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The Emergence of the Community Safety Ecosystem

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This paper is No. 1 of 3 in the ARRC White Paper Series, a project of the Center for Innovations in Community Safety at Georgetown Law.

Letter from the Executive Director

Not too long ago, describing Community Crisis Response as a ‘field’ would have invited skepticism. What existed was a scattered set of local pilot programs — pioneering experiments, mostly operating on limited funding and borrowed time, but still attempting to answer a question that the traditional first response systems had not yet agreed was even worth asking: *what if we sent someone other than the police?*

We can say now that this question has been answered. Decisively. Across the country, unarmed highly trained crisis responders are showing up to mental and behavioral health calls, substance use crises, neighbor disputes, welfare checks, etc. — and doing so effectively, safely, and in ways that their communities actually want. Albuquerque Community Safety Department has handled more than 150,000 calls for service; Seattle CARE has become a co-equal branch of emergency response; Atlanta PAD rallied their community to ensure continued funding.

But fields don't sustain themselves on momentum alone. Over the past two years, our team at Georgetown Law’s Center for Innovations in Community Safety (CICS) has convened the Alternative Response Research Collective (ARRC) to do something the field has rarely had the bandwidth to do: step back, compare notes, and document with honesty what it takes to build something that lasts. What we found is captured in this paper. The work is real. The results are real. And the gaps - in shared language, structural recognition, sustainable funding, and connection to the broader systems of care people need — are just as real.

This paper is the first in a three-part series. It names the field and maps the ecosystem. It describes what Community Crisis Response actually is, how it differs from mobile crisis and co-response, and what the programs doing this work have learned about building systems that communities trust and governments sustain. The two papers that follow take up workforce and sustainability — the two pressure points that will determine whether what has been built endures.

The challenge ahead is not proof of concept. That work is done. The challenge is institutionalization: making community safety a permanent, recognized, and properly resourced part of how this country responds to people in crisis. The practitioners, advocates, and community members who built this field from the ground up deserve nothing less. This series is our contribution to that effort.

Tahir Duckett
CICS Executive Director

Preface

Across the United States, communities are fundamentally rethinking how emergency systems respond to people in crisis. **Community Crisis Response (CCR)** has evolved from a set of local pilots into a rapidly expanding and essential component of modern community safety systems. Yet while the field is growing quickly, it is still being defined in real time.

The Alternative Response Research Collective (ARRC), convened by Georgetown Law's Center for Innovations in Community Safety (CICS), was created to meet this moment. ARRC brings together leading practitioners from pioneering CCR programs across the country to document what has been built, surface shared challenges, and translate on-the-ground experience into actionable guidance for the field.

Together, these programs represent a cross-section of geographies, governance models, and stages of implementation. Through in-depth interviews with program leaders and responders, analysis of programmatic data, site visits, and ongoing collaboration as a community of practice, ARRC has worked to capture not only what programs are doing, but how they are making critical decisions in environments that are often politically complex, resource-constrained, and rapidly evolving.

The ARRC White Paper Series is designed to move beyond theory and toward practical application. These papers surface key decision points, highlight emerging models, and offer grounded insights for practitioners, policymakers, and advocates working to build, expand, or sustain CCR programs in their own jurisdictions.

This paper, the first in a three-part series, explores the role of CCR in an evolving community safety ecosystem. Paper No. 2, *Who Responds Matters*, examines the workforce that staffs CCR programs, including how they are recruited, trained, retained, and compensated, and what it takes to build sustainable career pathways for community crisis responders. Paper No. 3, *Building What Lasts*, addresses how CCR programs move beyond pilot funding toward permanent fixtures of public life.

At its core, this work reflects a simple but urgent reality: communities across the country are asking for different responses to crises. CCR programs are answering that call. The task ahead is ensuring they can endure.

Acknowledgement

This work is grounded in the leadership, partnership, and generosity of the programs that make up the **Alternative Response Research Collective (ARRC).** We are deeply grateful to the practitioners, leaders, and responders who contributed their time, expertise, and lived experience to this effort.

ARRC members did far more than participate in interviews. They shaped the direction of this work, surfaced the field's most pressing questions, and shared candid insights about both successes and challenges. Their willingness to be transparent about what it takes to build and sustain Community Crisis Response systems has made this series possible and ensures that these papers reflect real-world practice, not theory. ARRC is made possible through the collaboration of the following programs:

ARRC Programs
Albuquerque Community Safety Department (ACS)
Atlanta Policing Alternatives & Division Initiative (PAD)
Dayton Mediation Center Mediation Response Unit (MRU)
Denver Support Team Assisted Response (STAR)
Durham Community Safety Department (DCSD)
Rochester Crisis Intervention Services Person In Crisis (PIC) Team
San Francisco Street Crisis Response Team (SCRT)
Seattle Community Assisted Response & Engagement (CARE) Department
Salvation and Social Justice's Trenton Restorative Street Team (TRST)

We also extend our appreciation to the broader network of practitioners, advocates, and policymakers across the country who continue to advance this work and contribute to the growing field of Community Crisis Response. This work was made possible through the generous support of **Charles and Lynn Schusterman Family Philanthropies**, whose investments have helped elevate the voices of those building community safety systems on the ground and accelerate the development of this emerging field.

The content contained within reflects the findings of the authors and does not necessarily reflect positions of Schusterman Family Philanthropies.

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Key Findings at a Glance

Community Crisis Response (CCR) is part of a broader convergence of care-based approaches within the Community Safety Ecosystem. **This paper situates CCR within that ecosystem and lays out how to strengthen it.**

THE COMMUNITY SAFETY ECOSYSTEM

THE SCOPE OF COMMUNITY SAFETY

- **Prevention:** Upstream work that reduces the likelihood crises occur
- **Immediate Crisis Response:** Real-time intervention via CCR, mobile crisis, and co-response
- **Stabilization & Sustained Engagement:** Continuity and follow-up that reduces cycling back into crisis
- **Integration with Long-Term Care:** Housing, behavioral health, treatment, and trauma recovery

A SHARED ECOSYSTEM

- CCR, Community Violence Intervention, homeless street outreach, and peer support share a common premise: meet people's needs through care rather than enforcement.
- These practices long operated in silos. The ecosystem frame names what already connects them and what could make them stronger together.
- In isolation, these practices are vulnerable to funding cuts, political shifts, and narrow public narratives. Together, they build the legitimacy, visibility, and durability that the field needs to last.

COMMUNITY CRISIS RESPONSE (CCR)

WHAT DEFINES CCR

- Trained, unarmed professionals dispatched to mental health, substance use, interpersonal conflict, and health-related social needs calls.
- No arrest authority. No clinical eligibility threshold.
- Operates via a four-part arc: **Respond. Assess. Address. Connect.**
- Reachable through 911, 988, non-emergency lines, and partner referrals.

HOW STRUCTURE SHAPES IMPACT

- **Cabinet-level departments:** e.g., Albuquerque Community Safety
- **Embedded units within existing departments:** e.g., Rochester PIC
- **Independent community-based organizations:** e.g., Atlanta PAD
- Different structures create different tradeoffs in authority, access, and community trust.

KEEPING CONSENT AT THE CORE

- The person defines the crisis.
- Voluntary engagement, autonomy, and care.
- Four stages of consent: **Respond. Engage. Access Services. Transport.**
- A shift from *compliance* to ***collaboration***.
- Distinguishes community safety from carceral approaches.

ADVANCING THE FIELD OF CCR

BUILD SHARED LANGUAGE

- **Common terminology shapes funding, policy, and public understanding.**
- A field that lacks shared definitions is difficult to fund, regulate, and sustain at scale.

BUILD PROGRAMS THAT LAST

- **Build the Right Operational Model:** Structure, staffing, and access pathways designed around local realities; consent embedded in operations
- **Build Community Legitimacy and Trust:** Formal accountability and transparent data that earn community confidence

BUILD THE CONNECTED FIELD

- **Build Strong System Relationships:** Coordination with survivors, public safety partners, and housing and long-term care systems
- **Build the Field at Scale:** State mandates, multi-level government action, federal data recognition

PART I

Introduction

The Shape of an Emerging Ecosystem

Across the United States, communities are rethinking what safety means, who should respond in the moments of crisis, and what systems are necessary to support long-term stability and care. Over the last decade, and particularly following the social and political shifts of 2020 — Community Crisis Response (CCR), Community Violence Intervention (CVI), homeless street outreach, peer support, and other care-based approaches have expanded rapidly as jurisdictions search for alternatives to enforcement-centered responses to social and behavioral health crises.

This shift reflects a growing recognition that many community crises cannot be solved through enforcement alone. For decades, police became the default responders to a wide range of social and health-related issues, often because no other accessible infrastructure was prioritized.

This paper **explores the emergence of Community Safety as a developing ecosystem and situates CCR as one of several care-based fields of practice within it.** Drawing from the experiences of the Alternative Response Research Collective (ARRC), it explores how programs are defining their mission, navigating operational tensions, building relationships with communities and public systems, and confronting the structural limitations of existing crisis response infrastructure.

How We Got Here

To understand where Community Safety is going, we must look at the historical context behind how it got here. For decades, the United States has relied on a narrow set of responses to address mental and behavioral health crises. In practice, this has meant that police became the default first responder, regardless of whether a situation was rooted in law enforcement concerns or unmet health and social needs. This mismatch has led to devastating consequences.

Encounters between law enforcement and individuals experiencing behavioral health crises have too often resulted in use of force, including officer involved shootings, particularly when situations escalate quickly or when officers make decisions without adequate tools, time, or support. Even with the growth of **Crisis Intervention Team (CIT)** training and other reforms, outcomes have remained inconsistent, in part because these trainings cannot, alone, overcome structural limitations such as dispatch practices, performance metrics, and the expectations of rapid scene control.

Throughout the late 20th century and into the early 2000s, efforts to improve crisis response led to the development of co-response models (pairing police officers with clinicians) and the expansion of **mobile crisis teams** within the behavioral health system. While these programs represented important progress, they remained limited in scale and availability; lacked authority; and were costly. In many communities, they operated only during certain hours, required law enforcement presence, or depended on complex eligibility criteria tied to insurance and Medicaid reimbursement.

For many individuals experiencing crisis, the practical choices became stark: a highly responsive system that too often ended in arrest or incarceration, or a clinical system that could offer care, but only if someone met the right thresholds, at the right time, under the right conditions.

2020 as a turning point

The dual crisis of the Covid-19 pandemic and the national reckoning following the murder of George Floyd exposed long-standing gaps and inequities that had often remained out of public view. The pandemic intensified social vulnerability, driving increases in homelessness, domestic violence, substance use, and behavioral health needs, while simultaneously straining already fragile public health and social service systems.

At the same time, high-profile incidents of police violence generated widespread public demand to reexamine the role of policing in responding to community needs. What had long been known within communities, particularly Black, Indigenous, and low-income communities, became undeniable at a national scale: too many social and health-related issues are being routed through law enforcement, often with harmful outcomes.

Together, these conditions — public health emergencies, civil unrest, and institutional strain — made the shortcomings of the status quo impossible to ignore. The visibility of these failures created a new level of political will, with leaders across the country recognizing the need for bold, innovative, structural change.

Centering *Community* in Community Safety

Community Safety did not emerge from traditional public safety institutions. It emerged from communities themselves, from organizers, advocates, survivors, behavioral health practitioners, mutual aid networks, and residents who recognized that existing systems were often unable or unwilling to meet people's needs with care, dignity, or safety.

Long before governments began creating departments or offices of Community Safety, communities were already building alternative ways of responding to harm and crisis. Mutual aid groups distributed food, transportation, supplies, and survival resources. Trusted messengers mediated conflicts before they escalated. Homeless street outreach teams built relationships with people living outside. Families and disability advocates pushed back against models that treated behavioral health crises primarily through enforcement and involuntary intervention.

These efforts shared a common belief: safety is not created solely through enforcement. It is also created through trust, relationships, care, stability, and connection to community.

The post-2020 moment accelerated and consolidated organizing efforts that had existed for decades. In Albuquerque, community members formed the Coalition for a Safer Albuquerque, bringing together disability advocates, behavioral health professionals, family members, and residents harmed by law enforcement. Their advocacy helped shape and influence what became the Albuquerque Community Safety Department (ACS), the country's first cabinet-level CCR department. The phrase "Community Safety" carried meaning before it carried policy weight. It reflected proximity to community and a deliberate shift away from enforcement-centered approaches to crisis and safety.

That shift is now influencing programs nationwide. But the field's roots remain community-led. Programs such as CCR, CVI, homeless street outreach, peer support, and mutual aid are connected not simply because they operate outside traditional enforcement systems, but because they are grounded in the idea that communities themselves possess knowledge, relationships, and capacities essential to creating safety.

The framework that follows builds from that foundation. Its goal is not to recreate what communities have already built, but to recognize, align, strengthen, and sustain the ecosystems of care and response that already exist.

Why This Moment Matters

The conversations surrounding community safety, crisis response, enforcement, care, consent, and public systems are deeply complex and shaped by local histories, political realities, community experiences, and differing philosophies about safety itself.

But this is also why this conversation matters now.

Community Safety is rapidly moving from experimentation to permanence. Programs that once operated as pilots are becoming embedded within local governments, emergency response systems, and broader public safety strategies. Jurisdictions across the country are building new departments, responder workforces, dispatch pathways, and funding structures while communities continue demanding responses rooted in care rather than punishment.

ARRC partners consistently emphasized that the field must now move beyond broad agreement around the idea of CCR and begin grappling more directly with the operational and structural complexities of the work itself. If Community Safety is to mature into lasting public infrastructure, the ecosystem must develop greater clarity around what these programs are designed to do, where their limitations exist, and how they fit within a broader system of care.

This moment also presents an opportunity for stronger alignment across care-based approaches that have often operated separately despite serving overlapping communities and responding to interconnected forms of harm. CCR, CVI, homeless street outreach, peer support, and other community-based models are increasingly part of the same evolving ecosystem of Community Safety.

Engaging these tensions and nuances should not be viewed as division within the field, but as a necessary part of its growth. Honest conversations about tradeoffs, challenges, and differing approaches are essential to building systems that are effective, sustainable, and grounded in community trust.

Importantly, this paper does not attempt to present definitive answers or a single model for the ecosystem. Our hope is that this paper offers validation to those building this work on the ground, provides food for thought for those grappling with these challenges, and creates space for thoughtful, honest, and open dialogue about where to go next.

PART II

The Rise of Community Safety

What Community Safety Is and Why It Matters

In 2020, new Community Crisis Response (CCR) programs — also known as Alternative Response, Alternative First Response, Community Response, among other names — began dispatching trained, unarmed responders to crisis calls historically routed to police. Community Violence Intervention (CVI) programs, which had been applying public health strategies to violence reduction for decades, replicated and expanded. **Now, both CCR and CVI are driven by sustained community demand for responses that are non-punitive, trauma-informed, and aligned with the underlying needs of people in crisis.** At the core of this shift is a new way of thinking about community safety.

For decades the question has been: ***Who is available to respond?***
The question *today* is: ***"What does this person need, and who is best equipped to provide it?"***

> **VOICE FROM THE FIELD**
>
> *"The idea from the beginning was, how do we transform what public safety means in the community? We're not enforcement. You're not required to give us your name when you're receiving services from us. We don't ask about your immigration status. We don't ask about any of that. It was just, you're a person, you need help. What do you need?"*
>
> **— Jasmine Desiderio, Deputy Director of Violence Intervention & Prevention**
> Albuquerque Community Safety Department

As we explored in *Our Neighborhoods, Our Safety: A Blueprint for a Unified Public Health Approach to Community Safety in Washington, DC*, "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."

It also helps us recognize the need for greater strategic alignment and partnership between programs that serve overlapping populations suffering from intersecting, systemic conditions like victimization, poverty, housing instability, untreated mental illness, historical trauma, and disinvestment in communities. **CCR and CVI are two fields of practice within this larger ecosystem, sitting alongside homeless street outreach, peer support, and other forms of care-based response.**

Common Threads, Different Weave: CCR, CVI, and the Community Safety Ecosystem

Safety is not achieved in isolation. Across the country, communities have built a wide range of programs that share a common orientation: **they meet people's needs through care rather than enforcement.** Community crisis responders show up when someone calls 911 in a behavioral health emergency. CVI workers leverage a variety of prevention and intervention tools to reduce the number of shootings in a neighborhood. Outreach workers build relationships with unsheltered neighbors. Mediators resolve conflicts before they escalate. Peer specialists walk alongside people navigating substance use, mental health, and housing instability. The work looks different in each setting, but the underlying logic is the same: **we can more effectively achieve safety by relying on a wide range of expert professionals who focus on building relationships, meeting people where they are, and providing necessary services.**

Despite the shared ethos and overlapping services, CCR, CVI, homeless street outreach, and mobile crisis are thought of, funded, and strategically implemented in silos, without anything to name and understand the connective tissue between them all. **Community Safety names that connection.**

> ***Community Safety*** *is an ecosystem that builds safety through a holistic framework of prevention, care, stabilization, and connection rather than enforcement alone. It focuses on preventing crises, responding to people with dignity and care, and addressing underlying needs by connecting communities to the housing, health, and social supports necessary for long-term well-being.*

This requires thinking about Community Safety as more than a collection of individual programs. CCR, CVI, homeless street outreach, peer support, and other care-based responses are stronger when understood as part of a shared ecosystem. When these efforts operate in isolation, they are more vulnerable to funding cuts, political shifts, and narrow public narratives. **Together, they represent a broader approach to safety rooted in prevention, care, stabilization, and connection to long-term support rather than enforcement alone and that collective framing strengthens the field's legitimacy, visibility, and durability.**

The Community Safety Ecosystem

Community Safety is not a single program or intervention. It is an ecosystem of interconnected functions operating across the full arc of crisis: prevention, immediate response, stabilization,

and long-term care. These layers describe stages of work rather than rigid organizational categories. Many functions, like CVI, homeless street outreach, and peer support, operate across multiple layers simultaneously, doing prevention work in some moments and stabilization work in others.

Community Safety occupies the structural space between two systems that were each built to do something different. Traditional public safety is built to respond and to enforce the law. Clinical and social service systems are built for intensive, long-term treatment. **Community Safety is built to do what neither is optimized to do alone:** provide immediate, care-based response to crises rooted in unmet needs.

Figure 1

The Community Safety Ecosystem

PREVENTION
Peer Support
Conflict Mediation
Community Crisis Response
CRISIS RESPONSE
Mobile Crisis Response
Co-Response
Secondary Response
Community Violence Intervention
STABILIZATION
Follow-up & Case Management
Mental & Behavioral Health Care
Housing & Continuum of Care
LONG-TERM CARE
Recovery
Street Outreach
Community Safety

Because these functions often overlap operationally, jurisdictions structure them in different ways. Some cities, like Albuquerque, Durham, and Seattle, have consolidated multiple functions into unified Community Safety departments, while others rely on nonprofit providers, behavioral health agencies, or independent community-based organizations. These structures reflect local politics, funding, community trust, and relationships with traditional public safety systems. *Part III takes up in detail the different types of models and structures.*

The ecosystem framework recognizes that community safety is not simply about dispatching the "right responder" in a singular moment of crisis, but about **building coordinated systems capable of prevention, stabilization, healing, and long-term support.** Several existing models informed our thinking, including the crisis services continuum, the social-ecological model, and Vera's Public Safety Anchor Institution model. Each captures part of what community safety requires, though none was built for the specific contours of this emerging ecosystem. The framework below reflects the current state of practice and will evolve as the field matures. Designations are not intended to be strict as each response may blur the lines between different categories.

Figure 2

The Scope of the Community Safety Ecosystem

Prevention

Upstream work that reduces the likelihood that crises, violence, or instability occur in the first place. It focuses on strengthening the social, economic, behavioral health, and community conditions that support long-term safety and well-being before emergency response becomes necessary.

Examples: CVI prevention and interruption, street outreach with unsheltered neighbors, peer support for people navigating substance use or mental health, and mediation before conflicts escalate. Where the other layers respond to crisis after they emerge, prevention works to reduce the conditions that produce crisis in the first place.

Crisis Response

Emergency response from non-police responders dispatched when someone is actively experiencing a crisis, conflict, or urgent destabilizing event.

Examples: Community Crisis Response (CCR), mobile crisis, and co-response. Their work follows a four-part frame: **Respond** to whoever calls, **Assess** what is actually happening, **Address** what can be addressed in the moment, **Connect** the person to longer-term or more appropriate resources for what cannot. Other Community Safety functions, such as CVI teams, can provide crisis response for emergency situations.

Stabilization and Sustained Engagement

Supports people after the immediate crisis has passed but before long-term recovery is fully established. It focuses on continuity, relationship-building, follow-up, and reducing the likelihood that individuals cycle back into crisis.

Examples: Second-responder programs that follow domestic violence incidents, community traumas, and other events; CVI's post-incident work with survivors, families, and impacted neighborhoods; sustained peer support through stabilization; and ongoing case management. This work operates over time and through ongoing relationships rather than singular crisis events.

Integration with Long-Term Care

Connects crisis response and stabilization efforts to the broader systems necessary for sustained recovery and long-term well-being.

Examples: Behavioral health services, housing and the broader Continuum of Care, substance use treatment, trauma recovery, survivor stabilization, and other social services. These systems often sit outside the direct scope of crisis response programs.

VOICE FROM THE FIELD

“We are, yes, some part public safety. We're also probably some part public health, some part social services, and some part homeless services.”

— Ryan Smith, Director
Durham Community Safety Department

Building a Shared Language for Community Safety

A name is not superficial. A name is structural. **What you call something determines how it is funded, how it is regulated, if and where it sits in government, who is recognized as part of it, and how the public understands it.**

VOICE FROM THE FIELD

"Legislators wrote a bill that said co-responders are now first responders in Washington, and we said, 'But we're not co-responders.' Their response: 'Well, we interpret it as you being included.'"

— Catriana Hernandez, Community Crisis Response Manager
Seattle CARE Department

Across ARRC partners, programs report that public recognition is growing faster than public understanding. Community members, policymakers, and even legislators often confuse CCR with policing, mobile crisis, or other adjacent models. Programs operate under widely different names — crisis response, alternative response, community response, co-response — making it difficult to establish a consistent public understanding of what the field is and what services communities should expect. As Ryan Smith, Director of Durham Community Safety Department, describes it, the challenge is "right-sizing expectations and understanding who we are and who we're not."

At the same time, the field has moved well beyond proof of concept. A recent national analysis identified more than 216 non-police alternative response programs operating across 40 states, while the Albuquerque Community Safety Department alone has handled more than 150,000 calls for service since launching. Programs are also becoming increasingly specialized and operationally distinct, including Dayton’s first-in-the-nation mediation-based Mediation Response Unit (MRU). The challenge facing the field is therefore no longer simply proving that non-police crisis response can work. The challenge is institutionalization.

That transition makes shared language increasingly important. A field that lacks common definitions becomes difficult to regulate, credential, evaluate, or sustain at scale. Existing

terminology is already creating operational and policy friction. Terms like “mobile crisis,” “co-response,” and “alternative response” may accurately describe some models while failing to capture others. In practice, the vocabulary itself is beginning to shape how programs are funded, regulated, and expected to operate.

> **VOICE FROM THE FIELD**
>
> *"Language and framing are key. This political alignment question is probably what I consult on more than anything else. I usually lead with: this is not political. This has nothing to do with political ideology. I am dwelling in the space of human suffering."*
>
> — **Amy Barden, Chief**
> Seattle CARE Department

The creation of entities like the NYC Office of Community Safety and the Congressional Community Safety Caucus signals where institutional language is moving. **As this ecosystem evolves, the question is no longer whether the field will be defined, but who will define it.** Without clearer shared language, programs risk being misunderstood, pushed beyond their intended scope, or absorbed into frameworks that do not reflect the values, operational realities, or goals of community-based crisis response.

As the field moves from experimentation toward permanence, shared language becomes increasingly necessary not for uniformity, but for clarity. The sections that follow examine how ARRC partner programs are operationalizing CCR within that evolving landscape.

PART III

Community Crisis Response

How CCR Exists in the Community Safety Ecosystem

Part II of this paper described our framing of the Community Safety ecosystem and how Community Crisis Response (CCR) is one field of practice within the broader Community Safety ecosystem. The sections that follow are grounded in the two-year research process conducted through the Alternative Response Research Collective (ARRC). Through interviews, site visits, convenings, program analysis, and ongoing collaboration with practitioners, ARRC partners consistently emphasized that CCR is far more complex in practice than it often appears in theory. While the public framing of "*the right response at the right time*" can sound intuitive, implementing care-centered crisis response within systems historically built around enforcement requires significant operational, cultural, and structural change.

The following sections reflect lessons, tensions, operational strategies, and emerging practices identified across ARRC partner programs as they continue navigating the transition from pilot projects to permanent public infrastructure.

Community Crisis Response in Practice

What is Community Crisis Response?

> ***Community Crisis Response (CCR)*** *is the practice of dispatching trained, unarmed professionals to crisis calls involving mental health, substance use, interpersonal conflict, health-related social needs, and other situations that do not require — and may be made worse by — a law enforcement response. Effective CCR requires more than a staffing model; it depends on organizational cultures, responder training, and operational practices grounded in care rather than coercion.*

CCR teams can be reached through 911, 988, non-emergency lines, and partner referrals. They show up without weapons, without arrest authority, and in most cases without the option to compel anyone to do anything. They rely on training, judgment, and the trust they build with the people and communities they serve.

What distinguishes CCR is not simply who responds, but the commitment to respond. Rather than limiting response to clinically eligible or enforcement-driven situations, CCR programs respond first and determine needs in real time. Operationally, the work often follows a four-part arc:

1. ***Respond*** to whoever calls
2. ***Assess*** what is actually happening
3. ***Address*** what can be addressed in the moment
4. ***Connect*** the person to longer-term or more appropriate resources for what cannot be addressed in the moment.

This commitment holds regardless of whether the call ultimately requires clinical treatment or whether it is Medicaid billable. As the Albuquerque Community Safety Department (ACS) frames it, the person defines the crisis, and the responding team commits to seeing the call through. **That distinction is what makes CCR a first response rather than merely expanded access to existing behavioral health services.**

That same commitment is also what makes the work hard to fund and hard to define using existing categories. CCR does not fit neatly into existing budget lines, professional credentials, or regulatory frameworks because it is doing something existing systems were not designed to do. The clearest evidence of this is how often CCR is conflated with related models like mobile crisis or co-response, which share some of CCR's features but differ in fundamental ways. The confusion has real consequences for funding, regulation, and public understanding.

In practice, operating CCR is more complex than defining it. Programs work within emergency response systems historically built around policing while navigating homelessness, behavioral health crises, housing instability, and broader social service gaps that no single response model can resolve alone.

> **VOICE FROM THE FIELD**
>
> *"Programs in this field may share a commitment to care-based, non-police responses, but they're often operating from different understandings of crisis, helping, or what safety even means. They're grounded in distinct values and practice traditions, and I think that diversity strengthens the ecosystem."*
>
> **— Cherise Hairston, Mediation Coordinator**
> Dayton MRU

Figure 3

What Makes Community Crisis Response Different

In practice, the boundaries between these models are increasingly fluid, and many programs operate across more than one. The distinctions below describe default operating logic, not rigid categories.

	Mobile Crisis	Co-Response	Community Crisis Response
Who responds	Clinically credentialed teams	Clinician paired with CIT officer	Staffing matched to call type; backgrounds vary by program
Dispatch pathway	Primarily 988, hotlines, behavioral health systems. Limited dispatch from 911, usually via transfer to 988 or a hotline	911	911, 988, non-emergency lines, partner referrals
Eligibility	Clinical criteria: strictly behavioral health; often Medicaid-billable	High-risk mental health calls	No clinical eligibility threshold; covers mental health, substance use, interpersonal conflict, welfare checks, health-related social needs, and situations historically defaulted to police
Third-party calls	Require subject's consent to dispatch; otherwise, will be referred to 911	Dispatched as needed; consent is limited by police presence	Dispatched; team works out consent on-scene
Where you can go	Limited; typically to EDs or preset Certified Community Behavioral Health Clinics; varies by program	Police-driven transport; typically in handcuffs; often to ED or into custody	Voluntary transport to a range of destinations: shelter, behavioral health services, sobering centers, family, home, and other community resources

For frameworks on how programs operationalize this identity through staffing, training, and credentialing, see CICS' paper, *Who Responds Matters*. For how programs sustain themselves financially and institutionally, see CICS' paper, *Building What Lasts*.

Where do CCR programs live?

There is no single model that defines the field of practice. CCR programs operate through a range of structures. Some exist as cabinet-level departments with direct access to 911 systems

and city leadership, while others are embedded within fire, human services, or emergency communications departments, or operate through nonprofit and community-based organizations. **Where a CCR program lives is important because structure shapes authority, visibility, access to calls, funding stability, public perception, and operational culture**. Programs embedded within government often gain stronger integration with dispatch systems and emergency response infrastructure, but may also struggle with being perceived as extensions of traditional public safety systems. Community-based models may hold stronger trust and cultural legitimacy, but can face challenges accessing 911 calls, securing stable funding, or scaling operations over time.

The diversity of structures across the field reflects an important reality: **CCR is not a single program model, but an evolving practice adapting to local community needs and political environments. Different structures create different strengths, vulnerabilities, and tradeoffs.** The examples below illustrate some of the most common structural models emerging across the field.

Figure 4

Where Does Community Crisis Response Live?

Cabinet-level Department

Examples:
- Albuquerque Community Safety Department
- Durham Community Safety Department
- Seattle CARE Department

Characteristics:
- ➔ Co-equal branch of emergency response with full operational autonomy
- ➔ Shared executive leadership and accountability with other public safety departments
- ➔ Maximum visibility, which brings authority and outsized expectations in equal measure
- ➔ Best access to 911 calls and situations that police might unnecessarily escalate
- ➔ Greater opportunity to influence citywide policy and systems coordination
- ➔ Increased political pressure and public expectations
- ➔ High risk of community perception being too closely tied to police

Embedded in an Existing Department

Examples:
- San Francisco Street Crisis Response Team — Fire Department
- Rochester Crisis Intervention Services Unit — Department of Recreation and Human Services
- Dayton Mediation Response Unit — Dayton Mediation Center
- Denver STAR — Denver Department of Public Health and Environment
    - Strong partnership with Denver 911, Contract with behavioral health care provider and emergency medical services provider
- Minneapolis Behavioral Crisis Response — 911 Department

- Contract with for-profit mental health organization (Canopy Roots)

Characteristics:
- ➔ Can be in-sourced functions within a department or contracts led by a city department
- ➔ Stability of established administrative infrastructure
- ➔ Requires persistent effort to maintain identity within a host department's culture
- ➔ Can create tension between innovation and institutional assimilation
- ➔ Often easier to launch politically and operationally

Community-Based Organization

Examples:
- Atlanta PAD — Nonprofit, city-contracted
- Trenton Restorative Street Team — Nonprofit, grant-funded

Characteristics:
- ➔ Maximum structural distance from city government
- ➔ Strong community trust
- ➔ Less access to high-impact 911 calls
- ➔ Greater flexibility in staffing, culture, and service delivery
- ➔ Range from grant-funded independence to direct city contracts
- ➔ Vulnerable to political shifts and contract instability

Who are the Responders?

CCR teams across the ARRC utilize a wide range of responder models. These differences reflect a core reality within Community Safety: no single profession or responder type can effectively address every form of crisis. Importantly, many programs emphasized that responders should reflect the communities they serve — not only professionally, but culturally, linguistically, and demographically. Trust is often built more quickly when responders understand the lived realities, histories, languages, and cultural dynamics of the communities they are responding within.

This does not diminish the importance of professional expertise. Rather, it reflects an understanding that expertise itself takes many forms. Clinical training, lived experience, de-escalation skills, cultural competency, and long-term relationship-building are all valuable forms of specialization within the broader Community Safety Ecosystem.

The goal is not for any one responder or program to do everything, but for communities to build systems where the right responder, with the right expertise and community connection, can respond to the right situation at the right time.

For a deeper dive into workforce considerations read CICS' paper, *Who Responds Matters*.

How do you reach Community Crisis Responders?

Across ARRC programs, there is growing recognition that CCR teams should function as true first responders, capable of meeting the same expectation of response that communities place on police, fire, and EMS. No matter how well designed a program may be, responders cannot effectively intervene if people cannot access them in moments of crisis. As a result, **one of the most significant operational and philosophical questions facing the field is how communities should reach community responders — and who controls that access.**

For many programs, integration into 911 dispatch systems has become central to this work. If dispatch systems cannot identify and divert appropriate calls to CCR teams, then police will remain the default response to many behavioral health, homelessness, substance use, and welfare-related calls. **Diversion rates — the percentage of calls shifted away from law enforcement toward community safety responders** — have therefore emerged as one of the clearest indicators of whether a jurisdiction is meaningfully operationalizing alternative response.

At the same time, **911 integration presents important tensions within the field**. Programs embedded within public safety or emergency communications systems often gain faster access to calls, operational legitimacy, and stronger dispatch coordination. But programs operating outside of government, particularly community-based organizations contracted by cities, frequently encounter barriers related to liability, data access, and integration into dispatch infrastructure. In some communities, there is also deep mistrust around calling 911 itself, particularly among communities historically harmed by law enforcement or involuntary crisis interventions. For these communities, accessing support through a police-connected entry point can feel fundamentally incompatible with the values of community care.

Many jurisdictions are experimenting with multiple access points into crisis response systems, including:

- 911 diversion pathways
- Direct dispatch through 988 crisis systems
- Warm handoffs between 911 and 988
- 311 or 211 non-emergency lines
- Referrals from outreach workers, hospitals, shelters, schools, and community organizations
- Self-referral lines or direct community access numbers
- Follow-up referrals generated through prior responder engagement
- Referrals from other on-scene first responders

> **VOICE FROM THE FIELD**
>
> *I think what we are doing incredibly well is moving the needle on the assumption that if you call 911, you're going to get a police officer.*
>
> **— Andrew Dameron, Director of Emergency Communications, City of Denver**

What's Your Mission and When to Expand

Community leaders, partners, and community members sometimes misunderstand the purpose and role of CCR programs. Some expect responders to function as softer versions of enforcement-based teams tasked with removing unhoused individuals from public spaces or managing visible social disorder. Others expect CCR programs to solve deeply entrenched social challenges such as homelessness, untreated behavioral health conditions, or substance use without the long-term infrastructure, housing capacity, or clinical systems necessary to do so.

> **VOICE FROM THE FIELD**
>
> *"It definitely takes a lot for us to sometimes put the brakes on folks' expectations that if we're out in an area, then why are all these people still on the street? And we have to remind people that we are not an enforcement-based team."*
>
> **— Catriana Hernandez, Director of Crisis Response**
> Seattle CARE Department

These tensions reveal one of the central challenges facing the field: defining mission and scope in environments where community needs are significant, visible, and often unmet elsewhere. In practice, many programs experience pressure toward "mission creep," not simply because organizations lack discipline, but because responders regularly encounter people falling through systemic gaps that no other institution is adequately addressing. A team dispatched to a mental health crisis may also encounter domestic violence, housing instability, trauma exposure, food insecurity, or substance use. These issues are often inseparable in lived experience, even if they sit in different funding streams, agencies, or professional disciplines.

Some of the field's most impactful innovations emerged precisely because programs responded to needs that existing systems were not adequately meeting. For example, Albuquerque Community Safety created an Overnight Shelter Transport effort to transport unhoused individuals to shelter and warming resources during extreme weather when other services were unavailable. Rochester's Person In Crisis Team and Dayton's Mediation Response Unit are both actively exploring how to integrate trauma-informed domestic violence response into their

operational models. What could be viewed as mission creep became a practical, life-saving intervention rooted in community need.

Other examples include:

- ➔ In-sourcing longer-term care, like Durham bringing the broader Continuum of Care under its departmental roof
- ➔ Building services that do not exist elsewhere, like ACS's Violence Intervention Program creating a Trauma Recovery Center for Albuquerque, where survivors of violence previously had no dedicated place to go for sustained care
- ➔ Formalizing strategic alignment and connection pathways with community service providers like Denver has with the STAR Community Partner Network
- ➔ Creating direct-access tools that close gaps in real time, such as housing voucher funds responders can deploy on scene, agreements with sober-living facilities, or partnerships for voluntary transport to non-clinical destinations

At the same time, ARRC partners emphasized that CCR programs cannot absorb the entire system of care. Programs that attempt to become housing systems, behavioral health systems, and long-term care systems simultaneously risk becoming overextended and losing the operational focus that makes crisis response effective.

The challenge is therefore not whether programs should evolve beyond their original mandate, but how to expand responsibly while maintaining mission integrity, responder capacity, and long-term sustainability.

Figure 5

When Mission Creep Is Necessary

- ➔ Does this address a critical gap that is actively harming the community?
- ➔ Is the need recurring and operationally connected to the program's existing work?
- ➔ Does the expansion align with the core values and culture of the team?
- ➔ Can the program safely and effectively perform the function?
- ➔ Is there sustainable funding or long-term political support behind the expansion?
- ➔ Will this strengthen community trust and credibility or dilute the program's identity?
- ➔ Does this expansion build organizational capacity and deepen the system of care or simply compensate for broader system failures?
- ➔ Are responders being asked to absorb responsibilities because no one else will or because the program is genuinely best positioned to respond?

> **VOICE FROM THE FIELD**
>
> *"As a field matures, certain ways of understanding problems and responses can quietly become normalized and taken for granted. There's real value in staying curious rather than assuming there's one model of helping. That's what keeps us learning, innovating, and adapting."*
>
> **— Cherise Hairston, Mediation Coordinator**
> Dayton MRU

What Happens After the Crisis

CCR programs can prevent harm and stabilize a crisis in the moment, but increasing long-term impact depends on what exists after responders leave the scene or hand off to a connection. Across ARRC partners, one lesson emerged repeatedly: crisis response alone cannot create lasting stability without meaningful alignment with housing, behavioral health care, detox and substance use treatment, trauma recovery services, and other long-term systems of support. **The effectiveness of CCR is ultimately tied to the strength — and availability — of the broader care infrastructure surrounding it.**

In many ways, CCR programs function as real-time stress tests for the broader system of care. Responders quickly encounter situations where housing, behavioral health, detox, trauma recovery, and long-term support systems are functioning — and where they are absent entirely. Communities have historically treated these systems as downstream referral destinations rather than core components of crisis response itself. CCR programs are increasingly exposing the limits of that separation.

Housing

Across all nine of our ARRC partners, access to stable housing was the most consistently cited barrier to meaningful outcomes for community members in crisis. Responders describe encountering the same individuals repeatedly — not because crisis response is failing, but because the underlying condition driving the crisis goes unaddressed.

> **VOICE FROM THE FIELD**
>
> *"If police are the path to jail, then far too often [CCR programs] are the path to nowhere."*
>
> **— Moki Macias, Executive Director**
> Atlanta PAD

This is not a failure of crisis responders themselves. It is a structural one. **CCR programs were not designed to solve homelessness**, yet they increasingly operate on the front lines of housing instability, economic displacement, and chronic poverty. The rapid expansion of the field following 2020 coincided with worsening housing affordability, pandemic-related economic disruption, and decades of underinvestment in affordable housing and supportive services.

Some programs are beginning to adapt. Durham Community Safety Department now administers housing coordination services and recently brought the Continuum of Care under its departmental umbrella, strengthening coordination between emergency response and long-term housing navigation. ACS provides housing vouchers that responders can access for individuals in acute need. These are meaningful steps — and they raise a strategic question that cities and programs must grapple with deliberately: **Where should CCR and housing systems align, and where should they remain distinct?** Absorbing too much risks diluting focus and stretching capacity. Absorbing too little leaves the path to nowhere intact.

What is clear across ARRC partners is that CCR programs need structured handoffs to housing resources. This is not just referrals but institutionalized relationships with housing providers, coordinated entry systems, and the follow-up infrastructure to know whether those handoffs actually worked. Communities also repeatedly emphasized the importance of improving the quality of shelters themselves. Many individuals decline shelter not because they reject help, but because shelters may feel unsafe, overcrowded, restrictive, traumatizing, or disconnected from their actual needs. The question is therefore not simply whether beds exist, but whether communities are building spaces people are willing and able to use.

CCR programs are increasingly revealing that housing cannot be treated as a downstream referral issue alone — it is a foundational component of crisis stabilization, recovery, and long-term community safety.

Detox, Behavioral Health, and Trauma Recovery

Similar gaps exist across behavioral health and substance use systems. Responders frequently encounter individuals seeking detox services, psychiatric stabilization, trauma support, or ongoing behavioral health care, only to find long waitlists, restrictive eligibility, or no available services.

This challenge is particularly visible around substance use crises. Many communities continue to rely heavily on emergency departments, jails, or involuntary systems because voluntary detox beds, sobering centers, medically supported withdrawal management, and low-barrier treatment options remain limited or nonexistent. Similarly, individuals experiencing

trauma-related crises often encounter fragmented systems where mental health treatment, violence recovery, victim services, and housing supports operate independently despite being deeply interconnected in people's lived experiences.

BLIND SPOT: Service Gaps and Moral Injury

For many responders, one of the most difficult realities is stabilizing a person in crisis while knowing there may be nowhere appropriate to take them afterward. As Chief April Sloan of San Francisco Street Response Team told us, "You have a first responder who wants to help and take care of people. But the pathways that you have to get that [help] aren't working. It causes moral injury [to the responder]." Providing ongoing support to responders is a key element of building a consent-based practice and for sustaining the CCR workforce.

To read more about moral injury and burnout, please reference CICS' paper, *Who Responds Matters.*

Increasingly, ARRC partners emphasized the importance of building stronger alignment between CCR and:

- Housing
- Detox and substance use treatment programs
- Crisis stabilization centers
- Trauma recovery centers
- Hospital-based violence intervention programs
- Behavioral health providers
- Domestic violence and sexual assault services
- Community violence intervention programs
- Long-term case management and peer support

The goal is not for CCR programs to become all of these systems themselves. Rather, it is to ensure that crisis response operates as part of a coordinated continuum of care instead of an isolated intervention point.

Ultimately, the long-term success of CCR will not be measured solely by how effectively responders de-escalate crises in the moment, but by whether communities build systems capable of supporting people after the crisis ends. The strongest CCR programs are increasingly recognizing that lasting impact requires more than response capacity alone — it requires alignment with housing, healing, treatment, and long-term care infrastructure capable of turning stabilization into sustained recovery.

Legitimacy and Trust

The stakes are real: as one ARRC partner put it, the long-term sustainability of these programs ultimately depends on the level of community support behind them. CCR programs must simultaneously build legitimacy with communities, emergency response systems, policymakers, funders, and elected officials — groups that often hold different expectations, values, and definitions of success. Building and maintaining that trust must be understood as a core operational strategy, not a secondary concern.

Relationships with Community

Operational partnerships alone are not enough to sustain CCR programs. Long-term legitimacy depends equally on visible, sustained relationships with the communities programs serve.

Many ARRC partners emphasized that community trust is not built solely through crisis response itself, but through **consistent engagement outside of crisis moments**. Albuquerque Community Safety, for example, maintains dedicated community outreach staff responsible for attending neighborhood meetings, hosting roundtables and community potlucks, visiting schools, and participating in violence prevention and wellness campaigns. Their Seasons of Non-Violence campaign hosted more than 20 events in 2025 and reached nearly 15,000 attendees. These efforts reinforce an important message: **CCR programs must become trusted community institutions.**

Formal accountability structures also play a critical role in maintaining trust and responsiveness. Programs such as Atlanta PAD's community board, and Durham's Community Safety and Wellness Task Force have established advisory boards, steering committees, or community task forces that allow residents and stakeholders to shape programs' direction and hold leadership accountable. These structures **build community ownership. And community ownership becomes political power when programs face moments of vulnerability.**

The value of sustained community connection was evident in late 2024, when Atlanta PAD faced a threat from city leadership, struggling to retain already allocated city funding. The program rallied its supporters both locally and nationally. What pushed the needle was not political relationships alone; it was community action. Residents, partners, and advocates showed up at council meetings, spoke on the record, and made the cost of eliminating the program politically untenable. That kind of community mobilization does not happen spontaneously. It is the product of years of intentional relationship-building, consistent transparency, and accountability structures that give community members genuine ownership over what the program does and how it does it.

Whether government- or community-based, **accountability to community is central to a CCR program's long-term sustainability.** Programs that cultivate trust, visibility, and community ownership are far more likely to survive political shifts, funding threats, and leadership changes because the communities they serve are willing to defend them when it matters most.

Transparency, Data, and Public Accountability

CCR programs arose out of sustained community demand for non-law enforcement and care-based responses to crises. As programs have become more institutionalized and publicly funded, they have also had to navigate a new responsibility: demonstrating accountability to advocacy movements, impacted communities, taxpayers, elected officials, funders, and public systems that increasingly expect measurable outcomes. **Transparency and data infrastructure are foundational to the long-term sustainability of the field.**

Data dashboards help make CCR work visible to the public. Programs that openly share information about call volume, response times, diversion rates, call types, demographic trends, outcomes, and follow-up services help communities understand what responders are actually doing and what they are not doing. Durham HEART and Atlanta PAD have built public-facing dashboards that track service delivery and operational outcomes while also incorporating community stories, testimonials, and qualitative feedback. The data itself is only part of the story. Just as important is the willingness of programs to be publicly visible, explain their limitations honestly, and demonstrate how decisions are being made.

Transparency and trust are inseparable. When programs consistently publish data they signal accountability not only upward to funders and policymakers, but outward to the communities they serve. Over time, that transparency can become a form of political protection. Programs that communities understand, value, and see evidence of are often more resilient to political shifts, leadership changes, or funding threats.

At the same time, the field continues to wrestle with deeper questions about what metrics should be used to measure success. Traditional public safety metrics often prioritize response speed, enforcement outcomes, or reductions in visible disorder. **CCR programs are increasingly pushing for broader measures of success, including reduced law enforcement contact, successful diversion from hospitalization or incarceration, continuity of care, community trust, responder safety, and long-term stabilization outcomes.**

The challenge moving forward is not simply building data systems, but ensuring that the outputs and outcomes measured by those systems reflect the values of community-based crisis

response rather than reproducing the narrow metrics of the systems these programs were created to transform.

The figures below are examples of how cities are helping to tell their story through data.

Figure 6

Atlanta PAD Data Dashboard

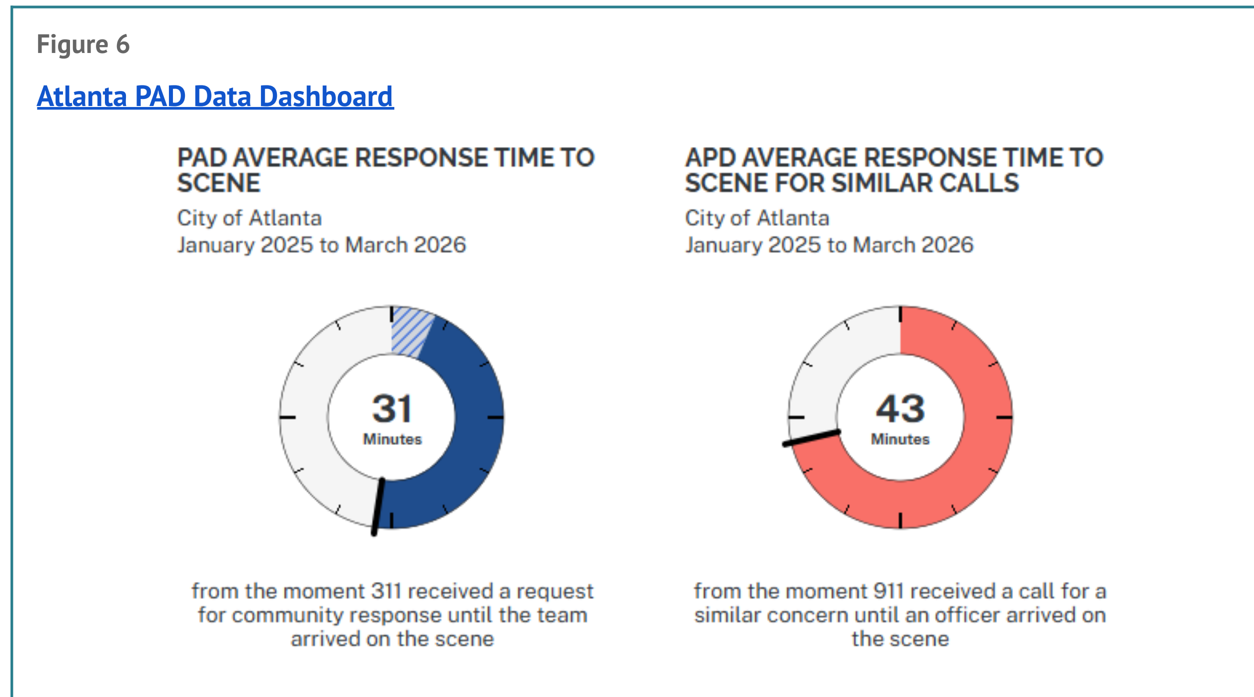


Figure 7

City of Rochester PIC Dashboard

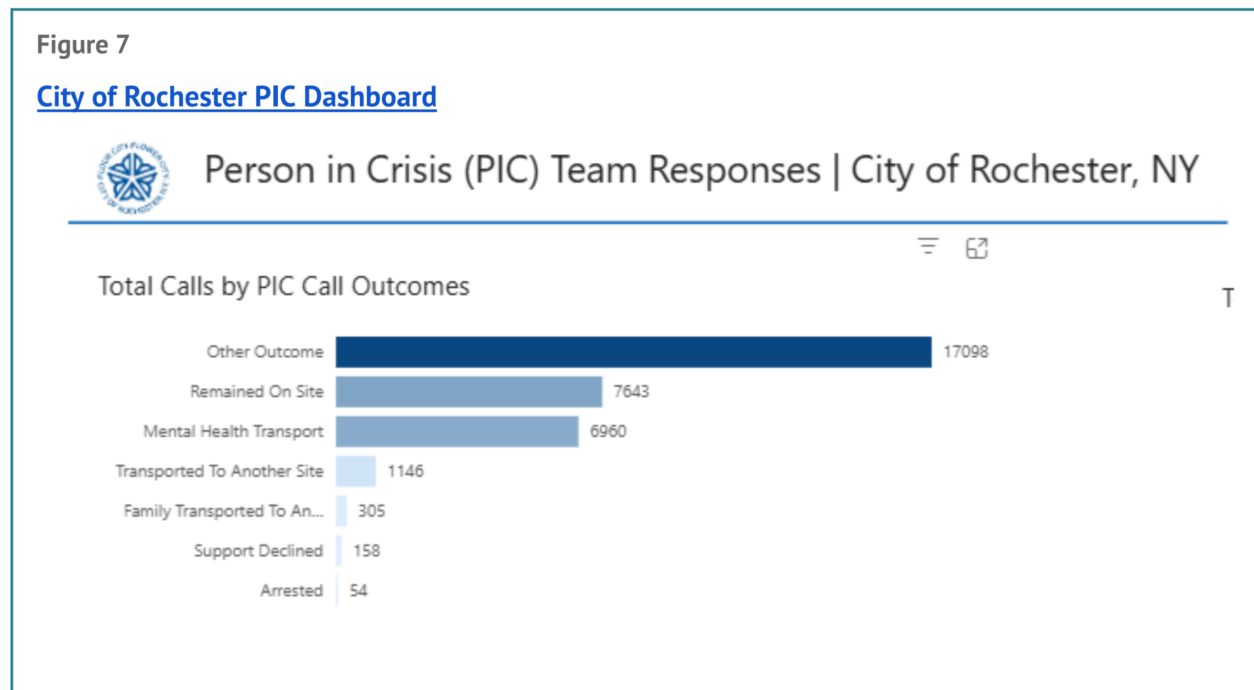
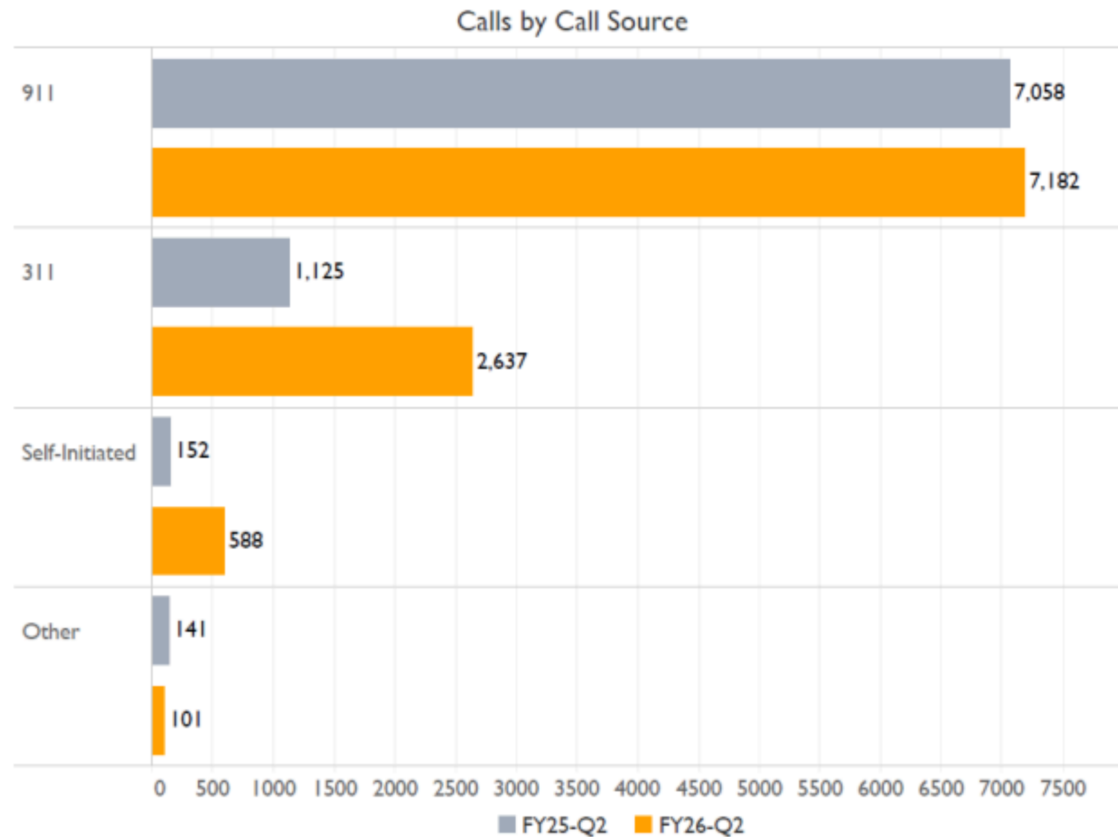


Figure 8

[Albuquerque Community Safety Quarterly Reports]



Building Relationships with Police, Fire and EMS

No matter where a Community Crisis Response (CCR) program aligns philosophically, operating within existing emergency response systems requires some level of relationship with police, fire, and EMS — even among ARRC partners that intentionally maintain minimal law enforcement involvement on calls. For many programs, these partnerships are essential to gaining operational access to 911 systems, integrating into dispatch protocols, and establishing legitimacy within broader emergency response infrastructure.

At the same time, the relationship between CCR and law enforcement is inherently complex. Programs that align too closely with police may risk undermining the very community trust that makes them effective. Communities with long histories of harmful interactions with law

enforcement may approach CCR with understandable skepticism, particularly when programs appear too closely tied to policing rather than meaningfully distinct from it.

This tension is not unique to CCR. Community Violence Intervention (CVI) programs have long navigated similar dynamics. Many intentionally maintain distance from police and government structures because their effectiveness depends on trusted relationships with individuals and communities who may avoid systems associated with enforcement. CCR programs often face a similar balancing act. **Proximity to police can create operational advantages, including stronger dispatch integration, funding stability, and institutional support. But distance from police may be precisely what allows responders to build trust with the people they are trying to reach.**

Across ARRC programs, partners emphasized that there is no universal formula for navigating these relationships. **Several common lessons emerged across the field:**

Building trust and buy-in takes time and intentional effort
Addressing initial skepticism from police and fire must be part of an early program strategy. Even well-established programs are intentional about maintaining a regular presence in police departments by attending roll calls, participating in training academy sessions, and showing up when police request backup. That consistency builds credibility without requiring ideological alignment.
Line-level officer support matters as much as leadership buy-in
Frontline officers and dispatchers often become some of the strongest advocates for CCR programs once they trust the response model. Rochester's Person In Crisis Team initially responded to only three mental health-related call types. Within two years, officers were requesting the team so frequently that the program expanded to twelve call categories, and the Fire Department began seeking their support on additional calls as well.
Clear boundaries must be continually reinforced
As programs gain trust and visibility, police departments and city partners may begin routing calls that fall outside the program's intended scope or operational capacity. ARRC partners repeatedly emphasized the importance of ongoing communication around what CCR programs are — and are not — designed to do. Maintaining mission clarity requires not only setting boundaries early, but revisiting them consistently as programs evolve.

BLIND SPOT: Too Much Alignment Can Cost You

The line between productive partnership and problematic proximity is real, and programs should draw it deliberately. Being perceived as an extension of policing — even informally — can damage the community trust that CCR depends on. **Some programs have responded by creating explicit policies limiting when police are present on CCR calls or clearly defining the conditions under which co-response occurs.** These decisions are not simply operational; they communicate values. Every jurisdiction must ultimately ask the same question: ***what level of alignment builds operational effectiveness, and what level begins to cost the program credibility with the communities it is intended to serve?***

PART IV

Consent

Care, Autonomy, and the Limits of Coercion

Foundational to both the philosophy and practice of Community Crisis Response (CCR), consent offers individuals in crisis a non-coercive approach to support that centers personal autonomy and dignity. This is not just an abstract concept; it is an urgent mandate to remedy dangerous disparities in outcomes for people in mental health or behavioral health crisis who interact with traditional crisis response systems (including those centered around law enforcement). Consent-based care is always challenging, but premising CCR on consent is complicated further by political pressures, legal frameworks, and professional liabilities that place structural limits on a person's ability to determine how, when, and whether they access care.

While CCR programs work to center consent-based practices, they are also facing an increasingly hostile political landscape, particularly regarding housing insecurity. Federal, state, and local governments are shifting away from "Housing First" models and returning to policies that prioritize containment and disappearing people from public view. Most alarmingly, President Trump's July 2025 Executive Order calls for the expanded involuntary commitment of unhoused individuals, representing a direct threat to consent-centered crisis response models. The order conditions federal funding on a state's willingness to adopt more punitive measures for addressing homelessness and threatens programs that offer harm reduction services. This measure, along with state efforts such as Utah's "accountability center" — which proposed moving 1,300 unhoused people in Salt Lake City to the outskirts of the city for forced treatment — is antithetical to the mission of CCR programs. CCR program leaders should institutionalize consent-based practices to better withstand the push toward the criminalization of our most vulnerable neighbors.

This section examines why consent is central to the identity of CCR, the legal boundaries that govern its operationalization, and the ways ARRC partners navigate consent-based practice within systems that still frequently default to coercion.

Why Consent Matters in Community Crisis Response

Traditional first responders and some clinicians often rely on enforcement-based approaches, including **involuntary civil commitment** (a process by which a person is forced into treatment), for mental health, behavioral health, and substance use crises. **CCR programs place greater weight on the importance of preserving individual agency to determine how, when, and whether they receive care.** Further, consent is not simply a philosophical

value within CCR. It is a practical tool for building trust, improving outcomes, and reducing harm in moments of acute vulnerability. For that reason, survivors of violence must also guide the ways that CCR programs think about and practice consent. Community members who have experienced violence (e.g., interpersonal, structural, and police violence) may also have intersecting experiences with mental and behavioral health crises, substance use, and housing instability. Community Crisis Responders who respond to these calls must understand how victimization shapes both a moment of crisis and a person's willingness to engage in care.

For many communities, particularly those historically over-policed or underserved, crisis response systems have been sources of coercion, surveillance, and loss of autonomy. Encounters with emergency systems can escalate quickly, sometimes resulting in arrest, hospitalization, or family separation. In this context, consent becomes essential to reimagining the relationship between communities and crisis response. **It signals a shift from control to care, from compliance to collaboration.**

Consent-centered approaches recognize that individuals in crisis are not problems to be managed, but people with expertise in their own lives. Research on co-responder models has found that the presence of a mental health clinician can reduce the incidence of involuntary psychiatric detentions; CCR programs have the potential to further this reduction. By prioritizing voluntary engagement, CCR programs create space for responders to implement trauma-informed approaches to their work that build rapport, de-escalate, and connect people to supports they are more likely to sustain. **Individuals who consent to treatment engage more durably with services than those who are forced.** At the same time, operationalizing consent is not straightforward. CCR programs often operate within systems that still rely on coercive mechanisms. Responders must navigate these constraints in real time, balancing safety considerations with a commitment to autonomy.

The Legal Foundations and Limitations of Consent

The legal definition of consent requires that a person voluntarily and willfully agree to a proposition, free from coercion, fraud, or error, and with the mental capacity to make an informed choice.

Involuntary civil commitment "is the legal mechanism by which a person is admitted to a treatment facility or supervised outpatient treatment against their stated will." This process is typically invoked when individuals are deemed to lack the capacity to consent due to mental illness, developmental disability, or substance use disorder. While statutes vary by state, the prevailing standard centers on whether a person poses a danger to themselves or others — a threshold that can include the inability to provide for one's own basic needs. A key point of contention

here is whether those experiencing homelessness meet the criteria of being unable to provide for their own basic needs, with those advocating for more punitive responses to homelessness arguing that these individuals lack the capacity to consent or refuse services. This is an area where practitioners, advocates, and policy makers are pushing back.

Although involuntary civil commitment and similar practices are sometimes premised on the idea that coercion is sometimes necessary to get people the help they need, this is often not how these practices play out in reality. Consider a concrete example that many of our ARRC partners shared as a common occurrence: a community member experiencing suicidal ideation who, despite lacking an immediate plan or intent, is transported against their will to an emergency department, evaluated as stable, and released within hours without meaningful follow-up care. This outcome is not unusual. And it illustrates the gap between legal authority and therapeutic value that CCR programs are navigating every day.

While long-term commitment generally requires judicial oversight, the authority to initiate emergency evaluations rests with law enforcement and certain licensed professionals, such as psychiatrists or clinical social workers. The question CCR programs are actively grappling with is not whether involuntary interventions are ever warranted — sometimes they are — but whether the current rates at which coercive methods are applied are truly necessary, or whether they reflect the path of least resistance in systems not designed for nuance.

Breaking the Cycle of Carceral Logic

Carceral logic describes a punishment-based framework that treats retribution, control, and containment as the primary instruments of public safety. Closely tied to the historical and contemporary impacts of racism in the United States, carceral logic extends beyond policing and permeates adjacent fields, including mental health and social work. When people in crisis are seen as problems to be controlled and contained rather than people in need of care and dignity, coercive intervention becomes the norm rather than the last resort.

CCR programs are not immune to this logic. The pressure to "resolve" a scene quickly, to transfer liability through a psychiatric hold, or to defer to law enforcement rather than hold the complexity of a difficult call — can be expressions of carceral thinking operating within systems that were not designed to do otherwise. Naming this dynamic is part of how programs resist it.

This requires navigating the divide between legal authority — what programs can do — and moral imperative — what they should do. It also raises **practical design questions that programs must answer deliberately: Does your program require licensed clinicians on every call?** If so, are you creating the conditions for involuntary holds even when that's not

your intent? Are your SOPs written to support consent-based practice, or do they default to risk elimination? These are not rhetorical questions. They shape what happens when a responder is standing in front of someone in crisis at 2 a.m.

Consent at Every Stage of the Crisis Call

For ARRC partners, consent is understood as a continuous, relationship-based practice and not a legal checkbox or a one-time authorization. Programs consistently describe it as dynamic: something that must be built into every stage of the response, re-established when circumstances change, and understood as active engagement rather than passive non-refusal. This is an understanding of consent that goes beyond the low bar of a legal definition and involves informed, affirmative agreement and engagement. For example, a particularly important dimension of CCR consent practice — and one that distinguishes it from many mobile crisis and 988-based responses — is the role of the third-party caller. **Many CCR calls are initiated not by the person in crisis, but by someone on their behalf: a family member, neighbor, business owner, or passerby. This creates a multi-stage consent dynamic that programs must navigate deliberately.**

Figure 9

Stages of Consent in Community Crisis Response

Stage	What It Means in Practice	Key Considerations
Consent to Respond	CCR programs **can be dispatched based on the third-party caller's report.** This is a fundamental distinction from traditional mobile crisis (which typically requires the person's own call or a referral). The subject's consent to engage is a separate and subsequent question.	Programs should train dispatch staff and embedded triage specialists to recognize when a call is third-party-initiated and to set appropriate expectations and protocols. The goal is not to determine whether the person "wants help" before sending a team, but to send responders who are skilled at reaching consent on arrival.
Consent to Engage	When responders make contact with a person, their job is to obtain consent to engage. Responders approach without authority to compel, without weapons, and often without any existing relationship with the person in front of them.	Trauma-informed motivational interviewing, active listening, mediation, and culturally responsive engagement are the operational core of CCR. Training should treat consent to engage as a skill, not an assumption. Responders should train and practice on what to do when engagement is refused.

Consent to Access Services	Responders often encounter needs beyond the initial call. Someone reported for a behavioral health issue may actually want housing assistance or simple connection. Meeting people's actual needs defines consent-centered practice.	Programs should equip responders with resource knowledge and the flexibility to respond to what they actually encounter. SOPs that constrain response to the original call type can inadvertently undermine consent-based practice by limiting what responders can offer.
Consent to Transport	Transport is where the tension between consent and safety is sharpest. Programs that build voluntary transport capacity reduce reliance on coercive mechanisms and reduce the trauma associated with emergency psychiatric intervention.	Programs should establish clear protocols for escalating to higher levels of care and distinguish voluntary from involuntary transport. Where legally permissible, telehealth supervision can reduce the need for in-person clinical presence.

Consent and Risk

CCR programs often operate under rigorous risk management frameworks, particularly those within municipal governments. The high threshold of liability exposure and the perception of being at constant risk of litigation shape program design in ways that are not always transparent. This is not unique to CCR, but it has particular consequences for consent-based practice.

Standard operating procedures and training are where risk management most directly intersects with consent. SOPs are critical for accountability, legal compliance, and operational consistency. But they can also calcify risk-averse defaults: defer to police, initiate a hold, document the transfer of responsibility. **Programs that want to practice consent-based response must write SOPs that actively support it and must train supervisors to reinforce consent-centered decision-making even when it is harder in the moment.**

Other risk management decisions have subtler effects on consent practice. Uniforms make responders identifiable and protect their safety, but they also affect how community members perceive them. Vehicle branding communicates that a program is official and accountable, but the wrong branding can signal proximity to law enforcement and undermine trust — reducing the likelihood of consent to treatment — before a responder says a word. **These are not trivial design questions.** They shape the conditions in which consent is sought and either offered or refused.

What Comes Next

Ultimately, consent-centered practice means making coercive intervention the last resort rather than the default. Programs that sustain consent-centered practice treat it as a core design principle from the beginning by shaping hiring, training, SOPs, and relationships with partner agencies. This requires ongoing reflection about whether systems are truly creating space for voluntary engagement or defaulting to the path of least institutional liability.

While CCR programs still operate within systems that overly rely on coercion, the goal of a CCR program is to become a response in which care, autonomy, and voluntary engagement are central. In an increasingly punitive political environment, programs must continue to demonstrate the value of consent-based approaches through clear protocols, transparency, and measurable outcomes that distinguish CCR from enforcement-based response.

PART V

Advancing The Field

Policy Recommendations for Advancing Community Crisis Response

The advances, tensions, and operational challenges described throughout this paper emerged consistently across ARRC partner programs as jurisdictions worked to move Community Crisis Response (CCR) from pilot projects to durable public infrastructure. **The recommendations that follow translate those lessons, insights, and emerging practices into concrete actions for policymakers, practitioners, funders, researchers, and system leaders working to strengthen the broader Community Safety Ecosystem.**

Build Shared Language

The field operates under widely different names (alternative response, crisis response, community response), which fragments the way funders, legislators, and the public understand it.

FIELD-WIDE

Move toward shared language across the field

Shared language shapes funding, policy, and public understanding.

As Community Safety and CCR continue gaining institutional traction, greater alignment around shared terminology may help strengthen public understanding, funding pathways, research, and policy development across the field. Practitioners, funders, researchers, technical assistance providers, and national associations all play a role in shaping how these models are defined and understood through publications, convenings, RFPs, and grant categories.

Build the Right Operational Model

How a program is designed determines whether it can deliver on its mission. The operational foundations established early often shape whether a program can sustain growth, navigate political shifts, and endure through changes in leadership.

PROGRAM ACTION

Tailor program design to your community's unique needs

Structure, staffing, and how calls reach the team all have to be designed to fit local realities.

Structure, staffing, and access pathways should be designed around local realities, including community needs, existing service systems, political conditions, and patterns of crisis calls. Where a program lives shapes its relationship to 911, long-term care systems, and community trust. Staffing models should reflect the actual situations responders encounter, while access pathways such as 911, 988, partner referrals, and self-referral lines should be selected based on who they reach and where unmet need exists.

Guidance: See CCR Staffing Models Framework or see CICS's paper, *Who Responds Matters* for complete staffing context.

PROGRAM ACTION

Balance community need with mission integrity

CCR program operations should be flexible and responsive to community needs. But that responsiveness must be balanced with a continual alignment of the program's mission.

Even programs with a clear mission face scope drift from city partners, frustrated community members, and responders absorbing what they encounter. Building explicit scope guidelines into SOPs, training, partnership agreements, and public communications, and revisiting them regularly, is essential for maintaining clarity and long-term sustainability.

PROGRAM ACTION

Embed consent into program operations

Consent-based practice has to be designed into SOPs, training, and supervision.

Programs with co-response components or involuntary hold authority should establish explicit policies that treat coercive intervention as a last resort, with documentation and supervisory review. Voluntary transport capacity, agreements with non-clinical destinations, and clear escalation protocols expand the consent-based options available on scene.

Build Strong System Relationships

Crisis response only works as part of a larger ecosystem. The partnerships a program builds with survivors, with public safety agencies, and with the longer-term care systems that pick up where response ends are what turn stabilization into stability.

PROGRAM ACTION

Center survivors and trauma-informed practices in program design

Survivors of violence are disproportionately represented on CCR calls. Program design should reflect that reality from the start.

Programs should integrate survivor-serving organizations as core infrastructure with shared training, established handoff protocols, and direct connection to dispatch and follow-up. Responders should be trained to recognize victimization in the calls they take, and protocols should protect confidentiality when working alongside community-based advocates whose effectiveness depends on operating at distance from law enforcement and government data systems.

PROGRAM ACTION

Develop intentional relationships with public safety partners

Productive partnerships with police, fire, and EMS expand operational access. Too much alignment can cost a program its community trust.

Building working relationships with police, fire, and EMS requires sustained engagement at both leadership and line levels: attending roll calls and training academies early on, maintaining consistent presence, and writing clear protocols for when each agency leads. Programs should also draw the limits of those relationships deliberately, with explicit policies on data sharing, co-response conditions, scene leadership, and dispatch coordination.

PROGRAM ACTION

Strengthen alignment with housing, behavioral health, and long-term care systems

Crisis response is only as effective as the systems people can move into after the call. Programs should build structured connections to those systems, not just referrals.

Programs should establish institutionalized handoff protocols with housing providers, coordinated entry systems, behavioral health services, detox and substance use treatment, and trauma recovery centers, along with the follow-up infrastructure to confirm those handoffs actually worked.

Build Community Legitimacy and Trust

Community trust is what carries a CCR program through budget cycles, leadership transitions, and political shifts. It is the most reliable form of political insulation available, and it has to be built deliberately over time.

PROGRAM ACTION

Build community ownership through formal accountability structures

Community ownership is built through formal structures and sustained engagement, not goodwill alone.

The programs that endure are the ones with formal accountability structures (steering committees, advisory boards, community task forces) that give residents authority to shape direction and hold leadership accountable, ideally established by statute or charter so they cannot be dissolved by a single administration.

PROGRAM ACTION

Make the work visible through transparent data and evaluation

Public data and transparent reporting are operational priorities. They build the trust that sustains programs through political shifts.

Programs that consistently publish call volume, response times, diversion rates, and outcomes (including data that reveals gaps and unmet demand) build the trust that becomes political protection when budget cycles shift. They should also partner with independent evaluators from the beginning and push beyond standard public safety metrics.

Models: Durham HEART and Atlanta PAD both publish dashboards that pair operational data with qualitative community feedback.

Build the Field at Scale

Community Safety scales beyond municipal programs through state action, multi-level government infrastructure, and recognition in federal data systems.

STATE ACTION

Mandate or incentivize CCR in jurisdictions above a population threshold

Voluntary adoption is uneven, leaving large parts of the country without access to non-police crisis response. State-level requirements paired with funding create durable expansion.

Washington's House Bill 1816 shows how this can work. As drafted, cities over 500,000 and large counties are allowed to create civilian alternative response teams, and it prevents police union contracts from limiting what those teams are allowed to do. A stronger version would require these teams rather than just allow them, paired with state funding so cities can afford to comply.

STATE ACTION

Scale community safety across all levels of government

Public safety operates at every level of government. Community safety has yet to scale the same way.

Each level of government has a role in building durable community safety infrastructure. Counties can establish programs serving unincorporated and rural areas beyond municipal reach, while states can coordinate jurisdictions and provide funding pathways for communities that may lack the capacity to compete directly for grants.

Model: State-level Offices of Violence Prevention in California, Colorado, Illinois, Maryland, New York, and others already operate in this funding-and-coordination role

FEDERAL ACTION

Recognize CCR event-level data in federal systems

Federal data systems track adjacent categories like mobile crisis at SAMHSA and alternative response within law enforcement agency surveys at BJS, but CCR is not yet recognized as its own response type.

Formal recognition of CCR *event-level* data (not Personally Identifiable Information) would let jurisdictions and researchers track programmatic trends, operational outcomes, and system-level impacts, and would support funding opportunities aligned with the actual work CCR programs perform.

Conclusion

The Community Safety Ecosystem is no longer emerging quietly at the margins of public safety systems. It is operating at scale across the country, reshaping how communities respond to crisis and challenging long-standing assumptions about who safety belongs to, who can provide it, and what people actually need in moments of vulnerability. Community Crisis Response is no longer a pilot project or political experiment. The question is no longer whether these programs work. The question is whether communities are willing to build the systems, infrastructure, and political commitment necessary for this work to endure.

However, permanence demands clarity.

Clarity about what CCR is: not a softer extension of policing, not simply a mobile crisis by another name, and not a temporary workaround for failing systems. CCR is a distinct field of practice grounded in public health principles, community trust, prevention, stabilization, and care-based intervention.

And clarity about what the field requires to survive. Community Safety cannot sustain itself on momentum, political trends, or isolated pilot funding. If communities want alternatives to enforcement, they must build the conditions that make those alternatives viable: shared language, durable funding, workforce development, structural recognition, trusted community relationships, and robust long-term support.

This white paper lays the groundwork for the other two papers in this series:

- ***Who Responds Matters: Workforce Development in Community Crisis Response*** examines the workforce that staffs CCR programs, including how they are recruited, trained, retained, and compensated, and what it takes to build sustainable career pathways for community crisis responders.
- ***Building What Lasts: Sustaining Community Crisis Response Programs*** addresses how CCR programs move beyond pilot funding toward permanent fixtures of public life.

These papers aim to support practitioners, funders, researchers, advocates, and communities working toward a future where safety is built through care.

Appendices

Appendix A: CCR Implementation Roadmap

This implementation roadmap offers a general structure for jurisdictions developing a Community Crisis Response (CCR) program, using a city-led Community Safety Department (CSD) as a working example. The phases and principles are broadly applicable to programs housed in community-based organizations or existing government agencies.

Each phase should be tailored to local governance, political history, and the priorities residents themselves articulate. The Center for Innovations in Community Safety's blueprint, *Our Neighborhoods, Our Safety: A Blueprint for a Unified Public Health Approach to Community Safety in Washington, DC*, offers one example of how these field-level principles translate into recommendations shaped by a specific city's political reality and community voice.

PHASE 1

Establish the Foundation

- [ ] **Identify and appoint a champion for the program**
  - [ ] Decide what level of leadership is appropriate to champion this effort — e.g., Deputy City Manager
- [ ] **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, police, 911, Fire/EMS, health and housing departments, neighborhood engagement offices, etc.
- [ ] **Perform resource assessment across agencies**
  - [ ] Map current community safety-related contracts, systems, partners, and funding allocations spread across city departments
  - [ ] Identify coordination gaps and consolidation opportunities
  - [ ] Determine program data sharing capabilities across systems
- [ ] **Perform crisis response data analysis**
  - [ ] Analyze 911 and police data to understand diversion opportunity
  - [ ] Calculate demand independent of current funding availability
- [ ] **Release Steering Committee strategic vision for CSD**
  - [ ] Public-facing document defining CSD purpose, scope, and guiding principles

PHASE 2

Design the Model

- ☐ **Clarify and establish executive leadership for public safety**
  - ☐ Determine if executive level restructuring is necessary to align reporting structure for leadership of police, 911, fire, and community safety departments — e.g., creating a leadership role to oversee all as a single portfolio.
  - ☐ Ensure CSD leadership has equivalent authority to police and fire leadership
- ☐ **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 existing program roles and other community safety functions for expanded scope within a CSD
  - ☐ Develop new roles to fill gaps identified in assessment
  - ☐ Develop job descriptions, HR classifications, org chart, budget
- ☐ **Integrate CSD with 911**
  - ☐ Integrate mental and behavioral health 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 911 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, City Council, Steering Committee, and public
    - [ ] Develop a public data dashboard
    - [ ] Establish a formal community feedback loop mechanism

Appendix B: [Glossary of Community Safety Terms]