Low Acuity Calls for Service in the City of Milwaukee: Part 1 MPD

Wayne State University's Center for Behavioral Health and Justice contracted with the City of Milwaukee to assess Milwaukee's low acuity calls for service that could be serviced by alternative, non-sworn responders. The potentially low acuity calls include calls coded by the 911 Emergency Communications Center with the following codes: Child Custody (MPD), Cruelty Animal (MPD), Family Trouble (MPD), Mental Observation (MPD) coded as priority 2, Property Pick Up (MPD), Solicitation (MPD), Suicide Threat (MFD), Welfare Citizen (MPD), Altered Level of Consciousness (MFD) Fall-17A (MFD), Person Down/Unknown (MFD), and Vehicle Accident (MFD).

In this report, we detail our approach and findings, and offer recommendations for identifying, documenting and triaging low acuity Milwaukee Police Department calls to non-sworn responders.

Approach

Our approach to analyzing the data began with observations at the Milwaukee emergency communications center on both the Milwaukee Police Department (MPD) and Milwaukee Fire Department (MFD) sides of the floor to familiarize ourselves with the call taking and dispatch processes. We also reviewed the MPD Technical Communications Division Handbook for the call types of interest.

We then requested MPD call for service data for calendar year 2023 for our selected call types. We subsequently requested body worn camera (BWC) video for a sample of 50 MPD calls. A team member coded the sample MPD CAD narratives for each category. Ten percent of the narratives and recordings were coded by a second team member and discrepancies reviewed and resolved as a team. The coding was used to identify behavioral health indicators and call factors that would exclude diversion to non-law enforcement or emergency medical response. In addition to coding and analyzing CAD narratives and call recordings, we examine call volume by day of the week, time and district for the call categories of interest.

Milwaukee Police Department Dispatch Call Categories

Based on observation of MPD dispatch procedures, interviews with key MPD and MFD personnel, reports from similar community responder projects in the United States, and expert consultants, WSU requested MPD dispatch data for the following call categories for the entire year of 2023:

- Trouble with Subject
- Welfare Citizen
- Mental Observation
- Call for Police
- Suspicious Person/Auto
- Noise Nuisance
- Family Trouble
- Trouble with Juvenile
- Suicide Attempt
- Property Pickup
- Trouble with subject - DV
- INJ Person/Sick person
- Child Custody
- Cruelty to Animal
- Suspicious-Other
- Indecent Exposure
- Landlord/Tenant Trouble
- Soliciting

Milwaukee Police Dispatch Data Elements

Among all call types listed above, following data elements were requested to assess eligibility for non-sworn response consideration. The data elements below will inform recommendations for program structure and specialization.

- Call number
- Number that corresponds with associated police report (IR number)
- Segment narrative, or call taker narrative prior to the officer arriving on scene
- Narrative that includes officer on scene information*
- Call created date
- Call created time
- Call dispatch date
- Call dispatch time
- Call entry date
- Call entry time
- Call en route date
- Call en route time
- Call on scene date
- Call on scene time
- Call close date
- Call close time
- Call type final
- Call type original
- Priority
- Location address
- X coordinate
- Y coordinate
- District
- Disposition
- Caller phone number
- Modifying circumstance*
- Any information on officer self-dispatched vs assigned*

*indicatesinformation not received

Sampling Strategy

TABLE 1. Sample

CALL TYPE	TOTAL CASES	CASES W NARRATIVES	SAMPLE
TRBL W/SUBJ	24,748	22970	400
WELFARE CITIZEN	18,693	18033	400
CALL FOR POLICE	11,147	10947	99
MO	7,785	7610	304
INJ PERSON/SICK	7,592	7341	101
SUSP PERS/AUTO	5,655	5488	76
NOISE NUISANCE	4,629	4586	75
PROPERTY PICKUP	4,566	2137	49
FAMILY TROUBLE	3,836	3773	75
TRBL W/JUV	2,071	2016	74
IND EXPOSURE	807	786	49
CHILD CUSTODY	1,035	1004	45
SUICIDE ATTEMPT	1,293	1262	74
CRUELTY ANIMAL	1,403	1378	49
SUSPICIOUS-OTH	560	547	54
LANDLORD/TEN TRB	675	657	50
SOLICITING	91	90	22
TOTAL CALLS	96,586	90,625	1996

Across the requested call categories, we received data on 96,587 MPD calls for service. The table below shows the distribution of the calls across the call categories. Before pulling our sample to code, we eliminated calls without any CAD narrative data, or about 6.2% of the calls. We then pulled a systematic random sample of calls from each category for coding. To ensure that our sample was representative of all calls, we compared the sample to total calls in each category on district, priority and call disposition.

Coding Strategy in Brief

Public response situations can be fluid and dynamic, thus, it is doubtful that 100% of calls within any of the categories above would be appropriate for diversion to a non-sworn civilian response. Further, based on the limited information provided in the CAD narrative, we cannot confirm any call for service is appropriate

diversion to a non-sworn response. Thus, our approach involved assessment of calls in each category and coding of relevant behavioral health information and safety and medical factors that would require police or EMS response. We then analyzed this information to determine the proportion of calls in each category that appear eligible for diversion consideration. In the last section of this report, we discuss options for screening and triage protocols for these eligible calls to determine appropriateness for diversion to non-sworn responses.

CODING FINDINGS

Table 2. Calls Eligible for Diversion Screening

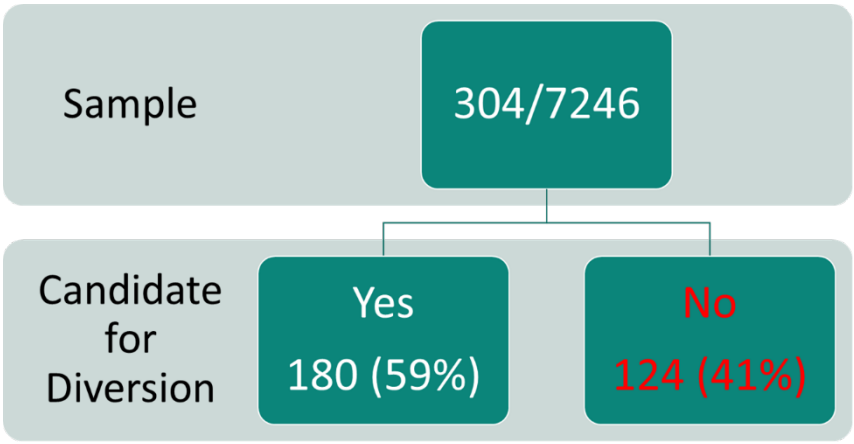
Call Type	2023 Total	Percent Eligible for CRT	LEAP Estimate %	Extended Estimate-nonLE	MH and Eligible	Extended Estimate MH
Mental Observation	7246	59.21	86	4290	59.21%	4290
Suicide	1293	0	7.5	0		
Welfare Citizen	18693	77	75	14394	44.75%	8365
Trouble with Subject	24748	84.25	73.5	20,850	8.75%	2165
Injured Person/Sic	7592	15		1139	6%	456
Trouble with Juvenile	2071	19	55.8	393	1.4	29
Family Trouble	3836	35	67.5	1343	4	153
Noise Nuisance	4629	59	100	2731	0	0
Suspicious Other	560	31	45	174	5.5	31
Cruelty Animal	1403	100	86.4	1403	7	98
Indecent Exposure	807	84	64.1	678	38.8	313
Solicitation	91	82	95.6	75	0	0
Landlord/Tenant	675	42	86.4	284	0	0
Property Pick Up	4566	59	93.8	2694	0	0
Child Custody	1035	11	65.7	114	0	0
Call for police*	11147	89*	37.8			

Table 2 Displays the percentage of MPD calls in each category that we coded as eligible for diversion screening, the estimates from prior analysis conducted by LEAP, estimates of the total number of calls in each category that would have been eligible, followed by the percent and total number of calls in the subgroup of eligible calls related to mental health issues. In what follows, we provide additional detail on the analysis of call categories with larger numbers or percentages of calls involving mental health issues that could be considered for diversion to a clinician in the ECC call room or to a non-law enforcement mobile team.

Mental Observation (MO) 2023

Mental Observation (MO) calls are typically coded as priority 2 (97.5%). The CAD narratives for calls in our sample coded as MO were examined for information that would exclude diversion to an unarmed response. These factors, which are not mutually exclusive include:

Figure 1.

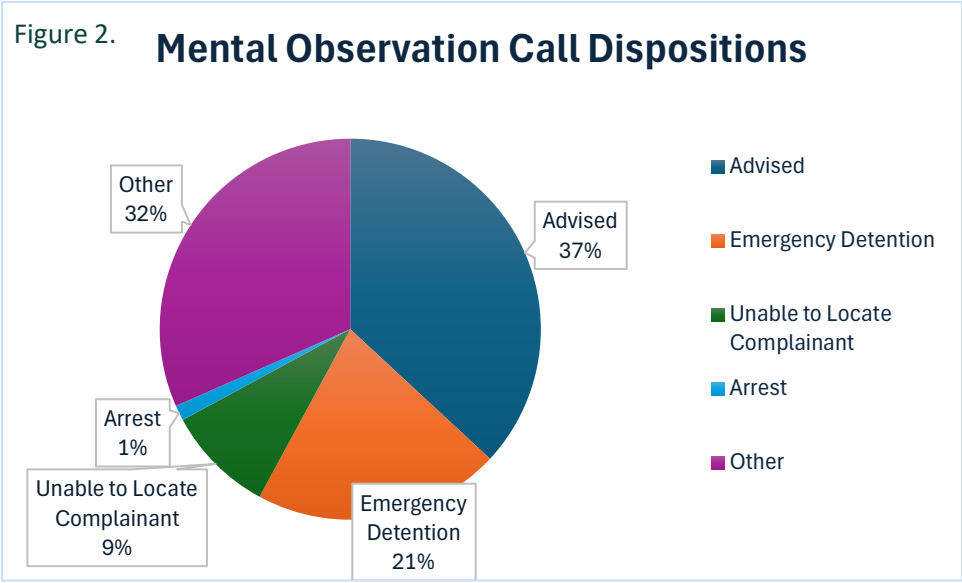


- Active suicidal behavior=22 (7.2%)
- In traffic =7 (2.3%)
- Threats/actual violent=63 (20.7%)
- Weapon present=13 (4.3%)
- Serious crime =5 (1.6%)
- Medical requiring EMS=15 (4.9%)
- Request from facility, Chapt=12 (3.9%)

Mentions of suicide were noted in 46% of the call narratives in this category. Almost a third involved a person calling for themselves (29.3%), and 20.7 percent involved a family member calling for a loved one.

Dispositions listed for these calls, displayed in Figure 2, include: Advised (36.9%), Emergency Detention (21%), Unable to Locate Complainant 9.2%) and Arrest (1.3%). In total, 59 percent (180) of calls in this category were identified as eligible for diversion consideration.

Figure 2.



Example CAD narratives for calls identified as candidates for diversion:

- *CLLR STS HE IS HEARING THINGS. STS ISSUE WITH VIDEO GAMES. CLLR STS HE HAS SCHIZOPHRENIA. STS HAVING VISUAL HALLUCINATIONS. NOT HARM TO SELF OR OTHERS
- *CLLR STS SHE WANTS TO TALK TO SOMEONE ABOUT SPIRITS- STS SHE HEARS EXBOYFRIEND VOICES IN HER HEAD/ SUBJ SAYS DOES NOT BELIEVE IN DIAGNOSIS
- *CALLER STTS SHE WOULD LIKE A WELLNESS CHECK ON HER MOM, HAS BEEN DRINKING AND HAS SENT SOME MESSAGES THAT MADE HER WORRY. MEDICAL REFUSED. STTS MOM HAS MADE STATMENTS ABOUT

ENDING HER LIFE. LAST SPOKE TO HER MOM A FEW MINUTES AGO OVER TEXT, HAS NOT DONE ANYTHING TO HARM HERSELF SO FAR.

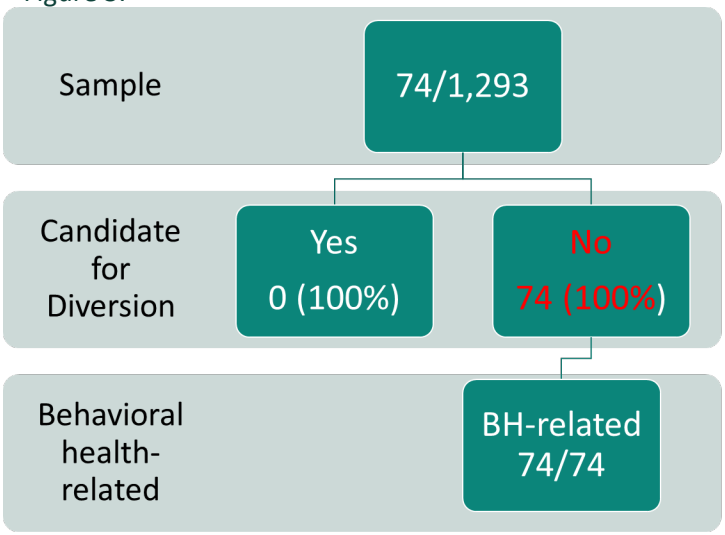
Body worn camera video was reviewed for these three calls and confirmed there was no threatening or violent behavior, criminal issue, or immediate medical need. The dispositions listed for the above 3 calls was "advised."

Recommendation: Screen MO Calls for Diversion. It is clear that a significant portion of MO coded calls could be diverted to be handled by a clinician on the phone, or for those needing in person response, a mobile crisis team. Milwaukee County Behavioral Health clinicians or mobile crisis teams can de-escalate callers and connect or reconnect them to MCBH and other agencies' services.

Suicide Attempt

Suicide Attempt calls are typically coded as priority 1 (90.6%). The CAD narratives for calls in our sample coded as Suicide Attempt were examined for information that would exclude diversion to an unarmed response.

Figure 3.

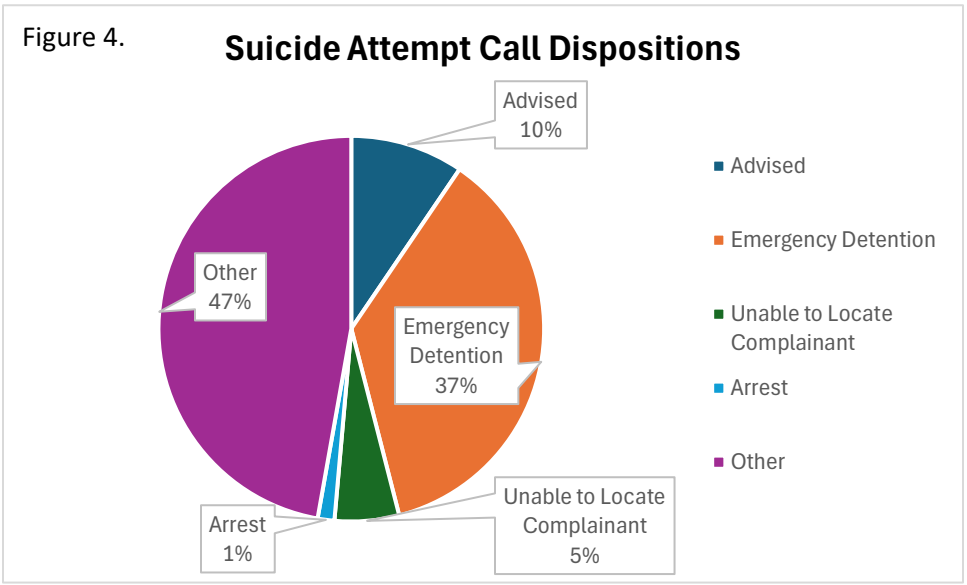


These factors, which are not mutually exclusive include:

- In traffic =4 (5.4%)
- Threats or actual violent behavior =2 (2.7%)
- Weapon present=19 (2.6%)
- Serious crime (or caller reporting a crime) =0
- Medical indication requiring EMS =68 (92%)
- Suicidal action=67 (90.5%)

All of the calls were behavioral health-related, given the nature of suicide attempts. All were excluded from consideration for diversion as the coded is used for calls involving immediate threat of harm. Analysis of the CAD narrative indicates that 36.4% of the calls in this category were people calling for themselves, 38.6 percent were family members calling with a concern about a loved one. Dispositions displayed in Figure 4, included: Emergency Detention (36.5%), Advised (9.5%), Unable to Locate Complainant (5.4%), Arrest (1.4%).

Figure 4.



Example CAD narratives, note none were identified as candidates for diversion.

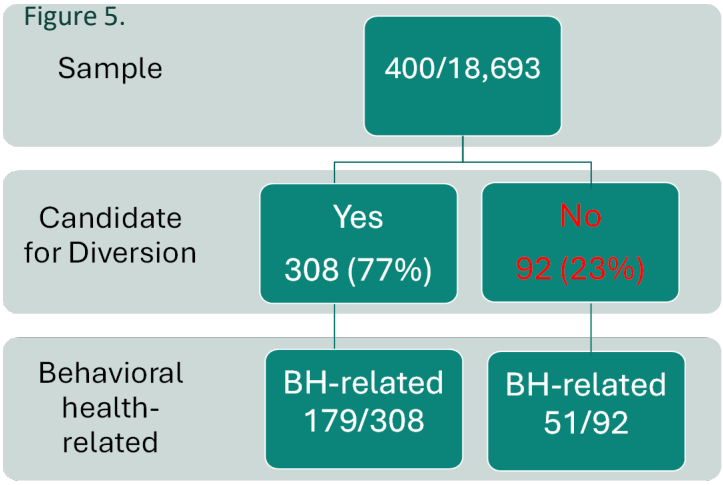
- CLLR STS HIS GIRLFRIEND SWALLOWED SOME PILLS AND SHE IS NOW GAGGING..MFD RESPONDING..
- CLLR REQUESTING WELFARE CHECK FOR SUBJ WHO WAS MAKING SUICIDAL THREATS ON SNAPCHAT AND TOLD HIM THAT SHE JUST TOOK 19 PILLS.
- CLLR STS THAT SUBJ1 HAS SOMETHING AROUND HER NECK AND IS TRYING BLUE/ CLLR STS THAT DOSENT KNOW NUMBER CALLING FROM

Recommendation: Given this code is used for calls involving active suicide attempts requiring immediate medical and/or police response, we do not recommend this call category be included in diversion protocols.

Welfare Citizen

Welfare Citizen calls are typically coded as Priority 2 (99.7% of all Welfare Citizen calls). The CAD narratives for calls with this code were examined for information that would exclude diversion to an unarmed response.

Figure 5.

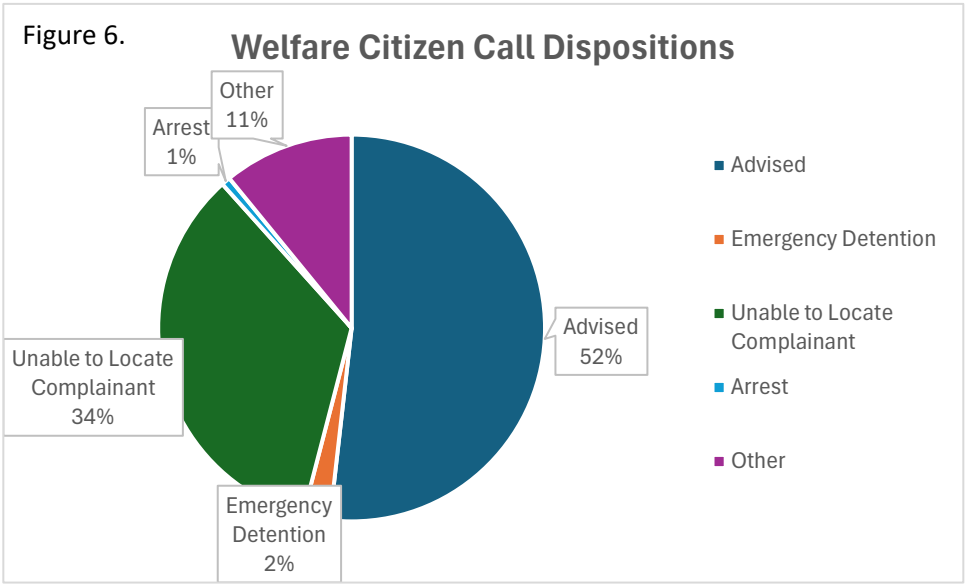


These factors, which are not mutually exclusive include:

- In traffic =35 (8.7%)
- Threats or actual violent behavior =9 (2.2%)
- Weapon present=11 (2.8%)
- Serious Crime=18 (4.5%)
- Medical requiring EMS attention=23 (5.8%)

Coders noted information suggestive of behavioral health issues in 58 percent of the calls in this category; six percent of the narratives had specific mentions of mental illness and 4.5 percent had mentions of suicide. CAD narratives indicate that 17.5% involved a person calling for themselves and 17.3% were family members. Dispositions displayed in Figure 6 include: Advised (51.8%), Unable to Locate (34.3%), Emergency Detention (2.25%) and Arrest (0.75%). In total, 77 percent (308) of calls in this category were identified as eligible for diversion consideration, 44.75 percent (179) were coded as behavioral health related and eligible for diversion consideration.

Figure 6.



Examples of call coded as candidates for diversion.

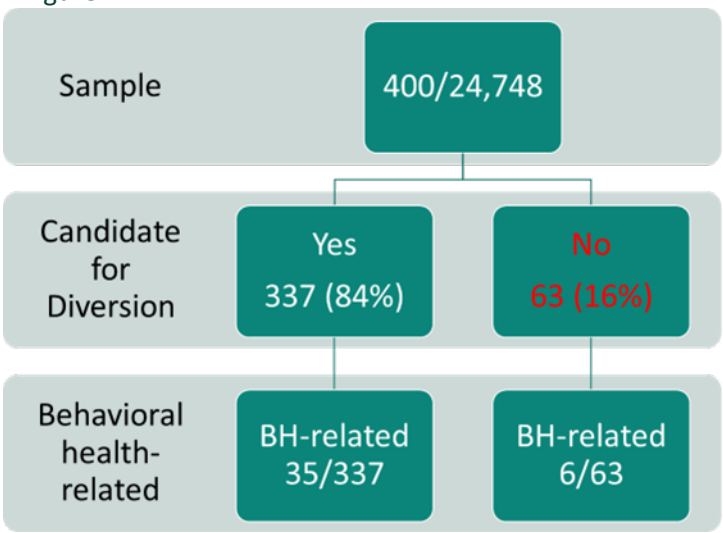
- CLR STS AFTER COMING BACK FROM CHECKING HER MAIL, SOMEONE KNOCKED ON HER DOOR -(TC SUMMARIZED THAT STATEMENT) CLR SEEMS VER CONFUSED, NOT REALLY FINISHING HER SENTENCES, HAVING TROUBLE
- CALLER STATES SHE WANTS A WELFARE CHECK DONE ON HER FRIEND..CALLER STATES SUBJECT HAS BEEN STATING SHE IS DEPRESSED AND TIRED..CALLER STATES SUBJECT STATED SHE DOES NOT WANT TO BE HERE ANYMORE..CALLER IS SUBJECT'S FACEBOOK FRIEND.
- CLLR IS REPORTING THAT SUBJS MADE 2000 CLONES OF HER THEN PUT THEM IN THE LAKE TO DIE
- CLLR STS HER LIFE IS BEING THREATNED BY LASERS // CLLR STS LOWER LEVEL INTELLIGENT OFFICERS WORKING AS TERRORIST ARE ATTACKING HER // CLLR STS SHE CAN NOT SEE ANYONE BUT CAN FEEL THEM // STS SHE HAS AN UNK MENTAL HEALTH DIAGNOSIS AND SHE TOOK MEDS BUT IT IS GETTING WORSE // LOCKED LOBBY // RING BELL FOR ENTRY // NFI

Recommendation: Screen Welfare Citizen calls for Diversion. Welfare Citizen calls are good candidates for diversion, particularly when the caller is the person whose welfare is in question or a family member/friend who can provide information. A clinician may be able to resolve the situation over the phone by de-escalating and connecting the person/family to resources or send a mobile crisis team to the person in the community. Many of the CAD narratives in this category had explicit information indicating behavioral health concerns, thus, call takers are regularly gathering the information needed to identify and triage calls for potential diversion.

Trouble with Subject

Trouble with subject calls are typically coded as priority 3 (95.9%). The CAD narratives for calls coded as Trouble with Subject were examined for information that would exclude diversion to an unarmed response.

Figure 7.

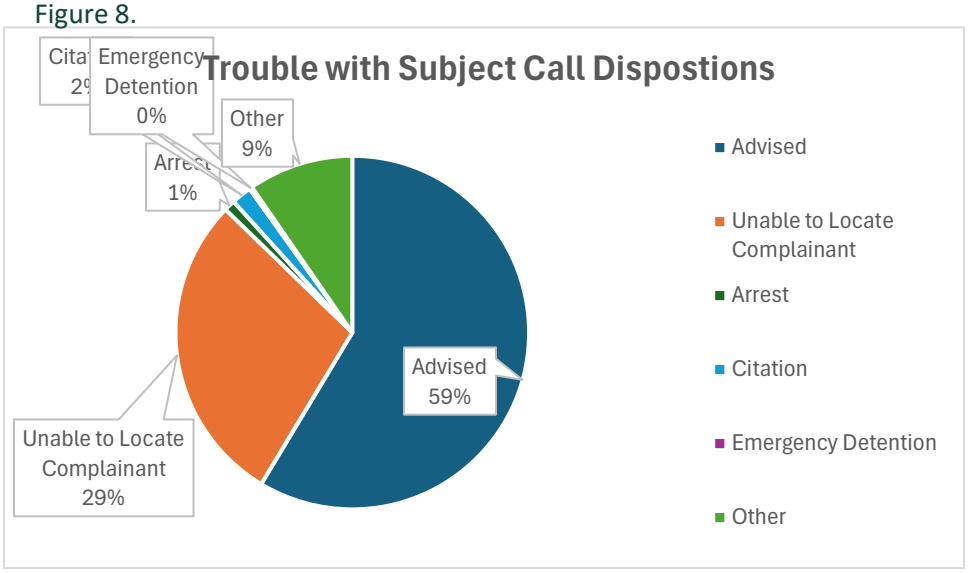


These factors, which are not mutually exclusive include:

- In traffic =10 (2.5%)
- Threats of or actual violent behavior=34 (8.5%)
- Weapon present=7 (1.8%)
- Serious crime =17 (4.3%)
- Medical requiring EMS =0 (0%)

Coders noted information suggestive of behavioral health issues in 10.3% percent of the call CAD narratives in this category; 4 (1%) of the narratives had specific mentions of mental illness. 230 of the 400 (58%) had explicit mentions of either homelessness, panhandling, trespassing, loitering, or other social determinants of health. Dispositions for these calls, displayed in Figure 8, included: Advised (57.3%), Unable to locate complainant (28%), Citation (1.8%), Arrest (1%), and Emergency Detention (0.25%). In total, 84 % (337) of calls in this category were identified as eligible for diversion consideration, 8.75 % (35) were coded as both behavioral health related and eligible for diversion consideration.

Figure 8.



Examples of call coded as candidates for diversion.

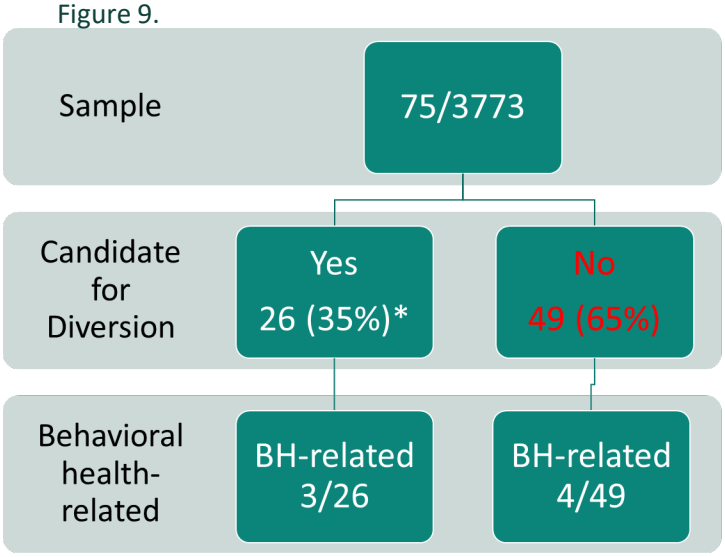
- CLLR STS HE HAS A MENTALY TROUBLED SUBJ AND HE CANNOT GET HIM TO CALM DOWN, CLLR STS HE HAS HIM SOMEWHAT CALM DOWN NOW BUT WILL NEED HELP GETTING HIM TO GO SOMEWHERE ELSE, CLLR WILL BE INSIDE FOOD HAUL BY SHUFFLE BALL, NFI
- CLLR STS MALE SUBJ IS WALKING AROUND MAKING HAND GESTURES AND DOES NOT APPEAR TO WAITING FOR BUS OR TRAIN//STS SUBJ IS WALKING AROUND, SITTING ON BENCHS, AND AVOIDING SECURITY//STS SUBJ POSS ALTERED
- CLR STS SUBJ IN SE STAIRWELL SLEEPING, NEEDS TO BE REMOVED / ONGOING ISSUES WITH SUBJ
- CLLR REPORTING FEMALE REFUSING TO LEAVE STATING SHE WAS ROBBED AT THE PFISTER HOTEL / / SUBJ IS REFUSING TO TELL CLLR HOW SHE WAS ROBBED / FEMALE IS INCOHERENT

Recommendation: Screen Trouble with Subject calls for diversion if mobile response teams can address calls from third parties and address quality of life issues. Many of these calls are consistent with the types of calls community/alternative response teams such as Denver Star and Albuquerque public safety address.

Family Trouble

Family Trouble calls are typically coded as priority 3 (92.7%). The CAD narratives for calls coded as Family Trouble were examined for information that would exclude diversion to an unarmed response.

Figure 9.

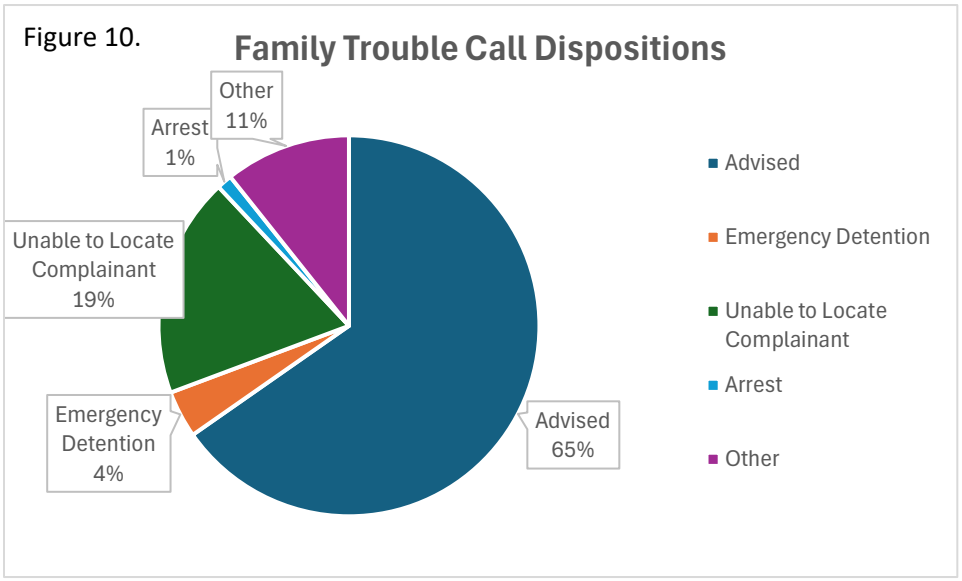


These factors, which are not mutually exclusive include:

- Threat or actual violence/property damage=34 (45.3%)
- Caller uncooperative/unavailable =5 (6.6%)
- Request to remove yelling/escalated person=2 (2.6%)
- Weapon present=1 (1.3%)
- Child welfare concern =3 (4%)
- Eviction/return after evicted=3 (4%)
- Medical indication requiring EMS =2 (2.7%)

Coders noted information suggestive of behavioral health issues in 9% percent of the call CAD narratives in this category. The caller was requesting that a person be removed from their home in 30.7% of the CAD narratives. Dispositions, displayed in Figure 10, included: Advised (65.3%), Unable to locate complainant (18.7%), Emergency Detention (4%), and Arrest (1.3%). In total, 35 percent (26) of calls in this category were identified as eligible for diversion consideration, 4 percent (3) were coded as both behavioral health related and eligible for diversion consideration.

Figure 10.



Examples of call coded as candidates for diversion.

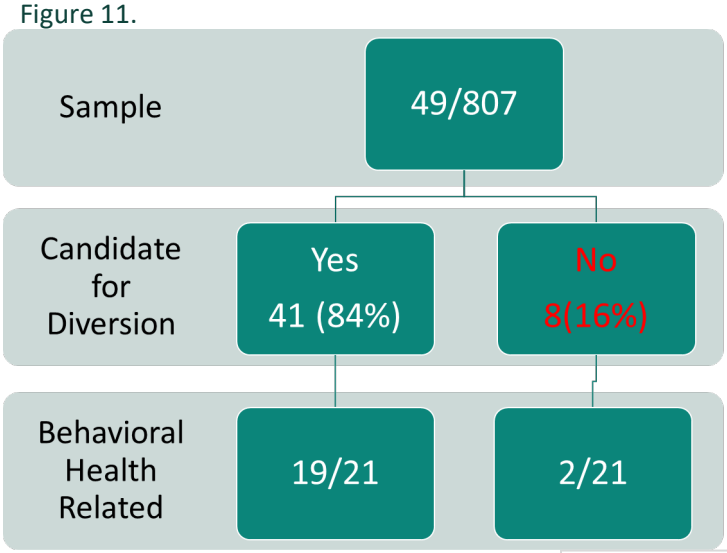
- CLLR IS HAVING ISSUES WITH HER DAUGHTER AND IS REQUESTING SQD, CLLR SAID SHE AND DAUGHTER HAS BEEN DRINKING
- CLLR STS HE NEEDS HIS BROTHER REMOVED // CLLR STS HE IS REFUSING TO LEAVE HIS HOME // CLLR STS THE SUBJ YELLED HE WILL BE THERE WHEN THE POLICE GET THERE // NFI
- ESCORT TO PICK UP HER BELONGINGS// MOM IS THREATNING TO SELL HER STUFF AND WON'T GIVE IT BACK TO HER // CLLR IS NEAR THE AREA 106TH //
- CALLER STATES 12 YR OLD SON REFUSING TO GET INTO VEH AND THREW HER KEYS.. WANTS OFFICERS.

Recommendation: Consider including this category for diversion screening. Only four percent of calls in this category were deemed behavioral health related and eligible for screening. However, training of emergency communications staff in identifying behavioral health related calls may lead to more calls being identified. If this category is included, response teams may require training in mediation and domestic violence.

Indecent Exposure

Indecent Exposure calls are typically coded as priority 2 (85.7%). The CAD narratives for calls coded as Indecent Exposure were examined for information that would exclude diversion to an unarmed response.

Figure 11.

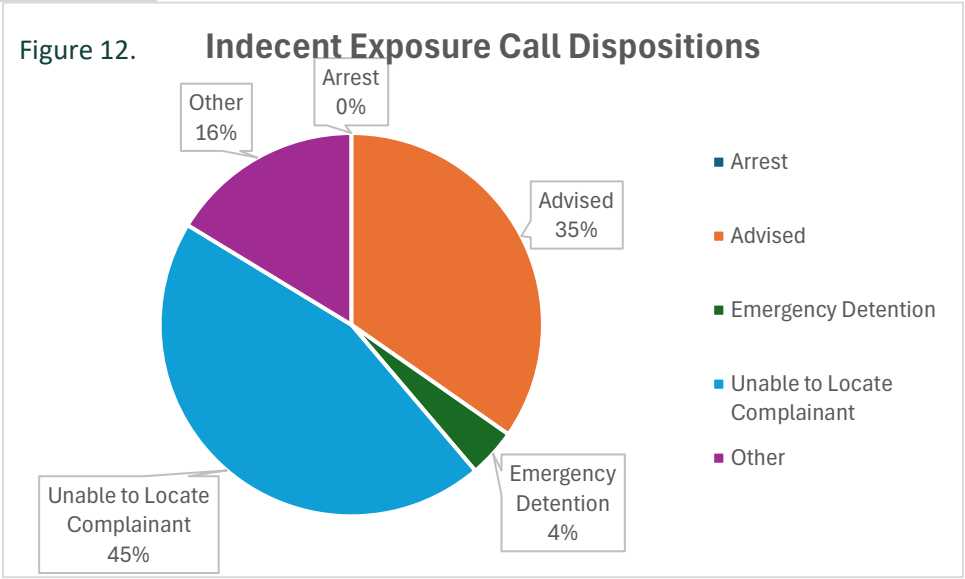


These factors, which are not mutually exclusive include:

- Presence of weapons=1 (2%)
- Exposure to/near children=7 (14%)

The appropriateness of calls in this category is dependent on the ability of responders to address situations related to public urination (22.4%)) and public masturbation (16%). CAD narratives frequently included indications the call was mental/behavioral health related (38.8%) and homelessness was mentioned in 14.3%. None of the CAD narratives in this category included information indicating emergent medical issues, threats, or interpersonal aggression. Dispositions displayed in Figure 12 included: Unable to locate complainant (44.9%), Advised (34.7%), Emergency Detention (4.1%). There were no arrests in our sample of calls. In total, 84 percent (41) of calls in this category were identified as eligible for diversion consideration, 38.8 % (19) were coded as both behavioral health related and eligible for diversion consideration.

Figure 12.



Examples of call coded as candidates for diversion.

- CLLR'S RESIDENT IS BANGING ON THE WALL, REFUSING TO TAKE MEDICATION // SUBJ PULLED OUT HIS PENIS AT CLLR AND STAFF WORKER // PER PATIENT'S CHART, WHEN SUBJ BEHAVES INAPPROPIATELY LIKE THIS, STAFF IS TO CALL POLICE FOR INTERVENTION // NFI
- CLR STS A HOMELESS MAN IS SLEEPING ON THE SIDE OF THE BUILDING AND HE JUST PULLED HIS PANTS DOWN AND USED THE BATHROOM, THERE'S FECES ON THE SIDE OF THE BUILDING
- CHECKING FOR A BF, COMPLETELY NUDE SITTING ON THE CORNER OF THE PLS CHECK CASHING, POSS MENTAL HEALTH CHALLENGES

Recommendation: Screen Indecent Exposure calls for diversion. While a portion of Indecent Exposure calls need to be handled by police due to children and others being victimized, many of these calls did not appear to be active attempts to victimize anyone. Rather, they generally involved public urination and defecation related to lack of housing, substance use and mental illness. Thus, they could be addressed by mobile response teams with the capacity to solve problems and connect people to resources.

Additional Call Categories

Among the additional categories reviewed, we noted that many of the Trouble with Juvenile calls were for incidents at schools such as drug possession, fights and requests to remove a suspended student. Our analysis suggests that collaborative work with schools and alternative strategies to address some of the issues without engaging police is warranted. We also noted that alternative responders trained in mediation could handle a significant portion (larger than our estimates) of family trouble, child custody, landlord/tenant and property pickup calls. We did not extend estimates for the Call for Police category, as the CAD narratives did not have much information. We coded exclusionary factors when they were mentioned in these narratives, however, we do not feel confident in making estimates for this category.

Summary of CAD Narrative Coding Findings

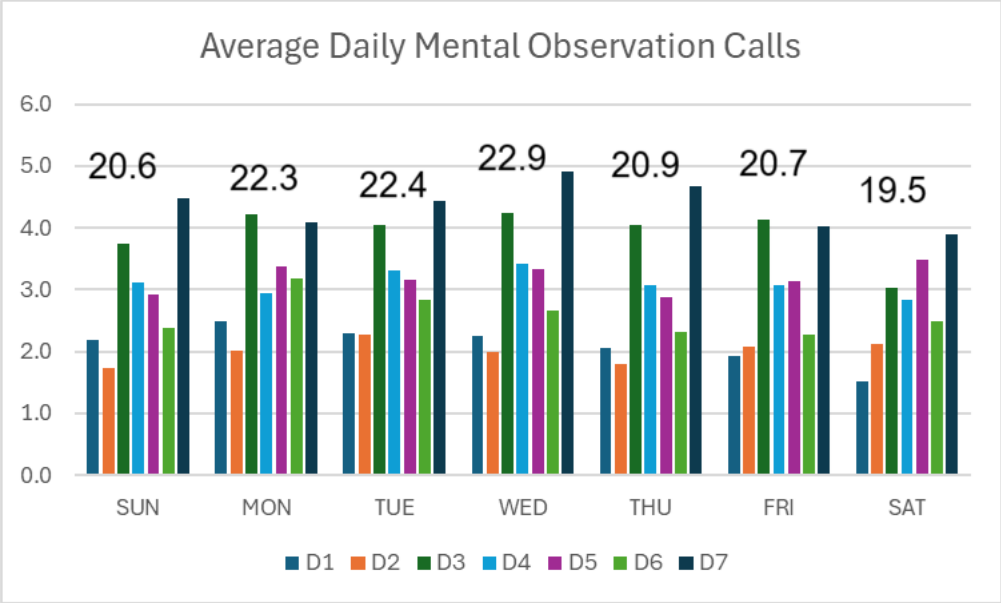
Our analysis of CAD narratives indicates a substantial number of calls could, with further screening, be diverted to non-law enforcement responses. Focusing on calls with a behavioral health component, close to 15,000 were identified as potentially divertible. While the information contained in CAD narratives is limited, with further screening, it is likely that many, but not all these calls would be good candidates for non-law enforcement response. In particular, many of the MO and Welfare Citizen calls from family members or the individuals themselves could be handled by connecting the person to a clinician by phone or dispatching a mobile crisis response unit. Alternative response teams with the capacity to respond rapidly and address a broader set of behavioral health and social vulnerability concerns could also take on some Trouble with Subject, Indecent Exposure and Soliciting calls. Teams with mediation training could address some Family Trouble, Noise nuisance, Landlord/Tenant, Child Custody, Property Pick-up and Cruelty animal calls.

Day/Time Distribution of Calls

We utilized the full sample of all 2023 calls coded as MO (n=7,785) and Welfare Citizen (n=18,693) to examine the distribution of potentially divertible behavioral health calls across police districts, days of the week and time periods.

MO Calls

Figure 13.



As Figure 13 indicates, the number of MO calls by day of the week was relatively consistent, ranging from an average of 19.5 calls on Saturday to 22.9 on Wednesdays, with Mondays, Tuesdays and Wednesdays having slightly a higher volume of MO calls than on other days of the week. District 7 had the highest annual number of MO calls (1,591) followed by District 3 (1,434). District 2 had the lowest number of MO calls (730). Our analysis of MO call CAD data indicated that 59% of calls would be eligible for diversion consideration, or 12 to 14 calls per day. It is likely that with further screening, some of these calls would be determined ineligible.

Figure 14.

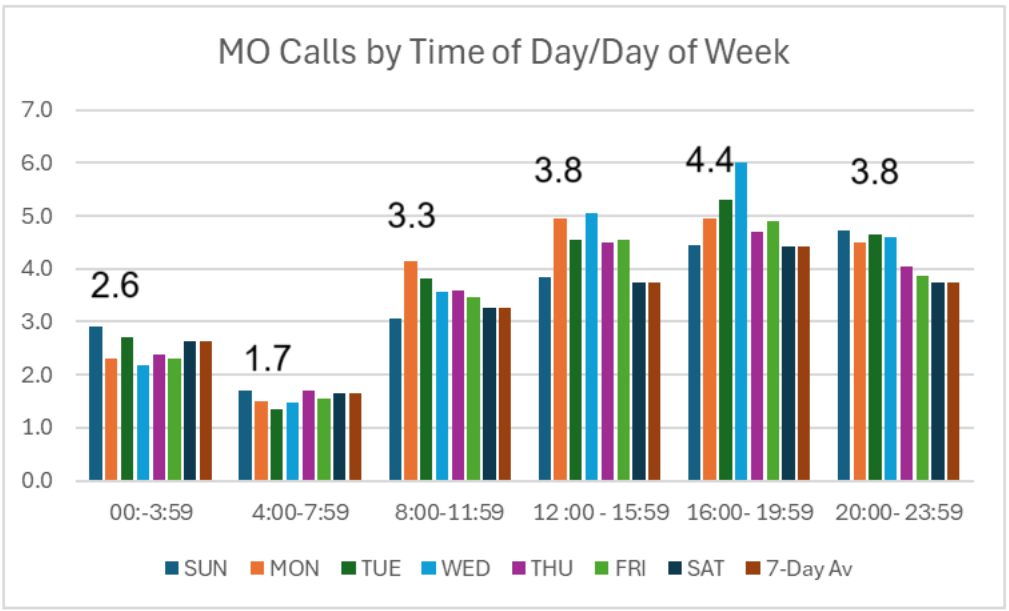


Figure14 displays the number of calls by day of the week and four-hour time blocks. The time blocks with the lowest frequency of calls are midnight to 3:59 (average 2.5) and 4:00 to 8:00 (average 1.6). The busiest time periods were 12:00 to 15:59 (average 4.5) and 16:00 to 19:59 (average 5). Our analysis of MO call CAD data indicated that 59% of calls would be eligible for diversion consideration, or roughly 1 to 3 calls per 4-hour time period per day. It is likely that with further screening, some of these calls would be determined ineligible.

Welfare Citizen Calls

Figure 15.

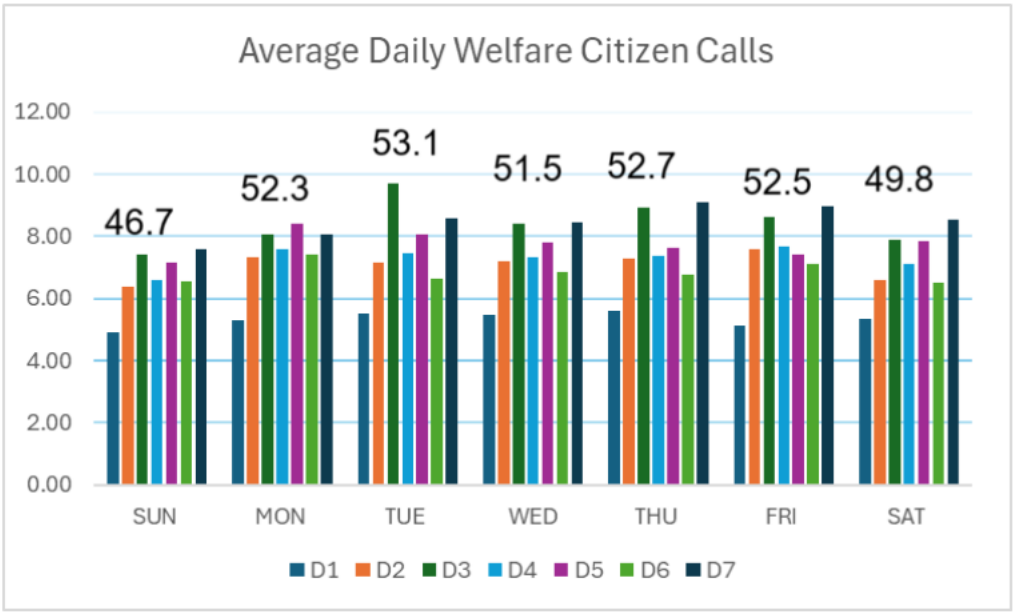


Figure 15 displays Welfare Citizen calls by day of the week and district. The average number of calls by day of the week ranges from 46.7 a day on Sundays to 53.1 a day on Tuesday. Overall, weekdays are busier in terms of this call type. Our analysis of Welfare Citizen call CAD data indicated that 44.75% of calls would be both mental health related and eligible for diversion consideration, or 20 to 24 calls per day. It is likely that with further screening, some of these calls would be determined ineligible.

Figure 16.

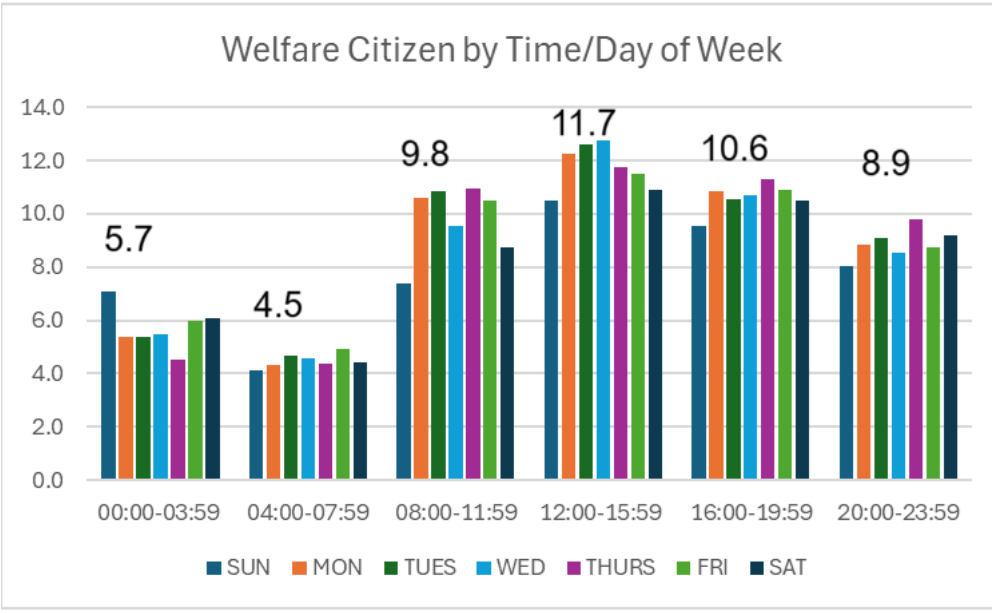


Figure 16 shows Welfare Citizen call volume by day of the week and four-hour time blocks. The busiest periods are 8:00 to 11:59 and 20:00, with averages of 9.8, 11.7, and 10.6 Welfare Citizen calls for the three respective 4-hour time blocks during this period. Our analysis of Welfare Citizen call CAD data indicated that 44.75% of calls would be both mental health related and eligible for diversion consideration, or 2 to 5 calls per 4-hour time period per day. It is likely that with further screening, some of these calls would be determined ineligible.

Recommendation: Implement call diversion screening protocols 24/7 to begin document volume of MO and Welfare Citizen calls. Initially, staff diversion options (phone, mobile crisis) from 8:00 to 23:59, Monday through Friday and expanding to weekends as staffing allows.

Discussion and Recommendations

Current conversations with Milwaukee County Behavioral Health indicate that there is interest and capacity to receive and handle some behavioral health related 911 calls by phone and or mobile response. Thus, our discussion recommendations will focus specifically on MO and behavioral health related Welfare Citizen calls.

Call Volume

Analysis of Milwaukee Police Department 2023 911 data indicates that daily, 32-38 of these calls for service could be further screened by call takers for diversion to non-law enforcement responses. Volume of calls in these categories is slightly higher on weekdays and between 8:00 am and midnight (noon to midnight for MO, 8:00am to 8:00pm for Welfare Citizen). While our review of BWC video for a small subsample of calls generally supported our initial assessments of diversion eligibility, the limited information included in 911 CAD narratives makes it difficult to confidently estimate the proportion of these calls that would be excluded from diversion with further screening. Further, what is divertible will also be impacted by the capacity of the diversion options.

Data from cities that have implemented call diversion programs may be useful in considering call volume. Houston Police Department has a Crisis Call Diversion (CCD) program that diverts non-emergent crisis calls to a CCD counselor who can link the caller to needed services instead of dispatching a police or EMS unit. While CCD is not 24/7, they handle approximately 200 diverted calls per month.[i] Austin Texas has also embedded clinicians in their 911 call center. While they report that 10-15% or 100,000 to 150,000 of their approximately one million calls per year are flagged as mental health related, only about 100 of these calls are transferred to the embedded clinician each month. Out of those transfers, on average, 16 are determined to require police involvement, a mobile crisis team is deployed to 15 and the remaining transferred calls are handled over the phone.[ii]

Call Screening/Triage

The number of mental health calls diverted may be influenced by the defined eligibility criteria, the specific call screening/triage protocol, the training provided to emergency communications staff in the use of the protocol, and their understanding of and comfort with the diversion options.

Diversion Eligibility criteria. Agencies determine diversion eligibility based on the capacity of the diversion resources. For example, in Durham, North Carolina, eligible calls include suicide threats, mental health crises, and any calls involving a known or suspected behavioral health need.[iii] The Denver Support Team Assistance Response (STAR) program responds to a somewhat broader range of calls, including those related to checking welfare, intoxication, suicidal ideation, indecent exposure, syringe disposal and trespassing.[iv]

Triage Protocols. Triaging potential calls for diversion begins with identifying that a call involves a behavioral health issue. In many instances, this information will be readily provided by the caller. In other instances, the call taker may need to ask direct questions. For example, Houston Police Department call takers ask two questions when someone is calling about another person:

> *Are you aware of or do they appear to have mental issues?*
>
> *Is this call in reference to their mental state?*

If the answer to both questions is yes, further questions are asked to determine the appropriateness of a transfer to the Crisis Call Diversion (CCD) program. Exclusions include active suicide attempts or attempts to harm others, any involvement of weapons, loss of consciousness, and bleeding. Austin Police Department has a similar approach, starting with a mandatory screening question for every call "*Are you aware of or does it appear the subject is in mental health crisis?"* Exclusions include possession of weapons, severe intoxication, violent behavior, imminent risk of hurting self or others and commission of a crime. Durham Community Safety does not dictate specific screening questions, rather they train call takers on recognizing mental health related calls and screening for the following exclusions: Presence of a weapon, physical violence, and need for medical, fire, law enforcement or community safety in person response. Emergency communications staff in Sioux Falls, South Dakoka ask for the location of the caller and what has happened, and if they determine the call is a behavioral health call, they follow the structured EMD script to determine the appropriate response.[v]

Once a call is determined eligible for diversion to a clinician/mobile crisis team, then, depending on call center protocols, the emergency communicator can either tell the caller they are being transferred, or ask the caller if they would like to be connected to the clinician/mobile crisis team.

Training Emergency Communications Staff. Emergency communications staff will need training in identifying mental health-related calls and the call diversion protocol. Training should include basic information on mental health crisis presentations, cues that may indicate a call is mental health related and basic de-escalation skills. It should also include opportunities to practice asking mental health and triage related questions and introducing the diversion option to callers.

Emergency Communications staff comfort. Many emergency communications staff may be concerned about the potential liability of not sending police or Fire/EMS to respond to a 911 call for service. The Law Enforcement Action Partnership (LEAP) has published a report addressing this concern that concluded that instead of increasing risk, sending non-law enforcement responses to low-risk calls may decrease overall liability risk.[vi] They may also simply not fully understand the types of calls that can be diverted or trust that a new response option will be capable of addressing the call. Many agencies have found that placing a clinician in the emergency communication center call room, at least initially, can be extremely helpful for building trust and supporting call takers in identifying calls appropriate for diversion.

Recommendations

The City of Milwaukee contracted with the Center for Behavioral Health and Justice to assess low acuity 911 calls for service and to make recommendations for identifying, documenting and triaging low acuity calls to non-sworn responders. As our analysis of 911 CAD suggests, there are a substantial number of calls that could be screened for diversion. Focusing on calls coded as Mental Observation and Welfare Citizen with a behavioral health component, between 32 and 38 calls each day were eligible for diversion consideration. With further screening, some of these calls would be excluded, however, there would likely be enough eligible calls to justify staffing the call room clinician and mobile response team (s) to address these calls. Further, calls in other categories may be appropriate for

diversion depending on the capability and training of the diversion clinicians/teams. We recommended the following steps to prepare for the initial implementation of call diversion.

1. Convene agency stakeholders to assess diversion resources and constraints. This includes the Emergency Communications Center, Milwaukee Police Department, Milwaukee Fire Department, the Milwaukee Police and Fire Commission, and Milwaukee County Behavioral Health.
2. Determine diversion options and capacity.
3. Develop initial identification, triage and transfer protocols.
4. Seek feedback from city and community agencies, along with broader community constituents.
5. Incorporate feedback and finalize the initial plan.
6. Train emergency communications staff on call identification, screening, and diversion protocols. Include call-room clinician and mobile response team staff.
7. Soft launch the protocol applied to MO and Welfare Citizen call categories from 8:00 to 23:59 Monday through Friday.

We also recommend a separate convening including Milwaukee Public School leadership to review MPD calls to MPS schools and explore options for addressing drug possession, fights, and requests to remove suspended students. Implementation of restorative justice practices and strategies may reduce the reliance on MPD.

Low Acuity Calls for Service in the City of Milwaukee: Part 2 MFD

Milwaukee Fire Department Analysis Approach

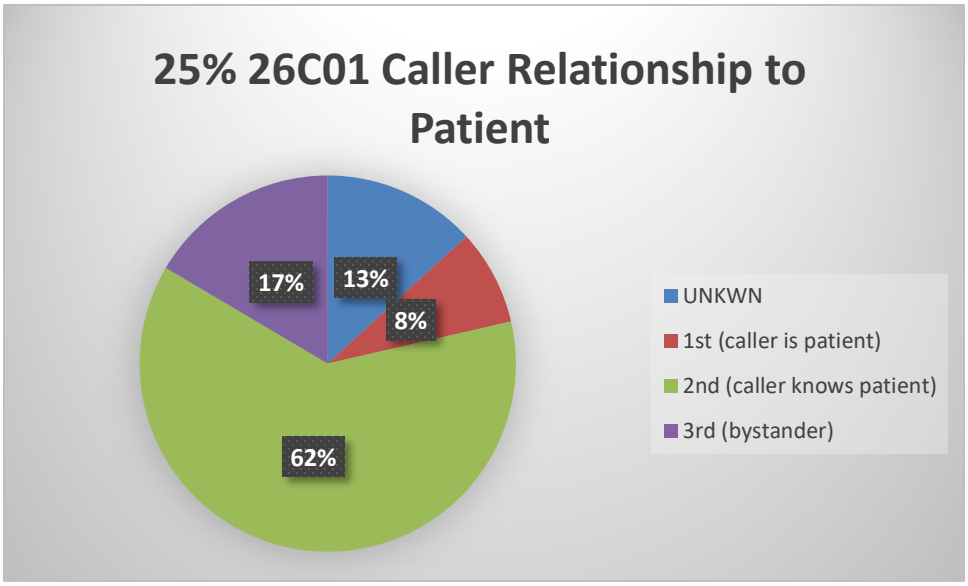
We were provided with access to MFD call data and audio recordings via a secure MFD SharePoint folder. Table 3 illustrates the total number of calls in each CFS code category for which data was provided, the number of associated audio files available, and the number of audio files randomly selected for further coding.

CFS CODE	TYPE	TOTAL CASES	Missing Audios	With Audio	Coding Sample #
25%, 26C01	Psych, ALOC	878	0	878	52
17A, B, D	Falls	839	370	464	42
29B	Vehicle Crash	1,816	462	1,354	45
32%	Sick, Med Alarm, Unk Problem	1,423	381	1,042	52
	TOTAL	4,952	1,213	3,738	191

Table 3. MFD Call Sample July 1 through October 31, 2023

PSYCH ALOC 25% 26C01

We were provided with data on 878 calls during the 4-month period from 7/1/2023 through 10/31/2023 coded as Psych ALOC 25%, 26C01. Among these calls, the majority had Altered Level of Consciousness (26 C01) (623, 71%) listed as the "Problem" code. 200 (23%) had Psychiatric Crisis (25A0x), Psychiatric suicidal, or Suicide Threat or Suicidal (25B0x, 25D0x) list as the "Problem." The remaining 45 (5%) included Limited Response, Seizure, ALSSC, BLSDG, and Curtiss Turnback.



The majority of calls (545, 62%) came from someone that knew the patient, most often a family member (271, 31%), followed by a business or facility that the patient was known to (146,17%) and a friend/acquaintance/co-worker (59,7%). The patient was the caller in 8% (59), a stranger/bystander was the caller in 17% (145) and caller information was not available for 13% (116).

Figure 17. 25%, 26C01 Caller Relationship

Call outcomes are displayed in Figure 18. Transport by ALS or BLS was the most frequent outcome (405, 46%), followed by Patient Assist/EVAL POV/Treat/Refusal (202, 23%) and Police Matter Only (97, 11%). Crosstab analysis with Chi^2 indicates that caller relationship is not significantly associated with call outcome (Chi^2(30, n=878) 34.534, p.=260).

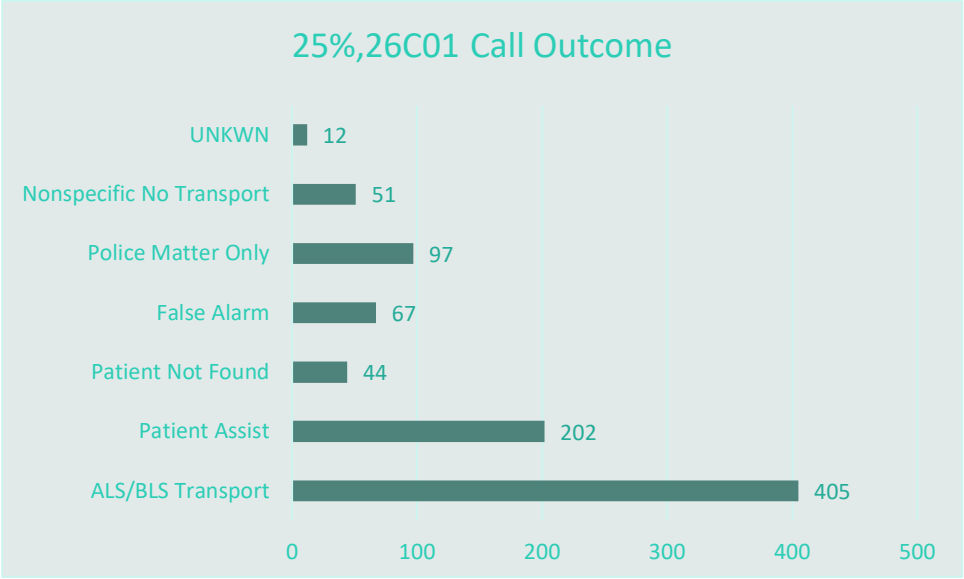


Figure 18. 25%, 26C01

There were 200 (23%) calls with an indicator of psychiatric or suicide related crisis and 188 (13%) with either violence or a weapon indicated (all but five of which had a psych/suicide indicator). Crosstab analysis with Chi^2 was used to examine whether these factors were associated with call outcome.

As displayed in Table 4, both were statistically significant. While approximately 44% of calls with a psych/suicide indicator and and 38% of calls with a violence/weapon indicator were resolved with a ALS/BLS transport, both were less likely to be resolved with transport or patient assist and more likely to be patient not found or false alarm than calls without the indicators.

Day of the week analysis is displayed in Figure 19. During this period, the average number of calls on a given day ranged from 5.88 to 8.29. Mondays and Wednesdays had the highest volume; Saturday had the lowest volume.

Call Outcome	Psych/Suicide n=210	Violent or Weapon n=118
ALS/BLS	92	45
% within variable	43.8	38.1
%within Outcome	22.7	11.1
Patient Assist	39	22
% within variable	18.6	18.6
%within Outcome	19.3	10.9
Patient Not Found	16	10
% within variable	7.6	8.5
%within Outcome	36.4	22.7
False Alarm	26	20
% within variable	12.4	16.9
%within Outcome	38.8	29.9
Police Matter Only	25	14
% within variable	11.9	11.9
%within Outcome	25.8	14.4
Non-Specific No Transport	12	7
% within variable	5.7	5.9
%within Outcome	23.5	13.7
UNKNWN	0	0
	Chi2(6,n=878)18.548, p=.005	Chi2(6,n=877)23.666, p<.001

Table 4. 25%, 26C01 Call Outcome by Psych/Suicide and Violent/Weapon

We reviewed and coded call audio for a subsample (52) of calls in this category. This process confirmed our impressions that few of the calls in this category could be easily identified and diverted to non-EMS responders, either due to the need for immediate response and/or medical intervention. It is clear that initial call takers have screened for medical need before transferring for EMS/Fire response

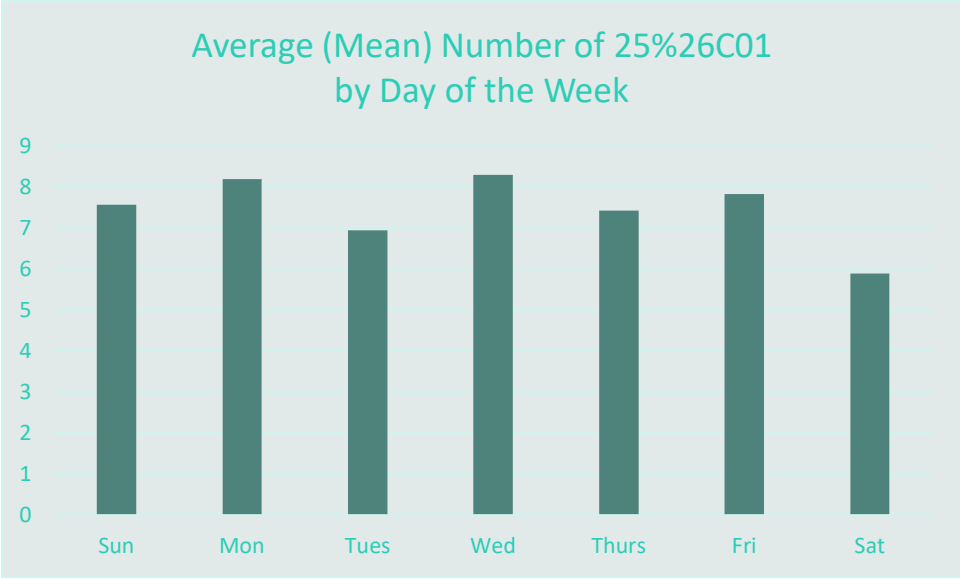


Figure 19. Psych/ALOC Average Calls by Day of Week

FALLS 17A, 17B, 17D:

We were provided with data on 835 calls for Falls (17A) during the 4-month period from 7/1/2023 through 10/31/2023. The majority, 753 (90%) were coded as Fall with No Injury-Needs Assistance. Table 19 displays call outcomes for all calls and No Injury and Injury indicated calls separately. We focus on the No Injury calls as they present an opportunity for an alternative response. Among the No Injury/Needs Assistance calls, 278 (37%) had an outcome of patient assist, 214 (28%) had an outcome of ALS or BLS transport, and 261 (35%) had some other outcome (no patient found, false alarm, police matter only, non-specific-no transport).

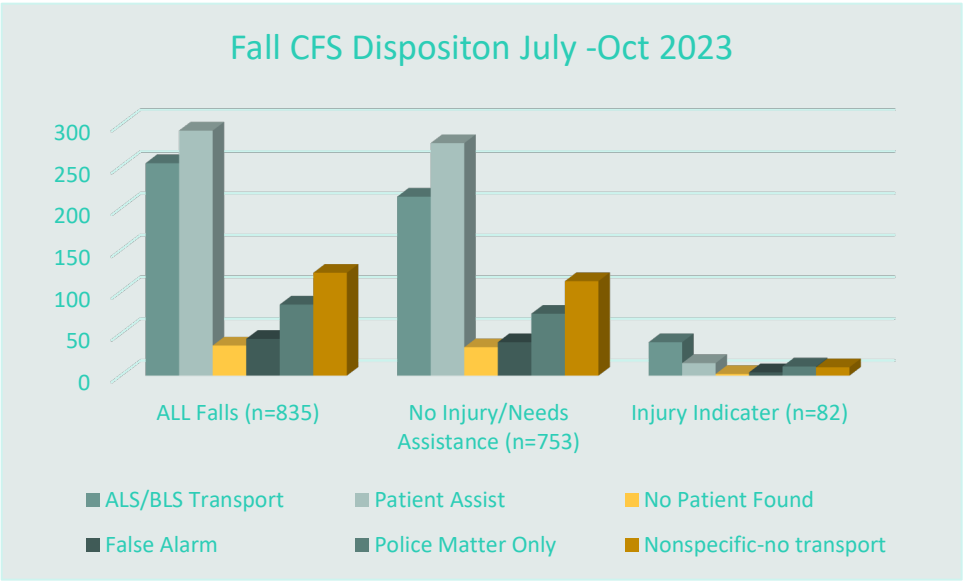


Figure 20. Falls Disposition

Caller relation to the person assistance is being requested for was available for a subsample of calls (n=470), 419 (89%) of which were coded as No Injury/Needs Assistance. Patients calling for themselves comprised 31 percent (145) of the sample. Second person callers, or people that knew the patient made up 53% percent (248) of the sample and included family members (123, 26%), friends (35, 7%), nursing homes or facilities that knew the patient (59, 13%), unknown relationship (31, 7%). Third party callers made up 13% (63) of the sample and included strangers/bystanders (20, 4%) alarm companies (41, 9%), and unknown (2, 0.5%). We were not able to determine the type of the caller for three percent (14) of the calls.

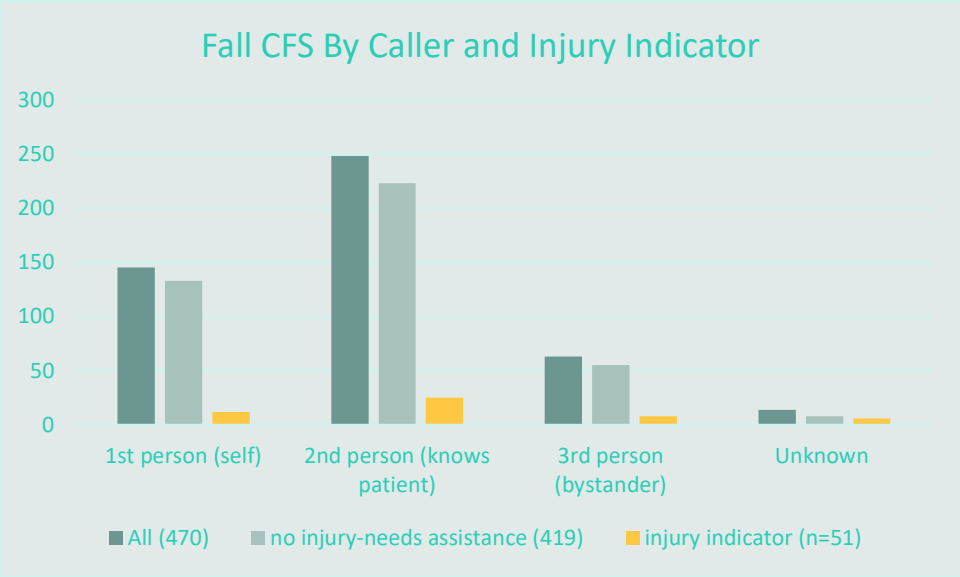


Figure 21. Falls by Caller and Injury

Calls from the patient or someone that knew the patient were slightly more likely to be coded as No Injury/Needs Assist than those coming from 3rd party callers. Chi^2 (4, n=470) 16.317, p.003

Table 5 Displays Fall call outcomes by type of caller. Regardless of caller type (when known), Patient Assist was the most frequent call outcome, ranging from 41.27 to 47.58%. ALS/or BLS transport made up 26.21 to 28.57% of the outcomes, and Non-specific/no transport was the outcome in 17.24 to 23.81 of calls. Finally, when the caller type was unknown, outcomes were more likely to be listed as ALS/BLS transport or Police matter only (each being 35.71%). Patient assistance was slightly more likely to be the outcome when the caller knew the patient (2nd person) and ALS/BLS transport was slightly more likely when the caller was a bystander or stranger (3rd person). Chi^2 (20, n=459)102. p<.001

Fall CFS Disposition	All Falls (n=470)		1st Person Caller, n=145		2nd Person Caller, n=248		3rd Person Caller, n=63		UNK, n=14	
	#	%	#	%	#	%	#	%	#	%
ALS/BLS Transport	126	26.81	38	26.21	65	26.21	18	28.57	5	35.71
Patient Assist	208	44.26	63	43.45	118	47.58	26	41.27	1	7.14
No Patient Found	8	1.70	2	1.38	5	2.02	0	0.00	1	7.14
False Alarm	17	3.62	10	6.90	4	1.61	2	3.17	1	7.14
Nonspecific-no transport	86	18.30	25	17.24	45	18.15	15	23.81	1	7.14
Police Matter Only	25	5.32	7	4.83	11	4.44	2	3.17	5	35.71

Table 5. Falls by Caller and Outcome

Our review of call audio for a subsample of Fall calls for service showed similar patters and provide information of the nature of the calls. Typical situations involve falls while transferring to a wheel chair, falling out of bed, and falling on the ground and needing assistance getting up. While 28% of the Fall -No injury/Needs Assistance calls resulted in an

ALS or BLS transport, 72% did not. Thus, this group of calls present an opportunity for alternative responders (a Falls team) trained in lifting and assisting people who have fallen or need assistance transferring. Falls team responders would need to be able to conduct basic medical screening and recognize when medical intervention is needed. We did not have complete date and time data for falls calls, and thus were not able to complet time/day of the week analysis.

29B Vehicle Crash

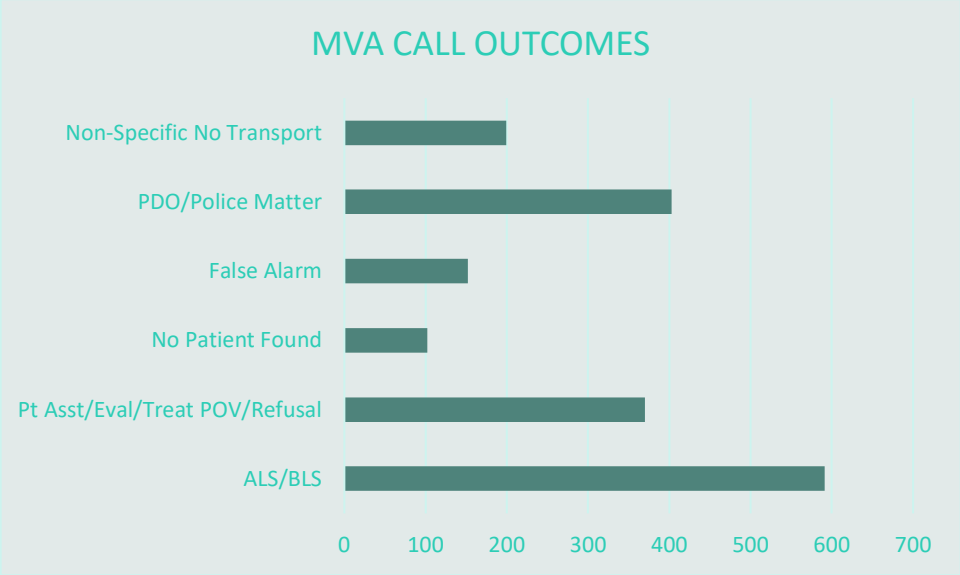


Figure 22. MVA Outcomes

We were provided with data on 1,816 Vehicle Crash calls for service that occurred from July 1 through October 31,2023. Call outcomes are displayed in Figure 22. 1,398 (77%) of these calls had an injury indicator in the call code/problem description. Among the 418 that did not, the majority (295) were resolved without ALS/BLS transport. With further screening, some of these calls may have been appropriate for an alternative response. However, based on our review of recordings from a subsample of calls, it appears that initial PSAP triaging to MFD/EMS is reasonably accurate.

32% Sick, Med Alarm, Unk Problem

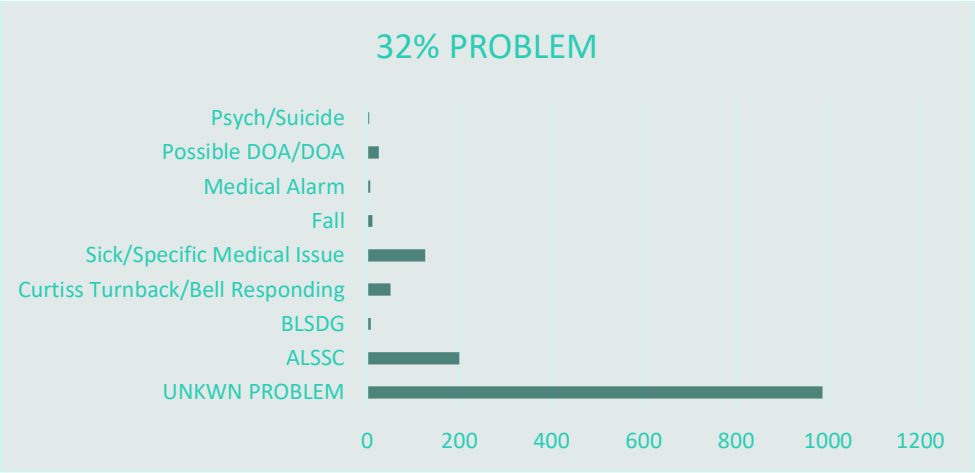


Figure 23. 32% Sick-Problem

We were provided with data on 1,423 calls coded as 32% Sick, Med Alarm, Unk Problem. Figure 23 displays the problem description for these calls.

Approximately 70% (987) of the calls had “Unknown Problem” indicated. The majority of the remaining 30% had a medical indication in the description.

Figure 24 displays outcomes of 32% Sick calls comparing the proportion of calls with each outcome comparing those listed as “Unknown Problem” to all others. The most common outcome was ALS or BLS transport, however, a lower percentage of “Unknown Problem” calls (34.2%) were transported than other calls (45.2%).

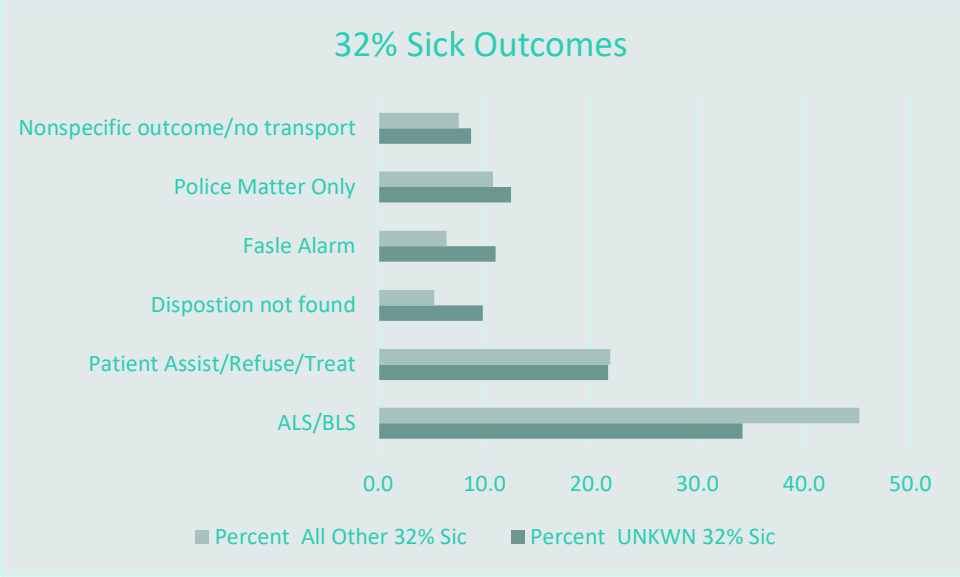


Figure 24. 32% Sick Outcomes

Our review of audic
a subsample of calls
this category consis
include an indicatec
likely medical issue,
including those liste
“Unknown Problem
Thus, it appears tha
initial PSAP triaging
MFD/EMS is approp

Summary and Recommendations

We analyzed data on 4,592 MFD calls for service coded as Fall (17A, B, D), Psych/ ALOC (25%, 26C01), Vehicle Crash (29B) and Sick/Med Alarm/Unknown Problem (32%) that occurred July 1 through October 31, 2023. In general, it appears that most calls in the Psych/ALOC, Vehicle Crash and Sick categories have been screened appropriately as needing MFD/EMS response due to an identified or likely emergent medical issue. However, calls coded as Fall-No Injury may be candidates for an alternative response team trained to assist people who have fallen or need assistance transferring and conduct basic medical screening to determine is medical assistance is needed.

Low Acuity Calls for Service in the City of Milwaukee: Part 3 Assessment of Community Service Officer Job Description and Reporting Structures

Community Service Officer (CSO) positions could potentially be utilized as non-sworn responders to low acuity calls. The CSO Job Description (dated 9/12/2023) and Job Announcement (dated 5/5/2023) were reviewed. The current position as described in these documents is heavily focused on quasi-law enforcement activities or determining if law enforcement intervention is needed. Recommended revisions to these documents are contingent on the City's conceptualization of the alternative response role of the CSO and the specific calls for service that the CSO handles.

Recommendations for Community Service Officer Job Description

If these responders are tasked with responding to eligible MO, Welfare Citizen, neighbor and landlord/tenant disputes, soliciting, child custody, property pick-up, and cruelty to animals calls for service, we recommend the following essential functions; education and experience; and knowledge, skills and abilities in the Job Description:

Essential Functions

- Regular and consistent attendance.
- Respond to non-emergency, police calls for service including: low acuity MO calls, welfare checks, neighbor and landlord/tenant disputes, soliciting, child custody, cruelty to animals, and property pick-up calls to aid and determine the need for intervention from other agencies (police, EMS, MCBH) and community resources.
- Assists individuals who are experiencing mental, behavioral, social, and / or emotional incidents. CSOs provide first level assistance and assessment to individuals before referring individuals to health and / or social services
- Assists individuals with resolving conflicts with neighbors, landlords and business owners.
- May serve as a training officer for new Community Service Officers.
- Responds to Department call-outs in cases of emergencies, severe weather, and natural disasters.
- Performs various other duties of an emergency and non-emergency nature as designated by a supervisor.

If responding to no injury falls calls:

- Responds to MFD fall-no injury calls and assist community members who have fallen or need help transferring.
- Performs basic medical screening to determine need for EMS or other medical services.

Education and Experience:

- Two years of successful job experience in behavioral health, violence prevention, housing or other social services, customer service, community relations, or other closely related area.

- Must be 20 at date of application and in good physical condition. Graduation from high school or G.E.D. Possession of a valid Wisconsin driver's license. Training and experience in community, social or

behavioral health services preferred.

If responding to no injury falls calls, consider adding EMT Basic certification.

Knowledge, Skills and Abilities:

.

- Ability to learn skills related to engagement and outreach, de-escalation, conflict mediation, basic suicide and behavioral health screening; basic first aid and overdose prevention.
- Ability to develop knowledge of and navigate community resources to assist community members.
- Ability to learn relevant laws, ordinances, and policies governing law enforcement in the state of Wisconsin and City of Milwaukee. (landlord/tenant, animal cruelty, etc)
- Ability to understand and carry out oral and written instructions during emergency and non-emergency situations.
- Ability to maturely deal with conflict and with emotionally upset persons.
- Ability to mentally visualize locations and routes within the City of Milwaukee.
- Ability to deal with unusual and emergency situations, such as injured, frightened, distraught, and disorientated people or fatalities.
- Ability to learn and accurately recall names, places, and incidents.
- Ability to stand and walk for extended periods of time and to sit for several hours while operating a vehicle.
- Ability to work in inclement weather conditions.
- Ability to establish and maintain effective working relationships with department officials, employees, members of other agencies, and with the general public.
- Ability to write basic reports using proper grammar.
- Ability to maintain a mental capacity which allows for the exercise of sound judgment and rational thinking under strenuous and hectic circumstances; evaluate options and alternatives and choose an appropriate and reasonable course of action; and demonstrate needed intellectual capabilities during testing and training.
- Ability to lift and operate a fire extinguisher.
- Ability to use standard office software and hardware.
- Ability to use standard Police communications equipment
- Valid Wisconsin's driver's license

If responding to no injury fall calls:

- Ability to safety lift community members and assist with transfers.
- Ability to provide basic medical screening (vitals) and assess for need for EMS or other medical services.

Reporting Structures

The Policing Project estimates there are currently 130 alternative response programs in the United States.[vii] These programs exist within a variety of reporting structures. Both Durham North Carolina and Albuquerque New Mexico have created civilian led Departments of Community Safety that oversee their alternative response programs. Other cities house their alternative response programs within existing city agencies. For example, Olympia Washington's Crisis Response Unit (CRU) operates out of the Olympia Police Department with a civilian supervisor. Portland (OR) Street Response operates out of Portland Fire and Rescue. Evanston's (IL) Crisis Alternative Response Evanston (CARE) team operates out of the Parks and Recreation Department and reports to the Parks and Rec director, who is a social worker. Still other programs are housed in community agencies. For example, in Minneapolis, MN, the Behavioral Crisis Response teams are housed within a nonprofit agency, Canopy Roots, that contracts with the city. These programs vary in terms of staffing, with those housed in fire departments being more likely to include EMTs and/or paramedics on the team and those focused solely on behavioral health crises being more likely to include clinicians. Teams responding to a broader range of calls not requiring law enforcement response (behavioral health, neighbor disputes, animal cruelty, etc.) tend to have fewer formal educational requirements for frontline staff and provide extensive initial training.

Reporting Structure Recommendations

To avoid alternative responders being perceived as law enforcement, we do not recommend housing the program within the Milwaukee Police Department or having teams answer directly to a sworn program manager. We recommend the City consider housing alternative responder CSOs in the Milwaukee Fire Department, reporting to a non-sworn program manager that answers to an Assistant Fire Chief. MFD is well regarded in communities across the City and operates a variety of community health and safety programs. Another option to consider is the Office of Community Wellness and Safety (OCWS). CWS currently supports several programs that respond to community issues such as the Critical Response Team and 414Life. If housed in OCWS, the program would report to the OCWS Director.

---

[i] Houston Police Department (n.d.) Crisis Call Diversion Program. https://www.houstoncit.org/ccd/
[ii] Transform911 Implementation Case Studies (n.d.) Austin, TX: Mobile Crisis Outreach Team. https://www.transform911.org/resource-hub/case-studies/austin/
[iii] City of Durham Community Safety (nd) DCSD 400 SOP 124 Crisis Call Diversion Policy. https://public.powerdms.com/Cit5252/tree/documents/2002803
[iv] Dee, T. S., & Pyne, J. (2022). A community response approach to mental health and substance abuse crises reduced crime. *Science Advances, 8*(23), eabm2106-eabm2106. https://doi.org/10.1126/sciadv.abm2106
[v] Brooks Holliday S, Matthews S, Hawkins W, Cantor JH and McBain R. (2024). The Road to 988/911 Interoperability. Rand Corporation. https://www.rand.org/pubs/research_reports/RRA3112-1.html
[vi] Irwin A (2024). Community Responder Liability. Law Enforcement Action Partnership. https://lawenforcementactionpartnership.org/wp-content/uploads/2024/05/LEAP-Community-Responder-Liability-Report.pdf
[vii] Friedman, Markham & Neath. (May 30, 2025). A Revolution in Public Safety is Underway. New York Times. https://www.nytimes.com/2025/05/30/opinion/911-public-safety-george-floyd.html