City of Boulder

Crisis Intervention Response Team

Statistical Report

2022-2023

PREPARED BY

BAUMAN CONSULTING GROUP

FOR

THE CITY OF BOULDER HOUSING AND HUMAN SERVICES

DATE

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Contents

Executive summary

The City of Boulder's Crisis Intervention Response Team (CIRT) is a co-response team of licensed behavioral health clinicians who respond to situations involving a behavioral health crisis as an alternative to police-only responses. CIRT also employs case managers who work with people on connecting to services following a CIRT response. CIRT has documented 4,119 contacts (or unique interactions) from January 1, 2022, through December 31, 2023. Approximately half of these contacts were responses to requests for service from 911 dispatch or officers in the field. CIRT clinicians were engaged in roughly 1,000 responses annually throughout 2022 and 2023. The day of week and time of day of responses generally follow demand metrics for CIRT during the work week but demand for CIRT services exceeded CIRT's availability on the weekends during the two years analyzed by this report. Staffing on weekends was increased in 2024, and the city will continue to assess capacity and demand. Most CIRT responses were face-to-face, but about one in five were by phone (phone was far more common among case management and follow-up contacts).

CIRT clinicians resolved nearly two-thirds of face-to-face responses within one hour. Concerns — the reason for the call for service — were varied. The most common primary reason was suicidal ideation, followed by substance use or intoxication. Looking across primary, secondary, and tertiary concerns, substance use / intoxication / withdrawal and/or suicidal ideation / suicide attempts were present in nearly half of all responses.

Following the best practice in behavioral health crisis response, community members were stabilized in the community in more than two-thirds of responses. The initiation of involuntary treatment, in the form of emergency mental health holds, was rare, as were arrests and use of force. Diversions are noted by CIRT clinicians when their intervention changed the outcome of the call. It is hard to know what would have happened if CIRT had not responded, so the team only records diversion when officers' statements indicate a different action would have been taken had CIRT not been there. Diversions from emergency mental health holds were the most common type of diversion.

Referrals to other services were quite common, with nearly seven in ten community members receiving at least one referral. CIRT clinicians referred community members to nearly two dozen different services overall. More than half of community members who received any referral for other services received referrals to multiple services.

Two in five CIRT responses involved someone who was already receiving behavioral health services. Most of these community members, however, were not well-connected and engaged with those services, with over three quarters either facing engagement barriers or needing additional services beyond what they were already receiving.

Introduction

The City of Boulder launched the Crisis Intervention Response Team (CIRT) in February 2021. CIRT is a co-response team of licensed behavioral health clinicians from the city's Housing and Human Services Department (HHS) who respond with Boulder Police Department (BPD) officers. Clinicians and police officers respond to situations involving a behavioral health crisis as an alternative to police-only responses. CIRT also employs case managers who work with people on connecting to services following a CIRT response. The City of Boulder has funded behavioral health co-responder clinicians since 2014, previously through Mental Health Partners' Early Diversion Get Engaged (EDGE) program. In 2021, the city transitioned from a contracted program to hire clinicians as city staff, forming CIRT.

This report was prepared by Bauman Consulting Group under contract with the City of Boulder to provide analysis and evaluation services. This is an interim report and is not a holistic look at the program. Data sharing agreements that will allow more sensitive person-level analyses for evaluation purposes are still being explored with the goal of having Bauman Consulting Group conduct a comprehensive evaluation that includes demographics and outcomes. The interim report uses data and process documentation provided by the City of Boulder, combined with discussions of operations with key staff members. The interim report includes data from calendar years 2022 and 2023. In general, the two years were similar; where there are notable differences, we report results separately by year.

A report on the first year of the Community Assistance Response and Engagement (CARE) program, a non-police response team with behavioral health clinicians and paramedics, will be published in 2025.

Services provided by CIRT

Crisis intervention and response

CIRT's licensed behavioral health clinicians are dispatched to emergency behavioral health crisis situations. Typically, these responses are requested either by The City of Boulder's Police and Fire Communications Center (911 dispatch) or by police officers in the field. CIRT clinicians can also attach themselves to calls when the subject is someone CIRT is familiar with or when the call clearly has a behavioral health component.

When CIRT clinicians respond to an incident location with BPD officers, the officers assess the situation for safety of both the CIRT clinicians and community members involved in the incident. Officers generally make first contact with the people involved in the call. Officers may have information related to previous calls with a person or an address, and officers work with clinicians to gather information about the current situation from multiple parties

when possible. When there is probable cause for an arrest, officers may make an arrest, but as is discussed below that is rare. Officers can also provide transportation, especially when secure transport is required.

After a BPD officer has assessed the incident location for safety, the CIRT clinician leads the team's response with the person who is experiencing a behavioral health crisis. The CIRT clinician's goal during the encounter is to resolve the immediate crisis. That resolution can take many forms, but the most common outcome is that the person experiencing a crisis is stabilized in the community.

Clinical case management

Clinical case managers work with clinicians on the team to support people following a crisis. CIRT's clinical case management component began in August 2022 with one case manager. Two more case managers were added to the team between August and October 2023. The clinicians on the team recognized that some people they were encountering were in crisis because they were having trouble getting the services they needed. That might look like someone having difficulty getting insurance or benefits because of the number of steps they needed to go through to qualify, someone who felt discouraged after being put on a long wait list for therapy, or someone having problems getting a medication filled due to an insurance issue. It can be challenging to address those needs during an acute crisis, where the focus is on more immediate needs of safety. But the team recognized there were often underlying issues that, if addressed, could prevent future crises from happening and advocated for the addition of clinical case management to CIRT.

CIRT clinical case managers act as a critical bridge by working with people immediately following an acute crisis. The case managers provide short-term, intensive support with the goal of connecting people to available resources, benefits, and care in the community. The CIRT case management service is designed to be low barrier and is tailored to the needs and goals identified by the person being served.

The case managers generally have small caseloads of 10-15 people, which means they have time to build relationships and trust. Some of CIRT's clientele have had negative experiences trying to engage with services in the past, so the case managers do a lot of engagement up front to build willingness on the part of the client to try again. For someone who is in a time of heightened distress, case managers may spend time with them every day over a few weeks and may end up spending four to five hours with one person if that is what's needed to help bring them out of crisis and into a place where they can engage in working towards their goals.

The case managers' work is highly collaborative and often involves bringing treatment providers together to work through barriers and meet client's needs. Many of the people with the most acute needs receive services from multiple providers, who may not be aware of this fact or communicating with each other. CIRT case managers provide a

communication bridge between service providers so efforts are not duplicated, and the client can be served more effectively.

When not working directly with clients, case managers spend time meeting with other providers in the community, getting to know new and evolving services, and building relationships so they can more effectively serve the community. Case managers report that some providers in the community have been willing to work with high-acuity clients they were previously unwilling to work with because of the involvement of CIRT clinical case managers and the level of support they are able to provide to keep the person engaged in services. The CIRT clinicians report that the addition of case management has not only improved outcomes for the people they serve, but it has also improved their feelings of efficacy, since clinicians know they have more to offer than an intervention during a moment of crisis.

CIRT Contacts 2022-2023

There were 4,119 documented CIRT contacts from January 1, 2022, through December 31, 2023.[1] Half of these (49.4%) were CIRT *responses*. Responses are assigned by dispatch and are most often started by a 911 call.

The next largest category was *case management* (22.2%). Case management describes CIRT case managers assisting people who have complex needs over a period of time that can last from weeks to months. Case managers typically identify needs and goals, help the community member access benefits and services, and coordinate existing care. As shown in Figure 1, case management increased 141% from 2022 to 2023 while all other contact types showed little change year-over-year. Case management was added to the CIRT program midway through 2022, so some of this increase occurred due to expanding the case management services over time.

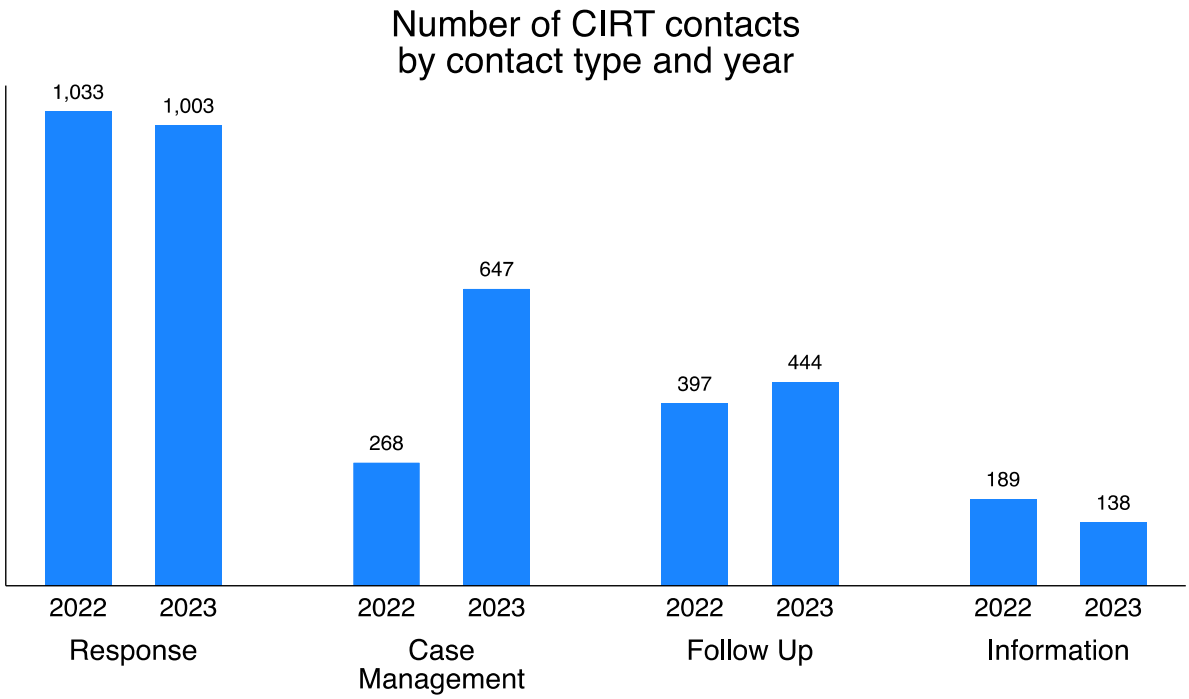
The next most frequent contact type, *follow up*, was about one in five contacts (20.4%). Follow up contacts typically involve CIRT clinicians recontacting a community member after the immediate crisis has passed or in response to a message left by a community member. Follow up is usually a one-time contact post-crisis.

Information was the least common contact type (7.9%). The information contact type refers to situations where the team provides information about resources or team services in response to a community inquiry unrelated to a follow up. It also describes situations where the team receives information from police or other source about a community member but there is no action requested or determined to be appropriate to take at the time of the contact.

[1] An additional 11 Community Assistance Response and Engagement (CARE) program responses occurred. CARE entered the field in mid-December 2023. Due to the small number of CARE responses, they are excluded from further discussion in this report.

Contact Type

Figure 1: Number of CIRT contacts by type and year



The contact method (face-to-face, phone, or other (i.e., information received by email)) varied by contact type. More than two-thirds of responses (70.6%) occurred face-to-face, and one in five (22.4%) responses were by phone. Case management and follow up were far more likely to occur by phone, with eight in 10 of these contact types occurring by phone. Nearly half (48.5%) of all contacts were by phone. Another 11.6% of contacts were by other methods (primarily email). Table 1 shows the percent of each contact type that occurred by each contact method.

Table 1: CIRT contact method by contact type

	Responses	Case Management	Follow Up	Information	Total
	n=2,036	*n*=915	*n*=841	*n*=327	*n*=4,119
Face-to-Face	74.7%	15.8%	5.4%	2.4%	41.7%
Phone	25.3%	79.3%	86.4%	31.2%	50.3%
Other		4.8%	8.2%	66.4%	8.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Note: Columns may not sum to 100% due to rounding.

Duration

Durations for each contact were calculated from the beginning and end time of the contact. As shown in Figure 2, more than two-thirds of CIRT contact time is spent on responses.

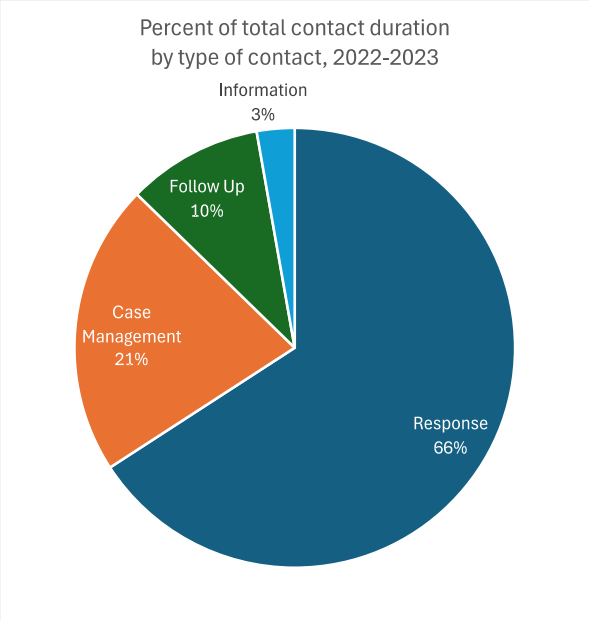


Figure 2: Percent of total contact duration by type of contact, 2022-2023

It is important to note that CIRT staff have many tasks that are not captured in the available data; the total number of hours worked is considerably greater. Durations that were likely due to data entry errors were recoded to missing.[2]

Compared to 2022, in 2023 there were increases in the number of hours spent in responses (+16% year-over-year), case management (+61%), and follow-up (+9%).

The average duration of contacts varies by contact type, with responses having the longest average duration. Average durations were slightly shorter in 2023 relative to 2022, with the average call for service taking 42 minutes in 2022 and 35 minutes in 2023. This is shown in Table 2.

Table 2: Average duration of contacts by contact type, 2022-2023

	Average duration (minutes)		Percent missing*
	2022	2023	
Responses	52	48	12.8%
Case Management	43	28	3.2%
Follow Up	21	18	17.8%
Information	23	17	40.9%
Total	42	35	13.9%

*Note: End times were missing or unlikely for some contacts, particularly for Information contacts. Averages may be impacted by missing data. Elements may not sum to total due to rounding.

[2] The data received thus far does not include the contact date, making calculating durations difficult for some contacts. It is difficult to differentiate between likely data entry errors and unusually long contacts. For example, the data received may include a start time of 11:30am and an end time of 12:30am. Without the date to cross check, we cannot determine if this was 1) a data entry error, with a correct end time of 12:30pm, or 2) it was a 13-hour contact. Our approach is conservative; we code 25 such contacts (less than 1% of the total contacts) to missing.

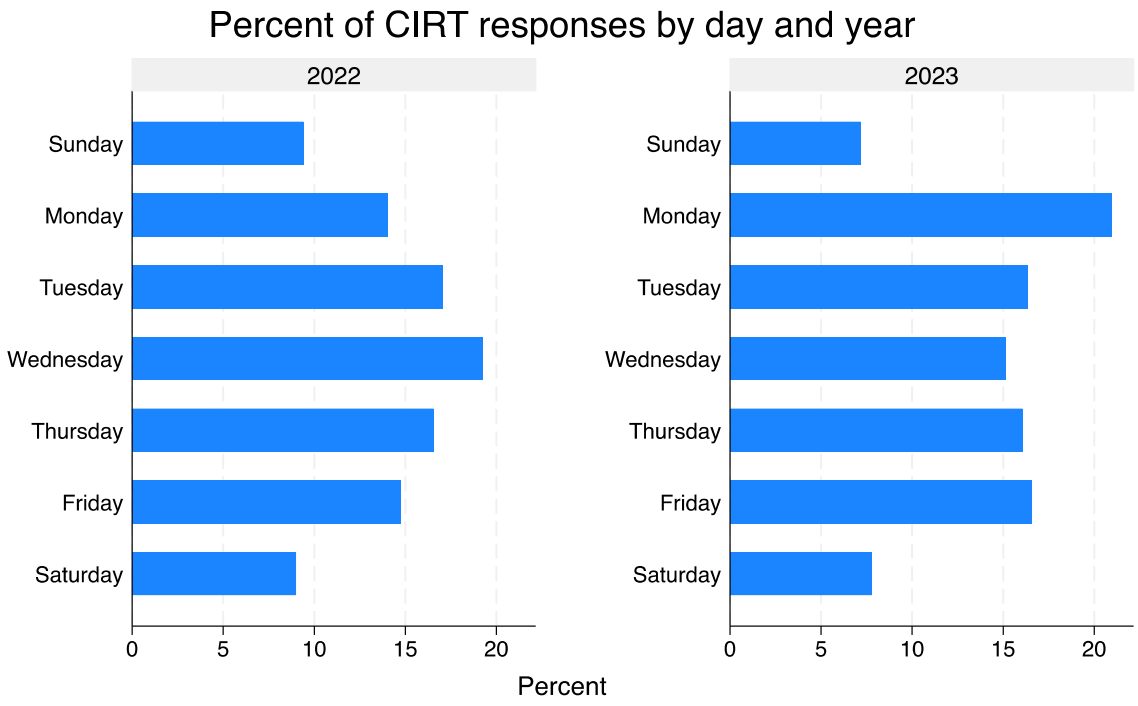
CIRT Responses

As shown in Figure 1 above, the largest category of documented contacts was CIRT responses. CIRT responses were down marginally (3.0%) in 2023 compared to 2022.

Responses by Day of Week and Time of Day

By day of week, the overall pattern of responses shows a modest increase in responses on Mondays in 2023 relative to 2022. One in five (20.9%) of CIRT responses occurred on Monday in 2023, while only 14.0% of CIRT responses occurred on Monday in 2022. This reflects changes in staffing patterns; CIRT had more availability on Mondays in 2023 compared to 2022.

Figure 3: Percent of Responses: CIRT contacts by day and year



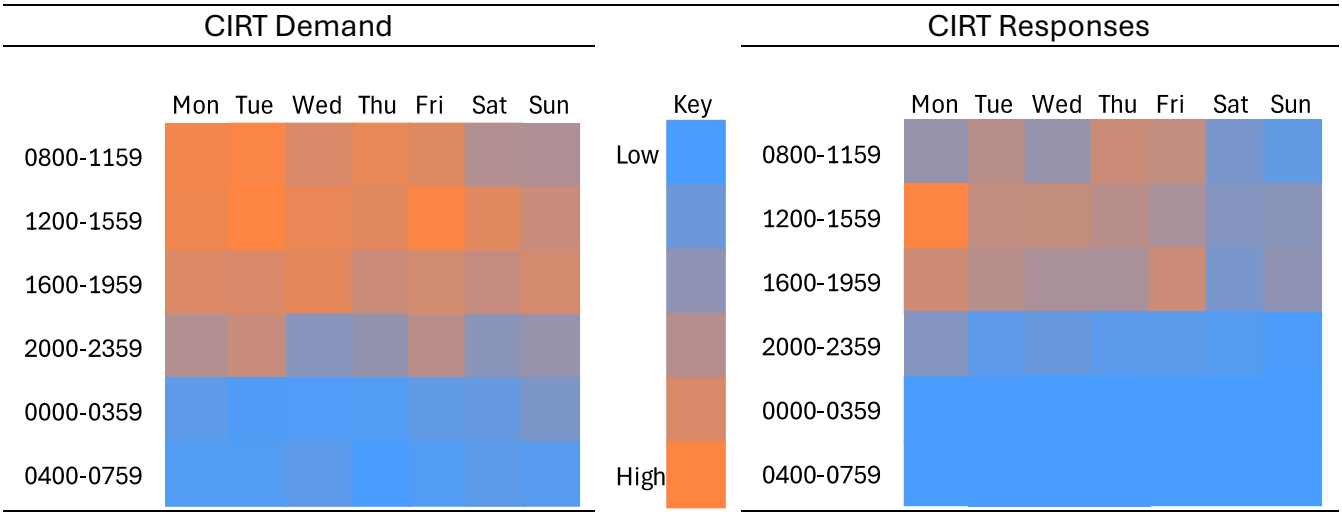
Demand

As of September 2024, CIRT operates and is available for responses from 8:00am to 11:00pm on weekdays and 9:00am to 9:00pm on weekends. Program hours were similar in 2022 and 2023, with some adjustments due to staff capacity and training. While it is difficult to measure demand for CIRT services with precision, CIRT and Boulder Police Department staff have created a reasonable approximation of demand based on key words

in the computer-aided dispatch records.[3] The left pane of Figure 4 shows a time of day and day of week heat map for this proxy measure of demand, with periods of higher demand symbolized in orange and periods of lower demand shown in blue. Demand was highest Monday-Friday between 8:00am and 8:00pm in calendar year 2023. Nearly half (48.8%) of all demand occurred Monday-Friday between 8:00am and 8:00pm. Demand was approximately equal across weekdays during the hours of 8:00am to 8:00pm, with 9% to 10% of all demand occurring during those hours each day. Demand was slightly lower on Saturday and Sunday, with 8% each day during the hours of 8:00am and 8:00pm. Demand dropped quickly after 8:00pm and was particularly low during the hours of midnight to 8:00am.

The right pane of Figure 4 shows CIRT responses in 2023. Like demand, the highest periods of CIRT responses were also between the hours of 8:00am and 8:00pm Monday through Friday. Three quarters (77%) of CIRT responses occurred between those hours. About one in seven of CIRT responses occurred between 8:00am and 8:00pm on the weekend (7% each day). CIRT responses were far less common during the overnight hours.

Figure 4: Demand and CIRT Responses time of day and day of week heat maps, 2023



Note: Percent of total is symbolized.

[3] BPD and CIRT have agreed on this list of key words as a proxy measure of demand: mental health crisis, psychotic, hallucinations, suicidal, hearing voices, panic attack, anxiety, depression, bipolar, schizophrenia, paranoid, talking to him/herself, delusions, acting erratically, and variations of these terms. This is meant as a reasonable approximation of demand, not an exact measurement. Not every call matching these key words is appropriate for CIRT, and not all CIRT calls match these key words.

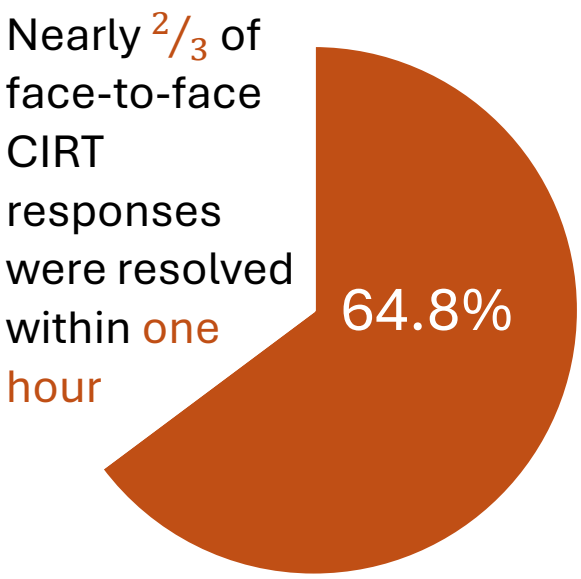


Figure 5: Percent of face-to-face CIRT responses resolved within one hour

Duration information was available for 1,775 (87.2%) CIRT responses.[4] The overall average duration of a CIRT response was 49.5 minutes. This does not include the time needed to complete required documentation and reporting. The average duration varied considerably by contact method, with face-to-face responses taking nearly twice as long (55.8 minutes on average) as phone encounters (31.1 minutes on average). While some responses took considerable time to resolve, nearly two-thirds (64.8%) of face-to-face responses were resolved within one hour or less. Across all contact methods, 95% of responses were resolved within two hours, and 99% were resolved within three hours.

Concerns

The concern can be thought of as the reason for the call — why were CIRT staff involved?

[4] End time was missing for 269 responses. Another 18 responses had improbably long durations that were most likely the result of data entry errors. These calls had, for example, start times of 11:30am and end times of 12:30am. This was either the result of 1) a data entry error, where one of the times should have been P.M.; or 2) it was a 13-hour call. Because the median duration is less than an hour, these improbably long responses tended to inflate the mean duration. As of this writing, our approach has therefore been to code durations longer than 10 hours to missing to avoid inflating the mean durations reported.

Figure 6: Primary Concern, All CIRT Responses 2022-2023

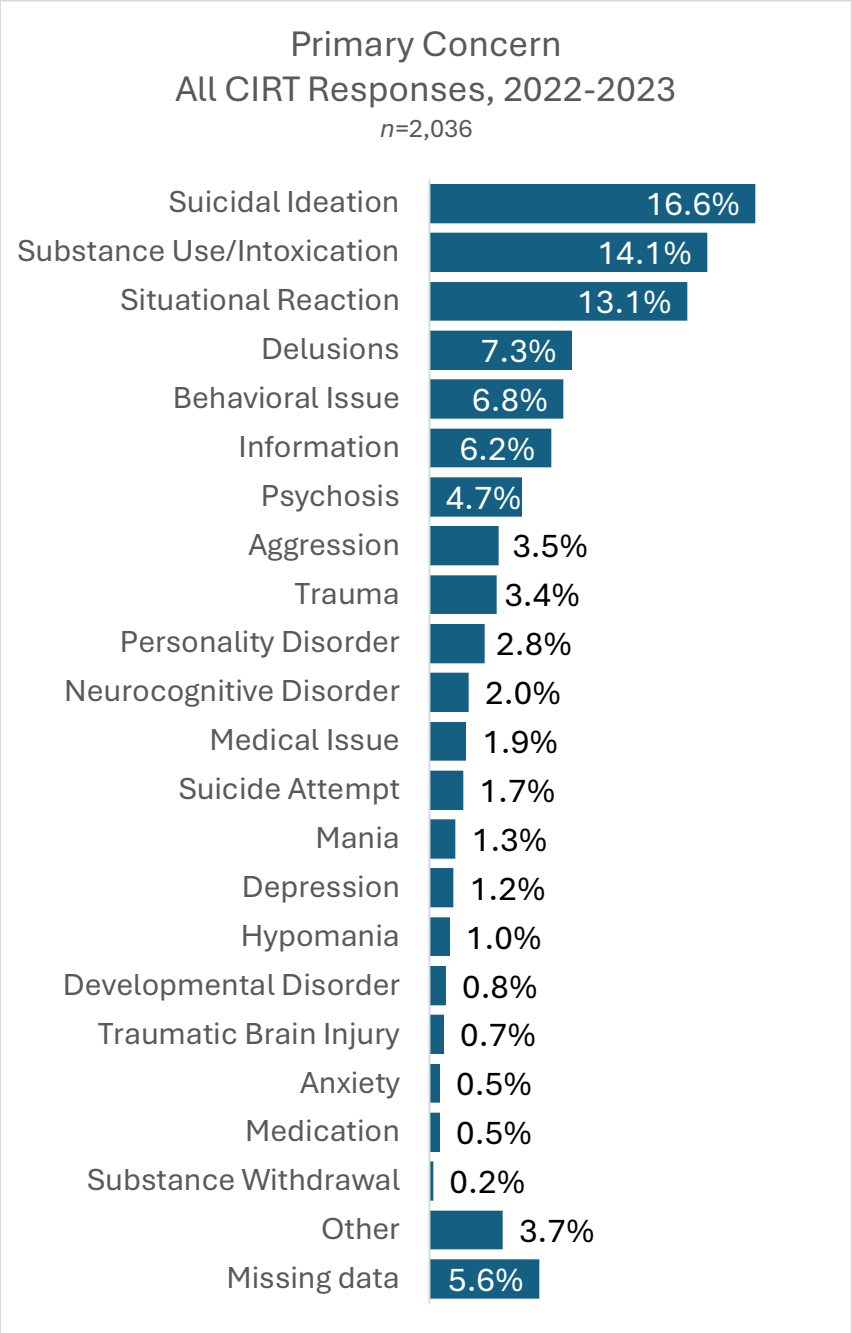


Figure 6 shows all primary concerns. The most common primary concern in 2022-2023 was suicidal ideation (16.6% of all CIRT responses), followed by substance use or acute intoxication[5] (14.1%) and situational reactions (13.1%). Situational reactions are circumstances where the person's behavior is driven by a reaction to a specific situational stressor rather than a mental illness or substance intoxication. Examples include a relationship breakup, failing a test, or being fired from a job. Situational reactions are often paired with underlying issues that make persons more vulnerable to behavioral or emotional dysregulation such that external events precipitate a crisis reaction.

Table 3 shows the primary concern by contact method. The most common primary concern differed for phone contacts and face-to-face contacts, with information being the most common primary concern for phone contacts (16.9% of phone contacts). *Information* concerns typically

[5] CIRT clinicians have changed how they categorize substance use or acute intoxication over time. This is due, in part, to the difficulty of knowing what substance(s) a community member may be intoxicated by at the time of a call for service. Polysubstance use is also common. The category reported here includes alcohol use, alcohol/drug intoxication, methamphetamine use, methamphetamine use suspected, methamphetamine use suspected/ confirmed, substance intoxication, and substance use.

result from community members seeking information about what an in-person response could look like, but the community member does not want an immediate response. Delusions were the next most common primary concern for phone contacts (14.0%) and are commonly persons with whom CIRT has prior contact. Even in phone contacts, however, suicidal ideation was the third most common primary concern (13.8%).

Table 3: Primary Concern by Contact Method, 2022-2023

	Contact method		
	Face-to-Face (%) *n*=1,521	Phone (%) *n*=515	Total (%)
Aggression	4.3	1.4	3.5
Anxiety	0.4	1.0	0.5
Behavioral Issue	7.7	4.3	6.8
Delusions	5.0	14.7	7.3
Depression	1.2	1.2	1.2
Developmental Disorder	0.9	0.6	0.8
Hypomania	1.4	0.0	1.0
Information	2.6	16.9	6.2
Mania	1.3	1.4	1.3
Medical Issue	2.1	1.2	1.9
Medication	0.7	0.2	0.5
Neurocognitive Disorder	1.9	2.3	2.0
Personality Disorder	2.2	4.5	2.8
Psychosis	5.1	3.7	4.7
Situational Reaction	13.9	10.9	13.1
Substance Use/Intoxication	16.4	7.4	14.1
Substance Withdrawal	0.3	0.0	0.2
Suicidal Ideation	17.2	13.8	16.6
Suicide Attempt	2.1	0.6	1.7
Traumatic Brain Injury	0.7	0.8	0.7
Trauma	3.6	3.1	3.4
Other	3.4	4.7	3.7
Missing Data	5.3	6.4	5.6
Total	100.0	100.0	100.0

Note: Elements may not sum to total due to rounding.

Substance use and suicide were common concerns

CIRT clinicians can record up to three concerns for each response (primary, secondary, and tertiary concerns) because people often have multiple concurrent issues. The primary

concern is based on the clinician's clinical impression of the predominant issue addressed during the contact. Secondary and/or tertiary concerns are contributing factors to the primary concern. For example, suicidal thoughts (also referred to as suicidal ideation) may be the primary concern for the call, with a secondary concern of trauma. Not all responses had secondary or tertiary concerns.

Focusing on only the primary concern can tend to undercount some concerns that often co-occur with other concerns. For example, suicidal thoughts or attempts were the primary concern in nearly one out of every five CIRT responses (18.3%), but were any concern (primary, secondary, or tertiary) in more than a quarter of all CIRT responses (27.7%). As shown in Figure 7, when suicidal thoughts or attempts were any concern, suicidal thoughts were the primary concern in three out of five (60.0%) contacts. Another 6.2% of these contacts had a primary concern of suicide attempt. Other common primary concerns for these contacts included substance use (11.5%), situational reactions (8.4%), trauma (2.5%), and personality disorder (2.3%).

Similarly, substance use, acute intoxication, or substance withdrawal were the primary concern in one out of every seven CIRT responses (14.3%) but were any concern in more than one out of five (23.1%) of CIRT responses.

When substance use, intoxication, or withdrawal was any concern (primary, secondary, or tertiary), substance use was the primary concern in three out of five (61.3%) contacts. Suicidal ideation was the primary concern in 6.8% of contacts where substance use, intoxication, or withdrawal was a secondary or tertiary concern. Situational reactions were the next most common primary concern at 5.3% of incidents where substance use, intoxication, or withdrawal was any concern. Delusions were the primary concern in 5.1% of contacts where substance use, intoxication, or withdrawal was any concern. All other categories of primary concern occurred in fewer than 5% of contacts where substance use, intoxication, or withdrawal was any concern.

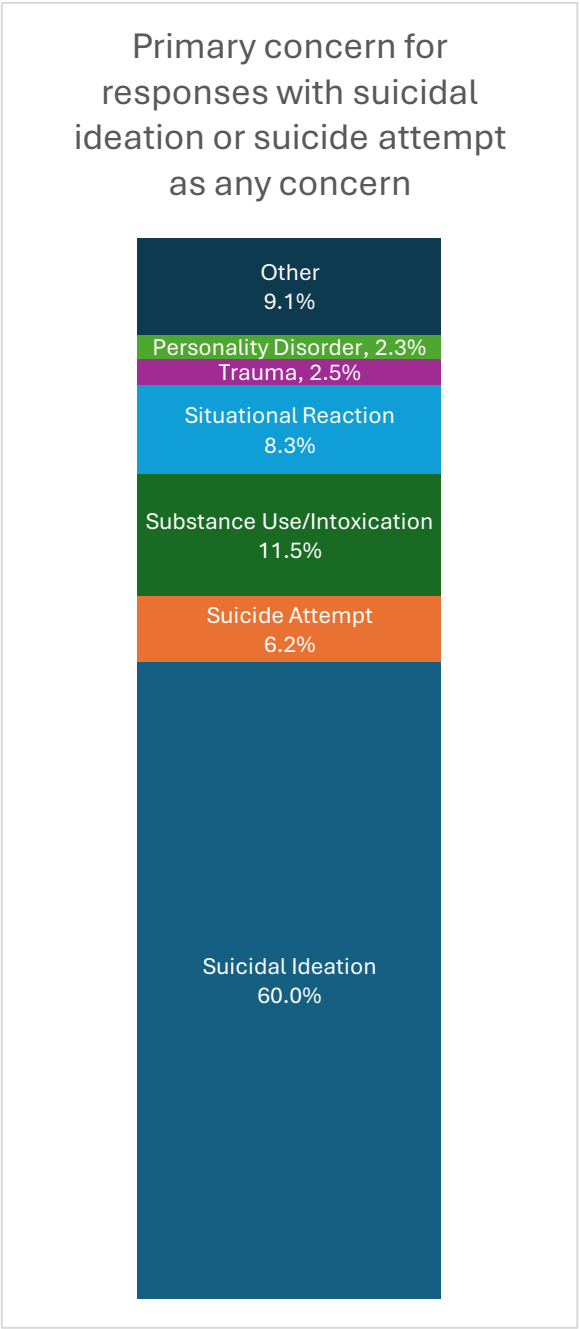
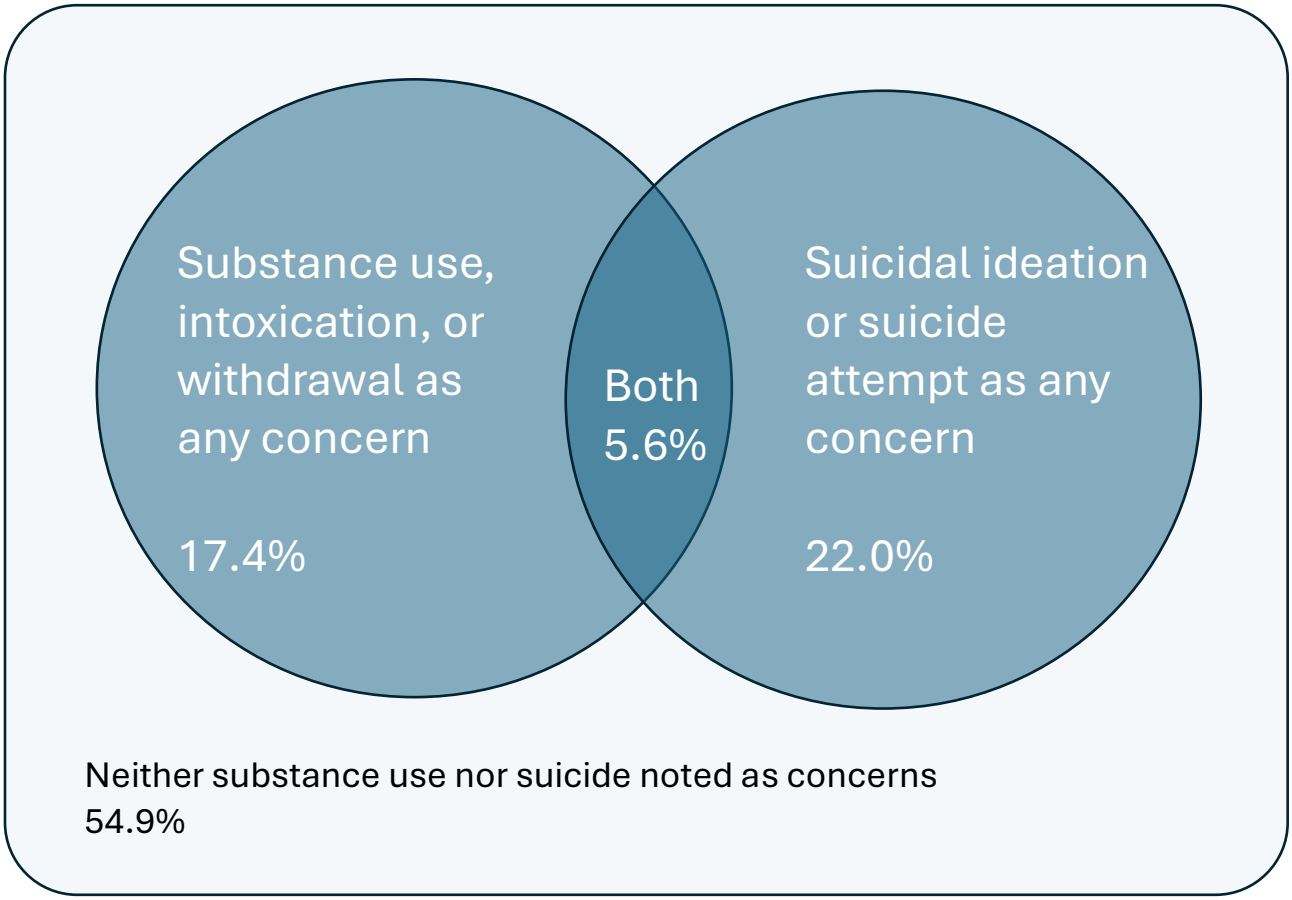


Figure 7: Primary concern for suicidal ideation or attempt was any concern

These two concerns — suicide and/or substance use — were present in nearly half of all CIRT responses (45.1%).

Figure 8: Substance use, intoxication, or withdrawal and suicide as any concern



Diversion and outcomes

Diversions are noted by CIRT clinicians when their intervention changed the outcome of the call. For example, clinicians note a diversion when officers would have placed the community member on an emergency mental health hold had a CIRT clinician not responded and intervened. It is hard to know what would have happened if CIRT had not responded, so the team only records diversion when it is clear from officer's statements that they would have taken a different action had CIRT not been there. When officers and CIRT arrive on calls around the same time and CIRT conducts most of the intervention, diversion generally does not come into play because the clinician is taking the lead on the call. Additionally, as officers work with CIRT over time, they report they are less likely to put someone on an emergency mental health hold or take them to the hospital based on what they have learned from CIRT clinicians. Due to these nuances in how diversion is defined, it

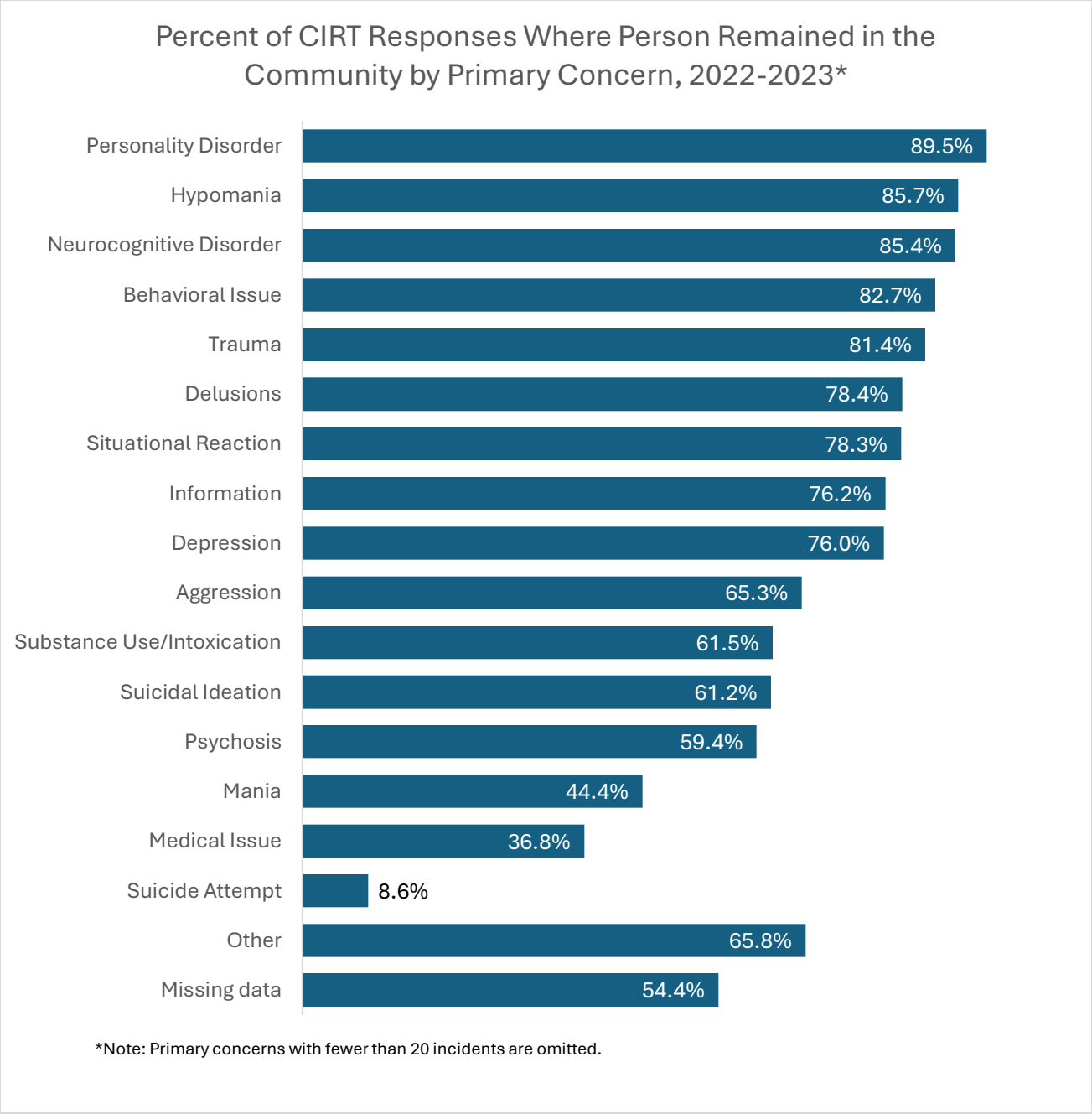
is challenging to capture diversion from higher levels of care and mental health holds because officers generally let clinicians take the lead on CIRT calls, and it is unclear whether they would have initiated these steps without a CIRT staff member present.

Diversion from higher levels of care, emergency mental health holds, and jail or tickets were recorded in 11.4% of contacts. Diversion from emergency mental health holds were most common (6.5% of all contacts), followed by diversion from higher levels of care (4.4%). Diversion from jail or tickets was rarer, occurring in just 12 contacts (0.6%). The low rate of diversion from jail may be due to dispatch procedures that rarely send CIRT to incidents that are clearly criminal in nature.

The preferred outcome in mental / behavioral health crisis response is typically for the community member to remain in the community. Remaining in the community has several advantages over hospital stays, including providing care in a less disruptive manner, improved recovery rates, easier access to support networks, lower health care costs, and reduction of stigma.

Overall, more than two-thirds (68.1%) of CIRT responses resulted in the person remaining in the community. As shown in Figure 9, the percentage of people who remained in the community varied by primary concern. Suicide attempts had the lowest percentage (8.6%) of persons remaining in the community. Suicide attempts have a lower percentage of people who are able to remain in the community than situations where someone is thinking about suicide but has not tried to end their life. Three in five (61.2%) people who were having thoughts of suicide received stabilizing care from CIRT and were able to remain in the community.

Figure 9: Percent of CIRT responses where person remained in the community by primary concern, 2022-2023



Remaining in the community is not appropriate in all circumstances. About one in eight CIRT responses (12.0%) resulted in a voluntary transport of the community member. Emergency mental health holds were initiated by CIRT in 4.1% of responses. Non-CIRT staff (including police, emergency department doctors, and other licensed professionals) initiated emergency mental health holds in another 2.5% of CIRT responses. CIRT clinicians were unable to contact the community member in 3.6% of responses.

Arrests occurred in 50 contacts between 2022 and 2023 (2.5% of contacts). In half (25) of responses with an arrest, CIRT had no or very brief contact with the subject of the call.[6] One-third of all arrests (32%,16 responses) involved mandatory arrests for outstanding warrants, violations of protective orders, or police discovered probable cause for a domestic violence crime during their investigation. Six of the arrests were for a menacing or assault. The remainder were for a combination of charges including burglary, possession of a controlled substance, harassment, criminal mischief, and trespass.

Use of force by police was exceedingly rare, occurring just six times over the two-year span (0.3% of responses). Each of these six responses is briefly described below:

1. A person assaulted officers during a call involving CIRT. Officers completed a takedown to end the assault.
2. Officers were dispatched to a call for a suicidal person who had a gun. Officers displayed (but did not fire) firearms and less than lethal weapons when contacting the person. CIRT was requested once officers determined the scene was safe.
3. A person was being placed on an emergency mental health hold by CIRT when they became threatening and resisted being taken into custody. An officer used a knee-strike, and the person was taken into custody for the mental health hold.
4. Officers were dispatched to a burglary in progress where it was reported that the person involved had a firearm. Officers displayed (but did not fire) firearms when contacting the person. CIRT was requested after officers contacted the person.
5. During a CIRT response, officers determined that there was probable cause to believe the subject of the call had committed a domestic violence offense. The person tried to jump off a balcony after officers informed the person that they were to be arrested for the domestic violence charge. Officers completed a takedown to prevent the person from jumping off the balcony. The person then assaulted officers and another takedown was completed and a leg restraint device was used to prevent further assault.
6. A person broken into a home. CIRT responded with officers, conducted an assessment, and determined that an emergency mental health hold was appropriate. The person then barricaded themselves inside. Officers used pepper balls to get the person to come out. The person then resisted being taken into custody and officers used a takedown. The person repeatedly kicked officers, so a leg restraint device was used.

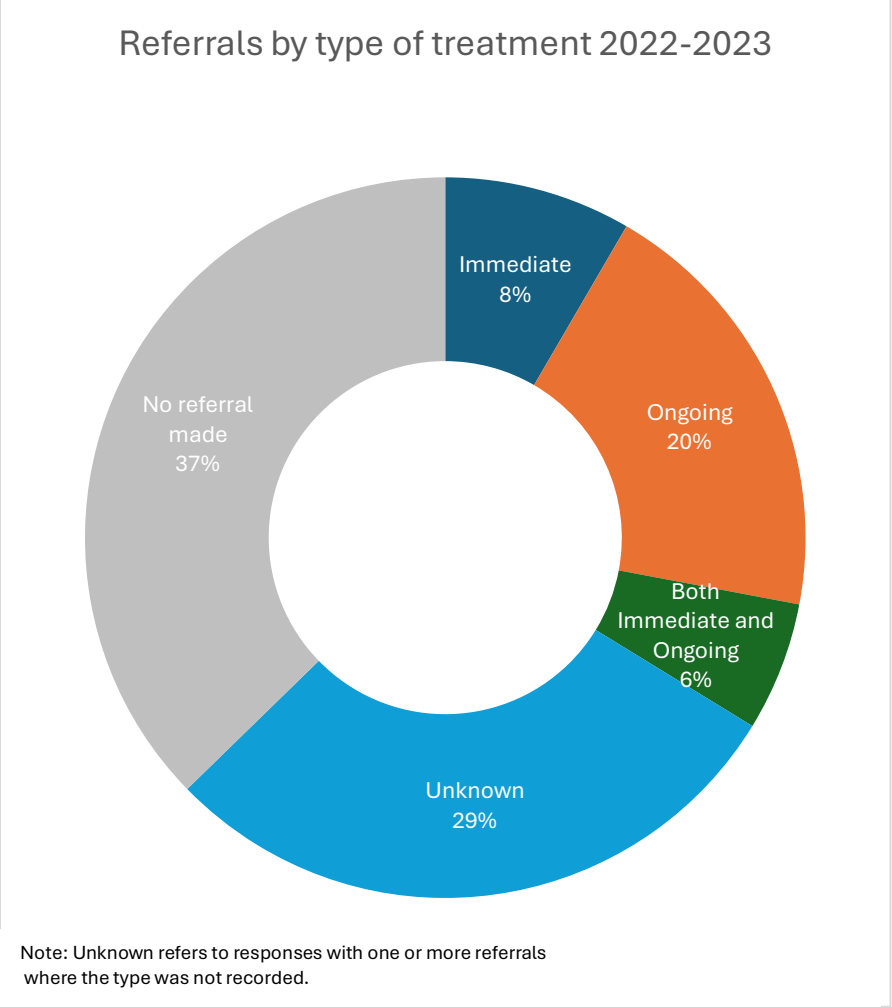
[6] Examples include CIRT having been canceled prior to interacting with the subject of a call, arrests that occurred prior to CIRT arrival or after CIRT departure from the scene, and CIRT being called out to SWAT incidents, staging near the incident scene, but not contacting the subject of the call.

Referrals

Referrals to services were common. Across all contact methods (phone, face-to-face), referrals were made in 63.5% of responses. Referrals were more common in face-to-face contacts (68.1%) compared to phone contacts (49.9%). Community members often received multiple referrals; three out of five community members who were referred to any service received referrals to more than one service.

Community members could be referred for immediate treatment, defined as emergency or other care relevant to an acute behavioral health or medical concern; these were referrals that the clinician intended the community member to use that same day. Examples include the hospital emergency department, Walk-in Crisis, or detox. Community members could also be referred for ongoing or future treatment, defined as non-emergency service referrals to be provided on an ongoing or future basis. Examples include their primary care physician, a private therapist, or benefit services through Boulder County Housing and Human Services. Community members could also be referred to both immediate and ongoing services. The referral type (immediate or ongoing) was not recorded in 29% of responses.

Figure 10: Referrals by type of treatment



Note: Unknown refers to responses with one or more referrals where the type was not recorded.

CIRT clinicians referred community members to 21 different services. Some services were more commonly referred than others. Community members can be referred to multiple services, depending on their needs. The total number of referrals reported below therefore exceeds the number of incidents.

The most common referral was further follow up by CIRT (18.3%), followed by Walk in Crisis (15.2%), and the local safety net behavioral health provider, Mental Health Partners (MHP) (14.9%). Referrals to the Emergency Department (12.8%) or private therapists (12.9%) each occurred in one in eight contacts. Other referrals occurred in fewer than 10% of responses. Table 4 shows the percent of CIRT responses that resulted in a referral to each service.

Table 4: Percent of referrals by service, 2022-2023

Service	Percent of CIRT responses *n*=2,036
CIRT	18.3%
Walk-In Crisis	15.2%
Mental Health Partners	14.9%
Private therapist	12.9%
Emergency department	12.8%
CIRT Case Management	7.2%
Private psychiatrist	6.5%
Homelessness resources	5.8%
Law Enforcement/Legal resources	4.3%
Detox	2.8%
Primary Care Provider	2.3%
Boulder County Housing and Human Services	2.0%
Adult Protective Services/Older adult services	1.9%
Other	1.8%
CU Counseling and Psychiatric Services	1.3%
Intellectual or developmental disability resources	1.1%
Substance use disorder services	0.7%
Victim resources	0.6%
Intensive outpatient	0.3%
Traumatic brain injury resources	0.1%

Note: Community members can be referred to multiple services in one call for service; percentages sum to more than 100%.

In addition to referrals made by CIRT clinicians, two in five community members (39.0%) were already receiving behavioral health services prior to the CIRT call for service. Just 9.4% of community members were well-connected and engaged to these services. It was more common for CIRT response to involve community members already receiving services who either had engagement barriers (15.4%) or were receiving services but need additional services (14.3%). Engagement barriers can be a spectrum of issues: the person

might need higher intensity services than they are currently connected to, they might not be able to make it to appointments during weekdays due to other commitments, they may have behavioral issues that outpatient providers are not able to accommodate, or they may be using substances so frequently that engaging in treatment is no longer a priority. Fewer than one in five incidents (18.3%) involved a client who was receiving no other services.[7]

Follow-up

More than half of responses (56.8%) were marked for follow-up by CIRT staff. The most common reason for no follow up from CIRT was that it was not needed (21.0% of responses). About one in seven (15.3%) of community members declined follow up. Clients were transported for immediate further assessment in 9.0% of incidents.

Conclusion

CIRT offers community members in mental health crisis a supportive response that often leads to positive outcomes including remaining in the community and referral to services, while avoiding negative outcomes such as arrest. While the data contained in this report are helpful in understanding the program and its role in the community, additional information about the program is sought in areas including the demographics of those served by the program, patterns of frequent responses to some individuals, and case management services. Data in these areas can sometimes be challenging to share and analyze due to confidentiality concerns and other unique aspects of crisis situations. The City of Boulder is analyzing options to provide more in-depth data in the next iteration of this report while complying with federal and state privacy regulations.

Some data captured by CIRT points to limitations in the wider community safety net and prevention options. For example, while the majority of CIRT responses involve people already connected to some sort of behavioral health services, many of those community members struggle to get everything they need from existing care. Similarly, the high prevalence of the issues of suicide and substance use resulting in calls to dispatch points to a need for further community prevention and intervention. The City of Boulder is currently a partner in the Boulder County Behavioral Health Roadmap, and can utilize findings like these from CIRT data to better direct its efforts in strategy and funding.

[7] CIRT team members were unable to determine whether the community member was receiving services about a third of the time (33.3%). Receipt of other behavioral services was not recorded in 5.8% of responses.