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Evaluation of the SEPTA Transit Police SAVE Initiative



Title Page

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Grant Number: 15PNIJ-21-GG-02717-RESS

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Abstract

This report presents the findings of a mixed-methods randomized field experiment evaluating the *Serving A Vulnerable Entity (SAVE)* initiative operated by the Southeastern Pennsylvania Transportation Authority (SEPTA) Transit Police. The initiative sought to determine whether adding a contracted civilian outreach specialist to a police outreach team improved the likelihood that individuals experiencing homelessness, mental illness, addiction, or other vulnerability conditions would be transported to an appropriate treatment or shelter facility. The study responds to national interest in alternative crisis response models and the increasing intersection of policing and public health within urban transit systems.

Across a 12-month period (June 2022–June 2023), SAVE officers conducted 158 treatment conversations involving 165 individuals in or around central Philadelphia transit stations. Shifts were randomly assigned to either a police-only condition or a police-plus-outreach-specialist condition. Treatment conversations were extended, need-focused discussions that included identifying appropriate facilities and offering transportation. Two primary outcome measures were examined: (1) “agree to transport,” indicating willingness to accept services, and (2) “treatment initiation,” defined as successful conveyance to a treatment or shelter facility. Complementing the quantitative experiment, the research team conducted 150 hours of field observation and semi-structured interviews with SAVE officers, outreach specialists, and police leadership to explore implementation processes, contextualize outcomes, and assess program fidelity.

Results showed that individuals were modestly more likely to be transported when engaged by a police-specialist team (41 percent) than by police officers alone (32 percent), representing a relative increase of 29 percent. However, this difference did not reach statistical significance, due in part to staffing-related implementation

challenges that produced an imbalance in treatment exposure (specialist-supported conversations with 61 people vs. police-only conversations with 104 people), and in part due to the overall low n of the study. Qualitative findings illuminated factors influencing outcomes, including pervasive client resistance, the narrow and unpredictable window in which individuals are willing to accept help, and the importance of relationship-building through repeated contacts. Stakeholders also emphasized substantial variation in specialist readiness, difficulties with hiring and retention, the physically demanding nature of the transit environment, and the need for clear co-response protocols, safety procedures, and consistent training.

The evaluation demonstrates that co-response in a transit environment is feasible and can produce modest operational benefits, but that outcomes depend heavily on specialist quality, program stability, and the practical realities of street-level outreach. Findings suggest that well-trained police officers can independently achieve treatment initiation at rates nearly comparable to specialists. Agencies considering similar programs should prioritize specialist recruitment, durable staffing models, and robust preparation for both partners in co-response teams. Further research is warranted to explore long-term engagement outcomes, cost-benefit implications, and alternative deployment strategies within transit and urban settings.

Executive Summary

This report presents findings from a mixed-method, shift-randomized field experiment evaluating the *Serving A Vulnerable Entity (SAVE)* initiative implemented by the Southeastern Pennsylvania Transportation Authority (SEPTA) Transit Police. The SAVE program sought to determine whether adding a contracted civilian outreach specialist to a police outreach team improved the likelihood that individuals experiencing homelessness, addiction, mental illness, or other vulnerability conditions would be transported to appropriate treatment or shelter facilities. The evaluation responds to increasing national interest in alternative crisis response models and the growing overlap between policing and public health responsibilities in urban settings.

Purpose and design

The experiment tested a simple but consequential question: *Does the presence of an outreach specialist increase the rate at which treatment conversations result in treatment initiation?* Over a one-year period (June 2022–June 2023), SAVE officers conducted 158 treatment conversations involving 165 individuals across Philadelphia’s busiest transit stations. Shifts on which SAVE officers worked were randomly assigned to either:

Control: police officers working alone, or

Intervention: police officers accompanied by a civilian outreach specialist.

A treatment conversation was defined as a specific and detailed discussion about entering treatment between a police officer or an outreach specialist, and a person who appears to have specific needs or vulnerabilities. These discussions included identifying suitable facilities, and offering transportation to the appropriate facility. The study examined two outcomes: *agreement to transport* (intermediate) and *successful treatment*

initiation (primary). Quantitative analysis was complemented by 150 hours of field observation and semi-structured interviews with officers, specialists, and supervisors.

Key findings

- **Modest but non-significant improvement with specialists:** Individuals were transported to a facility 41% of the time when engaged by a police–specialist team, compared to 32% with police alone. While in the hypothesized direction, the relative increase (29%) did not reach statistical significance due to implementation challenges, unequal sample sizes, and limited statistical power.
- **Severe personnel instability:** The contracted provider experienced high turnover, inconsistent worker readiness, and difficulty retaining specialists capable of handling the physical and emotional demands of transit-based outreach. Officers often had to lead treatment conversations, manage safety, and provide direction.
- **High levels of client resistance:** In 65% of treatment conversations, individuals declined services. Practitioners consistently described a narrow and unpredictable “window of opportunity” during which clients might accept help. This challenge constrained the potential impact of either outreach configuration.
- **Officer skill and adaptability:** SAVE officers demonstrated strong communication skills, patience, and compassion during engagements. Some appeared to incorporate techniques observed from specialists, suggesting potential for long-term skill transfer.
- **Operational realities shape outcomes:** The transit environment—characterized by crowded stations, entrenched vulnerability, frequent safety

hazards, and dynamic calls for service—complicates consistent implementation of co-response models.

Implications for policy and practice

The SAVE experiment demonstrates that police–specialist co-response in a transit environment is feasible and can produce incremental gains in treatment initiation. However, its effectiveness hinges on recruiting and retaining qualified specialists, providing robust joint training, establishing clear safety protocols, and ensuring consistent program oversight. Agencies implementing similar models should anticipate significant staffing challenges and consider the potential benefits of enhanced officer training if specialist availability is limited.

Conclusion

Although the intervention did not yield statistically significant improvements, the direction of the effect, combined with consistent qualitative insights, suggests that co-response remains a promising but operationally demanding strategy. Continued research is warranted to explore long-term client outcomes, cost-effectiveness, staffing models, and variations in deployment strategies within public transit and other high-need urban environments.

Introduction

Background and context for the study

Homelessness, mental health issues, and drug abuse are all rising across the United States. The estimated number of persons experiencing long-term, chronic homelessness increased 8.5 percent between 2018 and 2019, according to the most recent data available from the Department of Housing and Urban Development (Henry, Watt, Mahathey, Ouellette, & Sitler, 2020). Homelessness frequently co-occurs with health issues, such as behavioral health challenges, or drug and alcohol addiction. It has been estimated that more than seven million US adults have co-occurring disorders across mental health and drug abuse. Furthermore, more than half of them do not receive treatment for either behavioral health or substance abuse needs (Han, Compton, Blanco, & Colpe, 2017). Drug trends are particularly worrying. Urine drug tests of over 150,000 patients indicate that substance use has increased during the COVID-19 pandemic. This is exacerbated by an increase in fentanyl and methamphetamine use (Wainwright et al., 2020).

We also know that socioeconomically marginalized people, such as those with drug additions, mental health issues, or experiencing homelessness, receive worse health care than more privileged populations (Matsuzaki et al., 2018). These conditions can be both a cause and a consequence of homelessness, and more than one third of individuals who are homeless have co-occurring issues related to health and wellbeing (Polcin, 2016). People transition to being homeless because of a complex mix of needs and vulnerabilities (Boyle, 2016), but once experiencing residential instability, people are more likely to have involvement with the criminal justice system (Polcin, 2016), and are more likely to die (O'Connell, 2005). Safety and security are therefore vital, and

transit systems have long been attractive to people who are homeless or experiencing vulnerability.

The transit environment provides relief from the weather and relative safety. Those same systems are, however, increasingly struggling to cope with the influx of people who are experiencing residential instability (Berger, 2020). Example news articles from New York¹, Los Angeles², and Philadelphia³ document complaints from passengers and transit workers about the increases in homelessness in the transit system. Passengers, for a variety of reasons, do not feel comfortable around people who are homeless, and this issue has affected all public transit systems, and the larger ones in particular, for at least 30 years (Ryan, 1991). Consequently, for a variety of reasons (including improved outcomes for the person, public health, reduced disruption, and improved public perception of the transit system), getting individuals into treatment is increasingly a goal of transit authorities.

This proposal presents a randomized, controlled field experiment to test the effectiveness of adding a social worker to a police frontline team dedicated to helping move vulnerable people suffering a variety of public health challenges into appropriate shelter or treatment. In 2022, a year-long collaboration between the transit police for the Philadelphia region and a contracted developmental and behavioral health non-profit provider will commence. This study will examine if pairing a social work outreach worker with a transit officer can increase the success rate of getting vulnerable people delivered to a treatment facility. It will specifically answer the question; Can the effectiveness of a police outreach unit in getting people into treatment be significantly enhanced with the addition of a civilian social worker?

¹ <https://www.ny1.com/nyc/all-boroughs/transit/2020/04/24/commuters--mta-workers-grow-frustrated-with-homeless-subway-riders>

² <https://www.latimes.com/local/lanow/la-me-metro-homeless-20180406-htmlstory.html>

³ <https://why.org/articles/expanded-hub-hope-homeless-center-opening-suburban-station/>

Changing strategic goals for transit policing

Engagement in treatment, regardless of a patient's drug problem or the type of treatment setting, is generally connected with positive outcomes (McLellan et al., 1994). Barriers to entering treatment are however significant. Challenges include a failure to recognize that a problem exists, a lack of positive social support, a fear of treatment, concerns about privacy or the necessary time commitment, or the lack of available treatment or difficulty in accessing it (Rapp et al., 2006). Two particular challenges are relevant here. Marginalized communities tend to have less access to healthcare (Canavan et al., 2012) and illicit drug users in particular report difficulties in getting transportation to appropriate facilities (Matsuzaki et al., 2018).

The transit system provides safety and protection from the elements but is not a treatment facility. Transit police have long known that simply expelling people with co-morbidity needs from their facilities is ineffective as a long-term solution. As Boyle (2016: 2) points out, "Case workers and others at social service and nonprofit agencies have a much greater understanding of people who are homeless and they can persuade these individuals, who may initially be service-resistant, to accept services." There may also be less stigma associated with talking with a social worker (Ahern, Stuber, & Galea, 2007). The current scrutiny with which police departments find themselves may not be welcome; however, it provides an opportunity to examine different ways to achieve public safety, as with the current project.

For decades, police have been left propping up the process of surveillance and care of people who would otherwise be under the supervision of social services, had those other services not been severely underfunded for years (Wood, 2020). In this vacuum of service provision, police used the only tool available—enforcement—to attempt goals that could be better achieved with greater infrastructure support. Recent high-profile police-community contacts have reenergized the impetus to reallocate resources away from police to other social service agencies. Since the 2014 death of Michael Brown in

Ferguson, MO, through to the recent death of George Floyd in Minneapolis, pressure has mounted on municipalities to de-emphasize the police response to problems that are increasingly seen as public health, rather than crime and policing, concerns.

Specific to the current project, in Philadelphia, PA, the October 2020 death of Walter Wallace Jr. in a police-involved shooting while armed with a knife and suffering a behavioral health crisis, has accelerated calls for a more social service-oriented response to people in crisis or demonstrating increased vulnerability. These vulnerability conditions include homelessness, residential instability, domestic abuse, sexual violence, drug addiction, alcohol abuse, mental health crises, and associated trauma. They can often present together in multiple ways that challenge police officers to understand the complexity of co-morbidity issues affecting a person's vulnerable state. Disentangling these requires professional expertise and it can be advantageous for individuals and broader public safety goals to move people with complicated needs to specialized facilities such as intake centers, treatment facilities, or shelters.

The eventual goal of many proponents of reimagining policing is to remove police from this sphere entirely. Given the interconnection of vulnerability and public safety, and the deficiencies in community health systems (Wood, Watson, & Barber, 2021), that goal might be a significant challenge. Furthermore, recent work examining calls-for-service data from Philadelphia has revealed the complexity between police work and vulnerability, with up to 20 percent of calls from the public at the intersection of policing and public health resulting in a different outcome than the original call indicated (Ratcliffe, 2021). Specifically, of all the calls that originated with a health classification or resulted in a health-related outcome, 11.6 percent were initially recorded as health-related but resulted in crime or policing outcome, and 8.8 percent were originally crime or policing calls but ended with a health-related result. There could be a variety of reasons for this; however, policing and public health will continue to be interconnected into the immediate future.

Figure 4 from the publication is reproduced here. It shows the roughly 8 percent of public-health related calls to the Philadelphia police in 2019. Of these, nearly 80 percent go on to result in a health-related outcome, and are shown in grey. But it also shows blue lines reflecting the 11.6 percent of calls that originate as a health-related CAD event but result in a crime or other policing outcome, and red lines indicating the 8.8 percent of events that originate as non-health related, but on investigation by police result in a health-type disposition. While there are possibilities to reduce police involvement in many health-related calls, there is clearly a minority of incidents that cross categories and defy easy classification.

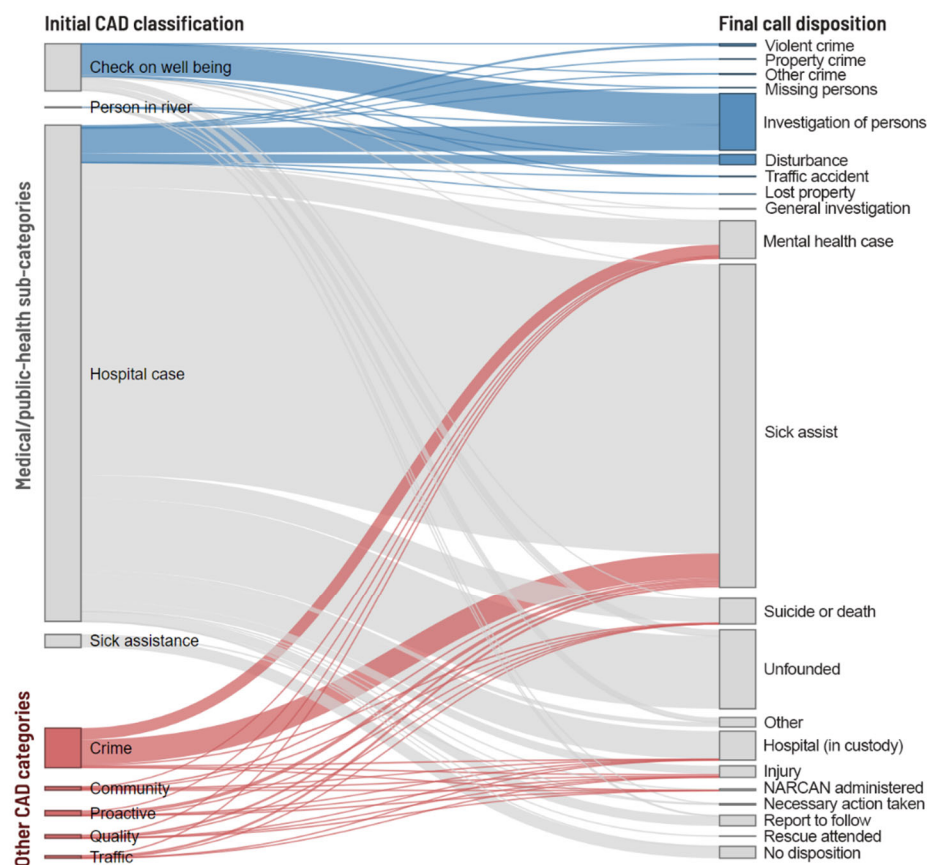


Figure 1 Distribution of public health-related CAD calls for Philadelphia in 2019 at initial classification and final disposition, from Ratcliffe (2021) *Policing and public health calls for service in Philadelphia*. *Crime Science*, 10(5), 1-6.

An intermediate step could be the co-production of public safety and improved public health. Accurately diagnosing people with co-occurring needs is beyond the scope of most officers and requires professional expertise. Furthermore, social workers may be more willing to ‘meet people where they are at’ (Sherraden, 2020). In a co-production model, police work closely with public health professionals to better de-escalate responses, tailor handling of activities, and coordinate improved outcomes. To facilitate this, some cities have initiated Crisis Intervention Teams (Compton et al., 2014; Ellis, 2014; Watson, Compton, & Draine, 2017) and a few police departments have started to explore combining a social work response in collaboration with police as co-responders, though robust evaluations have been minimal to date. The current project seeks to add to this limited body of work with a methodologically rigorous, outcome-oriented evaluation of a co-responder team centered on a large public transit system.

The problem at the local level

In the city to be studied—Philadelphia—people with public health needs and vulnerabilities are often drawn to the public transit system as if it affords many benefits to someone living on the street or otherwise displaced from a secure and safe residence. The combination of train stations, bus terminals, and mobile transportation (trains, subway cars, buses, and trolleys) provides shelter from the rain, a cool environment in summer, a warm atmosphere in winter, and most importantly, relative safety. The transit system is well lit, has an extensive network of surveillance systems and personnel throughout its system of stations and interconnecting tunnels, and a dedicated police department.

The Southeastern Pennsylvania Transportation Authority (SEPTA) is the sixth-largest public transport system in the United States. In a normal (i.e., non-COVID)

year, it moves over 300 million people between 155 regional rail stations, 50 subway/elevated line stations, and 18,000 bus stops. At any time, there are over 1000 buses on the street, over 100 trolleys, and nearly 40 subway trains on the go. Three-quarters of a million people live within half a mile of a train or trolley stop. They are two-thirds non-white, and more than one quarter live below the poverty line (see Appendices A and B). One quarter of the city travels to work on public transport, the lifeline of the 6th most populous city in the country. SEPTA's police department has 275 employees, the vast majority of whom are police officers⁴.

Moving funding from additional police resources to support frontline social workers (albeit to assist police officers), as SEPTA police will do with the program to be evaluated, is predicated on the assessment that it will improve specific outcomes. Police departments make strategic decisions like this for many reasons such as genuine need, optics, or response to external or internal pressure (Crank & Langworthy, 1992; Crank & Rehm, 1994). In the case of SEPTA police, they have a sizeable community of people who occupy the transit system with needs and vulnerabilities that can cause disruption to public transportation. People who are homeless can create health issues in public transit spaces, and drug overdose incidents regularly disrupt and delay the train system. Leaders in SEPTA police, like many police executives, have recognized they need to move beyond policing solutions when addressing a chronic public health crisis.

Lofty goals of measuring the impacts of the project on people in vulnerable situations within the transit system are too vulnerable to exogenous impacts. External conditions (such as weather, economics, pandemics, and the policing of the wider city) have always been a factor driving changes to the transit system. And evaluating if people engage with treatment is also outside the scope of police capability. It has long

⁴ SEPTA Police Chief Tom Nestel, personal communication.

been known that “the contribution of police to the wellness and recovery of people and their families is constrained by the ability of the community health and social service system to do its job.” (Wood et al., 2021: 29) Therefore, the intervention and outcome measures are grounded in the constraints and realities documented during hundreds of hours of field observations conducted for a current and related BJA-funded project that will complete fieldwork in July 2021. Details of the BJA project—and how it has contributed to our understanding of the current application—are in the project design below.

Public health researchers have recognized the role similarities in that, “Both public health and policing are, in part, front-line organizations which intervene directly in the lives of people, with goals and missions that could sit well together but are expressed in a radically different language.” (Dijk & Crofts, 2017: 265) The current application is an attempt to bridge that ‘radically different language’ with an evaluation that could guide police departments across the country. Increasing the number of people moving to treatment has direct public safety benefits, but does adding an outreach worker to a police team significantly enhance this goal?

Purpose, goals, and objectives

The purpose of this research was to examine the implementation and outcomes of attaching a civilian social worker to the *Serving A Vulnerable Entity* (SAVE) police team tasked with helping people with public health needs get admitted to a recognized facility for treatment and care. In late 2020, SEPTA police started developing a small internal unit, comprising a handful of officers, called *SAVE*. The objective of the *SAVE* unit was to get more people into treatment and care facilities, where their needs could be better met. The broader goal was to reduce harmful impacts on the public transit system. For one year, intervention-related contacts between the *SAVE* team and

vulnerable people in and around the transit system were be documented, along with relevant data such as basic demographics, transportation availability, and accessibility of treatment facilities. The control condition was established by randomizing shifts so that during control shifts, the outreach team consists of only police officers. The treatment condition was randomized shifts when the social worker worked alongside police.

The primary goal was to estimate the value of the inclusion of the social worker to the police team on the main outcome variable (treatment initiation). Secondary goals included understanding the impact of transportation availability and responsiveness in helping facilitate the primary goal. A further secondary goal was to use qualitative methods to discover effective implementation strategies—and impediments—across dispatch, response, transportation arrangements, treatment provider coordination, and frontline support. If the primary goal was successful, this qualitative secondary goal could provide other police departments and cities with a roadmap to successful replication.

Specific objectives included:

- Randomize shifts through 2022 and confirm implementation of the experimental conditions,
- Ongoing measurement of ‘treatment conversations’ (dosage), ‘agree to transport’ (intermediate outcome) and ‘treatment initiation’ with successful delivery to a facility (primary outcome),
- Field observations from trained researchers documenting interventions,
- Qualitative investigation of police officer, social worker, and command-level perceptions of the intervention and program logistics,
- Comparison of treatments vs control outcomes,
- Mixed-methods summary and contextualization of qualitative and quantitative findings, and

- Reporting of results, activation of dissemination strategy, and preparation of outputs.

Literature Review

As stated earlier, and drawing substantially from Ratcliffe and Wight (2024) and the forthcoming dissertation of Hayley Wight, we know that people transition to being homeless because of a complex mix of needs and vulnerabilities (Boyle, 2016). Once they experience residential instability, they are more likely to have involvement with the criminal justice system (Polcin, 2016), and die (Leifheit, Chaisson, Medina, Wahbi, & Shover, 2021). The transit environment provides some respite from adverse weather and relative safety for people experiencing homelessness and conditions related to vulnerability. But those transit systems are not designed as shelters and struggle to cope with the influx of people who are experiencing residential instability (Berger, 2020) as well as other co-occurring challenges. Passengers report that they do not feel comfortable around people who are homeless (Ryan, 1991). Furthermore, it has been argued that the presence of the vulnerable community leads to issues related to transit service, quality, sanitation, and safety (Ding, Loukaitou-Sideris, & Wasserman, 2022).

Police interventions addressing vulnerability

A foundation of the emerging field of law enforcement and public health (LEPH) (Bartkowiak-Théron, Clover, Martin, Southby, & Crofts, 2022) is the recognition that police and public health professionals need to collaborate in order to deliver optimal responses to incidents that fall between the fields of policing and public health (Dijk & Crofts, 2017). Recent work on policing vulnerability, in particular, has acknowledged the complex, delicate nature of interactions between police officers and individuals with vulnerability conditions (Bacon & Spicer, 2022). Recent high-profile police killings, such as the death of Walter Wallace Jr. in Philadelphia, a man who was shot by police while armed with a knife and suffering a mental health crisis, and emergent

movements such as Black Lives Matter, have spurred discussion about pivoting non-criminal calls for service from police to social institutions better suited to handle marginalized, vulnerable populations in order to reduce potentially volatile police interactions. Police acknowledge that they are not the sole solution to many of these challenges and are increasingly partnering with service agencies to deliver a collaborative response and different response models are being trialed as alternative options that provide more compassionate, service-oriented approaches to the social problems they encounter (Wood et al., 2021).

A spate of collaborative policing approaches such as crisis intervention teams, police-social worker co-response teams, and overdose response teams have been implemented across the country. These collaborative policing interventions employ civilian specialists such as mental and behavioral health professionals, harm reduction specialists, social and outreach workers to train officers and help deliver a non-punitive, service-oriented response to individuals in crisis (Dupont & Cochran, 2000; Formica et al., 2022; Shapiro et al., 2015; Southeastern Pennsylvania Transportation Authority, 2021). The following sections review the varieties of police-based interventions that address vulnerability conditions, as well as research on the interventions' effectiveness.

Crisis Intervention Teams

As discussed previously, the fallout of deinstitutionalization had vast implications for the criminal justice system, particularly for first responders tasked with responding to calls stemming from mental health crises (Teplin, 2000). In some circumstances, police may unnecessarily escalate mental health-related encounters and invoke force due to insufficient de-escalation training and feelings of unpredictability and dangerousness (Ruiz, 1993; Ruiz & Miller, 2004). Unfortunately, such encounters may

even become fatal. Estimates of those killed by police in 2015 show that of the 1,099 individuals killed by police in the United States that year, 215 (23%) displayed signs of mental illnesses (Saleh et al., 2018). The fatal police shooting of a Memphis man with mental health and substance abuse history prompted the Memphis Police Department to collaborate with local mental health practitioners and advocates to create the Crisis Intervention Team (CIT) model (Dupont & Cochran, 2000).

Crisis Intervention Teams, sometimes also known as the Memphis Model, represent an internationally adopted community partnership between police, mental health and substance use professionals and advocates, all working to improve the outcomes for individuals experiencing or affected by behavioral health vulnerabilities (CIT International, 2019; Dupont & Cochran, 2000; National Alliance on Mental Illness, 2023). CIT was developed in 1988 and has since been implemented in over 2,700 communities throughout the United States (National Alliance on Mental Illness, 2023). CIT contains two basic goals: to improve officer and consumer safety, and redirect individuals with mental illnesses from the judicial system to the health care system (Dupont et al., 2007). CIT involves a partnership between law enforcement, mental health, and advocacy communities, each playing a vital role in the operation of CIT. Within the law enforcement community, CIT trained officers intervene in situations involving a mental health crisis, and through their training can better de-escalate the situation appropriately. CIT officers are also tasked with determining the appropriate services for an individual in need and transporting them to those services. The mental health community in a CIT model are treatment providers and providers of education and training to CIT officers. Partnership with the mental health community is necessary to facilitate access to services and treatment. The advocacy community consists of individuals with serious mental illnesses (SMI), their families, and advocacy groups such as the National Alliance on Mental Illness. These groups contribute to CIT

by informing the practitioner partners about the reality of living with mental illnesses or being directly affected by an individual with mental illnesses.

At the core of CIT development is a forty-hour comprehensive training for patrol officers participating in an intervention team (Dupont et al., 2007). This training provides officers with enhanced knowledge of mental health-related topics, crisis resolution skills, de-escalation training, and facilitation of a service partnership with community-based services. In communities implementing CIT, the call dispatchers are trained to identify mental-health related calls and dispatch the CIT accordingly, rather than a traditional police response (CIT International, 2019). Responding CIT officers will then utilize their specialized training to deescalate an ongoing mental health crisis and assess next steps for the individual, which may involve referral or transportation to appropriate services within the local public health treatment system.

Early research on CIT reviewed by Compton and colleagues (2008) focused primarily on officer-level outcomes, rather than patient-level outcomes. Overall, officers who receive CIT training expressed enhanced feelings of preparedness for dealing with mental health-related calls for service, more positive views of the mental health and emergency services, greater knowledge and less stigma towards individuals with schizophrenia, and increased knowledge of local treatment. Parsing out generalizable findings from the studies reviewed is difficult due to the methodological limitations of available studies, such as the lack of control groups and small sample sizes. Further, patient-level outcomes cannot necessarily be drawn from studies examining officer perceptions. A more recent systematic review and meta-analysis of CIT research found no effect of CIT on arrests of individuals with SMI or of CIT on police officer safety (Taheri, 2016). While some studies included in the review presented promising results, there was a lack of statistically significant cumulative effects that would allow conclusions of the effectiveness of CIT training. Despite the null effects, Taheri (2016)

and others do not discourage the adoption of CIT, but instead emphasize the need for enhanced evaluations.

Co-response strategies

Some police departments have gone beyond the implementation of a police-based CIT by employing civilian professionals, such as social workers, addiction specialists or mental health workers who accompany police on certain calls for service, creating a co-responder team (International Association of Chiefs of Police, 2021). A co-responder team model is defined as “a model for crisis response that pairs trained police officers with mental health professionals to respond to incidents involving individuals experiencing behavioral health crises”, typically issues stemming from substance use and mental health conditions (International Association of Chiefs of Police, 2021, p.3). The key difference between CIT and co-response is the presence of a civilian worker alongside the police during calls for service in a co-responder model, while CITs often involve a police-only response (Reuland, 2010). The co-responder team will patrol together during their shift and offer primary response to calls by being dispatched directly to the scene or provide secondary response by being called in after initial response by police (International Association of Chiefs of Police, 2021). The specific implementation of these models is highly variable, as local interventions are tailored to meet the needs of the communities they serve. Many of them have also come into existence organically, without an agreed operating model across departments.

Overall, existing evaluations of co-responder programs appear to demonstrate that co-response teams are effective in responding to behavioral health needs. A recent analysis of an embedded police social worker (PSW) model, a type of co-response that employs a civilian social worker within the police department who works alongside police to respond to social calls for service, found that the PSW demonstrated efficacy

by utilizing de-escalation and crisis intervention training on-scene with clients (Ban & Riordan, 2023). The analysis also found the PSW to be more efficient in making referrals for high-need clients compared to officers. Additional studies have similarly found that co-responder programs appear to be an effective approach to connect vulnerable individuals with needed services through follow-up contacts and service treatment referrals (Formica et al., 2022; Shapiro et al., 2015; White & Weisburd, 2018). In regards to criminal justice outcomes, there is some evidence that individuals experiencing a behavioral health crisis who received response from a co-response team were less likely to be arrested in the short-term (Bailey et al., 2022; Lamanna et al., 2018), but these individuals are a source of long-term system demand as they are more likely to have follow-up calls for service (Bailey et al., 2022).

Methodology

Trial design

The evaluation was designed as a randomized two-group posttest design and largely implemented in that manner⁵. Police officers on the existing police team were accompanied by outreach specialists on certain shifts selected through randomization. Due to administrative limitations and access to the police team, pretest measurements were not possible.

Participants

The participants in this study are vulnerable people whom the police team (with or without an outreach specialist) assessed to be in a crisis of homelessness or another vulnerable situation, and with whom they had a 'treatment conversation'. Asquith and Bartkowiak-Théron (2021: 14) define a *vulnerable person* as “any individual likely to experience harm as a result of their individual, social, or situational contexts, and who is unable to mitigate that harm”, and *vulnerability* as “any circumstance or condition that is likely to create or exacerbate harm.” Vulnerability can be “transient (like unemployment), permanent (e.g., Down syndrome or autism), incremental (e.g. an escalation of legal or illegal drug use), or cross-sectional (in the case of co-, tri- or multiple morbidities)” (Bartkowiak-Théron et al., 2022: 4). Most of the people that participated in the study were experiencing homelessness; however, about 20 percent had other conditions that brought them in contact with the police.

⁵ This section is largely drawn from the methodology section of the related publication, Ratcliffe and Wight (2024) Co response and homelessness: the SEPTA transit police SAVE experiment, *Journal of Experimental Criminology*.

Patrol officers often encounter vulnerable people throughout their shift, and more-often-than-not will have passing conversations with them. These brief meetings are sometimes classified as *contacts* or in some cities '*mere encounters*' (City of New York Police Department, 2016). These can involve a check on the person's welfare and perhaps an offer of social service support, but little more than that. They tend to last a few seconds, and if services are declined--as they usually are--culminate in an instruction to leave the transit system.

For the current study, we are interested in more in-depth conversations than mere encounters. Our previous fieldwork with the agency (Ratcliffe & Wight, 2022; Wight & Ratcliffe, 2024) identified that some mere encounters expand into what we term '*treatment conversations*'. *Treatment conversations* are more extensive discussions that go beyond just the regular check-in or passing comment of a contact. We define a *treatment conversation* as “a specific and detailed discussion about entering treatment between a police officer or an outreach specialist, and a person who appears to have specific needs or vulnerabilities”. In practical terms, we found that a good indication that an encounter had morphed into a treatment conversation was if the discussion started to delve into the specific needs of the person, and the officer or outreach specialist was considering, or offered to make, a phone call to a facility to arrange a place or transportation for the person.

We recognize that the distinction between a mere encounter and a treatment conversation might appear vague when described in this way; however, the officers and outreach specialists conveyed to us that they understood the distinction from their experience with the vulnerable community. Fieldwork confirmed that officers appeared to be identifying and recording treatment conversations appropriately.

We left the identification of a person experiencing a vulnerable situation to the officers and outreach specialists. They told us that they would often identify people because they were asleep, lying down, or otherwise on transit property but making no

effort to take a bus or subway train. In several cases, the person was known to them from previous contact. They contacted people in three main ways, by being:

1. assigned or accepting a call-for-service from the public through the police dispatch system to attend to a 'vulnerable person',
2. called by police colleagues to assist with a member of the vulnerable community they had encountered directly while on patrol or through a call-for-service, or
3. while on general patrol in or around transit authority property (mainly subway stations).

Settings and locations

This experiment took place within or near the stations and facilities of the Southeastern Pennsylvania Transportation Authority (SEPTA). SEPTA is the public transportation system for the Greater Philadelphia (Pennsylvania) area. SEPTA's trains, two subway lines, trolley and bus services support an area of approximately 2,200 square miles and is the sixth largest transportation system in the United States.

Most treatment conversations during the study took place at central Philadelphia train stations (either subway or regional rail), within the interconnecting network of subterranean tunnels in the Center City area of Philadelphia that link Suburban Station, 15th Street Station, and City Hall Station. If we included the street level of JFK Boulevard above these locations, these three sites account for more than 50 percent of the recorded treatment conversations. Table 1 shows all recorded locations that saw at least 4 treatment conversations.

Two details are relevant. First, the 16th Street and 17th Street junctions with JFK Boulevard are busy public transit intersections with numerous bus stops. Second, there was another project running during this study, and there were a few specific stations the SAVE team were asked to avoid so as to limit cross-project contamination. As a

result, Table 1 is more for information than an indication of frequent locations of people experiencing vulnerability conditions. All of these locations are in the Center City area of Philadelphia, which (alongside Kensington) is one of two main hotspots of medical and public health police calls for service in the city (Ratcliffe, 2021).

Table 1 Main locations for recorded treatment conversations.

<i>Location</i>	<i>N (%)</i>
15th Street Station	37 (27.6%)
Suburban Station	12 (9.0%)
City Hall Station	10 (7.5%)
17 th Street & JFK Boulevard	9 (6.7%)
13th Street Station	8 (6.0%)
16 th Street & JFK Boulevard	8 (6.0%)
2nd Street Station	6 (4.5%)
5th Street Station	4 (3.0%)
8th Street Station	4 (3.0%)

Note: Percentages are based on the 134 treatment conversations that had a recorded location.

Interventions

In late 2020, SEPTA police started developing a small internal unit, comprising two or three officers, called *SAVE* (Serving A Vulnerable Entity). The objective was to move people sheltering in the transit system into treatment or care facilities, where their underlying needs could be met. The broader goal was to improve conditions within the public transit system. The study ran from June 2022 to June 2023, a period of just over one year, and covered a period when SEPTA transit authority entered a year-long contract with a private company to deliver outreach specialists to work alongside the officers. The outreach specialists recruited for the project wore reflective vests (usually labelled 'Outreach Navigator') over civilian clothing. They would patrol the subterranean network of tunnels and station platforms with the uniformed *SAVE* police officers. At a minimum, the outreach specialists were required to have crisis

intervention and CPR training, and instruction on the use of NARCAN® naloxone nasal spray (an opioid overdose treatment). Some had received additional training, such as narcotics awareness and training on helping people experiencing a behavioral health crisis.

Over the year or so of the study, there were just under 12 treatment conversations reported per month (11.85, standard deviation = 8.14), with as few (in a complete month) as 3 and peaking in April 2022 (Table 2).

Table 2 Treatment conversations by study month.

<i>Study month</i>	<i>Treatment conversations</i>
June 2022	14 (9.1%)
July	8 (5.2%)
August	8 (5.2%)
September	15 (9.7%)
October	3 (1.9%)
November	15 (9.7%)
December	8 (5.2%)
January	14 (9.1%)
February	5 (3.2%)
March	10 (6.5%)
April	34 (22.1%)
May	19 (12.3%)
June 2023	1 (0.6%)

Note: Table does not include four treatment conversations with insufficient date information. June 2023 does not include a complete month of data, as the experiment was curtailed on 3rd June.

The intervention involved a member of the SAVE team (either with or without a specialist) having a *treatment conversation* with a *vulnerable person* (see definitions in 'Outcomes' and 'Participants' sections of this article). It was reported that many treatment conversations lasted up to five minutes (n=104), while 28 were reported to take between five and ten minutes, and 11 took more than 10 minutes (15 interactions

were missing a time estimate). Our fieldwork experience suggests that these time estimates are generally conservative, and many took longer than documented.

No two treatment conversations were the same; however, here are two example scenarios broadly representative of the encounters the researchers observed during fieldwork observations. A patrolling team member encountered a man struggling to get up a set of station steps. On speaking to him, it became clear that the man was not only struggling physically, but also mentally. The SAVE team member engaged in a treatment conversation with the man, discussing his needs, and previous experiences with the city's shelters and facilities. Subsequently, the officer made a phone call to find a suitable space in a shelter facility. The man was offered the place, and the officer drove him to the location in a police car.

In a second example, an officer asked a group of people to move away from a station, because they were not engaged in taking public transport. During this interaction, the officer struck up a conversation with a woman in the group. During this extended conversation, they discussed her drug addition, experiences of drug treatment facilities in the city and beyond, and her current situation. The officer offered to make the necessary phone calls to get her accepted into a more suitable treatment facility, but she stated that today was not the day for her, and she wanted to stay with her friends. At that point she left the station.

If a participant declined assistance, usually the police officer would then explain that the person had to leave the transit authority property, either by taking a train elsewhere (if at a train station) or leave the station or transit concourse via an exit. Sometimes the officer remained while they left, or the officer left the scene with a promise to return shortly to confirm the person had left the location.

Outcomes

We report the primary outcome, *treatment initiation*. *Treatment initiation* occurred when the SAVE police team, or the police officers along with the outreach specialists successfully concluded a *treatment conversation* by delivering a vulnerable person, or otherwise arranging for the conveyance of a person, to the care and control of a *treatment facility*. For this study, a *treatment facility* is a hospital, intake center, evaluation site, triage clinic, shelter or other program that has been approved by the SAVE team or outreach provider as a location to which they can transport vulnerable people.

There were no times when a treatment initiation occurred and there were no suitable facilities. This was due to the police officers or outreach specialists often making direct calls to facilities and drawing on personal contacts, or taking a vulnerable person to a triage facility. While the triage facilities we visited on fieldwork were sometimes closed for walk-in clients, they would accept clients delivered by the police team.

The extent of our study ends at treatment initiation because the SAVE team could not control what happens once a person enters a treatment facility, whether they will be successfully enrolled, or whether they will stay for the duration of care. In public health parlance, this distinction exists between ‘treatment initiation’ and ‘treatment engagement’ (Brown, Bennett, Li, & Bellack, 2011). The study was designed with an acceptance of the limitation that treatment engagement was beyond the remit of the transit police department.

Sample size

The participants for this study are drawn from the population of vulnerable people in and around the transit system as encountered by the teams of officers or officers and outreach specialists. Field observations showed the teams had varying degrees of

contact with numerous vulnerable persons throughout each shift, ranging from a simple check-in to a treatment conversation, however, to minimize the officer's already extensive paperwork burden we were asked to limit the data capture for the officers to only record treatment conversations. The available data therefore reflect all interactions interpreted by the officers as treatment conversations.

Because treatment conversations are organic and emerge as a natural progression of an ongoing encounter between a vulnerable person and the teams, it was not appropriate to sample from the vulnerable community that spend time in the transit system. Of the 158 recorded treatment conversations, they occurred with 165 individuals (we did not include in the individual count two children under the age of two that were with their parents).

Randomization

The study was planned for one year, with three SAVE officers working 5 shifts each per week. Our initial attempt at randomization was to identify the 30 work shifts every two weeks, and then randomly assign outreach specialists to half of those shifts in a two-week block with a 1:1 random assignment. This randomization schedule was provided to the police department at least four weeks before each block, so that they could manage the outreach specialist contract. Because of the need to assist with operational planning, no attempt was made to conceal the sequence. Frequently, due to loss of personnel to other assignments, sickness, vacation or training, the police officer team was reduced to two, and we adjusted to a 20-shift per two-weeks randomization pattern.

The lead researcher randomized the schedule using a random number generator in Microsoft Excel and emailed the schedule to the supervising lieutenant at SEPTA police

department. The lieutenant independently consulted with the officers and the outreach specialist contract provider to organize the logistics.

As will be clear from the results section that follows, the randomization was created for an idealized situation where the SAVE officers and specialists were accessible throughout the study period, but this did not manifest in reality. Problems associated with recruiting and retaining outreach specialists meant that officers were sometimes not accompanied on intervention shifts when they should have been, resulting in an imbalance in the eventual count of people contacted by officers alone (104) as compared to contacted for a treatment conversation with an officer/specialist team (61). It was an implementation problem caused by real-world conditions recruiting people to a difficult job involving walking all day, working with the police, and being in a challenging work environment.

Blinding

The experimental assignments were not blinded, because the officers knew which shifts would have an outreach specialist before the shift started.

Statistical methods

The study was designed as a posttest-only randomized controlled experiment, also called a prospective cohort design (Morgan, Gliner, & Harmon, 2000; Ratcliffe, 2023; Viera, 2008), though note the subsequent lack of equivalence across treatment and control implementation mentioned above. We report the incidence risk ratio of treatment initiation between police-only and the police/outreach specialist team with 95 percent confidence intervals (c.i.). The incidence risk ratio is the ratio of the incidence risk of treatment initiation (transport to a facility) by participant in the police and specialist group to the incidence risk of treatment initiation by participant

in the police-only group. As recommended by Moher et al. (2010) in the 2010 CONSORT guidelines, we also report absolute effect sizes with risk difference, and the number needed to treat (NTT), which represents the number of treatment conversations required for an outcome to have one additional positive result over the alternative outcome (Kim & Bang, 2020). In the ancillary analyses we report Chi-square values for the treatment conversation interaction and primary outcome by participant race/ethnicity.

Qualitative methods

To supplement the statistical findings of the SAVE experiment, we included qualitative insights from fieldwork and interviews with key SAVE stakeholders. Prior to the evaluation period, the researchers conducted preliminary fieldwork via walk-along observations with SAVE officers in vulnerability hotspots throughout the transit system in Philadelphia, mostly focused on the subterranean transit corridor in the city center. The preliminary fieldwork familiarized the research team with the project setting and provided on-the-ground insight into how police conduct treatment conversations with individuals sheltering in the transit system. Based on preliminary fieldwork exposure, the researchers developed a semi-structured fieldwork report template to organize notes captured during fieldwork. The fieldwork report included details of any treatment conversations observed, an overview of the conditions of the day, whether it was a SAVE team shift or an officer working alone, and additional space to comment on anything noteworthy that occurred outside of treatment conversations.

During fieldwork observations, the researchers traveled on foot with SAVE officers or teams through the subterranean transit system in Philadelphia. During treatment conversations, the researchers would maintain a respectful distance from the interaction, but remain close enough to see the interaction and hear the verbal

exchange. During occasional instances outside of treatment conversations that involved officers responding to a call that required a traditional police response, the researchers would separate from the SAVE officers and find a safe place nearby to wait until the encounter was resolved. The research team completed 33 fieldwork observations totaling 150 hours.

In addition to fieldwork, researchers conducted semi-structured interviews with five SAVE stakeholders involved in the project including officers, members of police management, and one specialist. These were in addition to informal conversations throughout the shift during the walk-alongs. Interview topics discussed the operation of the SAVE program, implementation challenges, and overall feedback on their experience of the program. While the researchers naturally discussed these topics with stakeholders during fieldwork observations or check-in meetings with management, the semi-structured interviews provided longer, in-depth conversations about the components of the program that worked well, and the components that need improvement, which is valuable insight for developing future co-response programs.

All project data were anonymized to prepare for analysis using ATLAS.ti 25 qualitative data analysis software. Field observation reports were collated, organized by date, and input to ATLAS.ti separately from the interview data. Each interview and the collated field observation reports were separately analyzed using an iterative categorization process, a method that lends well to interview and observational data (Neale, 2016). The coding process included a combination of inductive and deductive coding, with deductive codes drawn from topic areas included in the field observation reports and semi-structured interview guide. Inductive coding allowed themes to emerge organically from field observations and from the stakeholders' narratives (Chandra & Shang, 2019). The topic of resistance, for example, was an emergent theme in both field observation data and interview data as the researchers included aspects of resistance in their descriptions of treatment conversations and the stakeholders

explained in detail the resistance they felt from the vulnerable population during the project.

After coding the field observation and interview data, researchers composed analytical memos to discuss and organize the deductive codes and emergent themes, as well as reflect on how the findings fit into our perceptions and experiences of the SAVE program. We found that the qualitative insights in the current study provide important context to the quantitative findings in the experimental evaluation.

Results

Quantitative results

Participant flow

Across the 158 treatment conversations, 165 individuals were contacted. Figure 2 shows that of the 104 participants contacted through a treatment conversation with only officers, 33 (31.7%) were conveyed to a treatment facility. Of the 61 people contacted by the combined team of an officer and specialist, 25 were conveyed to a facility (41%). In only two cases did a person agree to be transferred to a treatment facility or shelter and then subsequently change their mind. In both cases, this change of heart was caused by what the officers referred to as being distracted by an external trigger. Both cases were with only SAVE officers.

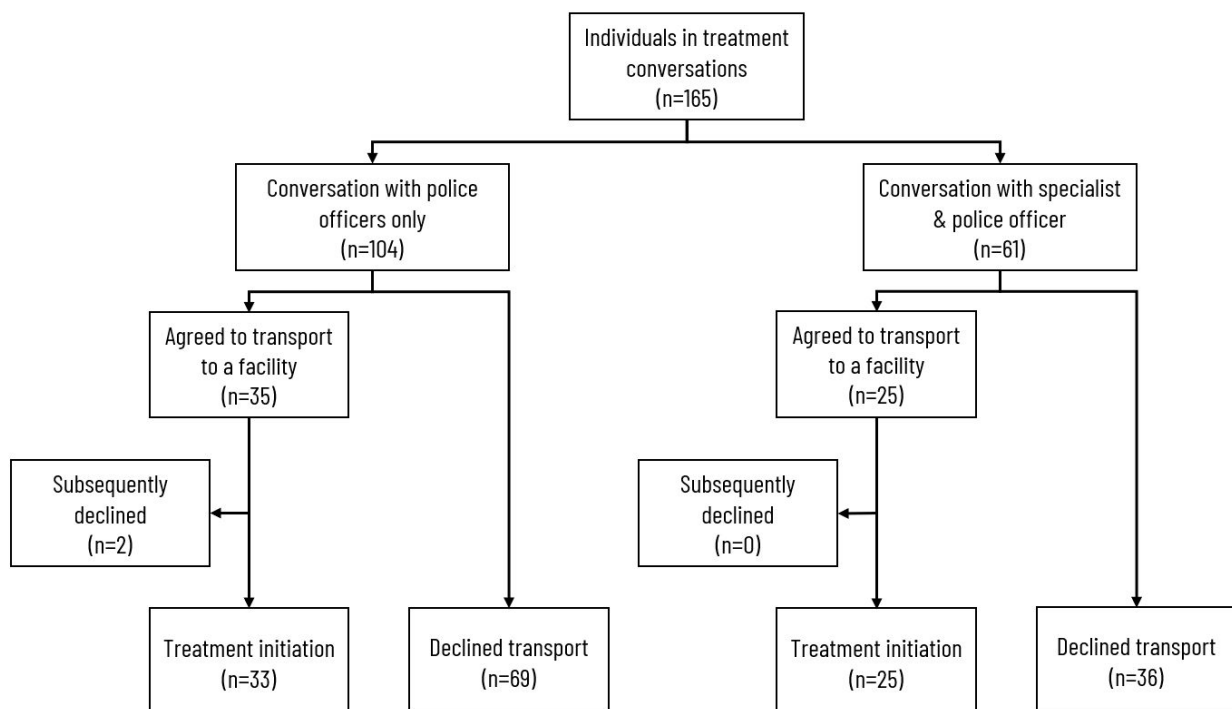


Figure 2. Participant flow chart.

Recruitment

Although the study was initially set up with a 1:1 randomization of shifts between officers only and officers with specialists (see randomization section), the eventual distribution of 165 cases is unbalanced (104 to 61). This lack of equivalence was largely due to staffing issues on the part of the third-party specialist contractor. They experienced considerable turnover during the year of the study, with some specialists staying for only a few days before resigning, or just disappearing and not reappearing. Some staff were diligent, caring and effective, but others said they were not interested in the role, did not like working with the police, found the physical demands of working on foot all day too strenuous, the hours were unappealing, or were otherwise not suitable for the task. One outreach specialist had to be reported to the police department when they revealed they were (illegally) carrying mace and a handgun during shifts. Another was a diligent and effective worker but was injured when his foot was inadvertently run over by a police vehicle. One SAVE officer who remained on the team for the study's duration estimated that the officer had worked with at least ten different outreach specialists during the experiment. The result of this was that the likelihood of there being an outreach specialist available for assigned shifts was never guaranteed and fluctuated day-to-day.

Recruitment stopped at the beginning of June 2023 when SEPTA concluded the project and the specialist contract, disbanded the SAVE team, and returned the officers to patrol.

Baseline data

Baseline demographic and characteristics of the 153 individuals for whom race/ethnicity and/or sex were estimated by the officers are shown in Table 3 and Table 4. Black males were the predominant group, which reflects a national trend. African

Americans comprise about 13 percent of US population, but about 40 percent of the homeless population (Sultan, 2020). For reference, as of July 2023, the US Census estimated Philadelphia's population to be 40.1% Black, 37.1% white, and 15.7% Hispanic (U.S. Census Bureau, 2024).

Table 3 Race or ethnicity, and sex of treatment conversation population, with row totals and percentages.

<i>Race/ethnicity</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
Black	58	32	90 (58.8%)
White	34	15	49 (32.0%)
Hispanic	3	4	7 (4.6%)
Not recorded	5	2	7 (4.6%)
Total	100 (65.4%)	53 (34.6%)	153

Note: Not included are 12 individuals for whom no race/ethnicity or sex was recorded.

SAVE officers had an option to report the primary vulnerable condition or conditions pertinent to the treatment conversation, either as perceived by the officer or as indicated by the person experiencing vulnerable circumstances. Table 4 shows that homelessness was overwhelmingly the primary condition encountered, followed by addiction and mental health issues.

Table 4 Vulnerability condition(s) estimated by reporting officer.

<i>Vulnerability condition</i>	<i>N</i>	<i>%</i>
Homelessness	131	(82.9%)
Addiction	67	(42.4%)
Mental health	33	(20.9%)
Other	8	(5.1%)

Note: Officers had one field to report what they perceived were the main vulnerability conditions at each treatment conversation, but they could indicate more than one condition. Given the prevalence of co-morbidity, percentages will not total 100%. We did not record

data on whether the recorded value was as perceived by the officer or indicated by the individual.

Number analyzed

As shown in Figure 2, two individuals agreed to be transported to a treatment facility but subsequently changed their minds while waiting for transportation. We therefore report (from the last row of boxes in Figure 2) treatment initiation (transported) versus declined transport, adding the subsequently declined figures to the declined transport count (Table 5 **Error! Reference source not found.**).

Table 5. Outcome data merging 'subsequently declined' into 'not transported'

	<i>Transported</i>	<i>Declined transport</i>	<i>Total</i>
<i>Police and specialists</i>	25	36	61
<i>Police only</i>	33	71	104
<i>Total</i>	58	107	165

Outcomes and estimation

The relative risk ratio for treatment initiation (transported to a facility) is 1.29 (c.i. = 0.86, 1.95). The likelihood of an individual in a treatment conversation with a specialist and a police officer being transported to a treatment facility for treatment initiation is 29 percent greater than the likelihood for an individual in a treatment conversation with only a police officer. In terms of absolute effect size, the risk difference is 9.25 (c.i. = -5.99, 24.50) while the number needed to treat (NNT) to get one expected *additional* transportation to a treatment facility is 10.8 (c.i. = 4.08, -16.69), suggesting that it would take approximately 11 treatment conversations to achieve one additional treatment initiation with specialists compared to SAVE officers working alone. None of

the results reported here are statistically significant using 95% confidence intervals (c.i.).

Ancillary analyses

We examined the race/ethnicity of the treatment conversation participants by the type of interaction they had (with either only officers or an outreach specialist with an officer) as shown in the first two numeric columns in Table 6. There were no significant differences between the racial/ethnicity composition of the participants by interaction, $X^2_{(df=3)} = 2.525$, $p = 0.4707$ (we should note that every police officer who worked on the SAVE team during the experiment was Black).

We also explored whether there were racial/ethnicity disparities in the primary outcome, as reported in right-hand numeric columns in Table 6. Differences between the racial/ethnicity composition of the outcome by race were significant, $X^2_{(df=3)} = 8.825$, $p = 0.031$; however, this was largely driven by the disparity in the 'not recorded' category. When this was omitted from the analysis, the result using just the known race/ethnicity categories was not significant ($X^2_{(df=2)} = 1.517$, $p = 0.468$).

Table 6 Race or ethnicity of treatment conversation population by interaction and outcome.

Race/ethnicity	Interaction		Outcome		Total
	Specialist/officer team	SAVE officer only	Transported	Not transported	
Black	36	54	31	59	90 (58.8%)
White	18	31	14	35	49 (32.0%)
Hispanic	3	4	1	6	7 (4.6%)
Not recorded	4	15	12	7	7 (4.6%)
Total	61 (37.0%)	104 (63.0%)	58 (35.2%)	107 (64.8%)	165

Note: Not included are 12 individuals for whom no race/ethnicity or sex was recorded.

Harms

No harms or otherwise unintended effects were reported or observed across any groups.

Qualitative results

Initiating treatment conversations

The evaluation of the experiment found that SAVE teams, which included an outreach worker and a SAVE officer, were slightly more successful in treatment conversations compared to officers working alone (Ratcliffe & Wight, 2024). To provide context to these findings, we discussed with stakeholders the different approaches that officers and specialists took when initiating treatment conversations. For officers, they approach treatment conversations with safety at the forefront: “I’m always moving like an officer. I’m always trying to observe where [clients’] hands are. If they have a blanket over them, I’m asking them to remove it.”

Another officer noted,

When you take off the blanket, it might be a weapon or knife. When they stand up, there’s drugs falling off of them. When they reach over, you see open sores, blood...you’re got to think about all of those things.

The SAVE officers are assessing the safety of the scene for themselves and their outreach partner, but they are also operating within the confines of the busy transit stations in Philadelphia, so it is essential to minimize the risks of any potentially volatile encounters.

While assessing safety, the officers also noted that they choose their words wisely in order to convey compassion and courteousness to the vulnerable individuals they are engaging:

I'm always starting with 'good morning.' If you approach them with a certain level of kindness, nine times out of ten, you're going to get that kindness back. Be consistent in your approach and you will eventually earn their respect.

Similarly, another officer stated, "I'll try to let them know that I'm sympathizing with them without accusations. Just to use that verbal judo to keep it an even playing field." This officer noted that they will lead with statements such as, "I notice that you've been down here for over an hour...did you miss a train? Are you waiting for someone?" instead of expressing accusations or hostility. Conducting these engagements with compassion is intentional and vital in order to not only establish rapport with the vulnerable community, but also to set the tone of the conversation.

Setting the tone of the conversation was discussed by a specialist stakeholder as well, who stated, "I'm not going to say it can't get out of control, but you have the most control how you start the engagement. Even if somebody goes a little sideways, you can always keep that warm demeanor." Similar to the officers, the specialist noted that he will assure vulnerable individuals that he is not here to make their life difficult or cast judgement on their situation, but instead he is trying to help. Further, the specialist stakeholder explained that even when clients decline services initially, he will try to reframe his offer. For example, he will say, "You sure? You're not hungry? They're feeding over a [a nearby ministry] right now so you can go get a hot meal." A short-term offer like a meal might be easier to accept than beginning a treatment intake process. "I'll get him a ride, and then he just got off [transit property] without me even telling him. So it's always your approach." In this case, the specialist is leveraging his

knowledge of resources to offer more specific, short-term offerings compared to initiating a lengthier treatment process. In this instance, he turned initial uninterest into a successful treatment conversation.

Resistance

Resistance is a central theme that emerged during the fieldwork and interview components of the SAVE experiment. As mentioned previously, SAVE teams spent the majority of their time in the field proactively approaching people who are sheltering in the transit system and appear to have unmet needs. This approach is different than a response-based co-response program where teams are dispatched to calls (Seo et al., 2021b). When approached for a treatment conversation, the SAVE teams would triage individuals' needs and offer transportation to appropriate services. Individuals were free to decline services, and if they declined, they would simply be asked by officers to leave the station. It became evident early in the project that the majority of individuals approached would decline services. Out of treatment conversations with 165 people, transportation to services was declined 107 times (Ratcliffe & Wight, 2024).

While discussing the relative success of treatment conversations with our stakeholders, they identified consistent engagement and relationship building as key to chipping away at clients' resistance. One stakeholder noted, "I would say there is a 93% resistance rate of wanting to [initiate treatment], right? So you've got to constantly build relationships with them to try to trigger that fire, that desire to get clean. So, you're constantly engaging."

One of the stakeholders discussed the small window of opportunity to successfully initiate treatment once a client expresses interest:

The window of opportunity is like a basement bathroom window. That's the size of this opportunity for someone wanting [to initiate treatment]. You're got to be right there when they want to go.

Interviewer: So you're got to be in the basement with them?

Yeah, and you've got to show them how to squeeze through that window.

Related work on policing behavioral health vulnerability has demonstrated that many of the individuals practitioners encountered in the field are repeat clients (Bailey et al., 2022; Wood & Beierschmitt, 2014). During fieldwork observations, we noted that a significant portion of individuals approached for treatment conversations were already known to the officers, and it was not uncommon for the officers to have recent contact with the individual. One example of this is a vulnerable individual named Jay (pseudonym), who one author encountered during fieldwork on one day, and the other author encountered during fieldwork the following day. The stakeholders identified the importance of consistently showing up with an offer of service initiation, regardless of how many previous attempts have been denied.

Program staffing

Staffing the SAVE program was an implementation issue identified by stakeholders throughout the duration of the project. Through a combination of informal conversations with individuals working on SAVE teams and observations during fieldwork, it was apparent that there was difficulty staffing outreach specialists for SAVE teams. Specialist turnover was a continuous issue, and stakeholders recalled some specialists working only a few shifts before not returning. One of the SAVE officers recalled working with approximately eight different specialists throughout the duration of the roughly one-year project.

Coupled with their turnover rate, stakeholders also expressed dissatisfaction with some specialists' willingness to engage with the vulnerable population during treatment conversations. The SAVE teams should approach treatment conversations as a team, however, with the high specialist turnover, it seems that it was difficult for specialists to find their footing and be comfortable and willing to proactively engage in treatment conversations with the officer. In reality, the officers often ended up taking the lead in treatment conversations. Reflecting on the specialists who staffed the project, one stakeholder noted,

There were a few [specialists] that were actually good, as far as engaging the people, knowing what to do and providing a good service. Then there were a few of them that probably should not have been with the [staffing company] or with [the police]. They had a problem showing up on time or showing up at all. They had a problem engaging the people as much as they should have been, to where our officers were doing more of the engagement.

Further, when this stakeholder addressed these concerns with the specialist staffing company, they would often receive new specialist replacements: “When you taking to the [staffing] management about it, it’s ‘Okay, I’ll talk to them’ and the next thing you know, we’ll get someone else new. Well, that’s not solving the problem because we’re going to have the same issue again.” Stakeholders expressed that it would have been preferable to have a few specialists on for the duration of the project who could function as a true partner to the officer.

The SAVE stakeholders attributed some of the difficulty staffing specialists to the physically demanding nature of this model of co-response. SAVE teams spent the majority of the shift proactively patrolling the transit corridor on foot. While SAVE teams occasionally traveled to transit stations throughout the city in a vehicle, the vast

majority of work was on foot. One stakeholder we spoke to commented on the physical demands on the job:

This outreach, the SAVE program, all that walking, it's more demanding and you're more outside. [With other outreach programs], you're driving in a van and you might have to walk up to somebody, but you're back in the van. So this is more demanding. If you don't have the physical and the mental for it, you ain't staying.

This stakeholder continued to discuss how the design of the SAVE program puts you “in the trenches,” or working, and walking, directly in vulnerability hotspots, which exposes you to graphic and potentially triggering situations:

They don't pay you enough to do this. I think it's more of how strong your desire to help people is, because the stuff you see is very rough. Most people that do this job may be in recovery, whether they disclose that or not, or they might not have the stomach for it because the people we engage have sores, they shoot drugs in front of you. Sometimes I've got to clear the [transit station] elevators, and they're in there smoking crack or whatever. These are the things you see. So a lot of that stuff, people are like, 'Man, I can't deal with this.' Or even the walking. You're out here in the cold walking. So if your desire is not strong, you ain't staying.

Taken together, the job's physical demands, coupled with the exposure to intense imagery may have attributed to the turnover with specialists working on the project. As the specialist stakeholder identified, without a strong desire to work in this field, it is unlikely for specialists to work with the program long-term.

Specialist qualities

During our staffing discussions, we asked stakeholders about the ideal skillset and qualities of co-response specialists. Stakeholders identified proper training as an essential component of recruiting specialists. They noted that training and experience of specialists varied greatly, and when it was lacking, the officers would need to step in:

Not that the officers don't need [training], but I think the outreach specialists need a certain level of training on services that are available, patience, compassion, initiating contact, how to initiate [contact], how to approach the homeless. I've had too many incidents where I had to tell [the specialist] that you do not, under any circumstances, just wake somebody up. I need you to pay attention to your surroundings. And they just don't know that. They didn't come with that training. So as much training as an officer may need, I think the outreach specialist needs training as well.

The stakeholder identified safety concerns that stem from a lack of training or experience, such as the potential for escalation if you suddenly wake a sleeping person or startle them in the transit station. This comment connects back to an earlier theme about a safety-first mindset being forefront with the officers, but not the specialists. The dynamic environment of co-response poses unique safety concerns for specialists by not only having to deal with potentially volatile clients, but also handling situations that may require the police to step into their law enforcement role and separate from the specialist for their own safety:

So, if it's something that's require, also, for us to split up, I'll say, "This is our meeting point," or "When this is done, when it's over, I'll contact you. Don't try to come to me." If it's a fight ... We had a shooting at the station before. So, if it's not directly happening here, "No, don't follow me. You stay

here." Because, that way, I know you're safe. You're my responsibility, and I still have to watch over you. But if I know I'm going into the line of fire, I'm going to need my specialist to stay back and understand and just to know that you're helping me more with us not together than for you to follow me in.

In these situations, SAVE officers need to navigate their police role with the additional responsibility of ensuring the safety of a specialist who is adjacent to unpredictable scenes (as a side note, we recognize that the addition of the authors on fieldwork added additional responsibilities to the officers' workload). Establishing a safety protocol for such situations is essential, however, with the high turnover of specialists, police stakeholders expressed that they would have to frequently reestablish ground rules with new specialists.

This is not as unusual an occurrence as one might expect. At our request, SEPTA Police extracted the computerized dispatch record of every incident that a SAVE police officer dealt with during the course of the experiment. When the SAVE role is performed by a police officer, they are a uniform police presence in the subway and can be called on by their dispatchers or even directly from the public. And as can be seen in Table 7, the officers dealt with a considerable volume of incidents ranging from loitering to assaults.

Table 7. SEPTA CAD incidents dealt with by SAVE officers during the trial

<i>Incident type</i>	<i>Transported</i>
<i>Assaults</i>	20
<i>Disturbances</i>	100
<i>Fraud</i>	32
<i>Investigations</i>	126
<i>Loitering</i>	165
<i>Medical</i>	158
<i>Other</i>	103
<i>Theft/Robbery</i>	32
<i>Total</i>	736

Managing their traditional police role with the additional responsibilities of a civilian partner could become daunting:

Because that person is not trained, that person is just a body, I become the police officer, the mental health worker, the outreach specialist. That's what I've just become. Yes, we both need the same type of training. We both need that training, but I just think that it's not really about the officer. We are there for safety because if you're coming in contact with people with mental health issues, you're coming in contact with people who they're on drugs and have mental health issues.

During one fieldwork observation, one of the authors accompanied a SAVE team that included an established specialist and an additional specialist, who was new to the profession and out to receive additional training. An incident occurred on a subway platform in which a SEPTA rider was splattered with paint by two juveniles. The specialists and the author stepped aside while the officer talked to the rider to figure out next steps. The rider became increasingly irate and made an unpleasant comment to which the newer specialist responded sarcastically, which further angered the rider. The newer specialist was asked by the officer to stand down and refrain from further

commentary. In this instance, the lack of training and experience from the specialist unnecessarily escalated the situation.

Officer qualities

We also inquired about the ideal skillset and qualities of co-response officers. Patience and compassion were mentioned by all of our stakeholders:

I think one of the biggest things that you need to have is patience. Actually, two big things. Patience and compassion. Patience because you may be dealing with the same person ten times within the same day, every day. At some point, a lot of [officers] get to the point where it's, "Listen, I've been dealing with you every single day and you're not taking any services. Now I'm going to grip you up and take you out." Well, you can't do that, and you shouldn't do that. You should be able to just offer the services, escort them out respectfully, and then hopefully the next day you engage them and you have that same kind of rapport with them.

As long as you have an officer that has care and concern, they're driven by care and concern, it's fine. But if you've got an officer that goes "Get your ass off the..." it can become problematic real quick. Because [the vulnerable population] will look at you like, "Oh, he ain't nothing but a cop."

Patience is an essential quality for those staffing co-response programs because of the repeat clientele they encounter (Bailey et al., 2022; Wood & Beierschmitt, 2014). In order to build rapport and trust, officers and specialists alike must remain committed to the goal of offering services whether their client is someone new, or someone they've seen multiple times that day or that week.

In addition to patience and compassion, stakeholders identified that co-response officers need to be levelheaded in order to not escalate encounters or diffuse volatile scenarios.

You can't be one of them gung-ho cops doing this job, because you deal with a lot of mental health challenges out here and stuff like that. So you have to understand that these people are not well. And you don't know their story, you don't know why they aren't well.

The individuals approached by the SAVE team experienced a range of vulnerability conditions, including homelessness, mental health issues, and addiction (Ratcliffe & Wight, 2024), so a traditional police response is not appropriate and could unnecessarily escalate encounters. Officers working on co-response programs should have the patience and sensibility to deliver a service-oriented response to the vulnerable population.

Discussion

Historically, the police role goes beyond law enforcement to include order maintenance and peacekeeping tasks, especially with vulnerable populations such as those experiencing mental illnesses or homelessness (Bittner, 1967a, 1967b). Officers on foot patrol, in particular, spend a great deal of time interfacing with populations that require interventions beyond arrest and criminal processing and accordingly, develop practical strategies to interact with this population and maintain community safety. Co-response programs are being implemented globally as a strategy to deal with populations experiencing behavioral health vulnerability (Seo et al., 2021b). Co-response programs can take a variety of forms, from a dispatch-oriented model in which teams respond to calls, to the SAVE program that spent the majority of time proactively approaching individuals who appear to have unmet needs and offering transportation to nearby services (Ratcliffe & Wight, 2024).

The underlying rationale behind the police chief's initiative was that staff with greater training in handling people experiencing vulnerability would be more able to encourage them to accept referral or transportation to an appropriate public health service, such as was reported by the study of CIT-trained police officers from Compton et al. (2014). From the perspective of the transit authority, this is an output rather than an outcome. A more pertinent outcome would likely be fewer people experiencing homelessness in the transit system. From the perspective of the individual, however, just increasing engagement with treatment is arguably a promising outcome. A recent review concluded "the co-responder team model is best labeled as a *promising practice* in police-behavioral health collaboration for crisis response" (IACP / UC, 2021: emphasis in original).

In our study, there was a greater rate of people being transported when engaged by a police officer and an outreach worker, than when approached by a police officer alone.

Is this sufficient to consider the intervention a success? If viewed through the lens of process inference, whereby "the null hypothesis is a statement about the data-generating process rather than about a population" (Fotheringham & Brunsdon, 2004: 448) then the process in our study did not produce sufficiently greater numbers of vulnerable people being transported to treatment or shelter to achieve statistical significance.

There are many possible reasons for this. While the rate at which the co-responding team of an officer and an outreach specialist was greater than that of the officers alone, the overall low study *n* of 165 participants limited our capacity to discern a statistical difference. Second, as Hall (2017: 28) notes, "Each party to the outreach transaction—workers on the one hand and homeless people on the other—has a part to play and a stake in what might (or might very well not) be accomplished." It is possible that the deciding factor is not who makes the invitation as part of a treatment conversation, but instead the condition of the person experiencing vulnerability at that time, and whether they are ready to accept help.

The proactive outreach approach was a unique feature of the SAVE program, and one that distinguishes it from other types of alternative policing interventions that offer treatment services in lieu of traditional criminal justice processing (Zhang et al., 2024). Individuals approached for a treatment conversation were free to decline services and were simply asked to leave the station if they were otherwise loitering; there was no threat of arrest or other type of sanction. With the proactive offering of services in mind, it is interesting to note that services were declined 65% of the time in recorded treatment conversations over one year. Philadelphia's transit system is a place of great service need (Gordon, 2023), but a relatively low uptake of services (Ratcliffe & Wight, 2024). Stakeholders and the researchers alike noted the prevalence of resistance during the SAVE experiment, but stakeholders identified how consistent engagement and

relationship building, particularly with the same individuals, can be essential to breaking down that resistance.

Our fieldwork confirmed that the job requires compassion, patience, and an extensive understanding of the treatment and shelter system in the city. Many of the people encountered had widespread and repeated involvement with the various shelters and treatment options available and could talk about their benefits, though more often limitations, from personal experience. The work involves not only a social work mindset, but also contextualized local training. The SAVE officers received both a basic and advanced crisis intervention training course and spent time familiarizing themselves with local facilities. In one instance, the lead author accompanied two of the SAVE officers while they introduced their outreach specialists to staff at a local triage facility located within the subway system. This would suggest that there may have been a smaller gulf between the experience and skill set of the officers and the outreach specialists than originally anticipated.

A reviewer of a related academic paper asked if SEPTA could just train customer staff members or police officers to have these conversations without the need to hire outreach specialists. Knowledge of the city's byzantine social support structure appeared necessary, as both outreach specialists and SAVE officers would often make specific calls to individuals in their contact network to arrange suitable facilities for participants. This would suggest that a dedicated team or an extensive training arrangement might be required. Moreover, given the co-morbidity of challenges such as mental health and drug abuse alongside homelessness, there appears a necessity for a specialized function. That being said, the evidence from this research is that while the rate of transportation is greater with the addition of an outreach specialist, this increased rate did not approach statistical significance. The lack of a substantial disparity between the treatment conditions would suggest that officers with sufficient training and experience might adequately fulfil that role to a level approximately

commensurate with that of an outreach specialist. This is important because staffing the SAVE program was the most apparent implementation challenge of the project. Well-trained specialists are needed for a dynamic co-response program like SAVE, but the stakeholders felt that several of the specialists who worked on SAVE were not a good fit. The physically demanding nature of the program, along with the graphic environment encountered at close proximity were identified as potential reasons for specialist turnover and staffing issues. Other agencies who adopt a similar co-response program should therefore be mindful of the physical and mental fortitude needed to by specialists and officers alike.

Limitations

Multiple limitations exist. We conducted about 150 hours of fieldwork across more than 30 shifts to both ground-check the data capture but also to answer the officers' questions about what counted as a treatment conversation. That being said, the data reported here relies on officers' interpretations of a treatment conversation, and it is possible that they might exclude conversations that participants might consider a specific discussion about entering treatment, and vice versa. As such, we should caveat that the effect of the intervention is also conditional on the police/co-responders initiating a treatment conversation and recording it as such.

Second, another study on civilian staff engagement with the vulnerable community was taking place at other stations within the SEPTA system over the course of this research. We were not involved in that study, nor were the SAVE team or the outreach specialists; however, it limited the number of stations that the officers could attend. In general, we understand that the overall goals of both projects were similar, but we recognize that both studies could have had some impact on the other. For example, they might have caused a degree of displacement of people with vulnerable conditions

from one location to another. There is therefore the possibility of some contamination across studies, even though the locational boundaries were generally adhered to by SAVE officers and specialists.

A more likely contamination issue is that of learning within the study framework. Over the course of the year, it is possible that the police officers learned skills and knowledge from the specialists that improved their capabilities to enroll people with vulnerabilities into shelter or treatment. We also think it is possible that the reverse could have occurred. One of the SAVE officers had previously been a social worker before joining the police while some of the specialists were new to the role, and from our field observations, relatively inexperienced at dealing with the vulnerable people. Therefore, contamination is a possibility, but the direction is unclear.

An additional caveat is that our outcome measure, *treatment initiation*, is not a measure of 'treatment engagement' (Brown et al., 2011). The study was designed with consideration of the limitations of the transit police department, who could convey a person to a facility, but could not mandate that the person remain there or complete any treatment.

We have already noted that, while this was a randomized experiment, the distribution of treatment conversations was not balanced between the officers and the officers accompanied by treatment conversations. While this results in a lack of balance in the study data, we would contend that this was not caused by any systematic bias introduced by anyone involved with the study. As we noted, it was an exogenous implementation problem caused by recruitment challenges encountered by the third-party outreach contract provider.

Qualitatively, findings drawn from fieldwork observations are subjected to the authors' perceptions and interpretations of treatment conversations and related encounters, and it is possible that the field observation report did not capture the entirety of any given encounter. Further, the practitioner perspectives included in the

study were drawn from semi-structured interviews with individuals who were involved throughout the duration of the project, so their experiences may differ from those that were only involved in SAVE for a short term. Considering the high turnover of specialists, it was difficult to complete interviews with other specialists on the project. Given these complications, the practitioner perspectives are mostly those in policing, so their experiences may differ from the outreach specialist side of the program.

A final limitation we would mention is that the indicators of demographics and clinical condition may be as perceived by the officers, rather than reported by the individual participant. We did not ask the officers to indicate the source of the information they reported.

Implications for Policy and Practice

Notwithstanding the important caveats mentioned in the previous section, there are some potential policy considerations, because the work has considerable generalizability. The intervention was implemented in a metropolitan transit system not dissimilar to many urban (largely) subway systems with platforms, ticket areas, and linking tunnel systems. The treatment conversations were not limited to this environment however, so the applicability of an outreach specialist working alongside a police officer to offer support is broadly applicable to a range of situations beyond that of the transit system. The officers were provided with basic and advanced CIT training, de-escalation training, as well as training on mental health issues and recognizing and responding to individuals with special needs. Such training opportunities may be reasonably accessible and affordable to police departments. Access to an outreach provider either through city services or on contract would be required, though we draw attention to the lack of statistical significance.

First, the addition of a specialist to the team did increase the uptake rate of service acceptance, even if the rate was not statistically different (an issue of low experimental power) and even when many of the specialists were not as experienced or effective as the program anticipated. Therefore, even with the limitations of the specialists identified within this article, there were still some positive outcomes. We would argue that the findings would at minimum justify experimental replication in other locations.

Second, an ongoing program of training for both specialists and officers must be addressed prior to implementation. This training should include not only the skills necessary for dealing with people in vulnerable situations, but also the mechanics of working in a co-response team. Even when a trained social worker approaches a person in the transit environment, the presence of a police officer in uniform can affect the dynamic.

Third, agencies should create standard operating procedures for what to do when the officer has to engage with more traditional police work. As we noted earlier, this is not an insignificant or rare occurrence, especially somewhere like Philadelphia. SOPs to cover as many eventualities as possible should be created and discussed in the training regime.

When an agency hires a social work specialist, that person will largely only perform the social work role. But when police officers are not acting as social workers, they are incident reporters, intelligence gatherers, dispensers of medical aid, finders of lost children, disorder preventers, givers of directions, crime fighters, settlers of minor disputes, and a visible deterrence bringing social order. In the situation where the officer has to manage a fluid and dynamic event, knowing there is a protocol in place and they do not have to worry about the safety of the specialist will give the officer one less distraction during what can be a tense situation.

Conclusion

This evaluation of the SEPTA Transit Police SAVE initiative provides one of the few rigorous, randomized examinations of a police–civilian co-response model operating within a public transit setting. The project sought to answer a straightforward but nationally relevant question: *Does adding a civilian outreach specialist to a police outreach team improve the likelihood that individuals with significant vulnerability conditions will be transported to a shelter or treatment facility?* Across a full year of implementation, the study found that co-response teams achieved a modestly higher rate of treatment initiation than police officers working alone. However, the difference was not statistically significant, and the practical challenges observed throughout the program underscore the complexity of translating co-response theory into consistent operational success.

One of the central findings of the evaluation is that *the intervention produced directionally positive but limited effects*. When an outreach specialist accompanied a SAVE officer, treatment initiation occurred 41 percent of the time, compared to 32 percent for officers working alone. While this represents meaningful improvement in real-world terms, the study’s statistical tests did not reach significance, largely due to uneven implementation stemming from persistent specialist turnover and varying levels of specialist preparedness. It is also strongly reflective of a low powered study, so the findings should be considered accordingly. These implementation challenges—rather than flaws in research design—muted the strength of the evaluable contrast.

The qualitative component of the study offers crucial insight into why the measured effect size was not larger. *Client resistance*, described by practitioners as a near-constant barrier, proved to be a defining feature of proactive outreach in the transit environment. Many vulnerable individuals declined services even when rapport was established, facilities were available, and transportation was immediately accessible.

Officers and specialists emphasized that the “window of opportunity” for accepting help is extremely narrow, often dependent on unpredictable shifts in mood, substance influence, or group dynamics. This pervasive resistance limited the ability of either team configuration to consistently convert conversations into treatment outcomes.

Additionally, the evaluation revealed that the co-response model’s value depends heavily on the *capacity, training, and stability of the civilian workforce*. The contracted staffing provider experienced high turnover, substantial variation in worker readiness, and difficulties preparing specialists for the physical and emotional demands of the transit system. SAVE officers often assumed responsibility for leading conversations, maintaining safety, and setting the tone of interactions. In some cases, officers’ knowledge of the treatment landscape exceeded that of specialists. These issues complicate the assumption that specialists will necessarily deliver a higher level of engagement skill or service-oriented influence.

At the same time, the study documents strong potential for *positive cultural impact within the police organization*. Officers consistently approached treatment conversations with compassion, patience, and strategic communication skills, qualities reinforced through training and experience. Some officers appeared to adopt techniques or perspectives observed from specialists, suggesting that co-response partnerships may create informal pathways for skill transfer. This possibility raises important policy questions: if officers can, over time, approximate specialist contributions, is a standalone civilian role essential, or should agencies instead invest more deeply in officer training?

Ultimately, the SAVE experiment illustrates that co-response should be understood not as a simple substitution of expertise, but as a *complex, labor-intensive strategy requiring coordinated staffing, reliable training pipelines, and sustained organizational commitment*. The transit environment introduces additional layers of unpredictability—high call volume, safety hazards, and encounters with highly marginalized individuals

who rely on the system for shelter. Under these conditions, even modest improvements in treatment initiation are meaningful, as each successful transport may contribute to improved health outcomes and reduced disruption within the transit system.

For agencies considering similar programs, several implications emerge. First, *carefully structured recruitment and retention strategies* are essential to ensure specialists are physically and emotionally equipped for frontline outreach. The lowest bidder is not necessarily the best. Second, *training and clear standard operating procedures* are critical to help partners operate cohesively during dynamic incidents. Third, co-response programs should include mechanisms for *ongoing monitoring and iterative adjustment*, allowing teams to refine their approach as conditions evolve.

In sum, while the intervention did not produce statistically significant improvements, it demonstrated feasibility, directional benefit, and valuable lessons for future practice. The SAVE evaluation contributes to a limited but growing evidence base on co-response strategies and highlights the need for continued research that examines long-term client outcomes, cost-effectiveness, and model variations across diverse operational contexts.

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