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Our Neighborhoods, Our Safety

A Blueprint for a Unified Public Health Approach to Community Safety in Washington, DC

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Credits

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Letter from CICS Executive Director

When people call 911, they are often at their most desperate moments. Stretched beyond their own capacity to fix things. Our emergency response system is relatively well designed to respond to certain kinds of crises: a fire, an on-going armed robbery, a heart attack. But the hidden truth of 911 is that most calls don't fall neatly into the police/fire/EMS buckets. They often involve problems exacerbated by the failures of the rest of our social services system. And we ask police to show up and solve these problems, not because they're best equipped to do so, but because we have provided no other options.

It is past time to develop another tool to add to the emergency response toolbox. We know we can do it, because we have done it before. It wasn't always the case that you could count on 911 to respond well to a heart attack. Up until the 1960s, if you had a heart attack you might expect emergency medical services to be provided by police, fire departments, volunteer groups, directly by hospitals, or even undertakers. Ambulances staffed by standardized, professionally trained emergency medical providers are a relatively new innovation.

Over the past five years, our team at the Center for Innovations in Community Safety has partnered with municipalities across the nation that are taking a broader approach to keeping their neighborhoods safe. One by one, cities keep coming to the same conclusion. Putting every social problem at the feet of law enforcement and hoping for the best isn't just insufficient–it's counterproductive. Once cities start sending community responders to behavioral health calls, everyone benefits: including the people in crisis and the police officers who can focus instead on serious crimes.

Nationwide, this innovation in emergency response is quickly becoming the standard. And it's not just because sending mental health professionals to respond to people having mental health crises is required by the Americans with Disabilities Act and the Rehabilitation Act. It's because this approach provides better services to residents and doesn't waste precious law enforcement resources. This paper is a suggested roadmap for how to bring this innovation to DC. It reflects input from a wide range of expert stakeholders from here in the District–people with lived experience, advocates, clinicians, and more–all of whom agree that it is long past time for Washington, D.C. to commit to making community response work. With new leadership coming to the Mayor's office this year, there is no better time to embrace a more comprehensive, sustainable, and effective way of helping people in crisis.

Tahir Duckett

Preface and Acknowledgements

Across the country, communities are reimagining what it means to keep people safe. In Washington, DC, this moment calls for a thoughtful, coordinated approach to responding to crisis—one that recognizes that not all emergencies require a law enforcement response, and that care, connection, and community expertise are essential components of public safety.

This Blueprint is grounded in a simple but transformative idea: that safety and health are deeply interconnected. When residents call for help, the response they receive should be aligned with their needs, whether those needs are rooted in mental health, substance use, housing instability, or other social challenges. This Blueprint is designed to support the District in building a comprehensive, care-centered crisis response system that operates alongside and in partnership with existing emergency infrastructure.

This work is not starting from scratch. DC is home to a strong network of community-based organizations, public agencies, and advocates who have long been responding to crises with compassion and expertise. The Blueprint builds on that foundation, drawing from local leadership, national best practices, and the lived experiences of those most impacted by crisis response systems.

At its core, this document is both a roadmap and an invitation. A roadmap for how DC can strengthen and align its crisis response system. And an invitation to continue working collectively across government, community, and systems to create a model of safety that is responsive, equitable, and rooted in care.

This Blueprint reflects the contributions of many individuals and organizations who are deeply committed to advancing community-centered approaches to safety in Washington, DC. We are especially grateful to the community members, advocates, and individuals with lived experience who shared their perspectives, stories, and vision for what a more responsive and humane crisis system can look like. Your voices are essential, and this work is stronger because of your leadership.

We also recognize that this process was time-bound, and we were not able to connect with everyone whose voice is critical to this work. We know there are perspectives and experiences that are not fully captured here. As this Blueprint moves forward, we are committed to continuing to engage, listen, and build with additional partners, ensuring that future iterations reflect an even broader set of voices and lived experiences. Though we relied heavily on input from our partners, any mistakes herein are ours alone.

This Blueprint is the product of collective effort. It reflects a shared belief that a stronger, more effective crisis response system is not only possible—but necessary.

For a list of contributors please see **Appendix A**.

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Executive Summary

Every day, residents of DC call 911 for help during moments of crisis—mental health emergencies, substance use, domestic conflict, and housing instability. Yet too often, the system responds in ways that do not match either the scope or the scale of the need. A person in crisis on the street is seen as a problem to be removed–by force, if necessary. A neighborhood's trauma after a shooting is barely addressed, if at all. Our response, or lack thereof, reflects a system that is fragmented, over-reliant on enforcement, and not designed to address the root causes of crisis.

This Blueprint puts forward a clear and urgent path forward: **community safety must be treated as a public health responsibility**. Safety is not only about responding to harm, it is about preventing it, addressing the conditions that drive it, and ensuring that every resident receives the right response at the right time. A truly public health approach to safety must also explicitly account for how violence and victimization shape mental health outcomes, housing instability, and repeated system involvement. The individuals most likely to call for help are often survivors of violence themselves—and the system must be designed with that reality at the center.

DC has already made meaningful investments in crisis response and community-based services. But these efforts are spread across agencies, funding streams, and leadership structures that operate largely in silos. The result is a system that is difficult to navigate, inconsistent in delivery, unable to fully meet the scale of need, and strategically disconnected. **The challenge now is not whether the District has the right pieces, but how to bring them together into a coordinated, integrated, durable system.**

A Structural Shift Toward Coordination and Accountability

This Blueprint's central recommendation is to establish a Community Safety Department (CSD) and Deputy City Administrator for Community & Public Safety to lead and operationalize a unified, public health–anchored approach to crisis response.

CSD would serve as the operational backbone of this strategy—built from DBH's existing Crisis Services Division and expanded to consolidate related functions. It would strengthen and expand the District's crisis response infrastructure, integrating fully into 911, and ensuring that community responders are deployed as a reliable, first-line response for nonviolent crises.

The Deputy City Administrator for Community & Public Safety would oversee the District's first response system as a unified portfolio—a recognition that the public health approach of community safety must be strategically aligned with the efforts of our traditional public safety infrastructure. The Deputy City Administrator will have supervisory authority over the **Community Safety Department (CSD)**, **Metropolitan Police Department (MPD), Fire and EMS Department (FEMS), and Office of Unified Communications (OUC)** — elevating community response to the same institutional

level as police and fire, and providing the focused executive leadership needed to drive coordination across agencies.

Together, these changes move DC from a collection of programs to a cohesive system of care—one that connects prevention, response, and long-term stabilization.

Why This Matters Now

DC has the resources and leadership to build a national model for community safety. But without alignment, even strong programs will fall short. Fragmentation is the barrier and coordination is the solution.

Establishing a Deputy City Administrator for Community & Public Safety and a Community Safety Department is not simply a new structure. It is a commitment to governing safety differently: centering care, aligning systems, and building a response that reflects the real needs of DC residents.

Building a durable, sustainable safety ecosystem requires political will that extends beyond reactive policymaking, instead turning towards long-term, care-centered approaches. The District has an opportunity to move from incremental change to system transformation—to build a model where safety is defined not just by how we respond to a crisis, but by how well we prevent it. This is the moment to create a unified public health strategy for safety, and to build the infrastructure to deliver it.

Summary of Recommendations

Establish a Community Safety Department

Create a Community Safety Department (CSD) built from DBH's existing Crisis Services Division, to house and strengthen the District's community response capacity while consolidating related community safety functions, including violence prevention, street outreach, and other services requiring specialized, non-law enforcement expertise. CSD would better align strategy, funding, and operations across programs that currently operate in silos but serve overlapping populations.

Unify First Response Under a Deputy City Administrator

Create a **Deputy City Administrator for Community & Public Safety** to oversee the District's first response system as a unified portfolio: **CSD alongside MPD, FEMS, and OUC.** This structure elevates community response to the same level as police and fire and provides focused executive leadership for the agencies that must work together every day.

Community Priorities and Recommendations at a Glance

The table below maps the nine community priorities to specific recommendations for how CSD should be designed and governed.

Community Priority	Recommendation
"Community Safety Must Center Survivors"	Integrate survivor-serving organizations as essential infrastructure, not just referral partners. Ensure system-wide education on the role of advocates, and establish confidentiality and trust protections when connecting community-based advocates to government systems.
"The Right People Should Show Up"	Design CSD community response roles spanning prevention, intervention, outreach, and follow-up. Expand scope beyond CRT's current model, including transport capability, non-police domestic violence response, and street medicine.
"When You Call, Help Should Come"	Staff responder roles at levels that will meet actual demand. Equip CSD as first responders with vehicles, radios, and dispatch integration.
"One Call Should Be Enough"	Integrate CSD response into 911 dispatch. Rely on 911 to dispatch in-person responses; 988 for telephonic support.
"Bring the Pieces Together"	Consolidate community safety functions under CSD through insourcing, coordination, and funding oversight. Ensure CVI and community response operate as a unified strategy. Redesign contracts to empower community providers. Support, don't supplant, the existing provider ecosystem.
"Show Us What's Happening"	Mandate public reporting, build a data dashboard, partner with evaluators from day one.

“Community Has a Seat at the Table”	Establish a Steering Committee by statute. Institutionalize feedback and multilingual public education.
“Build It to Last”	Anchor CSD as a permanent department with its own budget authority. Invest in workforce.
“Housing, Housing, Housing”	Treat housing as part of the response, not a referral. Embed stabilization services and housing coordination within CSD, with dedicated vouchers and care navigation for high-need situations.

Introduction

Our DC neighbors are calling 911 during some of the most vulnerable moments of their lives: a mental health or substance use emergency, a domestic dispute, a moment of grief that has intensified. All of these are crises and, too often, the only response available is a police officer with a firearm. Nationally, a significant share of police killings involve individuals in mental health crises, underscoring a dangerous mismatch between need and response (1). The 2024 killing of Clifford Brooks by MPD officers is a stark reminder of the consequences when care is not the default (2). Even when outcomes are not fatal, untreated behavioral health needs often escalate, leading to deeper system involvement and long-term harm (3). This mismatch is not just ineffective—it can be life-altering or deadly (1,4). DC deserves a community safety system that delivers the right response at the right time.

A safer DC is a DC where a person in crisis can reach a skilled mental or behavioral health responder, where a young person caught in a cycle of violence can find a credible messenger who has walked the same road, and where the conditions that breed crisis (specifically racism, poverty, trauma, and disconnection) are addressed before they escalate into emergency.

This Blueprint advances a vision of community safety rooted in a public health approach and operationalized through emergency response systems and other forms of crisis care. It begins by anchoring our approach in a *public health framework*, proceeds to define what it means to build a *care-centered crisis response infrastructure*, maps the *District's current safety ecosystem*, and finally outlines a path toward a *more equitable and effective crisis response* for all residents.

DC has made meaningful progress in recent years. Homicide rates declined significantly in 2024 and 2025, and new crisis response models have begun to take hold (5,6). But progress is uneven, funding is fragile, and the structural inequities driving crisis remain largely intact. For the residents of Wards 7 and 8, (particularly Black and Brown Washingtonians who have been most impacted by violence and aggressive policing), incremental change is not enough. This Blueprint calls for a systems-level rethinking of how the District keeps its residents safe through care, coordination, and sustained investment in well-being.

In 2025, Georgetown Law's Center for Innovation in Community Safety (CICS) launched a community-driven process to develop a comprehensive blueprint for alternative 911 responses in Washington DC. This work included (1) a review of publicly available information on the District's Community Response Teams (CRT) to understand the current landscape; (2) a partnership with the University of Chicago Health Lab to assess and analyze available 911 diversion and crisis response data; and (3) engagement with community members, government agencies, and business stakeholders to identify strengths, gaps, and opportunities.

The sections that follow define community safety, examine the role of community responders and crisis response teams, describe DC's current crisis response infrastructure, and elevate community perspectives. The Blueprint concludes with recommendations to strengthen and sustain a more responsive, equitable crisis response infrastructure in the District.

Defining Community Safety: A Public Health Approach

Community safety is a public health issue. And like all public health issues, it demands sustained investment, strong coordination, evidence-informed practice, and a commitment to the principle that every DC resident (irrespective of their race, immigration status, or income level) deserves to be safe, seen, and supported.

Community safety involves more than the absence of crime. Through a public health lens, safety is a condition shaped by the social, economic, and environmental factors that either protect people from harm or leave them exposed to it. The Centers for Disease Control and Prevention Foundation defines public health as "the science of protecting and improving the health of people and their communities"(7). A public health approach to safety helps us understand violence and crime as symptoms of deeper, often systemic conditions: poverty, housing instability, untreated mental illness, historical trauma, and disinvestment in communities (8). When these systemic conditions go unaddressed, violence, victimization, behavioral health emergencies, and other crises are inevitable.

Understanding the intersection between poverty, housing instability, untreated mental illness, trauma, and safety does not mean that those afflicted by these social inequities should be thought of as "unsafe." It is actually precisely the opposite—these neighbors of ours are more vulnerable to violence and victimization than those more privileged.

For DC residents, this framing matters enormously. The District is simultaneously one of the wealthiest jurisdictions in the nation and home to profound inequality, particularly for Black and Brown residents east of the Anacostia River. **A public health approach to community safety recognizes that sustainable safety is built through prevention, early intervention, treatment, and healing.** It asks, What conditions allow people to thrive? What disrupts those conditions? And what interventions at the individual, community, and policy level can restore them?

The Social Ecological Model of Safety

Public health practitioners rely on the Social-Ecological Model (SEM) to understand how individual behavior is shaped by multiple, overlapping layers of influence: **individual, relationship, community, and societal**. The Centers for Disease Control and Prevention applies this model directly to violence prevention, recognizing that no single factor determines whether someone will experience or perpetrate violence (9). Applied to community safety in DC, the SEM reframes the question from "Why did this person commit a crime?" to "What conditions made violence more likely, and what conditions can make safety more likely?"

At the **individual level**, risk factors such as prior trauma, untreated mental illness, substance use disorders, and lack of educational or economic opportunity are well-documented contributors to violence. At the **relationship level**, exposure to domestic and other kinds of violence, lack of positive mentors, and social isolation compound individual risk (10). Victimization extends beyond intimate partner and domestic violence. Community members, particularly young Black men in disinvested neighborhoods, who are regularly exposed to shootings, assaults, robbery, and other forms of street violence can have their sense of physical and psychological safety profoundly shaped by those experiences. Research consistently indicates that victimization by community violence is one of the strongest predictors of symptoms of trauma, including post-traumatic stress disorder (PTSD), and experiencing multiple forms of victimization compounds these effects (11,12).

At the **community level**, concentrated poverty, lack of access to quality schools and healthcare, and the physical deterioration of public spaces create environments where violence can take hold (10). And at the **societal level**, structural racism, historical disinvestment, punitive drug policies, and policies that have criminalized poverty and mental illness have shaped unequal safety landscapes across the District.

A public health approach grounded in the SEM demands responses at every level. This approach tackles not just downstream interventions after a crisis has occurred but also upstream investments in the conditions that make crises less likely in the first place.

The Public Health Approach to Community Safety

Public health offers the same proven, four-step framework for addressing violence as it would any other preventable health condition: define and monitor the problem, identify risk and protective factors, develop and test prevention strategies, and assure their widespread adoption. Applied to community safety, **this approach shifts the focus from reactive response to intentional, evidence-driven prevention** (13). This is the backbone of the approach the District must begin to take.

- **Define and Monitor the Problem:** This first step involves systematic data collection to track where violence and emergencies occur, who is most impacted, and how patterns change over time. The goal is to analyze safety data by demographic group, neighborhood, and ward to reveal the structural disparities that drive harm.
- **Identify Risk and Protective Factors:** This step focuses on research to understand the conditions that make safety more or less likely. It identifies risk factors (e.g., concentrated poverty, housing instability, untreated mental illness, and a contaminated drug supply) and protective factors (e.g., strong social networks, economic opportunity) to inform investments "upstream."
- **Develop and Test Prevention Strategies:** This involves developing and evaluating evidence-informed interventions like Community Violence Intervention (CVI) programs, Hospital-Based Violence Intervention Programs (HVIPs), evidence-based and age-appropriate drug education and harm reduction services, and Community Response Teams (CRTs). It also requires a commitment to discontinuing approaches, such as aggressive policing, that cause harm.
- **Assure Widespread Adoption:** The final step is to scale effective, evidence-based strategies, ensuring they are not just piloted but become embedded as durable infrastructure. This requires sustained funding, cross-agency coordination, workforce development, data collection, and building community trust.

Understanding community violence as a public health issue requires taking seriously the downstream consequences of victimization. **This includes both the act of violence itself and the cascading effects on mental health, housing stability, and accessing social services and resources** (14). These consequences are predictable, well-documented, and must inform how DC designs its community safety infrastructure. For DC residents, particularly Black and Brown residents, untreated trauma from victimization is both a by-product and structural driver of violence and crime.

Victimization also contributes to housing instability and homelessness. Survivors of violence, including those who have experienced sexual or domestic violence or repeated exposure to neighborhood and community violence, are often forced to leave their residences due to safety concerns, are unable to maintain employment due to trauma symptoms, or face financial instability as a direct consequence of their victimization. **High rates of housing instability and homelessness in communities with concentrated violence are symptoms of the underlying failure to treat victimization as a health issue.**

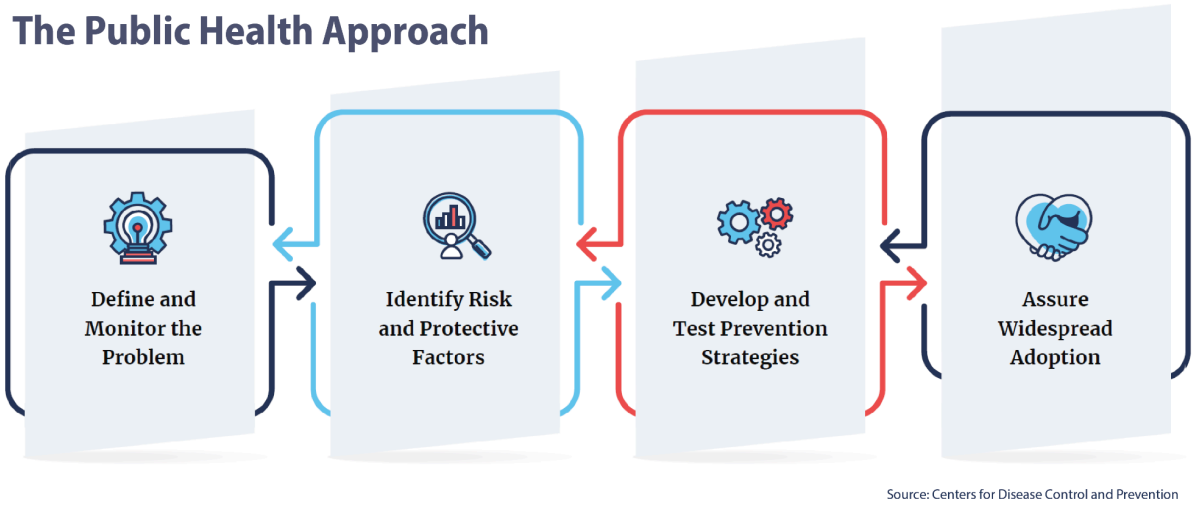
Victimization can shape patterns of repeated interaction with the criminal legal, child welfare, and behavioral health systems, often in ways that deepen harm rather than resolve it. Adults with unaddressed PTSD from prior victimization are at elevated risk for future system contacts. Disrupting this cycle of victimization, trauma, and system involvement requires treating

victimization as the public health issue it is: with screening, trauma-informed care, and community-based supports built into every point of contact across DC's safety ecosystem.

Taken together, the downstream impacts of victimization reveal a tightly linked chain of harm that extends far beyond the initial act of violence. **Exposure to community violence predictably destabilizes mental health, housing, and economic security, increasing the likelihood of further system involvement and compounding vulnerability over time.** Without early, trauma-informed intervention, victimization diminishes community safety by reproducing harm rather than resolving it.

The symptoms of victimization often show up in crises–in the moments where someone calls 911. The interventions we provide in these moments can either set people on a path to healing or exacerbate underlying conditions. That is why sending the right response matters.

Figure 1: CDC Public Health Approach



Source: Centers for Disease Control and Prevention

The Right Response at the Right Time

Across the United States, communities are increasingly recognizing that emergency response systems must be designed to match the nature of the need. Just as **we do not respond to a heart attack with a police officer, we should not routinely respond to a mental health or behavioral health crisis with a police officer.** National guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes that it is "unacceptable and unsafe" for law enforcement to function as the default response to behavioral health crises (3). And, as many courts have found, it is also likely a violation of the Americans with Disabilities Act and the Rehabilitation Act (e.g., *Bread for the City v. District of Columbia*). Instead, crisis systems should be structured to deliver the right response at the right time.

This Blueprint is an opportunity for specialization and optimization. A mental health crisis calls for a mental health professional and a substance use emergency calls for harm reduction expertise. Building a system that responds to these distinctions by deploying the right responder at the right time is the central goal of community safety design.

> *A community that is truly safe is one where its most vulnerable residents can call for help without fear and receive a response that meets their need.*

Understanding Community Responder Teams and their Role in Community Safety

The overall goal of **Community Responder Teams (CRTs) is to divert nonviolent mental health, behavioral health, and quality-of-life calls for service away from law enforcement and toward professionals trained to address these needs.** CRTs are designed to de-escalate potentially volatile situations, provide immediate on-scene support, and connect individuals to ongoing care and services (15,16) .

This model responds to a longstanding gap in traditional emergency response systems. Law enforcement officers are frequently tasked with responding to mental health and other emergency calls that are not best handled with a law enforcement intervention–this despite often lacking the specialized training or dedicated units required to address these situations effectively. A national survey of more than 2,500 law enforcement agencies found that over half reported responding to mental health-related calls without specially designated personnel or units(17).

This mismatch between need and response can have serious consequences. Police officers, who are not trained to be clinicians or behavioral health professionals, may default to enforcement-based approaches when responding to individuals in crisis. Research shows that **people with serious mental illness (SMI) are 11.6 times more likely to experience police use of force than those without SMI, and one in four individuals with mental health conditions have a history of arrest** (18).

Growing evidence suggests that CRTs are better equipped to respond to many of these calls for service. These teams provide specialized, care-centered responses to incidents such as welfare checks, behavioral health crises, disputes, and other nonviolent concerns. An analysis of eight unarmed CRT programs found that 91% of the calls they handled fell into these categories (16). Across these programs, **CRTs requested law enforcement backup in only 2% of cases,** indicating that the vast majority of situations can be safely and effectively managed without police involvement (16,19).

Examples of CRTs Across the United States

Cities across the country have adopted a range of governance models for alternative response. Some are housed inside cities as standalone community safety departments or as part of other departments like Fire, EMS, or even Parks and Recreation. Others are contracted out to nonprofit or for-profit service providers. These structures shape how programs are funded, staffed, and integrated into 911 systems. The following chart highlights examples of how these models have been implemented across different jurisdictions.

Figure 2: Community Safety Program Examples

A comparative table of CRT programs across jurisdictions, including staffing models, call volumes, funding structures, and scope of response. → **View the full table**

Funding CRTs

Jurisdictions across the country use a range of funding strategies to support Community Responder Teams (CRTs), each with distinct advantages and limitations. State funding, dedicated grant programs, Medicaid reimbursement, and philanthropic support have all played important roles but these sources are often time-limited, administratively complex, or restricted in how funds can be used (20).

As explored further in our upcoming Alternative Response Research Collective (ARRC) white paper Building What Lasts, local general funds have emerged as the most stable and effective foundation for CRT operation (21). These funds provide flexible, consistent support for core functions such as staffing, training, and infrastructure and signal that CRTs are a permanent component of the public safety system. DC has taken this approach and should continue to prioritize it.

At the same time, leading programs layer in additional funding streams such as Medicaid, state and federal grants, and philanthropy to support innovation and reduce reliance on any single source. DC should continue advancing this diversified strategy, including efforts to maximize Medicaid reimbursement.

Finally, in a constrained fiscal environment, sustainability will also require more strategic use of existing resources. Jurisdictions are increasingly examining how to reduce duplication, better align funding with call types, and reallocate dollars toward more appropriate, cost-effective responses. DC should pursue similar analysis to ensure its public safety investments are as efficient and impactful as possible.

Power of the People

Funding decisions are not driven by quantitative data and policy alone, they are **shaped by the voices, priorities, and advocacy of the communities these systems are meant to serve**. Across the country, community members, grassroots coalitions, and individuals with lived experience have played a decisive role in advancing alternative response models. Their ability to organize, tell their stories, and demand more appropriate responses to crises has helped move CRTs from pilot concepts to funded programs that meet the real needs of real people. Public testimony, community forums, and sustained advocacy efforts can influence budget decisions, build political cover for elected leaders, and ensure that investments reflect community-defined needs.

This "power of the people" is not a peripheral force, it is a core driver of sustainability. Programs that cultivate strong relationships with community stakeholders, center lived experience, and maintain transparency in their outcomes are better positioned to secure and protect long-term funding. In a landscape where political priorities can shift, community trust and advocacy often provide the most consistent and enduring foundation for continued investment.

Outcomes of CRTs

A growing body of national research demonstrates that Community Responder Teams (CRTs) can produce meaningful outcomes for individuals, public safety systems, and communities. While the evidence base is still developing, early findings across multiple jurisdictions point to consistent trends: reduced reliance on law enforcement, improved alignment between need and response, and decreased involvement in the criminal legal system.

For example, an evaluation by the Urban Institute found that individuals who had a clinical encounter with Denver's Support Team Assisted Response (STAR) program experienced statistically significant reductions in criminal legal system involvement one year after their initial interaction (22). The study also found that, compared to individuals who received a police response to similar calls, those served by STAR were less likely to have subsequent police contact within the following year (22). These findings suggest that care-centered responses can improve safety, interrupt cycles of repeated system involvement and better connect individuals to appropriate support.

Emerging evidence from other jurisdictions highlights the operational impact CRTs can have on broader public safety systems. In cities such as Albuquerque and Durham, Community Responder Teams have demonstrated the ability to safely handle a significant volume of nonviolent calls that would otherwise be routed to law enforcement (19). By diverting these calls, CRTs reduce the number of incidents requiring police response, allowing officers to focus on higher-priority public safety needs.

Across programs, additional emerging outcomes include:

Improved community trust and willingness to call for help (23)
Vera Institute of Justice, 2021

Cost efficiency and system savings (22)
Urban Institute, 2026

High rates of call resolution without law enforcement involvement or requests for backup (12,16)
Harvard Kennedy School Government Performance Lab, 2025; *Mayors Innovation Project. The Right Response at the Right Time: Rethinking Public Safety in Cities, 2025*

Reduced arrests and criminalization of behavioral health (1,3)
Treatment Advocacy Center, 2015; *SAMHSA, 2025*

Increased access to behavioral health and social services (3)
SAMHSA, 2025

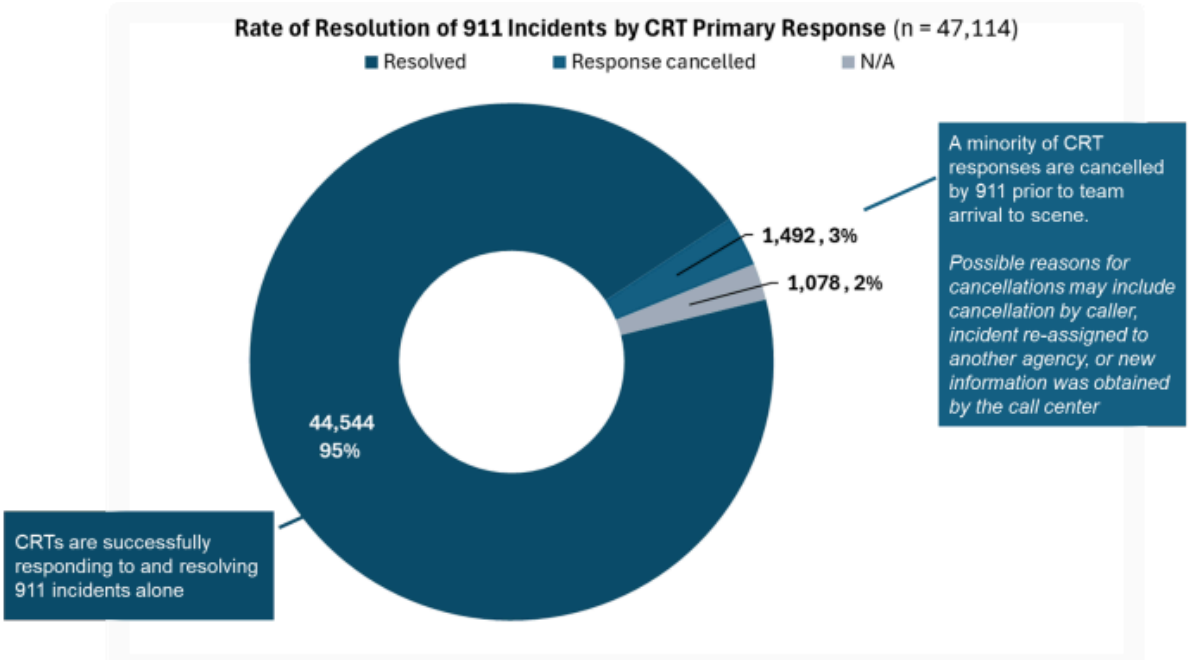
Reduced emergency department utilization (24)
National Alliance on Mental Illness, 2019

Workforce specialization and economic opportunities(21)
Center For Innovations in Community Safety, 2026 (Forthcoming); *SAMHSA, 2025*

Together, these outcomes underscore that alternative response programs are not only effective at addressing crises, but are essential to building a more efficient, equitable, and care-centered public safety system.

IS IT SAFE?
Across these programs, CRTs requested law enforcement backup in only 2% of cases, indicating that the vast majority of situations can be safely and effectively managed without police involvement (12,16). Figure 2 is a summary of calls for services that 8 CRTs responded to as reported and analyzed by the Harvard Kennedy School Government Performance Lab, demonstrating that 95% of eligible 911 calls were successfully responded to and resolved without police.

Figure 3: Harvard GPL Analysis of Rate of Resolution of 911 Incidents by CRT Primary Response



Source: Examining Alternative Response: A Landscape Analysis of Nine Community Responder Teams by the Harvard Kennedy School Government Performance Lab.

The Current DC Community Safety Ecosystem

What Shapes Safety in DC?

Safety in Washington, DC is shaped as much by political and social conditions as it is by any individual program or intervention. Understanding this context is essential to designing a community safety system that is both effective and sustainable.

DC occupies a unique political position. While the District has home rule authority, its budget and policies remain subject to Congressional oversight. Federal priorities (particularly related to policing and prosecution) have long influenced how the District allocates public safety resources, at times constraining the ability to scale or sustain alternative approaches, even when community needs and evidence support them.

Local dynamics further shape these decisions. In moments of heightened concern about crime, there is often pressure to prioritize visible, enforcement-based responses. This can make sustained investment in prevention, behavioral health, and community-based care more difficult to maintain. Building a durable safety ecosystem requires political will that extends beyond reactive policymaking and supports long-term, care-centered approaches.

At the same time, safety in DC cannot be separated from its history. Longstanding patterns of racial segregation, discriminatory housing policy, inequitable enforcement, and disinvestment have concentrated risk in certain parts of the city, particularly in Wards 7 and 8. These disparities (reflected in higher rates of violence, poverty, and unmet behavioral health needs) are the result of decades of policy decisions, not chance.

Community trust is another defining factor. Decades of over-policing and systemic inequities have eroded trust in public institutions, particularly among Black and Brown Washingtonians. This mistrust directly impacts crisis response: when people believe calling for help may lead to harm rather than support, they are less likely to reach out. Research shows that lower levels of institutional trust are closely tied to poorer health and safety outcomes (25).

Rebuilding trust has to be foundational. A community safety system cannot function effectively if residents do not trust it.

Services in the Crisis Continuum

DC's crisis response infrastructure is spread across several programs operated or contracted through the Department of Behavioral Health (DBH) and other city departments. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies three foundational elements that everyone should have access to in a crisis: **someone to contact, someone to respond, and a safe place for help** (3)**.** This section walks through the services DC **currently** offers along this continuum, who operates them, and where gaps exist.

Figure 4 : The Crisis Services Continuum

Someone to Contact

DC has several ways for people in crisis to reach help by phone, including 911, 988, and the Access Helpline, a direct line to CRT. (26–28). However, not all of these options are widely known. Some providers have learned to call CRT directly, but many residents and organizations are only aware of 911. How well the system works often depends on which number you know to call.

Service	Operated By	Available	What It Does
911	Office of Unified Communications (OUC)	24/7	Emergency dispatch for police, fire, and emergency medical services. Limited behavioral health diversion to the Access Helpline, Co-Response (COR) teams, and the Community Response Team (CRT), Registered nurses assess non-emergency 911 callers and redirect to appropriate care (urgent care, clinics, telehealth).
988 / Access Helpline (AHL)	DBH	24/7	Telephonic crisis support for mental health, substance use, and suicide crises. Can activate CRT or Child and Adolescent Mobile Psychiatric Service (ChAMPS) for in-person response. Also receives calls routed from OUC (29).
CRT Direct Line	DBH	24/7	Direct request for CRT response, bypassing 911. CRT team leads assess whether in-person or telephonic response is needed (30) .
DC Victim Hotline	National Center for Victims of Crime	24/7	Funded by Office of Victim Services and Justice Grants (OVSJG), the hotline is a chat, text-based resource, and crisis line for all crime victims in DC. Provides emotional support, information, resources, and connection to advocates from other partner organizations (31).
Crisis Hotline for Sexual Assault	DC Rape Crisis Center	24/7	The DC Rape Crisis Center provides immediate crisis and emotional support to people who have experienced sexual violence (32).

Someone to Respond

There are several resources and provider teams that respond to behavioral health crises in the field. However, it is important to understand how they are activated. If someone calls 911, the Metropolitan Police Department (MPD) and Fire and Emergency Medical Services (FEMS) can be dispatched directly through OUC. CRT can respond to 911 calls as well, but OUC must first refer the call to DBH, who then can dispatch CRT. In practice, this process is rarely completed, and CRT is rarely activated to respond to 911 calls. Based on the available data it was unclear if this is a process disconnect or a training issue. The other response teams listed below are also activated through referrals, direct calls, or internal coordination rather than through 911 dispatch. **This distinction matters: for most people in the District who call 911 during a behavioral health crisis, the default on-scene response is still a police officer.**

Service	Operated By	Available	What It Does
Crisis Intervention Officers (CIOs)	MPD	When available	984 officers (of ~2,000 patrol) trained in 40-hour Crisis Intervention Team (CIT) program. Can be requested for behavioral health-related calls.
Co-Response (COR)	MPD + DBH	M–F, 8am–7pm; Districts 1, 3, 5, 6	Five Crisis Intervention Officers (CIOs) paired with five DBH clinicians. Responds to 911 calls with a behavioral health component. Can also conduct proactive outreach and follow-ups.
Community Response Team (CRT)	DBH	24/7, 3 shifts, 69 positions	Two-person behavioral health teams (licensed clinicians, behavioral health specialists, peer support) respond to psychiatric, substance use, and trauma crises. Provides mobile crisis services, homeless outreach, and pre-arrest diversion.
Child and Adolescent Mobile Psychiatric Service (ChAMPS)	Catholic Charities (DBH contract)	M–F, 8am–8pm	Mobile psychiatric crisis response for youth ages 6–21. Responds at homes, schools, and in the community. CRT covers the ChAMPS line after hours and on weekends (33).
Homeless Outreach Teams	DBH, Department of Human Services (DHS), contracted community-based organizations	Varies	Street engagement with unsheltered individuals. Connect to services, provide crisis assessments, support basic needs. Includes the Projects for Assistance in Transition from Homelessness (PATH) program with 3 staff trained in Critical Time Intervention.
Assertive Community Treatment (ACT) Teams	Community-based organizations (e.g., MBI Health Services, Catholic Charities, Pathways to Housing, others) via DBH contracts	Varies by provider	Multidisciplinary mobile treatment teams (psychiatrists, nurses, addiction counselors, social workers, peer specialists) providing outpatient treatment wherever clients live, including outdoors (34).
Community Violence Intervention Programs	Community-based organizations (e.g., TRIGGER Project, Mute the Violence DC, and others) many with funding via ONSE	Varies by provider	Credible messengers with lived experience who interrupt cycles of violence and connect individuals to services. There are adult and youth-focused groups.
High Risk Domestic Violence Initiative	DC Safe with funding via OVSJG	24/7	Multi-agency response to the highest-risk domestic violence cases using a validated lethality assessment. HRDVI Lethality Assessment Program provides critical interventions within an hour of a crisis call and partners respond within 24–48 hours to implement expedited services and coordinated

Service	Operated By	Available	What It Does
			justice and social service support for survivors identified as high risk.

PERSPECTIVE FROM THE FIELD

"There is a significant gap in the District's system between ACT teams, primarily funded through Medicare/Medicaid, and CRT, which serves as the mental health emergency responder. This gap affects individuals with the most acute mental health needs, many of whom are justice-involved, chronically unhoused, and medically vulnerable.

These individuals require frequent intervention from CRT, law enforcement, hospitals, and fire/EMS, yet they often cannot be effectively served by ACT teams because they do not or cannot consent to services, a requirement under Medicaid/Medicare.

ACT teams, as currently structured, provide escalated case management but lack the intensive daily engagement needed for this population. CRT, by contrast, should be reserved for acute mental health emergencies rather than ongoing high-acuity casework."

— DC Business Improvement District (BID) Leader

This observation from a local service provider highlights a structural gap in the District's current system. When the right level of response is not available, providers and community members lean on whatever services they can access, even when those services were not designed for that purpose. ACT teams end up handling situations meant for crisis responders. CRT ends up managing individuals who need intensive ongoing support rather than emergency intervention. The result is that neither service can fully do what it was designed to do, and the people with the most acute needs fall through the gap between them.

A Safe Place for Help

The Department of Behavioral Health supports a number of services including psychiatric, housing, parental, behavioral health, substance use disorder services, and emergency psychiatric services. See chart below. In theory, any of these contracted service providers can serve as a safe place for help. However, **much like police with response, hospital emergency departments still become the default care facility when someone is in crisis and no other options are available.**

Service	Operated By	Available	What It Does
Hospital Emergency Departments	>10 Hospitals	24/7	Emergency psychiatric evaluation, stabilization, and discharge or referral to inpatient care. Often the default destination for behavioral health crises when other crisis resources are unavailable, at capacity, or unknown to the caller.

Service	Operated By	Available	What It Does
Comprehensive Psychiatric Emergency Program (CPEP)	DBH	24/7	24/7 emergency psychiatric services and extended observation beds for adults. Key gateway to emergency behavioral healthcare. Available via phone and in-person (35).
Crossing Place	Woodley House DC	24/7	Short-term therapeutic housing for adults experiencing mental health crises (36).
DC Stabilization Center	DBH + Community Bridges, Inc. (CBI)	24/7	24/7, no-cost, low-barrier crisis substance use disorder (SUD) services for adults regardless of gender, citizenship, or insurance status (37). Alternative to avoidable law enforcement and emergency room interactions.
Hospital-based Violence Intervention Programs (HVIPs)	Grant funded through OVSJG at 6 DC hospitals	Varies	Reduce unnecessary law enforcement contact by stabilizing individuals after injury, preventing retaliation, connection to pathways to support in partnership with Community Violence Interventionists (38).

> **PERSPECTIVE FROM THE FIELD**
>
> *"There is no dignity in going to CPEP. The team may be able to provide the best care, especially compared to a hospital, but the condition and location of the campus are undignified."*
>
> — Homeless services provider

Some service providers, particularly those that refer to crisis stabilization and sheltering services, observe that the conditions of many of the facilities people can go to are severely lacking, which discourages voluntary participation. These services, too, are stretched thin with resources. As a result, community partners and nonprofit organizations often step in as de facto safety nets—filling gaps the formal system cannot meet. **Drop-in centers, harm reduction providers, community centers, and libraries increasingly serve as trusted, accessible spaces where individuals can seek support, stabilization, and connection, even though they are not resourced or designed to carry this responsibility alone.**

What This Landscape Reveals

Taken together, these services represent a genuine investment in behavioral health crisis infrastructure. DC has people answering calls, teams responding in the field, and places for people to go. But several structural issues limit the system's effectiveness.

The next section brings together what we heard from community members, what the data reveal about how the system is performing, and a set of recommendations to move the District toward a more coordinated, effective, and care-centered crisis response system.

A Path Forward: Community Vision

Between October 2025 and March 2026, CICS held conversations with over 70 individuals at more than 45 organizations across DC to understand their perceptions of the current crisis response system and vision for improved systems. We connected with diverse organizations ranging from direct domestic violence, gun violence, mental health, and housing service providers to government, advocacy, and faith-based organizations. A list of the agencies that we spoke to can be found in Appendix A. These conversations focused on:

- **What is working well in DC crisis response now?**
- **What gaps and barriers do you see in accessing or providing care?**
- **What should a community-centered response look and feel like?**

The perceptions from community members who participated in this process provide important insights into their experiences and perceptions around alternative first responses in DC. Still, these perspectives are not comprehensive of all DC residents and leaders and only represent those from the individuals we engaged.

In addition to community conversations, **CICS partnered with the University of Chicago Health Lab to independently analyze the District's publicly available crisis response data** (see Appendix C).

Community members were clear about what works and what does not. They shared what they value in a crisis response system and what needs to change. Some offered specific ideas. Others described experiences that pointed toward solutions that have been developed and tested in other cities. Several people noted that it is hard to picture something different when the current system is all you know. This section brings together three sources: **what community members told us they need**, **what an independent data analysis confirms**, and **what we know works from helping other cities build these systems**.

Insights, Findings, and Recommendations

Establish a Community Safety Department and Unify First Response Under a Deputy City Administrator

Community safety functions in the District are currently spread across several city departments, under the purview of multiple Deputy Mayors. Crisis response, violence prevention, homeless outreach, and other critical safety services operate with separate leadership, contracts, data systems, and funding streams. The result is a system where overlapping populations are served by disconnected programs, and no single leader is responsible for ensuring these efforts work together. **The core recommendation of this Blueprint is to establish a Community Safety**

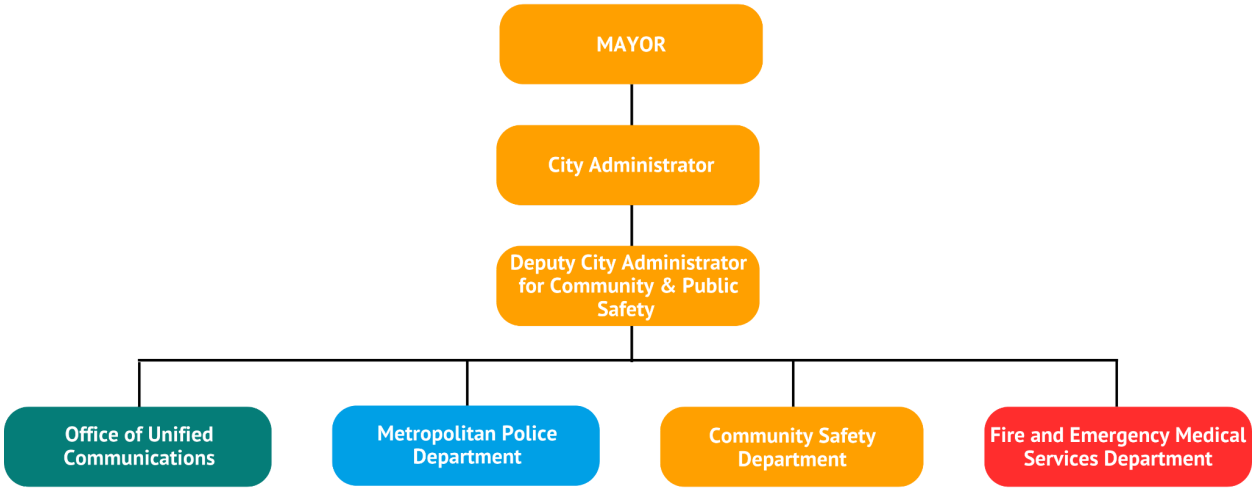
Department (CSD). CSD would be built from the foundation of DBH's existing Crisis Services Division and by consolidating related community safety functions and funding streams currently spread across city departments. **At its core, CSD would house and strengthen the District's community response capacity (the deployment of trained, unarmed professionals to crisis calls) expanding beyond the current CRT program's narrow scope.** But community response alone is not enough. The people this system serves face co-occurring challenges, including behavioral health crises, substance use, housing instability, and exposure to violence. **CSD must also bring in the complementary functions that intersect with community response, such as violence prevention and street outreach, so that a single department has the mandate, staffing, and infrastructure to address these interconnected needs together rather than in silos.**

CSD would not replace the full scope of services provided by agencies like the Department of Behavioral Health or the Department of Human Services. It would consolidate the functions where urgency, field response, and specialized expertise intersect, allowing other agencies to focus on their core missions while ensuring that crisis-level needs are met by a department designed for that purpose.

Focused Leadership for the First Response System

To ensure CSD has the institutional standing and executive support it needs, **this Blueprint recommends that the District create a Deputy City Administrator for Community & Public Safety to oversee the first response system as a unified portfolio: CSD alongside MPD, FEMS, and OUC.** This structure elevates community response to the same level as police and fire, establishes clear accountability for the District's entire first response system, and provides the focused leadership needed to drive coordination across agencies that must work together every day.

Figure 5: Proposed Deputy City Administrator Portfolio and Organizational Chart



The current Deputy Mayor for Public Safety and Justice oversees 12 agencies. That breadth of portfolio leaves limited bandwidth for the sustained, operational focus that building and integrating a new first response agency demands. A Deputy City Administrator with a tighter portfolio of four agencies, all focused on emergency response, can provide the intentional leadership, strategic direction, transparency, and coordination across agencies that community members and providers have said is missing.

The specific title and placement of this role matters less than the outcomes it must achieve:

- ➔ A single senior, executive-level leader with the authority to champion a unified public health approach to first response
- ➔ Ensure coordination across OUC, police, fire, EMS, and community safety
- ➔ Hold accountability for how the system serves DC residents.

A new administration will shape its own organizational structure. What matters is that community response is treated as essential public safety infrastructure, not a peripheral program.

This executive must also serve as a bridge to the broader continuum of care. Crisis response does not end at the scene. It connects to behavioral health treatment, housing, employment, and long-term stabilization managed by other parts of city government. The Deputy City Administrator would work in close partnership with Deputy Mayors and other senior leadership to ensure that first response is connected to the prevention and support services that residents need.

"Community Safety Must Center Survivors"

> *"A system that responds to crisis without recognizing victimization risks being incomplete at best, and harmful at worst."*
> — Service provider

WHAT WE HEARD

Community providers noted that mental health challenges, substance use, homelessness, and domestic conflict are deeply intertwined with victimization and survivorship. Individuals experiencing behavioral health crises, housing instability, or substance use are often also survivors of violence—including domestic violence, sexual assault, trafficking, and community violence. **These are not separate populations; they are overlapping realities.** A truly public health approach to safety must explicitly account for how violence and victimization shape mental health outcomes, housing instability, and repeated system involvement. Without this, the system risks treating symptoms while overlooking root causes. Providers also expressed concern over ongoing challenges when law enforcement and other system actors do not

consistently explain the role of advocates to survivors, leading to confusion, underutilization, and diminished access to support.

WHAT WE RECOMMEND

- **Integrate survivor-serving organizations within the broader community safety ecosystem**. Strengthen the role of community-based, trauma-informed survivor-serving organizations as first responders and long-term stabilizers, not just referral partners.
- **Ensure system-wide education on the role of advocates,** including within law enforcement and hospital-based systems, to ensure survivors are consistently informed of and connected to these supports.
- **Establish confidentiality and trust protections,** particularly when integrating community-based advocates into systems that may otherwise be tied to law enforcement or government data systems.

"The Right People Should Show Up"

> *"CRT has the right skillset, they just can't come."*
> — Service provider

WHAT WE HEARD

Community members strongly supported the existence of alternative first response options. There is shared consensus that police are not equipped to be first responders to behavioral health crises. One provider noted that a court in DC has already held that the Americans with Disabilities Act requires the District to deploy mental health professionals to respond to mental health calls (39). **Youth organizations** explained that putting people in handcuffs during a crisis is harmful, and that they instead try to handle situations in-house rather than call 911. Community members shared positive experiences with the **Child and Adolescent Mobile Psychiatric Service (ChAMPS) for youth and Assertive Community Treatment (ACT) teams for adults**, praising their outreach, follow-up, and responsiveness. However, ChAMPS saw its budget significantly reduced, **leaving a large gap in youth-specific crisis services**. Strengthening youth-focused services is essential to ensuring the right care, particularly in light of cultural disparities and the legacy of racial profiling in DC. Providers described the Community Response Team (CRT) as lacking an **"in-between" response** for people who need immediate help but not hospitalization. Furthermore, the Metropolitan Police Department (MPD) handles all CRT transports, meaning **police involvement remains regardless of the threat or level of crisis acuity. Domestic violence service providers** noted that police responses to domestic violence-related crises are not trauma-informed.

> *"Black youth are seen as a threat to white America and are denied healthy adolescent development."*
> — Kristin Henning, The Rage of Innocence: How America Criminalizes Black Youth (Pantheon Books, 2021)

WHAT WE FOUND

A meaningful share of 911 calls that could be handled by CRTs are not being diverted.

- DBH reports only 9 diversions from 911 that resulted in CRT deployment in all of FY25, though DBH staff have referenced additional referrals in conversation. Even those numbers are minimal relative to 1.4 million annual 911 calls.
- CRT's Medicaid-dependent model creates a structural disincentive to respond to calls that aren't eligible for Medicaid reimbursement.
  UChicago Health Lab Analysis, 2026
- In a recent DC Action survey of 108 young people, 70 — nearly two-thirds (65%) — reported that they wanted mental health help but did not get it.
  DC Action (26)

WHAT WE RECOMMEND

- **Design Community Safety Department (CSD) responder roles covering prevention, intervention, outreach, and follow-up, moving beyond CRT's current narrow scope**. Address gaps including non-police, post-crisis follow-up, street medicine, and connections to social determinants of health. Preserve and strengthen ChAMPS.
  (see ARRC White Paper, Who Responds Matters; forthcoming, May 2026) (40) for more detailed workforce solutions)
- **Equip CSD with transport capability,** including voluntary transport to providers and resources. In Albuquerque, community safety responders can transport even in involuntary hold situations, reducing trauma and police involvement.
- **Establish a dedicated Youth Crisis Response Unit** that deploys unarmed, multidisciplinary teams to respond to youth behavioral health and social crises through 911 and alternative dispatch pathways. This model should prioritize trauma-informed, culturally responsive care, family engagement, and connections to community-based services.
- **Strengthen the existing coordinated Domestic Violence Response (HRDVI)** that aligns CSD responders, advocates, community-based organizations, and MPD to respond to domestic violence related calls.

"When You Call, Help Should Come"

> *"Sometimes we're waiting hours for them to come out. But a lot of times they divert and tell us, just call the police. Or they say, oh, they have an ACT team assigned, so you have to call the ACT team. I just don't like the diversion sometimes that we get from CRT."*
>
> — Service provider

WHAT WE HEARD

Slow and inconsistent response times were the **most frequently raised concern** across every type of organization. Providers described waiting hours, being told to call police instead, or CRT arriving after the situation had resolved or escalated. Staff recalled CRT arriving in personal cars, while others said CRT could not be described as a "rapid response" resource. When CRT does arrive, the quality of care is often valued: providers describe responders as **prepared, informed, and able to de-escalate**. However, some providers also noted that response quality depends on relationships with individual team leads, not just availability, underscoring the need for standardized protocols and consistent staffing. A Business Improvement District (BID) safety leader and former firefighter argued that crisis response must be structured like an emergency service and that **co-locating responders in high-call neighborhoods** would improve both response times and community relationships.

WHAT WE FOUND

Response times reflect structural limitations, not individual effort.

- For the highest priority calls, the average time from 911 call to CRT arrival was 91 minutes in FY25.
- CRT requests MPD involvement on 11% of responses.
- DBH was unable to answer nearly 1 in 5 calls referred by OUC.

UChicago Health Lab Analysis, 2026

WHAT WE RECOMMEND

- **Staff CSD to actual demand.** Calculate 911 call volume appropriate for community response independent of funding. Use that analysis to drive staffing, shifts, and geographic deployment.
- **Equip CRTs as first responders** with marked vehicles, radios, mobile data terminals, and operational infrastructure on par with MPD and FEMS.

"One Call Should Be Enough"

> *"911 should be the one routing the call to other responders. It should not fall on the community to remember the different numbers."*
> — Youth-serving organization

WHAT WE HEARD

DC has multiple pathways for crisis help—911, 988, the Access Helpline (AHL), CRT's direct line, ChAMPS—but providers described them as **fragmented and poorly connected**. Multiple organizations were unsure which number to call or what resources were available. Staff expressed that it is **difficult to stay aware of all the developments** in the field and unclear where agencies work together. A harm reduction organization noted that DC has launched multiple initiatives with no coordinated structure connecting them.

WHAT WE FOUND

The Office of Unified Communications (OUC) already diverts tens of thousands of calls to non-police pathways—just not for behavioral health.

- In FY25, OUC diverted 35,461 calls to its Telephone Reporting Unit (TRU), 16,938 to the Department of Transportation, and 3,076 to the Nurse Triage Line, but only 870 to DBH.
- Of ~9,850 AHL/988 calls (FY24), only 2% resulted in a mobile crisis response.

UChicago Health Lab Analysis, 2026

WHAT WE RECOMMEND

- **Integrate CSD into OUC's 911 dispatch** with CSD embedded mental and behavioral health call takers or triage specialists at the dispatch center. For anyone needing in-person help, 911 is an effective front door.
- **Strengthen coordination between 911, 988, and community response.** A tighter relationship between CSD and OUC will ensure people in crisis are getting the right in-person or telephonic response.

How It Works Today vs. How It Should Work

Today, someone in crisis, or a community member trying to connect them to help, must navigate multiple phone lines, each with its own intake process and limited visibility into what other resources are available. Getting the right response often depends on which number the person happens to know. For many, the only way to reach CRT is to know its staff personally, and CRT is currently unable to respond to many call types that shouldn't require an officer.

The recommended model recognizes 911 as the most common front door for in-person crisis response, with well-trained call-takers, dispatchers, and CSD triage specialists embedded at OUC to help identify calls that can be safely diverted to a community response. This approach builds on a capability OUC already has — diverting tens of thousands of calls to non-police pathways every year — and institutionalizes it for behavioral health and community safety crises. For residents, the system becomes simpler: **one decision about whether they need someone there in person or someone to talk to.** Behind the scenes, the city's response becomes more comprehensive and better coordinated. **Appendices D and E** show the full process maps for readers interested in the operational details.

"Bring the Pieces Together"

> *"Nonprofits can't, and shouldn't, be expected to do everything. There must be broader systemic solutions."*
> — Harm reduction organization

> *"Services for youth must be provided in the spaces where young people are already physically present."*
> — Rachel White, Deputy Director of Youth Advocacy, DC Action

WHAT WE HEARD

DC funds crisis response, CVI, homeless outreach, safety ambassadors, ACT teams, ChAMPS, and a broad network of providers. **The investments and expertise exist**, but they are managed by different agencies—DBH, the Office of Neighborhood Safety and Engagement (ONSE), Safe Passage, the Department of Human Services (DHS)—with different leadership, contracts, and data systems. Some providers avoid city contracts entirely, citing hiring restrictions, mandated security firms, and reporting requirements that limit their ability to serve clients effectively. **Providers described bearing responsibilities the system should own**: youth organizations handling crises in-house, outreach workers pulled into mental health response, agencies coordinating across silos without support. People experiencing crises often face **interrelated challenges—housing, employment, family instability**—that a full department with a spectrum of roles can address through coordinated handoff to longer-term care.

We can't separate community violence prevention from crisis—they are two sides of the same coin. Community gun violence sends trauma shockwaves through neighborhoods. The best violence prevention models recognize the danger in those shockwaves and seek to deliver healing and recovery services through a variety of modalities. To have a well coordinated crisis response that delivers in all eight wards, CVI providers and Community responders must stay in

constant communication about on-the-ground developments. Violence prevention workers and crisis responders need a shared understanding of emerging trends and geographic patterns in crisis needs throughout the city to be able to effectively provide proactive guidance, support, and connection to services that can prevent a crisis from becoming a shooting.

> *Consistently we heard that many community-based organizations are filling critical gaps in services they were not designed or funded to provide. These needs reflect essential functions that should be more fully supported and resourced within the District's overall safety infrastructure.*
> — Homeless Services Provider

WHAT WE FOUND

DC invests at a level comparable to leading programs. The difference is structure, not funding.

- Both Albuquerque and Durham consolidated crisis services into a single department with dispatch integration and first responder infrastructure and responded to a dramatically higher volume and rate of calls than DC CRT.

Program	FY25 Budget Actuals	FTEs	Annual Responses	Responses per FTE
Albuquerque Community Safety Dept.	$18.5M	136	42,450	~312
Durham Community Safety Dept.	$7.9M	47	14,352	~305
DC Community Response Team	$11.3M	69	4,203	~61

- Crisis response functions in DC are spread across at least four agencies with separate contracts, data systems, and reporting.

UChicago Health Lab Analysis, 2026

> *The District is unique in that it is one of the few cities in the country that has the needed talent, ability, and resources to drastically reduce gun violence in the city. However, it is lacking the political commitment, coordination, and a coherent strategy to reduce gun violence.*
> - Washington GVR Report

> *"DC is resource rich and coordination poor".*
> - DC Youth Organizer

WHAT WE RECOMMEND

- **Consolidate community safety functions under CSD:** Evaluate all city-funded functions to determine what should be insourced, operationally coordinated, or aligned through funding oversight.
- **Ensure that CVI strategy and crisis response operate as a unified strategy.** CSD should be structured so that violence prevention and crisis response share real-time information and coordinated service delivery. These functions belong in the same department because the work is inseparable.
- **Redesign how contracts are managed.** CSD should oversee contracts with community providers in a way that empowers their work rather than constraining it. CSD should use its contract oversight to better coordinate services that currently overlap or operate in parallel without connection, reducing duplication and closing gaps between providers.
- **Support, don't supplant, community providers.** CSD should provide the emergency response infrastructure that allows community organizations to focus on longer-term care, prevention, and support that they provide to their clients.
- **Partner with immigrant and refugee-serving organizations.** CSD should proactively build relationships with trusted immigrant and refugee service providers to ensure crisis response is culturally competent, linguistically accessible, and responsive to the unique needs of these communities. This includes co-developing outreach strategies, referral pathways, and response protocols that reduce fear of engagement with government systems and increase access to appropriate care.

"Show Us What's Happening"

> *"DC has launched multiple projects over the years, but it's difficult to identify a clear path forward without understanding why some of these initiatives fail."*
> — Harm reduction organization

WHAT WE HEARD

DC has institutional infrastructure for public reporting, but community members described a **deep gap between what these tools promise and what they deliver**. Multiple organizations lacked basic information about existing resources. Some providers were unaware of crisis destinations like Woodley House and the Comprehensive Psychiatric Emergency Program (CPEP). Several stakeholders called for **honest evaluation of past initiatives,** arguing that the District needs to understand why programs lose effectiveness during implementation.

WHAT WE FOUND

Fragmented data reflects fragmented governance.

- Agency reports are inconsistent with each other: CRT intervention counts for FY21 vary between 1,157 and 5,452 depending on which report is cited. Three different documents report three different numbers for FY24 911-to-DBH diversions.
- OUC's public 911 dashboard has limited functionality, cannot export data, and shows numbers that contradict the agency's own performance reports.
- Public data portals do not have detailed call for service data.
- There is a reluctance to embrace transparency. OUC has been plagued by allegations that it improperly denies FOIA requests for years. (*Disclosure: CICS's FOIA request for OUC's basic call data was denied.)*

UChicago Health Lab Analysis, 2026

WHAT WE RECOMMEND

- **Mandate standardized public reporting** with consistent definitions across agencies. Fund personnel with data expertise who can build and maintain a functional data dashboard modeled on Durham's Holistic Empathetic Assistance Response Team (HEART) program (41).
- **Partner with independent evaluators from day one** to establish baselines, embed data collection into operations, and build the evidence base for sustained investment.
- **Establish shared data systems** for tracking department outcomes across OUC, MPD, FEMS, and CSD. More details in UChicago Health Lab Analysis, 2026**.**

"Community Has a Seat at the Table"

WHAT WE HEARD

DC has a deeply engaged and knowledgeable community sector. Business Improvement Districts (BID) have built their own coordination infrastructure. Advocacy organizations have built legal momentum. CVI organizations are trusted in their neighborhoods. **DC already has a strong community voice. What it needs is a system that builds that voice into how decisions are made and how services are delivered.** Some providers described CRT as disconnected from the communities it serves and called for more **relationship-building.** Multiple stakeholders raised a recurring pattern: initiatives launch with community engagement then lose that connection during implementation. The Neighborhood Engagement Achieves Results (NEAR) Act was cited as a cautionary example.

WHAT WE RECOMMEND

- **Establish a Community Safety Steering Committee through statute** with representation from community stakeholders, MPD, OUC, Fire/EMS, DBH, DHS, and ONSE.
- **Institutionalize community feedback and invest in multilingual public education** so residents and providers know what CSD does, how to access services, and what to expect.

"Build It to Last"

> *"When it comes to staffing, you need everyone at the table. The best people have done this for a while—they've been in the field."*
> — Homeless services provider

WHAT WE HEARD

DC has demonstrated willingness to invest—CRT's budget is comparable to leading programs nationally, ChAMPS has operated since 2009, and CVI contributed to a 35% reduction in violence in 2024. But investment has **not been sustained consistently**. ChAMPS funding was cut from $1.8 million to approximately $670,000. Multiple organizations described programs **launched, under-resourced, and judged as failures before getting a fair chance**. Workforce retention is a persistent challenge, with emotional demands driving turnover.

WHAT WE RECOMMEND

- **Anchor CSD as a permanent department** with its own budget authority, following Albuquerque and Durham's model.
- **Invest in workforce development** through a training academy, career pathways, competitive compensation, and hiring people with lived experience. Structure work like an emergency service to reduce burnout. (See Alternative Response Research Collective (ARRC) White Paper, Who Responds Matters (Forthcoming) (40).

"Housing, Housing, Housing"

WHAT WE HEARD

We can't talk about community safety without talking about **housing.** While Washington, DC does not have the largest homeless population in the country, it has one of the highest rates per capita—**more than three times the national average**—highlighting the intensity of housing need within a small geographic area. There simply isn't enough housing, especially affordable and supportive housing. And when there's nowhere for someone to go, crisis response systems

can only do so much. Responders can show up, de-escalate, and offer support, but if there's no shelter bed, no supportive housing, and no long-term or permanent options available, people often end up right back where they started. This creates a cycle where the same individuals repeatedly interact with 911, emergency rooms, and other systems, not because they want to, but because their basic needs aren't being met.

WHAT WE RECOMMEND

- **Treat housing as part of the Response, not a Referral,** embedding housing resources directly within CSD such as stabilization services and housing coordination.
- **Create dedicated housing vouchers for CRTs** allocating a small set aside or by using funds for housing/motel vouchers that CRTs can use via prioritization process such as DV situations or families with young children.
- **Pair vouchers with Care Navigation not just placement,** this can be done by contracting with a provider who already does this or as in Durham creating follow-up teams that connect individuals to long term services.

A Mandate For Change

Community members set a clear mandate through this process: **a DC where people in crisis receive the right response, where safety services work as a coordinated system, and where the communities most affected have a real voice in how that system operates.** Creating the Community Safety Department and unifying first response strategy under a Deputy City Administrator would be a major step toward delivering on that mandate. Community members also raised the need for more crisis stabilization beds, housing, long-term behavioral health services, and upstream prevention —the District should invest in those alongside the CSD. But a department that puts the right people on the scene, responds when called, and connects people to ongoing care provides the city the connective tissue to support what community providers, residents, and neighborhoods are already doing.

The implementation roadmap in the next section lays out how to implement this community safety blueprint.

Implementation Roadmap

The following roadmap translates the seven community priorities into a phased sequence of operational steps. These phases are not purely linear and several activities will overlap in practice. Together, they provide a step-by-step plan so that community leaders, policymakers, and stakeholders do not have to start from scratch when it comes time to act.

PHASE 1

Establish the Foundation

- ☐ **Appoint a Deputy City Administrator for Community & Public Safety**
- ☐ **Mayor's Office establishes the Community Safety Department (CSD) via proposed budget line item**
- ☐ **Establish Community Safety Steering Committee via statute**
  - ☐ Representatives from community stakeholders, MPD, OUC, Fire/EMS, DBH, ONSE, and DHS
- ☐ **Perform resource assessment across agencies**
  - ☐ Map current contracts, systems, partners, and funding allocations at DBH, DHS, ONSE, and others
  - ☐ Identify coordination gaps and consolidation opportunities
  - ☐ Determine program data sharing capabilities across systems
- ☐ **Perform crisis response data analysis**
  - ☐ Analyze OUC, MPD, and DBH data to understand diversion opportunity
  - ☐ Calculate demand independent of current funding
- ☐ **Release Steering Committee strategic vision for CSD**
  - ☐ Public-facing document defining CSD purpose, scope, and guiding principles

PHASE 2

Design the Model

- ☐ **Appoint interim CSD director with support staff**
- ☐ **Consolidate and expand existing resources**
  - ☐ Determine which programs, funding streams, and contracts transfer to CSD
  - ☐ Identify functions for insourcing, operational coordination, or funding oversight
- ☐ **Map the community safety ecosystem**
  - ☐ Define initial criteria for 911 call qualification to CSD
  - ☐ Calculate demand based on current 911 calls for service
  - ☐ Evaluate technology solutions: CAD, radios, MDTs, RMS/EHR
- ☐ **Design and redesign roles and functions**
  - ☐ Redesign current CRT program and other existing functions for expanded scope
  - ☐ Develop new roles to fill gaps identified in assessment
  - ☐ Job descriptions, HR classifications, org chart, budget

- [ ] **Integrate CSD with OUC**
  - [ ] Integrate mental and behavioral experts in the 911 system
  - [ ] Embed CSD triage specialists at the dispatch center
- [ ] **Develop Standard Operating Procedures and an operations manual**
- [ ] **Develop training plan**
  - [ ] Inventory what already exists (including police and fire training)
  - [ ] Identify what can be outsourced to community partners
  - [ ] Determine what must be developed internally
- [ ] **Create procurement process improvement plan**
  - [ ] Evaluate which contracts should run through CSD to build community capacity

PHASE 3

Implement with Accountability

- [ ] **Prepare for evaluation**
  - [ ] Partner with independent evaluators at the start of implementation
  - [ ] Establish baselines and embed data collection into operations
- [ ] **Establish continuous improvement cadence**
  - [ ] Regular coordination with OUC and AHL for real-time problem-solving
  - [ ] Ongoing protocol refinement based on frontline experience
- [ ] **Develop public education and communications plan**
  - [ ] Educate community on what CSD is and how to access services
  - [ ] Set realistic expectations for CSD impact and timeline
  - [ ] Multilingual outreach including offline channels
- [ ] **Institutionalize transparency**
  - [ ] Mandate formal reporting to Mayor's Office, Council, Steering Committee, and public
  - [ ] Develop a public data dashboard
  - [ ] Establish a formalized community feedback loop mechanism

Conclusion

DC stands at an important moment in how it defines and delivers community safety. The District has already taken meaningful steps to move beyond a one-size-fits-all emergency response system, investing in Community Response Teams, Community Violence Intervention, and survivor-centered services. These efforts reflect a growing understanding that safety is not achieved primarily through enforcement, but rather through care, coordination, and meeting people's needs at the right moment.

However, **this Blueprint makes clear that the current system remains incomplete**. Whether they are involved in a domestic dispute, witnessed a shooting on their block, or suffer from a serious mental illness, residents in crisis too often still encounter a response that does not match their needs. Lack of coordination among agencies engaging with people in crisis means too many people fall through the cracks or crises escalate unnecessarily. Too often, responders are left without the resources (particularly housing and long-term care options) needed to create lasting stability. And too often, community-based organizations are asked to fill gaps without the funding or infrastructure to sustain that work.

The path forward is not about replacing one system with another, but about building a more aligned and integrated one. A system where 911 can dispatch the right responder at the right time. Where crisis response is connected to a continuum of care that includes behavioral health, housing, and social services. Where prevention and intervention are resourced alongside emergency response. And where community voice and lived experience are not an after thought, but central to how safety is designed.

This work will require sustained commitment. It will require political will that extends beyond moments of urgency, investment that reflects long-term priorities, and coordination across agencies that have historically operated in silos. It will also require a willingness to rethink how resources are allocated, recognizing that more effective, care-centered responses are not only more humane, but often more efficient.

The recommendations in this Blueprint offer a path toward that future. They are grounded in national evidence, local insight, and the experiences of practitioners and community members across the District. But this is not an endpoint. It is a starting point for continued collaboration, iteration, and shared accountability.

Appendix A: Contributors from the Community

This Blueprint belongs to the people who built it with us. Over the past several months, community members, service providers, advocates, frontline workers, and government partners across the District shared their time, expertise, and hard-earned wisdom to shape what a stronger crisis response system should look like in DC. They told us what's working, where the gaps are, and what care and safety need to mean here.

What follows is not a complete list. Many people contributed in ways that cannot be fully captured on a page, including residents who shared lived experience in trust, staff who opened their programs to us, and partners who connected us to communities we would not have reached otherwise. **To every person who gave their time to this work: thank you.** This Blueprint is stronger because of you, and the District is better for the care you bring to it every day.

We are especially grateful to the following individuals and organizations for their contributions to this Blueprint:

- **Cortney Fisher, JD, PhD | University of Maryland Department of Criminology and Criminal Justice**
- **DC Justice Lab**
- **DC SAFE**
- **DC Victim Hotline**
- **Friendship Place**
- **Greater Washington Community Foundation**
- **Peace For DC**
- **The DC LGBTQ+ Community Center**
- **Volare**

Appendix B: Map of DC Wards

Appendix C: UChicago Health Lab Analysis

The full report, *Analysis of Washington D.C.'s 911 and Behavioral Health Response System Data and Diversion Options*, is an independent analysis by the University of Chicago Health Lab examining DC's 911 call data and behavioral health response system to identify call types and volumes that could be safely diverted to non-police crisis responses.

Appendix D: Current DC Crisis Response Workflow Diagram

Process diagram illustrating how crisis calls currently move through DC's response system, from initial contact through 911, the CRT Line, or 988/AHL to dispatch and field response across OUC, FEMS, MPD, DBH, and COR.

Appendix E: Proposed DC Crisis Response Workflow Diagram

Process diagram illustrating the proposed crisis response system under the Blueprint's recommendations, including Community Safety call types at OUC, improved call qualification and transfer between 911 and 988/AHL, and CSD field response alongside existing FEMS, MPD, and COR pathways.

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