BALTIMORE CITY COUNCIL
COMMITTEE OF THE WHOLE

The Honorable Zeke Cohen

CHAIR

PUBLIC HEARING

1/15/2026

5:30PM
CLARENCE "DU" BURNS COUNCIL CHAMBERS

LO25-0026
Legislative Oversight – Crisis Response

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Office of Council Services
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Baltimore, MD 21202

COMMITTEE OF THE WHOLE

The Honorable Council President Zeke Cohen
CHAIR

Legislative Oversight Hearing

LO25-0026
Legislative Oversight – Crisis Response

For the purpose of reviewing resources available to respond to individuals experiencing behavioral health crises in Baltimore City, assessing the integration and implementation of specific agencies' responses to such individuals, and determining improvements needed to city agencies' and partners' coordination and response to these crises

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BACKGROUND

This summer, Baltimore City experienced a spate of police involved deaths, several of which were preceded by active mental health crises. And, while these incidents are under active investigation by the Maryland Office of the Attorney General and, accordingly, are not themselves the focus of the Council's hearing, their occurrence in quick succession does highlight potential gaps in the City's crisis response system, warranting an assessment of those potential gaps by the City Council.

On June 17, 2025, well-known arabber, Bilal "BJ" Abdullah Jr. was shot during an encounter with Baltimore Police (BPD).

Just one week later, at about 9:40 PM on June 24, 2025, Dontae Melton approached a marked BPD car and asked officers for help, claiming someone was chasing him. Officers initially responded by requesting a medic to transport Melton to the hospital before detaining Melton to keep him out of the street. At 10:12 PM, with a medic yet to arrive, officers reported that Melton was unconscious, and at 10:27 PM, with a medic still yet to arrive, police transported Melton to the hospital themselves. By early June 26, Melton was dead.

Less than 24 hours after Dontae Melton approached BPD officers for help, police and fire officials responded to two 911 calls reporting a behavioral health crisis at a residence. In just the current calendar year, police have received about 20 previous calls reporting a mental health crisis at the same residence. Upon arrival, officials encountered 70-year-old Pytorcarcha Brooks who was later shot before being pronounced dead at a hospital.

While investigation into each event by the Maryland Office of the Attorney General is ongoing, the incidents left many residents frustrated with the City's crisis response system(s) and the actions of those currently responsible for responding to mental health crises.

Increasing public attention to mental health crises, and the less-than clear approach to responding to those crises, is not unique to Baltimore. In 2020, in response to growing concerns about the state of the nation's mental health, Congress designated 988 as a National Suicide and Crisis Lifeline. Subsequently, Maryland took steps to implement the law at the state level and the state is now home to several call centers hosting trained specialists who can provide resources and assistance to callers experiencing mental health crises. Baltimore City has also taken steps to bolster the state's 988 system. In July 2025, the Board of Estimates approved a five-year $10 million grant for Behavioral Health System Baltimore (BHSB) and its 988 hotline partners.

City services designed to address mental health crises predate recent efforts to reinforce the state's 988 service and stem, in significant part, from the City's 2017 Consent Decree with the Department of Justice. In relevant part, the Agreement requires that the City work to identify gaps in its behavioral health system, recommend solutions, and implement those solutions as appropriate. In addition, the agreement also requires that BPD revise its crisis intervention policies to establish a "least police-involved response," to divert individuals experiencing mental health crises to a behavioral health service whenever the response and diversion are consistent with public safety, and train officers to respond to behavioral health crises.

Since the Consent Decree, the City has taken action to improve BPD's response to behavioral health crises; however, the City's broader behavioral health ecosystem remains fragmented and largely outside of direct City oversight. In 2021, working alongside non-profit actors including BHSB and Baltimore Crisis Response, Inc. (BCRI), the City launched a 911 diversion program to redirect appropriate calls from 911 to mental health professionals via the 988 helpline. However, the diversion rate for 911 calls is low and BPD reports that many eligible calls are not diverted to 988, BHSB, BCRI, or another mobile crisis team, often leaving police as city resident's primary mental health crisis response team.

FISCAL NOTE

City spending on mental health services is primarily allocated through the Baltimore City Health Department's (BCHD's) budget; however, that spending is entwined with spending related to substance abuse disorder. In total, the City budgeted over $9.8 million for BCHD spending related to substance abuse disorder and mental health in fiscal year (FY) 2026. This represents a significant increase from FY 2025 wherein the City budgeted just over $5.2 million, which itself was about a $2 million increase from the FY 2024 spend. The primary driver for the increased budget for this BCHD service is the City's receipt of funds following the settlement of several lawsuits against opioid manufacturers and related pharmaceutical companies. Similarly, the $10 million grant awarded by the Mayor's Office of Recovery Programs to BHSB and 988 partners is allocated from the City's Opioid Restitution Fund.

REPORTING AGENCIES

- Mayor's Office of Overdose Response
- Behavioral Health Systems Baltimore

Analysis by: Ethan Navarre
Direct Inquiries to: ethan.navarre@baltimorecity.gov
Analysis Date: 8/13/2025
Revision Date: 12/22/2025

BALTIMORE CITY COUNCIL

COMMITTEE OF THE WHOLE

LO25-0026

Legislative Oversight – Crisis Response

Agency Reports

LO25-0026: Legislative Oversight – Crisis Response

January 15, 2025

AGENDA

1. Baltimore City Behavioral Health Collaborative Overview
2. What Baltimore City Has Built So Far
3. What Baltimore City Is Continuing to Build
4. Ensuring What Baltimore City if Building Can Last

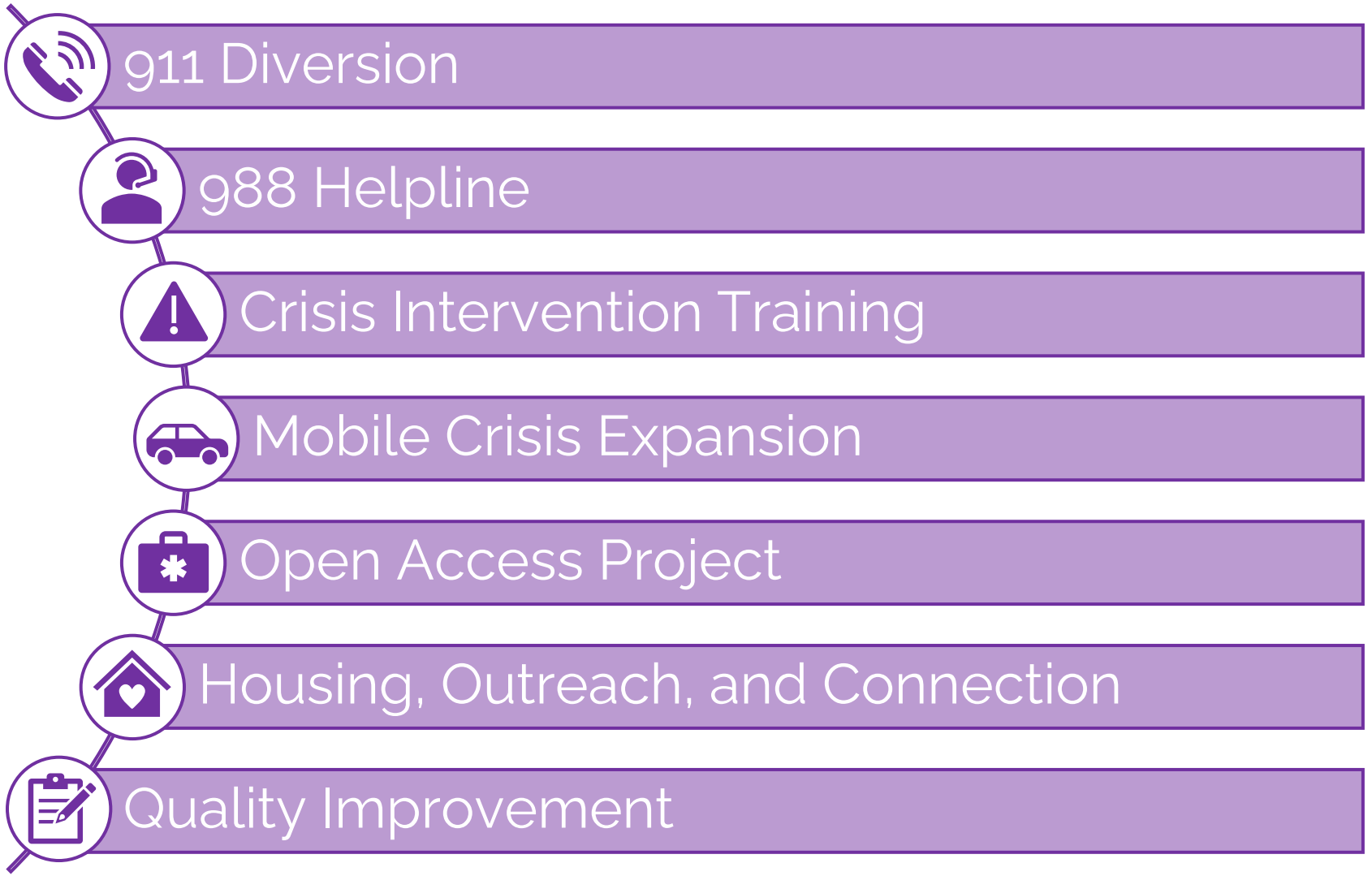
Baltimore City Behavioral Health Collaborative Overview

CONSENT DECREE

- Department of Justice (DOJ) investigated the circumstances of Freddie Gray's death and identified multiple civil rights violations by BPD
- On **April 17, 2017,** City of Baltimore and DOJ entered into a Consent Decree to guide comprehensive police reform
  - **Paragraph 97** of the Consent Decree outlines the City's responsibilities to identify and address gaps in the behavioral health service system
- The Baltimore City Behavioral Health Collaborative (BCBHC) convenes **cross-sector partners to drive system-wide transformation**
  - Co-led by:
    - Mayor's Office
    - Baltimore Police Department
    - BHSB

What Baltimore City Has Built So Far

WHAT WE'VE BUILT

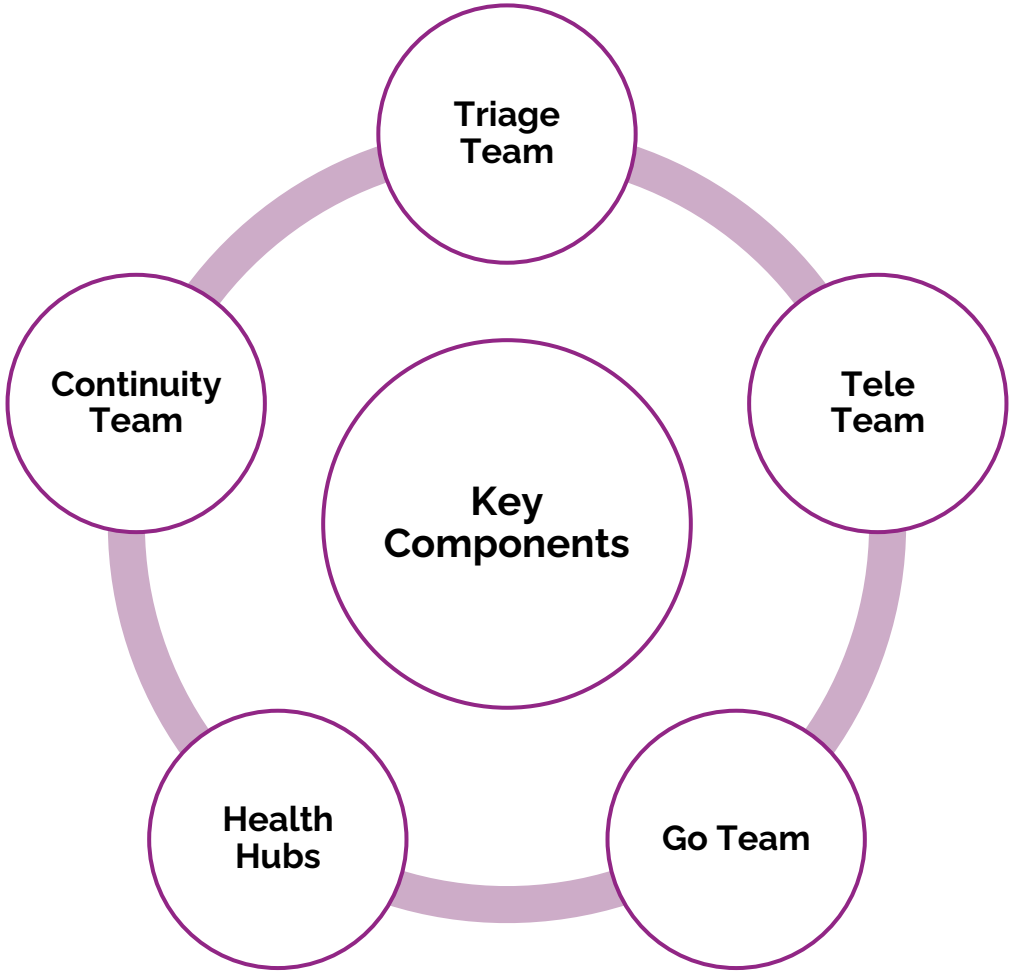


What Baltimore City Is Continuing to Build

24.7 COMPREHENSIVE SAFETY NET

Ensures the **right response** to every call for assistance, identifies people in need of help earlier, and reduces unnecessary use of emergency services.

- Secured $15 million in funding from the Opioid Restitution Fund
- Currently working with key partners to refine the model



Ensuring What Baltimore City Is Building Can Last

SUSTAINABLE SYSTEMS CHANGE

Ensuring what we are building in Baltimore City can last requires long-term partnerships and investments

- **Workforce development**
  - **Peer Workforce**
    - Advocated for peer delivered services to be reimbursed via Medicaid and the inclusion of peer delivered services in state regulations for crisis services
    - Secured ORF
  - **Behavioral Health Workforce**
    - Continued Advocacy
    - Example: state investment in school loan repayment for social workers and professional counselors (BHSB Recommendation #1)

THANK YOU! QUESTIONS?

Get involved with the Baltimore City Behavioral Health Collaborative: next meeting on January 27, 2026 at 10:30am

BehavioralHealth@baltimorecity.gov

LO25-0026 Legislative Oversight—Crisis Response

Presented to Baltimore City Council
January 15, 2026

Behavioral Health System Baltimore

BHSB'S CORE FUNCTIONS

Advocacy & Planning

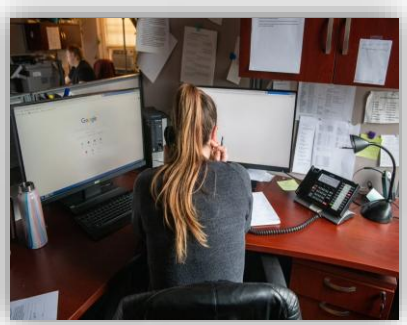
Local Partnerships

System Management

Managing Public Funds

Public Education

SAMHSA's National Crisis Now Model



Someone to call

Someone to respond

Somewhere to go

Principles for System Infrastructure Development

- Help anywhere, anytime for anyone
- Community-based care is prioritized
- Least police response possible
- A variety of emergency, urgent and non-urgent services are needed
- Coordination & connection between systems is critical - police, fire/EMS, hospitals & behavioral health providers
- Public education & engagement with the community is essential
- Planning & implementation takes time
- Accountability is multifaceted

System Infrastructure – Someone to Call

911

National emergency number for police, fire & ambulance

- Created in the 1960s
- Staffed by trained call takers in the fire department
- Quick decision making and immediate dispatch of law enforcement or medical care

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988

National helpline for immediate counseling & connection to resources

- Created in July 2022
- Staffed by behavioral health counselors
- Counseling and support as long as needed to determine next steps
- Can dispatch mobile crisis services
- Makes follow-up/care coordination calls
- 91% of calls resolved on the phone

System Infrastructure – Someone to Call

Diversion from 911 to 988

- 8 CAD codes eligible for diversion to 988
- 2 clinicians in 911 call center to facilitate diversion opportunities
- Direct line to 988 for police for support & diversion to mobile response services

Community engagement and outreach

- Culture change to increase awareness and use of the 988 helpline as alternative to 911
- Community shaped public education
- Community ambassadors – trusted people in community spreading the word about 988
- Supported with ORF $

CALL988 Campaign

- Public education to increase awareness & use of the 988 Helpline
- Community informed campaign
- Supported with ORF $

System Infrastructure – Someone to Respond

911

Police
- Immediate response for law enforcement

Fire/EMS
- Immediate response for fires and emergency medical care

Clinician police officer team
- Direct dispatch to scene for specialized support for police
- Follow up from EPs initiated by BPD patrol

988

Mobile crisis services
- Urgent response for high intensity behavioral health intervention
- Can provide follow up care
- Staffed by peers & licensed BH professional

System Infrastructure – Accountability

Consent Decree - Paragraph 97

- Details city's responsibility to improve system of response for people experiencing a behavioral health crisis
- Monitored by a federal judge. Releases bi-annual reports on progress
- Independent monitoring team evaluates compliance with requirements

Baltimore City Behavioral Health Collaborative (BCBHC)

- Group of community stakeholders formed through the consent decree process
- Oversees the City's success in improving the system of response for people in BH crisis
- Chaired by Mayor's Office, BPD & BHSB

Behavioral health services

- State driven accountability structure
- BHSB works with state to oversee services & funding
- State regulations & Medicaid reimbursement for mobile crisis services effective 1/1/2025

System Infrastructure – Accountability

Behavioral health awareness training

- 24 hrs for new recruits. Mandatory annual refreshers.
- 8 hrs for 911 specialists & police dispatchers.
- 40 hr specialized training for officers who volunteer to become Crisis Intervention Team (CIT) officers

BPD & Fire Department Quality Assurance Processes

- Multiple internal quality assurance audits/reviews to identify opportunities for improvement in health & safety response

Sentinel Event Reviews

- Multistakeholder process to examine critical incidents involving public safety response & identify opportunities for change within BPD, Fire Department and the larger BH system
- Implementation of recommendations overseen by BCBHC

System Opportunities

- Workforce development strategies to expand the number of clinicians choosing to work in crisis response
- Civilian response services to augment existing emergency response services

Workforce Development

Develop a school loan repayment program for social workers and professional counselors to work in crisis response

The average cost of loan forgiveness for social workers and professional counselors is $40,000

Partner with local academic institutions to explore the feasibility of MSW/professional counselor residency program

Form a local workgroup with local institutions to initiate discussions

Civilian Response Services

- Alternative to law enforcement and fire/EMS response
- Immediate, in-person support for nonviolent, non-medical calls
  - Low risk calls with no significant safety issues (ex. loitering, public intoxication, wellness checks)
- Team of trained community responders who are deployed through 911

System Infrastructure – Someone to Respond

911

Police
- Immediate response for law enforcement

Fire/EMS
- Immediate response for fires and emergency medical care

Clinician police officer team
- Direct dispatch to scene for specialized support for police
- Follow up from EPs initiated by BPD patrol

Civilian Response

988

Mobile crisis services
- Urgent response for high intensity behavioral health intervention
- Can provide follow up care
- Staffed by peers & licensed BH professional

How Could This Work in Baltimore?

- Starts with commitment & partnership which we have!
  - Partners include Mayor's Office, 911 call center, health, police, fire/EMS, BHSB, BH Collaborative
- Build from existing planning processes & infrastructure
- Planning to define the scope, accountability structure & funding mechanism - what calls to respond to, response time, etc.
- Build the team & test the model

Crista M. Taylor, LCSW-C
President and CEO
crista.taylor@bhsbaltimore.org

Find more information at bhsbaltimore.org
Follow us at @bhsbltimore

CENTER for INNOVATIONS in COMMUNITY SAFETY

GEORGETOWN LAW

City Council of Baltimore, Committee of the Whole

January 15, 2026

First class ambulance service exists in few cities. Some, such as Baltimore, employ highly trained full-time ambulance attendants with up-to-date vehicles and equipment as a separate mission of the fire department. Central screening and dispatching ensure open traffic lanes, communication en route, and distribution of casualties to assigned hospitals. In some cities, ambulance services are provided by the police department, some with ambulances and some with modified patrol station wagons.

National Academy of Sciences. Accidental Death and Disability: The Neglected Disease of Modern Society. National Academies Press; pg. 14, (1966).

Freedom House Ambulance Service, 1967

CENTER for INNOVATIONS in COMMUNITY SAFETY
GEORGETOWN LAW

A Broad Range of Emergent Crises

- Mental Health
- Poverty
- Substance Use
- Low-Level Conflict

CENTER for INNOVATIONS in COMMUNITY SAFETY
GEORGETOWN LAW

2024 Baltimore City 911 Call Data

Call Types	Number of Calls
Disorderly	≈ 60,000
Check Well-being	≈ 20,000
Family Disturbance	≈ 15,000
Noise Complaint	≈ 10,000
Behavioral Crisis	≈ 1700

CENTER for INNOVATIONS in COMMUNITY SAFETY
GEORGETOWN LAW

Examples of Models

Albuquerque Community Safety

City Pop ≈ 560k
Monthly 911 Calls ≈ 35k
ACS Calls/month ≈ 3200
Avg. Response Time ≈ 19 mins
No. of Responders ≈ 100
Annual Budget ≈ $17.9 million

Durham HEART

City Pop ≈ 296k
Monthly 911 Calls ≈ 21k
HEART Calls/month ≈ 1142
Avg. Response Time ≈ 13 mins
No. of Responders ≈ 37
Annual Budget ≈ $6.5 million

Minneapolis BCR

City Pop ≈ 429k
Monthly 911 Calls ≈ 24k
ACS Calls/month ≈ 950
No. of Responders ≈ 100
Annual Budget ≈ $17.9 million

CENTER for INNOVATIONS in COMMUNITY SAFETY
GEORGETOWN LAW

Core Program Elements

- Direct Dispatch from 911
- Sufficient Scale to Respond
- Prioritize Community Response
  - But Have a Co-Response Option

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GEORGETOWN LAW

Different Approaches

- Structural Decisions
- Priority Call-Types
- Scope of Followup/Case Management

❖ Structural Decisions

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GEORGETOWN LAW

Standalone City Agency
Albuquerque Community Safety
Durham HEART
Seattle CARE

Within Existing City Department
Evanston (Parks, Rec, & Comm. Services)
Rochester (Rec & Human Services)

Contract
Atlanta PAD (Non-Profit)
Canopy Roots BCR, Minneapolis (For-Profit)

Hybrid
Denver STAR (Denver 911 + Contract Responders)

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GEORGETOWN LAW

❖ Priority Call Types

Broader
Albuquerque Community Safety
Durham HEART
Denver STAR
Canopy Roots BCR

Narrower
Atlanta PAD (Poverty)
Dayton Mediation Response Unit (Disputes)

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GEORGETOWN LAW

Follow-up Questions?

Tahir Duckett
tahir.duckett@georgetown.edu

Mariela Ruiz-Angel
mariela.ruizangel@georgetown.edu

BALTIMORE CITY COUNCIL

COMMITTEE OF THE WHOLE

LO25-0026

Legislative Oversight – Crisis Response

Additional Materials

ABELL FOUNDATION

Ulysses Muñoz, The Baltimore Banner

PART 2

Greg Midgette | Thomas Luke Spreen | Peter Reuter
School of Public Policy and Department of Criminology and Criminal Justice,
University of Maryland

Improving Baltimore Police Relations With the City's Black Community

Alternate response to non-criminal emergency calls for service

The Abell Foundation
Suite 2300
111 S. Calvert Street
Baltimore, MD 21202-6174

This is one of two Abell reports
from a study supported by Arnold
Ventures and the University of Maryland.

Table of Contents

Executive Summary

The Baltimore Police Department (BPD) faces serious staffing challenges, particularly in its patrol ranks. The demands of the job amid strained police-community relations make recruitment and retention difficult. Under the 2017 Consent Decree between the City of Baltimore and the U.S. Department of Justice, behavioral health calls to 911 that do not necessitate a police response are to be diverted from BPD to a community behavioral health or crisis response service provider. We studied several recent police reforms instituted by other major U.S. cities that aim to reduce role of police in everyday life by transferring some police responsibilities to civilians. Albuquerque, Atlanta, and Houston now divert some categories of 911 calls, such as behavioral problems or suicide attempts, to civilian agencies rather than the police. Stakeholders view these diversion initiatives as successful in all three cities. Police, both as individuals and as departments, are also increasingly supportive of these initiatives. Diverting calls to civilian responders permits police to devote more time to controlling crime. The reduction in the workload placed on police may help to mitigate police staffing challenges.

Using BPD service call data, we identify which categories of 911 calls are very unlikely to be associated with dangerous crime or to require police intervention. Based on three potential program designs, emergency calls could be diverted to civilian first responders at comparable cost to BPD officers. Our baseline estimate indicates that diverting most low risk calls to civilians saves the BPD the equivalent of 59 full-time officers, about 10% of the BPD's present recruitment shortfall. A diversion program also has the potential to improve police efficiency, performance, and relations with the community.

We offer the following observations regarding the expansion of Baltimore's 911 call diversion program:

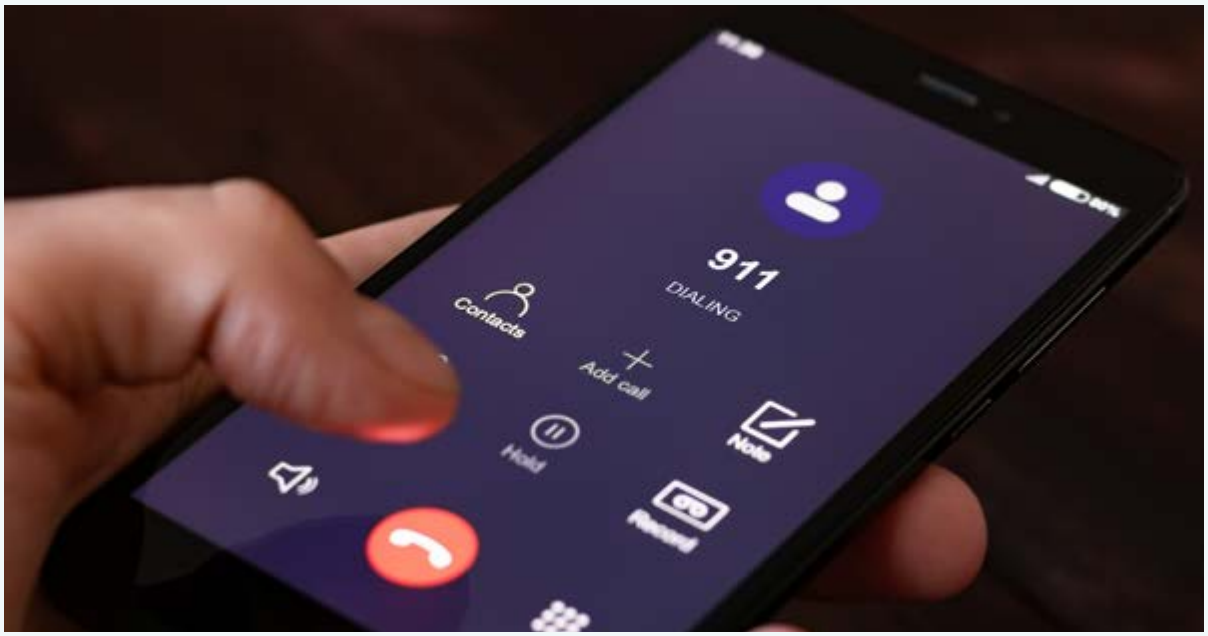
Expect this initiative to be successful. The early years of Baltimore's behavioral health diversion program are for ironing out the kinks and understanding local idiosyncrasies, not testing whether call diversion can work. The experience of other cities provides strong evidence that this kind of innovation can reduce police officer workload and improve 911 call outcomes for behavioral health clients.

Do not anticipate substantial reductions in service call demands or public spending on public safety in the early years of operation at scale in any community. It takes time to learn how to integrate these programs with other emergency services and to recruit appropriate staff.

Take advantage of existing data and analyses to identify categories of calls for service that are unlikely to require response by an armed officer. The analysis presented in this report is a starting point, not a definitive categorization. The BPD has access to additional data, which can be used to develop a more sophisticated scheme for identifying and diverting low-risk calls.

Develop performance metrics that match the goals of the program. The goal of this program is to improve service to citizens, not to save money. However, efficiency still matters because all programs face budget constraints. Assessments of a diversion program's success should reflect this trade-off.

Tailor the program to the city's needs and capabilities. Baltimore should learn from the experiences of other cities, but the types of calls that are diverted and the design of its program should be informed by lessons learned from its operating environment and a pilot program.



Introduction

In most jurisdictions, a significant portion of 911 calls to which police are dispatched do not involve a crime. Many of these non-criminal calls for service involve individuals experiencing acute mental health crises or other emergency personal welfare issues that do not pose significant risk to the community or first responders. If police handle these calls poorly, either through excessive use of force or inappropriate arrest, police-community relations erode and public safety suffers. This concern is central in Baltimore. The 2017 Consent Decree between the City of Baltimore and the U.S. Department of Justice stipulates that behavioral health calls to 911 that do not necessitate a police response should be diverted from the BPD to a community behavioral health or crisis response service provider.

Several U.S. localities now use an alternative response model that dispatches civilians with specific expertise in behavioral health services to 911 calls that meet certain criteria. Early evidence suggests these programs can yield ancillary benefits for the police departments and broader public safety. First, scarce patrol resources could be reallocated toward higher priority needs. Second, fewer arrests should occur in circumstances where police can use coercive force, but civilian responders cannot. These changes may lead to broader improvements in police-community cooperation, a key element of the community-oriented policing model Baltimore is pursuing.

This second report on police-community relations in Baltimore focuses on a new movement throughout the nation to reduce police contact with residents in stressful, non-criminal situations. This involves using non-police personnel to respond to some categories of 911 calls that do not involve crime and typically relate to behavioral health problems. Based on expert interviews and field observation, we analyze the experiences of Albuquerque, Atlanta, and Houston, three cities that have successfully embraced 911 call diversion. We found that the structure, goals, and performance measures associated with each program varied across each city. All are growing slowly, and none have encountered serious operational problems.

Our study of successful programs instituted by other major U.S. cities helped inform our study of emergency call diversion in Baltimore. Using a detailed dataset of Baltimore 911 calls over the period from 2015 to 2020, we identify which categories of emergency service calls could be diverted to civilian responders. We estimate a fully implemented diversion program could reduce police officer time devoted to emergency call response by the equivalent of approximately 60 officers per year.

For a police department with a chronic officer shortfall, a program to scale could provide an important boost to its capacity to suppress crime through more active investigation and patrol.

The report concludes with a short set of conclusions and recommendations for instituting a call diversion program in Baltimore. More extensive versions of several components of this study are available online.[1]

Jessica Gallagher, The Baltimore Banner

Diverting 911 Calls: Learning from Other Cities

Calls for service from individual residents drive a large share of police activity, but less than a quarter of calls are for a crime and only approximately 4-6% involve violent crime (Asher & Horowitz, 20202; Lum, Koper, & Wu, 2022).[2] Recognizing the widespread concern about unnecessary use of force, many cities have expressed an interest in reducing the role of the police in responding to a variety of call types. The fact that police departments in almost every city have been unable to recruit sufficient officers to meet their staffing needs has added to the interest in diverting calls to other agencies. In 2021, Baltimore began piloting the Behavioral Health Diversion (BHD) program, which authorizes dispatchers to route emergency calls related to non-weapon suicidal ideation to a community partner, Baltimore Crisis Response, Inc. (BCRI), potentially without the involvement of BPD officers. Through January 2024, 53% of the 543 calls to which BHD responded were addressed without police involvement. This equates to nearly 500 police and fire department hours saved through diversion so far.[3]

This section describes the experiences of three cities with relatively well-developed 911 call diversion programs. The goal is to provide information describing current practices from other cities and an analytic framework for Baltimore as it plans the expansion of its 911 call diversion program. It shows that there are a variety of models of 911 diversion, that in each city there was a different narrative as to how the city came to move forward, and that those local narratives are important for the design of a diversion model. Each city's innovation has demonstrated positive results, and none of the anticipated problems were realized. We synthesize the features of existing call diversion programs to produce estimates of the financial and staffing impact of expanding diversion programs to additional categories of emergency calls.

The three cities chosen for the study were Albuquerque, Atlanta, and Houston; in Houston we also studied a separate program implemented in Harris County, a suburban area which surrounds the city. Each city is like Baltimore in at least two ways, either in terms of demographic characteristics, evidence of racialized policing and police violence, or evidence of inadequate police responses to behavioral health issues in the community. We made a three-day visit to each city and met with the program operators, interviewed local legislators and other stakeholders, and observed first responders in the field.[4]

This study does not report outcome evaluations of the programs.[5] Rather we sought to learn how the programs operated, what factors led to their creation, how they were structured in relation to the city government, what problems and successes resulted, and

how they had affected the flow of 911 calls to the police. The variation in the form and function of these programs suggests that specific outcomes would be less useful to Baltimore than the formative evaluation we provide.

There are three categories of innovative responses to 911 calls involving behavioral health (BH) problems. One is the "crisis intervention" approach, which entails training police officers in how to respond to individuals in crisis and connect them with services. This is very different from the crime-fighting role police generally associate with responding to 911 calls.[6] The second category of response ("co-response") involves teaming up police officers with a mental health professional to accomplish the same goals. Many police agencies, including BPD, have invested in growing BH training and co-response units.[7]

Neither of these first two innovations deal with the current concern to reduce the involvement of police officers in the lives of residents. They still place an officer with a weapon in situations where the addition of an armed or uniformed responder could exacerbate the problem. Hence, there is an interest in a third type of innovation, sometimes called "community response," in which the response does not involve a sworn officer at all. The federally backed 988 suicide and crisis helpline is one such example where trained crisis interventionists assist callers exclusively over the phone. 988 intends to replace 911 for calls involving behavioral health that can be addressed remotely. In Baltimore, BCRI has been contracted to operate the 988 helpline in addition to operating the BHD program for responses in the field to more emergent non-criminal calls. Though community response is usually organizationally bundled with co-response programs, our study is focused on these exclusively civilian response programs.

The shift from police to non-police responders has many consequences. For example, no city vests their civilian responders with coercive powers. If the person they are tasked to help refuses the offer, that ends the matter. Similarly, the responders cannot direct traffic away when someone with a behavioral health problem is in the streets. They may not be able to enter private property, even with expressed consent. Some alternative responses, such as those involving licensed clinicians, are slowed by administrative processes imposed by professional regulations. Meanwhile, the field staff of the diversion agencies seem to be much more patient in dealing with behavioral problems than police. For the police, responding to an angry and unhappy young woman who has called 911 without a specific criminal complaint (as we observed in Houston) is a diversion from fighting crime. It is the essence of the new units' function: providing help to individuals in distress.

In all three cities, there was a history of recent incidents in which police were accused of killing young males, frequently from minority groups. Trust between the citizenry and police department was low (Ren et al., 2022).[8] This served as an important background motivation for the innovations, even if increasing trust was not identified as one of the objectives of the program.

Diversion Programs Case Studies

Albuquerque

Albuquerque is an ethnically diverse city of 565,000, with Latinos as the largest population group. The Albuquerque Police Department has a high rate of killings by officers and has been operating under a federal consent decree since October 2014. Albuquerque's diversion program (Albuquerque Community Safety: ACS) was initiated by the mayor as a response to the 2020 George Floyd killing. There is no evidence of substantial outside pressure in favor of this specific reform. The diversion program has been set up as an independent agency, at the same level of government as the Police Department and the Fire and Rescue Department, though still much smaller. Its focus has been particularly on the unsheltered population, a response to a very visible and prominent problem in the city.

ACS has expanded rapidly in its less than two years of operation. As of October 2022, when we visited, it had 40 field staff and 12 administrative staff. It is now part of the routine of the city's handling of 911 calls. In the first eight months of the Fiscal Year 2023, ACS handled 14,634 calls diverted from 911. For comparison, the Albuquerque Police Department receives 1.1 million calls annually.[9] The total budget for FY 2022 was $7.7 million, with expectations of substantial short-term growth.[10] The categories of emergency calls for service that are eligible for ACS response are provided in Table A2 of Appendix A.

ACS lists four goals: to implement a holistic and trauma-informed response to 911 calls; to build ties with other city and county agencies and nonprofit service providers; to engage with citizens and community stakeholder groups; and to inform the way public health and safety services are delivered.

After the ACS teams reach the site of a call, they may decide that police are needed either as a supplement or substitute. Similarly, police units might call for an ACS team. An initial concern, expressed particularly by police organizations, was that untrained and unarmed staff would be vulnerable to harm in dangerous situations. After two years and many thousands of responses, there were no recorded reports of any such incidents.

ACS leaders are concerned about the difficulty of finding services for their clients. Too often they can only take them to an Emergency Department at a local hospital. The city and state provide very limited substance abuse, mental health, and housing programs.

Atlanta

Atlanta's population was 499,000 in 2022; its metropolitan area contained 6.2 million. Atlanta is one of the biggest U.S. cities in which the largest racial group is Black (48%). The Atlanta Police Department (APD) is comparable to other departments around the nation when it comes to use of force and civilian complaints.

The origins of this diversion program (Police Alternative and Diversion Initiative: PAD) lie in activists' efforts to reduce the number of incarcerated persons in Atlanta. For many years, activists have sought the closure of the city's jail, which has a capacity of 1,100 inmates. The Atlanta Police Department's high levels of arrests for minor, non-violent offenses (particularly among minorities) and a high profile killing of an unarmed civilian (Rayshard Brooks) also provided impetus for the creation of PAD. The focus is particularly on the large and very visible population of unsheltered individuals, who have offered a major challenge for the APD.

PAD is operated as a nonprofit organization, which is funded by but independent of the Atlanta City government. Initially, it responded only to 311 calls but now accepts 911 calls that fall in a small number of specific categories that are likely to involve non-violent behavioral health problems. These include calls related to homelessness, drugs, public intoxication, and mental health issues.

Police officers can also call PAD to send a Harm Reduction Team or bring individuals to PAD's offices, where they receive very short-term services (clothing, food, a place to rest) and connection to other services, such as medical care and housing. Individuals can also go to the PAD offices directly if they have an "open warrant and active criminal case." The PAD management is concerned that the program be targeted to reduce police-citizen interaction and not to provide police with another way of disposing of non-criminal behavior (net-widening). Reflecting those concerns, its monthly reports include data on the criminal charges faced by its clients. One of its metrics is criminal recidivism before and after contact with PAD.

In 2022, PAD had a budget of $7.8 million (much of it from the federal pandemic funds received under the American Rescue Plan) and a staff of approximately 50. The program has received few diverted 911 calls. In the first five months of 2023, 96 individuals were diverted from police arrest and most responses were calls to provide basic needs for unsheltered persons.[11] Another operational problem comes in connecting individuals to resources. This led PAD to successfully lobby state agencies to make an additional $4 million available for housing vouchers; this outreach is laudable, but it also involves time spent outside the PAD's core purpose. The nonprofit status of PAD makes it vulnerable to local politics.

Houston and Harris County

Houston is the fifth largest city in the nation, with a population of over 2.3 million. It is situated mostly in Harris County, which has an overall population of 4.9 million. Houston is one of the most racially diverse big cities in the country, and its police department has been accused of excessive use of force against its Black residents.

The Houston Crisis Call Diversion Program (CCD) was established in 2016 to handle non-violent mental health calls over the phone by trained crisis responders housed in the Houston 911 call center. In 2021, the call diversion infrastructure grew to include Mobile Crisis Outreach Teams (MCOT) for in-person assistance and case management. Both CCD and MCOT are administered by the Harris Center, a nonprofit mental health authority, in partnership with Houston Police. These programs follow CIT and other successful BH-focused Houston PD programs. The main objectives of CCD and MCOT are to provide a more appropriate response to mental health crises than the actions police officers can take, to link patients to services, and ultimately to reduce police burden.

CCD operates from 6 a.m. to 10 p.m. and routes calls for mental health crises that do not require immediate physical response to trained counselors. Counselors spend about an hour per call working with a client to de-escalate and resolve each incident. MCOT responds to calls that cannot be resolved over the phone but do not need a police or EMT response, and these teams are available 24/7. The MCOT teams include psychiatric professionals and provide acute care, case management, and referrals for continued treatment.

One interesting aspect of CCD is its main objective—to avoid sending police to 911 calls when they're unlikely to be needed. The program is widely seen as successful, but it has not significantly scaled up.

Harris County created the Harris County Holistic Assistance Response Teams (HART) Program in 2022. It operates in a 148 square mile suburban portion of Harris County that borders Houston. It is not affiliated with CCD or the Harris Center. The program is similar in organization and function to PAD in Atlanta. Administered by a nonprofit, it diverts non-criminal emergency calls to civilian teams consisting of an EMT and a behavioral health specialist. The program's goals are to reduce the workload on patrol officers, decrease repeat-call volume, and connect citizens with county services. The program currently only fully serves roughly 10% of the entirety of the county. Nonetheless, HART's successes cannot be overlooked, with 40% of calls receiving social services on-scene and 6% entering a case management relationship with the program and subsequently being connected with longer-term services when possible.

Both CCD and HART face challenges, including limited inter-agency trust and politics for CCD and risk aversion and ambiguous calls for HART.

Concluding Comments

One important observation is simply that these programs operate as intended. In each of the three cities, they are seen as successful and face, as best we could tell from interviews and scrutiny of the local media, little criticism.

Police, both individually and as departments, are increasingly supportive of these initiatives. Even police unions do not appear hostile, notwithstanding that shifting to social or clinical workers reduces the need for more police officers. There are two principal motivations for this support from the police. First, many individual police officers do not feel well equipped to respond adequately to behavioral health calls; it is inconsistent with their understanding of what constitutes police work. Second, the persistent and large recruiting shortfall of each city's police department makes them supportive of load shedding. Moreover, 911 call diversion programs are marked by compassionate and patient responses to incidents. This will likely grow public expenditures in the short run. Staffing requirements grow with the reciprocal of time spent responding; spending an hour per call instead of 20 minutes effectively triples the number of responders necessary to resolve the situation. Staffing these positions may be difficult. Labor shortages are as serious in the behavior health sector as in policing.

Justin Fenton, The Baltimore Banner

None of the programs has encountered serious operational problems. The fear that unarmed civilians would be placed in dangerous situations has not been realized. Selecting the right categories of 911 calls to pass on to these diversionary units is clearly important. Each city has worked out its own set of criteria and procedures for diversion, and some encompass riskier calls than others, though every list is shorter than program advocates would like because of agency risk aversion.

A tenet of the 911 system is that every call should produce an in-person response. That is what makes calls for service such a burden on the police, as most calls do not, ex post, require a visit by an armed officer with coercive powers. Houston's CCD program directly challenges that assumption.

Each program has a distinctive origin story, both in political and administrative terms. For example, ACS came out of the Albuquerque mayor's office during political crises, while Houston's CCD was an almost routine administrative initiative by mid-level police officials with no political instigation or visible involvement.

The origins shape how the program is structured in two senses. First, it helps explain where each program is placed in the city's government. The origins have a second effect. The goals of the program may be shaped by what sparked its creation. Atlanta's experience makes that point most distinctly. PAD was created as part of the effort to reduce incarceration. Referral to PAD was an alternative to arrest, and the operators of the program are explicitly concerned about avoiding net-widening, which involves the police bringing individuals whom they would not otherwise have arrested to PAD. PAD publishes statistics on the reduction in arrest frequency for the six months before and after a PAD contact. In contrast, Houston and Harris County were concerned about improving the efficiency with which 911 calls are handled. They each focus on the volume of calls diverted away from police; a comparative cost analysis is important to the managers of the program.

The potential for load shedding may be substantial but none have yet made more than a small contribution. Even in Houston, by far the most mature of these programs, the results seem modest to date. In 2022, the CCD only handled about 4,500 calls that were initially directed to the Police or Fire Departments. By comparison, the total service call volume for Houston PD and Houston Fire Department in the same period were 1,075,954 and 384,229, respectively.[12]

Considerable time is needed to set up these diversion initiatives. It involves not just recruitment of staff and planning of how the service relates to existing emergency response but also the time needed to bring potential stakeholders along. In Atlanta, where the initiative came from outside government, external funding to bring local politicians and other stakeholders to see the operation of a related reform in Seattle—Law Enforcement Assisted Diversion (LEAD)—was very helpful, in part because it improved relations between the advocates and the elected officials.

Consequences of Transitioning 911 Calls to Civilian Responders in Baltimore

Police in Baltimore face two difficult challenges when responding to 911 calls. The first is an issue of scale. The BPD is stretched thin by shortfalls in officer recruitment and retention that are far worse than broader trends. Nationally, police officer staffing declined 3.5% between 2020 and 2022, and more than 5% of budgeted sworn officer positions are currently unfilled.[13] Baltimore was nearly 20% below its planned force size in April 2021 (Baltimore Police Department, 2021). Officers in the city are thus more likely than the national average to be required to work overtime, which is beneficial neither for officers (increased stress) nor for the city's budget (increased pay). When deciding how to distribute scarce labor, the BPD must decide how to distribute officers across patrol and numerous other duties. Under today's severe labor force constraints, they must also confront trade-offs in patrol officer structure between the number of patrols per shift and the number of officers per patrol. Fewer patrols may mean less presence and less responsiveness to community needs, while fewer officers per patrol may lead officers to be more cautious and less able to respond effectively in times of acute need.

The second problem faced by the BPD in responding to citizen calls for service is an issue of scope; officers must deal with a great variety of calls requiring very different responses. There is essentially a coin flip's chance that officers may be called to respond to a criminal incident where coercive force is needed or to an incident where the probability that a crime occurred is vanishingly small, and the very appearance of coercion undermines officers' ability to provide services effectively. There is a growing consensus that many emergency calls could be addressed by civilian first responders with expertise in mental health and crisis intervention but without the competing demands associated with crime prevention and investigation. The national 988 program should divert some calls for which no field response is needed at all. Early experiences in Baltimore with BHD and in other large U.S. cities—detailed above—demonstrates that civilian first responders can potentially handle a large share of 911 call volume where field response is required.

Transitioning low-risk 911 calls to civilian responders frees patrol officer time and can help mitigate the department's current sworn personnel shortfall.

This has the potential to remove police from situations that extend police officers beyond their core competencies. There are several prominent instances where this resulted in tragic outcomes, documented in detail in a 2016 U.S. Department of Justice report on BPD use of force (Kelly, 2016). Diversion programs also free police to focus on their core function of crime fighting. This should lead to improvement in Black citizens' trust in the police based on the feedback of Baltimore residents described in the first volume of this report.

To examine the feasibility of an alternative response program, we used the BPD's data to develop a simulation-based model.[14] We demonstrate the model's value by considering three call diversion program design scenarios. The first is based on existing practices in three large urban jurisdictions that have already begun diverting some calls to civilian responders, as described in the previous section. The second is based on the empirical probability that a call pertains to a serious crime, based on the information provided to call-takers and reported by responding officers.

The third incorporates empirical evidence of need for police as indicated by Baltimore patrol officers themselves.

Our research adds to the nascent evidence suggesting 911 call diversion is a promising policy option. Dispatching civilian first responders to emergency calls results in direct cost savings because police officers are typically better compensated than civilian responders, such as paramedics and social workers. On a per-call basis, these savings however are offset by increases in the time first responders are likely to spend on-scene at an incident; taking care of individuals with behavioral problems is a time-consuming activity. On a per-caller basis, a successful resolution to one call, however time consuming, may obviate many future calls.[15] Call diversion also generates indirect time and fiscal cost savings through a reduction in arrests. Pilot programs in several U.S. cities dispatch civilian responders to a variety of emergency calls, and early evaluations indicate that they reduce criminal activity (Pyne & Dee, 2022).

Design Scenarios for 911 Call Diversion in Baltimore

The BPD responded to about 421,000 community-initiated emergency calls each year between fiscal year 2015 and 2020.[16] Using administrative data provided by BPD we evaluate the budget and time use impacts of delegating low-risk emergency calls in Baltimore to civilian responders. These administrative data include the location, type of incident, time of day, investigation time, and how each call was resolved (e.g., whether a police report was written).

In the first design scenario, we base the types of calls diverted to civilian responders on existing practices from programs in Albuquerque, Atlanta, and Houston, referred to hereinafter as early adopter programs. We identified five constructs for which call diversion is commonplace in these existing programs, then mapped these to the Baltimore data (see Table 1). We identify nine incidents to which the early adopter programs respond in the Baltimore calls for service data: behavioral crisis,

disorderly person, intoxicated person, lewd act, panhandling, person lying on street, sick person, suicide, and suspicious person.

Theoretically, just over 20% of all calls could be diverted to civilian responders under this scenario. This reduction effectively frees police time equivalent to 59 full-time patrol officers (95% Confidence Interval: 43 – 75 officers), which corresponds to nearly 10% of the department's current shortfall.[17] However, no program in a large city has grown to this scale to date. Assuming civilian and police training and materials costs are commensurate, we estimate that the net effect on the city's public safety budget is negligible.

Table 1. Calls Currently Assigned to Civilian Responders by Early Adopter Call Diversion Programs

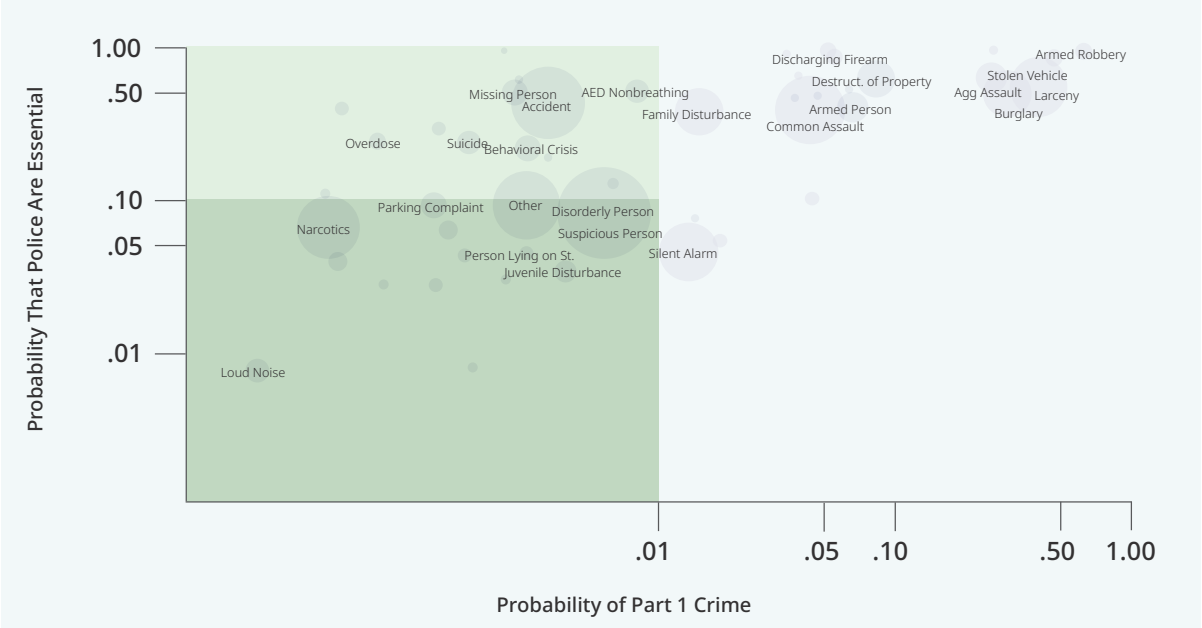
Construct	Baltimore	Albuquerque ACS	Atlanta PAD	Denver STAR	Houston CCD/ MCOT
Intoxication and substance abuse	Intoxicated person Person lying on street Sick person	Person down with no safety issues (with or without suspected drug use)	Intoxication and substance abuse	Intoxication	
Syringe disposal	None	Needle pickup		Syringe disposal	
Mental and behavioral health crises	Behavioral crisis Suicide	Mental and behavioral health crises Suicidal ideation and suicide attempt	Mental and behavioral health crises	Suicidal ideation and suicide attempt	Suicidal ideation and suicide attempt
Needs of unsheltered and indigent individuals	Panhandling Lewd act	Panhandler Unsheltered individuals Welfare checks	Homelessness and public indecency		Welfare checks
Non-criminal disturbances	Disorderly person Suspicious person	Disturbance Suspicious person		Trespass	Disturbance Suspicious persons and events Trespass

We also consider a "restrictive" scenario that diverts calls with less than 1% probability of Part I crime and less than 10% probability of generating a police report (darker shading alone).[18] The police report is an indication that police were in fact required to resolve the call. In the BPD data, we observe mutually exclusive and complementary officer determined call dispositions for incidents where officers can act: a report was written after an incident, police determined that they were not needed, or the incident was resolved by police without a report recorded. We consider the latter two outcomes to determine when police were not essential to resolve a call. Finally, we consider a "permissive" scenario; that is, one that diverts calls that have less than 1% probability of Part I crime.

In Figure 1 below, the shaded areas represent regions that would be diverted under the restrictive (darker shading) and permissive (lighter shading) 911 diversion program design scenarios. The size of each circle in the plot indicates the volume of each incident type observed over FY2015-FY2020. Over 40% of calls would be diverted under the restrictive scenario and nearly 60% would be diverted under the permissive scenario.

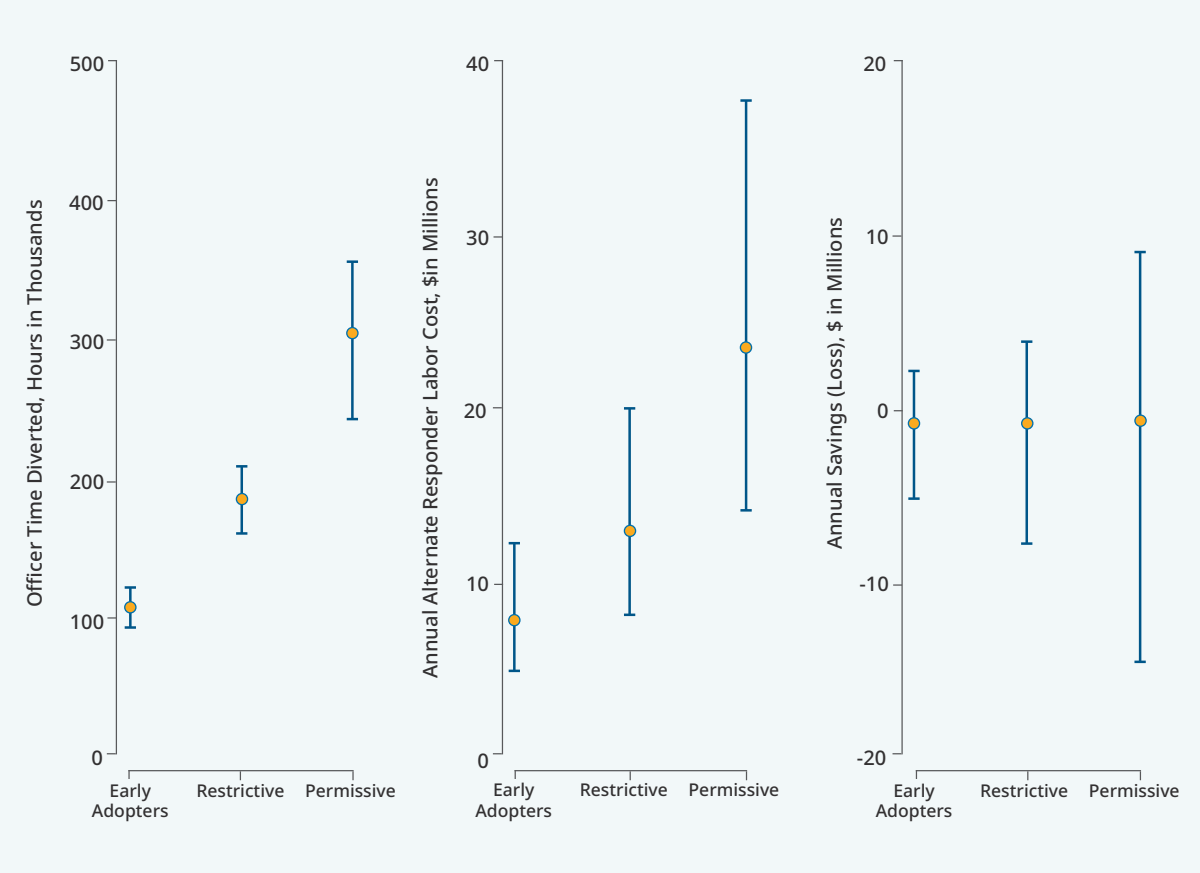
Notable in this plot is the concordance between the two measures. Many common incident categories rarely result in a recorded crime or the need for a police officer response. For example, fewer than 1% of calls involving disorderly persons resulted in a Part I crime, and the responding officer filed a police report for only 8.5% of disorderly person calls. Juvenile disturbances, parking complaints, and loud noises also fit this description.

Figure 1. Outcome Probabilities of Emergency Calls Assigned to Baltimore Police by Category, FY2015-20



The restrictive and permissive design scenarios each result in larger time savings for patrol officers but with commensurate increases in the uncertainty about whether a civilian will be dispatched to a call involving a crime in progress (See Figure 2). While we did not design these hypothetical programs to be cost-neutral, all three were with varying degrees of uncertainty.

Figure 2. Outcome Estimates for Alternate Design Scenarios



Note: Dots correspond to mean estimates generated for each scenario by a Monte Carlo simulation model; lines reflect 95% confidence intervals around the mean estimate.

Measuring the Relationship of Police Responses to Race, Ethnicity, and Structural Disadvantage in Baltimore

Our analysis assumes that 911 call diversion programs will function similarly across demographically distinct areas within a jurisdiction. We tested whether policing behavior depends on the characteristics of the community being policed to further probe this assumption. We consider the relationship between neighborhood racial and ethnic composition, socioeconomic conditions, and four measures of police performance in response to emergency calls for service: response time, investigation time, the rate of reports filed, and arrest clearance rate for Part I crimes. We found these outcomes are not strongly related to structural disadvantage after accounting for potential confounders. There is no measurable relationship between neighborhood racial or ethnic composition and the probability of report or arrest. We observed one puzzling finding that, all else equal, response times are on average faster and investigation times are shorter in communities with larger Latine populations.[19] See Appendix B for more details on this analysis.

While we find that neighborhood disadvantage does not exert a major influence on policing outcomes from 911 calls (see Appendix B), the measures we consider may miss important nuances in community-police interactions. Our data do not allow us to differentiate the nature or substance of police responses while on-scene, and we have no information on whether complainants were satisfied with the resolution of the incident.

Concluding Comments

Based on three potential program designs, call diversion to civilian first responders could help Baltimore fill police staffing gaps with civilian first responders at comparable cost to sworn officers. Our case studies of early adopter cities also suggest that a diversion program could also improve police efficiency, performance, and relations with the community. While this analysis is focused on the time use and cost implications of call diversion, the broader literature on civil-police relations suggests there may be significant nonpecuniary benefits that we do not consider. As already noted, reduced police involvement in low-risk emergency calls lowers the likelihood of violence between police and marginalized communities. Even if officers' propensity to misuse force against people from marginalized groups remains the same, the frequency of harmful incidents may decrease. Greater reliance on social workers and treatment programs may also improve community well-being, especially given that many programs entail follow-ups by civilian responders (Irwin & Pearl, 2020). These follow-ups generate financial and social benefits and may reduce the likelihood of future 911 calls concerning these individuals. In time, diversionary programs may even improve police-community relations, as residents learn that calling for help may indeed return the kind of help they are seeking.

Implications for Baltimore

Baltimore's Black residents know that the police are an important institution in their lives. Part 1 of this report describes the tension Baltimoreans feel when confronted with a public safety emergency, weighing their need for emergency response against their hesitation to engage with police. The residents we interviewed acknowledged that the Baltimore Police Department has a tough job and that many officers aim to improve citizen safety.

Given the existing mistrust, reducing police involvement to non-criminal incidents, thus the opportunities for inappropriate responses, is an important goal. The experiences of a few other cities that have tried to divert low risk categories of service calls to agencies other than the police department are likely to be helpful in that respect.

We conclude by offering a few observations about the feasibility of a 911 call diversion initiative in Baltimore:

Expect this initiative to be successful. Baltimore is typical in its cautious start with a small pilot program of limited scope. We believe that our more systematic analysis of the BPD emergency call response provides actionable guidance on which categories of 911 calls are suitable for diversion to civilian first responders. The experience of other cities provides strong evidence that this kind of innovation can be effective and helpful.

Do not anticipate substantial reductions in service call demands or public spending on public safety in the early years of operation at scale. Successful programs in Albuquerque and Houston handle only as much as 5% of all service calls, which indicates there are problems in moving to scale. No existing research addresses why this is so but there appear to be subtle barriers that can only be overcome with more experience and analysis.

Take advantage of existing data and analyses to identify categories of calls for service that are unlikely to require response by an armed officer. The analysis presented in this report is a starting point for evaluating which calls are feasible for diversion to civilian responders. The BPD has access to additional data, which can be used to develop a more sophisticated scheme for identifying and dispatching civilians to low risk 911 calls. A successful diversion effort will also likely entail an ongoing investment in dispatcher training and support, with attention toward minimizing misidentification of high-risk emergency calls.[20] Notably, BHD has already built out a quality assurance mechanism to review program operations, discuss challenges and opportunities can be discussed with stakeholders, and ultimately inform the program's growth.

The program that takes shape is a product of its environment. Baltimore's current diversion program relies upon a

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community partner. Unlike its Atlanta counterpart, the nonprofit is not engaged in political advocacy. Like its Harris County counterpart, it may benefit from integration with public health data and case management infrastructure. Reliance on external partners for call diversion increases the program's vulnerability to external criticism. If it runs into operational problems, then the diversion program's entire existence is in jeopardy; the city government can simply cut funding and ties with the external partner. Though political context varies from place to place, a government agency is better insulated against short-term political whims. Moreover, government agencies may enjoy greater access to data that will lead to improvement in their operational effectiveness over time. On the other hand, programs formed in nonprofit community-based organizations may avoid stigma associated with government and may be perceived to be more accountable and responsive to the community.

Each program we observed grew pragmatically based on its placement in existing local structures and politics. Even the programs that are used as benchmarks are likely to have limited generalizability. For example, Seattle's harm reduction-based LEAD program is not politically feasible everywhere. Further, its focus on low-level criminal events as the point of diversion rather than non-criminal calls also changes incentives for participation among clients and limits the scope of clientele to which services might be offered.

Baltimore has taken important steps to address gaps in behavioral health service provision through the establishment of BHD, the rollout of 988, and planning for the interoperability of BHD and 988. Given continued thoughtful planning and implementation, the expansion of Baltimore's 911 diversion program has the potential to achieve its goals of addressing the gap in behavioral health services in the city.[21] The program will not only have the short-term effect of reducing negative police-citizen interactions in behavioral health settings but may also have long-term effects for police legitimacy. Understanding how similar programs work in other cities, learning lessons from them, and adapting the plan to Baltimore accordingly is key.

Develop performance metrics that match the goals of the program. The number of 911 calls diverted is an incomplete accounting of the benefits of these diversionary programs. There are two, perhaps even three, other important benefits, each of which is hard to quantify. The first is that the response offered by ACS or HART or any of these programs may be more appropriate and higher quality than those provided by uniformed police officers. Social or clinical workers are comfortable spending more time with persons who need help and can better

connect them to post-call services that will help deal with the underlying problem. For most officers, this is time taken from their primary mission of fighting crime.

The second benefit, which is not only hard to quantify but even to properly conceptualize, is improving police-resident relations. Reducing the number of times an armed officer must manage an individual experiencing psychiatric problems is likely to reduce the number of times that force is used in troubling ways to control an arrestee.[22]

The other hard-to-quantify benefit is that these initiatives may either reduce or increase the number of calls for service. A modest share of callers account for a substantial share of all calls (Middleton et al., 2014). Helping one of them with their underlying problem may noticeably reduce calls. Thus, the demands for police services may be smaller. On the other hand, Baltimore's strained police-community relations complicate the way a call diversion program's success should be measured. Baltimore residents' current skepticism of the utility of police means that many potential calls for quality of life and lower-acuity circumstances that would be routinely reported in other cities do not take place in Baltimore.

Call diversion programs introduced by other localities are aimed in part to reduce 911 call volume. If a call diversion program is successful, residents may feel more comfortable or confident in calling 911 or 988, thereby increasing calls.

This phenomenon is most likely among incident types that are reassigned to civilian responders but may spill over to incidents for which police remain first responders.[23] If effective, 988 will replace 911 for some calls. Callers experiencing or witnessing a crisis are likely to continue to call 911 if they believe the situation requires a response in the field. In any case, we view increased emergency service utilization as desirable since it is evidence that residents trust the city to respond in their time of need.

Kaitlin Newman, The Baltimore Banner

A pilot that extends beyond the city's current diversion program to a wider variety of 911 call-generating incidents will produce useful data and insights for agencies and stakeholders.

Baltimore has rightfully avoided focusing solely on the financial cost of responding to emergency calls; doing so ignores other potential costs and benefits they create. Social and clinical workers will often take longer and hence may raise the cost of responding to certain types of emergency calls. However, recent evidence from an evaluation of Denver's STAR program suggests those costs are offset by the cost savings from averted arrests (Pyne & Dee, 2022). Caller satisfaction and the effect on caller recidivism (i.e., the number of emergency calls made by the same caller within, say, the next three months) are two other useful metrics. There are likely other measures that can provide useful guidance about the operational effectiveness of a diversion program that are not considered in this report.

Tailor the program to the city's needs and capabilities. To date, the first call diversion effort by each city from which we draw insights is just a small-scale pilot program. As the evidence base accumulates, perhaps codified by a broad-based association such as the U.S. Conference of Mayors or Council of State Governments, it will be possible to start larger scale efforts. Baltimore, too, should consider expanding the current diversion program, first in a limited-service area–e.g., two or three of the city's nine police districts–rather than citywide. A pilot that extends beyond the city's current diversion program to a wider variety of 911 call-generating incidents will produce useful data and insights for agencies and stakeholders. It would also allow program architects an opportunity to revise program design based on preliminary experiences. Eighteen months is probably a reasonable estimate of the time it takes from the initial decision to set up a diversion program to the actual implementation, though implementation is easier when building on existing partnerships (Houston) than forging new ones (Atlanta) or resolving past acrimonious interagency relationships (Albuquerque). An additional six to twelve months of program operations in a limited geographic scope would provide adequate data to inform expansion.

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Endnotes

1 A more detailed discussion of the data, model, and analysis presented in this report can be found in this journal article: https://www.tandfonline.com/doi/full/10.1080/07418825.2023.2300444.

2 Best practices for law enforcement agencies (LEA) suggest patrol officers spend roughly 40% of their time on calls for service. Many LEA develop staffing plans that follow the "Rule of 60," which dictates that 60% of officer time is spent on patrol and 60% of patrol time is spent responding to community-generated calls for service. See https://icma.org/sites/default/files/305747_Analysis%20of%20Police%20Department%20Staffing%20_%20McCabe.pdf.

3 According to BPD, the program had saved nearly 500 hours of police and fire department time as of January 2024. See https://www.thebaltimorebanner.com/politics-power/local-government/one-year-in-baltimore-officials-say-911-diversion-system-needs-more-time-to-prove-itself-TKSQFKR3UJE4BKUZBZ5ITZVZJQ/.

4 Appendix Table A1 reports key features of each of the diversion programs described below.

5 The Crisis Call Diversion Program operating in Houston is currently under evaluation by the Research Triangle Institute. The two other programs are too new to make any meaningful assessments.

6 Nationwide, over 2,700 departments have undertaken this kind of training for some or all their sworn personnel Most agencies follow a standardized 40-hour curriculum for crisis intervention training. For more information, see https://bja.ojp.gov/program/pmhc/learning#types-of-pmhc-programs, https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs, and https://www.citinternational.org/research.

7 All BPD patrol officers receive basic BH training in partnership with Roca, and the Department aims to equip 30% of patrol officers with 40-hours of crisis intervention training.

8 We could only identify one specific study for Houston, but there are a number of national studies (https://news.gallup.com/poll/394283/confidence-institutions-down-average-new-low.aspx) and some that use a subset of large cities that include those in this report in addition to a number of other cities.

9 See https://www.krqe.com/news/albuquerque-metro/apd-addressing-long-9-1-1-and-242-cops-call-wait-times/.

10 See https://www.cabq.gov/acs/documents/acs-organizational-plan-20211207.pdf.

11 See https://static1.squarespace.com/static/5e9dddf40c5f6f43eacf969b/t/648a0f803200333f6c45fe5a/1686769541615/PAD+May+2023+Report+-+Updated.pdf.

12 See https://houstontx.gov/fire/reportsandstats/index.html and https://www.houstontx.gov/police/department_reports/operational_summary/NIBRS_MonthlyOperationalSummary_Dec22.pdf.

13 A 2022 Police Executive Research Forum survey shows a steady decrease in staffing over the past two years. See https://www.policeforum.org/workforcemarch2022.

14 We developed the call diversion program simulation model for any jurisdiction considering 911 call diversion, allowing policy designers to choose inputs and underlying assumptions to fit the local conditions. Based on a set of inputs that are measured with uncertainty, the model uses a Monte Carlo method to estimate the most likely expected outcomes and quantify the uncertainty around that outcome.

15 Our analysis does not consider these potential downstream impacts of call diversion.

16 Baltimore's fiscal year begins on July 1 and ends on June 30.

17 In April 2023, the judge supervising the BPD's Consent Decree stated that the department required 2,600 sworn officers to achieve the objectives of the Consent Decree but was operating with only 2,100 sworn officers. See https://htv-prod-media.s3.amazonaws.com/files/quarterly-public-hearing-outline-4-13-23-6438611645ff8.pdf.

18 Part I crimes include the most serious crimes: assault, theft, homicide, among others. Unfortunately, no data were available on less serious crimes. For Part I crime definitions, see https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/offense-definitions.

19 We use "Latine" as a pan-ethnic, gender inclusive alternative to "Latina" and "Latino."

20 The Pew Charitable Trusts (2021) found less than half of emergency communication centers provided behavioral health crisis training to identify high priority calls. See https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/10/new-research-suggests-911-call-centers-lack-resources-to-handle-behavioral-health-crises.

21 The city of Baltimore provides an overview of the city's progress implementing 911 call diversion through spring 2023 in this report: https://drive.google.com/file/d/1cuacRAvPcucqLphzCk0Hts-XeDrhblGC/view.

22 For an example of this kind of incident, see https://www.washingtonpost.com/dc-md-va/2023/07/25/video-officers-tackle-mentally-ill-man/.

23 It may be difficult to ascertain the degree to which call volume changes are driven by residents' propensity to report incidents, as opposed to changes in the rates of actual incidents. This could theoretically be measured by comparing call volumes for potentially affected incident types to incidents that are reliably reported to 911 and unlikely to be impacted by a call diversion program, e.g., fires, traffic accidents, and motor vehicle thefts, but such a method makes strong assumptions about the relationship between impacted and non-impacted incident rates over time.

Appendix A

Table A1: Characteristics of diversion programs in three cities

	Albuquerque	Atlanta	Houston	Harris County
Creation date	September 2021	2016	2016	March 2022
Who runs the agency?	An independent public agency parallel to the Police Department	A nonprofit funded by the city	A county public health agency in collaboration with police	A nonprofit funded by the county
Why was it created?	Mayor responding to George Floyd killing; prior order of consent decree to reduce unnecessary police use of force toward unsheltered community	Part of struggle to close city jail; increasing population of unsheltered persons during pandemic for which police response was inadequate	Mid-level administrative initiative to reduce police workload burden	Sheriff responding to trends in deputy time use
What is the primary goal?	Reduce police/ citizen contact	Reduce use of incarceration as response to mental health calls	Reduce police/ citizen contact	Reduce use of officer time for non-criminal calls
Who responds to calls?	Mobile Crisis Teams, Behavioral health responders, Community responders, and Street outreach workers in teams of two	Two-person Harm Reduction team, made up of community engagement specialists, community responders, peer advocates, care navigators/caseworkers, and clinical advocates	CCD crisis phone counselors or Mobile Crisis Outreach Team (psychiatrists, RNs, licensed clinical therapists, and psychiatric technicians)	Employees of DEMA Consulting and Management
Types of calls diverted	Mental health, substance use, and homelessness. See Table 2 for full detail	311 calls concerning disturbances, public indecency, welfare, mental health, substance abuse, basic needs, or public health and pre-arrest diversion referrals	Mental health-related incidents that are low urgency (Priority 3 or greater)[24]	Non-violent incidents involving mental health episodes and unsheltered persons
Average calls handled per month	2,000 (Aug. 2022 - now)	125 (Jan. 2023 - now)	378 (2020)	278 (Jan. – June 2023)
% diverted from PD	~2.48%	~0.4%	~0.29%	~1%
Budget	$12 million	$7.8 million annually	$12.6 million	$7.6 million

Table A2. Categories of Calls for Albuquerque Community Service (ACS)

Responding Team	Call Description	
BHR: Behavioral Health Responders	• Suicide • Behavioral health issue • Disturbance • Suspicious/intoxicated subject	• Wellness check • Panhandler • Welfare check • Message for delivery
CR: Community Responders (Dispatched by AFR Alarm Room; Triaged by 311)	• Wellness check • Abandoned vehicle: APD: 24	• Abandoned vehicle: 311 Ticket • Needles
SO: Street Outreach and Resource Coordinators (Triaged by FCS and 311; Not Dispatched by AFR Alarm Room)	• Unsheltered individual • Needles	

24 See https://www.houstontx.gov/police/general_orders/600/600-01%20Response%20Management.pdf.

Appendix B: Measures for Analysis of Response Time

We use the Social Deprivation Index (SDI) to measure structural disadvantage in Baltimore prepared by the Graham Center (2023). Based on SDI, most residents of Baltimore face extreme structural disadvantage. In the city, 62% of census tracts are in the index's top quartile and 38% are in the top decile. Its socioeconomic conditions also stand in stark contrast to the rest of Maryland, which has an average SDI in the 38th percentile nationwide. Within the city, Black and Latine persons reside disproportionately in disadvantaged communities (Midgette, Spreen, Porter et al., 2024).

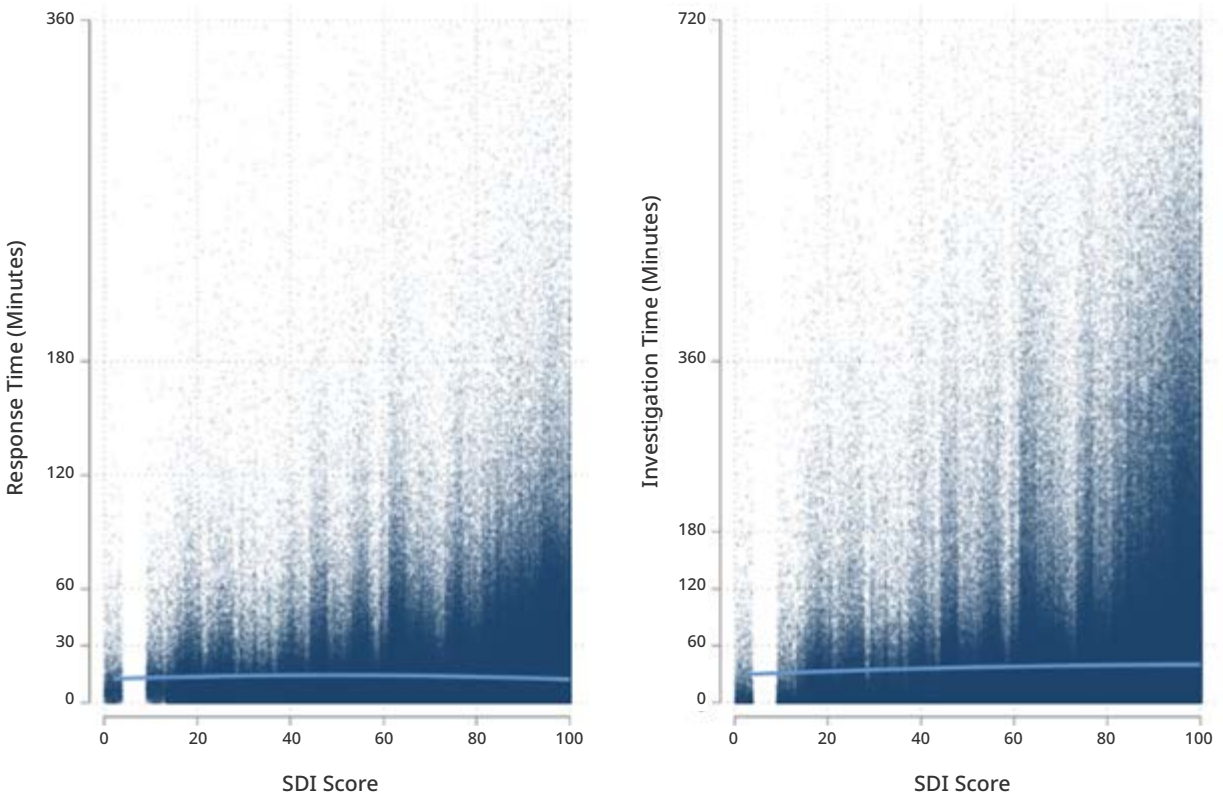
We measure response time, investigation time, report rate, and arrest clearance rate using administrative data provided by BPD (see Table B1 for descriptive statistics).[25] In Baltimore 911 calls are concentrated in disadvantaged Census tracts, and most 911 calls are made from communities with predominantly Black residents.[26] On average, BPD patrol officers respond to calls in under fifteen minutes and spend 39 minutes on-scene, though this varies by incident type and the final disposition of the call (Midgette, Spreen, Porter et al., 2024).

Table B1. Summary Statistics

Measure	Mean (SD)	[Min, Max]
Response Time (Minutes)	13.269 (21.040)	[1, 360]
Investigation Time (Minutes)	38.879 (71.090)	[0, 720]
Report Recorded	0.257	[0, 1]
Arrested (Among Part I Crimes)	0.111	[0, 1]
SDI Score	79.217 (21.010)	[2, 100]
% Black	0.647	[.006, 1]
% Latine	0.064	[.0003, .431]
N		1,456,387

Figure B1 combines scatterplots of the relationship between response time and investigation time with SDI. While the plots suggest positive relationships, the quadratic regression lines in each panel (light blue) indicate that the apparent relationship is driven mostly by the concentration of calls in areas with very high SDI. The bivariate quadratic relationship between response time and SDI suggests response times peak at 14.4 minutes (95% CI: 14.35, 14.48) when SDI score is near 50, which is below the citywide mean SDI. The estimated response time is otherwise symmetric at 13 minutes at both SDI=10 and at SDI=90. The relationship between SDI and investigation time, on the other hand, is positive and linear based on the bivariate quadratic regression. A ten-point increase in SDI Score increases investigation time by approximately 45 seconds. Similarly, the probability of a report being written and of an arrest conditional on a Part I crime are positively related to SDI.

Figure B1. Relationship of SDI with Response Times and Investigation Times



The relationships suggested by the simple bivariate relationships are echoed in multivariate regression estimates.[27] The models indicate that the outcomes lack strong relationships with structural disadvantage after accounting for confounders. The regressions indicate statistically significant but substantively small relationships between SDI and response time, investigation time, and the probability of arrest.

There is no measurable relationship between race or ethnicity and the probability of report or arrest, and the relationship between the percentage of the community that is Black and the percentage that is Latine is negatively related to response time. There is no relationship between race and investigation time; percent Latine is negatively related to investigation time.

Table B2. Components of the Social Deprivation Index

SDI Component Description
Percent Population Less Than 100% FPL
Percent Population 25 Years or More with Less Than 12 Years of Education
Percent Non-Employed for Population 16-64 years
Percent Households Living in Renter-Occupied Housing Units
Percent Households Living in Crowded Housing Units
Percent Single Parent Families with Dependents < 18 years
Percent Households with No Vehicle

25 We base the former two measures on time elapsed between dispatch, arrival on scene, and the time when officers indicate the incident to be cleared. We focus on the sample of cases with non-missing arrival times in this analysis. The fixed effects regression methods we employ should mitigate the risk of potential bias in our estimates, but it is prudent to consider these results with caution. We also have observations that have response times that are negative or greater than six hours and investigation times greater than twelve hours; these are rare and we assume they are erratic.

26 The average SDI Score across all calls is 79 (where 100 equals the most extreme disadvantage and the national mean is 50).

27 Results available upon request.

The Abell Foundation
Suite 2300
111 S. Calvert Street
Baltimore, MD 21202-6174

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Evaluating Alternative Crisis Response in Denver's Support Team Assisted Response (STAR) Program: Interim Findings

Sarah Gillespie, Will Curran-Groome, Amy Rogin

September 2024

Since 2020, Denver, Colorado, has been operating a crisis-response program known as STAR (Support Team Assisted Response). The STAR program pairs paramedics and behavioral health professionals on designated vans to respond to certain 911 calls in lieu of a conventional response from law enforcement or other first responders. The STAR van teams work to de-escalate the immediate crisis and make referrals to a network of community-based service providers through the STAR Community Partner Network. The STAR program offers an alternative to having police respond to behavioral health crises—reducing the potential for clients to experience additional trauma—and connects clients with resources that can help them obtain stability and address their longer-term service needs.

This report is part of an ongoing evaluation of the STAR program. Our prior brief described the STAR program and its early implementation (Gillespie, McGilton, and Rogin 2023). Here, we describe preliminary findings from our analyses of 911, public safety, and STAR encounter data collected from the Denver Department of Safety and WellPower, the mental health services organization that staffs STAR van teams. We also describe findings from qualitative data collected through surveys and interviews with STAR program stakeholders, staff, and clients.

This brief reflects early stage findings and is intended to keep program stakeholders informed about, and invite their input in, the ongoing evaluation. Next, we plan to identify a comparison group so that we can measure differences in public safety outcomes for people who received STAR services compared to people with similar characteristics who did not receive STAR services. We also plan to use

data collected by the STAR Community Partner Network to understand STAR follow-up referrals and services. Our goal for this year is to release a public report focused on STAR outcomes, conduct a cost study to better understand the public benefits and costs of the program, and perform a scaling-up assessment to estimate the full demand for STAR services and the implementation and budget requirements for meeting that demand.

Below is a summary of the research questions addressed in this brief and associated key findings. We then describe these findings in greater detail with accompanying figures, and conclude with a description of next steps for the evaluation of the STAR program.

Research Questions and Key Findings

Outcomes Study

1. What are the characteristics of STAR-eligible calls for service to 911?

- There were 38,375 STAR-eligible calls for service from June 2020 to December 2023 (see figure 1).
- STAR-eligible calls for service increased notably from 2020–21 to 2022–23 (see figure 1).
- STAR van teams have responded to approximately 24 percent (n = 9,244) of STAR-eligible calls for service since the program started, and over time have responded to greater shares and absolute numbers of STAR-eligible calls for service. In 2023, van teams responded to 38 percent of STAR-eligible calls for service, compared with only 16 percent in 2020. These STAR responses include both clinical and nonclinical encounters (see figures 2 and 3).
  - » Approximately 9 percent of STAR-eligible calls (n = 3,301) did not have a vehicle assigned from any agency. According to 911, a vehicle might not be assigned to a call if the original caller calls back and cancels the request or if the call is related to another call for which a vehicle has already been assigned.
- Most STAR-eligible calls for service—94 percent (n = 35,897)—occurred during STAR operating hours (figure 4).1
- Beginning in February 2023, the City and County of Denver began tracking caller requests for STAR-only assistance, in which the caller requests that only STAR van teams respond and no other agency.
  - » From February to December 2023, there were 467 STAR-eligible calls for service in which the caller requested STAR-only assistance (4 percent of all STAR-eligible calls during this time period), with the monthly number of such calls increasing substantially over the course of the year.
  - » STAR van teams responded alone to 50 percent of these STAR-only calls and responded with another agency—including the police—to an additional 13 percent. (By

comparison, in 2023, STAR van teams responded alone or with another agency to 31 percent of all STAR-eligible calls for service that were not STAR-only calls.) Police responded alone or with another non-STAR agency to 21 percent of STAR-eligible, STAR-only calls; nonpolice agencies responded to 1 percent of these STAR-only calls; and there was no responding vehicle for 15 percent of these calls.

- STAR van teams also responded to incidents that were not initially flagged by 911 as STAR-eligible calls for service. These incidents typically occur when another agency responds to a call for service, but then identifies STAR van teams as an appropriate responding agency.
  - » There were 7,899 such responses (reflecting 46 percent of all STAR responses) from June 2020 to December 2023.
  - » The characteristics of such responses were similar to those of all STAR-eligible calls for service.

2. **What are the characteristics of the calls for service to which STAR van teams respond and provide clinical services and what are the characteristics of the people served during these encounters?**

   - WellPower data reflect 6,700 clinical STAR encounters—a subset of the broader population of clinical and nonclinical STAR encounters reflected in call-for-service data—from June 1, 2020, to October 31, 2023, with 4,435 distinct individuals.[2]
     - » For the 12 months, from November 2022 to October 2023, that the STAR program has been operating at full implementation, STAR van teams had an average of 319 clinical encounters per month.
   - Approximately one in five people with a clinical STAR encounter had multiple such encounters.
   - More than three-quarters of all clinical STAR encounters identified "mental health" as a priority issue. By contrast, "suspected substance use" was cited as a priority issue in less than 20 percent of encounters (see figure 9).

Community-Engagement Network Study

3. **How was the network of service providers in the STAR Community Partner Network established? Who are the providers? What is the linguistic, cultural, and geographic diversity across providers? Are clients satisfied with the providers?**

   - All STAR Community Partner Network member organizations are BIPOC-led and have unique roles and connections with specific communities.
   - The goals of the Partner Network are to provide culturally, linguistically, and geographically responsive services based on client needs and to increase access to and utilization of services.

- Partner Network member organizations reported that some STAR clients expressed relief when connected with a culturally specific provider.

4. **How are STAR clients connected to services? What types of services are most commonly referred? What service gaps exist in the provider network? Are clients satisfied with the services?**

    - Partner Network member organizations receive referrals from STAR van teams through a shared data system. Servicios de La Raza serves as the hub organization for referrals; that is, it assigns referrals to appropriate member organizations based on cultural factors, client needs, and client preferences.
    - Partner Network member organizations noted challenges with receiving referrals and communicating and building trust with STAR van teams. The member organizations estimate they receive referrals for less than 20 percent of STAR encounters, even though they have capacity to take many more.
    - Data collection efforts for the STAR Client Survey were very difficult, with only 18 complete responses received. Case managers at Servicios de La Raza recorded over 130 meetings with clients during which they deemed it was inappropriate to offer the survey given the sensitivity of clients' needs.
        - » Collected client feedback on STAR encounters were largely positive.
        - » Housing; mental health services; food, clothing, or other basic needs; and transportation were the most commonly identified long-term service needs of clients in both the STAR Client Survey (see figure 10) and the Community-Based Survey.

5. **How does the STAR Community Partner Network facilitate access to community-based services at a systems level? What barriers to services are being addressed and what challenges remain?**

    - All Partner Network member organizations identified housing as the biggest unmet need as well as a need for which they can offer few resources.
    - All Partner Network member organizations identified wait times for initial mental health intake appointments at large community-based mental health organizations as a significant barrier to providing ongoing services (e.g. psychiatric and clinical services beyond what is provided by the Partner Network).
    - Many Partner Network member organizations identified major barriers to connecting people with disabilities to appropriate services.
    - Many Partner Network member organizations identified a need for more community outreach and education about the STAR program to reach those who need culturally specific services and who are less likely to call 911 or seek services from larger service providers that are not culturally specific.

Data Considerations

Current data limitations impact our ability to answer some key research questions. Table 1 highlights some of the major limitations, their implications, and related needs to address or minimize the impact of these limitations on the evaluation. We will continue to work with STAR program leaders to address these data limitations as the evaluation moves forward.

TABLE 1

Data Limitations, Implications, and Needs

Limitations	Implications	Needs
911 call-for-service data do not identify individual people.	We are unable to analyze 911 calls for service in relation to other related data, such as data on arrests and bookings. Only clinical STAR encounters have information that allows us to link calls for service to other public safety data. Initially, we planned to use call-for-service data as the source for identifying a comparison group, but we realized we cannot do so without individual identifiers that link to arrests and bookings.	An alternate source of data that includes personal identifiers for a population as similar as possible to those who had clinical STAR encounters. We are currently exploring whether street-check data could address this need.
WellPower data shared with Urban do not include demographic characteristics.	Without comprehensive demographic data on WellPower STAR encounters, we cannot describe trends, such as who had such encounters and what their subsequent criminal-legal system engagements look like. We also cannot create an accurate comparison group that parallels the demographic characteristics of those who had STAR encounters.	Demographic data for all WellPower STAR encounters.
The response rate was very low for the STAR Client Survey.	Findings from the STAR Client Survey were not representative of all people who encountered STAR van teams. Collecting client feedback remains an important goal across all STAR stakeholders, Partner Network staff, and community members.	More robust mechanisms to collect feedback from people who encounter both STAR van teams and STAR Community Partner Network member organizations.

Source: Authors' analysis.

Outcomes Study

One component of the STAR program evaluation is an analysis of quantitative program data. In this section, we describe STAR-eligible calls for service—that is, calls dispatched through 911 that are marked as appropriate for STAR van teams—using data from the Denver Department of Safety. We then focus on clinical STAR encounters[3]—that is, encounters with STAR van teams during which a substantive service need was identified and documented—using data from WellPower that describe the characteristics of these encounters and clients.

STAR-Eligible Calls for Service

All STAR-eligible calls for service include calls routed through 911 that dispatchers identify as appropriate for a STAR van team—instead of a conventional response by police or other first responders—based on characteristics such as the focus of the call (e.g., welfare check, intoxication, etc.) and the absence of any safety threats.[4] Note that the data on STAR-eligible calls for service include both those to which STAR van teams did and did not respond and do not distinguish between clinical and nonclinical STAR encounters; WellPower STAR encounter records, which describe only clinical encounters, correspond to far fewer calls for service than are reported in this data. This section also briefly covers data for calls that were *not* initially flagged as STAR-eligible but to which STAR van teams responded. These incidents typically occur when another agency responds to a call for service, but then identifies a need for a STAR van team to respond.

- There were 38,375 incidents in the call-for-service data reflecting the calls that were designated as STAR-eligible from June 2020 to December 2023 (figure 1).
- STAR-eligible calls for service increased notably from 2020–21 to 2022–23 (figure 1).
- There were no consistent trends in seasonality of STAR-eligible calls for service (figure 1).
- STAR van teams have responded[5] to approximately 24 percent (n = 9,244) of STAR-eligible calls for service since the program started, and over time have responded to greater shares and absolute numbers of STAR-eligible calls for service. In 2023, van teams responded to 38 percent of STAR-eligible calls for service, compared with only 16 percent in 2020. These STAR responses include both clinical and nonclinical STAR encounters (figures 2 and 3).
  - » This aligns with the shift from the pilot phase of the program to full implementation in spring 2022 (figure 3).
  - » As noted above, we were unable to distinguish between clinical and nonclinical STAR encounters; therefore, all data on STAR encounters in this section include both clinical and nonclinical encounters.
  - » Approximately 9 percent (n = 3,301) did not have a vehicle assigned from any agency. According to 911, a vehicle might not be assigned to a call if the original caller calls back and cancels the request, or if the call is related to another call for which a vehicle has already been assigned.
- The police department responds alone or with another non-STAR agency to 60 percent of all STAR-eligible calls for service, while STAR van teams respond alone to 17 percent (figure 3).
  - » STAR van teams respond in combination with the police to 6 percent of all STAR-eligible calls for service and in combination with other nonpolice agencies to 1 percent of calls.
  - » Calls that police arrived to first and STAR arrived subsequently account for 16 percent of all calls that STAR responded to (n = 1,454). Calls that STAR arrived to first and the

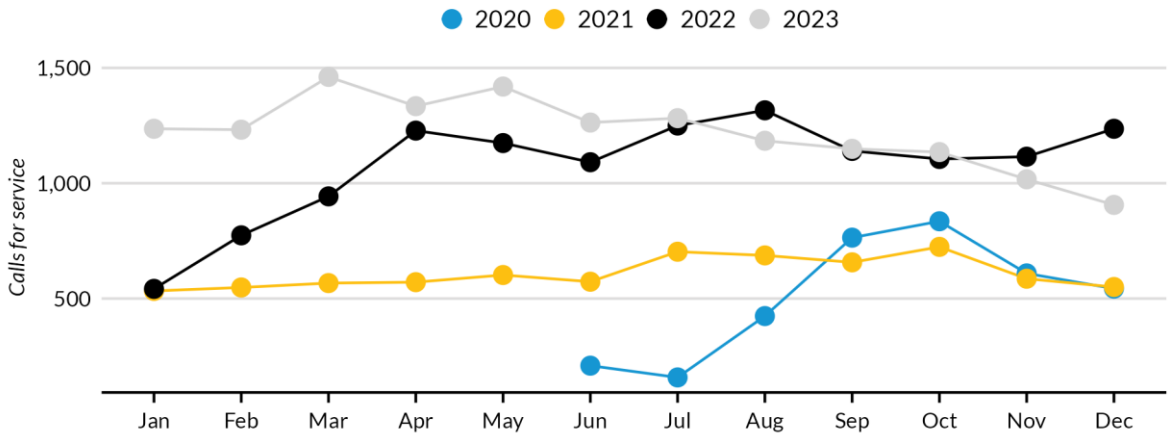
police arrived subsequently account for 7 percent of all calls that STAR responded to (n = 655).

- Most STAR-eligible calls for service—94 percent (n = 35,897)—occurred during STAR operating hours (figure 4).
- Welfare-related problems ("welfare check" problem codes) account for roughly half of all STAR-eligible calls for service and two-thirds of all STAR van team responses (figure 5).
- Beginning in February 2023, the City and County of Denver began tracking caller requests for STAR-only assistance: when the caller desired to have only STAR van teams respond and not another agency.
  - From February to December 2023, there were 467 STAR-eligible calls for service in which the caller requested STAR-only assistance (4 percent of all STAR-eligible calls during this time period), with the monthly number of such calls increasing substantially over the course of the year.
  - STAR van teams responded alone to 50 percent of STAR-only calls and responded with another agency—including the police—to an additional 13 percent. (By comparison, in 2023, STAR van teams responded alone or with another agency to 31 percent of all STAR-eligible calls for service that were not STAR-only calls.)
  - Police responded alone or with another non-STAR agency to 21 percent of STAR-only calls; nonpolice agencies responded to 1 percent of STAR-only calls; and there was no responding vehicle for 15 percent of calls.
    - Of STAR-only calls that did receive a response, STAR responded alone to 59 percent of calls and in combination with a nonpolice agency to another 5 percent of calls; STAR and the police both responded to 10 percent of calls; and the police (with or without another non-STAR agency) responded to 24 percent of calls.
- STAR van teams also responded to incidents that were not initially flagged as STAR-eligible calls for service. These incidents typically occur when another agency initially responds to a call for service, but then identifies the need for a STAR van team.
  - There were 7,899 such responses (reflecting 46 percent of all STAR responses) from June 2020 to December 2023.
  - The characteristics of such responses were similar to general STAR-eligible calls for service:
    - They increased in volume beginning in early 2022.
    - They followed a similar temporal distribution, with the greatest share of responses occurring in the late morning and early afternoon.
    - The "welfare check" problem code was the most frequently used, though "suicide or self-harm" was relatively more common compared with the broader set of STAR-eligible calls for service.

FIGURE 1

STAR-Eligible Calls for Service by Year and Month (N = 38,375)

Monthly STAR-eligible calls have increased substantially year over year.



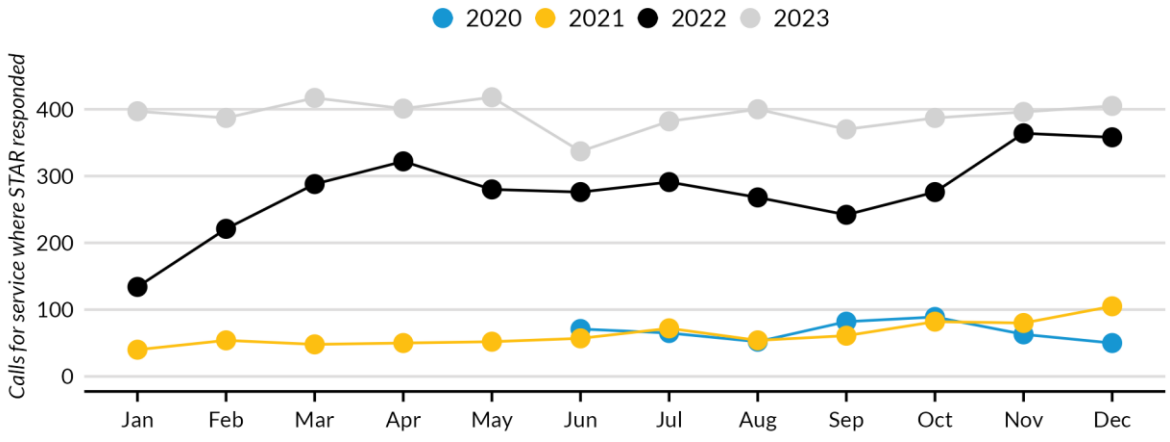
URBAN INSTITUTE

Source: Authors' analyses of STAR-eligible call-for-service data provided by the City and County of Denver.
Note: Data for this figure include STAR services from June 2020 (beginning of STAR program implementation) to December 2023.

FIGURE 2

STAR-Eligible Calls for Service to Which STAR Responded by Year and Month (N = 9,244)

Monthly STAR-eligible calls have increased substantially year over year.



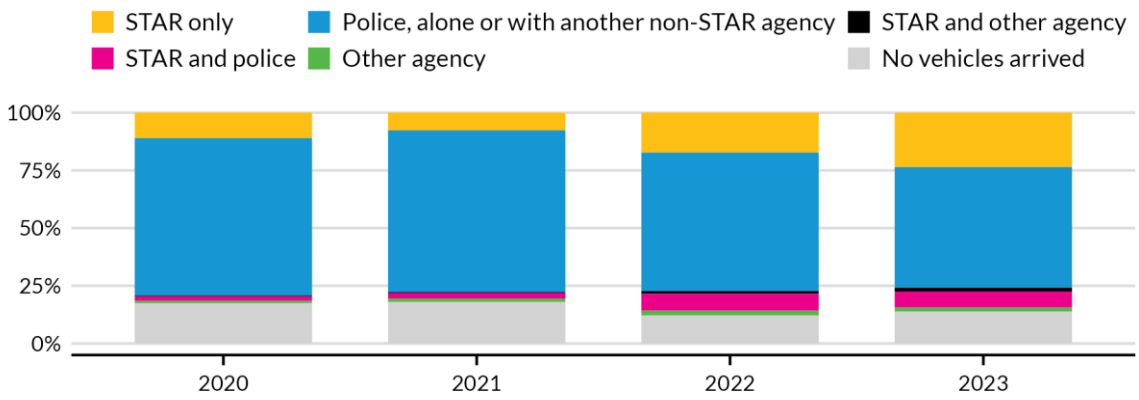
URBAN INSTITUTE

Source: Authors' analyses of STAR-eligible call-for-service data provided by the City and County of Denver.
Notes: The STAR program began in June 2020 and the dataset used for this figure reflects STAR services through December 2023. Accordingly, counts of STAR-eligible calls for service were not available for January to May 2020. Calls to which STAR van teams responded include those to which other agencies responded as well. "Responded" includes calls with listed vehicle arrival times and calls for which five or more minutes elapsed between the time the call was assigned and when it was cleared.

FIGURE 3

STAR-Eligible Calls for Service by Responding Agency by Year (N = 38,375)

In 2023, STAR van teams alone responded to one in five of all STAR-eligible calls for service—the highest share of calls for any year to date.



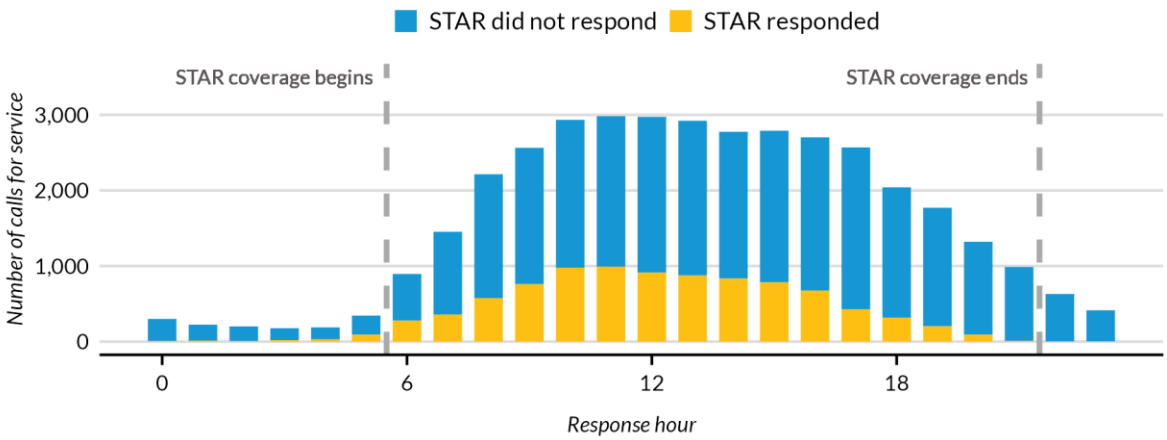
URBAN INSTITUTE

Source: Authors' analyses of STAR-eligible call-for-service data provided by the City and County of Denver.
Note: "Non-STAR agency" includes the fire department, emergency medical service (referred to as "EMS" in the data), detoxification (referred to as "DTX" in the data), and animal protection (referred to as "DAP" in the data).

FIGURE 4

STAR-Eligible Calls for Service by Time of Day (N = 38,375)

STAR-eligible calls for service outpace STAR responses by more than three to one.



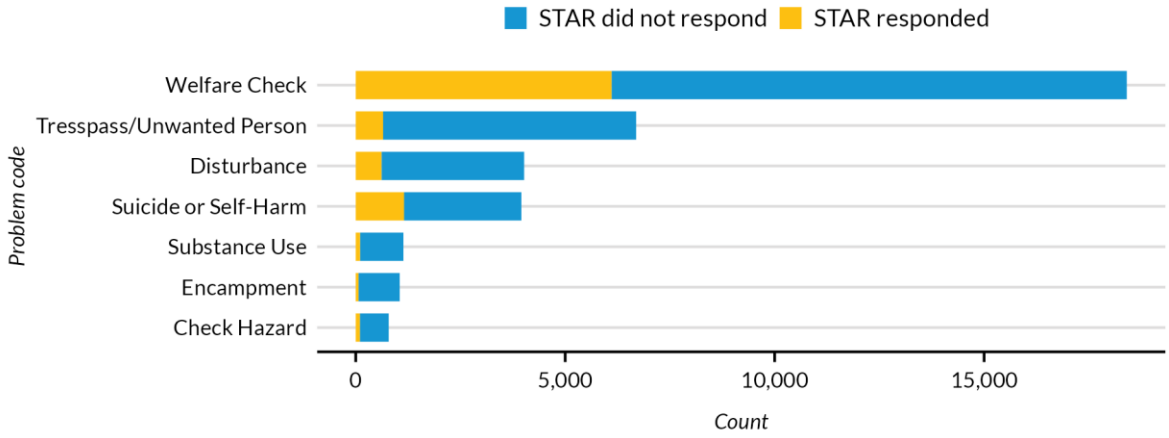
URBAN INSTITUTE

Source: Authors' analyses of STAR-eligible call-for-service data provided by the City and County of Denver.
Note: STAR-eligible calls for service categorized as occurring in hour zero came in between midnight and 1 a.m., while calls occurring in hour 23 came in between 11 p.m. and midnight.

FIGURE 5

STAR-Eligible Calls for Service by Problem (N = 36,049)

Welfare checks account for most STAR-eligible calls and STAR van team responses.



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Source: Authors' analyses of STAR-eligible call-for-service data provided by the City and County of Denver.
Notes: There are 170 different problem codes in the call-for-service data. We collapsed related codes using the following logic: "Welfare Check" = welfare or assist; "Disturbance" = disturbance, indecent, suspicious occurrence; "Suicide or Self-Harm" = suicide; "Substance Use" = narcotics, intoxicated, overdose, detox, syringe. We omitted codes that were used for ≤500 calls for service; in total, the omitted codes accounted for 2,133 calls (6 percent of all calls for service that had an associated problem). According to staff at Denver 911, the "Encampment" code is primarily used for tracking calls relating to encampments, not for dispatching Denver Police or STAR staff; in cases when STAR van teams do respond to "Encampment" calls, the precipitating incident relates to the wellbeing of someone in an encampment, not a more general response to the presence of an encampment. The "Check Hazard" code primarily describes incidents when an individual is on or near a roadway, such as when a person is walking or standing in the middle of a road.

Clinical STAR Encounters

When a STAR van team has an interaction with a person that leads to identifying and documenting a substantive need (deemed a "clinical encounter"), they collect information on the client using a clinical-encounter form. This data is important for tracking the nature of the interaction and the services that clients receive. WellPower provided the data for these clinical STAR encounters from June 1, 2020 (when the STAR program began), to October 31, 2023.

- WellPower data reflect 6,700 clinical STAR encounters from June 1, 2020, to October 31, 2023.
- Akin to the trends in the call-for-service data, clinical STAR encounters increased notably from 2020–21 to 2022–23. This is in line with the transition from the program's pilot phase to full implementation (figure 6).
- Approximately one in five people with a clinical STAR encounter had multiple clinical STAR encounters.

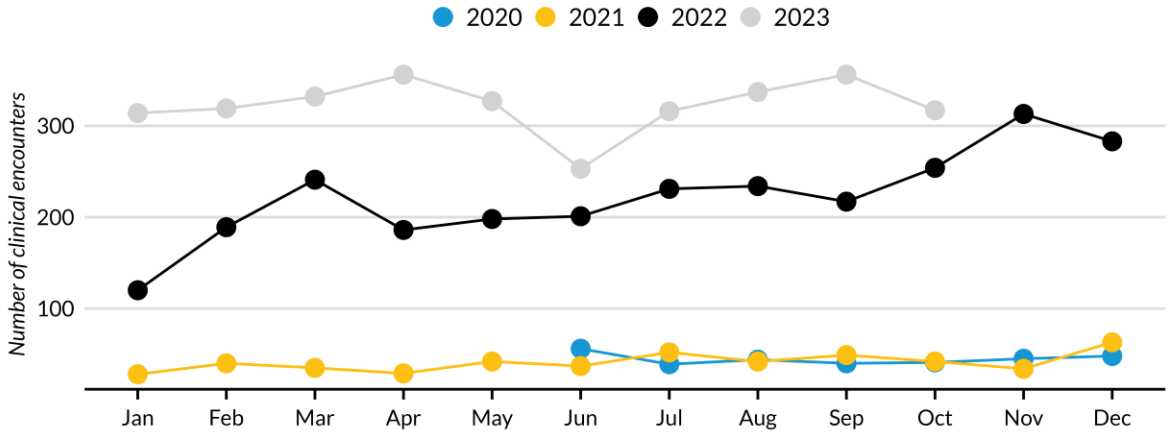
- » A small subset of high-frequency clients (n = 37) had 10 or more clinical STAR encounters; one individual had 42 clinical STAR encounters.

- Clinical STAR encounters are most common in the middle of the day, akin to trends reflected in the call-for-service data (figure 7).
- More than three-quarters of all clinical STAR encounters identified "mental health" as a priority issue (figure 8).

FIGURE 6

Clinical STAR Encounters by Month and Year (N = 6,700)

There were often more than four times as many clinical STAR encounters every month in 2022 and 2023 as in 2020 and 2021, which is consistent with the timeline for scaling STAR implementation.



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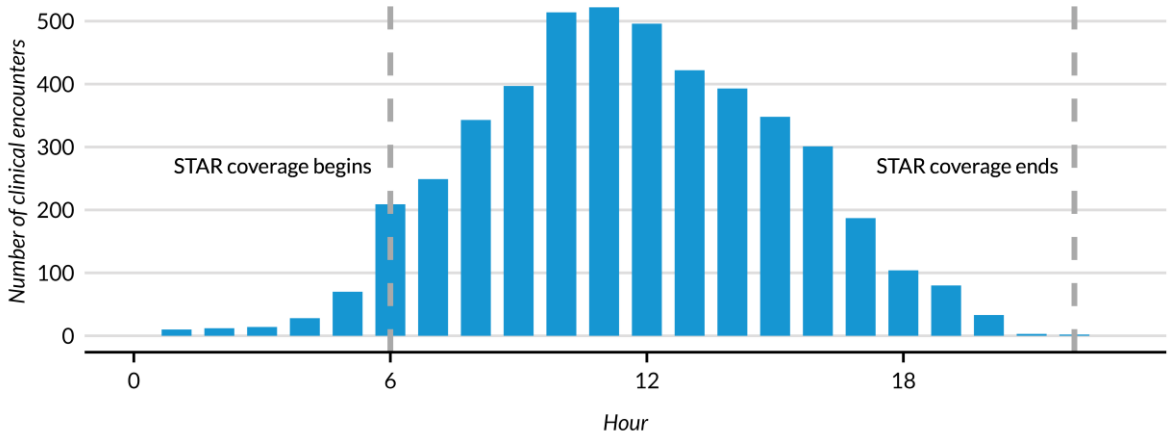
Source: Authors' analyses of Support Team Assisted Response (STAR) encounter data from WellPower.
Notes: The STAR program began in June 2020 and the dataset used for this figure reflects STAR services through October 2023. Accordingly, counts of STAR-eligible calls for service were not available for January to May 2020 nor for November to December 2023.

FIGURE 7

Clinical STAR Encounters by Time of Day (N = 4,742)

Clinical STAR encounters are most frequent from 10 a.m. to 4 p.m.



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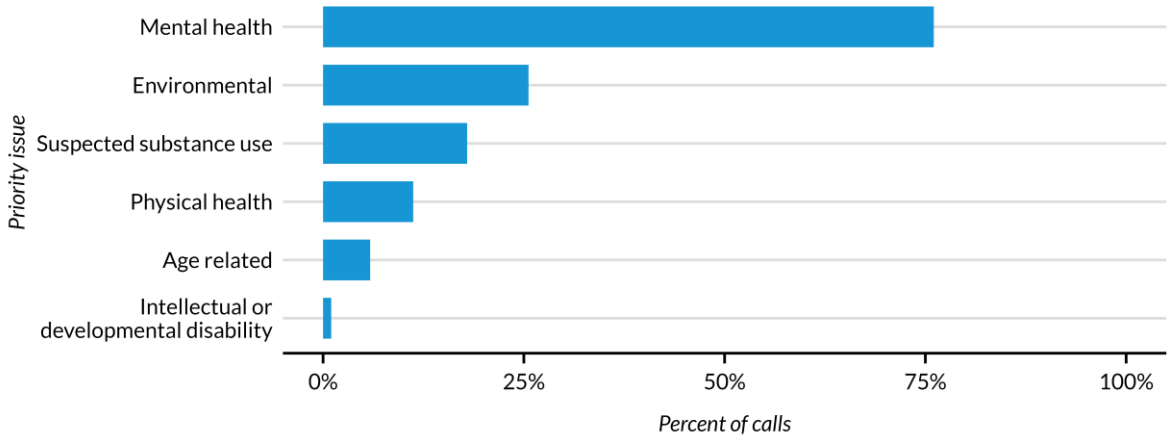
Source: Authors' analyses of Support Team Assisted Response (STAR) encounter data from WellPower and STAR-eligible call-for-service data provided by the City and County of Denver.

FIGURE 8

Clinical STAR Encounter Priority Issues (N = 6,700)

"Mental health" is identified as a priority issue in three-quarters of all clinical STAR encounters.



URBAN INSTITUTE

Source: Authors' analyses of Support Team Assisted Response (STAR) encounter data from WellPower.
Notes: An additional category of "Diagnosis previously given" was indicated 14 times in the data, but it has been omitted from the figure for clarity. Priority issues are not exclusive; as a result, categories in the figure add to more than 100 percent.

Community-Engagement Network Study

Another key component of the STAR program evaluation is to understand client and community experiences with the program and how clients who encounter STAR van teams are connected to follow-up services through the STAR Community Partner Network. In this section, we highlight: (1) findings from surveys and interviews with people who encountered STAR van teams and were referred to the STAR Community Partner Network, (2) an electronic survey of people in the community who have interacted with the STAR program, and (3) interviews with staff from STAR Community Partner Network member organizations who receive client service referrals from STAR van teams.

STAR Client Survey Findings

To understand STAR clients' experiences and perceptions of the STAR program, we partnered with Servicios de La Raza to administer a client feedback survey. Case managers at Servicios de La Raza administered the survey to clients between June 29, 2023, and November 21, 2023, though the online software Qualtrics. Clients who completed the survey were offered an opportunity to provide more detailed feedback through a follow-up interview with Urban Institute.

A main takeaway from the survey effort was how challenging it can be to identify an appropriate time to follow up with STAR clients to request feedback. Case managers often did not think it was appropriate to offer the survey to clients because of the sensitivity of clients' needs. Overall, we received 18 completed surveys. Among clients who completed the survey, we conducted 5 follow-up interviews. Beginning on August 30, 2023, case managers began tracking whether they offered the survey to clients; if the survey was not offered, their reasons for not offering it; and the number of times they offered the survey (surveys could be offered up to four times to each client). These data points helped us understand barriers to survey uptake. When clients declined to take the survey, the most common reasons were that they did not remember their encounter with the STAR van teams (n = 10; 7 percent) and that they did not want to provide feedback (n = 10; 7 percent).

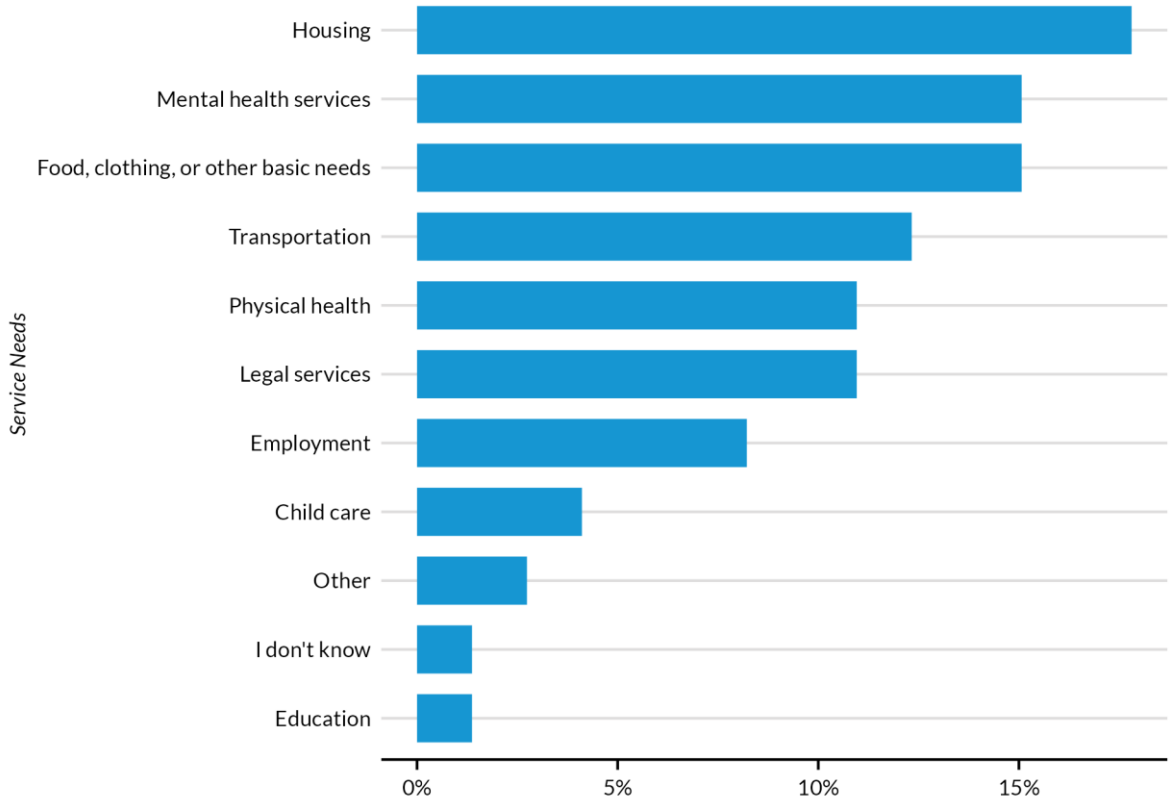
These findings are not representative of all people who encountered STAR van teams, given the very small number of survey responses and interviews. Among people who chose to complete the survey, feedback on the STAR program was largely positive. Their feedback mainly focused on encounters with the STAR van teams, because the survey was usually fielded at an intake meeting with the STAR Community Partner Network before follow-up services were provided.

- Over two-thirds (72 percent) of respondents agreed or strongly agreed that the STAR van teams understood and respected them, and 88 percent of respondents agreed or strongly agreed that the STAR program is an important program in Denver.
    - » These sentiments were also clear in follow-up interviews. Clients reported: "They really help your situation," and "They are able to help me get out of trouble, help me calm down, and get me what I need."

- Some respondents reported negative experiences with STAR van teams. Five respondents disagreed or strongly disagreed that the STAR van teams helped them get what they needed. During one follow-up interview, a client expressed concern that the STAR van team did not provide appropriate service connections and supports when they were in acute crisis and had clearly communicated their need and desire for mental health care.
- The most commonly identified long-term service needs of clients were housing; mental health services; food, clothing, or other basic needs; and transportation (figure 9).

FIGURE 9

Long-Term Service Needs Identified by STAR Client Survey Participants (N = 18)



URBAN INSTITUTE

Sources: Authors' analyses of survey data from clients who had a STAR encounter.

STAR Community-Based Survey

To understand the impact of the STAR program on the broader community, we fielded an online survey to capture the perspectives of people in the community who interacted with STAR van teams. We shared the online survey with the STAR Community Advisory Committee's and Caring for Denver's email lists of community organizations. The survey was open from July to October 2023.

Overall, we received 16 completed surveys. These findings are not representative of all people in the community who encountered STAR van teams, given the small number of survey responses. The survey focused on encounters with STAR van teams because the STAR Community Partner Network was still beginning implementation when the survey was designed and fielded. The following findings may help inform ongoing conversations about the impact of the STAR program in the community.

- The survey was primarily completed by people who called for a STAR van team response for someone else—a stranger (38 percent), a family member/friend (19 percent), or a witness to a STAR response (31 percent); one person who completed the survey received a STAR response.
- Half of the surveys completed (50 percent) were for STAR van team encounters that happened in downtown Denver, while the remainder were for encounters that happened across the rest of Denver.
- When asked about what went well during STAR van team encounters, open-ended survey questions identified the following themes in the responses:
  - Timely response to a call for service
  - Positive interactions with staff
    - Good tone, body language, patience
    - Professional, compassionate, and kind demeanor
  - De-escalation of crisis
  - Avoidance of criminal-legal action
  - Information and support in accessing services, such as to a shelter or Solutions Center
- When asked about what did not go well during STAR van team encounters, responses to open-ended survey questions identified the following themes:
  - Police respond when STAR van teams are not available
  - STAR van teams call for police backup
  - STAR van teams leave while crisis is still ongoing
  - STAR van teams do not provide enough information about appropriate services
  - STAR van teams do not follow up with the community-based service provider who made the call for service to coordinate ongoing client care
- When asked about how STAR van team encounters could be improved, responses to open-ended survey questions identified the following themes:
  - Quicker response times
  - More warm handoffs to case management and mental health services after the crisis
  - More teams and more vans
  - No police involvement
  - More trauma-informed training for STAR staff

    - » More solutions for needs that STAR van teams cannot meet, such as housing and immediate mental health care

- Similar to the needs identified in the STAR Client Survey (figure 10), the most commonly identified long-term service needs among those who responded to the STAR Community-Based Survey were mental health (75 percent); housing (69 percent); and food, clothing, or basic needs (56 percent).

STAR Community Partner Network Interviews

To understand implementation of services by the STAR Community Partner Network, which consists of six member organizations, we interviewed staff from four member organizations: Servicios de La Raza, DASHR, Struggle of Love Foundation, and Muslim Family Services. The staff from the other two member organizations—Face It Community and GRASP—were unavailable at the time we completed interviews in October and November 2023. We asked about goals, referral processes, client service needs, strengths of the Partner Network, challenges faced by the Partner Network, and suggestions for improvement. The following findings may help support conversations about potential midcourse adjustments and ongoing implementation of the STAR Community Partner Network.

GOALS OF THE STAR COMMUNITY PARTNER NETWORK

- Provide culturally, linguistically, and geographically responsive services based on client needs and increase access to and utilization of services.
    - » Partner Network member organizations reported that some STAR clients expressed relief when connected with a culturally specific provider.
- Connect STAR clients to culturally, linguistically, and geographically specific providers to increase client safety and self-sufficiency.

STAR COMMUNITY PARTNER NETWORK REFERRAL PROCESSES

- STAR van teams send referrals to the Partner Network in Julota, a shared data system.
- Servicios de La Raza serves as the hub organization for referrals; that is, it triages referrals based on clients' needs, identified communities, and/or cultural preferences. It connects clients based on not just race/ethnicity but other specific needs mentioned in the initial referral made by the van teams. This work is necessary because not every member organization can provide the needed services and because some service providers are better aligned with clients' identified communities.
- Each member organization has its own client outreach process, which often involves calling clients and visiting them at the provided addresses. The process can also involve street outreach for people experiencing homelessness.
- Client outreach can be immediate for high-priority referrals, but often staff try to make contact within 24 hours of receiving the referrals.

- Current STAR-specific staffing at Servicios de La Raza includes one director and five case managers. Other Partner Network member organizations each have one to two case managers working on STAR referrals.

BIGGEST CLIENT SERVICE NEEDS

- Housing: Some Partner Network member organizations can provide limited emergency motel vouchers, but otherwise there is not much the Partner Network can offer regarding housing.
  - » Some member organizations estimate that approximately 65 to 70 percent of their STAR referrals are for unhoused people.
  - » Member organizations seek to help clients get access to emergency shelter.
    - A big challenge is finding shelter for people with disabilities.
  - » Member organizations also get calls to help clients with evictions.
- Mental health: Partner Network member organizations report long wait times for initial mental health intake appointments at large community-based mental health organizations (e.g. psychiatric and clinical services beyond what is provided by the Partner Network); STAR case managers try to access other options for mental health services like referrals to telehealth providers or other private providers with more immediate availability.
- Physical health
- Mentorship for youth and support for parents
- Basic needs, food, transportation, and survival gear like tents
- Employment and income supports
- Help navigating systems, such as schools, criminal justice, and hospitals

STRENGTHS OF THE STAR COMMUNITY PARTNER NETWORK

- Partner Network member organizations are all BIPOC-led organizations that have unique roles and connections with specific communities.
  - » Staff reported the Partner Network includes trusted organizations in the community.

CHALLENGES FACED BY THE STAR COMMUNITY PARTNER NETWORK

- The Partner Network estimates that less than half of all STAR van team encounters result in a referral to the Partner Network.
  - » While STAR van teams have more than 300 clinical encounters a month, the Partner Network receives 80–90 referrals a month maximum; and up to 25 percent of those referrals have no contact information.
- Long delays between STAR van team encounters and referrals to Partner Network member organizations can make it difficult to connect with clients.

- To increase referrals, Partner Network staff suggested having more direct communication with STAR van teams about the services Partner Network member organizations provide and the importance of providing culturally specific services for clients.
- Partner Network staff also emphasized that client crises are not one-and-done incidents; they can be cyclical. Partner Network staff would prefer to receive referrals for all people who have a clinical encounter with a STAR van team so that the Partner Network can work to address a client's overall needs to prevent the next crisis.

NEEDS AND SUGGESTIONS FOR ONGOING IMPLEMENTATION AS IDENTIFIED BY STAR PARTNER NETWORK STAFF

- Build trust and rapport between STAR van teams and Partner Network staff to work as a single STAR team.
- Allow Partner Network member organizations to conduct community outreach and education about the STAR program, especially about services provided by both the van teams and the Partner Network.
    - » Partner Network staff emphasized that people who need culturally specific services may be less likely to call 911, and therefore less likely to encounter STAR van teams and get connected to the Partner Network. They suggested more outreach to these specific communities, which Partner Network member organizations believe they are well positioned to take on.
- Remove barriers between STAR van teams and Partner Network member organizations by providing options for direct connections (e.g., phone, etc.), particularly when there is an urgent client need; for such clients, more warm handoffs from van teams to member organizations would be helpful.
- Provide better documentation for referrals, including client contact information and needs.
- Offer more cultural-competency training for STAR staff to underscore the need for culturally specific services. Clients may appear "service resistant" until they are connected with a culturally specific provider.

Next Steps

The analysis in this brief reflects an interim point in the STAR program evaluation. Subsequent evaluation reports will extend this analysis to inform decisions about the ongoing STAR implementation and possible expansion. Planned next steps for the evaluation include the following:

- **Ongoing outcomes study:** The evaluation will identify a comparison group to understand how the STAR program impacts subsequent criminal-legal system outcomes. It will also analyze referrals to the STAR Community Partner Network and follow-up services provided by the Partner Network.

- **Cost study:** The evaluation will pair outcomes with estimated program costs and estimated costs of system interactions (e.g., 911 calls, arrests, and jail stays) to quantify the public benefits and costs of the STAR program.
- **Scaling-up assessment:** The evaluation will estimate overall demand for the STAR program, examine demographic data to understand who encounters STAR van teams, and interview STAR stakeholders and Partner Network staff to evaluate goals for expansion and assess what would be needed to meet those goals while maintaining fidelity to the service model.

Notes

[1] Due to awareness of STAR's operating hours among 911 staff, calls that occur outside of STAR's operating hours may be marked as "STAR-eligible" with less frequency than similar calls that occur during STAR's operating hours.

[2] We received the WellPower data analyzed for this brief on approximately December 5, 2023.

[3] The data captured about individuals who interact with STAR van teams depend on the clinical significance of the encounter. All STAR van team responses have some data about the encounter, like the date it occurred. However, other information—including personal identifiers, demographics, and characteristics of the person's mental health at the time of the encounter—is collected only if the interaction is deemed "clinically significant" (i.e., when there is an imminent mental health or clinical need observed during the encounter). Otherwise, STAR staff may opt to not collect this information because they do not consider it prudent. Additionally, trauma-informed care practices may preclude collecting this information. While the call-for-service data reflect both clinical and nonclinical interactions, the "Clinical STAR Encounters" section in this brief refers to the smaller set of STAR encounters during which there was a clinically significant interaction.

[4] A small number of calls for service—roughly 1 to 2 percent of all STAR-eligible calls for service during our analysis period—are STAR-only requests that are not explicitly flagged as STAR-eligible but are functionally STAR-eligible. These calls are evaluated for STAR eligibility, and dispatched accordingly, akin to other STAR-only calls for service. In this report, "STAR-eligible" refers only to calls that are explicitly flagged as such by 911 staff.

[5] We consider a vehicle to have "responded" if either (1) a vehicle (a STAR van or a police car, for example) notes that it has arrived at a scene or (2) the time between when a vehicle is assigned to a call for service and when that vehicle marks that call for service as cleared is greater than or equal to five minutes. We include this second condition because many records do not have data about if or when a vehicle arrived on scene, but for many calls that don't have a recorded arrival time, the amount of time between when a vehicle is assigned to and cleared from a call is quite substantial. We also take this approach because STAR vans may respond to a call for service via a phone call, rather than physically driving to the location of a call for service, and because a time of arrival is not applicable for a phone-based response.

References

Gillespie, Sarah, Mari McGilton, and Amy Rogin. 2023. "Understanding Denver's STAR Program: Alternative Crisis Response in Denver." Washington, DC: Urban Institute.

About the Authors

Sarah Gillespie is associate vice president of the Metropolitan Housing and Communities Policy Center at the Urban Institute. Her research focuses on ending homelessness. She is a coprincipal investigator of the Denver Housing to Health evaluation and was the project director for the Denver Supportive Housing Social Impact Bond Initiative. She is also the principal investigator of the evaluation of Denver's STAR and Co-Responder programs and other evaluations of alternatives to arrest for people experiencing homelessness.

Will Curran-Groome is a research associate in the Metropolitan Housing and Communities Policy Center. His work focuses on issues of housing justice, land use, and climate change mitigation and adaptation.

Amy Rogin is a former data scientist in the Metropolitan Housing and Communities Policy Center. Her research interests include disaster resilience, housing affordability, and urban sustainability. Rogin holds a BA in environmental science with minors in data science and Middle Eastern studies from Northwestern University.

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500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

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May 31, 2023

Durham Holistic Empathetic Assistance Response Teams (HEART)

Pilot Program Report

Prepared for

Durham Community Safety Department
City of Durham
101 City Hall Plaza
Durham, NC 27701

Prepared by

Kristin Stainbrook, PhD and Sean Wire, MA
RTI International
3040 E. Cornwallis Road
Research Triangle Park, NC 27709

RTI Project Number 0201841.001

RTI INTERNATIONAL

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1. Background and Purpose

The City of Durham Community Safety Department (DCSD) was established in July 2021 to enhance public safety through community-centered alternative approaches to policing. After significant planning and stakeholder input, including extensive analysis of 911 call data, consultation with established programs, and community neighbor input, the City of Durham identified three alternative response approaches and a community outreach program to pilot under DCSD.

DCSD launched the four pilot programs under the Holistic Empathetic Assistance Response Teams (HEART) initiative. The goal of the programs is to reduce unnecessary law enforcement involvement in low-level, non-violent 911 calls and provide community members with on-scene response and support, as well as follow-up care. HEART provides a range of response options to ensure community members are connected to the right level of care. This is accomplished by triaging 911 calls for service, assessing the level of call risk, and directly dispatching the appropriate responders.

1.1 HEART Program

The HEART initiative provides a comprehensive approach to addressing community behavioral health crises through three types of responses to 911 calls for service: remote response, unarmed alternative response, and co-response. The primary functions of each response are described below.

Providing a Remote Response

Not all 911 calls require an in-person response. The *Crisis Call Diversion* (CCD) pilot embeds a mental health clinician in Durham's 911 call center. Callers who are experiencing behavioral crises but do not require an in-person response are diverted to the clinician to assess their needs. Clinicians may deescalate situations over the phone and provide follow-up calls to connect individuals to services; further the clinician provides support to other HEART responders and police while en route to the scene.

Providing an Unarmed, Community Response to Nonviolent Crises

Many 911 calls are more appropriated handled by clinicians. The *Community Response Team* (CRT) pilot dispatches three-person teams to calls for service that involve nonviolent behavioral health and quality of life concerns. A CRT is dispatched by 911 telecommunicators to respond in lieu of law enforcement officers. Comprising a licensed mental health clinician, peer support specialist, and an emergency medical technician (EMT), the team provides on-scene care to individuals in crisis.

Providing a Joint DCSD and Durham Police Response for Higher-Risk Calls

Pairing a clinician with specially trained officers can provide de-escalation for situations that may have a higher risk. The *Co-Response* (COR) pilot dispatches a licensed mental health clinician and a CIT (Crisis Intervention Team)-trained law enforcement officer team to respond to mental and behavioral health calls that may pose a higher safety risk than CRT calls do.

Providing Community-Based Follow-Up

Providing follow-up can increase the likelihood that people are connected to community-based care. The *Care Navigation* (CN) pilot provides follow-up to callers and their families to ensure they are connected to appropriate community-based care. These two-person teams comprise a peer support specialist and a licensed clinician. Additionally, all HEART teams may provide follow-up as time allows.

Criteria for Dispatching HEART Response

Durham's Emergency Communication Center (DECC) is the primary answering point for Durham City and County and is charged with dispatching police, fire, and emergency medical services, and community safety. DECC 911 telecommunicators record and prioritize incident calls, identify the status and location of responders in the field, and dispatch the appropriate responders. The specific 911 call criteria for routing calls to CCD, CRT, or COR pilots are provided in Exhibit 1.

Exhibit 1. HEART Pilot Response and 911 Criteria

Pilot Response	Types of 911 Calls Eligible to Provide Response*
Crisis Call Diversion (CCD)	Suicide threat; mental health crisis; other calls involving behavioral health concerns
Community Response Team (CRT)	Suicide threat; mental health crisis; trespass; welfare check; intoxicated person; prostitution; public indecency; and assist person calls where the person is not in possession of a weapon or physically violent toward others
Co-Response Team (COR)	Attempted suicide; custody issue; involuntary commitment; and any of the following where there is an increased risk of violence and/or a weapon is present: trespass; intoxicated person; panhandling/nuisance; indecency/lewdness; prostitution; physical/verbal disturbance; harassment; threat; reckless activity; abuse; threat; domestic violence

*CN provides follow-up to individuals after an initial interaction with CCD, CRT, or COR staff.

Self-Initiated and Follow-Up Encounters

In addition to 911 call dispatch, CRT and COR may "self-initiate" a field response if they observe a neighbor[1] in need of assistance or if they are approached by someone requesting assistance. For example, CRT or COR may self-initiate a trespass call if they are approached by a neighbor requesting assistance with a trespasser and 911 has not been called. However, if an encounter is does not fit a call-nature category, it is coded as a "HEART Assist." HEART Assists are brief encounters intended to provide immediate assistance to neighbors and maximize unallocated time in the field. Examples of situations where HEART may self-initiate an assist include observing a neighbor who appears to be unhoused and is going through a trash can or sleeping on building steps or seeing someone in emotional distress in a parking lot. All response teams provide follow-up to neighbors who had a HEART service encounter. HEART Assist and follow-up encounters are only initiated when staff are not occupied with an active call.

HEART Operational Areas

The pilot program operational locations and hours were identified based on extensive analysis of the greatest need. Except for CCD, which is phone-based, the HEART program operates in 12 police beats. The teams currently operate between the hours of 9 a.m. and 5 p.m., except for CRT, which operates from 10 a.m. to 9 p.m. The police beats and operational hours were selected to maximize impact—covering the locations and times with the highest call volume. The implementation of HEART within these operational parameters was intentional, providing DCSD with an opportunity to test out the practices and procedures on a smaller scale.

1.2 Purpose of Report

RTI International conducted an independent analysis of the HEART program data to provide a descriptive summary of the HEART pilot activities during its first year. The report details the types of 911 calls to which pilot teams were dispatched, the duration of each response, and the disposition (outcomes) of the calls. The report will also describe the demographics and service needs of individuals served by HEART.

2. Methods

The report uses data from the DCSD management information system, which also include data from DECC's Computer-Aided Dispatch (CAD) system from the period of project initiation (September 26, 2022 through March 31, 2023). It is important to note that the COR pilot was not launched until September 26, 2022, and therefore has a shorter operational timeframe.

[1] DCSD uses the term "neighbor" to refer to individuals served by the program. This term was strategically chosen to capture the relationship the program seeks to develop with people it serves.

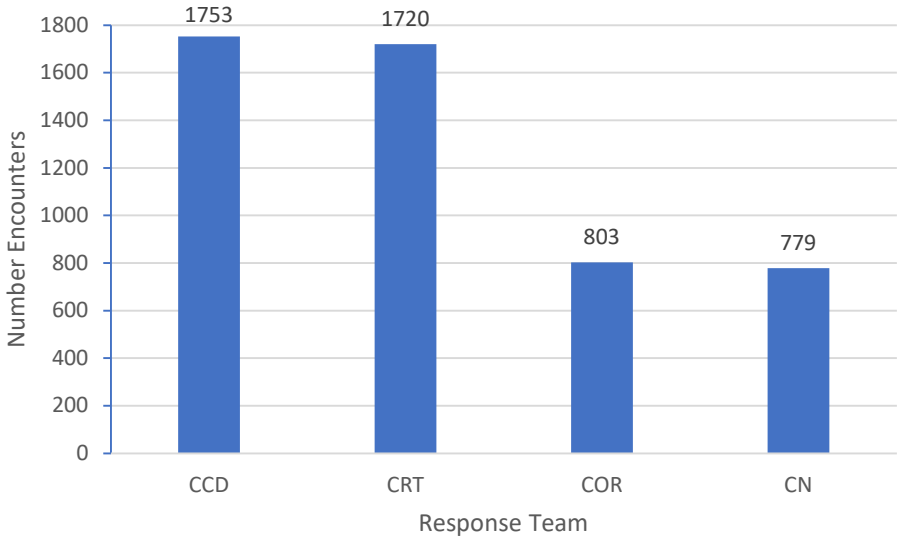
DCSD collects data on all HEART crisis response activities, including the types of calls to which HEART is dispatched, the amount of time responders spend on scene, and the disposition (result) of that call. The DCSD also includes call nature codes from the Durham ECC CAD system used to dispatch HEART responders.

3. Findings

3.1 HEART Calls for Service

The HEART program engaged in 5,055 service encounters—an average of 18 calls per day—between June 28, 2022, and March 31, 2023. These calls include the 911 dispatch and self-initiated calls. The volume of call responses has increased over time as the team has increased staff capacity and improved operational efficiency. During the initial implementation months, there were as few as seven responses per day; currently, the average is 23 call responses per day. Exhibit 2 presents the number of service encounters by response type.

Exhibit 2. HEART Service Encounters (N = 5,055)



Currently, the emergency dispatch system receives more eligible calls per day than the HEART teams have the capacity to handle. Analysis of the eligible calls in the service area (12 police beats) eligible to receive HEART response found that since program inception, CRT has answered 29.7% of eligible calls, CCD has answered 49.5%, and COR has responded to 12.9%. This is not an indictment of the teams' efficiency but rather an indication of the volume of calls that could be addressed by future program expansion. The following section describes the service encounters and call outcomes for the individual components of the HEART program, including the CCD, CRT, COR, and Care Navigator.

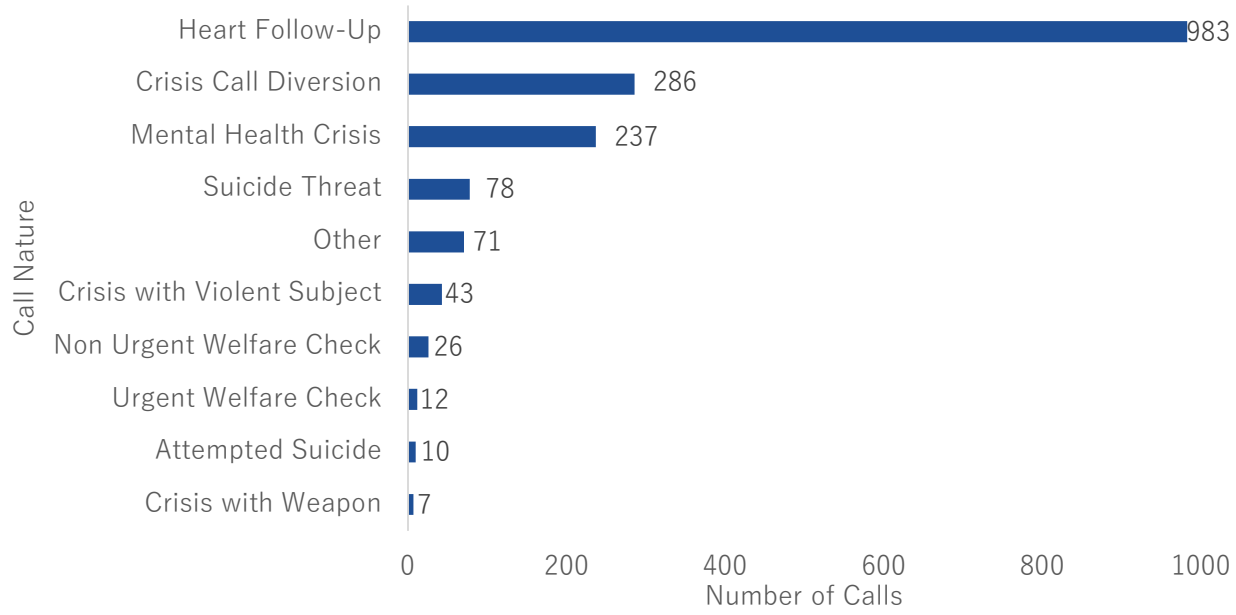
3.1.1 Crisis Call Diversion Response

During the observation period, CCD responded to 1,753 calls. Although the CCD counselor's primary function is to respond to incoming mental health–qualifying calls, CCD also provides proactive follow-ups to neighbors served by the CRT and COR responses and to callers requesting CCD services when the clinician is not available. A little over half (56%) of CCD service encounters were follow-up calls to neighbors requesting additional support. Among the service encounters initiated from 911 calls (N = 759), the most frequent call type was a request for crisis call diversion (N=265), followed by mental health crisis (N = 231). The crisis call diversion call nature code is used for individuals who are interested in talking with a clinician but are not in mental health crisis, such as someone seeking information on mental health–related resources for family members. In contrast, the mental health crisis call nature codes are used for calls in which remote counseling is provided. Exhibit 3 shows the CCD service encounters over the observational period.

CCD Provides Mental Health Support to Families

Many people call 911 seeking advice or guidance on supporting family members with mental health problems. CCD offers them information and community resources and supports.

Exhibit 3. CCD Call Nature Codes (N = 1,753)[2]

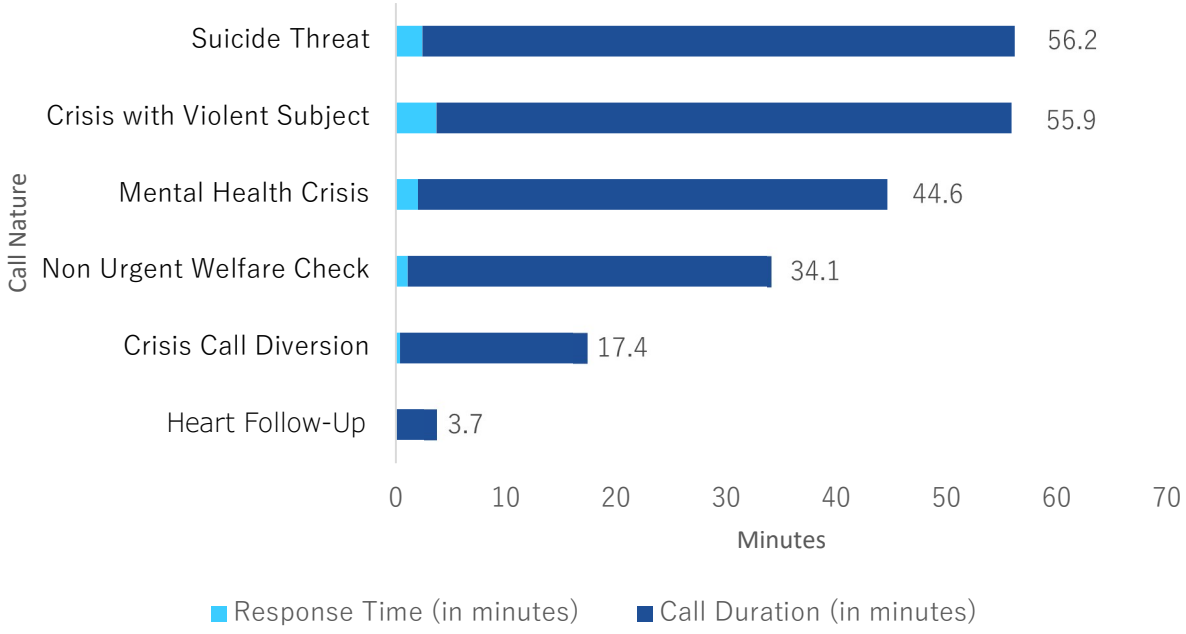


Note: 71 calls are not represented in this call nature distribution due to small sample size.

[2] These calls include both 911 and self-initiated follow-up calls.

Call Duration. CCD spent an average of 33.8 minutes on calls. Although calls related to suicide threats and violent subjects represent a small proportion of CCD service encounters (N = 78 and N = 43, respectively) these calls last the longest, an average of 56 minutes. In contrast, CCD calls, which typically provide informational support, last on average 17 minutes. Exhibit 4 shows the duration of the CCD service encounters over the observational period.

Exhibit 4. Average CCD Service Encounter Duration (N = 1,753)

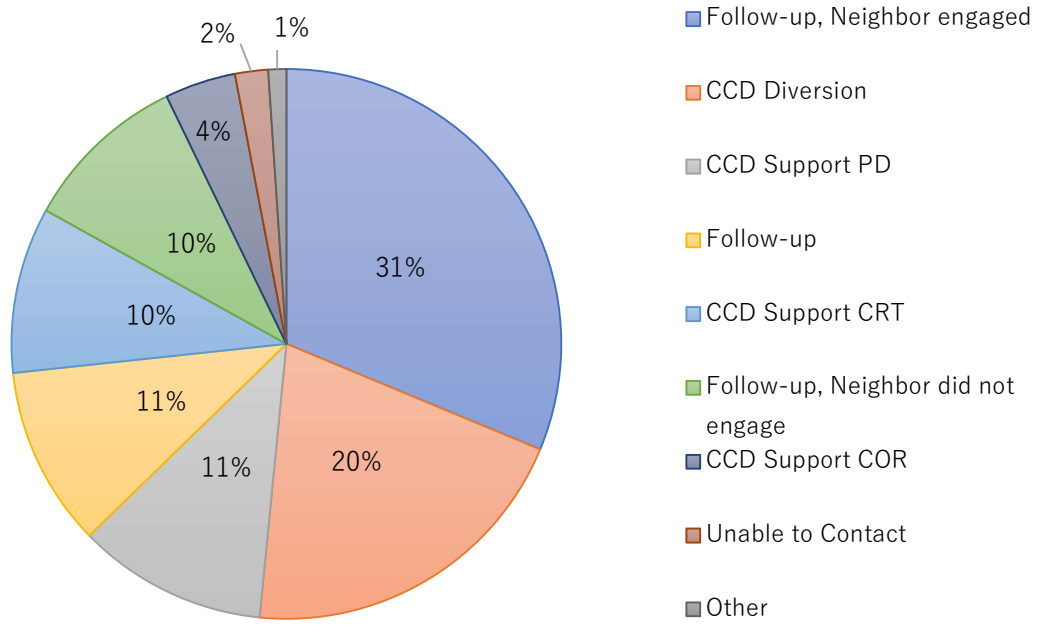


Call Dispositions. The primary goal of CCD is to resolve mental health crises over the phone and avoid unnecessary in-person responses. CCD documents the resolution of calls with disposition codes. CCD successfully resolved 49% (N = 372) of 911 calls without any in-person response. A secondary goal of CCD to provide phone support to callers while responders are en route to the scene. Among the remaining 911 calls, CCD supported police for 23% these calls (N = 184), supported CRT on 20% (N=163), and supported COR calls on 9% (N = 69). Exhibit 5 presents the dispositions of all CCD service encounters. Exhibit 5 shows the CCD disposition of service encounters over the observational period.

CCD Supports Police & HEART Responses

A neighbor who frequently calls 911 reported someone trying to break into their home. The neighbor refused to let in the police officer who responded on scene. The CCD clinician called the neighbor and talked with them until they felt comfortable speaking with the officer.

Exhibit 5. CCD Service Encounter Dispositions (N = 1,753)



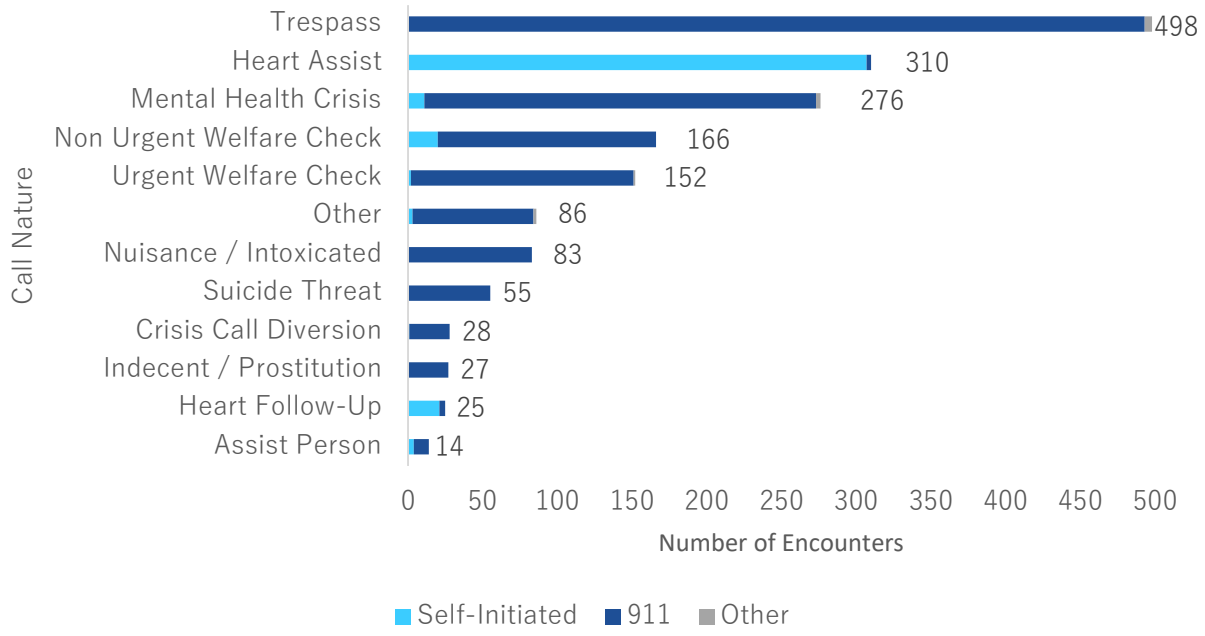
3.1.2 Community Response Team Activities

During the observation period, CRT responded to 1,720 events. These service encounters originated as responses to 911 calls and proactive "self-initiated" HEART Assist responses.[3] Most CRT service encounters (78%, N = 1340) were in response to resident 911 calls. The most frequent call natures are trespass calls (N = 498), mental health crises, (N = 310), and urgent welfare checks (N = 152). The self-initiated service events represent 21% (N = 369) of the service encounters, most of which are self-initiated "HEART Assists" (N = 303). As described in the introduction, the team typically self-identifies HEART Assist activities as a mechanism to provide immediate support to neighbors they observe in need between dispatch calls. As such, most of these activities do not fit a specific call nature criterion. However, there were a few self-initiated call natures that are categorized as non-urgent welfare checks and mental health crises, as shown in Exhibit 6.

CRT Help Deescalate Situations

Some CRT service encounters are generated from complaints from businesses (e.g., shelters, service providers) regarding neighbors who are causing a scene or are in conflict with their policies. Prior to HEART, police would have been called to the scene. CRT has successfully deescalated numerous situations without police involvement.

Exhibit 6. CRT Call Nature Service Encounters (N = 1,720)

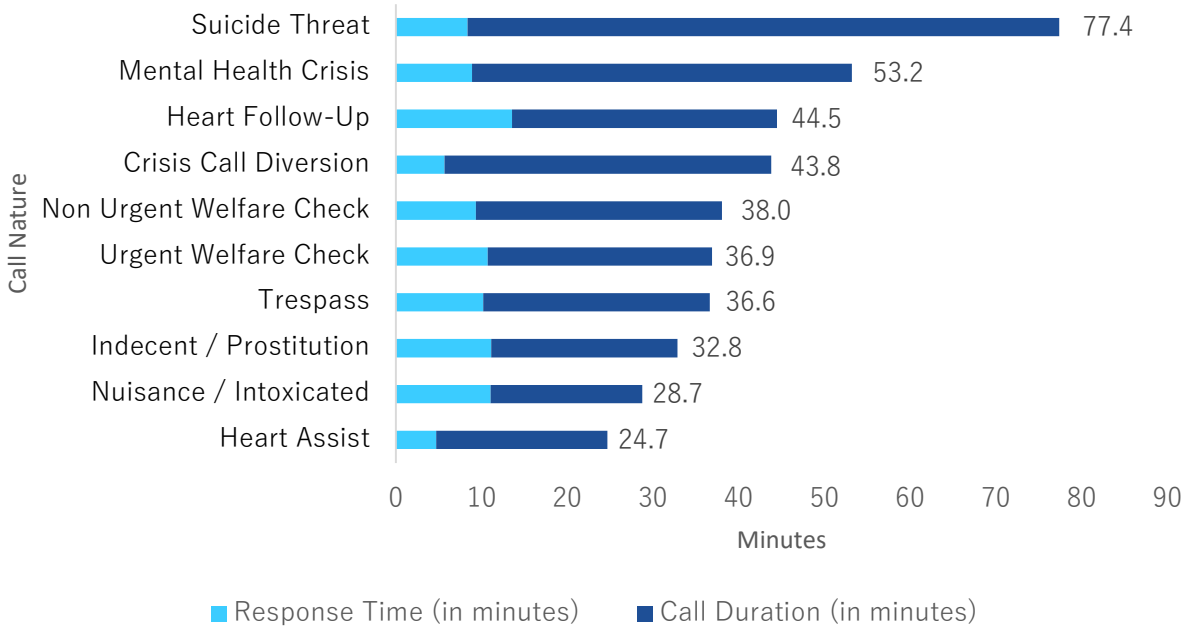


Note: There were 86 calls classified as other because they had small number of occurrences.

[3] A minority of events (n = 11) were initiated outside of the 911/self-initiated dichotomy.

Call Response Timing. It is important to understand the response time and on-scene call time for HEART responses, as it is an arm of the emergency response system. Across all call types, CRT have an average response time of 9 minutes and an average call duration of 32 minutes. As presented in Exhibit 7, the time on scene (call duration) varies by call type. CRT spend the most time on scene for suicide threats (average 77 minutes), followed by mental health calls (average 54 minutes) and crisis call diversion (average 44 minutes). The crisis call diversion calls are service encounters where a CCD counselor has engaged CRT to provide an on-scene response.

Exhibit 7. CRT Service Encounter Duration (N = 1,720)



Note: Averages are only provided for call natures with 15 or more calls.

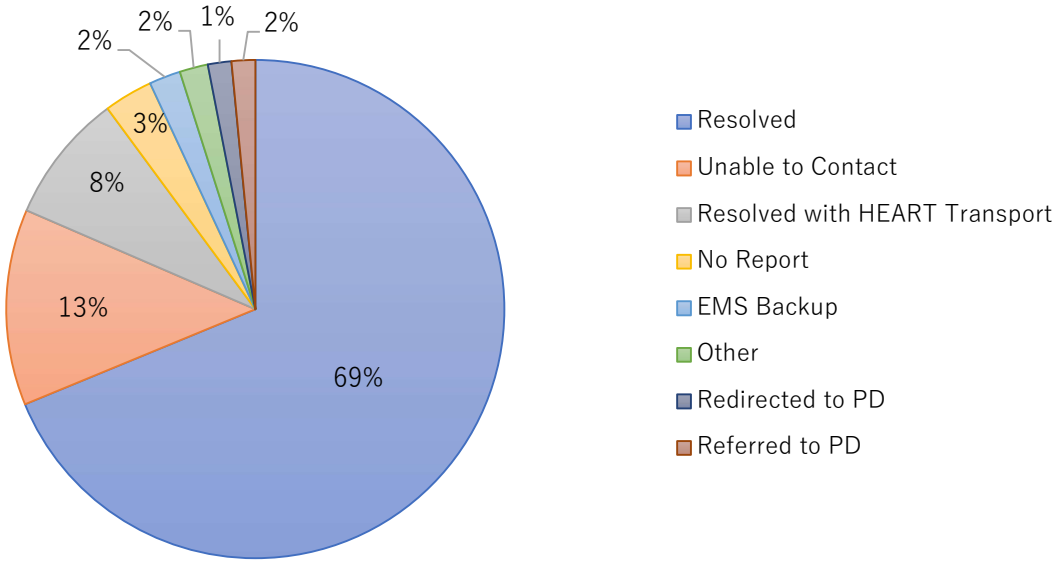
Call Disposition. CRT document call resolutions with disposition codes. Most CRT service encounters (69%) are resolved on scene (N = 1,211). In 13% (N = 224) of the service encounters, there was no one on scene when CRT arrived;[4] at least a third of these were trespass calls. CRT also provided transport for 8% of service encounters; transport was almost exclusively used for mental health–related calls. Notably, only 2% (N = 54) of CRT service encounters were redirected or referred[5] for police response, suggesting that CRT was the appropriate response for almost all service encounters. Finally, only 2% (N = 36) of calls—most of which were related to mental health crises—requested Emergency Medical

[4] For example, a third party may have reported a trespasser who is no longer there, or a caller may no longer be on the scene.
[5] Redirected calls occur when an officer arrives to a scene before HEART does; referred calls occur when the CRT determines a police response is necessary (e.g., to report a crime or file a report).

Services (EMS) backup. Among the 58 service encounters that included a PD response (calls referred to PD, redirected to PD, or required PD transport), 7 resulted in an arrest. Exhibit 8 shows the CRT service encounter dispositions over the observational period.

CRT report how safe they felt on each encounter as part of their post-encounter reporting. Notably, there were only six instances where a staff member reported feeling somewhat unsafe during the observational period.

Exhibit 8. CRT Service Encounter Dispositions (N = 1,720)



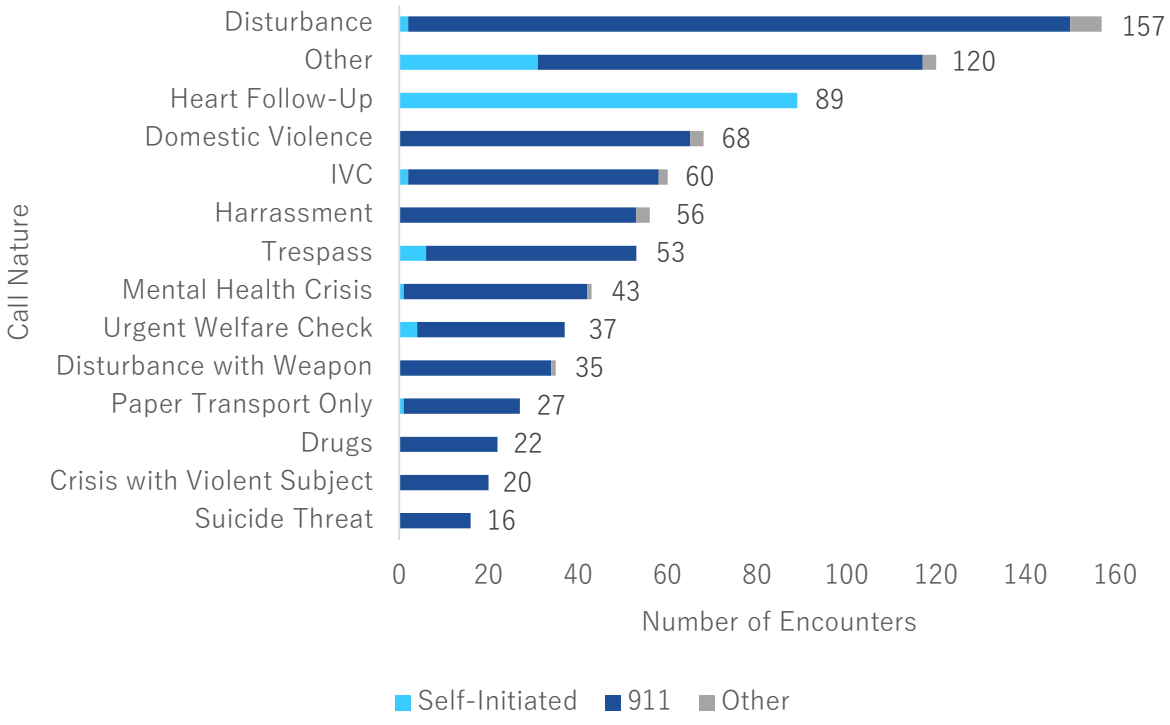
3.1.3 Co-response Team Response

COR responded to 803 calls during the observational period; as noted in Section 2, COR's observation period was shorter because it was not implemented until the end of September 2022. Like CRT, COR service encounters include both 911 calls and self-initiated events. Response to 911 calls represent 81% (N = 647) of the COR service events. Because COR includes an armed police officer, the team responds to a wider array of calls than CRT (see Exhibit 1). Self-initiated contacts make up about 16.9% (N = 136) of the COR service events, most (64%) of which are follow-up contacts (Exhibit 9). Among the 911 service encounters, the most frequent call natures were disturbances (N = 148), domestic violence (N = 65), and involuntary commitment (N = 56). During this period, COR also self-initiated responses to involuntary commitment, trespass, and urgent welfare checks.

COR Clinical Support

A neighbor reported receiving threatening text messages, but once on scene COR discovered that the neighbor was off their medication and distressed by an impending eviction. After COR engaged the neighbor, they allowed COR to safely (and voluntarily) transport them to the hospital.

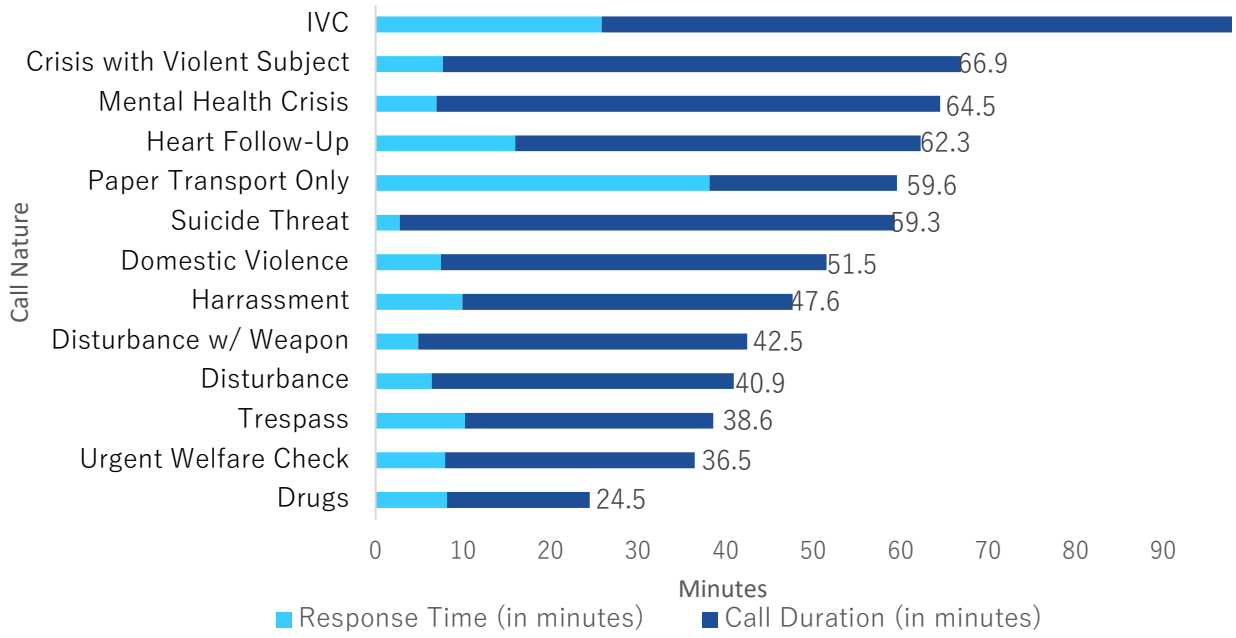
Exhibit 9. COR Service Encounter Call Natures (N = 803)



Note: There are 120 calls classified as "other" because they had small number of occurrences.

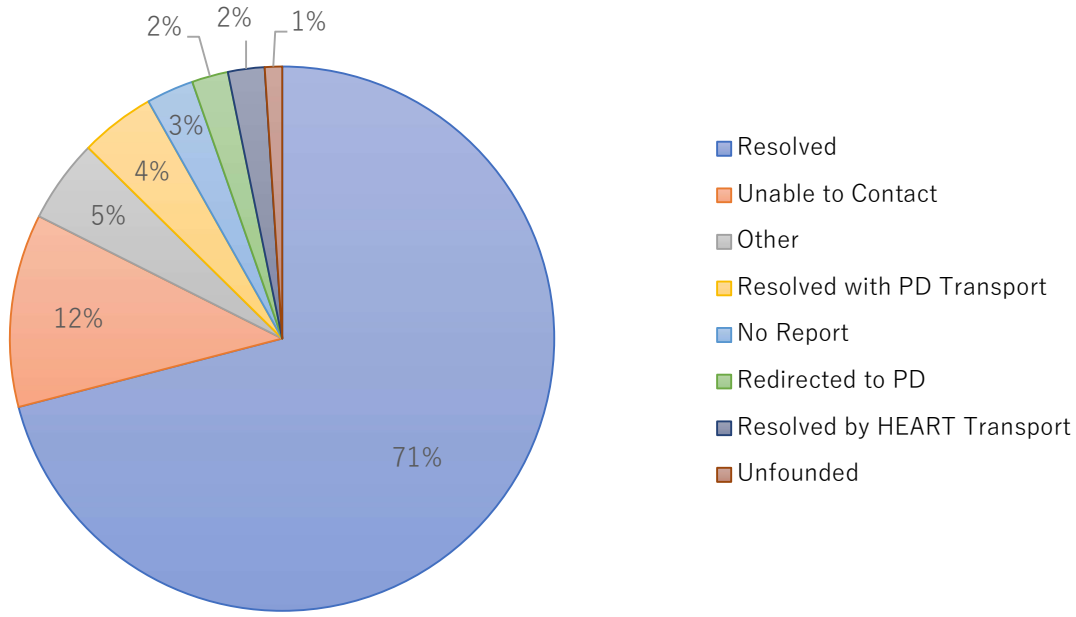
Call Response Timing. Across all service encounters, COR had an average response time of 10.5 minutes and an average call duration of 42.3 minutes. As presented in Exhibit 10, the time on scene and overall call duration varied by call type. COR spent the most time on-scene for Involuntary Commitment (IVC) calls (average 98 minutes) followed by crisis with violent subject (average 67 minutes) and mental health crisis calls (average 65 minutes), while trespass, urgent welfare check, and drugs took substantially less time.

Exhibit 10. Average COR Service Encounter Duration (N = 803)



Call Dispositions. There is a wider range of dispositions available to COR, including those available to a traditional officer response (i.e., arrest). However, during the observational period, COR resolved service encounters without any resulting in an arrest or citation. Most, COR encounters (71%) were resolved on scene. Only 12% (N = 98) of service encounters did not have a neighbor or caller at the scene, a slightly lower rate than CRT. COR also assisted with transport for 6.5% (N = 52) service encounters. A small percentage (2%) were redirected to Durham Police Department. The inclusion of involuntary commitments transports among the COR responsibilities contributed to a slightly higher rate of transport than CRT. Among the 57 service encounters that included a PD response (calls referred to PD, redirected to PD, or required PD transport), 12 resulted in an arrest. Exhibit 11 shows the COR service encounter dispositions over the observational period.

Exhibit 11. COR Service Encounter Dispositions (N = 803)



3.1.4 Care Navigation

CN exists outside of the emergency response environment, functioning as wraparound support provided with the CCD, CRT, or COR response. The response team can refer individuals to CN, or the CN can self-initiate. During the observation period, CN staff recorded 779 service encounters. Care Navigators typically spend an average of 20.3 minutes with each contact.

Follow-Up Care

After transporting a neighbor to a behavioral health clinic, HEART followed up with both the neighbor and the provider to ensure a connection to care.

3.1.5 Neighbors and Service Needs

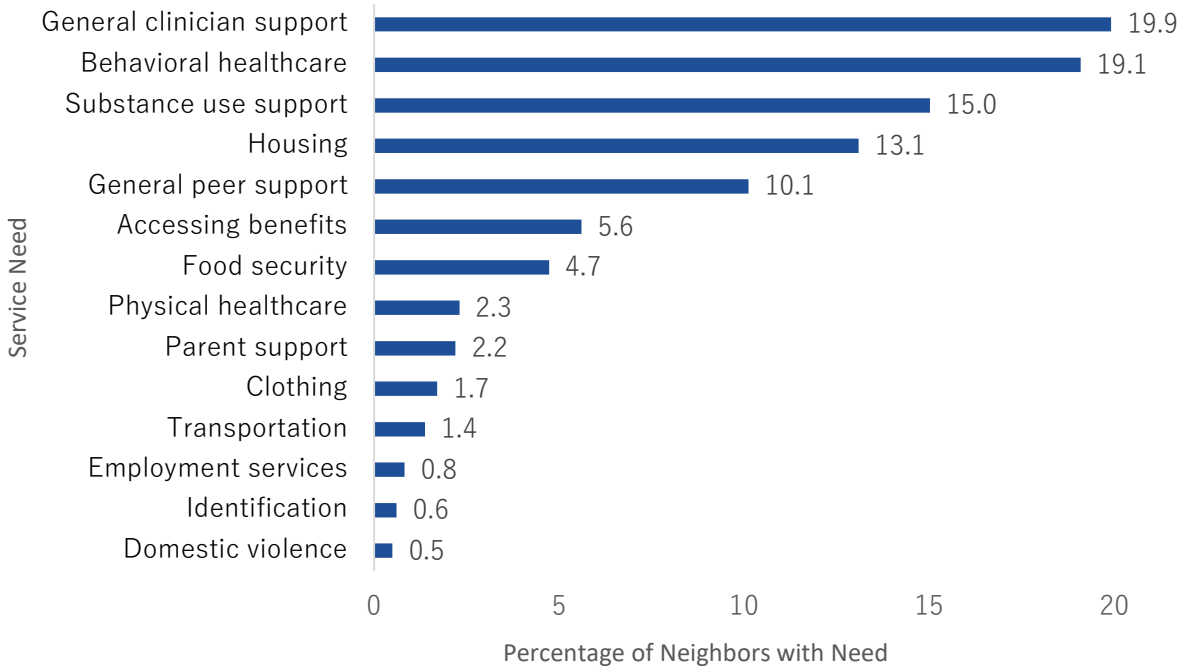
The HEART team collects demographics for neighbors whenever possible. Staff are asked to document the "perceived" demographics—what they have been told by a neighbor—for service encounters whenever possible. It is more difficult to capture demographics for remote responses, therefore these are largely unknown. Although it can be difficult to collect neighbor demographics in the context of a service encounter, they are important to understanding who the program is serving. As presented in Exhibit 12, neighbors served by the program are about equally split between male and female. It appears that about half of neighbors are Black and most are non-Hispanic. The race of nearly a of quarter of the neighbors is unknown; the ethnicity of slightly more than a quarter is unknown.

Exhibit 12. HEART Neighbor Demographics (N = 1,646)

Perceived Demographics	N	%
Sex		
Male	777	47.2
Female	737	44.8
Unknown	133	8.0
Race		
Black	725	50.3
White	300	20.7
Asian	3	0.2
Other	65	3.9
Unknown	356	24.6
Ethnicity		
Hispanic	86	6.12
Non-Hispanic	905	64.4
Unknown	414	29.5

Among the 1,646 neighbors whose information was captured in the DCSD system, roughly 56% had more than one service encounter with HEART. The number of contacts between HEART staff and the neighbors range from 1 to 182, with a small proportion (8.5%) receiving five or more contacts. HEART staff also record the service needs of the neighbors across their interactions. The most frequent service need (Exhibit 13) was general clinician support (19.9%), followed by behavioral health care (19.1%), substance use support (15%), and housing (13.1%). it is important to note that service needs are not mutually exclusive and that neighbors often experience a range of needs across the listed categories.

Exhibit 13. HEART Neighbor Service Needs (N = 1,646)



4. Summary

The following section highlights the main findings from the descriptive analysis.

- **Across HEART 911 service encounters, almost half (42%) are explicitly mental health–related crises**. In addition to the mental health crisis and suicidal ideation/threat calls that represent the bulk of HEART's work, many of the other types of calls have a mental health element, including welfare checks, trespass calls, disturbance calls, and nuisance/intoxicated calls.
- **Most CRT and COR service encounters are successfully resolved on the scene**. Sixty-nine percent of CRT and 70% of COR service encounters are resolved on the scene. If we consider the proportion of calls where the teams are unable to contact the neighbor because the neighbor is no longer on the scene (13% and 12%, respectively), the number of resolved calls increases.
- **Only 3% of CRT calls involved police.** The small number (N = 58) of CRT calls that were referred, redirected, or used police transport suggests that the designated call natures are appropriate for the team. Further, anecdotal information suggests referral or redirecting to the police is typically the result of staff learning on the scene that the neighbor would like to report a crime.
- **Less than 1% of CRT and COR service encounters resulted in legal sanctions.** Among the 2,523 calls directed to the CRT or COR teams during the observational period, only 19 resulted in an arrest.
- **Mental health–related calls take longer to resolve than other types of calls.** On average, CCD and CRT spent the most time on suicide threat calls (56 minutes and 77 minutes, respectively). For COR, involuntary commitment calls took the most time on average (98 minutes), likely due to the paperwork and transport involved.
- **HEART staff feel safe during service encounters.** There were only six instances where HEART staff reported feeling somewhat unsafe on scene.

Next Steps

This report is a descriptive analysis of the HEART data, limited by the data reported in the DCSD database. DCSD is currently collaborating with RTI International to conduct a comprehensive impact study of the HEART program. The mixed-methods study will include a process component to assess program implementation and fidelity, an outcome component to understand if HEART service encounters result in better outcomes than a traditional police response, and a cost component to assess the net-cost benefits.