



Understanding Denver's Co-Responder Program

Alternative Crisis Response in Denver

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Law enforcement agencies are often first responders for people experiencing mental health or substance use crises because most communities have few other options. In order to better connect people in crisis to the services they need, a growing number of communities are exploring alternative crisis-response strategies that, for example, pair police with social workers or other clinical professionals. The COVID-19 pandemic and the recent demand for police reform have accelerated the implementation of these alternative strategies in communities across the country; however, not much research has been done to understand the implementation and impact of these strategies.

Denver, Colorado, is implementing the above type of crisis-response strategy through the Co-Responder and Support Team Alternative Response (STAR) programs and has committed to the robust evaluation of program implementation, outcomes, and costs of each. This brief summarizes key themes from the first year of the Co-Responder program evaluation. It is focused on understanding program implementation, including successes and challenges, and informing practitioners and policymakers who are seeking to implement and improve similar programs. We review our findings from the first year of the evaluation of Denver's Support Team Alternative Response (STAR) program in a separate brief (Gillespie, McGilton, and Rogin 2023).

Background

Nationally, 6 to 31 percent of all police contacts are with individuals with mental illnesses, making effective responses to this population critical for community safety and well-being (Morabito et al. 2018; Watson et al. 2010; Wilson-Bates 2008). To this end, police departments have introduced specialized training, such as crisis intervention teams (Vickers 2000). Crisis intervention teams consist of police officers who have gone through advanced training in dealing with mental health and behavioral crises; they have been installed in 2,700 communities nationwide as of 2019, representing 15–17 percent of all police agencies (Helfgott, Hickman, and Labossiere 2016; Rogers, McNiel, and Binder 2019). Although specialized training for police officers continues to prove helpful in the US and abroad, it is not enough. Escalated interactions resulting in arrests and violence persist, and individuals remain without short- and long-term support (Boazak et al. 2020; Comartin, Swanson, and Kubiak 2019; Compton et al. 2014; Herrington and Pope 2011; Macauley 2021; Marcus and Stergiopoulos 2022; Rogers, McNiel, and Binder 2019; Skubby et al. 2012; Watson and Fulambarker 2012).

To better meet community needs, co-responder models are increasingly used by police departments worldwide (Balfour et al. 2020; Evangelista et al. 2016; Kirst et al. 2014; Lee et al. 2015; Mckenna et al. 2015). Originating in Los Angeles in 1993, a co-responder program typically pairs mental health professionals with police officers to respond to 911 calls involving mental health crises. However, there is significant variation in how these models have been implemented (Kriider and Huerter 2020). For example, in Kitsap County, Washington, responding officers refer people to behavioral health specialists after an initial response. Conversely, in Springfield, Missouri, clinicians offer virtual support upon the request of responding officers.¹ Co-response units can also vary in the representatives who accompany police officers, such as mental health clinicians, recovery coaches, peer support workers, and trained civilians.²

Denver's Co-Responder program began in 2016 as a partnership between the Denver Police Department (DPD) police officers and mental health clinicians.³ Co-Responder clinicians have also been assigned to work with the Denver Fire Department, and over time the program has grown to include partnerships between clinicians and a diverse range of city agencies including the Denver Sheriff Department, Denver Regional Transportation Department, Denver Parks and Recreation, and other specialty law enforcement units. By sending mental health experts to accompany police officers and others in first responder positions, the Co-Responder program is intended to divert individuals from excessive engagement with the criminal-legal and crisis-response systems by connecting them to culturally and geographically appropriate community support and services. The program also strives to improve coordination across systems and service providers and cut down on unnecessary costs related to engaging with individuals with mental or behavioral health needs.⁴

Through these clinical partnerships, responders are generally more effective in de-escalating crises, preventing injuries, and reducing pressure on the criminal-legal and health care systems by linking individuals to appropriate community services (Shapiro et al. 2015). In fact, scholarly evaluations of co-responder programs have found them to be effective in reducing pressure on the criminal-legal system,

resolving cases successfully, averting crisis escalation and injury, facilitating proper referrals to non-law enforcement services, increasing service use, and saving money (Allen Consulting Group 2012; Bailey et al. 2021; Helfgott, Hickman, and Labossiere 2016; Kisely et al. 2010; Rosenbaum 2010; Shapiro et al. 2015).

Denver has committed to a robust evaluation of its Co-Responder program. This brief outlines the methods and key findings from the first year of a two-year mixed-methods evaluation of the Co-Responder program, including recommendations and next steps as the evaluation enters its second year. We outline our findings from the first year of evaluation of Denver’s STAR program in a separate brief (Gillespie, McGilton, and Rogin 2023).

Co-Responder Program Overview

The Co-Responder program is primarily funded by Caring for Denver and the Crime Prevention and Control Commission. Housed in the DPD, the Co-Responder program pairs Denver police officers and other first responders with 34 licensed mental health professionals from WellPower, a local mental health center, to jointly respond to mental and behavioral health-related 911 calls. In some districts, clinicians are assigned to or choose to ride with different officers from shift to shift; in others, the clinicians partner closely with one or two officers over long periods of time. WellPower also employs five case managers to provide follow-up mental health services for people who encounter co-responders. DPD also manages a separate Outreach Case Coordinator program, which can also take referrals from co-responders to provide follow-up services for basic needs such as food and transportation.

The Co-Responder program first began in Denver’s downtown police district in 2016. By spring 2022, the Co-Responder program had expanded to all six police districts within Denver, with 24-hour coverage throughout the week comprised of day shifts, swing shifts, and night shifts. It also paired clinicians with first responders in other city departments, including Denver Fire Department, Denver Sheriff Department, and Denver Parks and Recreation, where clinicians were needed to support crisis response. Calls for the Co-Responder program are most commonly received through Denver’s 911 system and most commonly dispatched to co-responders who are riding with police officers. (Co-responders who work with other departments like the Denver Fire Department and Denver Sheriff Department often receive calls and referrals directly from those departments.) Based on the information collected by the call taker, the call taker and/or dispatcher flags calls that may be appropriate for Co-Responder teams. Co-Responder teams also monitor the computer-aided dispatch system and can respond to calls they deem appropriate. On the scene, the officer and clinician will decide together how to respond with the goal of de-escalating the crisis and making a connection to follow-up services. After the initial call, Co-Responder clinicians may follow up themselves to provide referrals or may direct clients to a case manager, outreach case coordinator, or other appropriate services.

Key Program Implementation Findings

In this section, we summarize the major themes we heard across interviews with program staff and community leaders. Interviews were focused on understanding program successes and challenges as well as opportunities for coordination and collaboration, and continued community engagement.

Co-Responder Program

GOALS

The Co-Responder program staff, leaders, and community stakeholders whom we interviewed largely aligned with the goals of the program and stated that the goals have remained the same since the program's inception. Interviewees described the two main goals of the Co-Responder program: (1) provide clinical resources not available during traditional police-only responses, and (2) divert people away from legal system involvement toward long-term community support and resources. A few also reported that the Co-Responder program strives to improve community and police relationships.

KEY SUCCESSES

Staff, leaders, and community stakeholders reported the largest success of the Co-Responder program is the increased capacity and competency of DPD's response to mental and behavioral health crises. They reported that Co-Responder teams, compared to officers alone, respond faster and can spend more time with people in need to understand the root causes of crises and provide support. They also reported that because of their expertise, clinicians de-escalate tense interactions more effectively than traditional responses and focus on providing support and services rather than quick problem-solving or punitive strategies. Staff reported that they strive to listen to everyone's unique needs to provide the best response possible, learning from each call and using those lessons and resources in future calls.

Staff and leaders of the Co-Responder program also reported—and community stakeholders affirmed—a positive impact on officers who ride with Co-Responder clinicians. This time together increases officers' access to clinicians and provides deep on-the-job training in responding to mental health challenges. Co-Responder clinicians and police officers consult on calls and support one another on and off shifts. They build close relationships. The clinicians equip officers with tools and response options that go beyond the officers' traditional training, and officers are able to use these tools and responses even when responding without a clinician. Staff and stakeholders also reported increased awareness of and interaction with service providers, which also increase options for police response beyond arrest.

Finally, interviewees, especially leaders, reported that the continued expansion of the program is helping reach more people in need. By functioning in all districts and around the clock, Co-Responder teams can provide assistance to those in need without a wait. Staff reported that adding Co-Responder clinicians to other response areas (e.g., responses that involve the airport, hostage negotiation, gang,

and fire) has allowed other agencies that encounter people in crisis to support them and connect them to services. It also increases awareness of mental health needs in other agencies and public arenas.

KEY AREAS FOR EXPANSION AND IMPROVEMENT

Increase awareness of and access to resources and service providers. Although staff, leaders, and stakeholders consistently reported that Co-Responder teams effectively meet the immediate needs of people, connection to long-term services remains a challenge. A lack of resources and service providers remains the largest challenge for the Co-Responder program. These deficits include a lack of staff knowledge of available services and a lack of existing geographically or culturally appropriate service providers for unique needs (e.g., cooccurring disorders, Medicaid-accepting providers, severe and persistent mental illness, housing, immigration). The Co-Responder program also has a lack of capacity for service providers to serve the number of people needing help. Community stakeholders also expressed concerns that some of the providers to which the program most commonly makes referrals do not provide consistent or quality services to all populations. Interviewees emphasized the need for a service provider network to increase connection to long-term services.

Clearly outline team roles and responsibilities. Although Co-Responder staff, especially clinicians, communicate with each other often and consult each other on calls, staff are largely unaware of the roles and responsibilities of other staff who intersect with the Co-Responder program. For example, Co-Responder teams were largely unaware of the outreach case coordinator's position, purpose, and activities even though many case coordinators are located in the same police stations as Co-Responder teams. Clinicians instead reported that they mostly follow up with people themselves after an initial encounter.

Increase internal and external outreach. Many staff, leaders, and community stakeholders expressed a large need for internal and external outreach and education about the program. They reported that many people internally do not understand the program or know it exists and, therefore, cannot use it properly when needed. Interviewees reported that very few people—including community members, community-based organizations, and leaders/policymakers—understand the program, which may hinder maximum impact.

Recommendations

Increasing Connections to Services after Crisis Response

Connection to services following crisis response is a primary goal and also a significant challenge for the Co-Responder program. Two potential recommendations for increasing service connections arose from the interviews we conducted in year one of the evaluation.

Build connections at a systems level. Staff reported both a lack of knowledge of potential service referrals and gaps in the availability of the most needed types of service referrals. One opportunity is to

build service connections at a systems level, rather than relying on individual program staff. This could happen through systems-level partnerships built between organizations and agencies. It could look like priority access to certain services after a Co-Responder encounter and/or formalized protocols for Co-Responder teams transporting a client to another service partner. For example, the continuum of care, which coordinates all local homelessness-assistance resources, could have a specific referral pathway for Co-Responder clients to be quickly assessed and connected to housing services.

Clarify the roles of case managers and outreach case coordinators. Another opportunity to increase connections to services is through working more closely with the case manager and outreach case coordinator roles at WellPower and DPD. Overwhelmingly, program staff did not understand who occupied these positions, how to work with them, and what their capacity was for follow-up with clients. Case managers themselves had different understandings of their roles and responsibilities and the goals of follow-up with clients after an encounter with co-responders. While outreach case coordinators are often separate from co-responders, people who were connected with these coordinators were eager to share their experiences with us and had many examples of how coordinators managed to meet their needs during the hardest times. Increasing communication and coordination among clinicians, medics, case managers, and case coordinators could accelerate progress toward follow-up service connections for more clients following an encounter with co-responders.

Balancing Cross-Program Collaboration

Although the Co-Responder and STAR programs are distinct in many ways, both programs share similar goals and are two important parts of the behavioral health network in Denver. Urban's evaluation examined both programs to understand the similarities and differences and highlight potential opportunities for coordination and collaboration.

For similarities, both programs receive funding from Caring for Denver, “a nonprofit founded by voter approval to use local tax revenue to fund efforts addressing mental health and substance misuse” in Denver. Also, the clinicians on both STAR and Co-Responder teams are Wellpower employees and collaborate often. Co-Responder and STAR clinicians frequently consult with one another, which was repeatedly recognized as a strength of the programs when we talked with frontline staff. Program staff and leaders reported that their ability to consult and collaborate across teams and agencies has improved the consistency of responses and increased their ability to connect people with appropriate support.

The programs also have several important differences, the most important being that the Co-Responder program pairs a police officer with a clinician, whereas STAR doesn't have a police officer as part of the team. The STAR program is housed in the Denver Department of Public Health and Environment, and the Co-Responder program is housed in the Denver Police Department. The Co-Responder program has been expanding for many years, while the STAR program is newer to the community. STAR began with the community's desire for an alternative crisis response, and many community stakeholders prioritize its separation from law enforcement. Recognizing the importance of

clear boundaries between these programs, our research highlighted two opportunities for productive collaboration.

Maintain internal collaboration among clinicians. Nearly everyone we talked to highlighted the strengths of clinicians supporting one another in preparing for and responding to calls. This type of internal collaboration happens over the radios and internal chat platforms and does not have to be client-facing to continue supporting better outcomes for both programs. We also think collaboration among clinicians will likely become more important as clinicians begin to refer clients to the new community engagement provider network funded by STAR.

Create clear outreach and awareness materials for both programs. Many staff and community members we spoke with highlighted common misunderstandings in the community about how these two programs are the same and how they are different. Many noted that the general public hears much more about STAR than the Co-Responder program, even though the latter is older. Sharing outreach and awareness materials about each program can help reduce confusion and highlight both programs as part of a set of expanding behavioral health strategies in Denver.

Program Metrics

As noted above, year one of this evaluation was largely qualitative, given the delay in data sharing between the city and WellPower. Year two of the evaluation will be more focused on understanding quantitative measures of program implementation and outcomes. In addition, as Co-Responder continues to expand throughout Denver, the city could broaden the types of metrics it monitors for Co-Responder beyond the typical public safety outcomes of interest. Based on our understanding of these programs to date, in table 1, we outline a potential framework for measuring program outputs (how many services were provided by the programs), program implementation (how well were programs provided), and program outcomes (what difference did the programs make to people who encountered them). Year two of the evaluation will seek to measure many of these metrics as feasible, given data availability.

TABLE 1

Metrics for Program Measurement

Measuring program outputs, implementation, and outcomes

Research questions	Process measures and outcomes	Data sources
Outputs: How many services are provided?		
How many services are provided?	<ul style="list-style-type: none"> ■ number of encounters ■ <i>time on scene</i> ■ number and type of referrals 	<ul style="list-style-type: none"> ■ WellPower ■ DPD
Implementation: How well do the programs perform?		

Research questions	Process measures and outcomes	Data sources
Are services appropriate for the demand?	<ul style="list-style-type: none"> share of 911 calls flagged as Co-Responder appropriate share of flagged calls with Co-Responder response 	<ul style="list-style-type: none"> WellPower 911
Are services culturally appropriate?	<ul style="list-style-type: none"> demographics/needs of encounters compared to city demographics/needs (race, age, <i>language</i>, geography, <i>disability</i>) <i>client satisfaction</i> 	<ul style="list-style-type: none"> WellPower DPD <i>client survey</i>
Do services vary by race and gender?	<ul style="list-style-type: none"> demographics type of response (STAR, Co-Responder, police, etc.) 	<ul style="list-style-type: none"> 911 WellPower DPD
To what extent does service connection occur after crisis response?	<ul style="list-style-type: none"> <i>number and date of referral</i> <i>number and type of service connection</i> <i>number of clients who take up service connection</i> <i>number of follow ups per client</i> 	<ul style="list-style-type: none"> WellPower DPD Servicios De la Raza
Are programs cost effective?	<ul style="list-style-type: none"> program costs cost offsets and shifts across systems 	<ul style="list-style-type: none"> WellPower DPD
Outcomes: What difference are the programs making?		
How do clients perceive the effects of programs on their well-being and quality of life?	<ul style="list-style-type: none"> stability access to services health support networks income and employment 	<ul style="list-style-type: none"> client survey
Are changes observed in clients' system utilization because of program encounters?	<ul style="list-style-type: none"> police contacts, arrests jail days 911 calls ambulance transport fire response detox <i>ED use</i> <i>shelter stays/assistance</i> 	<ul style="list-style-type: none"> Denver Public Safety DHHA for ED use MDHI for shelter use

Source: Framework developed by authors.

Notes: DPD = Denver Police Department, DHHA = Denver Health and Hospital Authority, MDHI = Metro Denver Homelessness Initiative. Italics indicate measures and outcomes that would require new data collection.

Conclusion

Overall, the Co-Responder program has proven to be an incredibly successful alternative response mechanism for meeting the immediate needs of people in crisis. The program provides human-centered care and de-escalates situations involving people in a mental health crisis and police. In addition to providing more thoughtful approaches to people experiencing crises, co-responders provide individual clinical support to police officers and provide them additional skills and resources to rely on. To stop the cycle of crisis response for people with ongoing mental and behavioral health needs, more strategies are needed to help connect clients to long-term, culturally competent, and accessible follow-up services. The new community service provider contract with Servicios de La Raza will be a central component of this, along with clarifying the roles of case managers and outreach case coordinators.

Evaluation Next Steps

A second year of the evaluation will allow data collection and analysis to focus on components of both the STAR and Co-Responder programs:

- A **community engagement/service provider network study** to document how much and how effectively Servicios de La Raza connects clients to a network of community-based providers created to support longer-term service connections for STAR clients, as well as a client satisfaction survey to measure the appropriateness and outcomes of service connections.
- An **outcomes study** to analyze linked WellPower and Department of Safety data and understand client outcomes over two years after encounters with the STAR or Co-Responder program, and to compare those outcomes to a similar population that did not encounter either program to understand the effects of the programs on individual outcomes.
- A **cost study** to understand the public costs and benefits of the STAR and Co-Responder programs and how these compare to the public costs and benefits of traditional first responder systems.

As with year one of the evaluation, year two is designed to help inform policymakers and program leaders as they assess implementation, outcomes, and costs and benefits for these programs. This information will also be valuable to other local leaders across the country who are pursuing similar strategies in their own communities.

Appendix A. Methods

The Urban Institute's two-year evaluation of the STAR and Co-Responder programs includes multiple study components to examine the implementation, outcomes, systems change, and costs of these programs in order to foster a greater understanding of implementation, coordination, and connection to services; support continuous improvement; and document participant outcomes and ongoing needs. In year one, the evaluation focused on qualitative methods that engaged a broad range of key stakeholders. We conducted a comprehensive review of program documentation, facilitated 38 individual interviews with program staff and leaders from Denver agencies, 10 individual interviews with STAR Community Advisory Council members and other community stakeholders, and four interviews with people who had prior encounters with STAR and Co-Responder teams or outreach case coordinators. We also conducted four in-person program observations of STAR and Co-Responder teams while on shift and observed monthly STAR Community Advisory Council virtual public meetings. We separated the programs when possible and appropriate. However, many interviewees spoke about both programs. To ensure the interpretation and reporting of the results were complete, accurate, and relevant, we facilitated two data walks: one with Denver staff and officials and one with community stakeholders who had participated in data collection. During these data walks, we presented the key findings from the study and solicited feedback on our interpretation and presentation, which was used to finalize the publications for this evaluation.

EVALUATION LIMITATIONS

- **Participant interviews.** We sought to interview participants who had direct experience with either STAR or Co-Responder programs to understand the perspective of people on the receiving end of these services. However, we had challenges connecting with participants, and our data collection efforts were limited to just four participant interviews.
- **Administrative data delays.** Our initial scope of analysis for the first year of the evaluation included analyzing administrative data from the Department of Public Safety and WellPower to understand program outcomes for STAR and Co-Responder. However, we encountered delays in finalizing data use agreements that pushed the outcome study to the second year of the evaluation.

Notes

- ¹ Ken Park, "Poulsbo 'Navigator' Program Partnering Law Enforcement with Behavioral Health Specialists," *Bainbridge Island Review*, August 30, 2019, <https://www.bainbridgereview.com/news/poulsbo-navigator-program-partnering-law-enforcement-with-behavioral-health-specialists/>; Shalaine Periman, Cody Jackson, Jr., and Corporal Chris Nuccio, "Virtual-Mobile Crisis Intervention Springfield Model," *Burrell Forward*, accessed December 2, 2022, <https://www.ibhi.net/2017MiamiPresentations/16%20Burrell.pdf>.
- ² "Community and Public Health (CARES)," Colorado Springs, accessed January 2022, <https://coloradosprings.gov/fire-department/page/community-and-public-health-cares>; Plymouth County Outreach, 2022, <https://plymouthcountyoutreach.org/>; "Programs and Services," Mental Health Association of Nebraska, accessed January 2022, <https://mha-ne.org/programs-services/real-program.html>; "Crisis Outreach and Support Team COAST," SHARE New Mexico, accessed December 16, 2022. <https://sharenm.org/crisis-outreach-and-support-team-coast/crisis-outreach-and-support-team-st>.
- ³ Alayna Alvarez, "Denver Police's Co-Responder Program Renewed for Another Year," February 6, 2020, *Colorado Politics*, https://www.coloradopolitics.com/denver/denver-police-s-co-responder-program-renewed-for-another-year/article_5bc47676-41ca-11ea-bf2e-2363816fe0cb.html.
- ⁴ "Co-Responder Program," WellPower, accessed January 2022. <https://www.wellpower.org/coresponder/>.

References

- Allen Consulting Group. 2012. *Police, Ambulance and Clinical Early Response (PACER) Evaluation*. Melbourne, Australia: Allen Consulting Group. <https://www.health.vic.gov.au/publications/police-ambulance-and-clinical-early-response-pacer-evaluation-report>.
- Boazak, Mina, Sarah Yoss, Brandon A. Kohrt, Wilfred Gwaikolo, Pat Strode, Michael T. Compton, and Janice Cooper. 2020. "Law Enforcement and Mental Health Clinician Partnerships in Global Mental Health: Outcomes for the Crisis Intervention Team (CIT) Model Adaptation in Liberia, West Africa." *Global Mental Health (Cambridge, England)* 7: e2. <https://doi.org/10.1017/gmh.2019.31>.
- Comartin, Erin B., Leonard Swanson, and Sheryl Kubiak. 2019. "Mental Health Crisis Location and Police Transportation Decisions: The Impact of Crisis Intervention Team Training on Crisis Center Utilization." *Journal of Contemporary Criminal Justice* 35 (2): 241–60. <https://doi.org/10.1177/1043986219836595>.
- Compton, Michael T., Roger Bakeman, Beth Broussard, Dana Hankerson-Dyson, Letheshia Husbands, Shaily Krishan, Tarianna Stewart-Hutto, et al. 2014. "The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest." *Psychiatric Services* 65 (4): 523–29. <https://doi.org/10.1176/appi.ps.201300108>.
- Evangelista, Eloisa, Stuart Lee, Angela Gallagher, Violeta Peterson, Jo James, Narelle Warren, Kathryn Henderson, Sandra Keppich-Arnold, Luke Cornelius, and Elizabeth Deveny. 2016. "Crisis Averted: How Consumers Experienced a Police and Clinical Early Response (PACER) Unit Responding to a Mental Health Crisis." *International Journal of Mental Health Nursing* 25 (4): 367–76. <https://doi.org/10.1111/inm.12218>.
- Gillespie, Sarah, Mari McGilton, and Amy Rogin. 2023. "Understanding Denver's STAR Program: Alternative Crisis Response in Denver." Washington, DC: Urban Institute.
- Helfgott, Jacqueline B., Matthew J. Hickman, and Andre P. Labossiere. 2016. "A Descriptive Evaluation of the Seattle Police Department's Crisis Response Team Officer/Mental Health Professional Partnership Pilot Program." *International Journal of Law and Psychiatry* 44: 109–22. <https://doi.org/10.1016/j.ijlp.2015.08.038>.
- Herrington, Victoria, and Rodney Pope. 2014. "The Impact of Police Training in Mental Health: An Example from Australia." *Policing and Society* 24 (5): 501–22. <https://doi.org/10.1080/10439463.2013.784287>.
- Kirst, Maritt, Katherine Francombe Pridham, Renira Narrandes, Flora Matheson, Linda Young, Kristina Niedra, and Vicky Stergiopoulos. 2015. "Examining Implementation of Mobile, Police-Mental Health Crisis Intervention Teams in a Large Urban Center." *Journal of Mental Health (Abingdon, England)* 24 (6): 369–74. <https://doi.org/10.3109/09638237.2015.1036970>.
- Kisely, Stephen, Leslie Anne Campbell, Sarah Peddle, Susan Hare, Mary Pyche, Don Spicer, and Bill Moore. 2010. "A Controlled Before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia." *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie* 55 (10): 662–68. <https://doi.org/10.1177/070674371005501005>.
- Krider, Ashley, Regina Huerter, Kirby Gaherty, and Andrew Moore. n.d. *Responding to Individuals in Behavioral Health Crisis via Co-Responder Models*. Delmar, NY: Policy Research, Inc. <https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf>.
- Macauley, Nayo. 2021. "Alternative Response to Mental Health- Related 9-1-1 Calls." *PCOM Capstone Projects*,41. https://digitalcommons.pcom.edu/capstone_projects/41.
- Marcus, Natania, and Vicky Stergiopoulos. 2022. "Re-Examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes across Police, Co-Responder and Non-Police Models." *Health & Social Care in the Community* 30 (5): 1665–79. <https://doi.org/10.1111/hsc.13731>.

- McKenna, Brian, Trentham Furness, Jane Oakes, and Steve Brown. 2015. "Police and Mental Health Clinician Partnership in Response to Mental Health Crisis: A Qualitative Study." *International Journal of Mental Health Nursing* 24 (5): 386–93. <https://doi.org/10.1111/inm.12140>.
- Morabito, Melissa S., Jenna Savage, Lauren Sneider, and Kellie Wallace. 2018. "Police Response to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model." *Victims & Offenders* 13 (8): 1093–1105. <https://doi.org/10.1080/15564886.2018.1514340>.
- Rogers, Michael S., Dale E. McNeil, and Renée L. Binder. 2019. "Effectiveness of Police Crisis Intervention Training Programs." *Journal of the American Academy of Psychiatry and the Law Online*, September. <https://doi.org/10.29158/JAAPL.003863-19>.
- Shapiro, G. K., A. Cusi, M. Kirst, P. O'Campo, A. Nakhost, and V. Stergiopoulos. 2015. "Co-Responding Police-Mental Health Programs: A Review." *Administration and Policy in Mental Health* 42 (5): 606–20. <https://doi.org/10.1007/s10488-014-0594-9>.
- Skubby, David, Natalie Bonfine, Meghan Novisky, Mark R. Munetz, and Christian Ritter. 2013. "Crisis Intervention Team (CIT) Programs in Rural Communities: A Focus Group Study." *Community Mental Health Journal* 49 (6): 756–64. <https://doi.org/10.1007/s10597-012-9517-y>.
- Vickers, Betsy. 2000. "Memphis, Tennessee, Police Department's Crisis Intervention Team, Practitioner Perspectives." Washington, DC: U.S. Department of Justice. <https://www.ojp.gov/pdffiles1/bja/182501.pdf>
- Watson, Amy C., and Anjali J. Fulambarker. 2012. "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners." *Best Practices in Mental Health* 8 (2): 71.
- Watson, Amy C., Victor C. Ottati, Melissa Morabito, Jeffrey Draine, Amy N. Kerr, and Beth Angell. 2010. "Outcomes of Police Contacts with Persons with Mental Illness: The Impact of CIT." *Administration and Policy in Mental Health* 37 (4): 302–17. <https://doi.org/10.1007/s10488-009-0236-9>.
- Wilson-Bates, Fiona. 2008. *Lost in Translation: How a Lack Of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*. Vancouver, CA: Vancouver Police Board. <https://vpd.ca/wp-content/uploads/2021/06/vpd-lost-in-transition-1.pdf>.

Authors' Note

This brief was updated on October 25, 2023. On page 2, information was added to the third paragraph to explain additional Co-Responder program partnerships. On page 3, the third and fourth paragraphs were updated to explain how the Co-Responder program has expanded to other city departments.

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