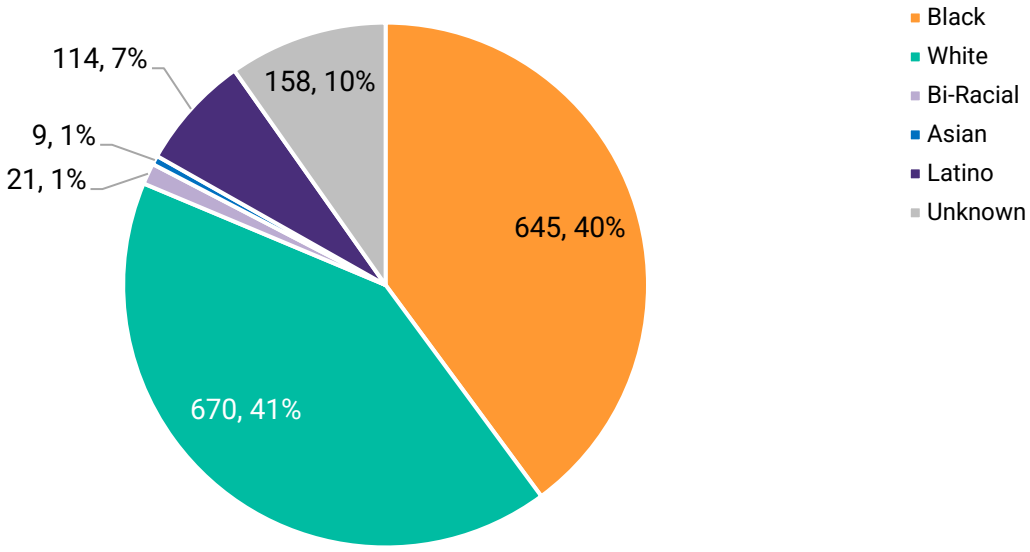


Figure 4 shows the gender breakdown of LECC clients. For comparison, according to the U.S. Census Bureau, the City of Burlington is 52.5% female and 47.5% male —nearly an exact match to the breakdown of LECC clients.[4]

Figure 4. Gender Breakdown of LECC Clients, Jan 2021 – Oct 2024[5]

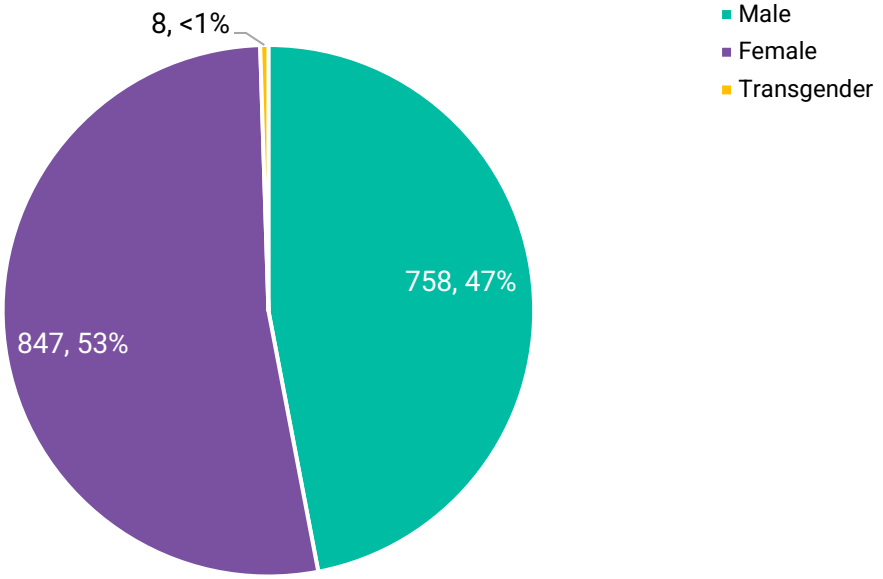
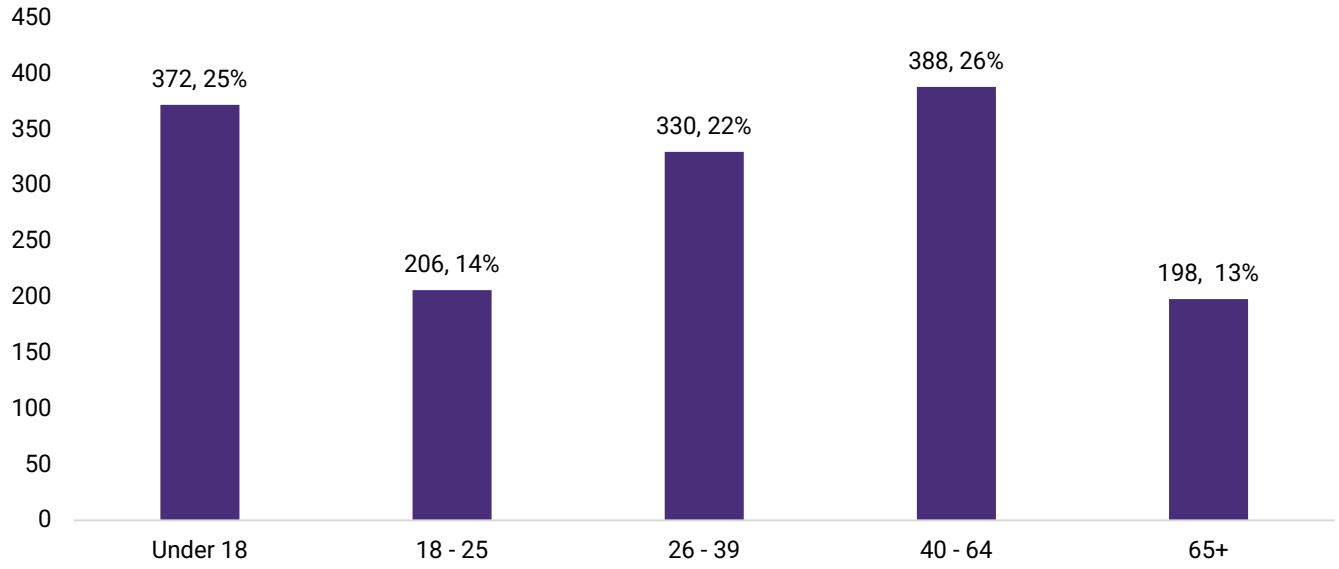


Figure 5 shows the age breakdown of LECC clients. Of the LECC clients that had a birth date available, 39% were under the age of twenty-five. Stakeholders hypothesized that the high proportion of young people served by the LECC program could be related to a shortage of behavioral health providers in local schools and the comparatively high number of group homes in the area. Alamance County has 108 licensed group

[4] *Id.*
[5] Four individuals did not have their gender listed and were removed from this figure for clarity.

homes, making it one of only ten counties in North Carolina that have more than 100 group homes. The average number of group homes per county statewide is forty.[6]

Figure 5. Age Breakdown of LECC Clients, Jan 2021 – Oct 2024[7]



Finally, we were also able to determine the proportion of homeless clients from the LECC case management data (Table 3). Across all years, 10% of LECC clients were homeless. This analysis is based on the total number of interactions the LECC recorded—not unique clients—meaning some individuals could be repeated in this data.

For comparison, the 2025 point-in-time count for Alamance County recorded sixty-one individuals experiencing homelessness, which is less than one percent of the total population.[8]

Table 3. Number and Proportion of LECC Clients Identified as Homeless, by Year and Overall

Year	Number of Homeless Clients	Proportion of Homeless Clients
2021	48	11.4%
2022	37	9.0%
2023	50	11.7%
2024 (Jan – Oct)	27	7.6%
Total	**162**	**10.0%**

Program Outcomes

After identifying LECC-eligible calls for service and isolating unique individual clients, we were able to do a number of analyses related to program outcomes. We present these findings below in two categories: call-level outcomes and individual-level outcomes.

[6] North Carolina Department of Health and Human Services. (2025). Licensed mental health facilities. *Division of Health Service Regulation.* https://info.ncdhhs.gov/dhsr/data/mhlist.xlsx?ver=3.8.
[7] 123 individuals did not have their age listed and were removed from this figure for clarity.
[8] North Carolina Coalition to End Homelessness. (2025). *NC-503 NC Balance of State CoC PIT Summary by County*. Data, Research & Publications - NC Coalition to End Homelessness.

Call-Level Outcomes

Type of Initial Referral

As described above, officers can request the crisis counselor assist with calls in a variety of ways. There are two types of potential responses that happen in real-time:

- co-responding to the scene alongside police officers; and
- providing remote consultation via phone to officers without being dispatched directly to the scene.

Additionally, the officer might submit a referral to the crisis counselor *after* an incident if they recognize that the subject of the call may benefit from additional services. We refer to these as post-incident referrals. Once the counselor receives a post-incident referral, they will try to visit the client in-person or contact them via phone or email.

Using the LECC case management data, we determined the initial referral type for each client interaction. As seen in Table 4 below, most interactions were initiated by a post-incident referral.

Table 4. Initial Referral Type for Each LECC Interaction per Case Management Data, by Year and Overall

	Real-Time On-Scene Co-Response	Real-Time Phone Response	Post-Incident Referral	Unknown
2021	146	54	200	23
2022	66	95	248	2
2023	28	79**	321	0
2024 (Jan – Oct)	48	62**	245	0
All Years	**288**	**290**	**1014**	**25**

** Table Note: A small number of responses in 2023 (5 responses) and 2024 (1 response) were listed as real-time email responses, where it appears the LECC was contacted by officers at the scene and immediately sent resources to an individual via email.

When presented with these numbers, Burlington Police Department stakeholders emphasized how the staffing patterns for the program have changed over time. In 2021, 2022, and 2024, there were periods where there were two LECC positions, while in 2023 there was only one position. This may help explain the fluctuation in real-time, on-scene responses in particular.

Patrol officer interviews may offer additional insight. The thirteen officers we spoke to, all of whom had been with the department for at least five years, explained that they often only called for an on-scene co-response if a behavioral health crisis was particularly complex or severe. They felt they were well-equipped through other training to de-escalate many crisis situations on their own, and they were mindful of the potential safety risks of bringing a civilian crisis counselor to the scene.[9] They frequently referenced making post-incident referrals to the LECC and described the referral option as one of the most valuable components of the program. Therefore, the patterns presented in Table 4 may also be a reflection of how officers choose to engage with the crisis counselor.

[9] The Burlington Police Department prioritizes sending all officers through Crisis Intervention Team (CIT) training, a national training curriculum focused on improving responses to mental health crises. Additionally, many officers have received Mental Health First Aid training.

"When [the LECC program] first started [the crisis counselor] would still come out. Um, it was less of a referral system though, I think it was just, if they were available, great they come out. If they weren't available then we would just handle it basically the way we always handle it and, um, calm 'em down, take 'em to hospital, or just get them back home in a safe environment. But it's changed in that they're looking for referrals, they're reaching out to healthcare providers and services, which has been a lot more helpful I think." – BPD Patrol Officer

"There are some calls that I will go on because I'm an experienced officer, veteran officer, some calls I'll try to handle myself…for example, if there's a mild episode or someone has just asked questions about something, if I can answer them, I don't have to call LECC, I'll answer them, um, because that's what we used to do anyway." – BPD Patrol Officer

On-Scene Co-Responses

We were able to do additional analyses for calls that received a real-time, on-scene co-response based on the available information in the LECC case management data. Similar data was not available for calls that received a real-time phone response.

As seen in Table 5, most calls that received an on-scene co-response occurred at the client's home or out in the community, with a much smaller number occurring at a school or business.

Table 5. Location Breakdown for On-Scene LECC Responses, by Year and Overall

Year	Business	Community	Home	School	Unknown
2021	3	47	84	11	1
2022	1	20	32	12	1
2023	0	16	11	0	1
2024 (Jan – Oct)	0	19	26	3	0
All Years	**4**	**102**	**153**	**26**	**3**

Table 6 shows below the outcomes for calls that received an on-scene co-response per the LECC case management data. Most calls are cleared at the scene, meaning they are resolved without the need for additional transport of the client. Some clients are brought to the local crisis center or the emergency room, typically when the person is experiencing such a significant behavioral health crisis that they need further evaluation.

However, perhaps the most notable finding is that of the 288 on-scene co-responses since 2021, only one has ended in arrest.

Since 2021, only one call with an on-scene LECC co-response has ended in arrest

In interviews, officers described that it was not uncommon to arrest individuals who may have been experiencing crises in the past, before the LECC program and other behavioral health trainings were in place. Arrests have significant costs—both costs to the criminal justice system like the use of officer time, detention staff time, and court system resources, and costs to the individual who was arrested, like potential loss of employment.[10] In

[10] Engel, R.S, et al. (2018). Deconstructing the power to arrest: Lessons from research. *IACP/UC Center for Police Research and Policy.* https://www.theiacp.org/sites/default/files/2018-08/CPRP_Deconstructing%20the%20Power%20to%20Arrest_FINAL.PDF.

contrast, limiting the use of arrests in crisis situations can help ensure that individuals are connected to appropriate resources and can contribute to cost avoidance.

"I would say back in the day we would come out, you know, to a person causing a disturbance. You'd go in, you arrest them, take them to jail, and then that'd be it. But now it's, you respond, you're interacting more, kind of slowing purposely slowing down when you arrive on the scene. You know, evaluating what's going on, having more of a dialogue, and then identifying what's going on. Is it like, is this an actual disturbance? Is this person mad at something or is it they're in crisis?" – BPD Patrol Officer

Table 6. Outcomes for Calls with an On-Scene LECC Respons, by Year and Overall

Year	Arrest	Cleared	Crisis Center	Emergency Room	Unknown
2021	1	76	45	23	1
2022	0	47	12	7	0
2023	0	17	2	9	0
2024 (Jan – Oct)	0	28	5	15	0
All Years	**1 (0.35%)**	**168 (58.33%)**	**64 (22.22%)**	**54 (18.75%)**	**1 (0.35%)**

Emergency room transport was of particular interest to the Burlington Police Department, as it can be a considerable drain on officer time to take someone to the hospital and wait with them. Per Table 6 above, which uses the LECC case management data, about 19% of calls with an on-scene LECC co-response ended in an emergency room transport.

Behavioral health calls without an on-scene LECC response are more likely to end in ER transport

As a point of comparison, we used the CAD data to determine how many behavioral health calls *without* an LECC response resulted in emergency room transport. As seen in Table 7 below, **26.2% of behavioral health-related calls without an LECC response resulted in emergency room transport—a seven percentage point increase compared to calls with an on-scene LECC response.**

Table 7. Number and Proportion of Behavioral Health Calls with ER Transport without LECC Response, 2013 – 2023 (CAD Data)**

	Total Number of Calls	Total Number of ER Transports	Percent of Calls with ER Transports
Behavioral Health Calls for Service without an LECC Response	23,176	6,082	26.2%

**Table note: The incident logs were incomplete in 2024, so that year of data was excluded from these analyses.

Finally, we used the CAD data to look at time on-scene for calls with a real-time LECC co-response. We explored time on-scene by comparing three different groups: (1) behavioral health calls where there was a real-time LECC response, (2) behavioral health calls where there was no LECC response, and (3) non-behavioral health calls.

Table 8 below shows the mean and the median time on-scene for each type of call. On average, calls with a real-time LECC response took 21 minutes longer than other behavioral health calls and 47 minutes longer than non-behavioral health calls.

Table 8. Mean and Median Time On-Scene, 2013 – 2024

	Calls with a Real-Time LECC Response (n=335)	Behavioral Health Calls without LECC Response (n=16,921)	Non-Behavioral Health Calls (n=126,926)
Mean	88 minutes	67 minutes	41 minutes
Median	63 minutes	45 minutes	20 minutes

Additionally, we found that, in most cases, officers remain on-scene with the crisis counselor for the entirety of the call. Between 2020 and 2023, the LECC was the last unit cleared on the call—meaning they were the last person on the scene after all other units had left—in about 30% of co-responses. However, even in these cases, the LECC often left the scene only one or two minutes after officers. It was uncommon for the LECC to spend extended time on-scene by themselves after a co-response.

Table 9. Number and Percent of Co-Reponses where the LECC was the Last Unit Cleared, 2019 – 2023**

Year	Percent of Co-Responses with LECC Unit as Last Cleared
2020	32%
2021	23%
2022	33%
2023	31%

**Table note: The incident logs were incomplete in 2024, so that year of data was excluded from these analyses.

It does make sense that calls involving a co-response take more time. Officers wait at the scene for the crisis counselor, and then the counselor needs time to de-escalate, assess, and connect with the client. While this finding does not show direct time savings for officers on the scene, time savings can be reflected in other ways, like reducing the number of repeat calls for service by connecting vulnerable individuals to services or reducing the amount of time officers spend waiting with clients at the hospital.

"It frees up a lot of officer time. Um, like I said, used to be like you were a one-stop shop. So, you get dispatched, you'd have to go and respond, identify what's going on. You know, sometimes you get a commitment order, you still take them to the hospital, you stay with them the entire time. A lot of that's taken out of play now because LECC can respond. They have gone and actually done the IVC [involuntary commitment] paperwork and taken that off our plate. And sometimes they'll call ahead to like RHA and say, hey, look, police are bringing somebody in…so instead of having to take everybody to the hospital, it's definitely given us greater options on how to address mental health concerns." – BPD Patrol Officer

Client Follow-Up

No matter if the initial interaction is in real-time or a post-incident referral, the crisis counselor regularly follows up with clients to provide additional resources and check in on progress. The LECC case management data shows each follow-up contact, even if the client did not respond to that outreach. Table 10 shows the average number of follow-ups per client, which is 1.45 across all years.

Table 10. Average Number of Follow-Up Contacts per LECC Client by Year

Year	Average Number of Follow-Up Contacts per Client
2021	0.65
2022	1.93
2023	1.84
2024 (Jan – Oct)	1.36
All Years	**1.45**

Additionally, each follow-up contact in the case management data typically has a note describing the content of the follow-up and the outcome. For example, if the LECC calls a client and leaves a voicemail, that is documented.

Using a keyword system, we sorted through the case management notes to determine the outcome for each follow-up interaction (Table 11).

Table 11. LECC Follow-Up Outcomes, by Year and Overall

Year	No Contact with Client	Client Declined Services	LECC Provided Referrals	LECC Connected with Client's Existing Treatment Services	Involuntary Commitment
2021	118	39	160	43	17
2022	292	72	224	92	33
2023	375	70	235	37	12
2024 (Jan – Oct)	224	50	150	43	6
All Years	**1,009**	**231**	**769**	**215**	**68**

There was no contact in 1,009 (44%) follow-ups. However, most people have more than one follow-up (Table 10). As such, the large number of follow-ups resulting in no contact likely reflects multiple clients who did receive some kind of service from the crisis counselor but eventually stopped responding after multiple follow-up attempts.

Of the 1,283 remaining follow-up events where the LECC did make contact, 984 (76.7%) involved the LECC making a referral to services or connecting with clients' existing treatment services. When interviewing officers, they frequently cited ability to directly connect clients to services as one of the most valuable components of the LECC program.

"I think it's good to have someone I can do referrals to. 'Cause a lot of times when we encounter people, it's not even necessarily a mental illness, like call. But somebody who clearly, probably needs some help. And otherwise, I would just say, 'Well, you know, that person probably needs some treatment.' But what can you do? I may have observed this other thing, but that was the end of it….At least now, I can just send [the LECC] a referral and say, "Hey, you might want to just at least check on this person.' Like, I was taking a report for something totally unrelated, but I noticed this, too. Maybe y'all should, you know could check on them." – BPD Patrol Officer

"[The LECC] has done a great job of making sure that there's a follow up. Like, hey, even though I'm not able to show up, if it's something that I can handle, send me their name, send me their phone number, uh, give me the event number…Like, they're trying to, trying to help everybody in this sense, not just the people in crisis." – BPD Patrol Officer

Use of Force

Compared to the total number of calls for service, incidents where officers use physical force are uncommon. In a 2024 internal report, the Burlington Police Department found that 0.06% of police-citizen interactions resulted in the use of physical force. Even more rare are incidents involving use of force when the subject has a potential behavioral health concern.

In addition to the LECC program, the Burlington Police Department has a number of other training initiatives that teach officers how to identify and de-escalate behavioral health crises. As such, stakeholders were interested to see how trends related to use of force —particularly among individuals with mental health concerns—have changed over time in combination with these different initiatives. In interviews, officers described feeling that department culture emphasizes de-escalation instead of hands-on conflict in situations involving behavioral health crises.

"The culture has slowly changed. My mentality has changed…being hurt a few times, fighting mental health patients. What if I just would've slowed down and maybe tried to sit down and talk with 'em, relate like we do now, I would've never got hurt." – BPD Patrol Officer

"We train a lot. And all of that is very valuable, especially when you're dealing with somebody that's in crisis mode that might hurt you when otherwise they wouldn't. You know, learning how to de-escalate. Keep your distance if you need to. You don't have to rush in and make everything so escalated. And I think that's something that's different from back then versus now." – BPD Patrol Officer

By reviewing department data on Displays of Force and Use of Force from 2019 to 2024, we were able to calculate the number of incidents where:

1. the officer identified the subject as having a mental health concern;
2. the subject self-identified a mental health concern; or
3. a specific mental health concern was not identified, but behaviors were noted that could be consistent with a behavioral health issue (i.e. hallucinations, mania, out of touch with reality, etc).[11]

Displays of Force (DOF) are situations where an officer shows a Taser or firearm, but they do not deploy the weapon. In contrast, Use of Force (UOF) incidents are those where an officer applies physical force, which could involve a weapon, hard-hand tactics (i.e. Tasers, pepper spray), or soft-hand tactics (i.e. grabbing, pulling).

Table 12 focuses on Display of Force incidents between 2022 and 2024. Across all years, 17.3% of DOF incidents involved a subject with a potential mental health concern.

[11] Use of Force documentation prior to 2019 did not include specific indicators about behavioral health concerns. The full list of behaviors that we determined could be consistent with a behavioral health concern can be found in the Methodological Appendix.

Table 12. Total Displays of Force Incidents Involving Potential Mental Health Concerns, 2022 – 2024

Year	Total Displays of Force (DOF)	Number & Percent of DOF with Officer or Subject-Identified Mental Health	Number & Percent of DOF with Subject Behaviors that May Indicate Mental Health	Combined DOF with Identified Mental Health or Possible Mental Health
2022	15	0 (0%)	3 (20%)	**3 (20%)**
2023	18	1 (5.5%)	2 (11.1%)	**3 (16.6%)**
2024	19	0 (0%)	3 (15.8%)	**3 (15.8%)**
All Years	**52**	**1 (1.9%)**	**8 (15.4%)**	**9 (17.3%)**

Table 13 shows the type of DOF for incidents involving subjects with a potential mental health concern.

Table 13. Type of Display of Force in Incidents Involving Potential Mental Health Concerns, 2022 – 2024

	2022	2023	2024
Electronic Control Device (Taser)	0	2	2
Firearm	3	1	1
Total	**3**	**3**	**3**

Moving from Display of Force to Use of Force, Table 14 shows the proportion of UOF incidents that involved a subject with potential mental health concerns. While the total number of UOF incidents in 2022 (20 incidents) and 2023 (19 incidents) were stable, there was an increase in 2024 (27 incidents). Still, it is important to recognize that this is a very small number of incidents compared to the thousands of police-citizen interactions that take place each year.

The proportion of UOF incidents involving a subject with potential mental health concerns increased from 2022 to 2024. In 2022, 30% of UOF incidents involved a potential mental health concern. In 2023, that proportion was 36.8%, and in 2024 it was 48.1%.

Table 14. Total Displays of Force Incidents Involving Potential Mental Health Concerns, 2022 – 2024

Year	Total Use of Force (UOF)	Number & Percent of UOF with Officer or Subject-Identified Mental Health	Number & Percent of UOF with Subject Behaviors that May Indicate Mental Health	Combined UOF with Identified Mental Health or Possible Mental Health
2022	20	4 (20%)	2 (10%)	6 (30%)
2023	19	4 (21.1%)	3 (15.8%)	7 (36.8%)
2024	27	5 (18.5%)	8 (29.6%)	13 (48.1%)
All Years	**66**	**13 (19.7%)**	**13 (19.7%)**	**26 (39.4%)**

Table 15 below shows the type of force that was used in each UOF incident involving a subject with potential mental health concerns.

Table 15. Type of Use of Force in Incidents Involving Potential Mental Health Concerns, 2022 – 2024**

	2022	2023	2024	Total
Brachial Stun	0	0	1	**1**
Bean Bag Rounds	1	0	0	**1**
Electronic Control Device	3	3	5	**11**
Firearm	0	0	2	**2**
Hands On	3	3	1	**7**
Joint Locks	1	0	0	**1**
Punches	1	0	0	**1**
Take Down	4	2	6	**12**
Verbal	0	1	1	**2**

**Table Note: In some cases, multiple types of force may be listed for one incident.

Prior to 2022, the Burlington Police Department did not specifically separate Displays of Force versus Use of Force in their data. Therefore, we cannot provide a detailed breakdown in these earlier years. However, Table 16 shows findings related to all incidents since 2019 that involved a potential mental health concern.

Overall, the proportion of incidents involving individuals with an identified mental health concern has decreased, from 19% of all UOF/DOF incidents in 2019 to 11% in 2024. The total number of incidents with identified or possible mental health concerns declined from 2020 to 2023 but increased in 2024.

Table 16. Number and Proportion of UOF/DOF Incidents Involving Potential Mental Health Concerns, by Year and Overall

Year	Total Number of Incidents with a Display or Use of Force	Incidents with Officer or Subject-Identified Mental Health	Incidents with Subject Behaviors Indicating Possible Mental Health	Combined Identified Mental Health or Possible Mental Health
2019	67	13 (19%)	11 (16%)	**24 (35.8%)**
2020	39	12 (31%)	12 (31%)	**24 (61.5%)**
2021	63	9 (14%)	12 (19%)	**21 (33.3%)**
2022	35	4 (11%)	5 (14%)	**9 (25.7%)**
2023	37	6 (16%)	4 (11%)	**10 (27.0%)**
2024	46	5 (11%)	11 (24%)	**16 (34.8%)**
All Years	**287**	**49 (17%)**	**64 (22%)**	**113 (39.4%)**

Criminal Justice Outcomes

Since the focus of most mental health co-responder programs is to address immediate crisis situations, departments often have very limited information about clients' history or their long-term outcomes. To understand criminal justice involvement among LECC clients, we matched clients listed in the LECC case management data to our statewide court records database and to local jail data.

Court System Involvement

The Lab has statewide court records data from 2014 to 2023, which allow us to examine court system involvement for adult LECC clients over time and across multiple counties.[12] We matched clients in the LECC case management data to the court system data using a combination of names, birthdates, and gender. Additional information on the matching process can be found in the Methodological Appendix.

Of the 1,225 unique LECC clients, only 335 (28.9%) had a record of court system involvement from 2014 to 2023. **While the remainder of this section focuses on the criminal charges those clients have faced, it is important to recognize that this group is a minority. The majority (73.3%) of LECC clients had no criminal record between 2014 and 2023.**

Only 28.9% of LECC clients have a record of court system involvement

After identifying individuals with court system involvement, we were able to determine the number of incidents each client had and the most serious charge within those incidents. We use the term "incident" to refer to any charges that were served in the same county on the same day. This means one incident could capture multiple cases.

Table 17 shows the breakdown of the number of criminal incidents per client for those that have a history of court system involvement. The average number of incidents per client is six, and the median is three.[13] Sixteen percent of clients with a history of court system involvement had eleven or more incidents between 2014 and 2023.

Table 17. Number of Incidents per LECC Client with Court System Involvement, 2014 – 2023

Number of Incidents	Number of Clients	Percent of Clients
1	81	23%
2	58	16%
3	40	11%
4	32	9%
5	11	3%
6	17	5%
7	16	4%
8	17	5%
9	15	4%
10	14	4%
11+	56	16%

[12] Our court records data does not include juvenile cases. As shown in Figure 3 above, 25% of LECC clients were under the age of 18 at the time of their LECC interaction. We may not be capturing court system history for individuals who were charged in juvenile court.

[13] We report both the average and the median because averages are heavily influenced by outliers in the data, like the relatively small proportion of individuals with eleven or more incidents in their court system history. However, outliers have minimal impact on the median.

Table 18 shows the breakdown of these incidents based on the most serious charged offense, which we call the "highest charge." In the majority of incidents, the highest charge was a non-violent misdemeanor (34.1%) or a traffic misdemeanor (20.4% traffic administrative, 9.7% traffic safety).[14]

Table 18. Breakdown of Highest Charge per Incident for LECC Clients with Court System Involvement, 2014 – 2023

Highest Charge Type	Number of Incidents by Highest Charge	Percent of Incidents by Highest Charge
Violent Felony	75	3.6%
Drug Felony	57	2.8%
Nonviolent Felony	124	6.0%
DWI	95	4.6%
Violent Misdemeanor	388	18.8%
Nonviolent Misdemeanor	702	34.1%
Traffic Safety Misdemeanor	199	9.7%
Traffic Administrative Misdemeanor	421	20.4%
Total	**2,061**	**100%**

While the figures above speak to LECC clients' court system involvement overall, we also examined the proportion of incidents that occurred before a client's initial LECC interaction versus after their initial LECC interaction. To standardize the time at risk of acquiring new charges, we narrowed the dataset to only include LECC clients who had two full years of data available after their initial LECC interaction (99 clients).

When we narrowed down the data set, we found that fifty-six clients acquired new charges after their initial LECC interaction versus fifty-five clients who had charges prior to their LECC interaction (Table 19). This finding suggests that the LECC intervention alone is not enough to change a pattern of justice-involvement for clients who have a previous criminal history.

Table 19. Number and Proportion of LECC Clients with Criminal Incidents 2 Years Pre/Post LECC Interaction, Accounting for Time at Risk

	Number of Clients	Percent of Clients
Pre/Before Initial LECC Interaction	55	55.56%
Post/After Initial LECC Interaction	56	56.57%

To provide a comparison point, the Lab identified a proxy group of individuals in the court records data similar to LECC clients across demographic characteristics, history of homelessness, the percentage of charges served in Alamance County, and whether the individual had previously been convicted of a violent crime.[15] This comparison group can provide some insight into similarities and differences between LECC clients and other individuals in the community. However, there is no information in the court records data that definitively indicates if an individual has a history of behavioral health issues. Because of the nature of the program, we can assume that many of the LECC clients have a behavioral health concern. We cannot

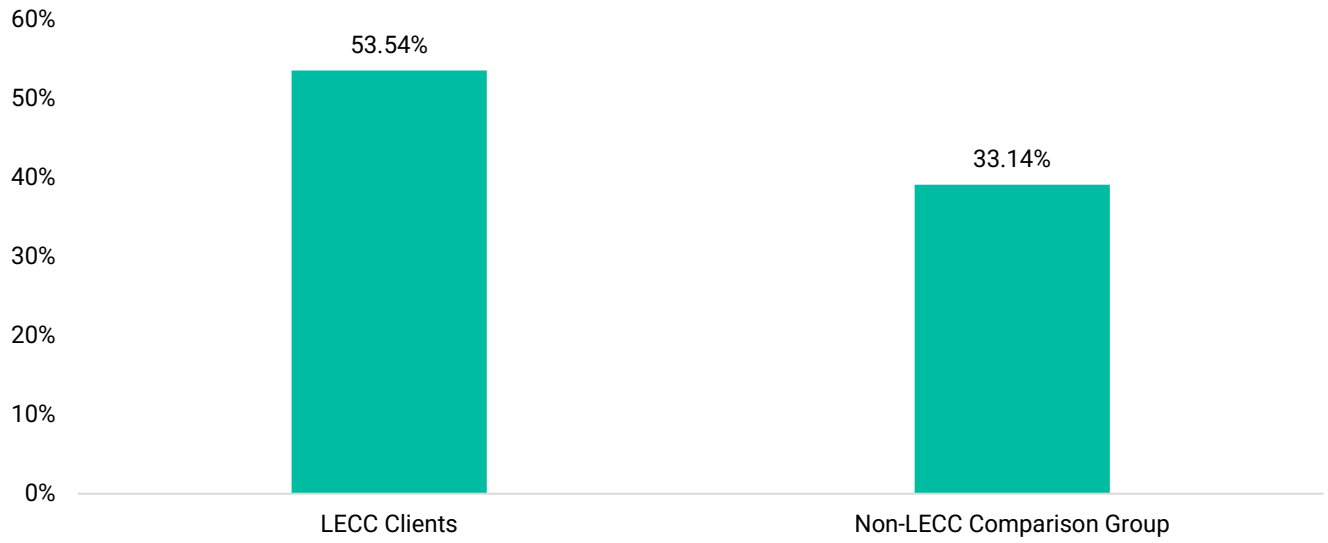
[14] For additional information on how the Lab categorizes offenses—for example, the difference between traffic administrative and traffic safety offenses—see the Methodology tab of our Measuring Justice Dashboard.
[15] This means that an LECC user who is male, White, between the ages of 23-27, with a history of homelessness, a prior violent conviction, and who has 75% or more of their charges within Alamance County will be matched to a *non-LECC user* who is male, White, between the ages of 23-27, with a history of homelessness, a prior violent conviction, and who has 75% or more of their charges within Alamance County.

assume the same about the comparison group. This is an important consideration to keep in mind when reading these results.

To create the comparison group, we matched 353 LECC clients to 353 individuals who did not engage with the LECC program.[16] Within the matched pairs, the earliest referral date for the LECC client was used as the benchmark for examining criminal history for the non-LECC client. More information about the construction of the proxy comparison group can be found in the Methodological Appendix.

Figure 6 below shows that LECC clients were more likely to have criminal charges in the two years prior to their LECC interaction (53.54%) compared to the non-LECC individuals (33.14%).

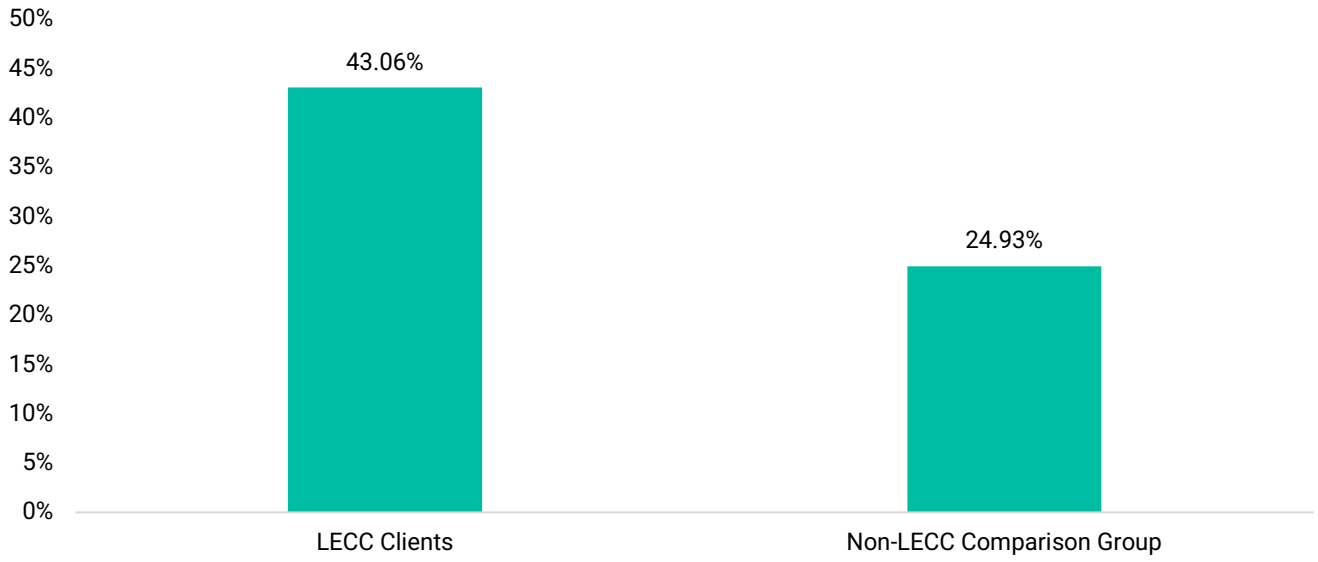
Figure 6. Percent of LECC Clients and Non-LECC Individuals with A History of Court System Involvement Prior to Initial LECC Interaction



Additionally, we found that LECC clients were more likely to be charged with a new crime within two years after their initial LECC interaction compared to non-LECC individuals (Figure 7). This analysis purely provides a point of comparison and does not suggest that LECC involvement *causes* an individual to be at increased risk of court system involvement. However, as described above, it does suggest that the LECC intervention alone is not enough to interrupt a pattern of involvement with the criminal justice system.

[16] Two LECC clients did not have a comparable match in the court records data.

Figure 7. Percent of LECC Clients and Non-LECC Individuals with New Criminal Incidents within Two Years After Initial LECC Interaction



We conducted additional supplemental analyses comparing LECC clients and non-LECC individuals, particularly as it relates to the types of charges they incur. We found that LECC clients were more likely to be charged with violent felonies, violent misdemeanors, and non-violent misdemeanors compared to non-LECC individuals. They were less likely to be charged with traffic misdemeanors. These results can be found in the Methodological Appendix.

When considering why LECC clients are more likely to have criminal charges over time and are more likely to be charged with certain offenses, it is important to emphasize again that there are no variables in the court data that allow us to definitively identify individuals in the comparison group with a history of behavioral health concerns. LECC clients, however, likely do have these risk factors. Research has shown that individuals with mental health concerns are more likely to be arrested than members of the general public.[17]

Jail Incarceration

We obtained jail data from the Alamance County Detention Center from 2014 to 2024 to determine the incarceration history of LECC clients. Unlike the court records data, where we can look at outcomes statewide, the jail data was only for the single county. As such, it is possible that we are not capturing clients who have been incarcerated in other jurisdictions.

We used names and date of birth to match clients in the LECC case management data to the jail booking data. Additional details on the match process can be found in the Methodological Appendix.

[17] Fisher, W.H., et al. (2011). Risk of arrest among public mental health services recipients and the general public. *Psychiatric Services, 61*(1). https://doi.org/10.1176/ps.62.1.pss6201_0067.

Of the 1,225 unique LECC clients, only 201 (16.4%) were booked into the Alamance County jail any time between 2014 and 2024. **Again, this is a minority of clients. Most LECC clients (83.6%) were not incarcerated in Alamance County at any time between 2014 and 2024.**

Only 16.4% of LECC clients have a record of incarceration in the Alamance County jail

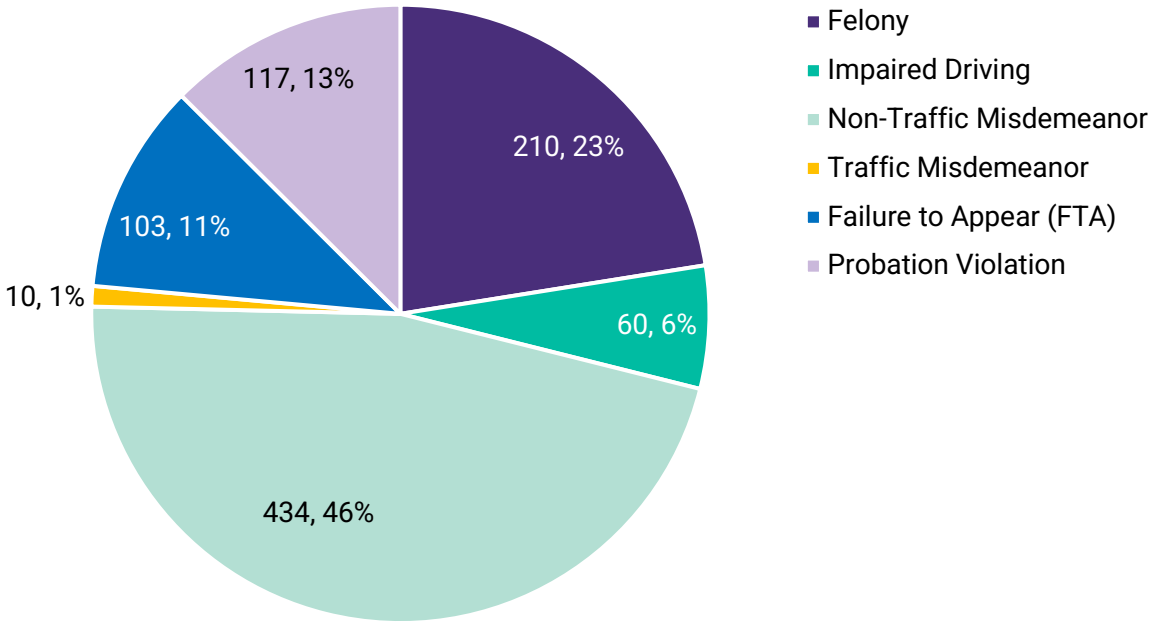
For those clients that do have a history of incarceration, Table 20 shows the number of bookings for each individual across the ten-year period. One-third of the clients with a history of incarceration were only booked once. However, the second highest proportion were clients with seven or more bookings (22.89%).

Table 20. Number of Criminal Jail Bookings per Client, 2014 – 2024

Number of Criminal Bookings	Number of Clients	Proportion of Clients
1	67	33.33%
2	33	16.42%
3	12	5.97%
4	22	10.95%
5	12	5.97%
6	8	3.98%
7+	47	23.38%

Just as we examined the highest charge within each court incident, we also examined the highest charge within each jail booking. Figure 8 below shows this highest charge breakdown. Forty-six percent of jail bookings among LECC clients were for highest charge non-traffic misdemeanors. Because the jail data contain less information about each individual charge, we are not able to provide the same level of detail about violent versus non-violent offenses. However, we can report that jail stays among LECC clients are typically short, with the median stay across all offense types being three days.

Figure 8. LECC Client Jail Bookings by Highest Charge[18,19]



We also considered the proportion of jail bookings that occurred before a client's initial LECC interaction versus after their initial LECC interaction. Again, to control for time at risk, we narrowed the dataset to only include LECC clients who had two full years of data available after their initial LECC interaction (111 clients). Similar to the criminal history analysis above, we saw a slight increase in the number of clients booked into jail after their initial LECC interaction compared to those booked prior to their LECC interaction (Table 21).

Table 21. Number and Proportion of Jail Bookings Before and After Initial LECC Interactions, Accounting for Time at Risk

	Number of Clients	Percent of Clients
Any Booking Prior to LECC Interaction	51	45.9%
Any Booking After LECC Interaction	56	50.4%

This finding does not suggest that interacting with the LECC *causes* someone to face an increased risk of jail incarceration. There are a variety of possible confounding factors we were unable to control for. Instead, this finding continues to suggest that the LECC intervention alone is not enough to have an impact on clients' continued justice involvement if they have an existing history of incarceration.

[18] 30 bookings had an unknown highest charge and were removed from this figure for clarity. These include bookings for non-criminal reasons, like failure to pay child support.
[19] While Failure to Appear is listed in the data as a "charge description," it is rare for jurisdictions to charge FTA as a separate crime. Instead, many of these entries are likely the result of individuals being arrested on an outstanding Order for Arrest after missing court on an existing criminal case. This is recorded in the jail data but does not equate to being charged with an additional criminal offense.

Program Satisfaction

We measured program satisfaction among the police department, clients served by the program, and community partners.

Department Satisfaction

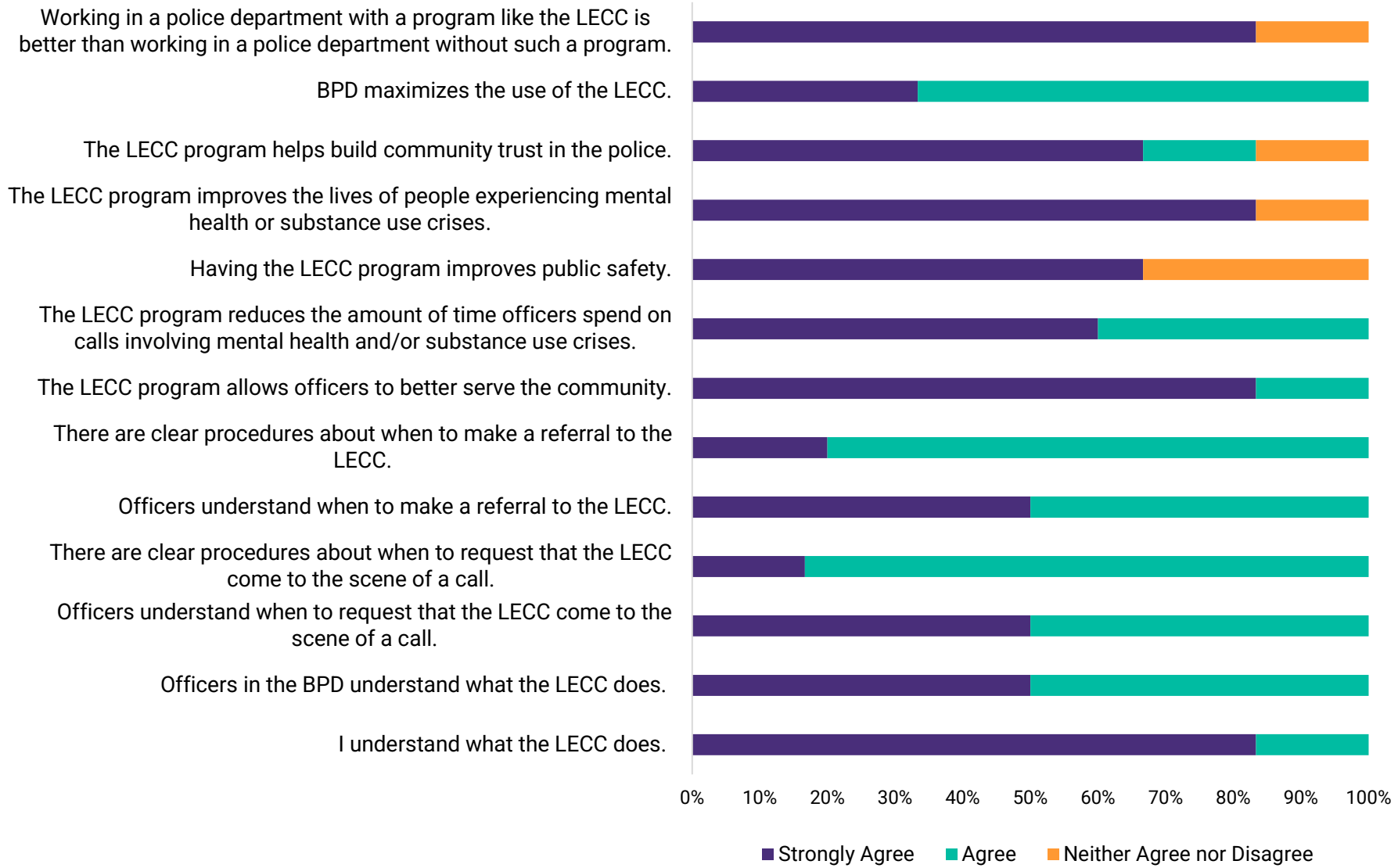
In September 2024, we conducted an anonymous electronic survey of BPD leadership and patrol officers about their satisfaction with the LECC program. The leadership survey was sent to seven officers, and we received six responses (an 85% response rate). The leadership responses are summarized in Figure 9 below. The patrol survey was sent to fifty-five officers, and we received twenty-six responses (a 47% response rate). The patrol responses are summarized in Figure 10 below.

Overall, both leadership and patrol officers were highly satisfied with the LECC program and reported a high level of understanding about the purpose and operation of the program.

There were a small number of questions with mixed results. For example, in the patrol officer survey, the question “the LECC program reduces the amount of time I spend on calls involving mental health/substance use crises” received answers ranging from strongly agree to disagree. Based on the findings presented in Table 8, we know, objectively, calls that involve an LECC co-response take longer to clear. However, as discussed above, some officers may be quantifying time savings by considering possible calls averted by LECC intervention or time saved by avoiding the emergency room.

The other question that received mixed results was “there are clear procedures about when to request the LECC come to the scene of a call.” This question appeared on both surveys. In the leadership survey, all respondents answered strongly agree or agree. However, in the patrol survey, answers ranged from strongly agree to disagree. This suggests that there may be benefits to ongoing training specifically surrounding in-person co-responses, since the same variation did not exist in the similar question about policies and procedures for making post-incident referrals.

Figure 9. Results from the Leadership Satisfaction Survey[20]



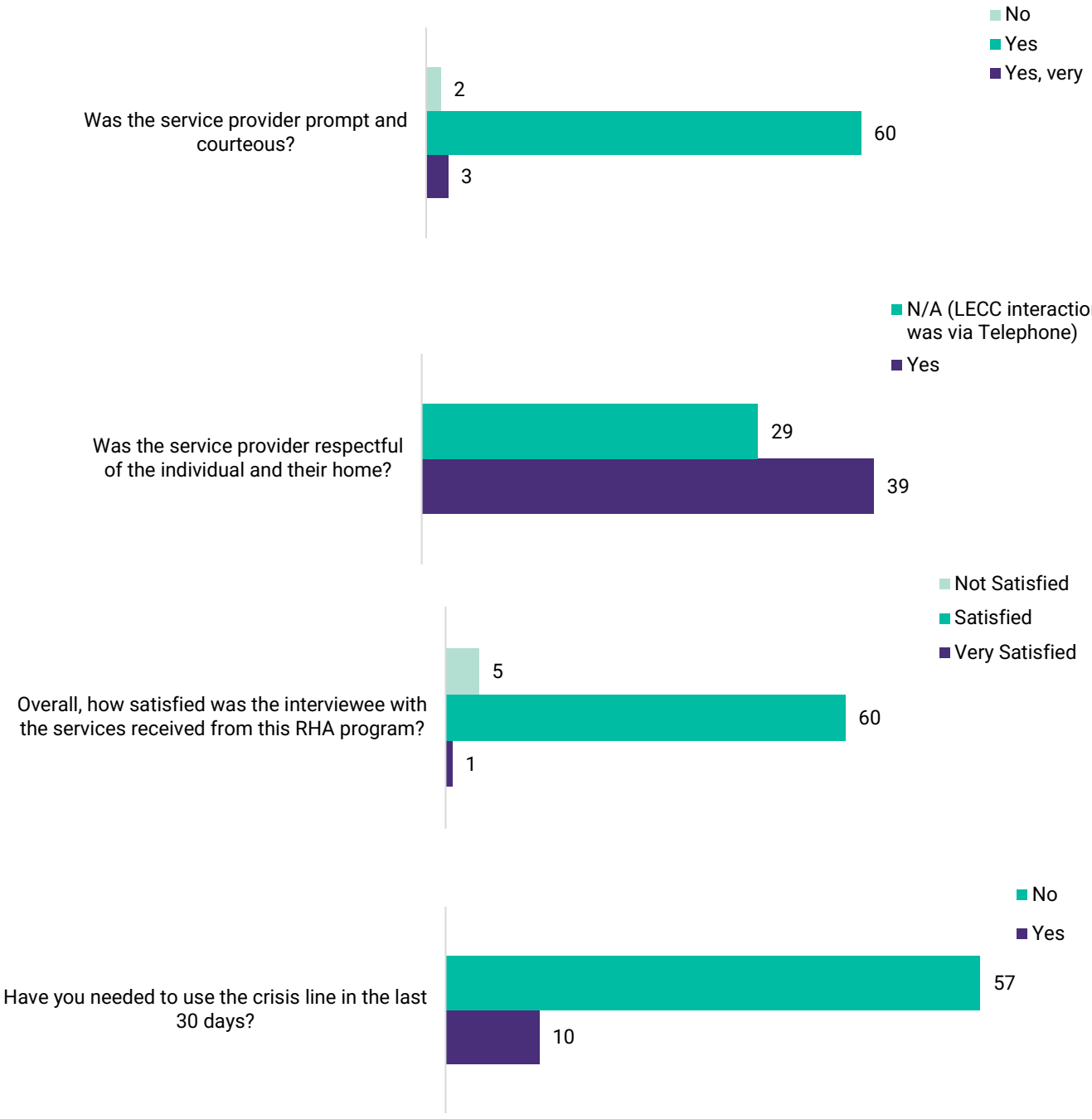
[20] Leadership did not answer "Disagree" or "Strongly Disagree" to any question.

Figure 10. Results from the Patrol Satisfaction Survey

Client Satisfaction

RHA has an existing Quality Call Back program where they randomly call clients who have been served by mobile crisis responders, including the LECC. Between April 2024 and February 2025, we asked RHA to focus their call backs to Burlington LECC clients. We received data from sixty-eight people, including sixty-four clients (94.1%), three family members of clients (4.4%), and one group home staff member (1.5%). Their answers to satisfaction questions are summarized in Figure 11. Overall, clients were highly satisfied with the LECC.

Figure 11. Summary Results for RHA Client Quality Call Back Surveys, April 2024 – February 2025



Community Partner Satisfaction

We intended to measure community partner satisfaction using a focus group of different service providers in Burlington and Alamance County. However, due to scheduling conflicts, we were only able to conduct two formal interviews with service providers. These formal interviews, along with informal conversations with community service providers throughout the life of the project, revealed a few central themes:

1. the LECC program has helped establish strong partnerships between the Burlington Police Department and community service providers;
2. choosing the right personnel has been critical to the LECC program's success; and
3. the benefits of the embedded LECC model versus a more traditional mobile crisis response.

Partnerships with Community Service Providers

The community service providers we spoke to were highly aware of the LECC program and its purpose. They noted that the crisis counselors have assisted with county and region-wide trainings on behavioral health, especially those for first responders, pointing to strong partnerships between the LECC program and the broader behavioral health infrastructure in the county. Service providers expressed a desire for additional LECCs in Burlington and a desire for LECC-type programs in other law enforcement agencies across the county. They noted that Burlington police officers are well-equipped to work with individuals who are experiencing behavioral health crises.

"A foundational skill that we teach in Crisis Intervention Training and in Mental Health First Aid is that, you know, you need to connect with [people in crisis] before you direct them… and I think that that's something [the Burlington Police Department] really have embodied." – Community Service Provider

The Importance of Personnel

Community partners noted that a key component of the LECC program's success was related to hiring the right personnel. They felt that the crisis counselors, especially in recent years, were successfully integrated into the department and that there was a strong bond between the crisis counselor and patrol officers.

"On the ground floor of [building a successful program] is, finding that right person, the right fit that's gonna be embedded in the culture of every day and being really clear…. you're viewed as not an officer per se, but you're part of this agency. Um, that you're not just some, you know, someone at another office that's coming into our agency. And I think that just takes time to build that trust and connection with those officers." – Community Service Provider

The Benefits of an Embedded Model

Similar to choosing the right personnel, community service providers also emphasized the benefits of having an embedded counselor in the police department. They described that all law enforcement agencies in the county have access to a mobile crisis unit that can be dispatched to calls where individuals are experiencing behavioral health crises. However, these units can take up to two hours to respond, and officers do not have the same relationship with the individuals who work with the mobile crisis unit. As such, the providers we spoke to felt that officers were less likely to use mobile crisis services.

"Working with law enforcement more and more, you realize if something's not effective, they're not gonna utilize it. Like if they have one bad experience or, you know, it's not getting them to the next step, then they're not gonna use it." – Community Service Provider

"Mobile crisis has up to two hours to respond... we know what happens in a crisis situation. It either goes like through the roof, and they're gonna have to arrest them… or it's gonna dissipate. And then when mobile crisis shows up, they're not in crisis anymore. – Community Service Provider

Discussion

In the introduction of this report, we describe how many alternative responder programs aspire to promote public safety, effectively connect people with needed services, and reduce reliance on the justice system to address social issues. The results of this evaluation demonstrate areas where the Law Enforcement Crisis Counselor program is achieving these goals, and areas where the impacts are mixed.

At its core, the LECC program has changed the default response to crisis calls in Burlington. Before the LECC program, officers responded alone to crisis calls and described having limited options to resolve the situation. Now, they regularly incorporate the expertise of a trained mental health professional, both in real time through co-responses and through the post-incident referral system. Hundreds of individuals receive support each year from the crisis counselor, and most clients do not have a repeat interaction with the program. Since 2021, only one call for service involving an LECC co-response has ended in arrest, and most calls are cleared at the scene. Additionally, calls with a real-time LECC response are less likely to result in an emergency room transport compared to behavioral health calls without an LECC response.

Satisfaction with the program is high across the board: among the police department, clients served by the program, and community service providers. Stakeholders attribute much of the success of the program to the specific embedded model used in Burlington, where the counselor is housed in the department, participates in department activities, and builds trust and rapport with the officers. In interviews, officers and community service providers frequently referenced how the LECC program, in combination with other initiatives, has led the Burlington Police Department to develop a culture that emphasizes de-escalation in crisis situations. Many officers felt that the LECC program has improved community relationships and increased trust in the police. While these benefits are not directly captured by the available quantitative data used in this report, they are important to recognize, particularly at a time when police departments nationwide are confronting strained police/community relationships and struggles to recruit and retain officers.

However, there are findings in this report that may speak to challenges achieving other program goals, like saving officer time on-scene and disrupting the cycle of justice-system involvement. On average, calls with a real-time LECC response took 21 minutes longer than other behavioral health calls and 47 minutes longer than non-behavioral health calls. While it is possible that calls receiving a real-time co-response are uniquely complex, the data show that there are not immediate time savings when a crisis counselor is called to the scene.

Additionally, these findings suggest that the crisis counselor intervention alone is not enough to successfully divert clients from justice-system involvement. While a minority of LECC clients have a criminal record or previous history of incarceration, those that do are at risk of continuing to cycle in and out of the court system and jails, even after they are referred to the LECC. We saw that clients continue to incur new criminal charges and be booked into jail at similar rates before versus after their LECC interaction. Additionally, when compared to a group of non-LECC individuals, LECC-clients were more likely to be charged with violent offenses and more likely to be charged with a new offense within two years of their initial LECC interaction.

It is possible that the Law Enforcement Crisis Counselor model is highly effective for some clients, which is why we see a relatively low rate of repeat interactions, but is less effective for clients that have additional risk factors—like an existing history of court system involvement. Future research could investigate outcomes among specific client populations to explore if different models of alternative response are, in fact, more or less effective depending on individual client characteristics, risk levels, and needs.

Recommendations

Other jurisdictions that have or are planning to implement alternative responder programs may be interested in conducting a similar evaluation to the one presented here. As such, we include the following recommendations for data collection and evaluation:

1. **Put procedures in place for robust data collection from the start.**
   One notable limitation of this evaluation is the fact that the LECC program began in 2015, but case management data was only available starting in 2021. Prior to 2021, crisis counselors did not keep separate records about their client interactions outside of HIPPA-protected health information. This gap in data collection means we were unable to conduct a true pre/post comparison and instead focused on program outcomes in recent years.

   Other communities that are interested in implementing alternative responder programs may benefit from having standardized data collection procedures in place from the start. This could include investing in case management software or simply creating an Excel spreadsheet with information on client interactions and outcomes.

   Keeping robust, clear records can make it easier for departments to conduct their own internal monitoring and evaluation over time, especially as staffing patterns might change. The ability to report on key outcomes can be critical for agencies seeking to maintain or expand funding for alternative responder programs.

   Appendix A includes a list of variables that agencies may consider tracking about their alternative responder programs. What a department chooses to track will depend on the needs of the agency and the goals of the program. However, generally, it is difficult to analyze data that consist of large amounts of free text or notes. It is simpler to track data in discrete categories with discrete answers. For example, instead of having an “Outcome” field where the alternative responder writes a note about what happened on the call, consider allowing only specific responses like “Arrested,” “Cleared,” “Emergency Room Transport,” etc.

2. **Create common definitions between alternative response data and other data sources.**
   When developing data collection procedures for an alternative responder program, agencies may benefit from first reviewing the data collection systems that are already in place. Most police agencies will have existing electronic CAD and RMS (Record Management Systems). When possible, ensure that the terminology and definitions used for the alternative responder program align with the existing definitions in current data collection.

   For example, many CAD systems have a “FOLLOW UP” nature code. What does this nature code mean in the context of regular law enforcement operations? Does it mean the officer has been

dispatched to follow up on a previous event? Does it mean that the officer is self-dispatching to an active call to gather more information? This can be an important distinction for alternative responders. If an alternative responder self-dispatches to an active scene and marks the call as "FOLLOW UP," it may be difficult to distinguish that activity from a scenario where the alternative responder is following up on a previous referral or following up with a client outside of an active incident. Alternative responders should be educated on how other first responders define and interpret different information, particularly in the CAD, so their documentation reflects a shared understanding.

3. **Use unique identifiers to tell the full story of a call for service.**
   For each call involving an alternative response, it may be beneficial for stakeholders to think about data collection as capturing the who, what, when, where, and why of each event. CAD data typically do not include reliable information about the person who calls 911 or the subject of the call. This means that CAD data alone are not enough to gather information on *who* receives services from an alternative responder. However, CAD data are an important tool to understand *when, where, and why* a call for service took place. As such, being able to link CAD data, case management data, and any other relevant event data the agency collects (i.e. RMS) is key to being able to tell the full story of a call for service. For each call, it may be beneficial to be able to identify:

   - When did the call come in? (i.e. date, time)
   - How did telecommunicators originally dispatch the call? (i.e. nature code)
   - How did the alternative responder get connected to the call? (i.e. direct dispatch, requested by officers at the scene, self-dispatch, etc.)
   - Who was the subject of the call, and why did they need support from the alternative responder? (i.e. demographic information, presenting symptoms, repeat client, etc.)
   - What did the alternative responder do when they arrived?
   - What was the outcome of the call? (i.e. arrest, transport, cleared, etc.)
   - Did the alternative responder connect with the client after the call for service?
   - What services did the alternative responder provide in subsequent follow up interactions?

   One way to facilitate this integration is to include the CAD event ID in every piece of documentation that relates to a call receiving an alternative response. For example, if the alternative responder records the CAD event ID in their case management spreadsheet, and the officer includes the CAD event ID in any records related to the call in RMS, then, all the relevant information for a single call for service could be linked back to the CAD. One potential benefit of investing in case management software for an alternative response program is that it may provide easier integration and linkage between different data sources.

4. **Consider additional training and collaboration with telecommunications to identify calls eligible for alternative response.**
   As described in the Program Scope section above, an important step in this evaluation was developing an algorithm to help identify calls that were potentially eligible for LECC intervention. The vast majority of the calls that we identified as LECC-eligible did not have any kind of flag, indicator, or nature code that would obviously signal that the call had a behavioral health

component. However, when reading the notes, it became clear that thousands of these calls for service were behavioral health related.

In real time and with limited information, it can be difficult for telecommunicators to differentiate between behavioral health concerns and a different type of emergency. Additional training and consultation may be beneficial to help telecommunicators identify and flag when a call may involve a behavioral health crisis. For data collection purposes, it may be beneficial to not only record these insights in the call notes, but also to have a discrete variable so that agencies could easily sort calls for possible behavioral health indicators. For example, there might be a checkbox that telecommunicators could click if they have a suspicion that mental health concerns or substance use are involved in the call. Even if that suspicion does not change the type of response that is dispatched in the moment, this type of data collection could help identify calls that are and are not appropriate for alternative response during later review of the data.

Appendix A. Variables to Collect for Alternative Response Evaluation

This appendix is meant to provide general guidance for jurisdictions that are deciding what information to track related to their alternative responder program. When making decisions about data collection, it is important to first consider the goals of your program, the key outcomes you want to track, and any reporting requirements for funders.[21] You may need to collect additional information that is not covered in the list below. Additionally, this appendix is focused on variables that may be helpful for evaluation and focuses on the who, what, when, where, and why of each event. There are other pieces of data that may be helpful for day-to-day case management, like collecting client contact information, which we have left off this list.

As discussed in the main body of the report, it is helpful to minimize the amount of data that is collected using free text or notes fields. It is time consuming to sort through notes manually, and data entry errors like misspellings can make automated sorting difficult. Instead, consider having discrete choices available for as many fields as possible to standardize the data collection process.

Department/Agency Information

- Number of police officers who have received any specialized behavioral health training (i.e. crisis intervention training, mental health first aid, etc.) [Record each training type separately]
- Number of dispatchers who have received any specialized behavioral health training (i.e. crisis intervention training, mental health first aid, etc.) [Record each training type separately]

Client Information

- Client First Name, Last Name, and Middle Initial
- Client Date of Birth
- Client Race
- Client Sex
- Client Housing Status (is the client unhoused?)
- Repeat Indicator (has the client had a previous interaction with the alternative responder?)

Incident Information

- CAD Event ID or other unique event ID
- Date of Incident
- Nature code from CAD (was the call initially coded as behavioral health-related?)
- Who responded? (law enforcement with an alternative responder? The responder by themselves?)
- Type of encounter (i.e. on-scene co-response, follow up, etc.)
- What were the presenting needs of the client? (i.e. mental health crisis, substance use crisis, homelessness, etc.)
- Location of encounter (both exact address and/or category like residence, business, etc.)

[21] To develop this appendix, we referenced the Bureau of Justice Statistics Connect and Protect performance measures. Stakeholders may find it helpful to review these performance measures to understand common requirements for state and federal grants. See https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/Connect-and-Protect-Measures.pdf.

- Was force used on the call? If so, what type of force?
- Were additional law enforcement resources called to the scene?
- Did the alternative responder feel safe on the call?
- Was an assessment or mental health screening done at the scene?
- Was anyone injured at the scene? (the officer, the alternative responder, or the subject)

Short-Term Outcomes

- Outcome of encounter (i.e. involuntary commitment, cleared at the scene, warm hand-off to resources, etc.)
- Did an arrest occur?
- Was a citation issued?
- Was the individual transported to the hospital? If so, was that transport for a medical emergency or for a behavioral health emergency?
- Was the individual transported to another facility or agency? If so, where?
- Was the client referred to additional services? If so, what services? (i.e. housing, mental health provider, food assistance, etc.)
- Was there a "warm hand-off" between the client and a social services provider? If so, what provider? (A warm hand-off would generally involve the alternative responder connecting the client to another provider face-to-face).

Long-Term Outcomes

- Did the alternative responder have additional follow-up contacts with the client?
    - What was the date of each follow-up contact?
    - What was the purpose of each follow-up contact? (i.e. routine check-in)
    - What was the outcome of each follow-up contact? (i.e. additional referrals, additional assessments, safety planning, etc.)
- Is there confirmation that the client has connected with or attended services? If so, what services?