The Crisis Assistance, Response, & Engagement (CARE) Team: Evaluating a Civilian Response Pilot in Orange County, North Carolina

Final Report
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Contents

Executive Summary

Across the country, jurisdictions are establishing alternative responder programs to promote public safety, effectively connect people with needed services, and reduce reliance on the justice system to respond to social issues. These programs take many forms, and some communities are exploring alternative response models where civilian teams respond instead of law enforcement to certain calls for service involving concerns like behavioral health and substance use crises. The following report evaluates a pilot of one such civilian response program, the Crisis Assistance, Response, and Engagement (CARE) Team, in Orange County, North Carolina.

The CARE Team includes a mobile crisis response team comprised of a mental health counselor, an emergency medical technician (EMT), and a peer support specialist. The Team also has a call diversion component, where a mental health counselor based in the 911 call center assists individuals in crisis over the phone while they wait for an in-person response, or, when appropriate, provides support that avoids an in-person response altogether. Through both components, the CARE Team provides a holistic response to 911 calls related to mental health concerns, substance use, intellectual and developmental disability, and low-level criminal offenses that are non-emergent and do not require a law enforcement response.

This evaluation focuses on the mobile crisis component during the first thirteen months of CARE Team operations from May 2024 to June 2025. Throughout this pilot period, the CARE Team only responded to calls in the town limits of Chapel Hill. Findings are divided into sections based on program scope, program outcomes, and criminal justice outcomes. The final section shares implementation lessons learned by Orange County and Chapel Hill Police Department stakeholders.

Key Takeaways

- **The CARE Team connects with the public in a number of ways, from responding directly to certain 911 calls to conducting follow-up and participating in community events.** During the pilot period, the CARE Team responded directly to 294 911 calls, provided a mobile response in an additional 394 events, and recorded 466 follow-up contacts.
- **The most common presenting issues for CARE Team clients were mental health concerns and homelessness.** Fifty-five percent of CARE Team mobile responses involved a homeless client, despite the fact that less than 1% of Orange County's population is experiencing homelessness.
- **Most calls that receive a CARE Team response are resolved at the scene after the Team provides supportive services like counseling and resource referrals.** CARE Team responses rarely end in a law enforcement action, with only six events resulting in arrest and five resulting in citations.
- **The data support that the types of 911 calls that have been identified for direct dispatch to the CARE Team are appropriate and safe for a civilian response.** The CARE Team did not abort any calls for safety reasons during the pilot period and the Team reported they felt they were able to effectively respond to community members' needs in 97.63% of mobile responses.
- **CARE Team responses save officer time.** When comparing similar 911 calls, CARE Team responses and law enforcement responses both took about 34 minutes on average. The CARE Team saved Chapel Hill Police Department officers between an estimated 118 and 172 hours of time during the pilot period by responding directly to 911 calls.

- **Chapel Hill and Orange County were uniquely positioned to support successful implementation of the CARE Team, yet lessons learned along the way may be applicable to any community interested in alternative response.** The Chapel Hill Police Department was one of the first in the country to incorporate alternative responders, so they had an existing supervision structure and culture to support the CARE Team. However, stakeholders in Orange County and Chapel Hill learned important lessons about prioritizing internal and external education, planning for necessary data collection, being mindful about alternative responder wellness, and creating space for ongoing collaboration that may be relevant for any community interested in establishing an alternative response program.

Introduction

As first responders, law enforcement officers are often tasked with addressing issues like homelessness, substance use, and mental health crises. In North Carolina, and across the country, there is growing interest in alternative responder programs to promote public safety, effectively connect people with needed services, and reduce reliance on the justice system to respond to social concerns.

Alternative responder programs take many forms. In a 2022 survey, 83% of responding North Carolina police departments reported they had access to at least one alternative response program, either housed within their department or through another community organization.[1] Some programs focus on having a behavioral health clinician respond alongside police when the department receives a call for service about a behavioral health emergency. Others focus on street outreach in an attempt to prevent future calls for service. Some are a mix of both or rely on different concepts altogether, like creating specially trained teams of officers who are able to identify and de-escalate behavioral health crises.

While not every alternative response model tries to divert individuals away from law enforcement interactions, there are communities exploring programs where civilian teams respond instead of law enforcement to certain non-emergent calls for service involving social issues and low-level criminal offenses. The following report evaluates a pilot of one such civilian response team in Orange County, North Carolina.

This evaluation was conducted by the UNC School of Government Criminal Justice Innovation Lab (the Lab), with support from Orange County, Alliance Health, and the North Carolina Department of Health and Human Services.[2]

About the Pilot Program

In 2023, Orange County approved a pilot of a new civilian crisis response program. A working group was convened in October of that year to develop, coordinate, and oversee implementation of the pilot. The original working group included:[3]

- Sarah Belcher, Police Crisis Division Supervisor for the Chapel Hill Police Department
- Caitlin Fenhagen, Orange County Deputy County Manager
- Celisa Lehew, Chief of the Chapel Hill Police Department
- Kirby Saunders, Orange County Emergency Services Director
- Christopher Ward, Orange County Emergency Services Division Chief for 911 Communications
- Landon Weaver, Orange County Emergency Medical Services Bureau Chief for Community Health and Safety; and
- Kim Woodward, Orange County Emergency Medical Services Division Chief.

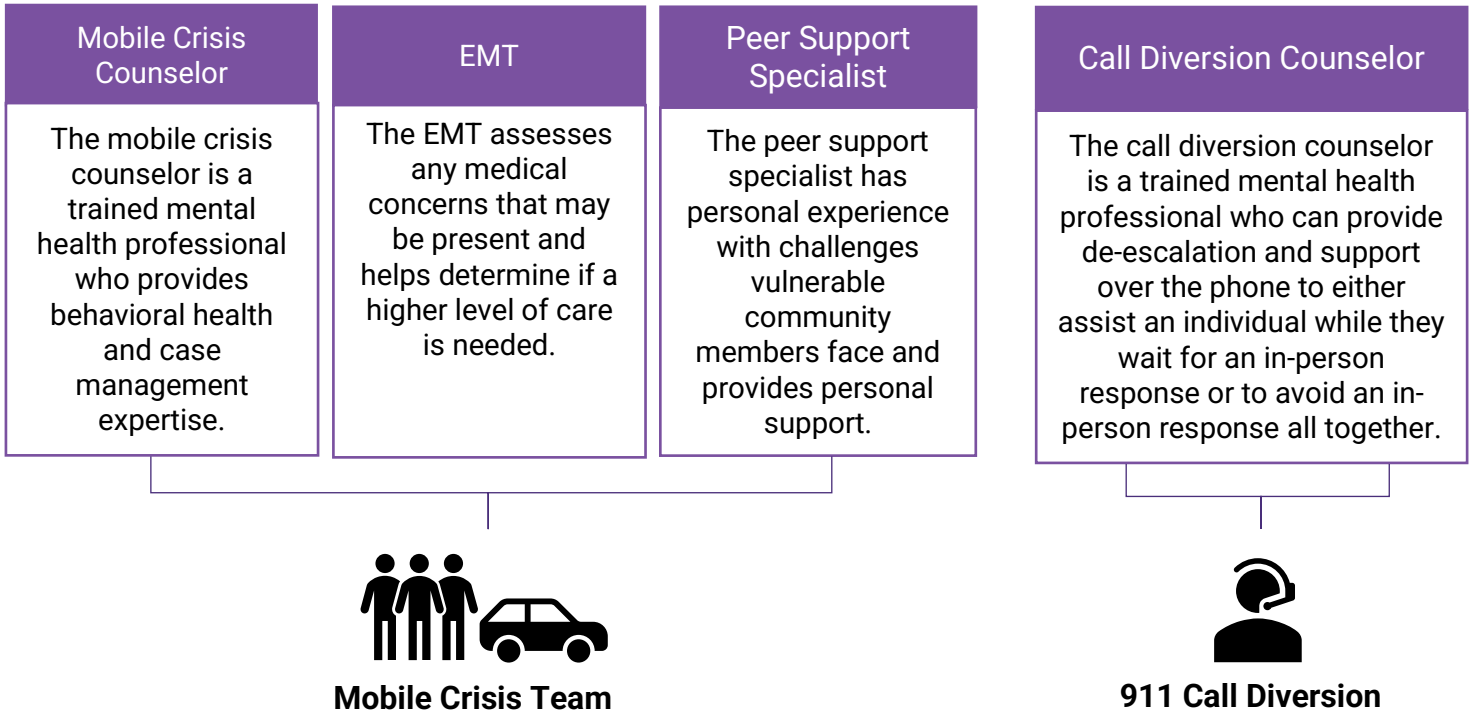
[1] Smith, J. et. al, (2023). *The alternative responder project: Final report.* UNC School of Government Criminal Justice Innovation Lab. https://cjil.sog.unc.edu/wp-content/uploads/2023/08/ARP-Final-Report_2023.7.31.pdf.

[2] Other contributors to this report include Jamie Vaske, Criminal Justice Innovation Lab Senior Research Associate; Maggie Bailey, Criminal Justice Innovation Lab Interim Director; and Jeff Welty, Professor of Public Law and Government.

[3] At the time of this report, this working group still meets regularly to discuss CARE Team operations. Additional individuals that contributed to the working group throughout the pilot period include CARE Team members Heather Palmateer, Jennifer Melvin, Alia Martin, Mari Hall, and RuthAnne Winston.

On May 6, 2024, the County officially launched the pilot of the Crisis Assistance, Response, and Engagement (CARE) Team. The CARE Team includes an all-civilian mobile crisis response team comprised of a mental health counselor, an emergency medical technician (EMT), and a peer support specialist. The Team also has a call diversion component, where a mental health counselor based in the 911 call center assists individuals in crisis over the phone while they wait for an in-person response, or, when appropriate, provides support that avoids an in-person response altogether. Through both components, the CARE Team provides a holistic response to 911 calls related to mental health concerns, substance use, intellectual and developmental disability, and low-level criminal offenses that are non-emergent and do not require a law enforcement response (Figure 1).

Figure 1. Members of the CARE Team



During the pilot period, CARE Team mobile crisis responses were limited to the Town of Chapel Hill.[4] Chapel Hill is the largest municipality in Orange County, with a population of about 60,000 people.[5] The Chapel Hill Police Department (CHPD) has had a Crisis Unit since 1973—one of the first police departments in the country to establish a partnership between the police and mental health professionals.[6] As such, CHPD had the existing infrastructure and expertise to supervise the CARE Team and support successful implementation.

It is important to note that Chapel Hill's Crisis Unit is a co-response model, where crisis counselors respond alongside police to calls for service involving psychiatric emergencies, intimate partner violence, accidents involving serious injury or death, and a variety of other circumstances that require a law

[4] At the time of the publication of this report, the CARE Team has now expanded operations into nearby Carrboro. However, since the data presented here were collected prior to the expansion, we will only focus on Chapel Hill.
[5] U.S. Census Bureau. (2023). *Chapel Hill, North Carolina.* American Community Survey 5-Year Estimates. https://censusreporter.org/profiles/16000US3711800-chapel-hill-nc/.
[6] Town of Chapel Hill. (2025). *Crisis Unit.* Chapel Hill Police Department. https://www.townofchapelhill.org/government/departments-services/police/specialty-units/crisis-unit.

enforcement response but benefit from the expertise of a behavioral health professional. In contrast, the CARE Team responds independently to calls that do not require a law enforcement response, like non-emergent welfare checks and some trespass calls. The types of events that receive a CARE Team response are described in detail in the Program Scope section of this report.

During the pilot, the CARE Team's business hours were Monday to Friday, 8:00 AM to 4:30 PM. The CARE Team wears polo shirts and drives a van with a CARE Team logo to clearly distinguish themselves from police (Figure 2).

Figure 2. Orange County CARE Team Logo

The CARE Team connects with community members in a variety of ways:

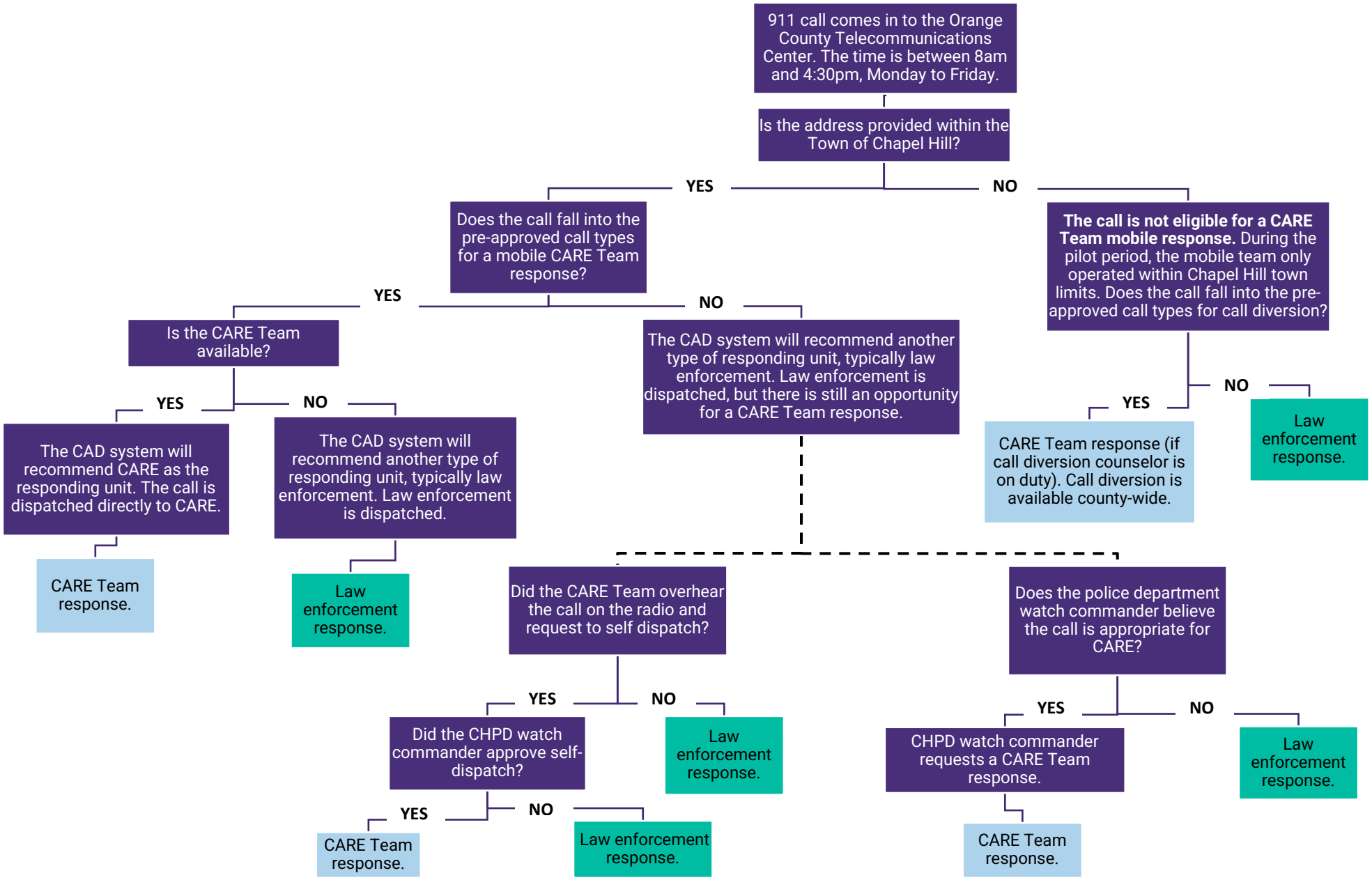
1. **Direct dispatch from 911.** The CARE mobile crisis team is dispatched directly to 911 calls related to social issues like substance use and mental health concerns, plus some low-level criminal offenses. The CARE Team is only dispatched to specific call types that stakeholders selected and programmed directly into the county's Computer-Aided Dispatch (CAD) system. When a 911 call comes in, a telecommunicator gathers information to determine if the call may be CARE-eligible. If the call is eligible, then the CAD system prompts the telecommunicator to dispatch the CARE Team. This direct dispatch model means that law enforcement officers are no longer the default response for the subset of CARE-eligible 911 calls.
2. **Request from the police department.** Sometimes, a call for service will be dispatched to police, but the senior CHPD officer overseeing the shift, called a watch commander, may determine that the call is appropriate for CARE Team intervention. These types of calls often involve individuals who are known to the police department and the CARE Team, so staff are able to appropriately assess the level of risk. In these situations, the police department might request that the CARE Team respond directly or co-respond to a call alongside law enforcement.
3. **Self-dispatch.** The CARE Team monitors radio traffic and may proactively request permission to respond or co-respond to a call for service if they believe they may be of assistance. Again, these types of requests might be because the CARE Team is already familiar with the individual who is the subject of the call. If the CARE Team requests a self-dispatch, the CHPD watch commander is responsible for deciding if it is appropriate for the Team to respond.
4. **Street outreach.** To provide a broader presence in the community, the CARE Team also regularly engages in street outreach, where they primarily connect with individuals in downtown Chapel Hill. While conducting outreach, they proactively provide resources and support to community members. The CARE Team also regularly participates in community events to increase awareness about the purpose of the program.
5. **Follow-up.** There are circumstances where CHPD officers come in contact with individuals who need additional support when the CARE Team is unavailable or off duty. In these situations, officers may refer community members to the CARE Team. In rare circumstances, a referral might also come from another community organization. When the CARE Team receives a referral, they will follow up with the community member and determine if they can help. In addition, the CARE Team

conducts their own self-directed follow-up with community members they have interacted with previously, though the program is not designed to provide long-term case management.

6. **Call Diversion.** The CARE Team includes a clinician position in the 911 call center to assist individuals in crisis over the phone while they wait for an in-person response or, in some cases, to provide support that avoids the need for an in-person response altogether. While the mobile crisis team only responded to calls within Chapel Hill town limits during the pilot period, call diversion was available for any Orange County 911 call. However, staffing challenges made it difficult to maintain a consistent presence in the call diversion role. Initially, two mental health clinicians were hired for the CARE Team with the intention of rotating the two between the mobile crisis role and the call diversion role. It was decided that the mental health clinicians would go through the full telecommunicator certification process so that they would be able to answer other 911 calls when diversion services were not needed. Each clinician went through the lengthy telecommunications training process separately, during which time the person in training had limited availability to answer calls and the other person was with the mobile crisis team. Then, in May 2025, one clinician left the program, and the remaining clinician was needed with the mobile team full-time. This resulted in a limited window during the pilot period where the CARE Team was able to successfully staff both the mobile crisis and call diversion components at the same time.

Figure 3 below shows the key decision points that result in a 911 call receiving a CARE Team response versus a traditional law enforcement response.

Figure 3. CARE Team Dispatch Flowchart



About the Evaluation

This evaluation report focuses on the mobile crisis component of the CARE Team during the pilot period, which ran from May 2024 to June 2025. As described above, it was difficult for Orange County to fully implement the call diversion component of the program during this time. **Only eighteen 911 calls received support from the call diversion counselor during the pilot period, which is not a large enough sample to use for the purposes of our data analysis.**

For analyses on the mobile crisis component, we used the following data sources:

- **Computer-Aided Dispatch (CAD) Data:** CAD data are primarily the information generated by telecommunicators as they answer 911 calls and dispatch resources. First responders 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. We received CAD data for every call dispatched to the Chapel Hill Police Department from January 1, 2022, to June 30, 2025.
- **Case Management Data:** CAD data typically do not contain specific identifiers about the subject of the call, so we rely on case management data collected by the CARE Team to provide information about individual contacts and services provided by the CARE Team. We received case management data from May 1, 2024, to June 30, 2025.[7]
- **Statewide Criminal Court Records Data:** Court records data from January 1, 2022, to September 30, 2025, are used in the criminal justice outcomes section of this report, in which we explore criminal court system involvement among CARE Team clients.
- **Incarceration Data:** Jail booking data from the Orange County Detention Center and state prison records from the North Carolina Department of Adult Corrections are also used in the criminal justice outcomes section to determine the incarceration history of CARE Team clients. We received jail data from January 1, 2022, to September 30, 2025. We reviewed historical state prison records for CARE Team clients that were incarcerated at any point before September 30, 2025.

Findings

The findings below are broken out into three sections: program scope, program outcomes, and criminal justice outcomes.

Program Scope

Between May 6, 2024, and June 30, 2025, the CARE Team was involved in 1,154 interactions with the public. We divide these events into mobile responses and follow up.

[7] Note that the CARE Team case management data does not include protected health information.

Mobile Responses

Direct 911 Dispatch

For the CARE Team to be dispatched to a 911 call, the call must meet specific criteria related to the content of the call, the request of the caller, and the safety risks presented by the situation. In general terms, most of the calls that the CARE Team is dispatched to are related to trespassing, welfare checks, behavioral health concerns, and public nuisances. When the 911 center telecommunicators route a call directly to the CARE Team, we refer to it as **direct 911 dispatch.**

624 911 calls were CARE-eligible, and **294** received a CARE Team response.

Between May 6, 2024, and June 30, 2025, 624 911 calls met the criteria for a direct CARE dispatch.

Of those 624 eligible 911 calls, the CARE Team responded to 294 (47.11%). Table 1 below shows the breakdown of the CAD nature codes for the 911 calls that were dispatched directly to the CARE Team. These nature codes are generated in the CAD system and provide a general indication about the primary reason for the call.

Trespassing/Unwanted Person was the most common nature code receiving a CARE Team response. Trespassing was followed closely by Public Service, which is the code used for general welfare checks (i.e., checking on someone who appears to be asleep in a car).

Table 1. Nature Codes of 911 Calls Receiving a CARE Team Direct Dispatch

Nature Code	Number of Calls	Percent of Calls
TRESPASSING/UNWANTED PERSON	137	46.59%
PUBLIC SERVICE	116	46.69%
DISTURBANCE/NUISANCE	22	7.48%
MENTAL DISORDER	15	5.10%
INDECENCY/LEWDNESS	4	1.36%

The remaining 331 eligible 911 calls did not receive a CARE Team response, which means they were routed to law enforcement instead. The reasons for those non-responses are outlined in Table 2 below. The most common reason that eligible calls did not receive a CARE Team response was because the team was out-of-service or logged out, followed by being busy on another call.

Table 2. Reasons the CARE Team Did Not Respond to Eligible Calls for Service

Reason for CARE Team Non-Response	Number of Calls	Percent of Calls
Out-of-Service/Logged Out[8]	144	43.50%
Busy on a Different Call	120	36.25%
Subject Left the Scene/Call Cancelled	18	5.44%
Safety Concern	11	3.32%
Caller Requested Police Response	17	5.14%
Other	21	6.34%
Total	**331**	**100%**

Table Note: The "Other" category includes situations where there was not enough information to determine why the CARE Team did not respond in addition to one-off, uncommon circumstances like calls that were transferred to a different police department.

Throughout the pilot period, there were a variety of factors that contributed to non-responses. For example, it was discovered within the first few months of operation that the CARE Team was occasionally marked as busy when they were doing street outreach activities, meaning 911 calls were being routed to law enforcement even though the CARE Team was available to respond. After changing practices to make sure the team was marked as "available" during street outreach, the number of non-responses dropped. Additionally, it is not uncommon for training, meetings, planned community events, or personal leave to result in one or more CARE Team members being unavailable during business hours. While the Team will still respond to calls in some circumstances without the whole group being available, absences can result in the Team being logged out and some CARE-eligible calls being routed to law enforcement.

Secondary Dispatch

While the CARE Team was primarily designed to be dispatched directly from the 911 call center, stakeholders recognized additional circumstances where it was appropriate for the Team to respond to a call even if it did not fall into the pre-determined eligible call types. For example, if a call comes into 911 about an individual who has already been served by the CARE Team, the Team may overhear the call on the radio and request to respond. Similarly, the CHPD watch commander may request a CARE Team response.

The willingness of CHPD and Orange County to expand the CARE Team's reach and allow for discretion when deciding to dispatch the Team is the result of a long history of civilian crisis response in Chapel Hill. CHPD leadership feels confident in their ability to assess a situation and determine if an alternative response is appropriate, and they have specific Crisis Unit supervision to provide guidance and oversight to alternative responders. Another community without an established culture of alternative response may not be as comfortable with this approach.

When the CARE Team responds to a call for service as a result of self-dispatch or police department request, we refer to this as **secondary dispatch**.

[8] Out-of-service and logged out are both indicators that the CARE Team is unavailable. Sometimes, calls that come in very close to the team's stated business hours (i.e., 8:05am, 4:25pm), do not receive a CARE response because the team is not yet ready to respond to calls or has already clocked out for the day. Twelve calls did not receive a CARE response because the Team was out-of-service, and 132 did not receive a CARE response because the Team was logged out.

In addition to the 294 calls that received a direct dispatch, the CARE Team documented 394 mobile crisis responses as a result of secondary dispatch. The CARE Team self-dispatched to 203 events and the police department requested they be dispatched to 168 events.[9] Additionally, while the Team and CHPD are ultimately responsible for deciding if the CARE Team responds to a call, sometimes these secondary dispatches are prompted by a third party requesting a CARE Team response.

394 CARE mobile crisis responses **were initiated by self-dispatch or police department request.**

Table 3 shows the breakdown of secondary responses resulting from a third-party request for a CARE response, and what entity made that request.

Table 3. Breakdown of Third-Party Entities Requesting a CARE Team Secondary Dispatch

Entity Requesting CARE Team Response	Number of Requests
Business	22
Community Agency	35
Community Member	67
Family Member	18
Individual in Crisis	21
School	2
Total	**164**

Follow Up

Along with mobile responses, the CARE Team also engages in follow-up and outreach activities that are not always tied to specific calls for service.

In the case management data, the CARE Team reported sixty-eight instances where they engaged in outreach. However, that number likely does not reflect the full scope of the team's outreach activities, as outreach was not always tracked in the case management data. When engaging in outreach, CARE Team members might pass out supplies, talk to members of the community, and generally increase awareness of social services and the CARE Team program. The CARE Team has also participated in a variety of community events, including resource fairs and conferences.

Outreach activities provide important opportunities for the CARE Team to build relationships with community members. If a call comes in involving one of these community members in the future, an existing relationship can contribute to a more effective response. Stakeholders reported that individuals who are familiar with the CARE Team are more willing to talk to and cooperate with CARE Team members compared to other first responders that they may not know, allowing the Team to successfully resolve situations. Furthermore, stakeholders expressed that the CARE Team's consistent presence in the community and their ability to engage in timely follow-up has resulted in a reduction in some 911 calls, although the absence of certain 911 calls is difficult to measure in the available data.

[9] We could not determine who initiated dispatch for twenty-three secondary dispatch events.

While outreach is not tracked as consistently, the CARE Team does document when they engage in follow up with members of the community. Follow up activities are either self-initiated by the CARE Team or requested by another entity. The majority of the time, these requests come from the CHPD after an officer has an interaction with an individual who may benefit from connection to the CARE Team. When the Team receives a referral, they then reach out to the individual, either via phone, email, or in person, to see if they can offer support.

In total, the CARE Team documented 466 follow up contacts between May 6, 2024, and June 30, 2025. Table 4 breaks down those contacts based on who made the request for follow-up. The majority of follow-up contacts were requested by CHPD officers (78.51%)

The CARE Team documented **466 follow up contacts** during the pilot period.

Table 4. Number of Requests for CARE Team Follow Up Contacts by the Requesting Entity

Entity Requesting CARE Team Follow Up	Number of Requests	Percent of Requests
Chapel Hill Police	369	78.51%
CARE Team Self-Initiated	61	12.98%
Community Member	19	4.04%
Chapel Hill Crisis Unit	15	3.19%
Family Member	3	0.64%
EMS	2	0.43%
Street Outreach, Harm Reduction and Deflection Program (SOHRAD)[10]	1	0.21%
Total	**470**	**100%**

Table Note: Four events had multiple requesters, which is why the total of requests (470) is larger than the total number of follow-up contacts (466).

Table 5 below shows the location of each follow up interaction. The majority of follow up contacts took place either via phone (46.81%) or email (28.72%).

Table 5. Location of CARE Team Follow Up Contacts

Location	Number of Follow Up Contacts	Percent of Follow Up Contacts
Phone	220	46.81%
Email/Mail[11]	135	28.72%
Community	79	16.81%
Business	13	2.77%
Virtual Meeting	11	2.34%
Residence	7	1.49%
Police Department	3	0.64%
Campsite	1	0.21%
Hospital	1	0.21%
Total	**470**	**100%**

Table Note: Four events had multiple locations, which is why the total of locations (470) is larger than the total number of follow up contacts (466).

[10] SOHRAD is an Orange County street outreach program specifically focused on serving people experiencing homelessness.
[11] 134 follow up contacts were via email; one was via paper mail.

Client Demographics

Across the 1,154 mobile responses and follow-up interactions described above, the CARE Team served 457 unique individuals in Chapel Hill. In the section below, we report on client demographic information divided up by whether the client appeared in the mobile response data (276 individuals) or the follow-up data (also 276 individuals). There are 95 individuals who appear in both categories and, as such, their data may be represented in both sets of analyses.[12]

Race & Ethnicity

Figure 4 below shows the racial and ethnic breakdown of individuals served by a mobile response. Figure 5 shows the same information for people served in follow-up interactions. As a point of comparison, the population of Chapel Hill is 63.8% White, 10.8% Black, and 13.1% Asian. Seven percent of the population is Hispanic.[13]

Note that racial information was not available for all individuals. One hundred sixty-six people (60.15%) in the mobile response data and 181 people (65.58%) in the follow up data had racial information available.

Figure 4. Racial Breakdown for Individuals Served via Mobile Response

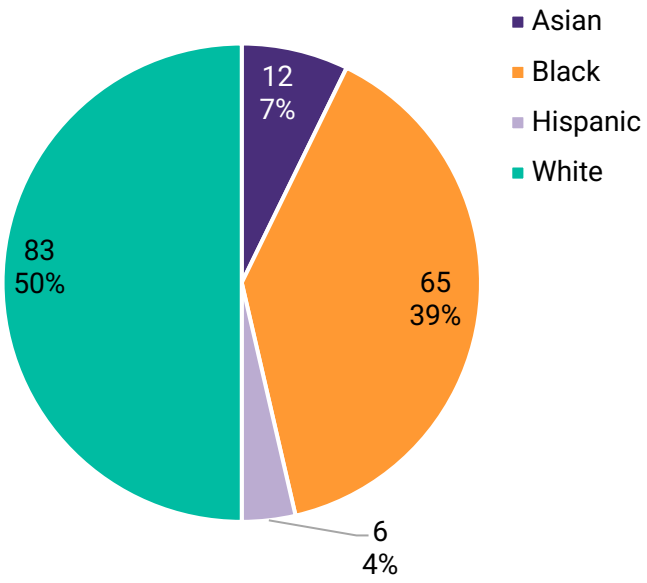
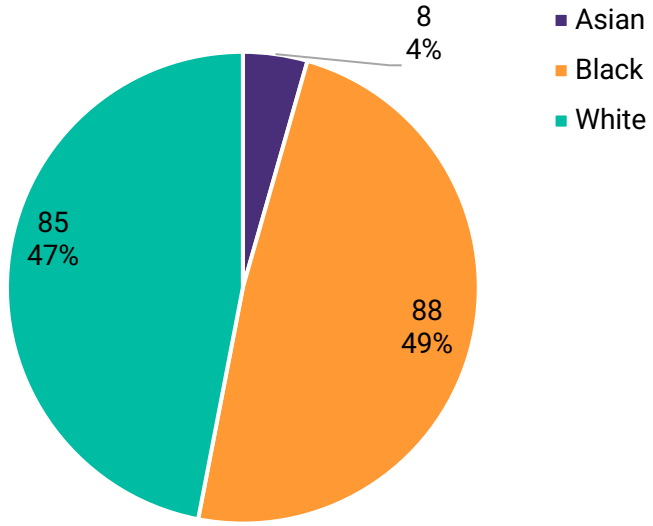


Figure 5. Racial Breakdown for Individuals Served via Follow Up Contact



Gender

Figure 6 shows the gender breakdown for individuals served by a mobile response, and Figure 7 shows the same information for people served in follow-up interactions. As a point of comparison, Chapel Hill's population is 53% female and 47% male.[14]

[12] While the CARE Team attempts to collect complete demographic information, some data on race and age is missing. In some crisis situations, it may not be appropriate or feasible to ask clients to provide demographic information.
[13] U.S. Census Bureau. (2023). *Chapel Hill, North Carolina.* American Community Survey 5-Year Estimates. https://censusreporter.org/profiles/16000US3711800-chapel-hill-nc/.
[14] *Id.*

Figure 6. Gender Breakdown for Individuals Served via Mobile Response

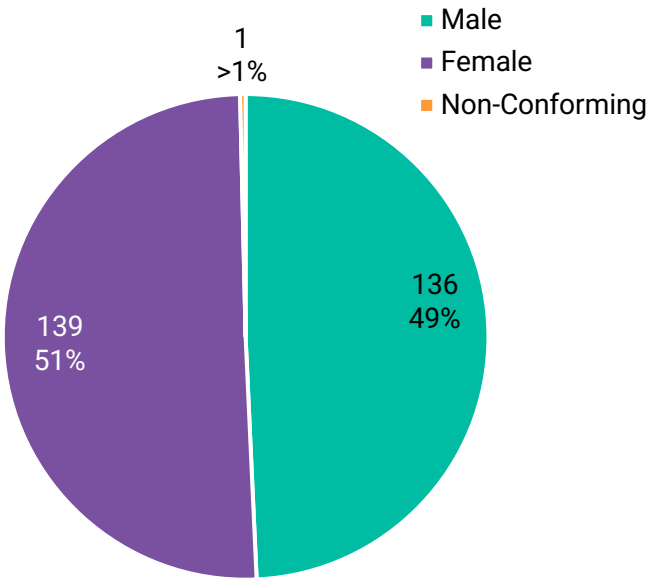
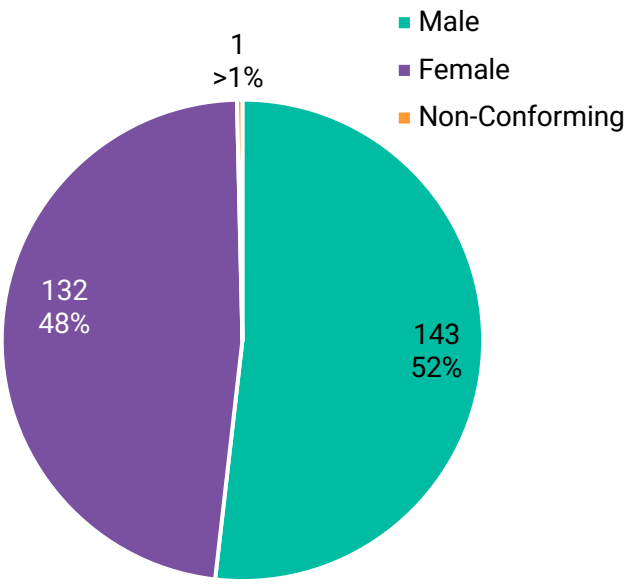


Figure 7. Gender Breakdown for Individuals Served via Follow Up Contact



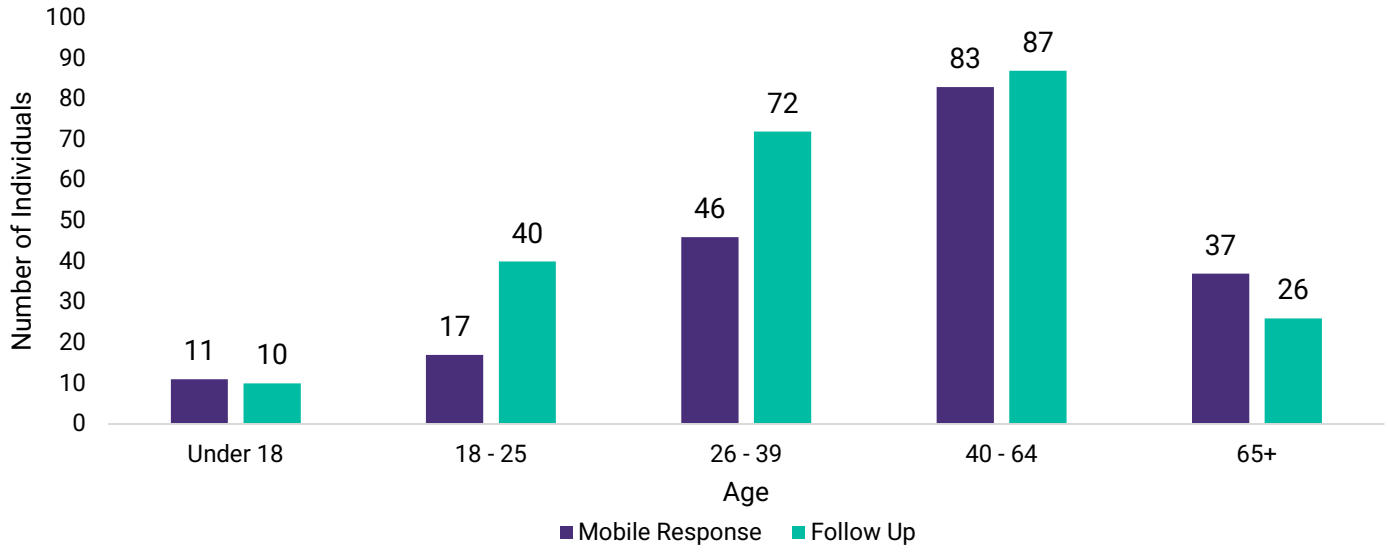
Age

Figure 8 shows the age breakdown for individuals served via mobile responses and follow-up interactions. The average age for an individual served via a mobile response was forty-seven, while the average age for an individual served via a follow up contact was forty-two.

The youngest person served by the CARE Team in either category was seven. The oldest person served in either category was ninety-eight.

Note that not all individuals had a birthdate listed in the data. One hundred ninety-four individuals (70.30%) served via a mobile response and 208 individuals (75.36%) served via follow up contact had a birthdate available.

Figure 8. Age Breakdown for Individuals Served via Mobile Response and Follow Up Contacts



Presenting Issues

When the CARE Team interacts with a community member, they document presenting issues that they are made aware of or observe. Some presenting issues relate to the reason for the response, like a mental health event or trespassing. Others reflect the individual's needs but are not the reason for a response, like homelessness or food insecurity. As such, most individuals have multiple presenting issues.

Table 6 below shows the prevalence of presenting issues for individuals served via mobile response and follow-up interactions. **Mental health events and homelessness were the most common presenting issues for both mobile responses and follow-up interactions.** The proportion of events that involve homeless individuals is notable considering that less than 1% of Orange County residents are experiencing homelessness.[15]

[15] Orange County Partnership to End Homelessness. (2025). *Point-In-Time Count and Monthly Homelessness Report.* http://server3.co.orange.nc.us:8088/WebLink/DocView.aspx?dbid=0&id=75759&page=3&cr=1

Table 6. Breakdown of Presenting Issues for CARE Team Clients

Mobile Crisis Response			Follow Up Interactions		
Presenting Issue	**Number of Individuals**	**Percent**	**Presenting Issue**	**Number of Individuals**	**Percent**
Mental Health	320	62.55%	**Mental Health**	268	57.51%
Homelessness	283	55.49%	**Homelessness**	220	47.21%
Substance Use	150	29.41%	**Substance Use**	156	33.48%
Trespassing	120	23.53%	**Trespassing**	123	26.39%
Interpersonal Conflict	100	19.61%	**Interpersonal Conflict**	99	21.24%
Financial Stressors	85	16.67%	**Disturbance**	80	17.17%
Disturbance	68	13.33%	**Financial Stressors**	66	14.16%
Medical Event	67	13.14%	**Medical Event**	36	7.73%
Elder/Aging Issues	64	12.55%	**Family Conflict**	32	6.87%
Housing Insecurity	50	9.80%	**Housing Insecurity**	27	5.79%
Family Conflict	50	9.80%	**Elder/Aging Issues**	27	5.58%
Psychiatric Emergency	20	3.92%	**Suicidal Ideations**	14	3.00%
Threats	19	3.73%	**Psychiatric Emergency**	12	2.58%
Suicidal Ideations	19	3.73%	**Threats**	12	2.58%
Interpersonal Violence	10	1.96%	**Physical Attack**	8	1.71%
Homicidal Ideations	9	1.76%	**Interpersonal Violence**	6	1.29%
Indecent Exposure	8	1.57%	**Homicidal Ideations**	5	1.07%
Physical Attack	8	1.07%	**Indecent Exposure**	5	1.07%
Sexual Violence	7	1.37%	**Stolen Property**	4	0.21%
Missing/Runaway	6	0.59%	**Sexual Violence**	3	0.64%
Legal Issues	3	0.39%	**Hygiene**	2	0.21%
Other	3	0.20%	**Other**	2	0.21%
Transportation	2	0.39%	**Food Insecurity**	1	0.21%
Stolen Property	1	0.20%	**Outreach**	1	0.21%
Reentry Needs	1	0.20%	**Missing**	1	0.21%
Medical Needs	1	0.20%			
Driver's License Inquiry	1	0.20%			
Dead on Arrival	1	0.20%			

Table Note: The CARE Team often documents multiple presenting needs, so the total number that is identified is greater than the number of unique clients.

Repeat Client Interactions

In total, the CARE Team documented interactions with 552 people between May 2024 and June 2025. Two hundred seventy-six individuals appeared in the mobile response data and another 276 appeared in the follow-up data. However, ninety-five individuals (17.21% of all clients) appeared in both categories, meaning of the 552 total documented interactions, the CARE Team served 457 unique individuals.

17.21% of clients appear in both the mobile response and follow up data.

Table 7 shows the number of mobile responses per unique individual. Of the 276 individuals who were served via a mobile team response, eighty-eight (31.88%) were the subject of more than one mobile response. One individual was the subject of twenty-eight mobile responses.

Table 7. Number of Mobile Responses per Individual

Number of Follow Ups	Number of Individuals	Percent of Individuals
1	188	68.12%
2	44	15.88%
3	16	5.78%
4	6	2.17%
5	9	3.25%
6	5	1.81%
7	0	0%
8	1	0.36%
9	1	0.36%
10+	6	2.17%

Table 8 shows the number of contacts for each unique individual in the follow up data. As described above, only ninety-five individuals appear in both the mobile response and follow up data. Meaning, despite the name, a follow up contact is frequently an individual's first interaction with the CARE Team, considering that many follow up interactions are the result of referrals from CHPD officers.

Seventy-three percent of individuals had one follow up contact. However, a small number of individuals (four) had ten or more follow up contacts between May 2024 and June 2025, with one person having nineteen follow up contacts in that time.

Table 8. Number of Follow Up Contacts per Unique Individual

Number of Follow Ups	Number of Individuals	Percent of Individuals
1	204	73.91%
2	35	12.68%
3	11	3.99%
4	10	3.62%
5	6	2.17%
6	4	1.45%
7	1	0.36%
8	1	0.36%
9	0	0%
10+	4	1.44%

These data reflect the fact that most individuals only had one interaction with the CARE Team during the pilot period. However, in rare circumstances, the CARE Team has become very involved in case management and invested considerable time in multiple interactions with the same clients.

Program Outcomes

This section provides an overview of outcomes for both mobile responses and follow up interactions. In total, between 911 dispatches and secondary dispatches, there were 688 mobile events. Five hundred sixty-seven were documented in the CARE Team's case management data, which is the data source used for the following analyses. As such, some mobile responses are not captured in these analyses. Case management data was available for all 466 follow-up contacts.

Event Outcomes

In the case management data, the CARE Team documents the outcomes for each interaction. The outcomes can include the services provided (i.e., resource referrals, supportive counseling, etc.) and the final disposition of the event (i.e., arrested, hospital, trespassed, etc.). As such, most events have more than one outcome. Table 9 below shows the outcomes for each mobile response and follow up contact.

Supportive counseling and resource referrals are the most common services provided during CARE Team interactions.

The most common outcomes among mobile responses and follow up interactions were similar, with supportive counseling, resource referrals, and informal supports in the top five for both categories. "No response" was the second-most common outcome for follow up interactions, meaning the CARE Team reached out to an individual but did not hear back.

Criminal justice outcomes like citation or arrest are uncommon, with only six total interactions across both categories ending in an arrest and five ending in citations. Twenty-five interactions resulted in a co-response, where law enforcement and the CARE Team interacted with the individual together.

Table 9. Outcomes for CARE Team Interactions

Mobile Crisis Response			Follow Up Interactions		
Outcomes	**Number of Events**	**Percent**	**Outcomes**	**Number of Events**	**Percent**
Referred to Resources	192	33.86%	**Referred to Resources**	218	46.38%
Supportive Counseling	140	24.69%	**No Response**	78	16.60%
De-escalation	73	12.87%	**Supportive Counseling**	50	10.64%
Education	66	11.64%	**Informal Supports**	37	7.87%
Referred to Law Enforcement[16]	42	7.41%	**Education**	23	4.89%
EMS	39	6.88%	**Obtained/Provided Collateral**	15	3.19%
Hospital	36	6.35%	**Trespassed**	14	2.98%
Informal Supports	35	6.17%	**Call Diversion**	9	1.91%
Safety Planning	32	5.64%	**Referred to Primary Treatment Provider**	9	1.91%
Transportation	30	5.29%	**Family Support**	8	1.70%
Referred to Primary Treatment Provider	28	4.94%	**Referred to Law Enforcement**	8	1.70%
Family Support	27	4.76%	**Safety Planning**	8	1.70%
Co-Response	24	4.23%	**Hospital**	3	0.64%
Trespassed	12	2.12%	**Shelter**	3	0.64%
Involuntary Commitment	12	2.12%	**De-escalation**	3	0.64%
Detox	10	1.76%	**Transportation**	2	0.43%
Call Diversion	9	1.59%	**Voluntary Commitment**	2	0.43%
Voluntary Commitment	8	1.41%	**Arrested**	2	0.43%
Shower	5	0.88%	**Harm Reduction**	2	0.43%
Arrested	4	0.71%	**Shower**	2	0.43%
Cited and Released	4	0.71%	**Care Coordination**	2	0.43%
Other	4	0.71%	**EMS**	1	0.21%
Harm Reduction	3	0.53%	**Co-Response**	1	0.21%
Welfare Check and Coordination	1	0.18%	**Detox**	1	0.21%
Shelter	1	0.18%	**Cited and Released**	1	0.21%
Declined	1	0.18%			
Outreach	1	0.18%			
Advocacy	1	0.18%			

While most CARE Team interactions are resolved at the scene, the Team does transport clients on occasion. In total, there were 24 interactions where the CARE Team provided transport. Table 10 below shows the breakdown of where clients were transported.

[16] The outcome category "referred to law enforcement" does not necessarily indicate that law enforcement was called to the scene or that the client received a legal consequence. It could also mean that the individual was referred to contact law enforcement to address a concern like domestic violence.

Table 10. Breakdown of Destinations for Transport Provided by CARE Team

Transportation Destination	Number
Behavioral Health Facility (Non-Hospital)	4
Community Resource	4
Emergency Room/Hospital	2
Family or Friends	2
Nursing Home/Elder Care Facility	1
Police Department	4
Shelter	4
Other	3

If an individual needs to be transported to the hospital for a medical or behavioral health emergency, the CARE Team will request EMS or law enforcement. Table 11 shows the breakdown of these transports based on if the emergency was medical or behavioral health-related, and who conducted the transport.

Table 11. Non-CARE Hospital Transports by Reason and Transporting Agency

Reason for Hospital Transport	Number of EMS Transports	Number of Law Enforcement Transports
Medical Emergency	12	3
Behavioral Health Emergency	13	9
Total	**25**	**12**

While it is difficult to determine exactly how many emergency room visits were avoided due to CARE Team intervention with the available data, the EMT on the CARE Team is asked after each response if their presence or actions diverted from unnecessary EMS usage. **The EMT reported that their presence or actions diverted from unnecessary EMS usage in fifty-four mobile responses and six follow up events.**

Connection to Services, Support, and Supplies

In addition to the services reflected in the outcome data, the CARE Team also distributes supplies like hygiene products, blankets, water, and other items to community members. The Team reported that they provided supplies during 229 mobile responses and fifty-eight follow up interactions.

Through the outcome data presented in Table 9, we can assume that at least 220 mobile interactions (38.80%) and 227 follow up interactions (48.30%) resulted in referrals to a treatment provider or other resources. Additionally, the Team documented 518 instances where they provided services directly, including supportive counseling, informal supports, education, de-escalation, safety planning, care coordination, and harm reduction.[17]

At least **38.8%** of mobile responses and **48.3%** of follow-up interactions result in resource referrals.

[17] The CARE Team often provides multiple services during a single interaction.

Team Confidence & Safety

A key consideration for communities with civilian crisis response programs is the safety of team members. **According to the case management data, the CARE Team aborted zero calls for safety concerns between May 2024 and June 2025.**

The CARE Team **did not abort any calls due to safety concerns** during the pilot period.

After every response, Team members also document if they felt safe on scene and if they felt the CARE Team was the appropriate response for the situation. **Of the 576 documented mobile responses, there were four instances where at least one CARE Team member reported feeling unsafe.** Three of these were situations where the CARE Team self-dispatched to a call, and one was a direct dispatch from 911.

The CARE Team did identify thirty-one calls where they felt that a different response would have been more appropriate, and the suggested response for those calls is outlined in Table 12. A police response was suggested as more appropriate in only six cases.

Table 12. Breakdown of More Appropriate Response Type Suggested by CARE Team Members

Suggested Non-CARE Response	Number
Call Diversion Clinician (No In-Person Response)	4
Chapel Hill Crisis Unit (Co-response)	13
EMS	7
Police	6
Street Outreach, Harm Reduction and Deflection Program (SOHRAD)	1

Finally, the CARE Team documents after every interaction if they felt they knew how to respond to the community members' needs. **The CARE Team answered "yes" in 97.63% of mobile responses and 99.14% of follow up interactions.**

Overall, these data suggest that the types of calls that have been identified for a CARE Team response are appropriate and safe for a civilian response team.

Time Savings

One of the primary goals of the CARE Team is to divert law enforcement time and resources away from calls related to social issues and low-level criminal activity that can be safely addressed by a different response. To assess potential law enforcement time savings created by the CARE Team, we compared:

(1) CARE-eligible 911 calls that received a CARE Team response; and
(2) CARE-eligible 911 calls that occurred during CARE business hours but did not receive a CARE response, typically because the CARE Team was busy on another call or logged out (Table 2).

The calls in the second category received a traditional law enforcement response.

Table 13 shows the median and average time on scene for calls that fall into both groups. Because averages are more susceptible to influence from outliers compared to medians, we provide both numbers. These results show that response times to eligible 911 calls are similar no matter whether there is a CARE

Team or law enforcement response. These data suggest that the CARE Team is able to provide additional services and support while continuing to clear calls in a time frame similar to law enforcement.

Table 13. Time on Scene Comparison for CARE-Eligible 911 Calls

Type of Response	Average Time on Scene	Median Time on Scene
CARE Response	33.52 minutes	26.20 minutes
Law Enforcement Response (During CARE Business Hours)	35.28 minutes	24.27 minutes

Since law enforcement and CARE responses are closely aligned in terms of time on scene, we can more accurately estimate officer time saved when the CARE Team is able to respond in lieu of law enforcement.

The CARE Team responded to 294 calls for service via direct 911 dispatch from May 2024 to June 2025. If we use both the average and median law enforcement response time estimates from Table 13 (24.27 minutes and 35.28 minutes), we can estimate that the CARE Team saved CHPD officers between 118.92 hours and 172.87 hours by responding to calls dispatched directly by 911.

By responding directly to 911 calls, the CARE Team saved **a minimum of 118 hours of officer time.**

These estimates should be considered a minimum. A complete picture of officer time savings would reflect time saved by all types of CARE Team responses, including follow-up activities, and would encompass time saved by avoiding arrests, reports, court dates, transport, and other administrative tasks. Stakeholders expressed that CARE Team responses also save time for staff members at local organizations that frequently engage with individuals in crisis, like staff members at the library and the local homeless shelter. Quantifying these additional, more nuanced time savings is not possible with the available data.

Criminal Justice Outcomes

As described in the program outcomes section, it is rare for a CARE Team interaction to result in a criminal charge or arrest. However, CARE Team clients may have other interactions with the criminal justice system. In this section, we review both court records data and incarceration data to learn more about criminal justice history for CARE Team clients both before and after their initial connection to the CARE Team.

Court System Involvement

Of the 457 total unique CARE clients, 426 (93.01%) had sufficient information, including their names and birth dates, to search court system records.

Court History Prior to CARE Team Interaction

Out of the 426 clients with sufficient information, 136 (31.92%) had a criminal charge in the two years prior to their initial CARE Team interaction. Because the court system records are statewide, these criminal charges could have occurred in Orange County or in another county.

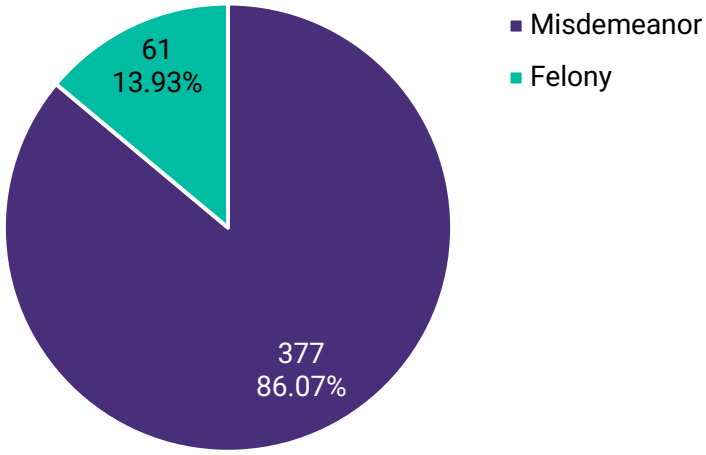
Of the people that had a previous history of court system involvement, 43.38% had one criminal incident in the two years prior to their CARE Team interaction (Table 14).[18]

Table 14. Number of Incidents per CARE Client with Court System Involvement Before CARE Contact

Number of Incidents	Number of Clients	Percent of Clients
1	59	43.38%
2	22	16.18%
3	14	10.29%
4	13	9.56%
5	12	8.82%
6	0	0.00%
7	4	2.94%
8	4	2.94%
9	0	0.00%
10	8	5.88%

The 136 CARE Team clients who had prior criminal court involvement accounted for 438 total criminal incidents.[19] In 86.07% of incidents the most serious charged offense, which we call the highest charge, was a misdemeanor (Figure 9).

Figure 9. Breakdown of Highest Charge per Incident for CARE Team Clients with Court System Involvement Before CARE Contact



To provide additional context, we examined the specific offenses CARE Team clients had been charged with. Table 15 below shows the most prevalent charges for CARE Team clients when the highest charge in the incident was a misdemeanor or a felony.

The most prevalent misdemeanor charge was second-degree trespass, followed by misdemeanor larceny. The most prevalent felony charges were breaking and/or entering, felony possession of a Schedule II

[19] The term incident refers to all charges that were filed for the same person, on the same day, in the same county. This means, in some circumstances, an incident may make up multiple criminal cases.

controlled substance, and habitual larceny. It is important to note that, while these were the most prevalent felony offenses, data show that they represented a very small number of charges.

Table 15. Most Prevalent Charges for CARE Clients in Highest Charge Misdemeanor and Felony Incidents Before CARE Contact

Top Five Most Prevalent Misdemeanors		Top Five Most Prevalent Felonies	
Offense	**Number of Charges**	**Offense**	**Number of Charges**
Second-Degree Trespass	145	Breaking and/or Entering	6
Misdemeanor Larceny	65	Felony Possession of Sch II Substance	6
Intoxicated and Disruptive	26	Habitual Larceny	6
Resisting a Public Officer	26	Larceny After Breaking/Entering	5
Communicating Threats	18	Malicious Conduct by a Prisoner[20]	5

These findings show that only a minority of CARE Team clients had any history with the criminal court system in the two years prior to their CARE Team interaction, and those clients who did have previous criminal history were primarily charged with non-violent misdemeanor offenses.

Court Involvement After Initial CARE Team Interaction

We also examined criminal charges that occurred *after* a client's first interaction with the CARE Team. Of the 426 CARE Team clients, 113 (26.53%) incurred new criminal charges after their initial contact with the Team. Table 16 shows that, of those 113 people, 42.48% had one criminal incident after their initial contact with the CARE Team.[21]

Table 16. Number of Incidents per CARE Client with Court System Involvement After CARE Contact

Number of Incidents	Number of Clients	Percent of Clients
1	48	42.48%
2	22	19.47%
3	12	10.62%
4	7	6.19%
5	8	7.08%
6	6	5.31%
7	3	2.65%
8	2	1.77%
9	1	0.88%
10	4	3.54%

The 113 clients who incurred new criminal charges after their CARE interaction accounted for 319 incidents, of which 318 could be categorized according to their offense level. As shown in Figure 10 below,

[20] Malicious conduct by a prisoner is an offense that is typically charged when an incarcerated individual throws bodily fluids or exposes their genitalia to detention staff.

[21] Considering the data collection period was from May 2024 to June 2025, clients vary widely in terms of the amount of available time after their initial CARE Team interaction. A client who first interacted with the CARE Team in June 2024 would have a full year of post-interaction time where they could potentially be charged with a criminal offense, while someone who interacted with the team for the first time in April 2025 would only have two months of post-period exposure.

the highest charge was a misdemeanor in 250 incidents (78.62%), and a felony in sixty-eight incidents (21.38%).

Figure 10. Breakdown of Highest Charge Type per Incident for CARE Team Clients with Court System Involvement After CARE Contact

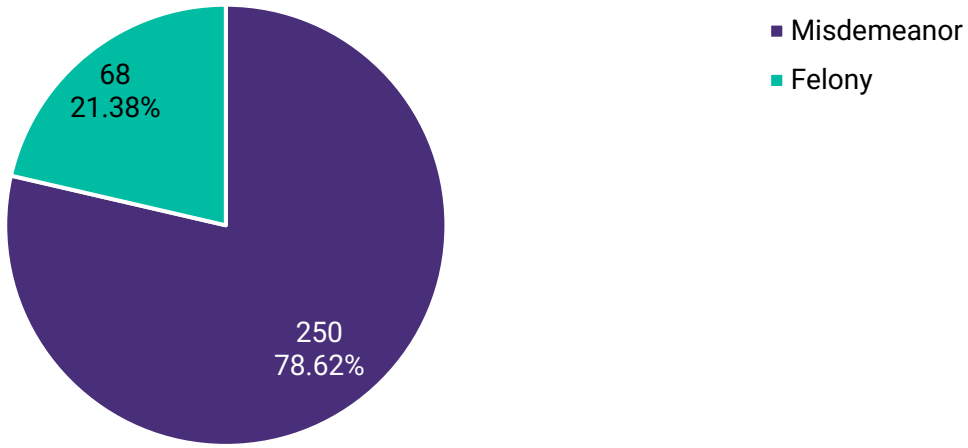


Table 17 shows the most common charges for incidents incurred after a person's initial contact with the CARE Team. Among incidents where the highest charge was a misdemeanor, the most prevalent charges were second-degree trespassing and misdemeanor larceny—the same as the most common charges incurred by people who had court system history prior to their initial CARE Team contact. Among felony incidents, the most common charge was obtaining property by false pretense.[22]

Table 17. Most Prevalent Charges for CARE Clients for Highest Charge Misdemeanor and Felony Incidents After CARE Contact

Top Five Most Prevalent Misdemeanors		Top Five Most Prevalent Felonies	
Offense	**Number of Charges**	**Offense**	**Number of Charges**
Second-degree trespassing	100	Obtaining property by false pretense	25
Misdemeanor larceny	41	Breaking and/or entering	10
Resisting a public officer	27	Identity theft	9
Communicating threats	13	Felony possession of Sch II	7
Possession of drug paraphernalia	13	Habitual larceny	7

Finally, we examined the percentage of individuals who incurred criminal charges within six months before and six months after their initial CARE contact. To standardize differences in time at risk, we limited our analyses to the 323 CARE clients who had at least 180 days after their initial CARE interaction to be charged with a new offense. Out of the 323 individuals, sixty people (18.58%) had a criminal charge in the six months before their initial CARE contact, and eighty-two people (25.39%) incurred a new criminal charge within six months after their initial CARE contact (Table 18).

[22] Additional analyses showed that three individuals accounted for 13 out of the 25 charges for obtaining property by false pretense and one individual incurred 4 identity theft charges (out of the 9 charges reported in the table). Thus, a small number of individuals may have disproportionately contributed to the number of property offense charges in Table 16.

Table 18. Number of CARE Clients with Criminal Incidents 6 months Pre/Post CARE Interaction, Accounting for Time at Risk

	Number of Clients	Percent of Clients
Pre/Before Initial CARE Interaction	60	18.58%
Post/After Initial CARE Interaction	82	25.39%

Of the sixty people who had a charge in the six months before their initial CARE contact, forty-three of those same people (71.67%) incurred a new charge within six months after their CARE contact. While a CARE Team response often diverts individuals away from having an interaction with law enforcement at that particular moment, these findings suggest that contact with the CARE Team may not be sufficient to reduce further criminal justice system involvement for the small portion of clients that have an existing history with the court system.

Incarceration

To determine the incarceration history of CARE Team clients, we reviewed jail data from the Orange County Detention Center and state prison data.

Incarceration in the Orange County Detention Center

We received jail data from the Orange County Detention Center from January 1, 2022, to September 30, 2025. Unlike the court records data, where we can look at outcomes statewide, the jail data was only for Orange County. As such, it is possible that we are not capturing clients who have been incarcerated in other jurisdictions.

Again, 426 of the 457 unique CARE clients had sufficient information, including their names and birth dates, to search in the jail data. **Of those 426 clients, ninety-eight (23.00%) had any history of incarceration in the Orange County jail between January 2022 and September 2025.**

Incarceration Prior to CARE Team Interaction

Of the 426 CARE Team clients, only fifty-eight (13.61%) had a history of incarceration in the two years prior to their initial CARE Team interaction. Forty-three percent of those clients were booked only once during the two-year period. However, as shown in Table 19 below, 10.34% were booked six or more times.

Table 19. Number of Jail Bookings per CARE Client Prior to Initial CARE Interaction

Number of Bookings	Number of Clients	Percent of Clients
1	25	43.10%
2	13	22.41%
3	7	12.10%
4	3	5.17%
5	4	6.89%
6+	6	10.34%

Incarceration After CARE Team Interaction[23]

We also looked at jail bookings that occurred after an individual's initial interaction with the CARE Team. Of the 426 CARE Team clients, sixty-nine (16.20%) had a history of incarceration after their CARE Team

[23] On October 1, 2023, North Carolina lawmakers modified the state's pretrial release laws in a bill referred to as the Pretrial Integrity Act. Orange County stakeholders noted that individuals who may not have previously been held in jail on the types of non-violent misdemeanor offenses common among CARE Team clients, like second degree trespass, are now required to be held in some circumstances under the Pretrial Integrity Act. Due the to the timing of this policy change, Orange County stakeholders expressed that the Pretrial Integrity Act could contribute to increased incarceration rates among CARE Team clients. Because of limitations in the jail data, we were unable to test this hypothesis directly in our analyses. To learn more about the Pretrial Integrity

interaction. As shown in Table 20, 46.38% of the individuals booked into jail after their CARE Team interaction were booked one time.[24]

Table 20. Number of Jail Bookings per CARE Client After Initial CARE Interaction

Number of Bookings	Number of Clients	Percent of Clients
1	32	46.38%
2	22	31.88%
3	4	5.80%
4	6	8.70%
5	2	2.90%
6+	3	4.35%

Finally, as with the court records data, we examined the percentage of individuals who were booked into jail within six months before and six months after their initial CARE contact. Out of the 323 individuals with six months of available pre-and-post data, twenty-eight people (8.67%) were booked in the six months before their initial CARE contact, and thirty-nine people (12.07%) were booked within six months after their initial CARE contact (Table 21).

Table 21. Number of CARE Clients with Criminal Incidents 6 months Pre/Post CARE Interaction, Accounting for Time at Risk

	Number of Clients	Percent of Clients
Pre/Before Initial CARE Interaction	28	8.67%
Post/After Initial CARE Interaction	39	12.07%

Of the twenty-eight people who were booked in six months before their initial CARE contact, sixteen of those same people (57.14%) were booked within six months after their CARE contact.

Most Common Charges

To understand the types of charges within these bookings, we examined the top ten most common charge descriptions in the data among the ninety-eight CARE clients with any history of jail incarceration. Table 22 below shows that second degree trespass was the most common charge description, followed closely by failure to appear on a misdemeanor.[25]

This analysis is not limited to a single highest charge, so someone may be booked on these charges in addition to other offenses or due to other factors. Additionally, if someone is charged with multiple counts of the same charge, all charges will be counted separately. After the top ten charges, there are dozens of less common charge descriptions in the data that make up very small percentages of overall charges.

Act see Pitts, M.J. (2023, August 23). North Carolina's new pretrial integrity act. *North Carolina Criminal Law Blog, UNC School of Government*. https://nccriminallaw.sog.unc.edu/2023/08/23/north-carolinas-new-pretrial-integrity-act/.

[24] As explained in note 21, clients vary widely in terms of the amount of available time after their initial CARE Team interaction. A client who first interacted with the CARE Team in June 2024 would have a full year of post-interaction time where they could potentially be booked into jail, while someone who interacted with the team for the first time in April 2025 would only have two months of post-period exposure.

[25] While Failure to Appear is listed in the data as a "charge description," it is rare for jurisdictions to charge Failure to Appear as a separate crime. Instead, many of these entries are likely the result of individuals being arrested on an outstanding Order for Arrest, which is recorded in the jail data, but does not equate to being charged with an additional criminal offense.

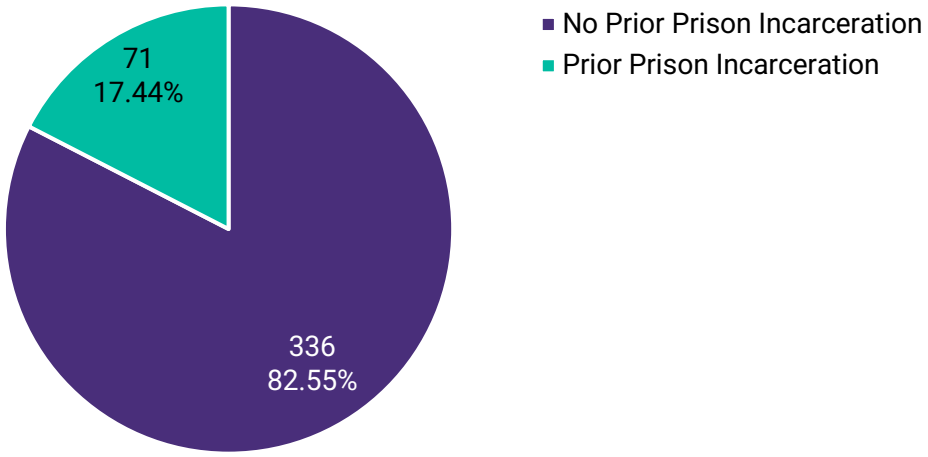
Table 22. Most Common Charge Descriptions Among CARE Client Jail Bookings

Charge Description	Count	Percent
Second Degree Trespass	86	12.23%
Failure to Appear on a Misdemeanor	84	11.95%
Misdemeanor Larceny	41	5.83%
Drunk and Disruptive	38	5.41%
Assault – Resisting Arrest	26	3.70%
Assault – Communicating Threats	22	3.13%
Possession of Drug Paraphernalia	20	2.84%
Assault on a Female	19	2.70%
Order for Arrest	19	2.70%
Possession of Stolen Goods	16	2.28%

Incarceration in State Prison

Using data from the North Carolina Department of Adult Corrections, we reviewed the number of CARE Team clients that had one or more previous incarcerations in state prison prior to September 2025.[26] We did not limit this search to a certain amount of time before or after CARE Team interaction. **Results showed that seventy-one CARE clients (17.44%) had any record of being incarcerated in state prisons (Figure 11).**

Figure 11. Number and Percentage of CARE Clients with a Prior Incarceration in a North Carolina Prison



Of those 71 individuals previously incarcerated in state prison, 24 (33.80%) had been in state prison seven or more times (Table 23).

Table 23. Number of Prior Incarcerations per CARE Client with a History of State Incarceration

Number of Prior Incarcerations	Number of Clients	Percent of Clients
1	14	19.72%
2	13	18.31%
3	10	14.08%
4	4	5.63%
5	3	4.23%
6	3	4.23%
7+	24	33.80%

[26] Prior incarceration data was available for 407 individuals out of the 457 CARE clients.

The combination of local jail data and state prison data show that only a minority of CARE Team clients have any history of incarceration. However, those that do have a history of incarceration are at risk for repeat jail bookings despite their interaction with the CARE Team. A majority of individuals who were booked into jail six months prior to their initial CARE Team interaction were also booked in the six months after their initial CARE Team interaction. These findings further support the notion that the CARE Team intervention alone is not enough to divert certain individuals away from repeated interactions with the justice system.

Discussion

Establishing the CARE Team changed the default response to certain 911 calls in Chapel Hill. Instead of relying on a law enforcement response in every circumstance, the CARE Team has demonstrated that civilian responders can safely and effectively respond to non-emergent calls related to issues like substance use, mental health concerns, and low-level criminal activity. During the pilot period, the CARE Team responded directly to 294 911 calls, had 394 additional mobile responses, and recorded 466 follow up contacts. The CARE Team did not have to abort any responses due to safety concerns, and Team members reported a high degree of confidence in their ability to address community members' needs. Most events that receive a CARE Team response are resolved at the scene, with very few incidents resulting in law enforcement action. Outcome data demonstrate that the CARE Team provides services and support to individuals in real time. And, even with an emphasis on holistic response, the CARE Team clears calls within a similar time frame as law enforcement. By responding directly to 911 calls, the CARE Team saved Chapel Hill police officers a minimum of 118 hours during the pilot period.

There are two data findings that suggest potential challenges for the CARE Team. First, the Team was only able to respond to 47.11% of eligible 911 calls during the pilot period. The number one reason that the CARE Team did not respond to eligible calls was being logged out or out-of-service, which can be attributed in part to inconsistent staffing patterns and logistical issues early on in the pilot period. The CARE Team being busy on other calls was the second most common reason, suggesting that there is sizeable demand for the CARE Team despite the fact that they only respond to a small subset of 911 calls. It is also possible that the CARE Team could have been involved in more 911 responses if the call diversion counselor was fully active throughout the pilot period but, as discussed above, training requirements and staffing challenges have made it difficult to implement that component.

Increasing the number of 911 calls that receive a CARE Team response is something that stakeholders are already looking to address. At the time of this report's publication, Orange County and CHPD are in the process of staffing a second CARE Team, which will begin operation in 2026. With two teams, the CARE program will be able to cover more hours of the day, answer more calls, and avoid periods where staffing shortages limit their ability to respond. Operations have also expanded into nearby Carrboro, giving more people access to the CARE Team.

The second relevant data finding is that CARE Team intervention alone is seemingly not enough to help divert certain individuals from repeat criminal justice involvement. Most individuals who had criminal court incidents in the six months prior to their initial CARE Team interaction also faced new charges in the six months after their CARE Team interaction. The same was true for most individuals who were booked into

jail in the six months before their CARE Team interaction.[27] Stakeholders may be interested to identify this particular group of clients and review the details of their criminal justice involvement. By nature of the fact that these people are CARE Team clients, it seems likely that they have behavioral health or other social service needs in combination with their interactions with the justice system. While the CARE Team is focused on changing the initial response to 911 calls and is not designed to provide long-term case management, it is possible other targeted services might more effectively divert this group of individuals out of a repeat cycle of justice involvement. Stakeholders expressed that there are a variety of available community resources that are better equipped for long-term intensive case management, including Assertive Community Treatment (ACT) Teams, Community Support Teams (CST), the Street Outreach, Harm Reduction and Deflection (SOHRAD) program, the County rapid-rehousing program, and other case management services provided by local nonprofit organizations and behavioral health providers.

Implementation Lessons

Chapel Hill and Orange County were uniquely positioned to successfully establish a civilian alternative response program. The CHPD has a long-standing history of integrating behavioral health professionals, and Orange County manages other street outreach and mobile response teams. Still, stakeholders learned valuable lessons during implementation that may be beneficial to any community interested in establishing an alternative responder program. The working group identified four primary implementation lessons to share with others: the importance of internal and external education, planning for data integration, supporting the health and wellbeing of alternative responders, and prioritizing ongoing collaboration.

The Importance of Internal and External Education

Internal Education

Throughout this report, we have emphasized the CHPD's existing Crisis Unit infrastructure and culture of openness to alternative response. However, the presence of existing programming did require CHPD and Orange County to engage in substantial internal education about how the CARE Team was different from the existing Crisis Unit and when it was appropriate to engage the CARE Team. When the CARE Team staff members were hired, they gave presentations to patrol officers and other first responders to introduce themselves and explain the purpose of the Team, which was an important step for integration.

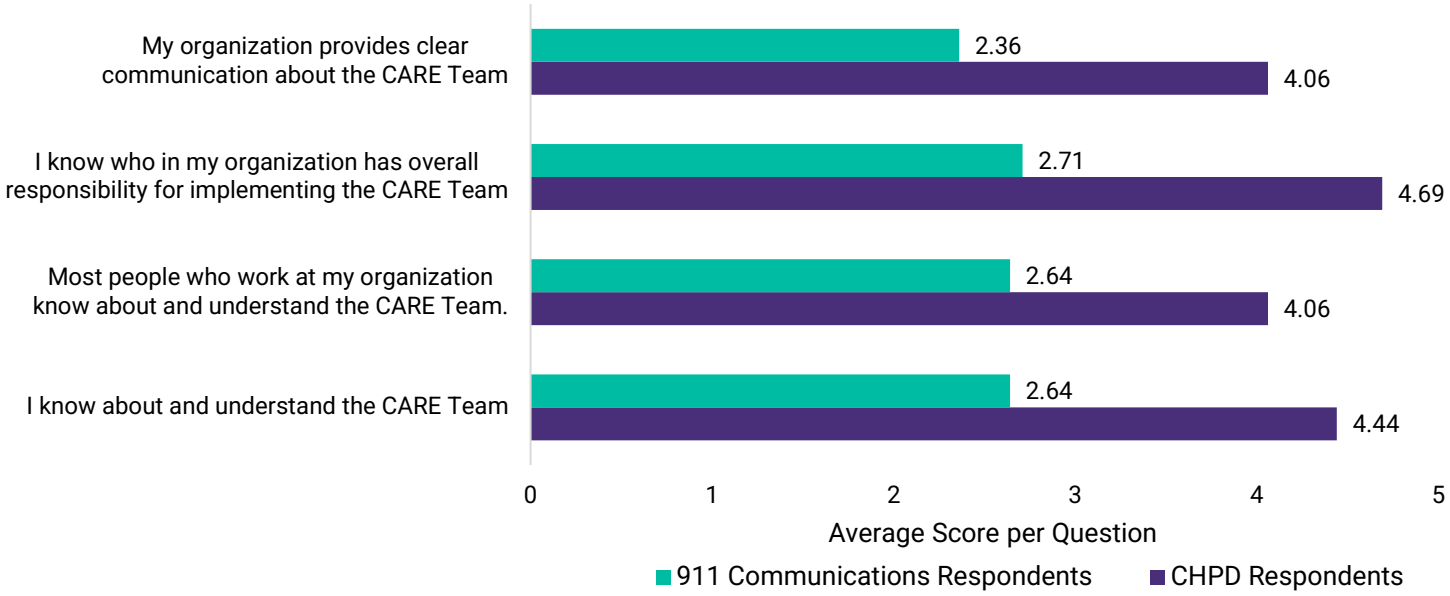
The CARE Team model also required much closer collaboration with Orange County Emergency Services and other County officials, which presented other critical opportunities for education. For the first time, CHPD alternative responders were going to be dispatched directly by 911 telecommunicators and a crisis counselor would be embedded in the 911 call center.

In April 2024, the Lab conducted an organizational readiness survey to assess the level of understanding and preparedness among CHPD officers, CHPD crisis unit staff, and telecommunicators prior to the launch of the CARE Team. The results from that survey showed notable differences between CHPD staff and 911 communications staff. The average scores for select questions are summarized in Figure 12 below. The

[27] These findings are similar to another recent Lab evaluation of a co-response program in Burlington, NC. See Turner, H. et. al. (2025). *Evaluating a mental health co-responder program in Burlington, North Carolina.* UNC School of Government Criminal Justice Innovation Lab. https://cjil.sog.unc.edu/wp-content/uploads/2025/10/Burlington-LECC-Evaluation_Final_2025.10.14.pdf.

scoring system was as follows: 1 = disagree, 2 = somewhat disagree, 3 = neither agree nor disagree, 4 = somewhat agree, and 5 = agree.

Figure 12. Select Results from April 2024 Organizational Readiness Survey



The four statements displayed in the figure relate to personal understanding of CARE Team implementation, perception of others' understanding of CARE Team implementation, and organizational communication. The average scores reflect that 911 telecommunicators perceived much less clarity about the CARE Team compared to CHPD respondents.

In the months following this survey, additional conversations about the role of the call diversion counselor led to the decision to fully train the CARE Team clinicians as telecommunicators so that they could answer other 911 calls when diversion services were not needed. This experience in Orange County highlights the importance of emphasizing internal education and fostering an open dialogue about new programs, especially for stakeholders like telecommunicators who may be expected to change protocols significantly to support a new alternative responder program.

External Education

Community education was, and remains, an important component of CARE Team operations. In the same way that CHPD and Orange County had to explain the purpose of the CARE Team to their employees, they were also tasked with explaining it to the public. Stakeholders had to provide clear direction about when community members should seek out various county and town resources, including police, the CARE Team, the Chapel Hill Crisis Unit, and other street outreach teams.

One important example of role clarity emerged around trespass calls. The CARE Team is now the default response for non-emergent trespass calls that do not involve weapons, violence, or other safety risks. Frequently, these types of calls come from businesses or other private property owners. When the CARE Team responds to trespass calls, they encourage individuals to move off the property while providing additional supports and resources. They do not have the ability to issue a legal trespass order.

There have been circumstances where the CARE Team arrives at a trespass call, only to have the caller express that they want someone to be legally trespassed from the property. In these situations, the CARE Team must call law enforcement, which takes additional time and can cause confusion or frustration for the caller. The CARE Team has worked to provide ongoing education on this issue, and the CAD data show that some callers are now specifying when they call 911 that they want to have an individual formally trespassed to avoid sending the CARE Team out when a law enforcement officer is needed.

Clarifying that the CARE Team is dispatched through 911 has been another essential component of community education. Many of the other alternative response resources available in Chapel Hill, including the CHPD Crisis Unit, have separate phone numbers where they can be contacted directly. As a result, some community members expect the option to call another number and may be hesitant calling 911 for the types of non-emergent issues that are designed to receive a CARE Team response. Thus, stakeholders have had to continually emphasize that calling 911 is an appropriate course of action and that telecommunicators will send an appropriate response.

Other jurisdictions interested in starting similar programs may want to prioritize coordinated public education campaigns, especially in the early days of implementation. While explaining the purpose and goals of the program is key, explaining its limitations can also be important—especially if community members are used to receiving a certain type of response, and that response will be changing. Community education is critical for building and maintaining community support.

Plan for Necessary Data Collection & Integration

Data collection and data integration were ongoing challenges throughout the pilot period. When the CARE Team was established, the CHPD Crisis Unit had an existing case management system that they had been using for years. The intention was for the CARE Team to document their interactions in that same system. However, it became clear early on that developing new documentation procedures in the existing system and extracting data from that system was extremely difficult. Furthermore, linking the case management data and the CAD data—which was relevant for the CARE Team because of their direct dispatch from 911—was only possible by the CARE Team manually entering the CAD event ID number into their documentation and then attempting to match the two data sources together on the back end. As such, analyzing the CAD data and the case management data separately often revealed slightly different results, which made reporting and interpreting data complicated.

CHPD spent considerable time and resources working with their existing software vendor to try to improve data collection and reporting processes. Data were, and continue to be, an important tool for the CARE Team working group. Data points are reviewed regularly to help guide decision-making. For example, it was a CAD data analysis that revealed the CARE Team was sometimes marked as unavailable when they were engaging in street outreach activities, causing some CARE-eligible 911 calls to be dispatched to law enforcement instead. Because data collection and internal reporting have been integral to program operation and expansion, CHPD has decided to switch to another case management system as of the publication of this report. That system should have more advanced integration and customization features.

Other communities interested in establishing alternative response teams, particularly teams that might involve cross-agency collaboration (i.e., 911 telecommunications, EMS, police), may want to consider data systems that allow for easy integration. Taking an inventory of the current software systems used by partner agencies and exploring whether any of those existing options could be appropriate for alternative

response documentation can be helpful. For example, the new case management system to which CHPD is switching is a system already in use by Orange County EMS. Still, stakeholders may want to be mindful that many case management systems are not designed for alternative responder programs. Some of the challenges that CHPD faced arose because its old case management system was not designed for alternative responders and was not easily customizable. Before choosing a case management system, it may benefit stakeholders to make a list of information they want to collect about their program to ensure that the selected system will meet all their needs.[28]

Be Mindful of Alternative Responder Health & Wellness

CHPD leadership shared that an important component of building a successful alternative response program is being mindful of the health and wellness of alternative responders. Some health and wellness considerations are subtle, like the fact that CHPD provided the CARE Team with comfortable shoes since they routinely walk for miles each day. Others are more obvious, like creating open opportunities for alternative responders to raise safety concerns and promptly addressing those concerns.

Additionally, like all first responders, alternative response teams can be exposed to emotionally challenging or traumatic situations. When clients have poor outcomes, it can take a toll on alternative responders who dedicate their time to forming relationships with these community members. It may benefit leaders who manage alternative response teams to be aware of the team's day-to-day interactions so that they can identify potentially challenging circumstances, provide opportunities for alternative responders to debrief, and create space for responders to take breaks if needed. The Chapel Hill Police Department has an in-house wellness coordinator to help promote health and wellness among all department employees.

Prioritize Ongoing Coordination and Collaboration

At the time of this report's publication, the CARE Team working group has been meeting consistently for over two years. While the original intention of the group was to develop the necessary procedures to launch the program and oversee the early stages of implementation, it continues to serve as a helpful forum for stakeholders to share ideas, concerns, and successes. Working group meetings also give stakeholders an opportunity to review data to inform decision-making. As the CARE Team has expanded, other individuals have been invited to participate in the working group meetings. When they are available, CARE Team members themselves join meetings, demonstrating that they play an important role in providing feedback to improve program operations.

Many alternative responder programs are reliant on partnerships, whether partnerships with external organizations or internal coordination with local agencies. Other communities interested in establishing alternative responder programs may consider creating a working group that is not only tasked with the initial implementation of the program but also provides a standing opportunity for stakeholders to discuss program operations. Maintaining an open line of communication can encourage quick problem-solving when issues arise and give all partners a continued sense of ownership and investment in the program.

[28] For a list of data points that may be helpful for jurisdictions to track related to their alternative responder programs, see Appendix A in Turner, H. et. al. (2025). *Evaluating a mental health co-responder program in Burlington, North Carolina.* UNC School of Government Criminal Justice Innovation Lab. https://cjil.sog.unc.edu/wp-content/uploads/2025/10/Burlington-LECC-Evaluation_Final_2025.10.14.pdf.