Memorandum

Date: October 31, 2025
To: City of Eugene Mayor and City Council
From: Mike Caven, Fire Chief

Re: Gap Analysis of Eugene's Crisis Response Services Post-CAHOOTS Closure

Background and Context

Earlier this year, the City's contract with CAHOOTS (run by White Bird Clinic) unraveled due to financial and staffing strains. In March 2025, White Bird announced it could no longer provide staff 24/7 services and would sharply cut back hours in April. This reduction (from continuous coverage to just two shifts a week) meant CAHOOTS could not meet their contractual obligations. On April 7, 2025, CAHOOTS ceased operations in Eugene, and the contract was mutually terminated. The abrupt loss of CAHOOTS after 34 years left a gap in Eugene's crisis and social system, prompting staff to evaluate how these services are being handled now and what un-met needs remain.

Eugene's Crisis Response Landscape After CAHOOTS

Lane County Mobile Crisis Services (MCS): Lane County is mandated by the State of Oregon to provide mobile behavioral health crisis services. Launched in late 2024, MCS is a county run 24/7 crisis team of mental health professionals available via the 988-crisis line or Central Lane Communications Center (CLCC) dispatch. MCS has scaled up to provide mobile response in Eugene and county-wide, and as of June 2025 it was on track to operate around the clock. Lane County reports recruitment challenges have delayed implementation of the program 24/7. Importantly, MCS is state funded and Medicaid billable, meaning it must focus on acute behavioral health crises as defined by state statute. MCS teams can perform *Director's Hold* involuntary transports when someone is in danger. However, unlike CAHOOTS, they do not provide many non-crisis outreach services (e.g. wound care, basic needs assistance, welfare checks, intoxicated subjects etc.) that fall outside Medicaid's billing scope. In short, MCS has absorbed *high acuity* mental health crisis calls but has a narrower scope centered on immediate behavioral health stabilization.

- *Eugene Springfield Fire (ESF) Alternative Response Units:* ESF has piloted two grant-funded Alternative Response (AR) units (sometimes called Community Response Units) staffed with a paramedic and EMT. AR1 operates 4 days/week (10-hour shifts)

to handle low acuity medical calls, and AR2 operates daily on outreach and education to reduce 911 calls (especially among senior care facilities). In late 2025 ESF pivoted AR1 to a community paramedic program called COMPASS that provides intensive case management and follow up for frequent 911 callers and high utilizer patients. These programs are promising for medical and preventative care needs, and they adhere to medical protocols and data reporting.

- Nationally certified (CP-C) trained paramedics will have the ability to be assigned clients that we deem will benefit from more intense case management and follow-up. These patients will be high utilizers of the 911 system and frequent ED visits.
- CP will identify patient needs and then coordinate with community partners to help the patient navigate through the healthcare system.
- The goal of this program is to provide lasting solutions for these patients, thus reducing their reliance on 911 as a solution to their healthcare & social service needs.
- Will use AR units as necessary to assist with work/follow up visits when appropriate.

Current EPD BH/SUD Alternative Response Assets

EPD has also moved in the alternative response arena through the grant-funded downtown co-responder program with a planned expansion within the next three to six months. The downtown co-responders work alongside downtown patrol officers and respond to CFS with a criminogenic and behavioral health nexus and provide street-level outreach to the large unhoused population residing in the downtown core.

Co-Responders

- operate 5 days a week from 0800-1700,
- staffed by a qualified mental health professional (QMHP) and a peer support specialist (PSS) whose clinical work is supervised by Lane County Behavioral Health,
- only operate in the downtown core area.

Peer Navigators

The planned expansion of the downtown co-responder program includes the addition of two PNs that will conduct street-level outreach directed at the unhoused population. The PNs will be social service provider employees contracted to work in collaboration with EPD officers.

- PNs will work to connect unhoused individuals to social services that can provide appropriate treatment and criminal justice system off-ramps.

- PNs will work in collaboration with the co-responder team and the downtown patrol team,
- primarily operate in the downtown core with the ability to work in other areas of the city as needed.

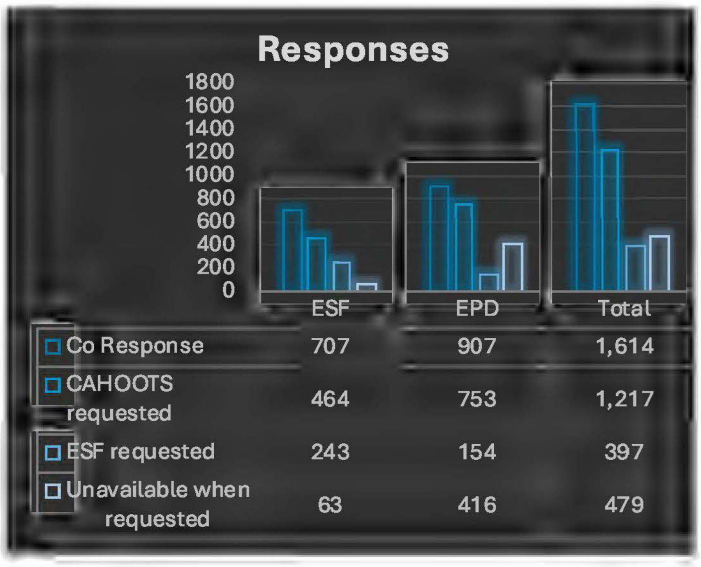
In summary, since April the heavy lift for crisis calls has fallen to Lane County MCS for acute mental health incidents, while routine "social service" type calls and sub-acute behavioral issues have diffusely shifted to police and fire units. Our system now relies on a patchwork of responses: some calls that CAHOOTS would have handled are diverted to MCS clinicians, others end up with EPD or ESF by default, and some needs simply go unmet. The community has multiple programs working in parallel but is missing a peer-based social services function that helps unhoused individuals connect with resources and navigate the complex behavioral health ecosystem.

"Then and Now" – Data Trends After CAHOOTS Closure

We analyzed call data from 2024 (with CAHOOTS in operation) vs. 2025 (post-closure) to understand shifts in workload:

*2024 Call **Volume:***

In 2024, CAHOOTS was dispatched on just under 14,000 CFS, This includes incidents where the unit may not arrive on-scene including: unable to locate and cancelled en-route. These included crisis counseling, welfare checks, intoxicated persons, non-emergency medical transports, and more. In 2024 CAHOOTS co-responded on incidents with both police and fire:



Call Nature	2024
ASSIST FD, CAHOOTS	1.46%
ASSIST PD, CAHOOTS	3.81%
CHECK WELFARE, CAHOOTS	29.47%
DISORDERLY SUBJECT, CAHOOTS	1.94%
DISORIENTED SUBJECT, CAHOOTS	1.20%
FOUND SYRINGE, CAHOOTS	0.97%
INTOXICATED SUBJECT, CAHOOTS	1.02%
PUBLIC ASSIST, CAHOOTS	40.19%
SUICIDAL SUBJECT, CAHOOTS	8.87%
TRAFFIC HAZARD, CAHOOTS	2.23%
TRANSPORT, CAHOOTS	8.84%

2025 Post Closure Call Volume

Lane County MCS Calls: After April 2025, Lane County's Mobile Crisis Service saw a significant uptick in usage. From April through October 2025, MCS handled 3,124 dispatched calls countywide (many in Eugene). The top call types were behavioral issues like *agitation (48% of calls)*, *disorganized or disruptive behavior (34%)*, *difficulty functioning (30%)*, and *suicidal crises (22%)*. On these calls, police or EMS were only rarely on scene (EPD present on ~4% of MCS calls, EMS on ~2%) – meaning MCS often managed without higher-degree backup. Outcome data shows over 72% of MCS cases were stabilized in the community without hospital transport, and only 0.3% resulted in an arrest, underscoring the importance of dedicated crisis responders. MCS reports steadily increasing demand in the absence of CAHOOTS and has been scaling resources accordingly. They have indicated they *can absorb* this workload and intend to flexibly add capacity as needed. However, MCS's mandate is limited to behavioral health crises; they are not tasked with general social service calls or ongoing street-level outreach, so they do *not* capture the full range of former CAHOOTS calls.

Co-responses with EPD and ESF:

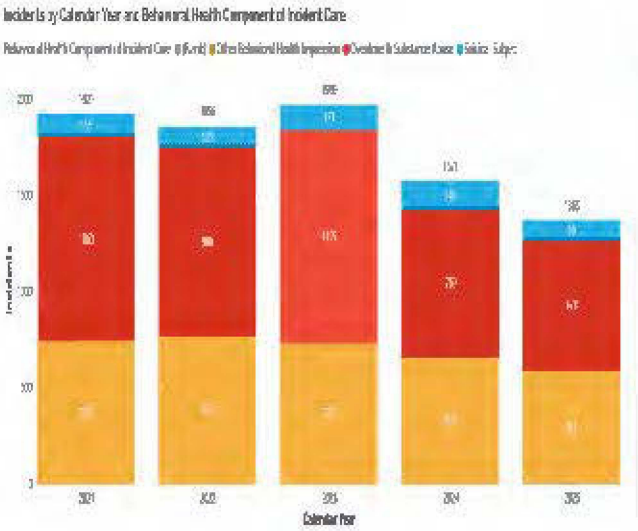
- EPD- 4% or about 120 CFS
- ESF- 2.2% or about 66 CFS
- *Fire/EMS Call Impacts:* Current analysis indicates there has not been a meaningful body of work shifted to ESF with the CAHOOTS closure. While the data set is still emerging, the data we do have indicates the following:
- Current numbers show a slight decrease in police assist calls after the CAHOOTS closure (police assist calls often have a nexus to community members served by CAHOOTS).
    - CY2025 YTD shows a mean of 26 police assist calls per week (peak of 41).
    - CY2024 YTD shows a mean of 28 police assist calls per week (peak of 40).
- Suicidal subject calls for ESF are at a historical low since 2014 (3.3 per week currently, down from 4.7 per week in the last several years).

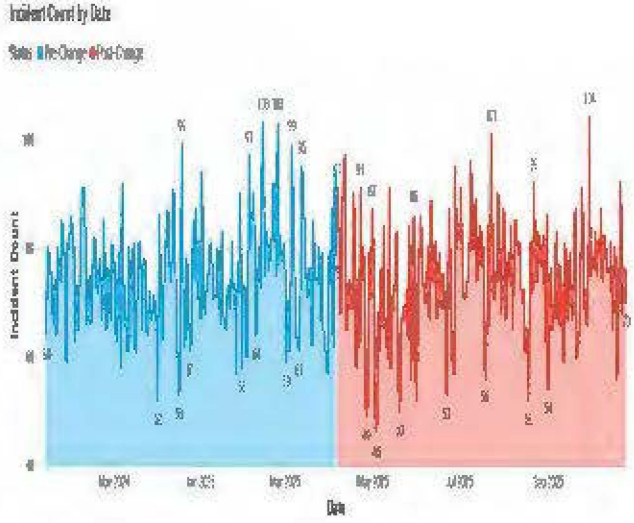
Feedback from ESF & EMS crews indicate the following:

- There was a demonstrated value with the ability to place community members seeking non-medical assistance in the "queue" for CAHOOTS. In other words, once an individual had been assessed by ESF crews as not meeting the definition of a medical patient or requiring ambulance transportation, notifying CAHOOTS that the individual had social service needs allowed engine companies to return to

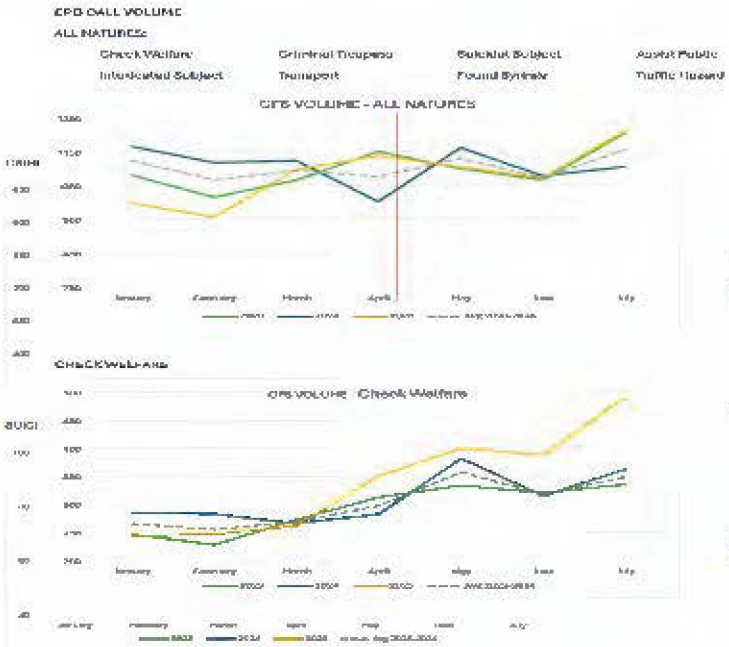
emergency response readiness. In the absence of CAHOOTS, that option does not exist in the same manner.

At night, when services have shut down, there is an inability to find lower acuity social service needs. Examples: transportation, shelter, food, clothing.





Police Call Impacts: EPD data likewise do not show a surge in *total* calls for service, but officers are reporting qualitative changes in their call mix. Patrol officers note they are more frequently being dispatched to low and mid-acuity behavioral health calls without criminal elements such as welfare checks, "subject down" calls for intoxicated or unconscious individuals,



and suicidal subjects who are not actively violent. In 2024, many of those calls would have been diverted to CAHOOTS. Now, if MCS is unavailable or if the call involves any safety concerns, police often handle it. Transport duties have shifted as well: without CAHOOTS, officers more often find themselves providing *courtesy transport* for people who simply need a ride to a detox center, shelter, or hospital (previously handled by CAHOOTS van). Certain gaps are especially problematic, for instance, juvenile mental health crises now lack a specialized field response, particularly after hours. These situations sometimes result in officers spending hours trying to locate emergency guardians or services or bringing the youth to the emergency department by default. In sum, while 911 call totals haven't spiked, the burden of complex social service calls on police has grown, and some calls may be unresolved or delayed.

Service Gaps Identified

Drawing on the data and feedback from ESF and EPD personnel, we have identified several persistent service gaps in the current system. These represent needs that are not fully met by existing police, fire, or county services, and which a street-level crisis team could address:

- *Mid-Acuity Behavioral Health Incidents (24/7 Coverage):* There is no dedicated team available *around the clock* to handle moderate behavioral health crises that are not immediately life-threatening but still urgent. Lane County MCS addresses high-acuity cases during their operating hours, but if MCS is busy or if the situation is borderline (not clearly meeting involuntary hold criteria), police are often the default responders, which is not always the appropriate responder. A gap exists for a 24/7 mobile team that can take the lead on these calls once any immediate safety issues are controlled, allowing police and EMS to step back.

- *Non-Emergency Transport & Destination Coordination:* Neither police, EMS nor MCS are well-equipped to transport individuals to services other than jail or the emergency room. CAHOOTS vans routinely transported people to the Detox/Sobering Center, crisis respite facilities, shelters, and even medical clinics for non-urgent needs. Since April, transport often "defaults" to police units if, for example, someone needs a ride to the Behavioral Health Stabilization Center or to a shelter for the night. This is inefficient and can be traumatizing (riding in a police car may feel like criminal treatment). There is also a gap in navigating placements ensuring the person is admitted into a treatment program or shelter, versus simply dropping them off. The system needs a service that can provide safe, comfortable transport and handoffs to appropriate facilities, as well as document refusals or unsuccessful placement attempts for follow-up.

- *Low-Acuity Social Service Calls (General Assistance)*: A significant set of calls involve people who are not in acute crisis or medical danger, but who need help with basic social or logistical problems. This includes scenarios like an unhoused individual needing a place to go on a cold night; a person with no way to get to aclinic appointment; someone who is intoxicated but not severely enough to require ambulance transport, yet too impaired to be left alone safely. CAHOOTS historically handled many such "public assist" or welfare check calls providing food, blankets, arranging shelter, or just checking on someone's well-being. Police occasionally do welfare checks but their time for social care is limited. This gap represents many of the humanitarian, preventative interactions that keep people from later 911 calls. Without a service here, the concern is that these situations either go unchecked or escalate over time.

- *Youth Crisis Response:* As mentioned, one gap area is handling juvenile behavioral crises, especially during evenings or nights. For adults in acute crisis, MCS or the ER can be options; for juveniles, the pathways are less clear (involving parental/guardian consent, DHS child welfare, etc.). Currently, if a teenager is violent or unmanageable due to a mental health episode, police and EMS are often the only responders available after hours. This gap calls for a specialized approach to youth in crisis, one that can activate proper youth mental health resources and escalating the behavior of a child who really needs treatment.

- *Aftercare and Proactive Outreach (Harm Reduction):* Another void left by CAHOOTS is in follow-up and preventative outreach for populations at risk. For example, CAHOOTS participated in harm reduction by following up after overdoses (providing naloxone kits and counseling to prevent repeat incidents). They also checked in on frequent utilizers or individuals repeatedly in crisis, to build relationships and trust. Currently, ESF's COMPASS program does some proactive case management for high 911 utilizers from a medical standpoint, and EPD's future Peer Navigators will do street outreach for unhoused individuals. But there is still a need for peer driven, street-level behavioral health outreach that can respond to non-emergency quality of life concerns (e.g. a business calls about a person sleeping in a doorway, police can trespass them, but a better outcome might come from a peer outreach worker who can connect that person to services and address underlying needs). This gap is about preventing the next call, ensuring those who frequently encounter emergency services are guided toward support, thereby reducing future crises (a role CAHOOTS played, as studies have shown it even helped prevent some police calls by intervening early).

Feedback from community partners indicates the following:

Whitebird Medical Clinics:

Julie Cumming, Whitebird Health Center Director

- Emphasized that meaningful wound care needs administered by wound care specialists (often RNs or higher) and require specialty supplies and IV antibiotics. Patients are best served at the emergency department or clinic environment.

Lane County Mobile Crisis Services (MCS):
Olivia McClelland, Behavioral Health Principal Manager

- Reiterated that MCS is for patients experiencing acute crisis/de-escalation. MCS is not the resource for patients experiencing low-acuity "life-crisis" events where extended scene times are needed.

St Vincent de Paul: Service Station & Dawn to Dawn
Blaze Kenyon, Director of Homeless & Shelters
Rick Hatfield, Shelter & Ops Manager
Teresa Patterson, Day Manager at The Service Station

- Clients often need a transportation option where they can take their belongings with them to obtain services.
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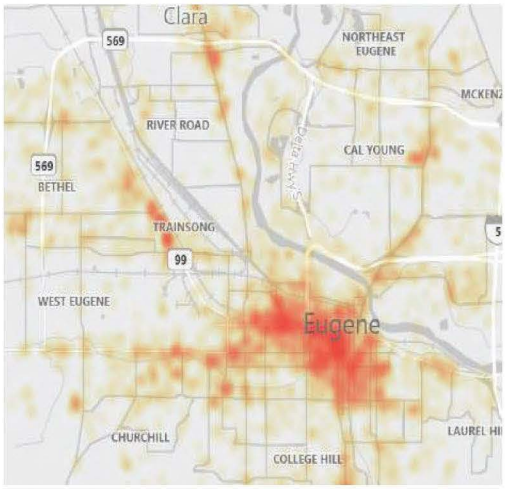
- Clients often have substance abuse issues or are intoxicated and that limits who will provide needed non-emergency transportation to services.
- Clients often experiencing "life crisis" events where they benefit from long term scene interactions (1-2hrs).
- Clients benefit from access to first aid & wound care supplies without having to call for an ambulance.

In essence, the gaps span a spectrum from low-acuity social needs to mid-level behavioral health crises. They define a "band of work" that neither Lane County's crisis team nor our current City services fully cover. These are the types of situations that fall between the cracks of pure health emergency and criminal incidents. The gap analysis makes it clear that a targeted service is needed to bridge this space.

Recommended service model:

- *Mobile Crisis Response*- Lane County Behavioral Health (Existing Medicaid Funded)
- *Peer Navigation*- EPD (Recommended new gap service)
- *Community Paramedics* – ESF (Existing Grant Funded) *Co-Responder*- EPD (Existing Grant and CSPT Funded)



Recommendation: Phase 1 RFP to expand Peer Navigation + Phase 2 Add-On Path

Purpose & scope

- Expand a social service mobile response via the peer navigation model capable of welfare checks, shelter support, non-acute mental health support, and transportation to alternative destinations (shelter, sobering/detox, clinics, appointments). Deliver proactive follow-up and resource navigation to reduce repeat 911 usage.
- Initial expansion should have geographic limitations to ensure resource reliability and scalability to meet demand.

Key design elements

- *Dispatch:* Call-typing and referral protocols with Central Lane 911 (direct dispatch on eligible calls; rapid secondary response to ESF/EPD requests).
- *County MCS:* Warm handoffs both ways; avoid duplication, MCS for acute clinical, Peer Nav for social/non-acute.
- *ESF AR/COMPASS:* Mutual handoffs; COMPASS for high-utilizer case management.
- *EPD CSOs & Co-Responders:* Coordinate when low-level criminal elements exist; Peers lead on social tasks.
- *Operating model:* Start with peak demand hours and expand to 24/7 as data/support allow.
- *Transport & placement:* Vans for non-emergency transport; documented placements and refusals; develop MOUs with shelters/detox/clinics.
- *Data & CQI:* Required monthly reporting (calls, dispositions, response times, handoffs, transport; ESF/EPD time saved; client outcomes).
- Equity & lived-experience: Prioritize peer led staffing, cultural competence, and trauma-informed practices.

Funding & timeline

- Utilize identified one-time funds and pursue ongoing funding in the FY26 budget; leverage Medicaid eligible activities where feasible and explore hospital/CCO participation.

- Rapid procurement: 60-90 day RFP window; implementation ramp 90 to 120 days post-award.

Phase 2 (Contingent/Optional): Clinician–Medic field team add-on

If monitoring shows persistent mid acuity BH gaps (e.g., after-hours youth crises, scene leadership and non-ED transport needs still defaulting to police), authorize a second RFP track or contract amendment to add a clinician/medic unit integrated with MCS, ESF AR/COMPASS, and EPD co-responders.

Triggers for Further Investment or Innovation

- ≥ X% of Peer Nav calls escalated for clinical response after hours.

- Continued police transport default on BH/non-ED placements above baseline.

- Youth crisis incident growth without timely placement.

Roles & Responsibilities (City vs. County)

- County: Statutory responsibility and funding for acute BH mobile crisis (MCS/988).

- City: Responsibility for public safety, prevention, and livability. The proposed model complements County services; it does not duplicate them.

Alignment with Council Goals & Strategic Plan

- Safe Community for Community Wellbeing: Improves perceptions of safety by sending the right responder, right away; reduces criminalization of crisis; supports downtown and high-CFS areas.

- Equity & Access: Peer-led, trauma-informed approach builds trust with underserved populations.

- Operational Excellence & Fiscal Stewardship: Frees sworn officer and EMS capacity for core missions; preventative engagement decreases high cost ER and justice system utilization embeds continuous quality improvement and performance reporting.

- Homelessness Response & Housing Stability: Directs transportation and navigation capacity to shelter, stabilization, and services, addressing a central driver of repeat CFS.

Expected Outcomes (12–18 months)

- Reduced ESF "Public Assist" load and faster return-to-readiness for fire/EMS units
- Fewer police courtesy transports; decreased officer time on non-criminal BH/social calls; improved patrol availability.
- Higher rates of on scene resolution and diversion from ED/jail to shelter, detox, and outpatient care; improved youth crisis pathways.
- Improved community satisfaction and trust through a visible, compassionate, peer-led presence in high CFS areas.
- Actionable data to refine deployment and determine the need for additional investments.

Appendix: Working definitions for Phase 1 (Peer Navigation) call types

- Welfare checks (non-criminal, non-medical or medically cleared).
- Non-acute mental health concerns (distress, conflict, anxiety/depression without imminent danger; safety planning).
- Transportation (non-emergency rides to shelter, sobering/detox, clinics/appointments, court/services).
- Proactive follow-up (after overdose, repeat CFS locations, high CFS corridors).