The Value of Partnership

How Colorado's Co-Responder Programs Enhance Access to Behavioral Health Care

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Contents

On the Cover:
Kalie Douberly, LPC, and Dep. Corey Chance of the Douglas County Sheriff's Office are partners on the Douglas County Crisis Response Team.

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Executive Summary

The Office of Behavioral Health (OBH) contracted with the Colorado Health Institute (CHI) to evaluate its funded co-responder programs throughout the state. This evaluation drew from findings from an interim report, previously distributed in June 2020. The full interim report can be found here. This evaluation finds that co-responder programs have continued to provide individuals experiencing a behavioral health crisis necessary interventions and referrals to needed services.

CHI used data submitted by the co-responder programs on individuals served by the co-responder team. Four programs collected and reported individual-level data from September 2019–September 2020, called pilot sites, and the rest of the programs (18) began reporting individual-level data in July 2020. CHI analyzed trends over time and answered key research questions about program reach, effectiveness in reducing formal actions and connecting to behavioral health services, and return of law enforcement to patrol.

The evaluation answered the following questions:

1) Did co-responder programs reach people with behavioral health needs in their communities?

Key Finding: Co-responder programs reached people in their communities who needed behavioral health services.

- Across all sites, 3,473 people with probable behavioral health conditions were served by the co-responder program between July and September 2020.
- High utilizers (i.e., individuals seen more than once by the program) represented about 25% of all calls.
- Co-responders provided some form of service (e.g., behavioral health assessment, behavioral health referrals) to individuals on 93% of active calls.

Recommendations for Next Steps: Law enforcement departments do not always know whether a call has a behavioral health component until they respond on-scene, which creates challenges to understanding how many calls would have benefited from a co-responder team response. Future evaluation could include a data reporting mechanism or approach that objectively determines the total number of calls that could have benefited from a co-responder team.

2) Did co-responder programs help reduce law enforcement formal actions among community members with behavioral health needs?

Key Finding: Co-responder programs were associated with a reduction in the number of involuntary mental health holds and other formal actions among people with suspected behavioral health issues.

- The percentage of responses that resulted in an involuntary 72-hour mental health hold among pilot sites trended down from 8.3% in September 2019 to 3.2% in September 2020.
- Per officer self-report, co-responder calls resulted in 9.4% of individuals being diverted from the emergency department, with another 2.6% diverted from jail.

Recommendations for Next Steps: Formal diversions are reported based on law enforcement officers' assessment of whether a formal action would have been taken if the co-responder had not been on scene. But there is no way to know what would have actually happened had the co-responder not been there using the current method. Future evaluation

activities could use a control group to evaluate actions taken in similar counties with and without co-responder teams to determine if co-responder teams increase the number of diversions from formal actions. This would also provide data to make evaluative statements about costs avoided through formal diversions.

3) Did co-responder programs connect those in need to behavioral health services?

Key Findings: Across all co-responder programs, nearly 30% of contacts (N=1,219) resulted in a new enrollment in behavioral health services as reported by co-responders. Over time, pilot sites were able to enroll a higher percentage of individuals in behavioral health services.

- Different co-responder programs across the state had varying levels of success enrolling individuals in behavioral health services with one program enrolling less than 3.0% (N=184) and one program enrolling just over 60% (N=205) of contacts in behavioral health services.
- A majority of co-responder responses were resolved on scene and did not require further medical, community, or law enforcement engagement.
- Co-responders reported being able to transport people to community-based settings (e.g. community-based organization, walk-in crisis center, mobile crisis unit, or a community mental health center), or medical-based settings (e.g., emergency department, hospital inpatient, or withdrawal management services) to avoid unnecessary incarceration. About 6% of people were in community-based settings after the resolution of a call, 15.5% were in medical-based settings, and 1.5% were in jail, suggesting that co-responders were able to provide behavioral health services and reduce unnecessary incarceration.

Recommendations for Next Steps: Variation in behavioral health enrollment in services may be the result of the type of response model that each co-responder program implements, client needs, or missing enrollment data across sites. There is an opportunity to collect data from community behavioral health agencies or identify ways to validate behavioral health enrollment data provided by co-responder teams, such as confirming individual enrollment in services, whether the individual was previously enrolled in services, and what type of services the individual received. To answer this question, future evaluation activities should assess opportunities to link co-responder program data to community mental health center enrollment data, as well as private and self-pay data, to understand how many people were connected to behavioral health services, who remained in services, and what services they received after being contacted by a co-responder program.

4) Did co-responder programs help facilitate the return of law enforcement to patrol activities?

Key Findings: Per officer self-report, the amount of time that law-enforcement spent on co-responder calls decreased over time and facilitated their return to patrol duties.

- Between July and September, sites increased the frequency of law enforcement returning to patrol duties from 26.4% to 38.4%.
- Overall, co-responders reduced unnecessary law enforcement involvement in one of every three calls, allowing officers to return to other duties.

Recommendations for Next Steps: Initial feedback from law enforcement officers involved in co-responder programs suggested that there were policy needs around working with mental health professionals on scene and establishing data sharing protocols that would support law enforcement officers in their work. Future evaluations could conduct key informant interviews to determine best practices for establishing policies and protocols for partnering law enforcement with mental health providers, and could translate those into recommendations for data sharing between law enforcement and mental health agencies. Other opportunities include reaching out to partners, including law enforcement and behavioral health providers, to assess what is considered important outcomes, and ensure that appropriate data is captured to measure outcomes of interest.

Introduction

A co-responder model is a coordinated effort between law enforcement and behavioral health professionals to connect individuals with behavioral health needs to services and divert them from settings that may not best serve their needs.

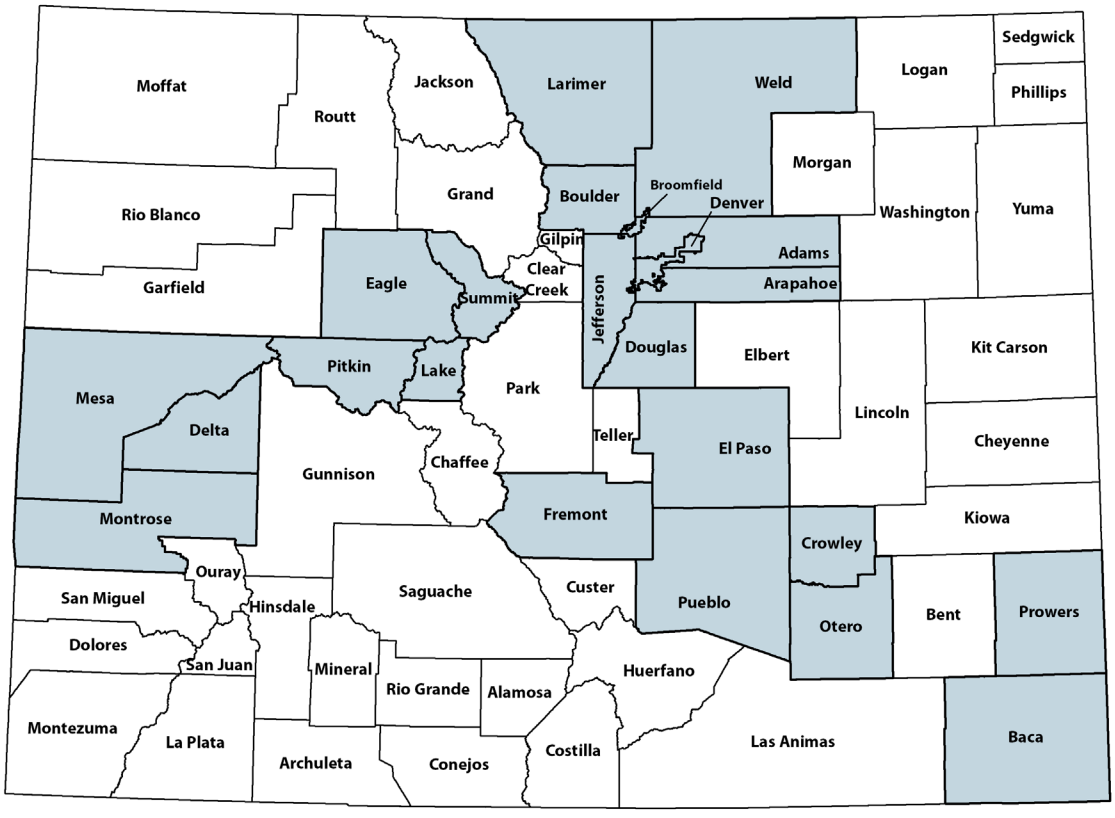
Through its Co-Responder Program, the Colorado Department of Human Services Office of Behavioral Health (OBH) provides funds to 23 counties to implement 26 co-responder teams to respond to calls with a suspected behavioral health component (see Map 1).[1]

The goals of the program are to prevent the unnecessary incarceration and hospitalization of people with behavioral health conditions, to provide alternative care through system coordination, and to return law enforcement officers to their patrol activities.[2]

Law enforcement officers are often called to assist individuals in crisis, and in some cases law enforcement officers may arrest an individual or take them to a hospital when a community-based behavioral health program may be a better alternative to meet the individual's need. This outcome often reflects a lack of resources or training to support law enforcements' response to behavioral health-related calls.

The co-responder model pairs law enforcement officers with behavioral health professionals when calls for service have a mental health or substance misuse component.[3] Evidence from other states that have co-responder programs suggests they reduce the use of deadly force, improve interactions between community members and law enforcement, and increase connections to appropriate services.[4,5,6,7] Although OBH-funded programs are relatively new, evaluation to date suggests that they can be successfully implemented and are beginning to demonstrate positive outcomes for law enforcement and people with behavioral health conditions.

Map 1. Counties Served by an OBH-Funded Co-Responder Program, 2020



Four funding streams support the OBH Co-Responder Program in Colorado, and funding for the effort has increased substantially:

- Senate Bill 17-207 authorized the development of eight co-responder programs in 2017, with a total budget of $2.9 million from the Marijuana Tax Cash Fund.
- The Offender Behavioral Health Services program allocated $2 million from the Marijuana Tax Cash Fund to Community Mental Health Centers to support co-responder teams.
- Starting in 2018, the Mental Health Block Grant, which is a federal grant issued to OBH by the Substance Abuse and Mental Health Services Administration, has allocated $500,000.
- Senate Bill 19-008 authorized an additional $1.2 million per year from the State General Fund in 2019.[8]

A list of the co-responder programs and the organizations involved in each program is detailed in Appendix A. CHI refers to these jurisdictions when discussing community-specific findings.

Members of the Douglas County Crisis Response Team, seated, left to right: Tinesha Younger-Qualls, LPC; Abigail Hoffbauer, LPC; Ellen Pronio, LSW; and Kalie Douberly, LPC. Standing, left to right: Officer Tom O'Donnell, Castle Rock Police Department; Steve Kalisch, Case Manager; Cpl. Brian Briggs, Douglas County Sheriff's Office; and Dep. Corey Chance, Douglas County Sheriff's Office.

Evaluating the Co-Responder Program

Previously, co-responder programs utilized an aggregate monthly reporting tool to track program impact in communities. Because the reporting tool did not connect specific co-responder calls to specific outcomes, inferences about program outcomes were limited and any differences between individuals (based on age, race, etc.) were unknown. Coinciding with the interim evaluation, OBH launched an updated monthly reporting tool with CHI's support to improve analytical insights by increasing the availability of individual-level data. Individual-level outcomes were tracked over time and across demographic characteristics to understand the impact of co-responder programs in local communities between July and September 2020 (see Page 8).

This evaluation report includes data from the monthly reporting tool completed by each co-responder program. Twenty-two of the 26 programs submitted complete data and were included in this analysis. The Denver Substance Use Navigators and Montrose co-responder programs submitted two months of complete data due to restructuring processes, but were still included in this assessment. Four programs (Grand Junction and Douglas, Pitkin, and Weld) initially piloted the individual-level monthly reporting tool and were able to provide data between September 2019 and September 2020.

The evaluation identified five research questions to understand the impact of co-responder programs on the communities they serve:

1. Did co-responder programs reach people with behavioral health needs in their communities? (Page 9)
2. Did co-responder programs help reduce law enforcement formal actions among community members with behavioral health needs? (Page 14)
3. Did co-responder programs connect those in need to behavioral health services? (Page 18)
4. Did co-responder programs help facilitate the return of law enforcement to patrol activities? (Page 23)
5. What system-wide costs were avoided through the diversion of formal actions such as hospitalizations or arrests? (Page 24)

New Co-Responder Data Reporting Tool

OBH has developed a more robust tool for co-responder sites to collect more data about the impact of the program. This tool was piloted beginning in 2019.

Previously, OBH used a tool that collected data at the aggregate level. The new tool captures data at an individual level. This means data are available about each individual served, including what services were provided, how the call was resolved, and if the person was contacted during follow-up calls. This level of detail illustrates how individuals engage over time with co-responders in their community. It also facilitates assessment of the programs' impacts on individual-level outcomes.

Agencies from four co-responder sites started using this new tool in July 2019. These programs are:

- Douglas County Crisis Response Team: Parker Police Department, Douglas County, and Caring Communities (Douglas)
- Greeley Evans Mobile (GEM): Evans and Greeley police departments and North Range Behavioral Health (Weld)
- Grand Junction Crisis Support Team: Grand Junction Police Department and MindSprings Health (Grand Junction)
- Pitkin Area Co-Responder Team (PACT): Pitkin County Public Health, Aspen and Snowmass Village police departments, Pitkin County Sheriff's Office, and Mind Springs Health (Pitkin)

This evaluation analyzed data from these four pilot sites from September 2019 through September 2020 to understand trends over time. Additionally, CHI analyzed the data collected by all co-responder programs that transitioned to using the individual-level tool in July 2020. Data for all sites is reported from July 2020 through September 2020. These data offer a more nuanced look at the impact of each co-responder program and at the success of the OBH Co-Responder Program as a whole.

Roles and Responsibilities of a Co-Responder Team

OBH-funded co-responder programs are relatively new, and each site implements the program based on its community needs. Some have a dedicated team of officers and behavioral health clinicians who respond to calls during their shifts (co-responder teams). Others deploy a behavioral health clinician to a scene only if an officer requests assistance (co-responder clinician). The term co-responder is used to describe all co-responder programs, including co-responder teams and co-responder clinicians.

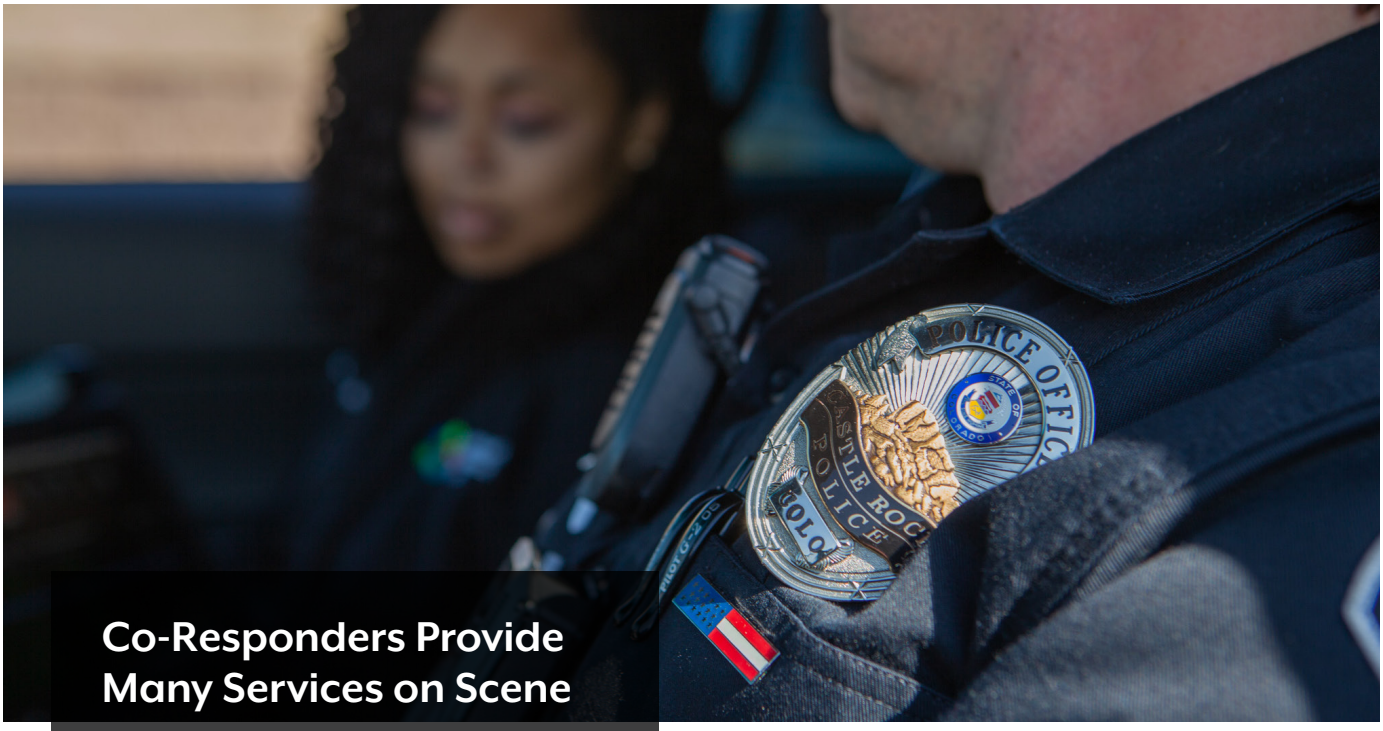
Any time a co-responder team or a co-responder clinician is deployed — either as first response or a request for help — it is considered an on-scene or active response call, and services provided are considered **on-call services**.

When co-responders are unable to respond to an emergency call, because they are not on duty or are unavailable on another call, law enforcement may send a referral for an individual with a behavioral health concern so that the co-responders may reach out to the person. This is called an **after-the-fact referral**.

And finally, co-responders follow up with individuals after initial contact to assess if they are enrolled in behavioral health services and if they need other services. These are considered **follow-up calls**.

Co-responders provide different types of assistance depending on the set-up and capacity of each program, and resources available at the local level. Staff turnover and other capacity issues may lead to changes in services over time. Examples of different types of services include behavioral health assessment, de-escalation assistance, consultation with an officer, and referral to community services or resources.

Additionally, based on the COVID-19 pandemic response protocols, some programs may have changed how they responded to active calls. The primary months of data collection, July to September 2020, were in the midst of the pandemic.



Tinesha Younger-Qualls, LPC, and Officer Tom O'Donnell of the Castle Rock Police Department are partners on the Douglas County Crisis Response Team.

Co-Responders Provide Many Services on Scene

Behavioral Health Assessment
Co-responders provide a behavioral health assessment to an individual on scene to determine the need for a 72-hour mental health hold, withdrawal-management services, or other behavioral health interventions.

Resource and/or Referral
Co-responders provide a resource or referral to behavioral health services or other community services to individuals while on scene.

De-Escalation Assistance
Co-responders help verbally calm or reduce the emotional intensity of a potentially harmful situation when they arrive on scene.

Support and/or Resources for Others
Co-responders may help others on scene in addition to or in lieu of assistance provided to the individual contacted.

No Assistance Provided
Co-responders work to provide the best level of care possible based on the situation. Sometimes, though, situations are unsafe, or the individual contacted declines assistance.

Evaluation of the Co-Responder Program

Evaluation Question: Did co-responder programs reach people with behavioral health needs in their communities?

Key Finding: Across all sites between July and September 2020, 3,473 people were served by the OBH Co-Responder Program.

Overall, co-responders provided services and resources to more than 3,400 people between July and September 2020 (see Table 1). The reach of a program was defined as the number of contacts between co-responders and individuals, including responses to active calls, after-the-fact referrals, and follow-ups. (For more information on the number of contacts made per month, see Appendix B.)

The average number of people served at each site per month ranged from three to 299 people during this period, depending on the geographic area of the state the program served. For example, Arapahoe reached nearly 10 people per day. Programs in smaller jurisdictions like those in Summit or Pitkin, reached about one person per day.

Table 1. Co-Responders Reached 3,473 Unique Individuals Between July and September 2020 Across All Sites*

Co-Responder Program	Total Served	Average Number Served per Month	Average Number Served per Day
Arapahoe	898	299.3	10.0
Arvada	53	17.7	0.6
Colorado Springs	171	57.0	1.9
Broomfield	88	29.3	1.0
Cañon City	51	17.0	0.6
Denver Crisis Intervention Response Unit (CIRU)	160	80.0	2.7
Denver Substance Use Navigators (SUN)**	<30†	2.5	0.1
Douglas	74	24.7	0.8
El Paso	332	110.7	3.7
Grand Junction	119	39.7	1.3
Lakewood	149	49.7	1.7
Larimer	298	99.3	3.3
Longmont	217	72.3	2.4
Montrose**	35	17.5	0.6
Pitkin	80	26.7	0.9
Pueblo	107	35.7	1.2
Lake	<30†	9.0	0.3
Southeast Colorado	125	41.7	1.4
Summit	80	26.7	0.9
Vail	30	10.0	0.3
Weld	233	77.7	2.6
Westminster	141	47.0	1.6
Total	**3,473**	**1,157.7**	**38.6**

*Unique individuals served means that individuals who had an interaction with a co-responder program more than once were only counted once in this table.

** Data were not available for July because programs were in the process of restructuring.

† Data are supressed to protect client privacy due to small client counts.

Potential Impact of COVID-19 Pandemic on Co-Responder Program Reach

Between December 2019 and May 2020, there was a decline in the number of responses each month by pilot site, a decrease that may be attributed to the COVID-19 pandemic (see Table 2).

All pilot sites experienced a decrease in the average number of responses to community members from December 2019 to May 2020. By September 2020, there was an increase in responses across all four sites, which coincided with stay-at-home orders and other restrictions being lifted. Programs have returned to normal response levels nearly on par with before the pandemic, and some programs have surpassed the average number of calls they were handling before the pandemic. Since client-level data were not available before the pandemic for all sites, it is unclear how COVID-19 affected capacity and reach at all sites. Even after the start of the COVID-19 pandemic, co-responder programs continued to engage community members who needed behavioral health services.

As sites continue to gather data over time, it will be easier to track the impact of environmental factors to the change in caseloads and identify more targeted methods to reach those in need of behavioral health services.[9] These data could also inform future planning efforts; as demand for behavioral health services increases, programs will need to increase capacity to serve more individuals.

Table 2. Even During the COVID-19 Pandemic, Many People Still Received Assistance From Co-Responders, September 2019–September 2020, Pilot Sites

Average Number of Responses per Month

Co-Responder Program	September 2019 – November 2019	December 2019 – February 2020	March 2020 – May 2020	June 2020 – September 2020
Grand Junction	78.3	58.0	41.3	45.3
Douglas	44.7	28.3	23.7	28.0
Pitkin	57.3	72.0	29.3	62.3
Weld	39.7	46.0	36.0	86.8
Total	**220.0**	**204.3**	**130.3**	**222.3**

Key Finding: Co-responders provided outreach through 1,666 after-the-fact referrals, which helped increase reach in their communities.

Co-responders provide services utilizing different response methods, with some answering active calls while others primarily provide after-the-fact referrals.

Overall, co-responders responded to 1,666 referrals to community members in their jurisdictions. (For more in-depth information on after-the-fact referrals per co-responder program, see Appendix B, Table 2.)

Across all sites, after-the-fact referrals accounted for nearly one-third of the teams' workload, but this varied greatly across sites. For example, over 98% of the workload in Arvada and Lakewood was designated as an after-the-fact referral, while programs at the Denver Crisis Intervention Response Unit and in Grand Junction reported zero after-the-fact referrals during the study period.

Each program provides behavioral health-related interventions based on how their programs are structured. Future analysis and qualitative research could explore the workload for programs

that respond both to active calls and provide after-the-fact referrals to understand how much time is spent on each type of outreach.

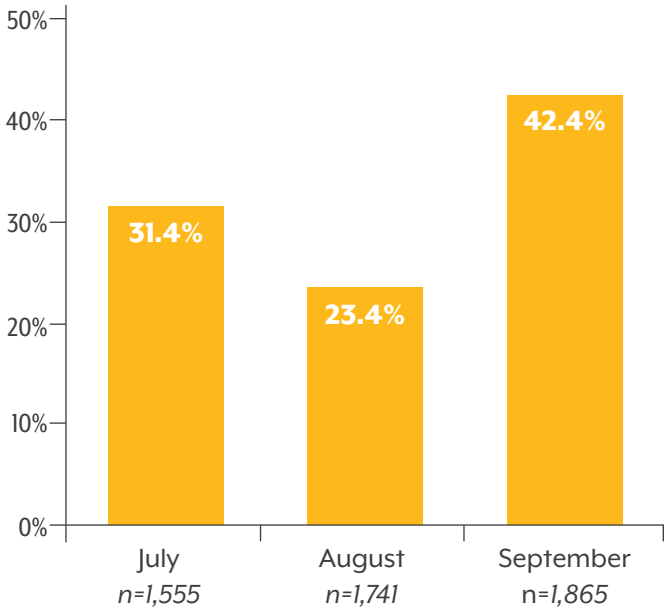
Key Finding: One-third of all responses involved individuals who had been seen more than once per month. These people are referred to as high utilizers.

High utilizers are people who encounter co-responders more than once per month, indicating they may need more support or have intensive needs. Connecting these individuals to behavioral health services is an integral part of co-responder programs; because of the comparatively high needs of this sub-population, many programs place intentional focus on serving high utilizers.

CHI identified the number of people who were contacted more than once a month in any given month to assess the level of effort dedicated to serving them. Across all sites in any given month, about a third of calls served high utilizers (see Figure 1).

Figure 1. About a Third of Total Responses Involved Serving Someone Seen More Than Once Per Month, July–September 2020, All Sites

Percentage of Total Responses Serving High Utilizers



Licensed professional counselors Abigail Hoffbauer, left, and Kalie Douberly are members of the Douglas County Crisis Response Team.

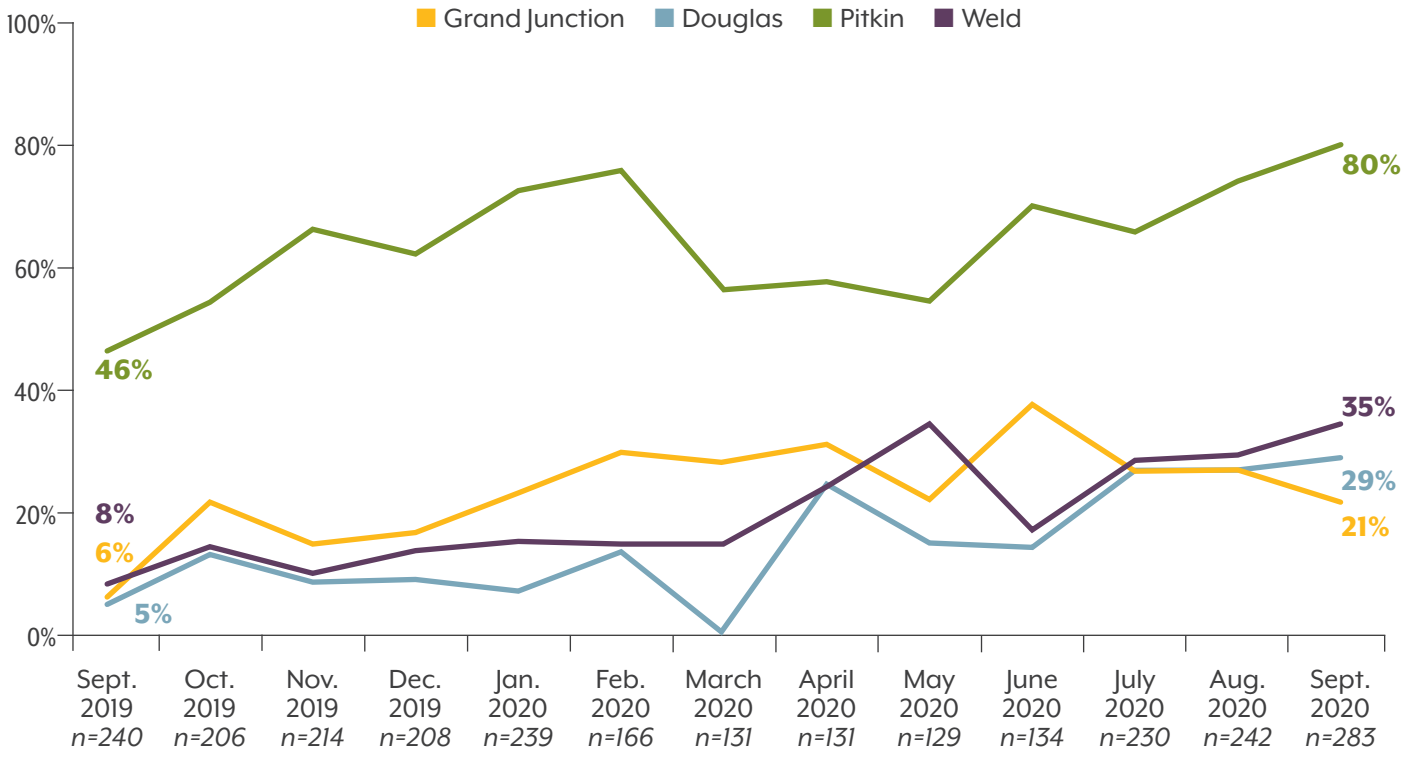
The amount of time dedicated to high utilizers varied by program – the percentage of calls involving a high utilizer ranged from 6% to nearly 70% of calls across sites. In Douglas, Lakewood, and Pueblo, for example, calls involving a high utilizer made up less than 20% of their workload. Programs in other locations, including Pitkin and Summit, dedicated 60% of monthly responses to high utilizers.

CHI analyzed data from programs in Grand Junction, Douglas, Weld, and Pitkin to understand how co-responder programs work with high utilizers (see Figure 2). Responses to the high-utilizer population in any given month in these programs increased over time in the form of active calls, referrals, or follow-ups. In September 2020, 80% of Pitkin's responses were to individuals who were high utilizers.

There could be several reasons for the increase. Co-responders may increasingly focus on individuals who have the greatest need or perhaps trust in co-responder teams grows as people become more aware of this service. The increase could also indicate that high utilizers have more acute needs than others or are experiencing repeated trauma or crises, which brings them into contact with co-responders more often.

Figure 2. Pitkin Had the Highest Number of Responses per Month to People Identified as High Utilizers, September 2019–September 2020, Pilot Sites

The Percentage of Contacts When an Individual Was Served More Than Once per Month



Key Finding: Across the study period, high utilizers represent about a fourth of all people served.

Some people may be served more than once, but not during the same month – these individuals were also referred to as high utilizers. Individuals who were served more than once by the program during the study period represent approximately 25% of all individuals served by co-responder programs — or 839 unique individuals. This means that a relatively small portion of individuals represent a rather large number of responses; high utilizers required about 1,688 responses (see Appendix B for total number of contacts by program). In some locations, like Arvada, nearly 75% of the individuals served came into contact with co-responders more than once during the study period.

In El Paso and Summit, about half the individuals receiving services were high utilizers. In other areas, like Douglas and Broomfield, less than 10% of the individuals contacted were high utilizers (see Appendix B, Table 3 for variation by site).

Co-responders spend a large portion of their time handling calls, follow-ups, and referrals for many of the same people in their communities. For many high utilizers, the co-responder programs might represent an important behavioral health service that provides them necessary care in time of crisis. Focusing efforts on these high utilizers to connect them to alternative services may help reduce the number of times co-responders are called to respond, meaning better health outcomes for these individuals.

Key Finding: Co-responders provided some form of service to individuals involved on 93% of active calls. One in every 10 calls necessitated de-escalation assistance.

Overall, co-responders provided behavioral health assessments on scene for about one-fourth of active calls (25.3%), while one in 10 calls

Table 3. Co-Responders Provided a Range of Services to Those Involved In Active Calls, July–September 2020, All Sites *n=2,389*

Assistance Provided by Co-Responder During Active Calls	Rate of Assistance Provided*
Behavioral Health Assessment	25.3%
Behavioral Assessment and Resource/Referral	17.9%
De-Escalation	10.0%
Provided Resources/Referrals/ Support for Individuals and/or Others on Scene	37.1%
None	7.4%

*2.3% of on-scene calls were missing data on co-responder assistance type

Defining Colorado's Involuntary Mental Health Treatment

Voluntary
Individual is not placed on any involuntary hold during call or contact with law enforcement.

Involuntary (M-0.5)
Individual is placed on a hold for involuntary transportation and screening at an outpatient mental health facility with crisis walk-in services or other clinically appropriate facility. [10]

Involuntary (M-1)
Individual is placed on a 72-hour involuntary mental health hold because they are considered a danger to themselves or others, or are gravely disabled.[11]

Involuntary (Alcohol or Drug)
Individual is transported to withdrawal management involuntarily due to substance intoxication (includes emergency commitment or involuntary commitment for alcohol or drugs).

(10.0%) needed de-escalation assistance. Only about 7% of calls did not result in co-responder support on scene (see Table 3).

These data represent one of the important parts of co-responders' work — connecting people who need behavioral health support to services in their communities. Co-responders can provide several services to individuals or their families to diffuse a potentially volatile situation. Co-responders can make referrals to community mental health centers or conduct behavioral health assessments on the scene of an active call.

See breakout box on Page 9 for more information about each type of assistance provided that is captured by the data reporting tool.

Evaluation Question: Did co-responder programs help reduce law enforcement's formal actions among community members with behavioral health needs?

Key Finding: The percentage of responses that resulted in an involuntary 72-hour mental health hold (M-1 hold) among pilot sites trended down from 8.3% in September 2019 to 3.2% in September 2020. Data from all co-responder sites suggest that the rate of M-1 holds is highest among those who identify as Asian or Other Race (see note about methods on page 16).

The following information includes co-responder contacts where data are available on involuntary procedures. This includes contacts where the co-responder did not respond to an active call, but made contact with an individual after law enforcement transported or placed the individual on an involuntary procedure.

About 82% of contacts where involuntary procedure data were available did not result in an involuntary procedure. This means that about 18% did result in an involuntary procedure.

Most co-responder calls that end with an involuntary procedure can be attributed to mental health issues. Of those involuntarily placed, 90% were M-1 holds, while another 8% were applications for emergency commitments due to alcohol or drugs (see Figure 3).

This trend holds true across the pilot sites' first year. Overall, 88.4% of responses did not result in an involuntary procedure; 10.1% were transported or placed on an involuntary mental health hold (M-0.5 or M-1); and 1.5% were placed on an application for emergency commitment due to alcohol or drugs (see Figure 4). Grand Junction had the highest number of involuntary transports (M-0.5) or M-1 holds at 14%, while Weld had the highest percentage of responses resulting in an application for emergency commitment due to alcohol or drugs, at a little over 3%.

Figure 3. Most Involuntary Transports Were for M-1 Holds, All Sites *n=582*

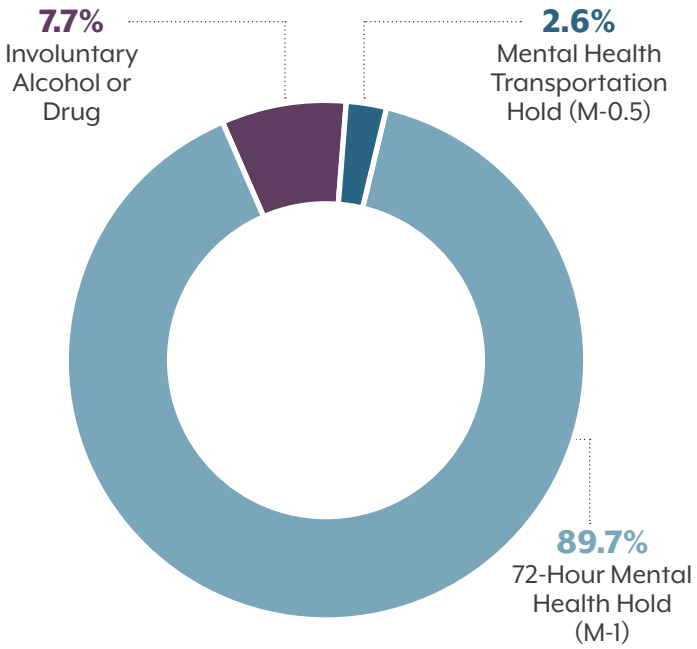
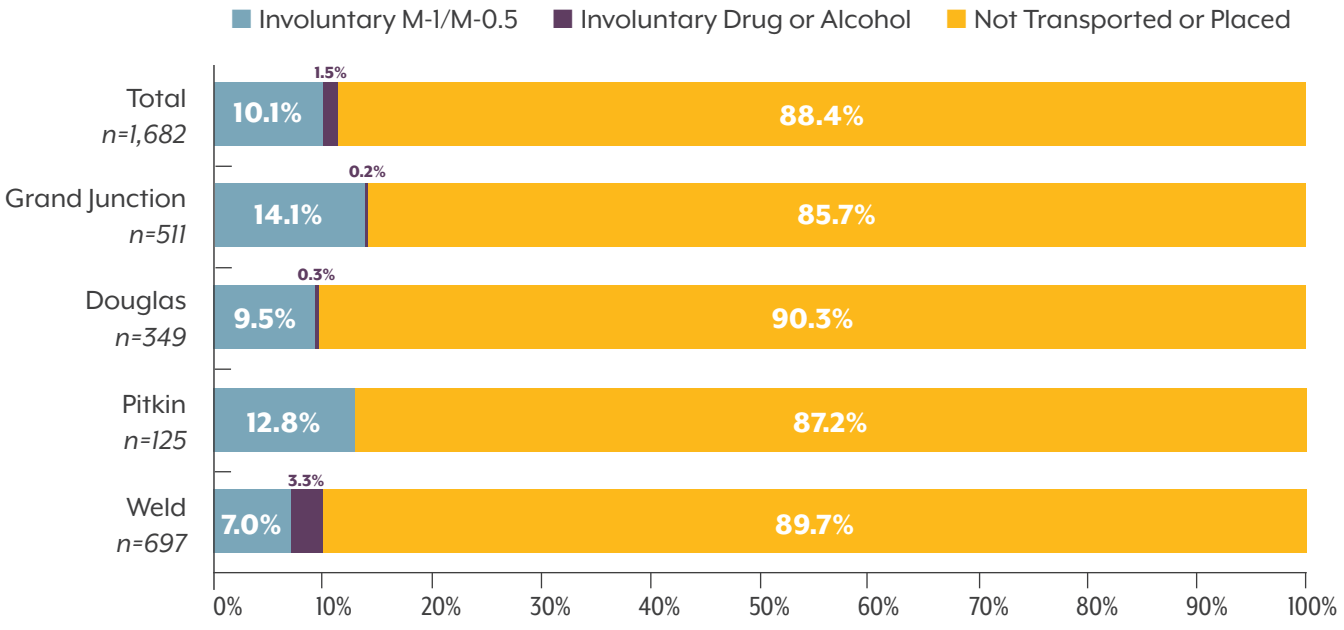


Figure 4. The Majority of Responses Did Not Result in an Emergency Transport or Placement by the Person Involved, September 2019–September 2020, Pilot Sites

Percentage of Contacts that Resulted in an Involuntary Placement of the Individual Involved

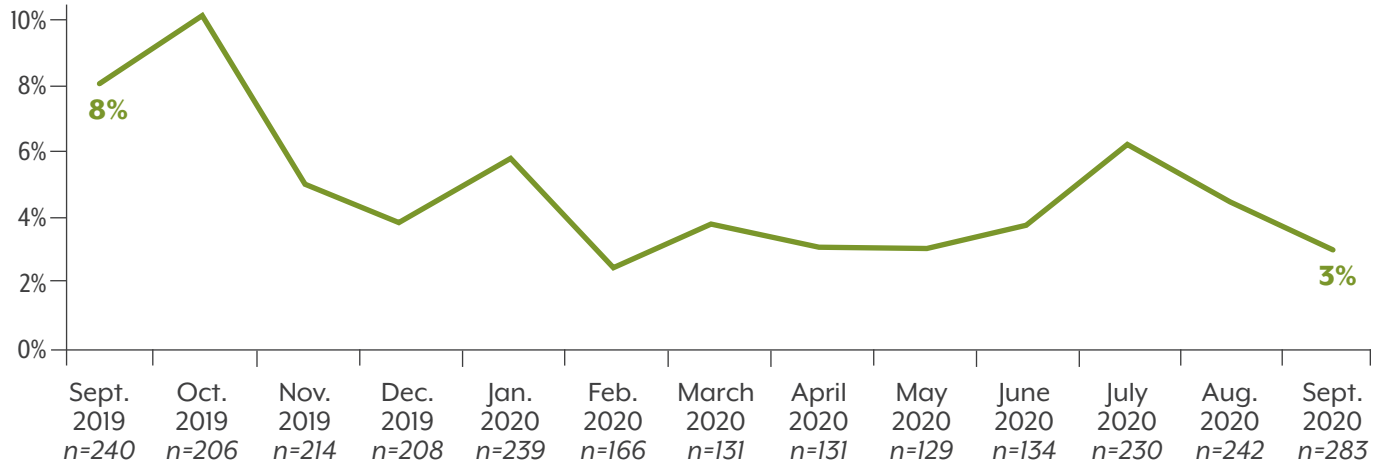


From September 2019 to September 2020, the percent of responses that resulted in an M-1 hold decreased across the four pilot sites (see Figure 5). This decrease could be because law enforcement officers are using de-escalation and other co-responder services.

The number of M-1 holds remained steady from the start of the COVID-19 pandemic in March through June 2020. However, since July, the number of responses resulting in an M-1 hold decreased over time. The decrease could be due to the increased number of people connected to community-based resources as well.

Figure 5. The Number of Responses That Resulted in M-1 Holds Decreased Between September 2019 and September 2020, Pilot Sites*

Percentage of Pilot Site Contacts Ending in M-1 Holds



* Data includes Pitkin, Grand Junction, Douglas, and Weld

The rate of M-1 holds varied between rural and urban areas of the states. About 12% of responses in urban areas resulted in an individual being placed on an M-1 hold, compared with about 5% of responses in rural areas. These differences may speak to the geographic differences in population composition or access to behavioral health services.

Based on data from all sites, different racial groups experience higher rates of placement on M-1 holds (see Figure 6). (Note about methods: Hispanic ethnicity was collected as a separate variable and was analyzed in a separate analysis to keep sample sizes large enough to report for more specific racial groups. Ethnicity should not be assumed based on the race variable or vice versa).

Individuals who identified as Black or African American had a slightly lower rate of M-1 holds compared with their white counterparts (14.0% to 16.0%, respectively).

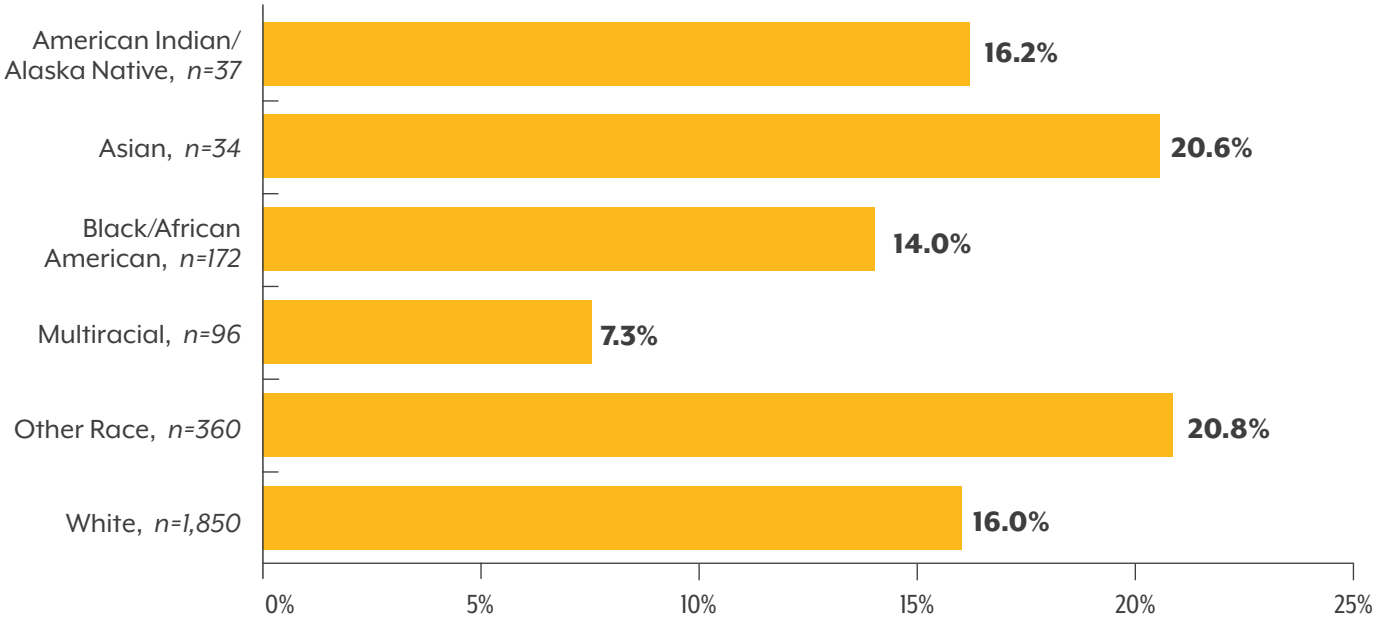
However, those who identified as Other Race or Asian were placed on M-1 holds at slightly higher rates: Just over 20% for both groups. Those who identified as American Indian or Alaska Native had a comparable rate to the average at 16.2%.

Those who were Hispanic had a similar rate of M-1 holds as those who were not Hispanic (15.0% to 15.5%, respectively).

Different racial groups have different behavioral health experiences and needs. For instance, research has shown that those who identify as American Indian or Alaska Native have more limited access to mental health treatment

Figure 6. Those Who Identified as Asian or Other Race had the Highest Rates of Being Involuntarily Placed on an M-1 Hold, All Sites

Percentage of Total Contacts that Ended in an M-1 Hold by Racial Group



services and are at higher risk of post-traumatic stress disorder and alcohol dependence, conditions that can be explained by historical trauma and a range of systemic economic, social, and policy issues.[12,13,14] Care seeking also differs between racial groups: Those who identify as Asian are less likely to seek professional behavioral health services compared to the general population, which may perpetuate issues over a lifetime.[15]

Small sample size for some racial/ethnic groups could contribute to the differences in the analysis, or there could be reporting bias as co-responders might not always be able to report an individual's preferred racial/ethnic identity.

While available data do not entirely explain differences for racial/ethnic populations, co-responder programs should continue to track and explore the potential causes of and approaches to address these disparities.

Key Finding: Co-responder response to calls resulted in 9.4% of individuals being diverted from the emergency department, with another 2.6% diverted from jail.

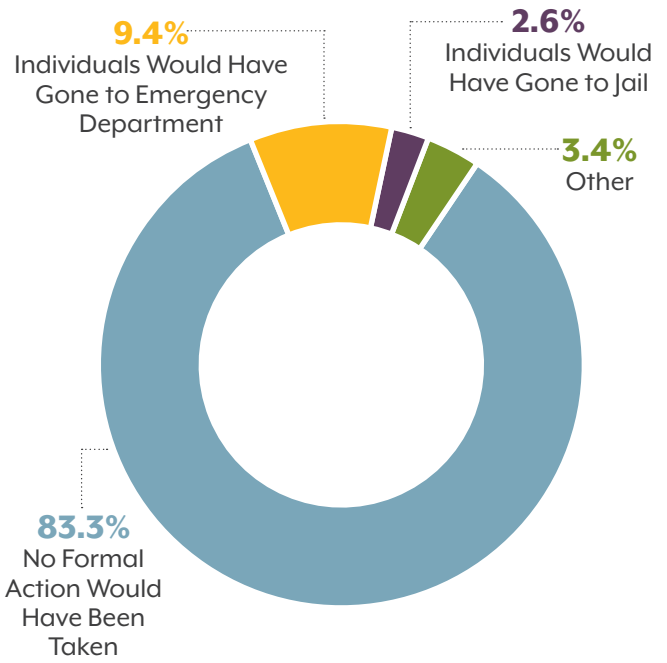
Referring people to behavioral health services rather than taking formal actions, which include emergency department transports, involuntary mental health holds, and arrests, can result in better outcomes and reduce unnecessary use of these resources. Overall, OBH-funded co-responder programs were able to divert 9.4% of people from the emergency department. Another 2.6% were diverted from jail. (See Figure 7.)

When reporting on co-responder activities, law enforcement officers assess whether a formal action would have been taken if the co-responder had not been on the scene. While based on experience, these data are subjective and potential diversions may be over- or under-reported.

Weld, for example, reported diverting 17.2% of individuals from the emergency department, compared with 11.7% reported by Douglas and only 1.5% in more rural Pitkin (see Figure 8). These

Figure 7. About 9% of Responses Resulted in People Being Diverted From Emergency Departments, July–September 2020, All Sites *n=1,595*

Percentage of Active Call Responses Diverted from a Formal Action



differences could reflect the community's available resources for alternatives to emergency departments, as some rural areas may not have the same level of access to behavioral health care services as urban areas in Colorado.

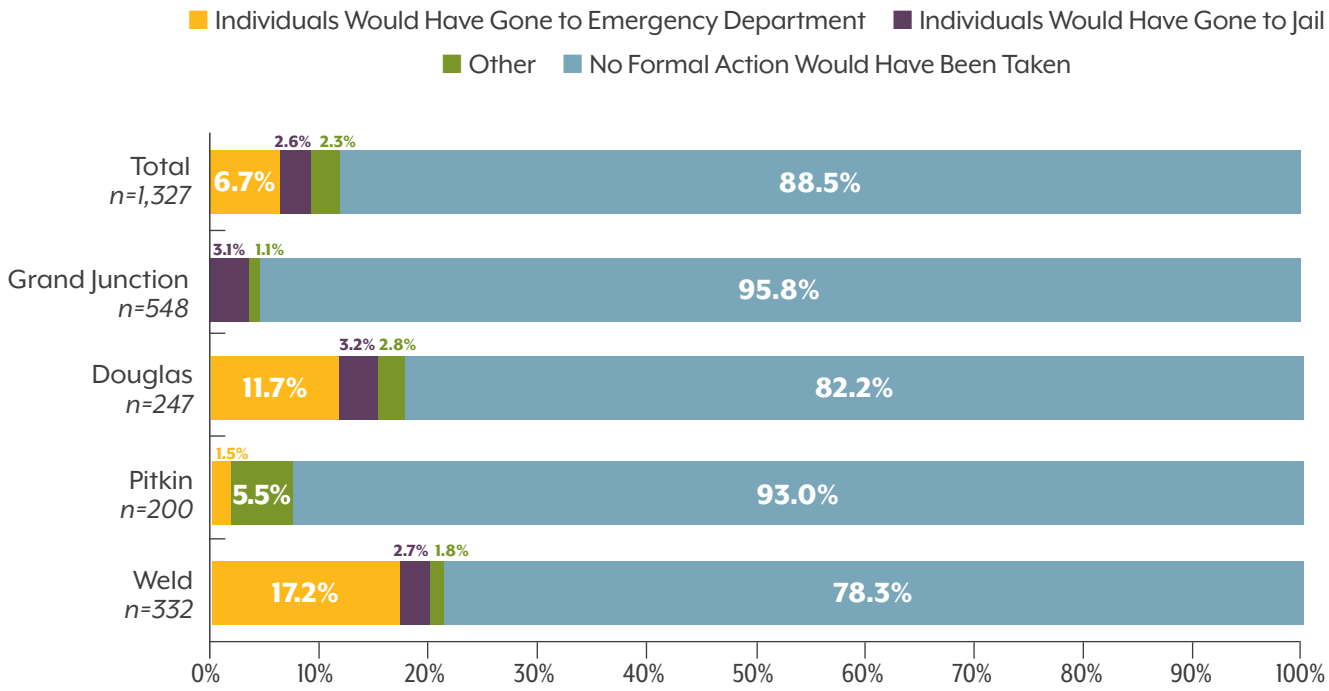
Evaluation Question: Did co-responder programs connect those in need to behavioral health services?

Key Finding: Between July and September 2020, about 49% of calls were resolved on scene. About 6% of people were in community-based settings after the resolution of a call, while another 15.5% were in medical-based settings, and 1.5% were in jail. There wasn't significant variability by race for those jailed after contact with co-responder teams.

Data provided through the monthly reporting tool identifies the location of individuals after a co-responder intervention. These locations were organized into three categories: community-based (community-based organization, walk-in crisis center, mobile crisis unit, mental health center), medical-based (emergency department/ hospital, withdrawal management services), and

Figure 8. Weld County Diverted the Highest Percentage of People from the Emergency Department Between September 2019 and September 2020, Pilot Sites

Percentage of Active Call Responses Diverted from a Formal Action



jail settings. Many sites, including Denver CIRU, Grand Junction, and Douglas, report over 75% of total responses resolved on scene. (For full location data by co-responder program, see Appendix B, Tables 4 and 5.)

Connecting individuals with fewer acute needs to community-based services could mean better outcomes down the road – and a reduced cost burden.

About one in six responses resulted in individuals being placed in medical-based settings. Although some people may need this type of care, unnecessary placements in hospitals or emergency departments can be costly for taxpayers, particularly if individuals are uninsured or underinsured.

In addition to on-scene responses, this analysis includes after-the-fact referrals and follow up calls, and about 28% of responses had missing location data.

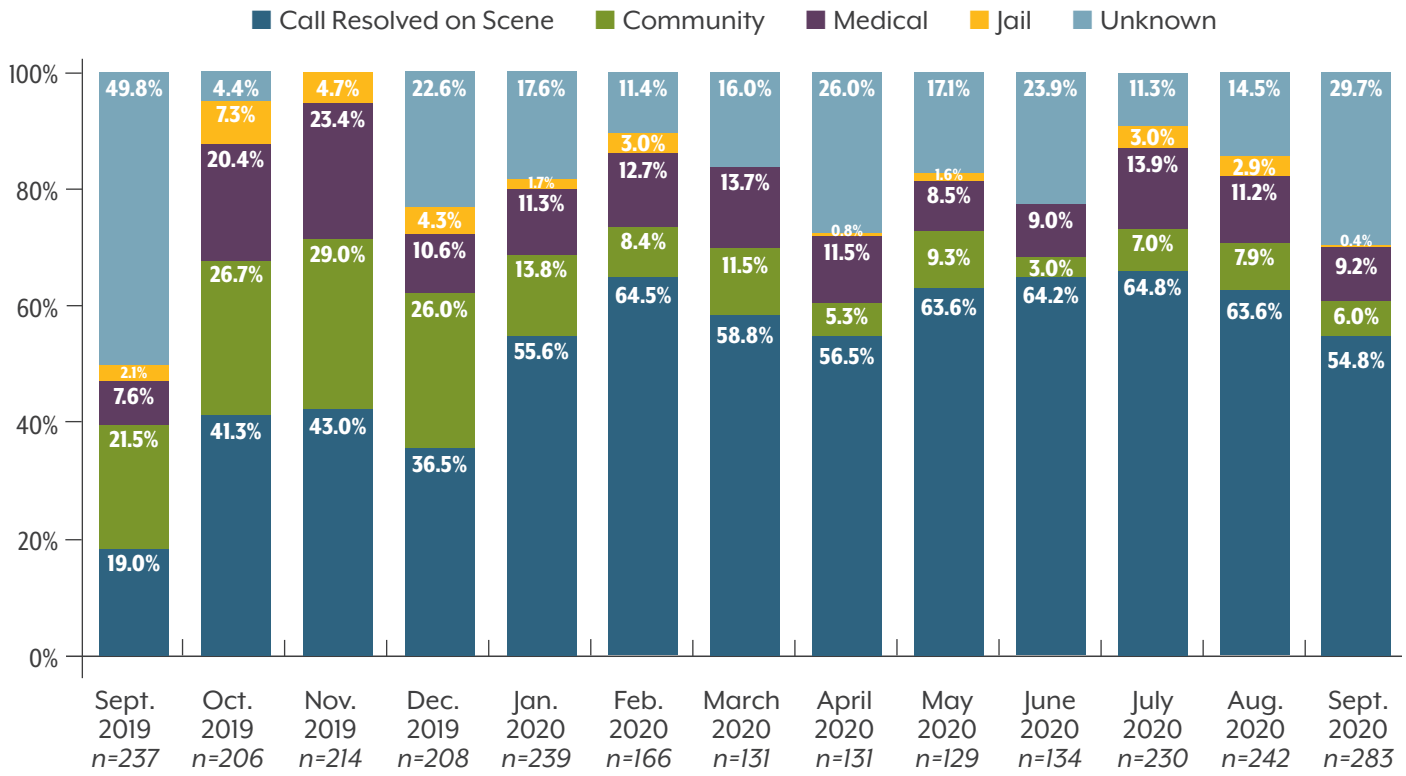
Tracking how these placements change over time could indicate if a co-responder program is increasingly successful in connecting people in crisis to needed community-based supports.

Across all four pilot sites (Grand Junction, Douglas, Pitkin, and Weld), most calls were resolved on scene after contact with the co-responder program (see Figure 9). The rate of people in medical-based settings fluctuated over time, hovering between about 10% and 13% for most months during the study period, but reaching over 20% from October through November 2020 during two months of data. This may indicate a need by some for more acute care. However, this also means there is still a sizable number of individuals who end up at emergency departments and other medical-based care. Missing data could be masking a greater number of resolved calls ending in medical- or jail-based settings.

Across racial groups, there is some variability in where individuals end up after resolution of a call (see Figure 10).

Figure 9. Co-Responders Were Able to Resolve More Calls on Scene Over Time, Pilot Sites*

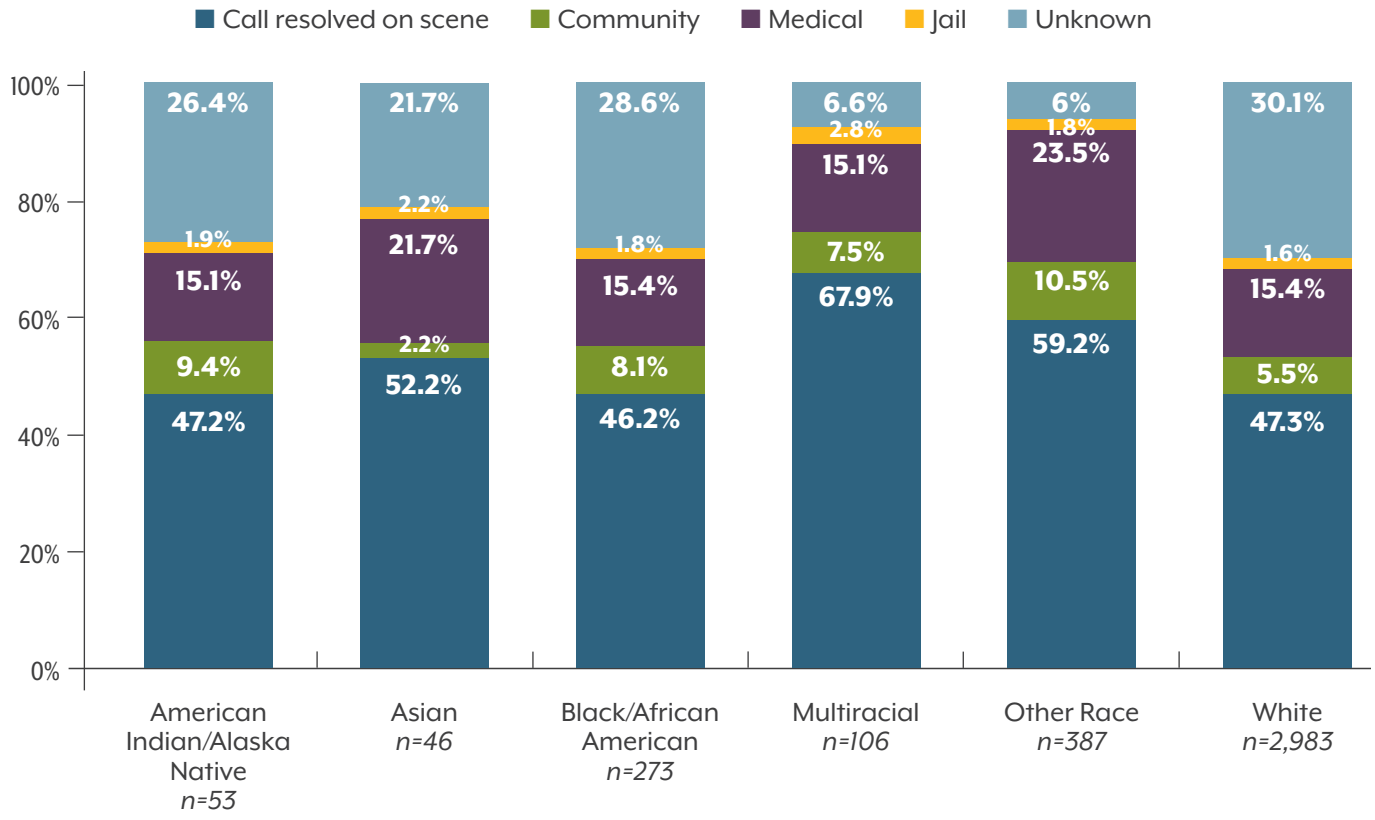
Percentage of Total Contacts in Community-, Medical-, or Jail-Based Settings After Contact



* Data includes Pitkin, Grand Junction, Douglas, and Weld

Figure 10. People Who Identified as Asian or Other Race Were More Likely to Be in Medical-Based Settings Compared with Other Race Groups, All Sites

Percentage of Total Contacts in Medical-, Community-, or Jail-Based Settings After Contact



The highest percentage of people located in medical-based settings identified themselves as Other Race or Asian. As discussed previously, those who identify as Asian are less likely to seek professional mental health care than the general population – as existing issues go untreated, more severe behavioral health issues may develop as a result.[16] Availability of culturally and linguistically appropriate care may be limited which may lead to some populations being less likely to seek professional mental health care.

There was not much variability between racial groups for those located in jail after contact with a program. Those who were multiracial were located in jail-based settings about 2.8% of the time, slightly higher than other racial groups.

There was a significant difference in the percentage of calls ending in jail among those who identify as Hispanic compared to those who were not Hispanic (3.3% to 1.4%, respectively). However, missing data could be impacting these rates, as calls involving an individual who was not Hispanic had a higher percentage of data missing compared to those who were Hispanic (28.9% to 18.9%, respectively).

Missing location data for some racial and ethnic groups made it difficult to draw conclusions. Continued use of the individual-level reporting tool will help fill these data gaps moving forward and clarify outcomes based on demographic characteristics of people involved on calls.

Key Finding: Across all co-responder programs, less than one-third of contacts resulted in enrollment in behavioral health services. Those who identified as multiracial had the highest enrollment rate at 49%. Over time, the pilot sites increased their ability to connect individuals to behavioral health services.

Enrolling people in behavioral health services in their communities is an important intervention provided by co-responder programs. These services could reduce the likelihood that individuals in crisis will encounter law enforcement again. Co-responder programs had mixed success enrolling individuals in behavioral health programs, based on available data from July to September 2020 (see Table 4). Co-responder programs enrolled between 2.7% and 61.5% of contacts in behavioral health services.

This variation may be the result of the type of response model that each co-responder program implements. These differences may also reflect gaps in enrollment data across sites, or that individuals contacted by co-responders may not need outpatient behavioral health services or are already enrolled. Across all sites, 8.2% of responses indicated that the individual was already enrolled in services but reporting across sites was not uniform.

Three of the four pilot sites (Grand Junction data were unavailable) reported an increase in the percent of contacts that resulted in behavioral health enrollment over the course of one year (see Figure 11). Across the pilot sites, 36.0% of contacts resulted in behavioral health enrollment in September 2020, up from 24.8% in September 2019. There is still substantial variation by site. Across the 12-month period, Pitkin reported an average enrollment rate of 51.4% compared with 11.8% average enrollment rate in Weld. Douglas reported a 31.6% average enrollment rate.

Table 4. Across All Co-Responder Sites, About 30% of Contacts Made Resulted in Behavioral Health Enrollment, July–September 2020, All Sites*

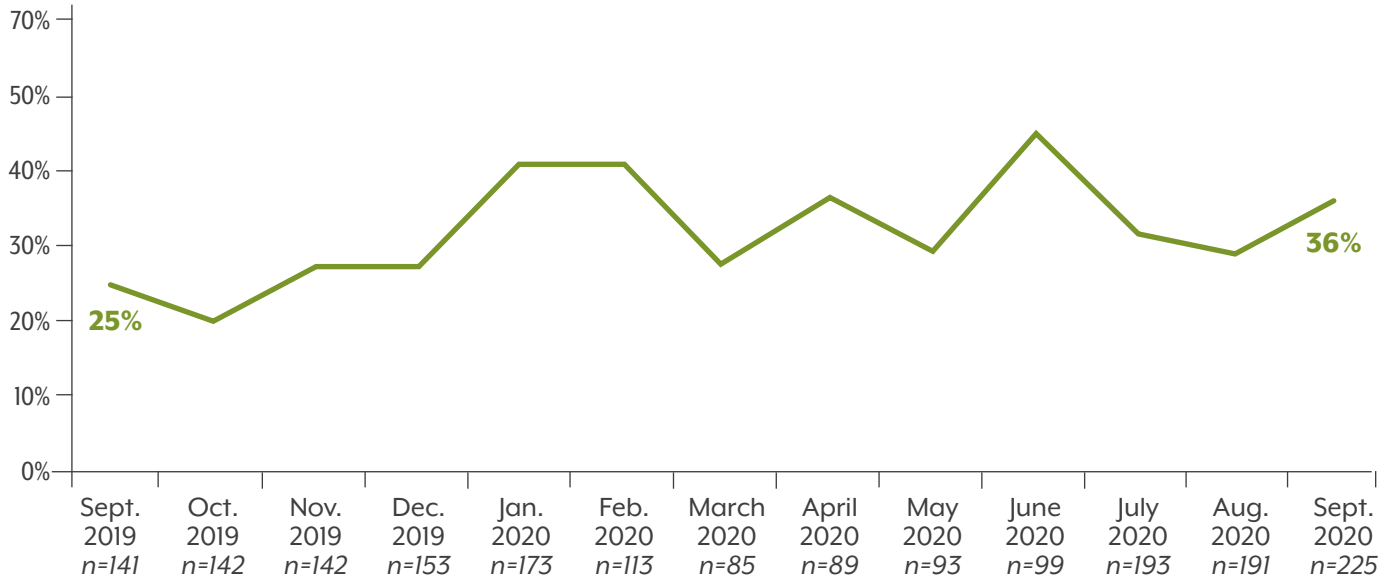
Co-Responder Program	Percentage of contacts that resulted in behavioral health services enrollment
Arapahoe	41.1%
Arvada	12.4%
Colorado Springs	57.2%
Broomfield	21.3%
Cañon City	28.2%
Douglas	39.6%
El Paso	16.9%
Lakewood	2.7%
Larimer	17.3%
Montrose**	21.6%
Pitkin	61.5%
Pueblo	33.1%
Lake	13.8%
Southeast Colorado	23.0%
Summit	17.4%
Vail	50.0%
Weld	42.0%
Westminster	40.1%
All Sites	**29.8%**

**Longmont did not report any behavioral health enrollments because the clinician is not affiliated with a mental health provider. Denver SUN, Denver CIRU, and Grand Junction were excluded due to low response counts.*

*** Data were not available for July because this program was in the process of restructuring.*

Figure 11. Over Time, Co-Responder Programs Increased the Percentage of Contacts that Resulted in Behavioral Health Enrollment, September 2019–September 2020, Pilot Sites*

Percentage of Total Contacts that Resulted in Behavioral Health Enrollment



*Includes data from Pitkin, Weld, and Douglas; Grand Junction data were not available for this analysis.

It can be time consuming to follow up with individuals, which could explain the variability in behavioral health enrollment across months and across sites. Some programs may have dedicated more time to follow-up than others or may have had more time to invest at different times during the year.

Enrollment rates did not seem to be significantly affected by the COVID-19 pandemic. Although rates declined between February and March during the beginning of the pandemic, a peak enrollment rate of 45.5% was reported across all pilot sites in June, followed by a drop to 31.1% in July 2020.

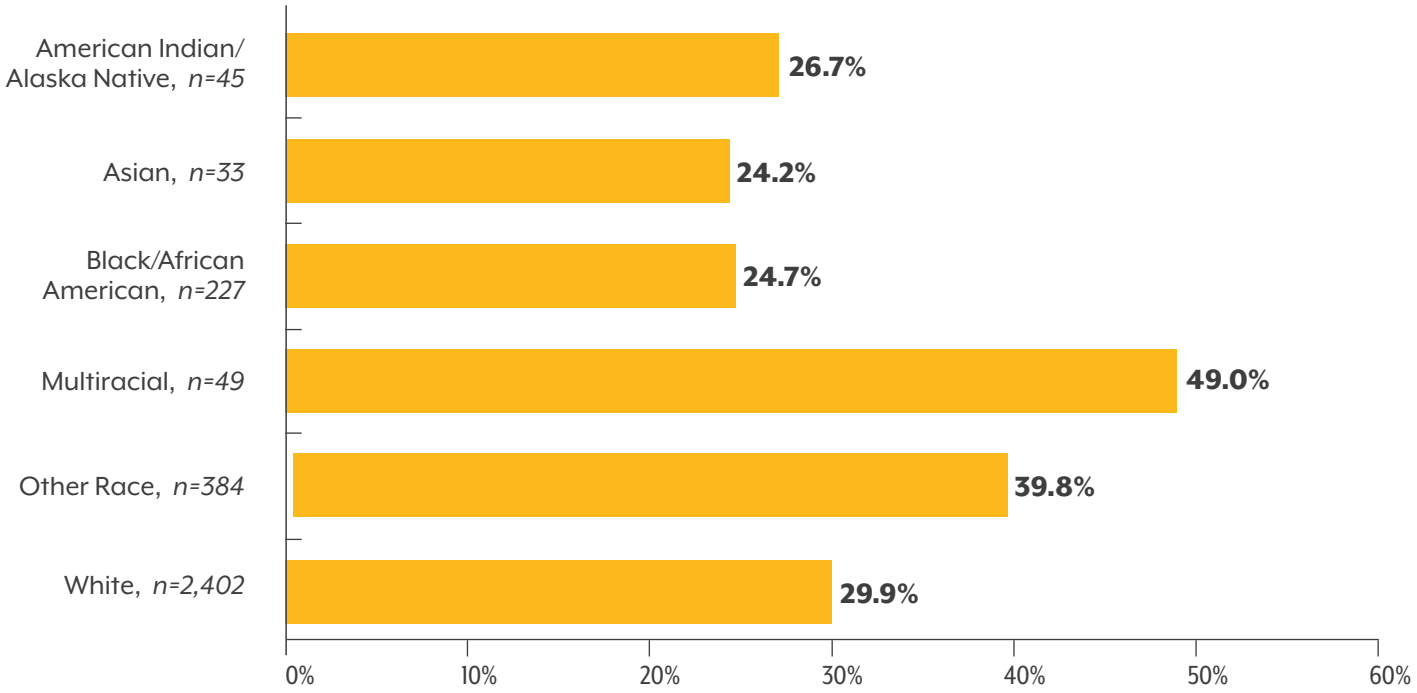
Black/African American and Asian individuals had slightly lower than average enrollment rates across sites (see Figure 12). Those identified as Other Race or multiracial had higher rates of enrollment. Those who were Hispanic had a similar enrollment rate as those who were not Hispanic (31.5% to 30.5%, respectively).

Differences in enrollment across racial groups could be related to any number of factors. The availability of behavioral health treatment facilities in different parts of Colorado or access to health insurance to cover the cost of care could be barriers that impact racial groups differently. Lower rates of enrollment among Black/African American contacts or Asian contacts could reflect these disparities, meaning these community members could be going without needed care.

As previously noted, some differences may be due to small sample size over a short period of time or reporting issues. With additional months of data, disparities that may exist between different groups in communities served by co-responders will become clearer. Programs will be able to use this information moving forward to find more effective ways to serve specific populations in their communities.

Figure 12. People Who Identified as Multiracial or Other Race Had Higher Rates of Behavioral Health Enrollments Compared with Other Groups, All Sites

Percentage of Contacts that Resulted in Behavioral Health Enrollment by Racial Group



Evaluation Question: Did co-responder programs help facilitate the return of law enforcement to patrol activities?

Key Finding: Between July and September, sites increased the frequency of law enforcement returning to patrol duties from 26.4% to 38.4%. Overall, co-responders reduced unnecessary law enforcement involvement in one of every three calls, allowing officers to return to other duties.

OBH's Co-Responder Program aims to facilitate the return of law enforcement personnel involved in behavioral health-related crisis responses to their patrol duties and devote more time and resources to providing behavioral health services to those who need them.

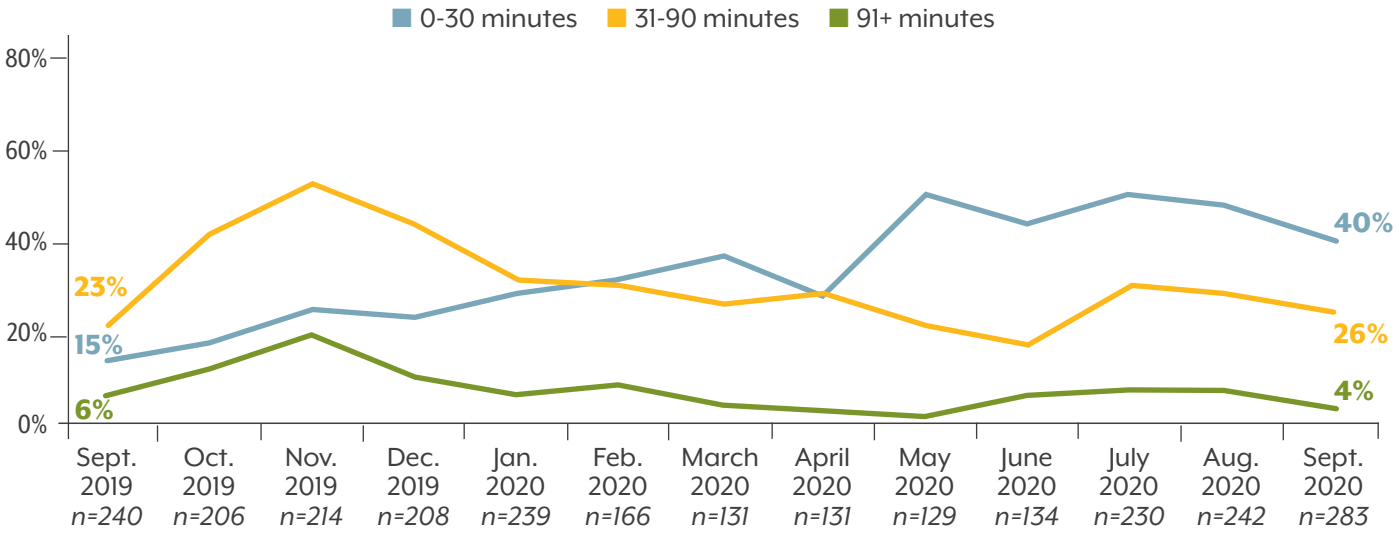
Across all co-responder sites between July and September 2020, about 32% of active response calls facilitated the return of law enforcement to their patrol duties (see Table 5). Sites in Douglas and Southeast Colorado had among the lowest rates of facilitated return at about 11%, while the Summit co-responder program reported a 73% rate of return of law enforcement.

There could be several reasons for differences in return rates across programs. Some calls may require an officer to stay on the scene to support a clinician; other times, the co-responder may not be able to respond to a call for service right away. In addition, sites have different response models and some of these may encourage law enforcement personnel to stay with the co-responder on calls.

The co-responder program also helped decrease time law enforcement spent on calls, based on data from pilot sites (see Figure 13). By September 2020, about four in 10 calls (40.3%) kept an officer's time on scene to under 30 minutes, compared with only 15.4% of calls at the beginning of the study period. Only 26.1% of calls involved law enforcement spending between 31 and 90 minutes. Most importantly, calls that lasted over 90 minutes represented only 3.9% of all responses, compared with 5.8% of all responses in the same month in 2019.

Figure 13. Officer Time Spent on Calls Decreased Between September 2019 and September 2020, Pilot Sites*

*Percentage of Total Contacts by Amount of Time Spent on Response***



*Data includes Pitkin, Grand Junction, Douglas, and Weld **Totals will not add up to 100 percent because missing or unknown data were excluded from the figure.

Table 5. Facilitated Return of Law Enforcement to Patrol Duties Differed Across Co-Responder Programs, July–September 2020, All Sites*

Co-Responder Program	Percentage of Active Response Calls Resulting in Return of Law Enforcement to Patrol
Arapahoe	39.7%
Colorado Springs	29.5%
Broomfield	50.0%
Cañon City	38.7%
Douglas	11.4%
El Paso	40.8%
Grand Junction	65.1%
Larimer	35.0%
Montrose**	38.5%
Lake	26.7%
Southeast Colorado	11.3%
Summit	73.2%
Vail	16.7%
Weld	18.3%
Westminster	25.8%
All Sites	**31.6%**

*Denver CIRU, Denver SUN, Pitkin, and Pueblo had incomplete response data.

**Data were not available for July because the program was in the process of restructuring.

This steady decrease in the time spent by officers on behavioral health-related calls suggests that co-responder programs are successfully responding to individuals in need while facilitating the return of law enforcement to other duties.

Evaluation Question: What system-wide costs were avoided through the diversion of formal actions such as hospitalizations or arrests?

Key Finding: Co-responder programs likely saved money by connecting people to services that more appropriately meet their needs. In three months, all sites reported diverting individuals involved in about one in every six calls.

Between July and September 2020, 150 individuals were diverted from emergency departments by all co-responder sites included in the evaluation (see Table 6). Another 42 individuals were diverted from jail during this period.

Data were not available to calculate the exact avoided costs or savings of each co-responder program. This analysis would require data on each

individual's behavioral health conditions and the services they received after contact with the co-responder program. Data were also not available about treatment that individuals received in an emergency department or length of stays in jail.

Estimates provided at the state and national level regarding the cost of hospital admissions and jail stays illuminate some of the program's potential avoided costs. (The following analysis uses the same approach as was provided in the interim report.)

An analysis of National Inpatient Sample by the Healthcare Cost and Utilization Project in 2019 estimated that the average cost per day for a hospital inpatient stay was $1,400 for individuals who had a mental health and/or substance use disorder diagnosis.[17]

Assuming people diverted from such care would have had at least one day of inpatient care, the OBH Co-Responder Program avoided about $210,000 in hospital costs. However, the average length of stay for such patients was 6.4 days, according to the National Inpatient Sample report. Assuming this length of stay, the OBH Co-Responder Program avoided more than $1.3 million in hospital costs during the three-month period.

Based on a report from 2017, the County Sheriffs of Colorado estimated that the average cost per day at a jail among a subset of 19 Colorado counties ranges from $20 to $250, depending on the county where the co-responder program operates.[18] Across all sites, co-responder programs reported that 42 individuals were diverted from jail between July and September. Using cost estimates in the 2017 report, the OBH Co-Responder Program could have avoided between $840 and $10,500 in costs among select counties during the study period. As these teams have operated for several years in some locations, more costs may have been saved since implementation.

Table 6. Most Diversions by Co-Responder Programs Were From Emergency Departments, July–September 2020, All Sites*

	July–September 2020 Total	Per Month Average
Individual would have gone to emergency department	150	50.0
Individual would have gone to jail	42	14.0
Other**	54	18.0

*Data in the table excludes calls where no formal action was taken.

**Sites were given the option to select "other" but were not asked to define what these actions were.

Bypassing jail and avoiding unnecessary hospitalizations for those who are uninsured or underinsured would accrue savings for taxpayers at the local and state levels. In some instances, insurance companies may also benefit from these avoided costs. Most importantly, avoiding unnecessary jail time or hospitalizations benefits Coloradans who receive the appropriate care, which can improve their quality of life and reduce recidivism.

Recommendations from the Report

From 2018 to 2021, co-responder program data collection has improved and allowed OBH to capture data at the client level to understand impact. As this program continues to advance, OBH could consider additional opportunities to measure impact and answer the key research questions outlined in this report.

Linking data between co-responder reports on the clients they serve and data systems on services provided by community mental health centers and other health care providers will allow OBH to assess co-responder programs' impacts on behavioral health outcomes. Currently, the behavioral health enrollment data collected by co-responders is self-reported, which means data are not available to identify whether clients served by co-responders receive services in the community, what services they received, and if they had been receiving services prior to using co-responder services. Linking these data sources would provide more insights into the co-responders' effectiveness in connecting people to behavioral health services and the success of their subsequent treatment.

Linking data between systems is complex, particularly between law enforcement and mental health systems, and may take time to implement. OBH can consider taking additional steps to enhance understanding of the co-responder program impact as OBH works to develop data linkages between sources, such as:

1) Determine the Number and Resolution of all 911 Calls with a Behavioral Health Component

Law enforcement departments do not always know whether a call has a behavioral health component until they respond on-scene, which creates challenges to understanding how many calls would have benefited from a co-responder team response. Future evaluation could develop a data reporting mechanism or approach that objectively determines the total number of calls that could have benefited from a co-responder team and assess how those calls were resolved relative to those with a co-responder team response. This will require working with dispatch systems to analyze current call coding mechanisms and develop solutions for coding behavioral health-related calls.

2) Create a Comparison Group to Assess Impact of the Co-Responder Program

Formal diversions are reported based on law enforcement officers' assessment of whether a formal action would have been taken if the co-responder had not been on scene. But using the current method, there is no way to know what would have actually happened had the co-responder not been there. Future evaluation activities could use a control group to evaluate actions taken in similar counties with and without co-responder teams to determine whether co-responder teams increase the number of diversions from formal actions, and also measure differences in how many people are able to get connected to behavioral health services. This would also provide data to formulate evaluative statements about costs avoided through formal diversions. Another option would be to create a control group within a jurisdiction and compare outcomes from clients who receive co-responder services on scene to individuals who do not.

3) Use Qualitative Research to Improve Data Collection, Sharing, and Measurement Tools

Initial feedback from law enforcement officers involved in co-responder programs suggested that policies should be clarified regarding how to work with mental health professionals on scene, and protocols need to be established that facilitate data sharing between mental health providers and law enforcement to support the co-responder teams' work. Future evaluations could conduct key informant interviews to determine best practices for establishing policies and protocols for partnering law enforcement with mental health providers and translating those into recommendations for data sharing between law enforcement and mental health agencies. Other opportunities include reaching out to community partners, including law enforcement and behavioral health providers, to identify local priorities for outcomes and ensuring appropriate data are available to measure these outcomes of interest.

From left: Cpl. Brian Briggs of the Douglas County Sheriff's Office, Licensed Social Worker Ellen Pronio, and Case Manager Steve Kalisch are partners on the Douglas County Crisis Response Team.

Conclusion

The OBH Co-Responder Program continues to connect individuals to care to address their behavioral health needs. But co-responder programs in different locations connected individuals to behavioral health services at differing rates. Some of these differences stem from how programs respond to calls for service, after-the-fact referrals, and follow-up.

This evaluation found many successes, including a decrease in those who were placed on an involuntary mental health hold as well as an increase in the return of law enforcement to patrol duties.

This evaluation also identified areas for improvement. For example, only about one-third of individuals were connected to behavioral health services after contact with co-responders. Increasing the rate of enrollment, or the ability to collect these data, could help with long-term well-being for those involved on calls. Many people who encounter co-responders are contacted more than once. It is important to intervene earlier rather than later to help connect high-utilizer individuals, who may need more help than others, to necessary services.

Several findings identified differences in outcomes among racial groups, potentially indicating more acute behavioral health needs among certain groups involved on calls, or limited availability of services. By gathering and understanding data based on demographics across co-responder programs, sites will now be able to track who they are reaching and what gaps may still exist.

As the COVID-19 pandemic continues to impact communities in Colorado, there will be an increased need for behavioral health supports, as many people are faced with job loss, isolation, loss of loved ones, and other factors. It is more important than ever to ensure these programs connect Coloradans with behavioral health services.

Although this evaluation is based on a year of data from four sites and only three months of data across all sites, the new monthly reporting tool has provided important insights into outcomes for people who come into contact with co-responder programs across Colorado. Sites can use these reports to understand their reach in their communities and how to better serve those in need of behavioral health services in the future.

Appendix A

The following list provides a detailed look at each co-responder program evaluated in this report with the law enforcement agencies and other organizations involved in each jurisdiction. Each program's designation in this evaluation report is highlighted in blue:

- AllHealth Co-Responder Program: Englewood Police Department, Glendale Police Department, Greenwood Village Police Department, Littleton Police Department, Sheridan Police Department, and AllHealth Network (Arapahoe)
- Arvada Co-Responder Program: Arvada Police Department and Jefferson Center for Mental Health (Arvada)
- B-CORE: Broomfield Police Department and Community Reach Center (Broomfield)
- Behavioral Health Connect (BHCON): El Paso County Sheriff's Office and UC Health (El Paso)
- Cañon City Co-Responder Program: Cañon City Police Department and Solvista Health (Cañon City)
- Colorado Springs Community Response Team (CRT): Colorado Springs Police Department, Colorado Springs Fire Department and AspenPointe (Colorado Springs)
- Crisis Outreach Response and Engagement (CORE): Longmont Police Department (Longmont)
- Denver Crisis Intervention Response Unit (CIRU): Denver Police Department and Mental Health Center of Denver (Denver CIRU)
- Denver Substance Use Navigators (SUN): Denver Police Department, Denver Department of Health and Environment and Denver Health Hospital (Denver SUN)
- Douglas County Crisis Response Team: Parker Police Department, Douglas County and Caring Communities (Douglas)
- Eagle County Mobile Crisis Co-Responder: Vail Police Department, Eagle County Sheriff's Office, Eagle Police Department, Avon Police Department and Aspen Hope Center (Vail)
- Grand Junction Crisis Support Team: Grand Junction Police Department and Mind Springs Health (Grand Junction)
- Greeley Evans Mobile (GEM): Evans and Greeley Police Departments and North Range Behavioral Health (Weld)
- Lake County and Leadville Co-Responder Program: Lake County Sheriff's Office, Leadville Police Department and Solvista Health (Lake)
- Lakewood Crisis Intervention Team Co-Responder Program: Lakewood Police Department and Jefferson Center for Mental Health (Lakewood)
- Larimer Interagency Network of Co-Responders (LINC): Loveland Police Department, Larimer County Sheriff's Office, Estes Park Police Department* and SummitStone Health (Larimer)

  ** Estes Park Police Department is not a part of LINC, but data is submitted with LINC.*

- Montrose Co-Responder Program: Montrose Police Department, Montrose County Sheriff's Office, and Center for Mental Health (Montrose)
- Pitkin Area Co-Responder Team (PACT): Pitkin County Public Health, Aspen Police Department, Snowmass Village Police Department, Pitkin County Sheriff's Office, and Mind Springs Health (Pitkin)
- Pueblo CIT Co-Responder Program: Pueblo Police Department and Health Solutions (Pueblo)
- Southeast Health Group (SEHG): Southeast Health Group, Baca County Sheriff's Office, Springfield Police Department, Walsh Police Department, Crowley County Sheriff's Office, Fowler Police Department, La Junta Police Department, Manzanola Police Department, Otero County Sheriff's Office, Rocky Ford Police Department, and the Colorado State Patrol (Southeast Colorado)
- Summit County System-wide Mental Awareness Response Team (SMART) Program: Summit County Sheriff's Office (Summit)
- Westminster Co-Responder Program: Westminster Police Department and Community Reach Center (Westminster)

OBH funds four co-responder programs that were not included in this analysis:

- Aurora Community Response Team
- East Boulder County Co-Responder Unit
- Delta Co-Responder Program
- Squad 1 in Weld County

Appendix B

Table 1. Co-Responder Programs Made 5,161 Contacts, July–September 2020, All Sites

Co-Responder Program	Total Number of Responses by Co-Responder Program*	Average Number of Responses by Co-Responder Programs per Month*
Arapahoe	1,094	364.7
Arvada	171	57.0
Colorado Springs	190	63.3
Broomfield	94	31.3
Cañon City	59	19.7
Denver CIRU	199	66.3
Denver SUN**	<30†	3.0
Douglas	91	30.3
El Paso	698	232.7
Grand Junction	146	48.7
Lake	39	13.0
Lakewood	184	61.3
Larimer	519	173.0
Longmont	364	121.3
Montrose**	41	20.5
Pitkin	205	68.3
Pueblo	126	42.0
Southeast Colorado	161	53.7
Summit	216	72.0
Vail	36	12.0
Weld	313	104.3
Westminster	209	69.7
Total	**5,161**	**1,720.3**

*Responses include all active calls, referrals, and follow-ups made by co-responders.

**Data were not available in July because programs were in the process of restructuring.

† Data are supressed to protect client privacy due to small client counts.

Table 2. Co-Responder Programs Dedicate Nearly a Third of Their Responses to After-the-Fact Referrals, July–September 2020, All Sites

Co-Responder Program	Total Number of After-the-Fact Referrals	Percentage of Responses Dedicated to After-the-Fact Referrals
Arapahoe	539	49.3%
Arvada	170	99.4%
Colorado Springs	51	26.8%
Broomfield	41	43.6%
Cañon City	<30†	47.5%
Denver CIRU	0	0.0%
Denver SUN*	<30†	16.7%
Douglas	46	50.5%
El Paso	71	10.2%
Grand Junction	0	0.0%
Lake	<30†	33.3%
Lakewood	182	98.9%
Larimer	212	40.8%
Longmont	<30†	4.4%
Montrose*	<30†	2.4%
Pitkin	67	32.7%
Pueblo	<30†	11.9%
Southeast Colorado	49	30.4%
Summit	<30†	1.4%
Vail	0	0.0%
Weld	89	28.4%
Westminster	72	34.4%
Total	**1,666**	**32.3%**

* Data were not available in July because programs were in the process of restructuring.

† Data are supressed to protect client privacy due to small client counts.

Table 3. High Utilizers Make Up Nearly a Fourth of All Individuals Served by Co-Responder Programs in Colorado, July–September 2020, All Sites

Co-Responder Program	Average Number of High Utilizers Served by Programs per Month	Percentage of Individuals Served by Programs Who Were High Utilizers
Arapahoe	50	16.6%
Arvada	13	73.6%
Colorado Springs	6	9.9%
Broomfield	2	8.0%
Cañon City	3	17.6%
Denver CIRU	12	14.4%
Denver SUN*	1	20.0%
Douglas	2	9.5%
El Paso	51	46.1%
Grand Junction	4	10.9%
Lake	4	25.9%
Lakewood	7	13.4%
Larimer	38	38.3%
Longmont	29	40.6%
Montrose*	3	17.1%
Pitkin	11	42.5%
Pueblo	4	10.3%
Southeast Colorado	7	16.8%
Summit	12	46.3%
Vail	2	16.7%
Weld	17	22.3%
Westminster	9	18.4%
Total	**280**	**24.2%**

* Data were not available in July because programs were in the process of restructuring.

Table 4. About Half of All Calls Were Resolved on Scene – But Gaps in Data Reported per Site Exist, July–September 2020, All Sites*

Co-Responder Program	Calls Resolved on Scene	Community-Based Settings	Medical-Based Settings	Jail	Unknown/ Missing Data
Arapahoe	62.3%	10.0%	26.6%	1.1%	0.0%
Colorado Springs	57.9%	6.8%	28.9%	0.0%	6.3%
Broomfield	60.6%	7.4%	29.8%	2.1%	0.0%
Cañon City	52.5%	5.1%	30.5%	8.5%	3.4%
Denver CIRU	79.9%	9.0%	11.1%	0.0%	0.0%
Douglas	80.2%	7.7%	8.8%	0.0%	3.3%
El Paso	29.7%	1.7%	7.4%	0.6%	60.6%
Grand Junction	76.0%	5.5%	15.1%	3.4%	0.0%
Lake	28.2%	5.1%	10.3%	0.0%	56.4%
Lakewood	60.9%	0.0%	14.7%	6.5%	17.9%
Larimer	33.3%	1.3%	8.3%	1.8%	55.3%
Longmont	35.0%	3.1%	11.7%	2.3%	47.9%
Montrose**	7.3%	12.2%	7.3%	0.0%	73.2%
Pitkin	25.4%	0.0%	3.9%	2.0%	68.8%
Pueblo	59.8%	19.7%	18.9%	0.8%	0.8%
Southeast Colorado	67.7%	4.3%	21.7%	3.7%	2.5%
Summit	20.4%	2.3%	4.2%	0.0%	73.1%
Vail	77.8%	2.8%	19.4%	0.0%	0.0%
Weld	70.9%	11.8%	15.0%	1.9%	0.3%
Westminster	60.3%	3.8%	23.0%	1.9%	11.0%
Total	**49.0%**	**5.6%**	**15.5%**	**1.5%**	**28.4%**

* Arvada was missing location data. Denver SUN was excluded due to small response counts.

** Data were not available in July because program was in the process of restructuring.

Table 5. About 4% of Calls Resulted in People Being Brought to a Walk-in Crisis Center or Mobile Crisis Unit, July–September 2020, All Sites*

Co-Responder Program	Walk-in Crisis Center/Mobile Crisis Unit	Community Mental Health Center
Arapahoe	9.1%	0.0%
Colorado Springs	6.8%	0.0%
Broomfield	2.1%	0.0%
Cañon City	0.0%	3.4%
Denver CIRU	7.0%	2.0%
Douglas	7.7%	0.0%
El Paso	1.6%	0.0%
Grand Junction	0.7%	4.1%
Lakewood	0.0%	0.0%
Larimer	0.2%	0.2%
Longmont	1.4%	0.0%
Montrose**	7.3%	4.9%
Pitkin	0.0%	0.0%
Pueblo	18.0%	0.8%
Lake	5.1%	0.0%
Southeast Colorado	1.9%	1.2%
Summit	0.0%	0.9%
Vail	0.0%	2.8%
Weld	11.5%	0.0%
Westminster	2.9%	0.5%
All Sites	**4.4%**	**0.4%**

*Arvada was missing location data. Denver SUN was excluded due to small response counts.

** Data were not available in July because program was in the process of restructuring.

Endnotes

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