INDEPENDENCE
MISSOURI

A GREAT AMERICAN STORY

A PROPOSAL FOR THE FUTURE OF PUBLIC SAFETY IN INDEPENDENCE, MISSOURI

A report on emerging challenges in emergency response and adapting services for community needs

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COMMUNITY OUTREACH RESPONSE to EMERGENCIES (CORE)

AT-A-GLANCE

With an ever-widening array of low-acuity emergency requests, Police, Fire and EMS responders increasingly find themselves handling community needs that can fall beyond their professional education and operational resources, such as mental health or substance abuse crises.

Independence Community Outreach Response to Emergencies (CORE) is a proposal for a partnership with Mental Health Services to staff a 911 response vehicle with a Paramedic and Mental Health Professional. This unit would be "on-duty" and integrated in the Independence 911 system, available to receive a wide array of low-risk 911 community requests. Their goals are to:

- Provide immediate low-impact, trauma-informed response and care for community members during moments of crisis.
- Connect with citizens for the purpose of resource awareness, education and collaboration in mitigating neighborhood challenges.
- Reduce the call load of low-risk 911 requests for existing emergency services, particularly in the area of quality-of-life, mental health and substance abuse crises.
- Support community first responder agencies by providing immediate professional mental health assistance following significant events.

"The health of American children, like their education, should be recognized as a definite public responsibility"

~ Harry S. Truman [61]

EXECUTIVE SUMMARY

Nearly 50 years after the first emergency call was placed in 1968, 911 has become the solution to any perceived crisis for millions upon millions of Americans. In the United States alone, about 240 million calls are placed to 911 each year, with a national average of nearly 675,000 calls placed daily.[1]

With that public trust comes considerable responsibility. Emergency services must maintain constant vigilance, ready to respond to a vast range of requests not only with speed but with appropriate resources and considerable skill.

As society has grown, so has the variation seen in emergency types. Today, first responders respond to an almost endless array of 911 requests, from "normal" emergencies like heart attacks and burglaries, to emerging issues such as a threat written on a social media website from across the country.

From hazardous materials to cybercrime, critical care to bariatric transport; firefighters, police officers, paramedics, and dispatchers continue to see their responsibilities extended as they seek to manage an ever-expanding list of community needs.

What happens when emergencies begin to creep beyond responders' level of expertise? The traditional reaction is to extend those responders' education and responsibilities.

This workload growth has costs. Expanding roles and expectations reduces specialization and dilutes resources. It is worthwhile to consider how many roles a particular response agency can perform before skillsets begin to suffer, with consequences for both themselves and the communities they serve.

EXECUTIVE SUMMARY

The past decade has seen considerable social unrest, in part due to a mismatch of public response resources to societal challenges. These challenges include, but are not limited to, mental health crises, substance abuse, and a broad array of 911 requests loosely defined as “quality of life” issues.

Quality-of-life, as discussed in this report, is a broad assessment of the "degree to which an individual is healthy, comfortable, safe, and able to participate in or enjoy life events." [42]

Emergency services have not been idle, and efforts have been made across the country to adapt to these new challenges, partly because of the ramifications from a public loss of trust in 911.

An analysis of 911 use after a 2016 incident involving off-duty Milwaukee police officers noted a 20% decrease in 911 calls (22,000 calls) citywide the following year.[2] Sadly, this is not an isolated incident.[3] A loss of trust in the 911 system has profound and far-reaching effects on the well being of both individual citizens and the communities in which they live.

In light of current events, it is prudent to examine our emergency response resources, focusing on matching resources with demonstrated community needs.

The following proposal is an opportunity to develop the City of Independence’s public safety delivery model to adapt to existing and emerging emergency response trends.

RESEARCH METHODOLOGY

Section Highlights

A Careful Analysis

of current community needs and emergency services data must be completed before any discussion of permanent changes to emergency response procedures.

911 Call Classification & Data

can be particularly challenging to analyze. The wide variation of call types, limited information given by callers, interpretation by call takers, and changes in operational policy can alter data in different ways. Consideration of context and other factors that affect this data is essential.

This study searched "Keywords"

in all 911 calls in an attempt to identify incidents favorable for CORE response. This is an incomplete method, but is the most accurate way available to search across all 911 call volume.

Undoubtedly, there are calls excluded and included which should be otherwise. Research shows that the incidence of mental health and quality of life within 911 calls are often significantly underreported. [6]

Initiation of a CORE pilot

program is the most effective means to identify "hard" numbers on eligible call volume, allowing dispatchers, responders and a CORE field unit to test and develop 911 criteria and field response for a short period.

This approach is supported by similar methods in existing programs, who continue to refine their response criteria even years after program initiation. [30] [49]

[65]

RESEARCH METHODOLOGY

Context is critical when reviewing 911 call data. As with most forms of metrics analysis, the circumstances in which the information was collected, classified, and measured is essential to drawing accurate conclusions.

When beginning an analysis of emergency response trends, a logical starting point is with the data collected by 911 call centers. Independence ECC (Emergency Communications Center) maintains records for every 911 call that comes through their system, averaging above 250 emergency calls a day in 2021.[4]

When a 911 call is received, the call-taker quickly interprets the information given by the caller and assigns a "nature code", or classification, to the emergency. This can be a difficult task. The call-taker must rapidly determine what emergency classification best defines the incident based on often-incomplete information, prior experience, and ECC operational policy.

This rapid analysis and determination can present a considerable data challenge, as there are a vast array of 911 classifications and substantial "overlap" in how 911 calls can be classified.

For example, when receiving a 911 call for a "*possibly homeless individual lying under a bridge*," one call taker may classify this as an "Suspicious Person/Activity." A different 911 call taker, receiving the same 911 call, might classify the response as a "Man Down" call based on minor variations in professional experience and methodology.

In both circumstances, minor discrepancies in the caller information and call taker interpretation can lead to considerable variation in 911 call classification. These variations can lead to significant ambiguity of data analysis when attempting to find trends in call history.

RESEARCH METHODOLOGY

A primary goal of this report is to demonstrate that the 911 call load exists for a Community Outreach Response to Emergencies (CORE) response unit. Anecdotal discussion with responders highlights the high volume of low-acuity/low-risk responses that could qualify for this response model, however demonstrating that need in data is a significant challenge, substantially due to the concerns discussed above.

In an effort to partially address this problem, Independence 911 call analysis has been completed based on keywords in the call taker's narrative of the call, rather than 911 call classification itself.

> "Over the past few years, leaders around the country have reported increases in mental-health calls and pointed to struggles in identifying them."
>
> - David Graham, The Atlantic, March 2022 [5]

Therefore, for the IPD and IFD studies within this report, 100% of Independence ECC call records for 2019 through 2021 were screened for keywords such as "suicide", "homeless", "psych" and 9 other keywords selected in the context of possible misspellings, word-for-word caller statements, or phrases/symptoms verbalized by the caller.

Two broad keyword groups were assessed. Those involving mental health and those involving homelessness. There is a considerable amount of other low-acuity 911 calls that will likely qualify for CORE response, however for the purpose of this study these two groupings were deemed a sufficient study group.

RESEARCH METHODOLOGY

The author acknowledges that there are still notable limitations to this analysis. In some cases, a keyword "hit" within a search could simply mean that the keyword is peripheral to the primary call.

For example, a 911 call involving a "*commercial building fire possibly near the homeless camp*" doesn't directly mean that the homeless camp was involved in the incident; it was simply used as a point of reference.

Attempts to obtain (mental health 911 data) have typically relied upon distinct mental health codes in computer-aided dispatch (CAD). This approach may grossly underestimate the true prevalence and impact of mental illness on emergency response providers."

- Mental Health Involvement in Police & Fire Calls for Service: Gresham Oregon 2016-2017 [6]

Therefore, based on a call-by-call review of data sample sets, this analysis should be considered to demonstrate overall community 911 trends versus a precise snapshot of 911 root causes in any given timeframe.

Furthermore, changes and improvements in how 911 calls are classified and stored can also impact data. In the last three years alone, at least two different policy shifts within city response agencies have caused changes in how 911 calls were classified. Thus, call volumes for certain classifications changed significantly simply because they were classified as a different subset of 911 call.

In conclusion, accurate and specific analysis of the root causes of 911 requests can be particularly challenging, due in no small part to the broad nature of emergencies, limitations in rapid 911 classification, and variations in how individuals and organizations classify data.

RESEARCH METHODOLOGY

Additional information was obtained through various other city and community resources. Local, state, and federal reporting agencies, news outlets, and non-profit organization data has been cited and is available for review.

The most effective means to determine program suitability and objective data is to initiate a CORE pilot program, thus allowing dispatchers, responders and a prototype CORE crew to develop, test and measure both 911 criteria and field response efficacy for a set period.

"What mental health needs is more sunlight, more candor, and more unashamed conversation"

- Glenn Close [62]

DEFINING THE CHALLENGES

Section Highlights

Mental Health Challenges

continue to grow on local, state and national levels. Mental health crises, in particular with young adults and youth, show concerning growth trends that reflect changing community needs, both immediate and long-term.

Suicide in Independence

consistently outpaces both the state and national averages. The most recent suicide data (2019) notes that Independence hit a rate of 31.99 per 100,000. [14] A significant hike above local, state and national rates. [14] [35] [36]

City response agencies

are often asked to respond and mitigate immediate and chronic issues related to mental health (and other life crises). Call volumes for these issues are increasing for every service. [4] Homelessness, often directly related to mental health, has also seen significant increases in 911 interaction. [4]

Police Mental Health Co-Responders

and the CIT program are the primary city-based programs available for emergency mental health outreach. Co-responders and CIT-trained officers are a valuable asset in addressing mental health in our communities. However, CIT officers and co-responders are dedicated to a number of various tasks, including policing work, and have some variability in resources available, such as time and transport limitations, that can affect community coverage.

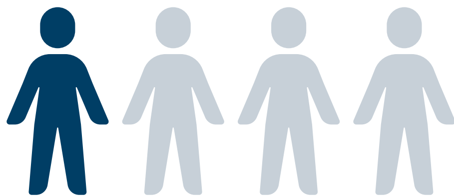
[65]

DEFINING THE CHALLENGES

City of Independence, Mo.

There is little necessity to highlight the need for increased awareness and response to mental, social, and substance use crises within American communities. Recent events, including COVID-19 and social unrest, have placed a national focus on the 911 system and its significant role in the face of broadening community needs.

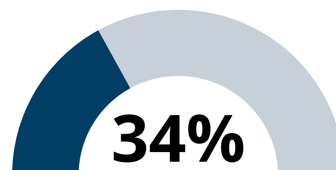
The prevalence of reported quality-of-life issues continues to increase on local, state, and national levels. According to the 2020 National Survey on Drug Use and Health (NSDUH), 25% of Missourians aged 18-25 reported experiencing a "Substance Use Disorder within the past year."[7] A remarkable one-in-four young adults.



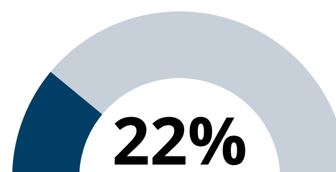
One out of four Missouri young adults (aged 18-25) reporting a substance use disorder in 2020. [7]

Equally disturbing are similar numbers from Missourians reporting "Any Mental illness in the Past Year," with an estimated 34% of respondents aged 18-25 and 22% of adults older than 26 reporting yes.[7]

34% of Missouri young adults (aged 18-25) reported having mental illness in 2020. [7]



22% of Missouri adults (older than 26) reported having mental illness in 2020. [7]



City of Independence, Mo.

These are not just “pandemic” numbers. Mental Health America, a non-profit agency focusing on national data on mental health, noted that “*the national rate of suicidal ideation among adults has increased every year since 2011-2012.[10]*

Additionally, it was noted that *"the percentage of adults with a mental illness who report unmet need for treatment has increased every year since 2011.*” [8]

A considerable amount of studies suggest that, although bringing more attention to mental health, COVID-19 has only accelerated the increase in a wide range of mental and societal challenges.[9]

The national rate of suicidal ideation among adults has increased every year since 2011-2012 [10]

There are ample reasons to see trends within Independence that reflect these state and national level issues. The most recent Independence Community Needs Assessment noted that mental disorders were the fourth most-likely event to cause hospitalization in the city.[11]

Taking this figure and comparing it to Missouri rates, Independence demonstrates a significantly higher rate of hospitalization from mental disorders from both the state and national average. A 2017 county-wide assessment noted that 21% of respondents state that they had a mental illness in the past year, with 5% describing that illness as something that impaired significant life activities.[12]

City of Independence, Mo.

A broad assessment of suicide in Independence is even more concerning. Utilizing the Missouri Information for Community Assessment tool, along with the Missouri CDC and National Center for Health Statistics Data, the graph below shows a comparison of National, Missouri and Independence suicide rates over the past decade.

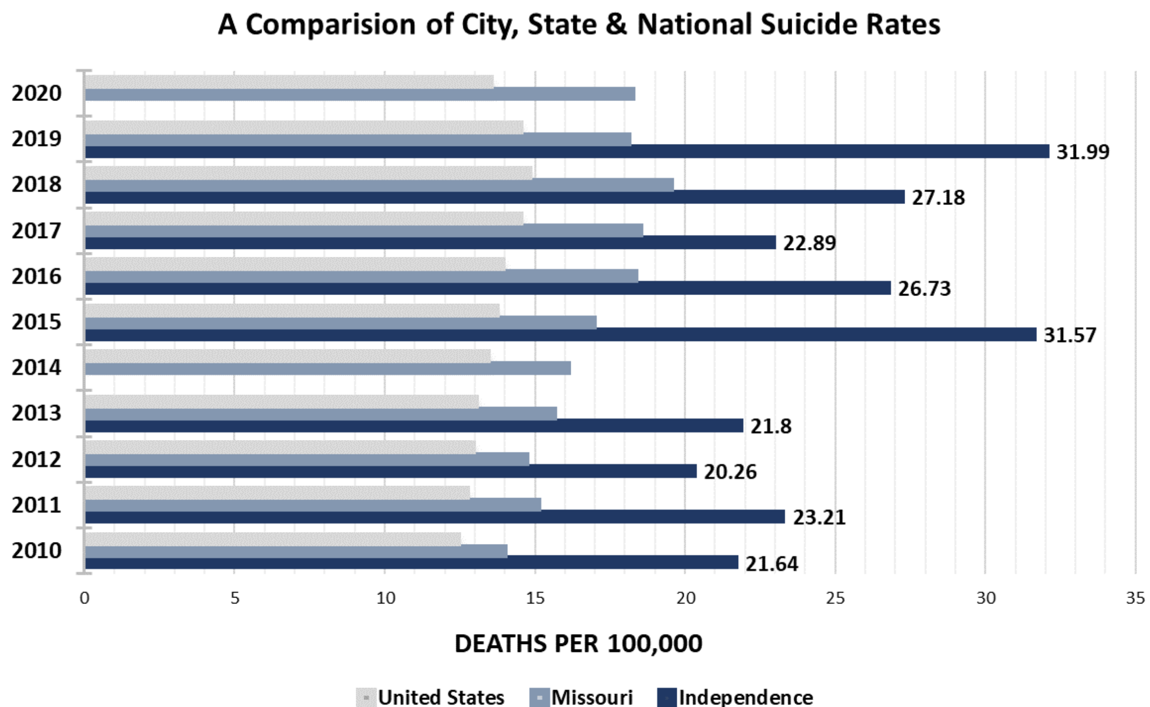


FIGURE 2 - A Comparison of City, State and Federal Suicide Data.
Compiled with data from the CDC, Missouri CDC and Missouri MICA Tool [13] [14] [15]

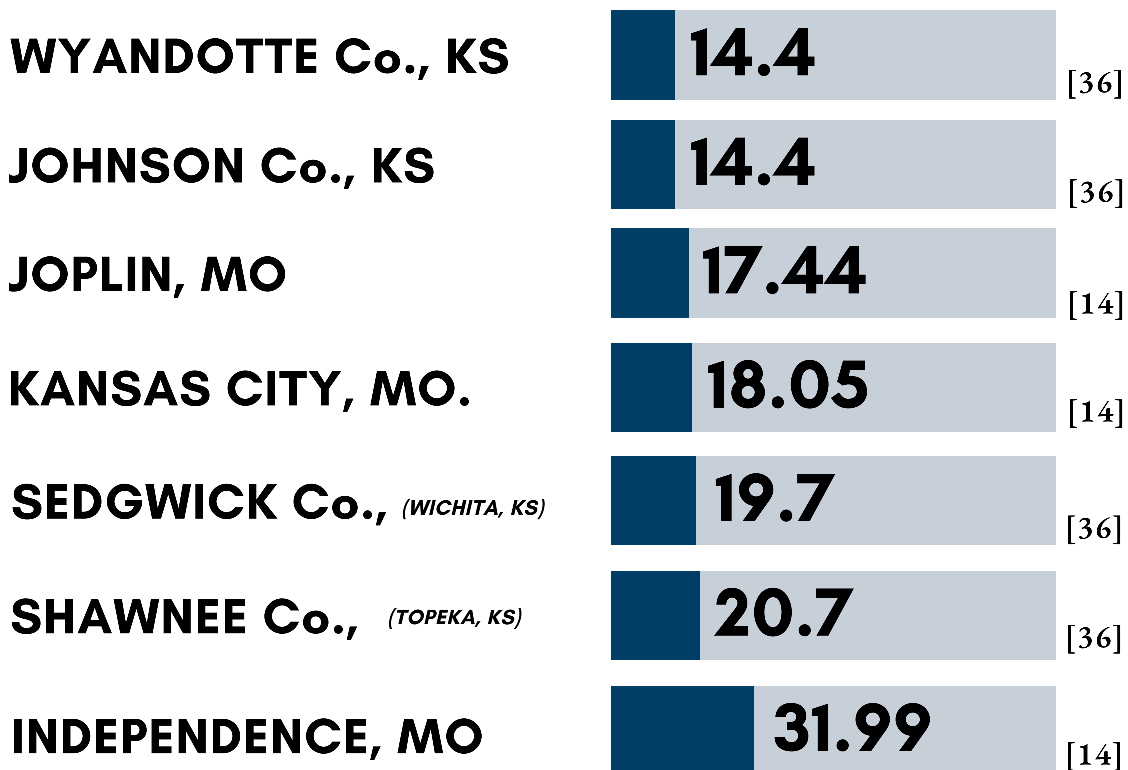
Independence Data - Suicide by age-adjusted rate (2000 Standard Population).
Source: DHSS-MOPHIMS - Death MICA - Pulled on 12 March 2022.

*2014 Independence Rate unreliable, insufficient data per MICA.
*2020-2021 Independence data not yet available.

A 17 year study documented in a 2020 report by the Jackson County Health Department, examining suicide in Eastern Jackson County, noted the highest rates of suicide by location were confined to the Independence zip codes of 64052, 64050, 64056, as well as the bordering areas of Sugar Creek & Buckner. [56]

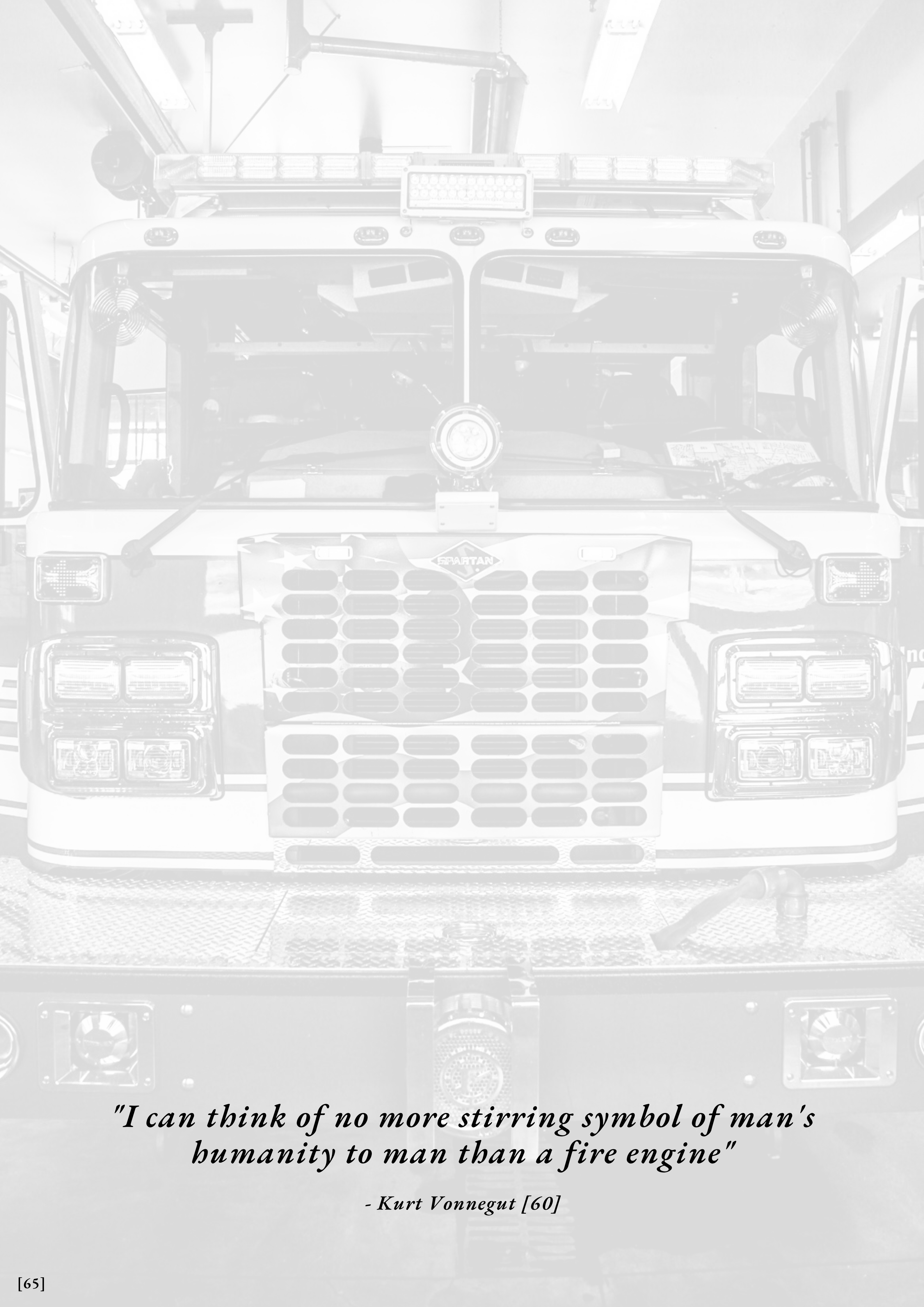
City of Independence, Mo.

A deeper review of suicide data from neighboring jurisdictions is equally concerning. Listed below is a comparision of suicide rates from local and regional population centers who had publically available government data on suicide rates in 2019.



- Crude Rate determination:
  - *(Suicide x 100,000 / 2019 population = Deaths per 100,000)*
- *Rates are further age-adjusted in an attempt to control for the effect of population age differences using the 2000 Standard Population.*
  - *Age adjusted death rate = deaths in age group ÷ estimated population of that age group × 100,000.*
- *At the time of writing, 2019 data was the most recent data comprehensively available from state and federal databases.*
- *Data gathered from Missouri and Kansas local government sources. [14] [36].*

Local and national 911 call volume are reflecting these trends.[17] An analysis of 911 call trends from 2019-2021 note that both mental health as well as quality-of-life requests are steadily increasing for all branches of emergency services.[4]



"I can think of no more stirring symbol of man's humanity to man than a fire engine"

- Kurt Vonnegut [60]

DEFINING THE CHALLENGES

Independence Fire Department

Upwards trends in IFD response are noted in both mental health and homeless/quality-of-life 911 categories.

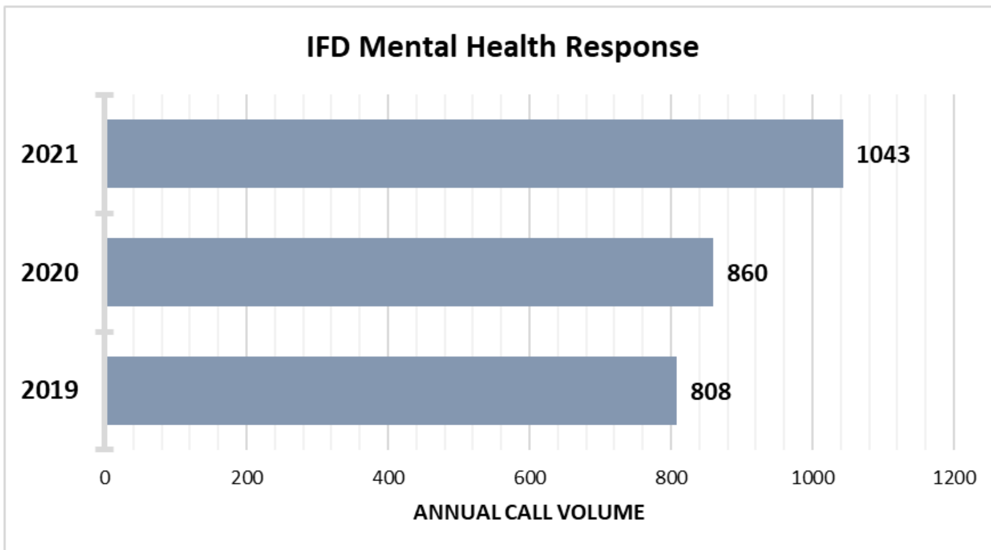


FIGURE 3 - IFD 2019-2021 Mental Health Response Data. [4]
Compiled with data from a study of 911 Data from Independence ECC (2022)

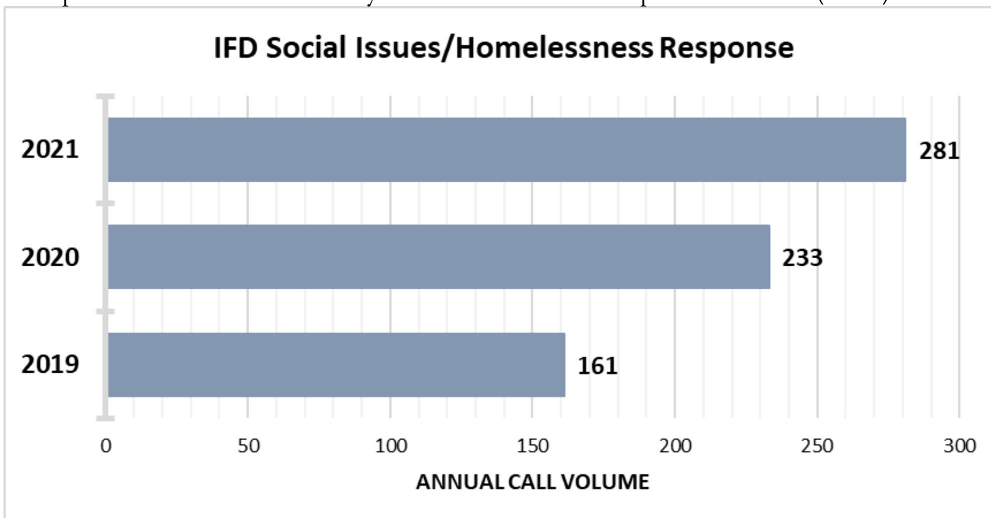


FIGURE 4 - IFD 2019-2021 Social Issues/Homelessness Response Data. [4]
Compiled with data from a study of 911 Data from Independence ECC (2022)

In 2021, 911 requests involving mental health accounted for approximately 4% of annual call volume, while social issues/homelessness concerns accounted for an additional 1% of annual volume. These categories account for 1,324 responses out of a 2021 total of 25,626 [58].

As discussed in several areas, there is a significant risk that both call sets are considerably under-reported and under-identified.

Independence Fire Department

When analyzed in the context of call volume alone, Independence Fire is the least affected by these response categories. However, it must be considered that fire response often brings more staffing and carries an inherent cost typically higher than other response organizations.

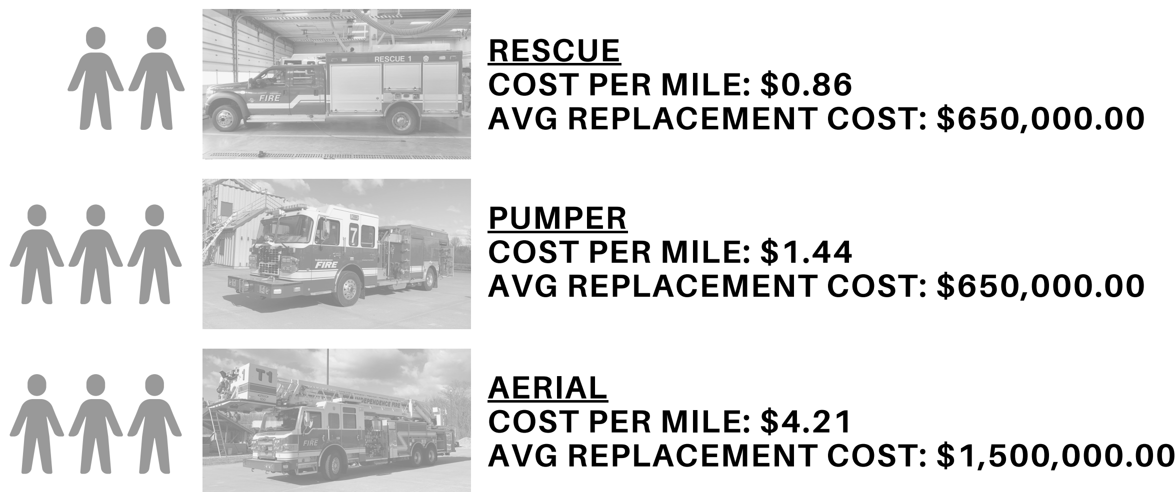


FIGURE 5 - Apparatus Information and Condition Data.
Compiled with data from IFD Study by Emergency Services Consulting International (2022)

In general, fire response is often associated with a high logistical cost. However, cost considerations especially become a factor when considering what resources firefighters bring to a given incident.

In their "traditional" role, firefighters are invaluable assets in the immediate mitigation of emergency incidents ranging from large commercial fires, vehicle accidents and emergency medical care.

Unfortunately, as Emergency Medical Technicians and Paramedics, firefighters only receive a minimum of behavioral health education. Nor do they possess the means to mitigate immediate crises and/or transport patients to crisis care facilities.

According to the National Standard Curriculum for EMTs, the behavioral health education component of EMT training can be completed in a minimum of 1.5 hours. This accounts for less than .02% of an EMT's overall education. [18]

Independence Fire Department

Paramedics generally receive 12-18 hours of didactic education in basic mental health/behavioral health awareness, along with a minimum of 12 hours in a mental health clinical environment. That education combined generally accounts for 30-40 hours of total education in an overall curriculum spanning over 1,000 hours, representing approximately 1/2 of a percentage point of total paramedic education. [19]

This minimal focus on mental health in EMS education for EMTs and Paramedics is notable. Compared to the relatively small amount of education received in mental health response, a disproportionate amount of 911 requests EMS professionals respond to in their career are likely to have a mental health component. In this aspect, EMT and Paramedics are considerably behind police organizations in adapting to mental health responses.

To some degree, the emergency response of fire assets in low-acuity circumstances will always be an unavoidable cost-of-business in emergency services. However, there is merit in considering both the risk-to-benefit and the cost-to-benefit of how we select and dispatch fire assets to low-acuity/low-risk mental health and quality-of-life 911 classifications.

"The police are the public and the public are the police; the police being only members of the public who are paid to give full time attention to duties which are incumbent on every citizen in the interests of community welfare and existence."

—Robert Peel, London Metropolitan Police Force [58]

DEFINING THE CHALLENGES

Independence Police Department

As with other response agencies, upward trending in both mental health as well as social crisis/homeless and quality-of-life issues was noted. As a reference, total annual 911 volume for IPD was 77,916 in 2020.[20]

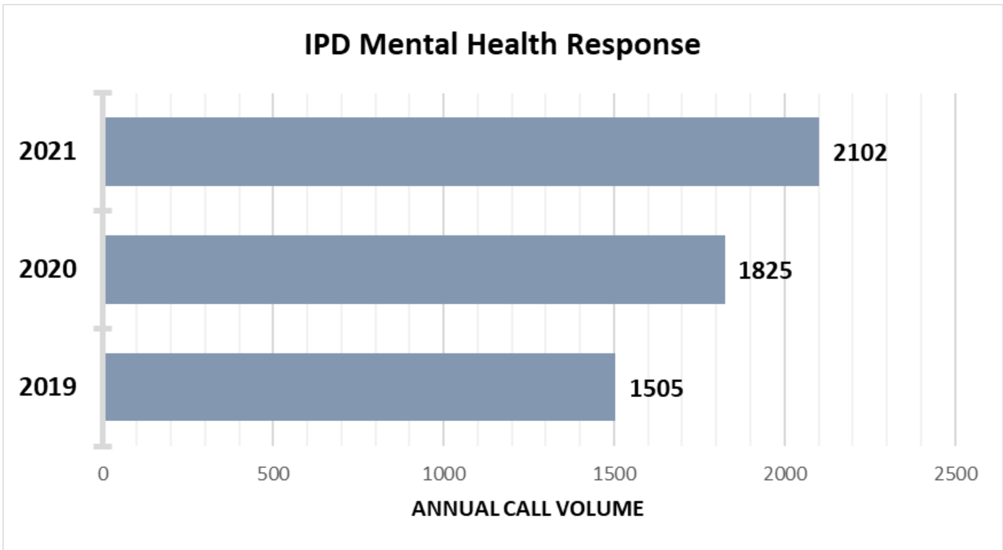


FIGURE 7 - IPD 2019-2021 Mental Health Response Data. [4]
Compiled with data from a study of 911 Data from Independence ECC (2022)

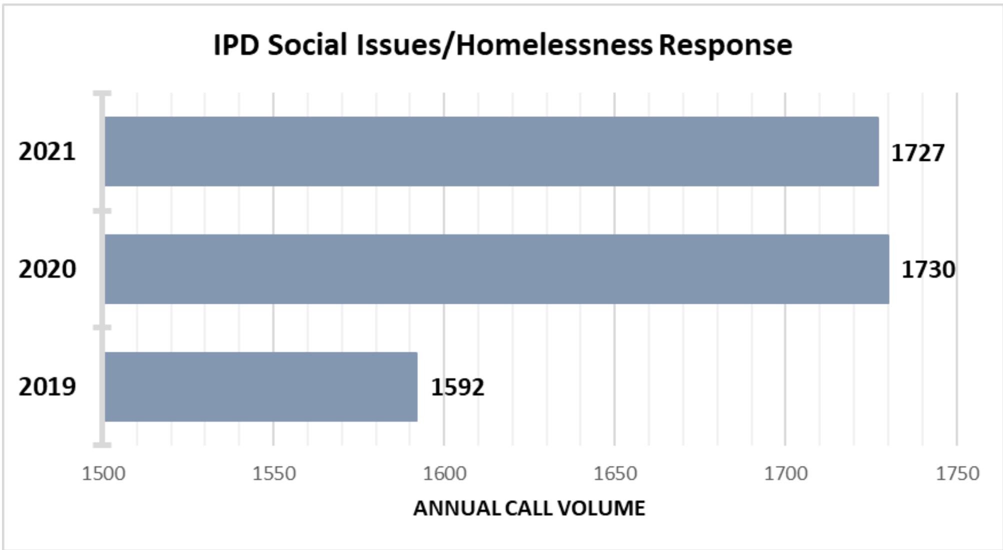


FIGURE 6 - IPD 2019-2021 Social Issues/Homelessness Response Data. [4]
Compiled with data from a study of 911 Data from Independence ECC (2022)

The notable decrease in "homeless" responses 2020-2021 are likely due to COVID-related changes in response, as well as changes in ways that calls were classified during the second half of 2021.

Independence Police Department

Often taking the lead in 911 response, officers are in a difficult position when addressing quality-of-life, substance and mental health crises. In some cases, officers must make challenging decisions between what is best for the caller/subject and what is optimal for the response system and community.

Partially, this paradox comes from the fact that identifying and addressing low-acuity community needs, particularly mental health and quality of life issues, often means that an officer must commit considerable time to the incident. These time consuming tasks include investigating the situation, determining needs and connecting with resources. This extended scene time to address community needs can clash with standard emergency services practices that emphasize a reasonably quick return-to-service.

Mental health calls occupy roughly from 7% to 12% of police call volume, but can account for approximately 25% of an officer's daily workload

- Mental Health Involvement in Police & Fire Calls for Service: Gresham Oregon 2016-2017 [6]

An officer's inclination towards quick resolution of an incident is an understandable expectation, as 911 call volumes continue to increase and having units "available and ready" to respond to a high-acuity event (such as a burglary) are ultimately the community's primary expectation of emergency services.

Immediate intervention in substance and mental health issues has consistently shown to be more effective than delayed care.[21] Unfortunately for officers, immediate intervention in a crisis can be counter to a community expectation of police units remaining available for emergency response.

Independence Police Department

Independence Police have made considerable strides in an effort to address mental health and quality-of-life needs. This includes initiatives such as Crisis Intervention Training (CIT) for officers, Mental Health Co-responders, and a Community Services Unit. In these operations, officers and mental health professionals work daily to address mental health, identify community needs and connect those needs with resources. [64]

As officers take on these additional roles, consideration must be made for the sheer amount of skill sets that the community expects police officers to be competent in. From weapons proficiency to domestic legal issues, officers have a massive job merely maintaining the education required to offer proficient and meaningful police response.

"Police Officers are held to a vast standard of performance. Negotiations, communication skills, mental health evaluation, civil law, family counseling, and juvenile issues.

And these are all on top of criminal law, firearms, defensive driving, self defense, computer skills, investigations, civil rights, case law, evidence law, and a dozen other required skill sets that the public expects us to be experts at.

The demands and expectations of an average sworn officer are incredible."

A reasonable question that must be asked is the prudence of expecting officers to continually widen their mission to cope with increasing community needs, or if this runs the risk of broadening police work to the point where the primary mission of law enforcement becomes diluted. *This is a question beyond the expertise of this report.*

IPD CIT Program

Crisis Intervention Training (CIT) is a 40-hour course designed to educate officers on the identification of persons with mental illness, increased knowledge of local treatment and services, and increased comfort in interaction with patients and citizens.[37]

The (CIT) program has lead to a greater understanding of mental illness on the part of officers. In turn, patients and family members have a greater understanding of law enforcement and law enforcement practices and protocols.

- Officer Michael Isberg, Lee's Summit, CIT Program Director [41]

A commonly cited model for CIT is based on practices out of Memphis, TN. The Memphis model has three main components, which are:

CIT Education for Officers: Mental health education is taught by mental health professionals & persons with mental illness. [63]

Dispatcher Education: Call takers receive specialized education to recognize calls that likely have a mental health component, with the goal of sending CIT officers to these requests when possible. [63]

Receiving Facilities: Police identification and transport of those in a mental health crisis to mental health facilities. [63]

When possible, IPD CIT officers are dispatched to response situations involving mental health. CIT officers also coordinate with the full-time CIT officer and Comprehensive Mental Health Co-responders for follow-up and secondary response for mental health issues identified by IPD officers during 911 incidents. [64]

IPD CIT officers have also transported mental health patients directly from scenes to mental health facilities, bypassing EMS an ERs in an attempt to facilitate immediate and appropriate care. [64]

IPD Mental Health Co-Responders

In addition to the IPD CIT program for patrol officers, Independence Police staff several full-time positions that are focused on community needs. These positions include a Community Services officer and a CIT officer, with the CIT officer acting as a full-time liaison with Comprehensive Mental Health clinicians and IPD officers, providing support to both groups in identifying and addressing community mental health needs. [64]

These clinicians, known as Co-Responders, are a valuable asset to the city and community. Staffed by mental health professionals contracted through Comprehensive Mental Health, these providers liaison with IPD and 911 assets to identify immediate mental health needs in Independence.

Currently, IPD hosts two Co-Responders from Comprehensive Mental Health. These dedicated mental health professionals divide their time between being present in the ECC and riding along with officers, ready to provide immediate mental health assistance in circumstances where both an officer and mental health clinician are required on-scene.

> Merriam Police Chief Darren McLaughlin said at the Feb. 28 city council meeting that the co-responder program is one of the most impactful things to happen in his 33-year career.
>
> "Unfortunately, right now, outside of the co-responders being embedded with us, we're it," McLaughlin said. "Law enforcement is the primary, first contact with most mental health crisis issues."
>
> *- Shawnee Mission Post "Police use of mental health co-responders expected to hit all-time high in JoCo this year"* [42]

Police Co-responders are quickly becoming an "industry-standard" for police work, and are an important component of Independence city services. Exploration and expansion of both CIT and Co-responders are an appropriate "next step" consideration when discussing mental health response in Independence.

Measuring Outcomes in mental health response

As will be discussed, there are considerable benefits to programs like CIT and Co-Responders. However, when reviewing the various forms of emergency services based mental health response, it is prudent to ask if these programs make a difference in mental health outcomes.

It must be noted that, in the field of mental health, measuring outcomes can be particularly difficult, as outcomes can be quite subjective and results on-going. A 2017 UK study of various forms of mental health response noted that:

"Kane et al. found no clear evidence from the studies reviewed of superiority for one approach over the others in terms of benefit for various criminal justice outcomes, such as the number of arrests or days spent in detention, or for primary health outcomes, such as identification of mental illness at an earlier stage." [37] [38]

There is no shortage of scholarly research in the area of mental health, CIT and police response. In most cases reviewed, there was a similar theme noted. In summary:

"There are considerable perceived positive effects in the implementation of these programs, but there are major challenges in standardizing metrics and demonstrating efficacy in community mental health outcomes, with notable variations in study methodology and outcomes." [37] [38] [39]

Several of these studies included community response programs similar to the one proposed in this report.

"Proving" that particular mental health response programs have positive results on mental health outcomes requires both standardization of measurable metrics and the collection and measurement of those metrics cross-jurisdictionally. This continues to be an on-going challenge.

Benefits of mental health response

Mental heath outcomes aside, there are considerable organizational and community benefits in the implementation of mental health education and response programs.

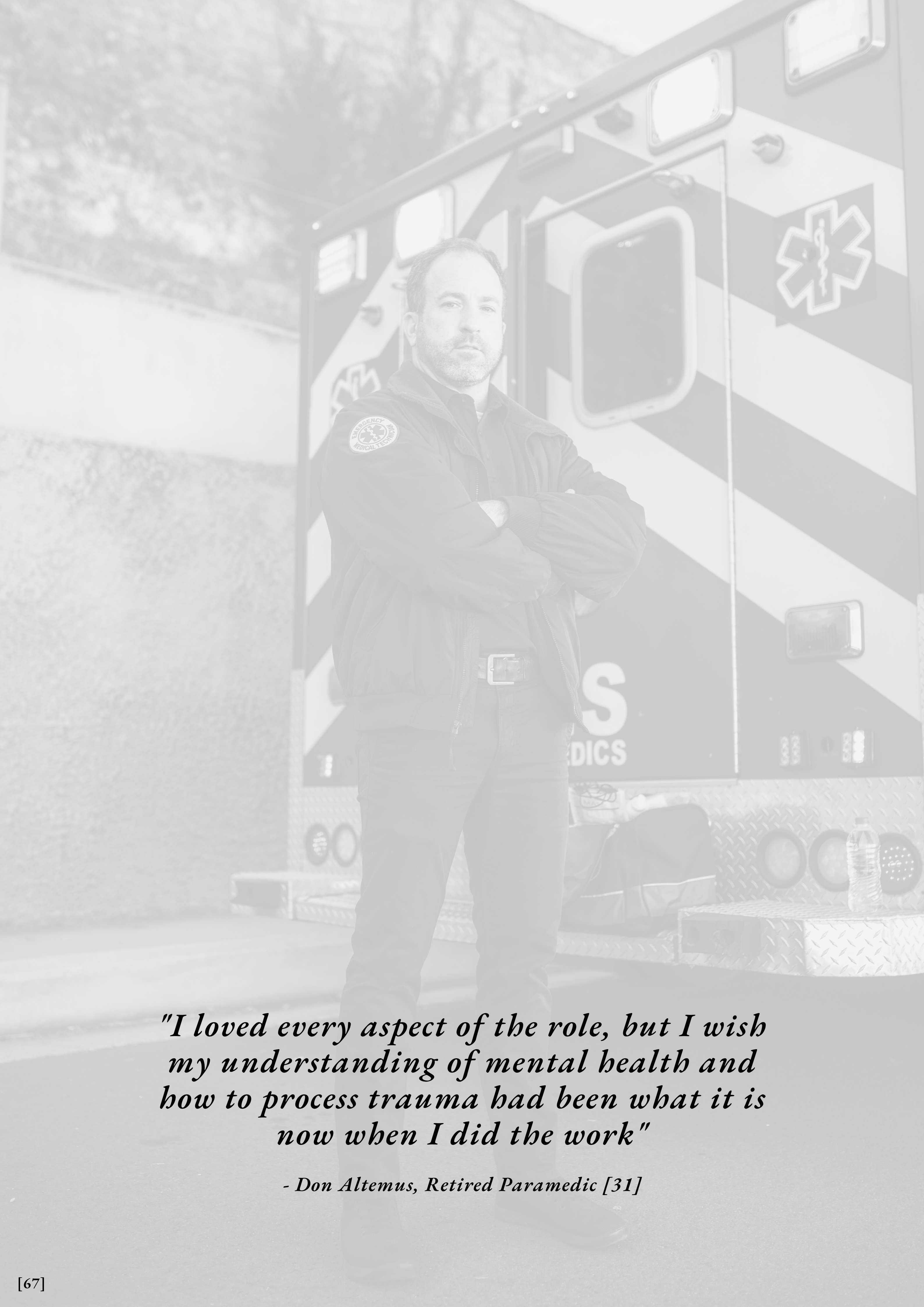
These notable gains include a better understanding of mental health for first responders, a better understanding of policing protocols and challenges within the community, and the tertiary effects of mental health conversations between city and community resources.

Much research has shown an improvement in attitudes and a reduction of stigma in police officers who received mental health training. There is good evidence for benefit in officer-level outcomes, such as officer satisfaction and self-perception of a reduction in the use of force. A survey of police officers indicated that CIT-trained officers perceived themselves as less likely to escalate to the use of force in a hypothetical mental health crisis encounter. [37]

Furthermore, the efforts of CIT officers and embedded Co-Responders undoubtedly provide support and relief for mental health emergencies in ways that are exceptionally difficult to measure, but are nonetheless important and relevant to the community.

Additional development of both programs should be explored as each initiative represents an important component of IPD's support for the community they serve.

In addition to these programs, there is merit in considering a community response that fully releases officers from some low-acuity/low-risk 911 events and provides the community with a resource that has the professional education and resources (including time and transport) to address immediate issues.



"I loved every aspect of the role, but I wish my understanding of mental health and how to process trauma had been what it is now when I did the work"

- Don Altemus, Retired Paramedic [31]

DEFINING THE CHALLENGES

American Medical Response

EMS transport agencies often bear the brunt of the management and transport of mental health and quality-of-life patients. As with IFD staff, EMS personnel frequently face limited options when asked to address mental health and quality-of-life challenges. This often results in the unnecessary transport of these patients to an ER for a lack of other options.

Low-acuity requests will always be a part of 911. However, there are certain sub-sets of calls that are particularly concerning, for all parties involved. In some of the most unfortunate examples, EMS units are utilized by patients simply because an ER visit is preferable to incarceration, or that EMS can simply be path to a bed, warm meal and reprieve from immediate social conditions that is otherwise unavailable.

It is important to note that persons calling 911 in these circumstances are often suffering from conditions and pain that can be hard to identify, even for themselves. 911 use in many of these circumstances is an often ineffective use of resources, both for the system and the person in need.

The reduction of emergency system capability these issues create is significant. Assets quickly bog down with low-acuity needs, often requiring long transports and diversions that draw emergency assets away from the city and 911 availability.

Current debates around increasing mental health call volume for paramedics, in the media as well as in academia, identify several factors as problematic, such as inappropriate use of paramedic services for mental health and other psychosocial issues, insufficient paramedic mental health training, and deficiencies in community mental health services.

~ A Critical Analysis of Debates Around Mental Health Calls in the Prehospital Setting, Ford-Jones, 2017 [22]

American Medical Response

An overview of American Medical Response call determinants notes a considerable number of responses and transports per year for "Psych/Behavioral" call classifications. These transports composed 3% of AMR's yearly average 911 call volume of 17,533 in 2021.[23]

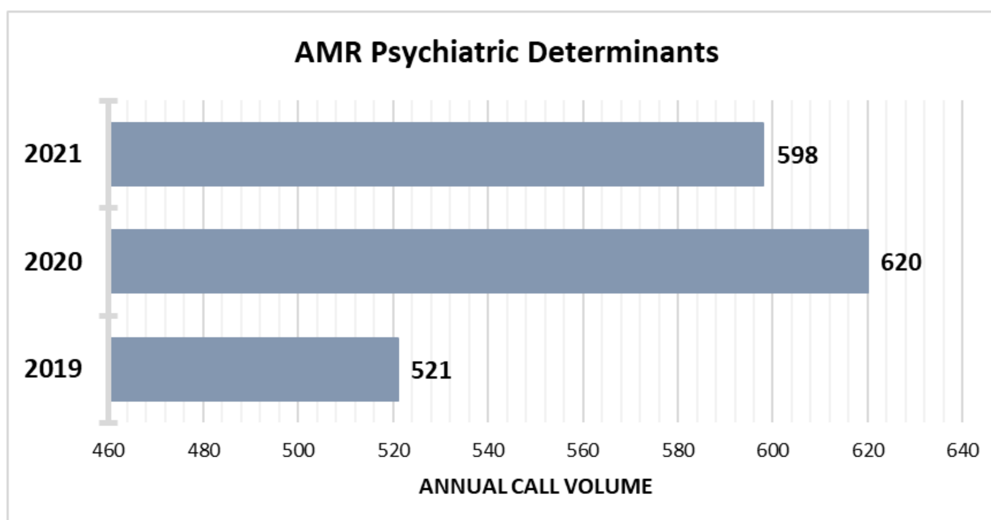


FIGURE 8 - AMR 2019-2021 Psychiatric/Behavior Crisis Determinant Data. [23]
Compiled with data from a study of 911 Data from AMR Independence (2022)

It is important to note that this AMR data was gathered differently than the IPD/IFD data. AMR volumes are an assessment of "call determinant" alone, and not a "Keyword" search. Anecdotally, there are a considerable number of additional calls not included in this data that could qualify as low-acuity and/or quality-of-life concerns. The reliability of this data to indicate accurate run numbers should be considered questionable.

The reliability of this data comes from how medical calls are classified. As an example: a 911 caller that calls for a mental health condition, but indicates that they are having "*shortness of breath*", may cause a "bump" in the classification from "Psychiatric/Behavioral" to "Respiratory", thus changing the response and classification to the most significant medical finding identified during 911 questioning. Although appropriate for medical call sorting, this method can make EMS 911 data assessment unusually challenging.

American Medical Response

Along with challenges in 911 data, EMS operations face considerable obstacles in mental health response; in particular with the transport of patients to an appropriate care facility. From heart attacks to toothaches, hospital emergency rooms must give a proper assessment and stabilizing care to all who enter their doors. Thus, Emergency Rooms are often the "catch-all" when it comes to medical issues within the community.

Although capable of handling mental health and quality-of-life crisis patients, ER staff will often (appropriately) sort, or "triage", these patients as low-acuity and delay care to focus on high-acuity medical emergencies. This process is an industry-standard practice in circumstances where health services are overwhelmed, as time-sensitive medical needs often outweigh mental health assessment and care.

This can create a considerable break in care as patients are shuffled backwards, as well as tighten the strain on limited resources such as ER beds. Emergency staff often do not have the considerable time required to assess, treat and connect these patients to resources.

In extreme cases, an ER will "divert" EMS transport of low-acuity patients away from an ER if that ER is excessively busy. This can be particularly difficult for EMS systems, who rely on the quick transport and hand-off of patients to maintain a functional EMS system.

During one 911 transport in January of 2022, an Independence AMR unit spent over two hours transporting in the KC Metro area attempting to find an "open" ER that would accept a low-acuity patient.[24]

AMR is taking steps to address these concerns, including the initiation of a "Nurse Navigator" call diversion program, where 911 callers with pre-identified complaints will be connected to a nurse, instead of an ambulance. This nurse will help connect the caller with the best appropriate resource, including self-care, private transportation, or re-connection to 911 services for an ambulance. [24]

"Phones ringing, calls piling up, using every approach at customer service and a huge dollop of luck to get through the shift. Providing Pre-Arrival Instructions to assist a son giving CPR to his father. Calming the mother whose child is missing……emergency dispatch is like being part of a room full of superheroes that no one knows is there."

– Kim Rigdon, Communications Commander, Toronto Paramedic Services [24]

DEFINING THE CHALLENGES

Independence Emergency Communications

The difficult role that 911 call centers face cannot be overstated. Call-takers and dispatchers are tasked with receiving incomplete and fragmented information and rapidly translating this into the most appropriate combination of emergency resources, often in the face of challenging circumstances. Their overarching goal is to ensure that the 911 caller receives the most appropriate emergency response as quickly as possible.

This can be exceptionally difficult for many reasons, not the least being the time-sensitive nature of 911 response often contradicts the need for time to gather additional information to better define what type of emergency is being reported.

These challenges are only increasing. In the coming years, it is predicted that continuing propagation of sensor-initiated 911 calls generated by smartphones, alarm systems and Internet of Things (Iot) devices (e.g. wearable medical monitors) will further escalate 911 call volume, escalating the demands placed on both 911 call centers and traditional emergency response agencies. [25]

Furthermore, the development and implementation of additional routes to 911, such as Text-to-911 or the National 988 Suicide Prevention Hotline, present new pathways to 911 use that likely will increase 911 call volumes beyond the unprecedented utilization levels seen today.[22] [23]

These increasing challenges are reflected in the service provided daily by call-takers and dispatchers in Independence Emergency Call Center (ECC). A broad analysis of call data from the Independence ECC notes a consistent annual increase in both emergency and non-emergency call volume.

Independence Emergency Communications

From 2019 to 2021, Independence ECC saw an overall 11% increase in non-emergency and 6% increase in emergency call volume.[4] This increase is expected to continue.

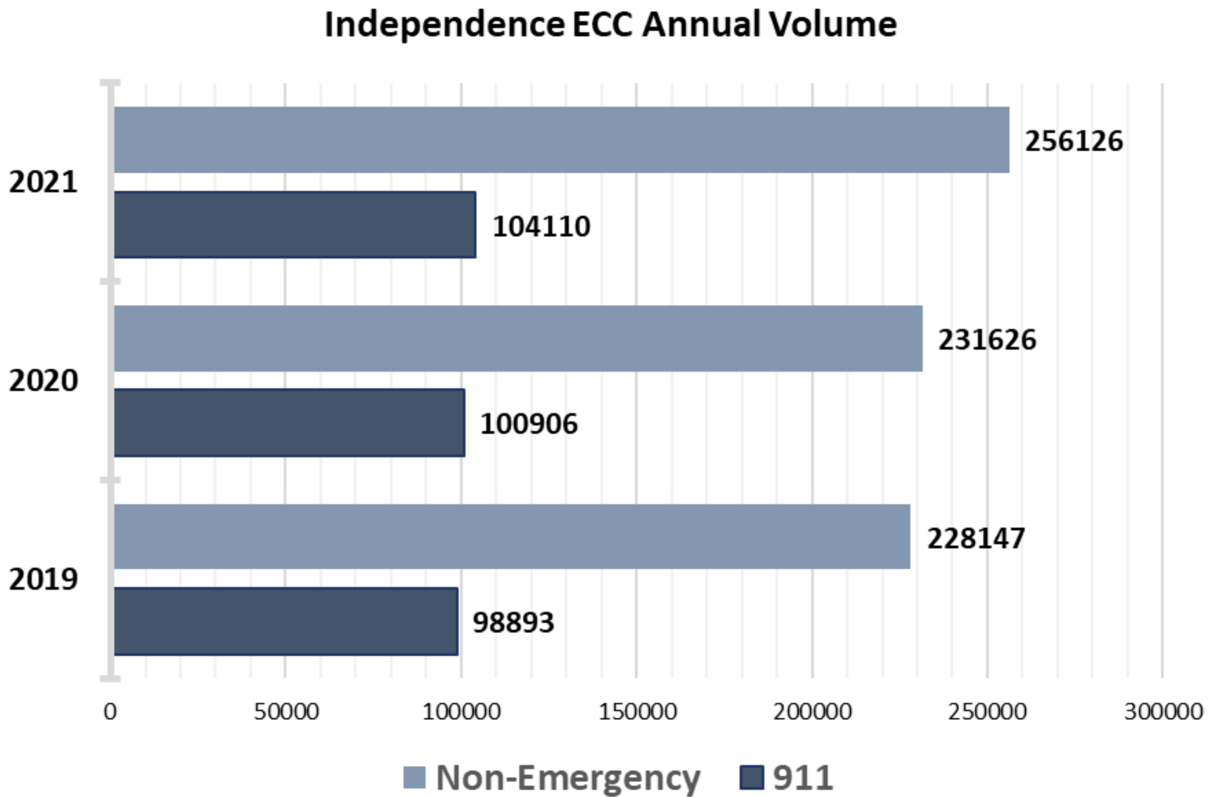


FIGURE 9 - Independence ECC 2019-2021 Total Call Volume Data. [4]
Compiled with data from a study of 911 Data from Independence ECC (2022)

The important role 911 plays in behavioral health emergencies has drawn frequent national attention. As the initial contact for any emergency response, call takers are under more pressure than ever to correctly identify emergency needs and send the right response.

Sadly, a national research study on 911 capabilities noted that most centers lack even the most basic training and resources to deal with mental health emergencies, despite being both the first contact with a caller and the entity responsible for classifying the emergency and dispatching the best available resources.[24]

Independence Emergency Communications

This same study noted considerable variation nationwide in how different call centers classify data relating to mental health and quality-of-life requests.[24] The lack of consistent coding and data management means that the information necessary to fully understand the scope of behavioral health crises in the community is often hidden in different 911 call classifications.

In response to a negative event involving a mental health emergency, Philadelphia 911 administrators reacted by creating a page-long "mental health script" including a flowchart and follow-up questions for call-takers to use if they suspected that the caller was dealing with mental health issues. The general response from the community and behavioral health specialists was the same: *It's a good thing, but the script is too long*.[25] Careful consideration of both call classification as well as time requirements must be taken into account before the implementation of mental health procedures in 911.

For community response units to respond to the right incidents, emergency dispatchers need to be able to decide what counts as a mental-health call, and they need to be able to do it from the incomplete information provided during a 911 call made in the heat of a crisis

Our 911 call-takers and dispatchers fill a wide variety of roles, from the first point of contact for 911, coordination and support of emergency response, logistical support for multiple city departments, gatekeepers for 911 call data, and more.

<u>This proposal largely rests on understanding and addressing the identification of mental health and quality-of-life service 911 requests and developing solutions to allow for the rapid, safe and efficient triaging and assignment of those requests to the most appropriate response asset</u>.

"It always seems impossible until it's done"

Nelson Mandela [57]

COMMUNITY OUTREACH RESPONSE to EMERGENCIES (CORE)

PROGRAM HIGHLIGHTS

Increase Independence 911 capabilities

with a specific focus on working with 911 professionals to identify emergency calls-for-service that would most benefit from a community response program.

Develop a 911-based community response

program staffed with medical and mental health professionals that will respond to 911 requests determined to be low-acuity in nature.

This unit will free Police, Fire and EMS assets to be available for emergency response, as well as providing a specialized asset that can offer immediate solutions and resources to community members.

Build an Organizational Structure

that supports this program's operational and administrative needs.

Organize a Community Advisory Board

composed of private and public organizations involved in community outreach within the City of Independence to provide community input and oversight for the program.

COMMUNITY OUTREACH RESPONSE to EMERGENCIES

CORE Overview

CORE is a proposal for a pilot program to provide person-centric mobile crisis response to community members who are experiencing problems related to mental health, depression, poverty, homelessness and/or substance abuse issues. [30]

The CORE pilot program will be dispatched by Independence 911. Dispatchers will receive education on 911 call triage and industry best practices on the most effective means for rapid and accurate low-acuity/low risk 911 call identification.

The CORE vehicle will be staffed by a paramedic and mental health professional. Once dispatched and on-scene, CORE will offer a broad range of no cost services such as providing information and referrals, crisis intervention, counseling, transportation solutions, and social service needs. These services may include access to low-barrier treatment options, reconnection to service providers, and transportation to safe locations or support systems. [30]

CORE staff will not be armed and will not perform any law enforcement, fire or emergency medical duties. CORE is an alternative response and will not respond to incidents involving violence or life-threatening medical situations. [30]

CORE does not replace the current IPD CIT and Co-Responder programs, but rather is an additional asset within our community.

More than 20 percent of people experiencing homelessness in the United States have a serious mental health condition, and roughly a third have a substance use disorder.

- Substance Abuse in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Office of the Surgeon General (US). 2016 Nov. [29]

CASE STUDY - DENVER S.T.A.R.

Denver, Colorado - Support Team Assisted Response

On March 7th, 2022, Independence representatives traveled to Denver to meet the leadership and staff of Denver STAR. STAR is a community response program through a collaboration the Caring for Denver Foundation, Denver Police Department, Mental Health Center of Denver, and Denver Health Paramedic Division.

Started in June of 2020, STAR began with a single van and two-person team. Over 3,000 responses later, STAR is expanding to six vans and more than a dozen staff members.

> They've responded to reports of people experiencing psychotic breaks and people screaming for no apparent reason. They've helped a woman experiencing homelessness who couldn't find a place to change, so she undressed in an alley. They've helped suicidal people, schizophrenic people, people using drugs. They've handed out water and socks. They've helped connect people to shelter, food and resources.
>
> - Elise Schmelzer, Greeley Tribune [48]

Independence representatives experienced all levels of STAR, from dispatch and leadership to road operations and clinical. In one 6-hour stretch with Independence staff on-board, a STAR unit took 8 low-risk calls-for-service that otherwise would have been handled by DPD units.

> "I want the police department to focus on police issues," Pazen said. "We have more than enough work with regards to violent crime, property crime and traffic safety, and if something like STAR or any other support system can lighten the load on mental health calls for service, substance abuse calls for service, and low-level issues, that frees up law enforcement to address crime issues."
>
> - Denver Police Department Chief Paul Pazen, 2021 [47]

STAR is an example of a successful partnership between the city and community to meet needs communicated via 911 where-they-are and as-they-are, as well as reducing Police, Fire and EMS responses to low-risk 911 requests.

CASE STUDY - EUGENE C.A.H.O.O.T.S

Eugene, Oregon - Crisis Assistance Helping Out On The Streets

"CAHOOTS (Crisis Assistance Helping Out On The Streets) is a mobile crisis intervention program staffed by White Bird Clinic personnel using City of Eugene vehicles. This relationship has been in place for nearly 30 years and is well embedded in the community." [27]

"CAHOOTS provides support for EPD personnel by taking on many of the social service type calls for service to include crisis counseling. CAHOOTS personnel often provide initial contact and transport for people who are intoxicated, mentally ill, or disoriented, as well as transport for necessary non-emergency medical care." [27]

CAHOOTS teams respond in a variety of ways. Some calls are a joint response, or CAHOOTS is summoned to a police or fire call after it is determined their services are a better match to resolve the situation. A 2020 EPD study noted that CAHOOTS diverts 5-8% of 911 requests from police, fire and/or EMS response. [49]

Developed as a community policing initiative in 1989, CAHOOTS in Eugene, Oregon is a long-standing community response program that has served as a model for a number of crisis response programs across the country. [27]

CASE STUDY - MADISON FIRE C.A.R.E.S.

Madison, Wisconsion - Community Alternative Response Emergency Services

Begun on September 1st, 2021, Madison Fire Department's CARES Program was initiated by a request from city council for an alternative response program for low-risk 911 mental health emergencies. This program is a collaboration between Madison Fire Department, Dane County 911, Dane County Human Services and Journey Mental Health.

Madison Fire Department's Community Alternative Response Emergency Services (CARES) team began responding to 911 calls effective September 1, 2021. [28]

CARES is currently 6 months in to their pilot program. They respond to a variety of mental health emergencies with a licensed clinical social worker and a paramedic.

Eligible CARES call types include: Suicidal Person, Assist Citizen, Intoxicated Person, Welfare Check, and Check Person.

If there is a weapon involved, sounds of a disturbance, allegations of assaultive or threatening behavior or the caller demands police contact, the call is NOT CARES eligible.

The following information MUST be verified with the caller and entered in the body of the call:

*Verified No Weapons
*Nature of assistance caller is seeking
*Demeanor/behavior of person needing assistance
*No acts or threats of violence

- Dane County PSC/CARES 911 Call Flow [50]

CORE Program

The type of program CORE represents is quite new, with an estimated 20 programs currently in operation across the nation. Despite the relative infancy of these programs, there exists a considerable amount of research on the topic of crisis response. CORE structure and guidelines have been built on industry-standard mental health publications.

CORE framework includes:

- A two-person team consisting of a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation; and a medical professional, licensed to assess clients' medical condition and assist as warranted in coordination with the mental health clinician.

- Response without law enforcement accompaniment unless special circumstances warrant inclusion.

- Implement integration with ECC CAD and asset tracking, along with an established procedure with the local crisis center call hub to support 988 crisis response as warranted.

- Connecting individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

"The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder"

"Additional objectives may include linking people to needed services and finding heard-to-reach individuals. The main outcome of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission"

"SAMHSA asserts that mobile crisis team care is one of three essential elements of a well-integrated crisis system of care"

- National Guidelines for Behavioral Health Crisis Care, 2020 [26]

CORE, CIT and Co-Responders

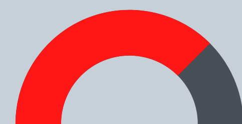
There must be a clear understanding of the uses and limitations of CORE. CORE is not a replacement for CIT and Co-Responder (CoR) programs. CORE is a component of a response system that fills a critical need not fully addressed by CIT and Co-Response programs.

The primary focus of CORE is "low-acuity" response, or community needs that do not involve violence, criminal activity, acute medical events, or time-critical incidents.

CORE, CIT and CoR each provide a specialized mental health response to varying degrees of assessed risk within a 911 request or incident.

- Police-based specialized police response: Sworn officers obtain special training and function as first responders to mental health calls in the community and coordinate with local mental health resources.

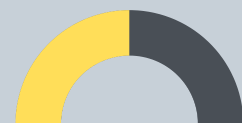
CIT



HIGH RISK

- Police-based specialized mental health response: Non-sworn mental health professionals provide on-scene consultation and advice to sworn officers in the field.

CoR



MODERATE RISK

- Mental-health-based specialized mental health response: Independent mental health response to 911 requests with mental health workers as primary agents.

CORE

LOW RISK

As already discussed, the question of risk and 911 assessment of acuity can be very ambiguous. Studies of other successful CORE-style programs indicate the necessity of focused education of 911 professionals on call assessment and the importance of pilot programs to test CORE viability and response criteria.

CORE Dispatch

CORE pilot eligible responses will begin with a small set of specific dispatch call nature codes, and slowly evolve as CORE staff, police officers and ECC staff determine the capabilities and limitations of the CORE program.

A 911 response reference guide is in draft form as of this writing and is being evaluated by ECC 911 professionals for feasibility.

Examples of CORE-appropriate 911 nature codes could include:

- Man Down
- Citizen Assist
- 602 - Trespassing (Homeless)
  - Loitering
- CTW - Check Welfare
- 647C - Panhandling
- 647F - Public Intoxication
- 5150 - Mental Health (No weapon, Non-violent)
- Suicidal Person (No weapon, No plan)

Examples of CORE-appropriate calls might include:

- *A bartender calls and advises there is a man who just left a bar and is intoxicated and they are worried about him walking in his condition.*
- *Caller has a friend who made comments about suicide. Caller would like someone to go check on friend.*
- *A clerk at a convenience store reports a drunk male who is sitting on the curb in front of his store.*
- *Caller is feeling depressed and wants to talk to someone.*
- *A gas station clerk says there is a man outside the store who is sitting on the curb talking to himself.*
- *Caller has someone sleeping at a table outside of their business.*

**Examples utilized from STAR Combined Reference Guide. [30]*

CORE Dispatch

Specific call nature codes cannot be considered an "always" or "never" for CORE response. CORE will rely heavily on the 911 dispatcher and CORE team's ability to discern appropriate versus non-appropriate responses.

An example of this is Denver STAR. As the crisis response program has matured in the 2 years of it's existence, call-takers and dispatchers have slowly gained confidence and comfort in their ability to both identify STAR appropriate responses, as well as clearly understand STAR crews' comfort levels and capabilities.

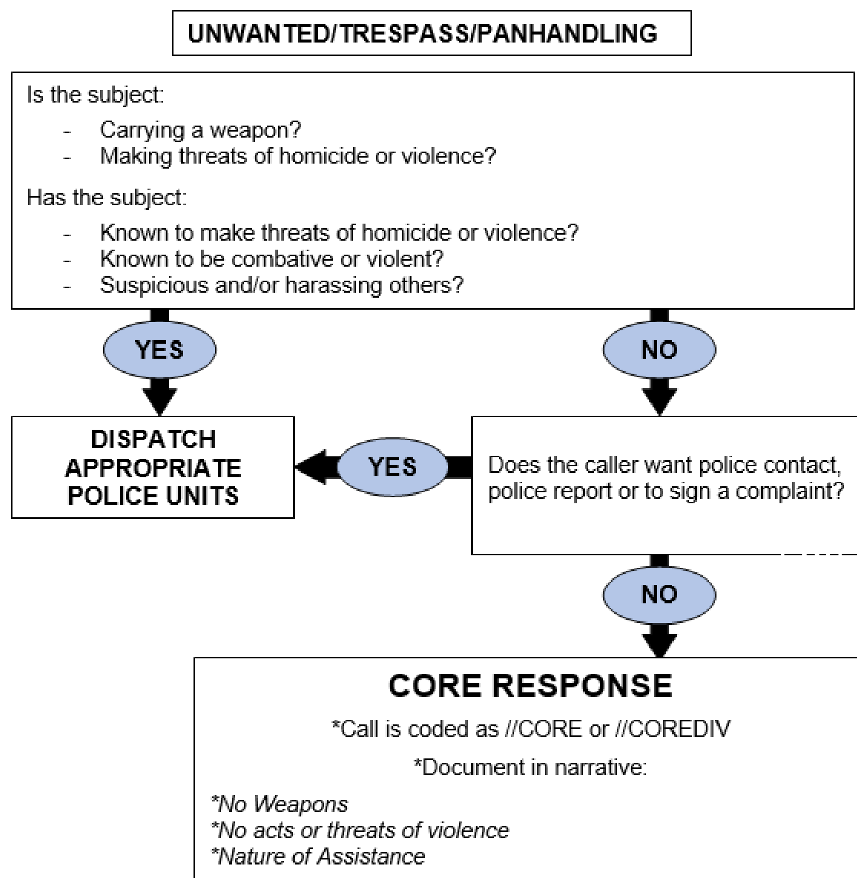


Figure 10 - Independence CORE - 911 Algorithm for CORE Response

It is important to note that CORE is designed to address a broad range of responses not just limited to mental health response. CORE is an appropriate option for a wide variety of community response needs, especially considering the considerable overlap in mental health, substance use, and quality-of-life challenges.

CORE Dispatch - 911 Diversion

A recurring theme in this report is the challenge of collecting, analyzing and interpreting 911 data.

A key consideration of the CORE program is the reduction of low-risk 911 requests on existing emergency services. Therefore, care must be taken to understand the complex relationship between data collection and interpretation of IPD and CORE response.

CORE will certainly "divert" some calls from Independence emergency response departments. In addition, it will likely increasingly handle unique calls that aren't normally handled by emergency services. These calls are likely to increase with CORE visibility, including calls that are self-initiated, called in direct to CORE, or initiated through follow-up via local aid services. Therefore, the assumption that all CORE calls are diversions away from other emergency services is faulty. [49]

Therefore, determining the true "divert" rate from emergency services is not as simple as removing all calls associated to CORE from the total number of 911 calls received by Independence ECC.

Care will be taken by CORE Leadership to establish key metrics that will be tracked both by 911 dispatchers as well as CORE field staff. Integration with Health Department and Police Department 911 analytics will be critical to show efficacy and benefit of the CORE program to both city and community leaders.

"CAHOOTS does divert calls from EPD, however it is not the 17-20% reported by just looking at the total number of CAHOOTS calls compared to EPD calls. Even with and full and comprehensive study of calls responded to by CAHOOTS, it is not possible to find an exact divert rate for specified period. It is likely that the true divert rate falls between approximately 5%-8%."

~ Eugene Police Crime Analysis Unit. (2020) CAHOOTS Program Analysis [49]

CORE Dispatch - Safety

CORE is designed to function as a response component within the Independence 911 system. As such, CORE will respond to 911 incidents as a single-unit asset, often with no accompaniment of other response agencies.

When discussing CORE response to 911 requests, scene safety is a frequently cited concern.

The purpose of CORE is not to take the place of 911 requests that clearly require a Police, Fire or EMS response. There should be no criminal activity, no disturbance, no weapons, no threats, no violence and no medical needs.

It should be noted that outreach response in the community happens every day. Outreach organizations walk through the woods, respond to requests in moments of crisis, follow up with patients and meet clients in their homes to meet similar needs to which CORE is designed.

The number "911" and word "Emergency" are inherently synonymous. Emergencies, by definition, are "a serious, unexpected, and often dangerous situation requiring immediate action"[44].

CORE seeks to address the ever-increasing 911 call load that exists on the margins of "emergency" response with the specialized resources to immediately address those still-important community needs.

Just as there are risks on every emergency scene, CORE responders must remain cognizant of their surroundings and circumstances.

It must be noted that, by being a part of the 911 system and "visible" to dispatchers, CORE has a certain level of security that case workers, counselors, social workers and outreach specialists do not enjoy, despite similar working conditions.

Denver STAR, a 911 crisis response program, boasts a call volume over 3000 since inception, without a single request for police backup since program inception in 2020. [48]

CORE - Vehicle & Equipment

CORE would utilize a van or other suitable response vehicle. This vehicle would have emergency lights only for use as warning lights for parking on the roadway and in high-traffic areas. The CORE unit would not have a siren and is not designed for "Code 3" emergency response.

CORE would be fully integrated in the CAD, as it is dispatched by 911 dispatchers. This would allow CORE providers to be aware of pending call requests, addresses of those requests, and mapping for response.

This CAD integration requires the installation of MDT equipment into the CORE van, as well as radio equipment and associated modifications. CORE providers would require a single handheld radio and cellular phone. Visual identification of the unit as CORE should be minimal but sufficient.

CORE units should have a minimum of equipment and supplies readily available for use. These items may include:

Medical:
- Automated External Defibrilator
- Basic Life Support Medical Kit
- Narcan/Fentanyl Test Strips
- Medical Gloves/Masks
- Biohazard Bags/Trash Bags

Support:
- Blankets
- Basic Clothing Items
- Hand Warmers
- Snacks/Bottled Water
- Sanitary Items

Resources:
- Handouts for various community resources
- Contact information for community resources

CORE - Transport & Facilities

A key asset of the CORE program is the ability to transport clients. This resource is critical as there are a host of resources available to the community within or close by Independence.

It should be noted that there exists considerable concern about the abuse of a free transportation resource. CORE staff must utilize discretion when facing possible abuse of the program. In those cases, reliance on CORE leadership and other clinical expertise is essential. When in doubt, crews will exercise clinical discretion and will always have the option to "phone a friend" to determine next actions. CORE exists to solve immediate issues so emergency services may continue to "stand ready" for high-acuity 911 events, therefore, a certain level of system "abuse" can be tolerated if it allows other response agencies to not be affected. This is in-line with other mobile crisis response agency practices.

A key asset to the CORE program is the development of nearby Mental Health and Substance Abuse Urgent care and 23-hour facilities. These facilities are often considerably more appropriate destination for clients than an ER, and can offer a wide range of services from pharmacies to psychological evaluation.

[65]

Independence Crisis Triage Center *(In Development)*

A 23-hour facility serving to divert persons with mental health and substance use disorders away from jails and area emergency rooms to a safe place where they can be assessed and stabilized.

Behavioral Health Urgent Care Clinic

The BHUCC is an 8am to 4pm facility open to any walk-in and voluntary adult 18 and older in need of immediate mental health or substance use services.

[65]

[65]

Kansas City Assessment and Triage Center

A 23-hour facility serving to divert persons with mental health and substance use disorders away from jails and area emergency rooms to a safe place where they can be assessed and stabilized.

CORE - Program Cost Estimates

Initial start-up expenses for the CORE program can be staggered to offset the impact of beginning this program "from the ground up". Furthermore, there are possibilities to explore for funding through federal programs such as Medicare and Medicaid to reimburse for services rendered through local mental health providers.

Denver STAR advised that they had a reimbursement rate of "98 percent" through state and federal Medicare and Medicaid funding. (C. Richardson, personal communication, March 9, 2022)

The information below was compiled using public sources and estimates of employee benefits, overhead expenses and item current market value as of this writing. It is meant to be a guide, not a specific analysis, of likely expenses.

Staffing

Paramedic - Average Yearly Salary..........$48,469 [51]
Total Expense Estimate...........$62,500 [52]

LCSW/LPC - Average Yearly Salary.......$64,773 [53]
Total Expense Estimate.....$84,120 [52]

Vehicle

2020 Ford Transit.......................................$50,000 [54]
Emergency Lights.....................................$2000
Seat Protection...$2000
Gateway, Computer & MDT.....................$5000

Equipment

Handheld Radio..$6700 (apiece)
Microphone, Lapel & Radio Pouch...........$700
AED & Medical "Jump Bag".........................$1000
Outreach Supplies.......................................$250
Uniform/Staff Identification.......................$1000

Based on these estimations, initial start-up expenses are likely in the area of $250,000. (Total above is $215,270)

This will cover the majority of expenses (excluding operating costs such as fuel and maintenance) for a single unit operating for four 12-hour shifts per week (or five 8 hour shifts) for one year.

CORE - Organizational Leadership

The limited number of mobile crisis response programs in existence have some commonalities in the manner in which they are structured.

Generally speaking, existing response agencies and cities refrain from directly managing and leading these programs. Instead, operations, personnel and equipment are run by the local mental health provider who serves as a contractor to the city. The city often will provide logistical support in the form of Paramedic or EMT staff, fuel, CAD interface and 911 system integration. However, day-to-day leadership is often run by mental health professionals, in partnership with 911 response and 911 dispatch authorities. This structure has several benefits.

Association with the area's Mental Health provider allows crisis response clinicians to be connected to a larger mental health organization, creating significant continuity of work in the monitoring and awareness of mental health and social needs within the community.

Crisis response clinicians, in responding to clients during 911 response, are connected to patient records and information that allow their contacts to feed into the larger mental health network of the local catchment provider, giving clinicians, co-responders and case workers the ability to provide secondary and follow-up care with clients they may not have been able to otherwise do.

Furthermore, the flexibility and logistical support that a mental health provider has on services rendered, legal liability, patient records and financial factors are often much greater than city government can provide.

If there is a single hallmark of crisis response programs, it is that they are customized and designed in ways that best suit the community and response program goals. CORE leadership structure doesn't necessarily need to imitate other programs, and instead should be created in such a way that best supports the mission.

CORE - Community Advisory Board

CORE is inherently a community-oriented program.

Therefore, an important component of this program would be the establishment of a Community Advisory Board consisting of both local community outreach programs and members of the community.

This will allow CORE to keep a sharp focus on community needs and how effective they are in meeting those needs.

This group would be responsible for reviewing data on CORE operations and make policy recommendations to CORE leadership.

About this proposal

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This proposal was developed and written by Independence, Missouri Fire Department staff with the goal of developing a pilot 911 crisis response program for the City of Independence, Missouri.

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