



Community Assistance and Life Liaison navigators Bill Li, left, and Heather Loychik respond to a call in St. Petersburg, FL, on Thursday, March 4, 2022. Loychik likes this job because she gets to be “proactive” to prevent reactive situations.

911 Analysis: How Civilian Crisis Responders Can Divert Behavioral Health Calls from Police

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In communities across the country, police have long been the only first responders available to provide timely responses to behavioral health–related 911 calls. Officer involvement in these situations can cause serious harm, and increasingly, civilian response programs are safely answering crisis calls without police. To better understand the extent of opportunities to reduce police involvement in behavioral health crises, Vera analyzed 911 data from nine cities and found that an average of 19 percent of calls for service could be answered by unarmed crisis responders. This finding suggests that a much larger portion of behavioral health–related calls could be handled without police response than has been found by past studies.

The tragic killings of many people experiencing behavioral health crises have driven demands across the country for systemic change. In turn, jurisdictions have increasingly empowered trained unarmed civilians to respond to behavioral health–related 911 calls as an alternative to police response. Drawing inspiration from the CAHOOTS program in Eugene, Oregon, which has dispatched trained civilians to 911 crisis calls since 1989, other cities have begun successfully dispatching non-police teams to these calls, including Denver, Colorado; San Francisco, California; and St. Petersburg, Florida.¹ Staffed by a mix of crisis workers, licensed clinicians, peer specialists, medics, and other responders, unarmed public health–centered teams are demonstrating the ability to safely deliver timely responses to people in crisis.²

But many jurisdictions struggle to evaluate which calls are best suited to a non-police response and how to implement these alternatives to policing. Historically, the number of such calls has been undercounted. For example, one well-publicized study determined that an average of just 1.3 percent of calls across nine police departments involved call types for people in “mental distress,” a finding

that suggests there are limited opportunities to shift 911 calls from police to civilian crisis responders.³ The same study suggests otherwise: the authors created a separate “disorder” category made up of 16.2 percent of calls, including situations that might benefit from civilian crisis response teams rather than police responses. These situations often involve health and social needs—such as “people who were drunk in public,” “public urination,” and “vagrancy.”⁴ Moreover, other experts note that dispatchers often code crisis situations with labels like “citizen assist,” “welfare check,” and “disturbance” rather than using clear “mental health” identifiers. They may miss other behavioral health calls entirely because they have not received training to properly identify them.⁵

Calls that meet the narrow criteria that allow them to be categorized as a “mental health” call make up a relatively small percentage of 911 calls for service. Criteria that is more inclusive of other call types—including those that existing civilian response programs routinely handle without police, such as welfare checks and intoxicated persons calls—can further reduce police involvement in managing health and social issues.⁶ This is reflected in another report that found that up to 38 percent of calls for service could be addressed by “community responders,” including but not limited to calls involving behavioral health concerns.⁷

Drawing on the available data, this fact sheet shows how an average of 19 percent of calls for service could be answered by civilian crisis response programs.

Methodology

This analysis uses publicly available 911 data from nine cities: Baltimore, MD; Burlington, VT; Cincinnati, OH; Detroit, MI; Hartford, CT; New Orleans, LA; New York, NY; Seattle, WA; and Tucson, AZ. The data includes a total of 15.6 million community member-initiated calls to 911 between January 2019 and November 2021, with specific timelines for each agency based on the data they have publicly shared. For more information on the timeline of the data collected, see [911 Explainers: Methodology and Limitations](#).

To determine which calls under behavioral health-related call types might pose a special challenge for civilian crisis responders, Vera researchers focused on priority levels. The priority levels that telecommunicators assign to 911 calls are based on their perceived seriousness and safety risks. Priority level systems vary across jurisdictions, so Vera researchers created a standardized top priority variable for the purpose of comparative analysis. All nine agencies whose data Vera analyzed use one or two priority levels with an “emergency” classification or similar language indicating both the need for an immediate response and an immediate threat to life or imminent danger. Vera researchers standardized these priority levels into a single “top priority” variable to identify and remove calls that, due to their potential urgency or danger, would likely still prompt police involvement even if a civilian responder option were available.⁸

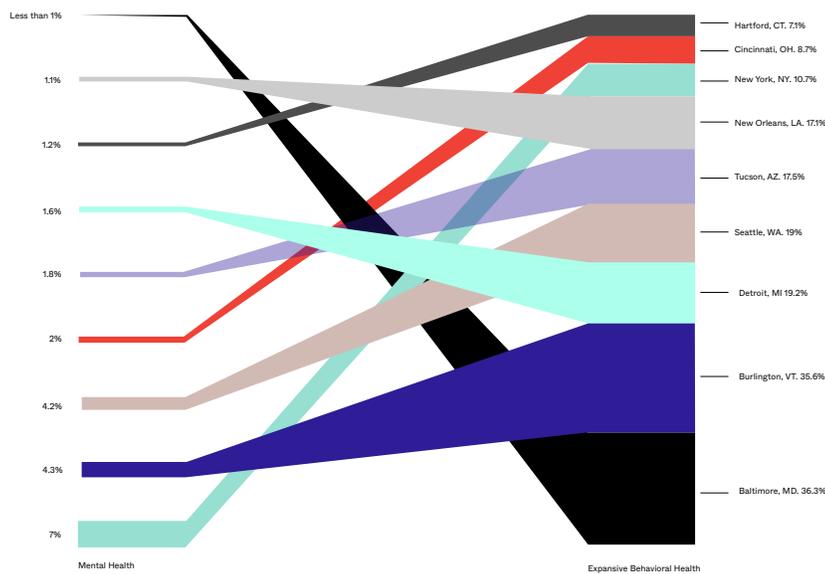
Although suicide-related 911 calls can be “immediate threats to life” that demand urgent responses, the 911 data Vera researchers used for this analysis indicates that most of these calls do not involve weapons or violence, and civilian responders specially trained in crisis intervention can safely resolve many of these situations without police.⁹

To determine the potential for expansion of civilian responses, Vera created two categories with progressively inclusive criteria—“mental health” and “expansive behavioral health.” While some analyses of 911 calls have used limited criteria to explore the potential scale of civilian crisis response programs, Vera’s analysis uses an expanded, more inclusive approach that is informed by how existing crisis response teams—such as the CAHOOTS program in Eugene, Oregon, and the STAR program in Denver, Colorado—operate in the field.¹⁰

For more information about the methodology behind this fact sheet, as well as the challenges and opportunities presented by 911 data analyses more generally, Vera has published a detailed [911 Explainers: Methodology and Limitations explainer](#).

Findings

Figure 1. Percentage of Mental Health Calls Compared to Expansive Behavioral Health Calls Across Nine Cities Analyzed



This chart shows how when the “expansive behavioral health” call category is added to the “mental health” call category, the percentage of 911 calls appropriate for civilian-led, health-first responses increases substantially.

Across the nine cities in Vera’s analysis, the average percentage of calls in the “mental health” category was 2.1 percent. This percentage is not far from the 1.3 percent average other researchers found in their analysis.¹¹

Mental Health Call Category

Figure 2. Percentage of Mental Health Calls in Nine Cities Analyzed

Baltimore, MD	Burlington, VT	Cincinnati, OH	Detroit, MI	Hartford, CT	New Orleans, LA	New York, NY	Seattle, WA	Tucson, AZ
<1%	4.3%	2.0%	1.6%	1.2%	1.1%	7%	4.2%	1.8%

However, existing civilian responder programs already handle a broader range of 911 calls than what is captured by this narrow “mental health” call category. To correctly answer the question of how many calls for behavioral health concerns could be diverted away from a police response, we must include additional call types beyond those recognized and labeled as mental health calls by 911 operators.

Expansive Behavioral Health Call Category

Figure 3. Percentage of Expansive Behavioral Health Calls in Nine Cities Analyzed

Baltimore	Burlington	Cincinnati	Detroit	Hartford	NOLA	NYC	Seattle	Tucson
36.3%	35.6%	8.7%	19.2%	7.1%	17.1%	10.7%	19.0%	17.5%

When the “expansive behavioral health” call category is incorporated into the analysis, the percentage of 911 calls appropriate for civilian-led, health-first responses increases substantially, averaging 19 percent across the cities examined in this analysis. For two-thirds of the cities in Vera’s analysis, the percentage is greater than 15 percent of calls. For two cities, the percentage is approximately one-third of all calls.

Conclusion

This analysis of 911 call data underscores the considerable potential of civilian crisis responders to meaningfully shrink the footprint of police. At present, police are tasked with responding to far too many behavioral health crises, even as police cause serious harm and the public demands more non-police responses.¹² Jurisdictions can divert a significant percentage of calls to unarmed crisis responders when public safety partners—and the elected officials who allocate funds—empower these programs to address a broad range of behavioral health situations. Moreover, with the passage of the American Rescue Plan, which includes an 85 percent federal Medicaid match for qualifying mobile crisis intervention services, communities have new financial incentives to develop civilian responses.¹³ They should seize this rare opportunity to address people’s unmet behavioral health needs with approaches that meaningfully narrow the scope of policing and promote community-based care.

Recommendations:

- › Public safety partners should adopt 911 protocols with broad criteria to ensure civilian crisis responders are dispatched to all behavioral health-related calls aligned with responders’ skills and expertise.
- › Elected officials must ensure that civilian crisis response programs are adequately resourced so they can consistently deliver timely responses to a broad range of behavioral health situations.
- › Any analysis of 911 data conducted to determine community needs for civilian crisis intervention should account for the limitations of these datasets and take care to consider the full range of call types appropriate for unarmed crisis responders.

Although this fact sheet focuses on behavioral health crises, communities have pursued a wide range of strategies to enhance public safety without police, and there are many other concerns coming to the attention of 911 operators that may benefit from civilian responders.¹⁴ For more information, see Vera’s companion analysis on [what 911 data tells us about the overreliance on policing](#), as well as our [fact sheet series on alternatives to policing](#).

Endnotes

- 1 Jackson Beck, Melissa Reuland, and Leah Pope, *Behavioral Health Crisis Alternatives, Case Study: CAHOOTS: Eugene, Oregon* (New York: Vera Institute of Justice, 2020), <https://perma.cc/CU6Q-KYYZ>; Brian Blick, Vinnie Cervantes, Blake Christianson, et al., *STAR Program Evaluation* (Denver: Denver Police Department, 2021), <https://perma.cc/C9KA-5289>; Mental Health San Francisco Implementation Working Group, *Street Crisis Response Team Issue Brief* (San Francisco: San Francisco Department of Public Health, 2021), <https://perma.cc/3ZK3-A63M>; Justin Garcia, “St. Pete’s Unarmed Responders Have Answered Nearly 3,000 Crisis Calls That Would’ve Gone to Cops,” *Creative Loafing Tampa Bay*, July 29, 2021, <https://perma.cc/2NK8-38YA>.
- 2 Beck, Reuland, and Pope, *Behavioral Health Crisis Alternatives*, 2020; Blick, Cervantes, Christianson, et al., *STAR Program Evaluation*, 2021; Mental Health San Francisco Implementation Working Group, *Street Crisis Response Team Issue Brief*, 2021; Garcia, “St. Pete’s Unarmed Responders,” 2021.
- 3 Cynthia Lum, Christopher S. Koper, and Xiaoyun Wu, “Can We Really Defund the Police? A Nine-Agency Study of Police Response to Calls for Service,” *Police Quarterly* (2021), <https://journals.sagepub.com/doi/pdf/10.1177/1098611211035002>.
- 4 Ibid.
- 5 Taleed El-Sabawi and Amy C. Watson, “The Risk of Relying on Existing 911 Data to Estimate Behavioral Health-Related Call Volume” (working paper, Florida International University and University of Wisconsin-Milwaukee, Milwaukee, Wisconsin, 2022).
- 6 Eugene Police Department Crime Analysis Unit, *CAHOOTS Program Analysis* (Eugene, OR: Eugene Police Crime Analysis Unit, 2020), <https://perma.cc/MN3F-DD2R>; and Blick et al., *STAR Program Evaluation*, 2021.
- 7 Amos Irwin and Betsy Pearl, *The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call* (Washington, DC: Center for American Progress and the Law Enforcement Action Partnership, 2020), <https://perma.cc/6ZA4-YADJ>.
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- 9 Eugene Police Department Crime Analysis Unit, *CAHOOTS Program Analysis*, 2020.
- 10 Eugene Police Department Crime Analysis Unit, *CAHOOTS Program Analysis*, 2020; and Blick et al., *STAR Program Evaluation*, 2021.
- 11 Lum, Koper, and Wu, “Can We Really Defund the Police? A Nine-Agency Study of Police Response to Calls for Service,” 2021.
- 12 Molly Bernstein and Sean McElwee, “National Poll: Shift Law Enforcement Funds to Non-Police Emergency Response,” *The Appeal*, April 8, 2021, <https://perma.cc/8X9C-YWYQ>.
- 13 Sandra van den Heuvel, Marta Nelson, and Linh Nguyen, *How the American Rescue Plan Can Foster an Equitable Recovery* (New York: Vera Institute of Justice, 2021), <https://perma.cc/2ASE-NF2X>.
- 14 Irwin and Pearl, *The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call*, 2020.

For more information

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