



THE UNIVERSITY OF CHICAGO

HEALTH LAB

Urban Labs

Chicago's Crisis Assistance Response and Engagement (CARE) Pilot

Implementation Evaluation

DECEMBER 2024

Science in Service
of Cities



University of Chicago Health Lab

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The City of Chicago launched the Crisis Assistance Response and Engagement (CARE) program in September 2021. This promising initiative was the result of a partnership between the Chicago Mayor's Office, the Chicago Department of Public Health (CDPH), the Chicago Fire Department (CFD), the Office of Emergency Management and Communications (OEMC), and the Chicago Police Department (CPD). Prior to launching a pilot of the program, the City asked the University of Chicago Health Lab to support their efforts by conducting an implementation evaluation, which includes a detailed look at the context, program logistics, processes and overall development of the pilot, key informant interviews conducted with participating agency leadership and CARE program staff, and quantitative descriptive analyses of the program's administrative data.

CARE is one example of the new types of crisis response programs that have proliferated throughout the country over the past decade. However, despite the rapid advancement of these novel models, much remains unknown regarding operational practices, comparability across sites, or effectiveness. This implementation evaluation was designed to help Chicago policymakers identify and address operational challenges before implementing CARE at-scale throughout the city, and to lay the foundation for a subsequent outcome evaluation.

As will be discussed below, our team encountered several challenges during the pilot period stemming from the way the partner agencies collected data about CARE. The partners were, of course, interested in identifying the issues so that they could be rectified. We worked closely with them to do so. Nonetheless, these data challenges prevented the implementation evaluation from addressing several questions of interest. These include, for example, whether different call types were associated with different on-scene response times. These challenges also prevented Health Lab from examining whether the different CARE team types responded to a divergent combination of call types. Such data challenges have become a common feature in implementing new forms of diversified crisis response nationally. Nevertheless, this study generates programmatic insights regarding these new models that we hope will help inform policymakers and practitioners responsible for implementation in Chicago, and in cities and other localities across the country.

None of this work would have been possible without the tireless dedication and effort put forth by our partners and Health Lab team members.

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I. Key Findings

- CARE teams responded to **1,348 events** and served **673 unique individuals** over the course of the pilot period from **September 2021 to October 2023**. Based on the events with a documented location, most events took place in outdoor spaces and private residences.
- CARE participants' self-reported Subjective Units of Distress Scale (SUDs) scores **decreased by an average of 19%** after interaction with CARE teams.
- Roughly **40%** of clients presented one or more symptoms of paranoia or schizophrenia, depression or anxiety, or substance use disorders.
- Over **30%** of clinically assessed CARE clients (N = 475) reported ideations of self-harm or harm to others at some point in their lives.
- Over **30%** of clinically assessed CARE clients (N = 475) reported use of alcohol or drugs not prescribed by a doctor.

Key lessons learned include:

- Traditionally, implementing risk management strategies is often an internal process for agencies. The **cross-agency CARE pilot, however, required the partners to work together to assess both internal** (e.g., within agency) and **external risks** (e.g., from outside and among the partners between agencies generally).
- **Agency culture, norms, values, and assumptions played vital roles in both implementation and decision-making.** In a cross-agency collaboration like the CARE pilot, these differences were evident in both leadership and direct service staff.
- **Staffing decisions—including hiring, pay scales, and retention measures—are key** to pilot development, sustainability, and considerations for scaling. These require dedicated and stable funding.
- **911 professionals are essential** to the success of new forms of crisis response.
- The **regulatory and policy environment exerted major and unexpected influence on the pilot**, particularly in the early days. These regulatory and policy issues occurred at the agency, local, and state levels, impacting the timing of the pilot launch, day-to-day logistics and operations, and—likely—the overall volume of calls responded to during the pilot period.
- Cross-agency partnerships like CARE will often require establishing new policies and procedures, including those for capturing operational information and programmatic data. **Partner agencies must collaborate closely to establish clear and practical data pathways for capturing CARE programmatic data** that are at least on par with the data collected for standard response units, and incorporate the ability to capture the additional behavioral health-related data required for a program like CARE.

About the Brief

Section II below provides pertinent, contextual information on each of the partner agencies involved in the CARE pilot. We also describe the landscape of mental and behavioral health in Chicago.

Section III presents operational details of the CARE program during the pilot.

Section IV includes a deeper dive into the CARE administrative data, highlighting the number of events to which teams responded, locations, services provided, and related dispositions for those responses.

Finally, in Section V we provide a synopsis of lessons learned during our observations of the program's planning and operational processes throughout the two-year pilot period. In addition to this brief, Health Lab will deliver updated analyses and findings from key informant interviews with CARE leadership and staff in a future report.

II. Background and Context

Key Agencies Involved in CARE

Given the multidisciplinary nature of CARE, pilot operations were spread across multiple agencies. To staff CARE, Chicago Fire Department (CFD) provided **five community paramedics** for daily operations from a rotating team of eight community paramedics. Chicago Police Department (CPD) provided **two rotating officers** on the CARE team, with over 20 officers participating over the course of the two-year pilot. Chicago Department of Public Health (CDPH) hired and provided **five clinicians** to staff the pilot, which later expanded to six clinicians. Each agency also provided supervisory and management support. CDPH initially purchased two vehicles for the program and by the end of the pilot had 10 vehicles. In addition to direct service support, CDPH provided project management and epidemiologist support. The following sections provide background on these key agencies as they functioned throughout the CARE pilot period.

Chicago Department of Public Health (CDPH)

CDPH served as the home agency for the Mental Health Crisis Clinicians that staff the CARE team. Outside of CARE, CDPH offers services related to behavioral health, emergency preparedness, clinical services, community health, food safety, family planning, infectious diseases, and more. In 2023, CDPH had a \$983.7 million budget, which decreased to \$888 million in 2024.² CDPH's 2024 budget includes 1,175 fulltime employees, an increase from 1,105 in 2023.³ Behavioral health, mental health and substance use account for 15%, 6%, and 4%, respectively, of CDPH's 2024 budget.⁴

Chicago Fire Department (CFD)

CFD served as the home agency for the Community Paramedics that staff the CARE team. CFD also provided the administrative building that served as the CARE operational headquarters during the pilot. CFD employs more than 4,500 firefighters and paramedics.⁵ In 2022, the department's budget was \$715.3 million, which accounted for 27% of Chicago's expenditures on public safety.⁶ CFD's budget rose to \$775.2 million in 2023,⁷ and to \$784 million in 2024.⁸ CFD's team of community paramedics have all completed community paramedicine education programs, which provides advanced training in skills designed to address barriers to health and wellness needs, and to decrease health disparities.

Based on data shared with us by the partners, CFD responded to more than 392,000 911 calls for service in 2021 (the year the CARE pilot launched) and approximately 402,000 calls in 2022. The number of mental health- or substance use-related 911 calls CFD responds to annually has increased steadily since 2019: from approximately 29,000 in 2019 to 38,000 in 2022, representing a 31% increase.



Figure 1. Neighborhood type map designed by James McDonald

Chicago Police Department (CPD)

CPD served as the home agency for the police officers that staffed the CARE team. CPD deployed 13,108 sworn officers in 2022, with a ratio of 4.7 officers per 1,000 Chicagoans.⁹ Chicago's 77 neighborhoods are divided into 25 police districts (see Figure 2). The CARE pilot was organized by police districts during the pilot period.

In 2021, CPD received over \$1.6 billion in funding, representing over 13% of the City of Chicago's budget that year.¹⁰ CPD's budget was \$1.9 billion in 2023, and rose to just under \$2 billion for 2024.¹¹ In 2021, CPD responded to a total of 2.9 million 911 calls for service, including over 100,000 mental health or substance use-related 911 calls.¹²

All officers involved in CARE received Crisis Intervention Team (CIT) training. CIT training prepares officers to respond to service calls involving people experiencing mental health crisis.¹³ In Chicago, CIT training is conducted in partnership with the National Alliance on Mental Illness (NAMI), with contributions from other stakeholders and community organizations.¹⁴ All CPD police officers are eligible to receive CIT training, though this training is not mandatory. As of 2021, 27% of CPD officers had received CIT training, rising to 34% in 2023.¹⁵

In addition to CIT training, CPD also employs District Operations and Community Support (DOCS) teams whose goal is to reduce the frequency and severity of 911 calls for service involving individuals in crisis.¹⁶ As of 2021, CPD fielded four DOCS teams involving five sergeants, 22 police officers, and a civilian data analyst.¹⁷ These DOCS teams regularly review CIT reports and conduct follow-ups with other officers, the individual subject of the report, and other involved parties, such as the person's family.

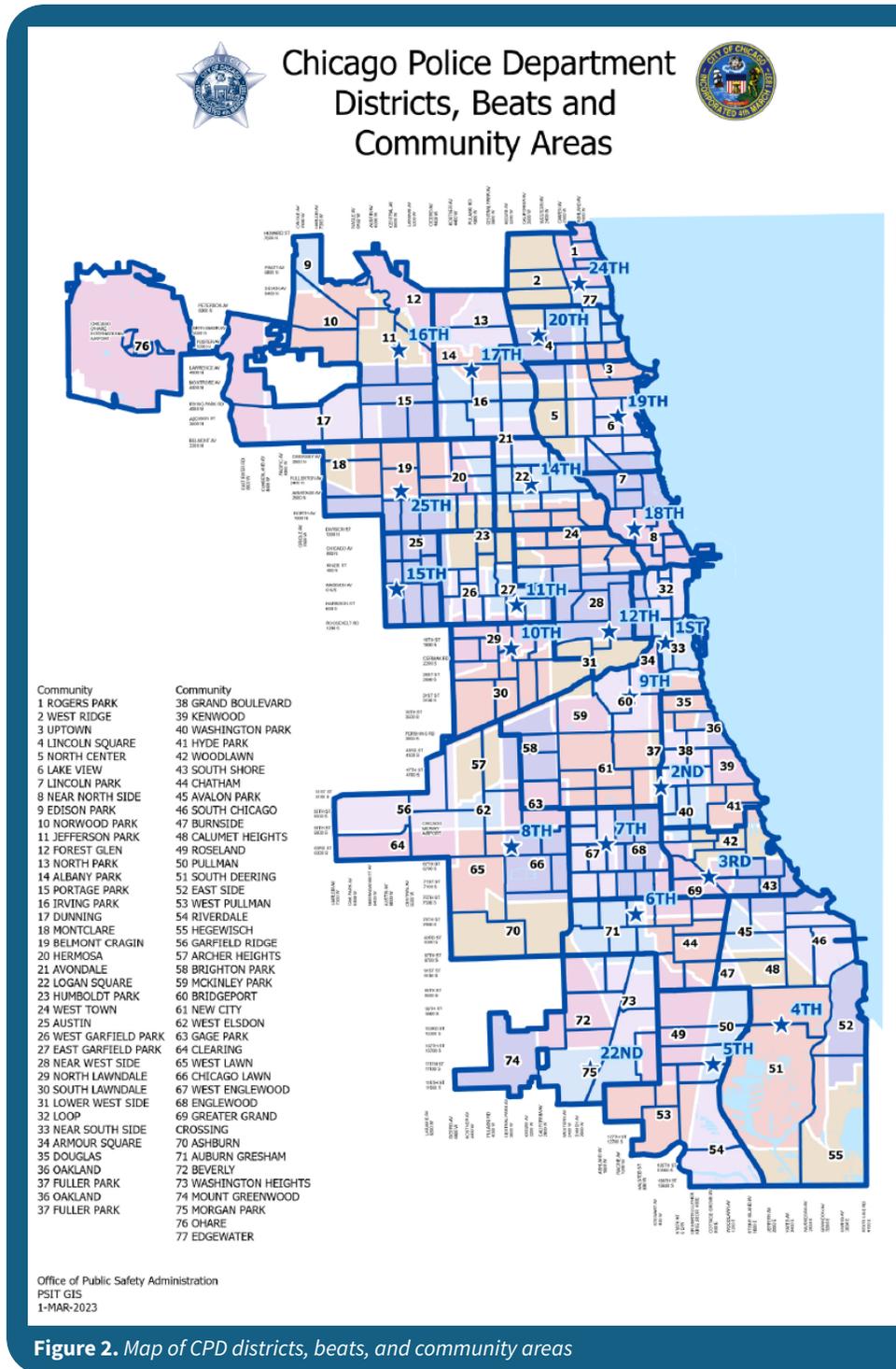


Figure 2. Map of CPD districts, beats, and community areas

During these follow-ups, DOCS team members can provide service referrals, or help arrange mental healthcare services for the individual. The DOCS team runs the Narcotics Arrest Diversion Program (NADP), which aims to divert individuals with substance use disorders from the criminal legal system or experience unnecessary hospitalization. From 2018-2023, the DOCS team diverted roughly 1,943 individuals, with 80% starting treatment.^{18,19} From 2018-2023, DOCS also led the Opioid Overdose Reversal Pilot Program, which oversaw administration of Naloxone (a safe and effective opioid overdose reversal nasal treatment) a total of 486 times.²⁰ Together, these initiatives aim to reduce high rates of unaddressed mental health and substance use challenges, and to reduce overdose mortality and morbidity.

Office of Emergency Management and Communications (OEMC)

The Office of Emergency Management and Communications (OEMC) is Chicago's Emergency Communications Center (ECC). OEMC oversees the city's 911 and 311 operations, emergency management, traffic management, and public alerts and outreach.²¹ Chicago's 911 operation is divided into two teams: police operations and fire operations. OEMC is responsible for triaging and dispatching police, fire, emergency medical services (EMS), and CARE to all emergency service calls in the city. In 2023, OEMC had a budget of just over \$105.8 million and employed 963 full-time staff members.²² Just over half of OEMC's \$110 million budget in 2024 supports police and fire 911 operations, while roughly 5% supports 311 operations.²³

Chicago's Mental and Behavioral Health Landscape

Based on Health Lab's analysis of OEMC computer-aided dispatch (CAD) data, behavioral health-related 911 calls in Chicago increased by 22% between 2019 and 2022. Due to the difficulties inherent to properly identifying and coding mental- and behavioral health-related 911 calls, this analysis likely undercounts the true number of such calls.

Like most jurisdictions, the City of Chicago has traditionally relied on police and EMS to address behavioral health calls for service. In 2015, the high-profile, fatal police shooting of 19-year-old Quintonio LeGrier and bystander Bettie Jones was followed by public outcry and calls for greater accountability and improved response to behavioral health service calls. In 2019, following an investigation by the U.S. Department of Justice, the City of Chicago entered into a consent decree related to its policing, requiring specific changes in 12 areas, including community policing, crisis intervention, officer training, and data collection, analysis, and management.²⁴

Later in 2019, under then-Mayor Lori Lightfoot, Chicago instituted a framework for mental health equity, which sought to expand outpatient mental health services, develop trauma-informed victims services, improve crisis prevention and response, and increase the visibility of mental health services.²⁵ In 2022, \$89 million was allocated to supporting these goals, a 641% increase from 2019.²⁶

To advance this framework—and also in response to recommendations from the Chicago Council for Mental Health Equity (CCMHE) related to improving crisis prevention and response—the behavioral health advisory board called for the creation of the Crisis Assistance Response and Engagement (CARE) Program in 2020.

III. CARE Pilot Overview

Background

Prior to the September 2021 CARE pilot launch, Chicago, like many jurisdictions nationwide, relied on traditional first responders (e.g., police, fire, and/or emergency medical services) to respond to mental or behavioral health-related calls placed to 911. Upon calling 911, callers are connected to a 911 professional, who uses operational protocols and their judgement to determine the best response given existing and available resources. Most calls result in dispatching emergency responders comprised of police, paramedic, and/or fire units. Once on scene, emergency responders implement their organizational protocols and personal judgement to resolve the incident.

The vast majority of first responders do their jobs admirably and professionally. Few, however, are specifically trained to handle mental health and addiction-related crises. Effective responses to these calls require training and experience that most first responders do not receive. Often, the best available pathway within traditional first response is transport to an emergency department, where patients are stabilized and released. In some instances, individuals in crisis may be arrested or be met with other criminal legal actions. These pathways rarely address the root causes of the crisis. Thus, many people with mental or behavioral conditions cycle again and again through the 911 crisis response system. Moreover, these calls for service also require substantial time and resources from emergency service agencies, even when services provided often do not address the issues that produced the call.

Such considerations are, in part, what led policymakers in Chicago to design and launch CARE. After the CCMHE behavioral health advisory board called for the creation of CARE, Chicago policymakers engaged in a year of planning to launch the pilot. The city's stated intentions for CARE were to ensure that individuals experiencing mental and behavioral health-related crises are

1. assisted by teams of trained professionals and resources who
2. address underlying unmet health and social needs, with the ultimate goal of
3. reducing cyclical utilization of emergency response services.

During the pilot period, CARE was operated as a partnership between CDPH, CFD, CPD, OEMC, the Office of the Mayor, and EMS Region 11. Additionally, the University of Illinois-Chicago Community Outreach Intervention Projects (COIP) provided peer recovery coaches to staff the opioid response teams (described in more detail below) when those teams were launched in early 2023.

During the city's planning phase, Chicago partnered with a consortium of local and national funders—including the [Charles and Lynn Schusterman Foundation](#), [Chicago CRED](#), the [Joyce Foundation](#), the [Pritzker Pucker Family Foundation](#), and an anonymous foundation—as well as the University of Chicago Health Lab to support an implementation evaluation of CARE. The implementation evaluation was designed to help Chicago policymakers and practitioners identify facilitators and barriers to effective and sustainable model implementation. The evaluation included 44 key informant interviews with leadership and staff from all participating agencies.

In these interviews, our team gathered information on operational details, with a particular focus on identifying the strengths and challenges of the model, neighborhood contexts, partnerships, and decision-making. Insights from the interviews were shared with CARE leadership, staff, and other policymakers in the city to help resolve potential operational challenges and inform the program's continued development and implementation. The implementation evaluation also includes descriptive and quantitative analyses of CARE programmatic and citywide emergency response administrative data, which forms the basis of this brief.

During CARE's pilot period, the City tested three field response models, each designed to address distinct, but overlapping issues:

- **Multidisciplinary Response Teams (MDRT)**

The first team to launch in September 2021, MDRT units included a CFD Community Paramedic, a CDPH Mental Health Crisis Clinician, and a CPD CIT officer. These teams were designed to respond to mental health- and behavioral health-related calls involving somewhat higher levels of risk. At launch, the team served Uptown, North Center, Lakeview, Auburn Gresham, and Chatham (for boundaries of police districts see Figure 2 above).^{27, 28}

- **Alternate Response Teams (ART)**

ART units launched in June 2022. These teams included a CFD Community Paramedic and CDPH Mental Health Crisis Clinician. Teams were designed to address a range of mental health and behavioral health issues with slightly lower levels of risk. At launch, these teams served West Englewood, West Elsdon, Chicago Lawn, West Lawn, and Gage Park. In March 2023, this team expanded to serve the Loop.²⁹

- **Opioid Response Teams (ORT)**

ORT launched in February 2023, composed of a CFD Community Paramedic and a COIP Peer Recovery Specialist. These teams were not dispatched via 911. Rather, they were deployed to address opioid overdose and substance use-related issues by offering follow-up services to people who experienced an overdose in the previous 24 to 72 hours. At launch, ORT served West Garfield Park, East Garfield Park, and Humboldt Park.³⁰

Average annual mental and behavioral health-related calls in MDRT neighborhoods (2019-2022)



*Includes Auburn Gresham, Chatham

**Includes Uptown, North Center, Lakeview

Figure 3. Average annual number of MH/BH-related calls in MDRT neighborhoods (data source: OEMC)

Average annual mental and behavioral health-related calls in ART neighborhoods (2019-2022)



*Includes the Loop

**Includes West Englewood, West Elsdon, Chicago Lawn, West Lawn, Gage Park

Figure 4. Average annual number of MH/BH-related calls in ART neighborhoods (data source: OEMC)

Average annual overdose-related calls in ORT neighborhoods (2019-2023)



*Includes West Garfield Park, East Garfield Park, Humboldt Park

Figure 5. Average annual number of overdose-related calls in ORT neighborhoods (data source: CFD)

Mental and behavioral health-related calls in the MDRT and ART neighborhoods comprised nearly one-third of all mental health and behavioral health-related calls across the city. Figures 3 and 4 reflect the level of need and scalable opportunities for crisis intervention in these specific pilot districts. In similar fashion, ORT neighborhoods account for more than one-quarter of Chicago's overdose-related calls. Figure 5 reflects the size and scale of potential need for ORT response and services in the ORT pilot district.

Pilot Operations and Logistics

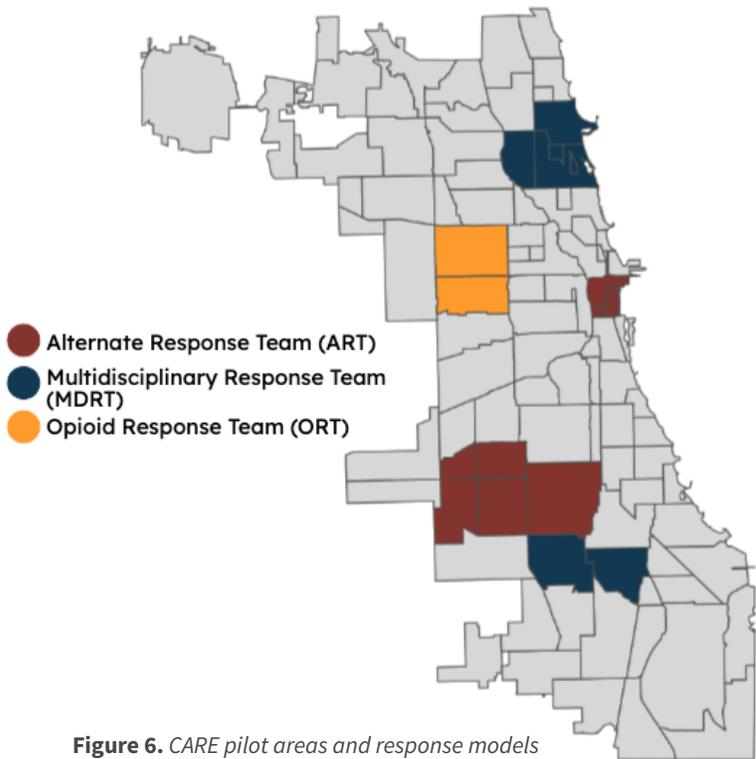


Figure 6. CARE pilot areas and response models

During the pilot period, CARE operated Monday-to-Friday between the hours of 9:30 a.m. and 5:30 p.m. excluding public holidays. The teams actively responded to calls in pilot districts between the hours of 10:30 a.m. and 4:30 p.m.³¹ CARE pilot neighborhoods were chosen based on their elevated levels of mental and behavioral health-related calls and related emergency transports, and, for the overdose response team, the district's elevated levels of overdose responses. CARE teams initially responded to eligible call types for individuals aged 18-65 (age eligibility was expanded to 12-65 during the pilot period; these changes and eligible call types are described in detail below). Figure 6 shows the districts in which CARE operated during the pilot.

During the response, CARE teams provided a variety of services, including face-to-face engagement, de-escalation, medical and psychosocial assessment, referral or warm handoff to community resources, non-emergent transport, and a variety of care coordination with other agencies and organizations.

In addition to conducting the primary filed responses outlined above, CARE teams sought to conduct follow-up visits with CARE clients for each of the response models at 1, 7, and 30 days after initial contact with the individual. Follow-up services included linking individuals to community-based services to ensure their continued safety and stability.

In the first year of the CARE pilot, MDRT units responded to mental health disturbances at private residences, workplaces, and public settings for calls that did not involve the risk of violence (e.g., punching, spitting, kicking, or throwing things), weapons, or criminal acts in progress.

CARE Pilot Expansion and Programmatic Developments

Chicago made several changes to CARE operations over the two-year pilot period. After one year of operating the pilot, the ART teams were launched in June 2022. CARE partners also hired two data analysts to help support CARE operations analysis. The pilot underwent further expansion and programmatic changes during its second year, including:

- In February 2023, ORT teams were launched.
- In March 2023, age eligibility for CARE was expanded from persons aged 18-65 to those aged 12-65; CARE also became eligible to dispatch to a wider variety of call types, including criminal trespass calls with a mental health (MH) component, suspicious persons calls with a MH component, wellbeing checks with a MH component, and threatening suicide calls.
- Between March and July 2023, the CARE pilot expanded into the Far North, the Loop, and South East neighborhoods.

Mayor Brandon Johnson took office in May 2023. Soon thereafter the Johnson administration initiated several changes to the CARE pilot, including ceasing the operation of MDRT and ORT teams. Going forward, from the end of the pilot period, only the ART models are being deployed. Further, the ART units will be comprised of a Mental Health Crisis Clinician and an Emergency Medical Technician (EMT), both employed by CDPH. Thus, CDPH is now the sole agency involved in CARE field responses, while CFD paramedics and CPD police officers are no longer involved in day-to-day CARE program operations.

As Mayor Johnson's Administration worked to implement and formalize these changes, program partners shared that several considerations played a part in eliminating these teams and CPD and CFD's continued involvement. Among the considerations shared was that having three distinct agencies involved in CARE field operations—including separate leadership structures and collective bargaining agreements—created operational complexity that were difficult to sustain, particularly as CARE expands citywide. The city also expressed a desire to pursue a purely behavioral health-driven response model that is more aligned with CDPH's mission.

Throughout the course of the pilot, Health Lab observed both CPD and CFD to be enthusiastic partners. Each agency brought to the table their expertise in emergency response and made meaningful contributions to the program. Nationally and locally, the involvement of these first responders in programs like CARE—particularly that of police—has at times been met with resistance or seen as controversial. We found these agencies and their staff to be extremely engaged and committed to CARE's success, and observed them to have a positive influence on the pilot. We did not see evidence of these agencies being removed from CARE due to any adverse incidents or a lack of support for the project and its goals.

IV. Analysis of CARE-Related Data

During initial planning stages, the City of Chicago asked the University of Chicago Health Lab to support the CARE pilot by conducting an implementation evaluation. The evaluation includes a detailed look at the context, program logistics, processes, and overall development of the pilot, key informant interviews conducted with participating agency leadership and CARE program staff, and analyses of available programmatic data. Through this evaluation, Health Lab sought to test program logistics, provide critical insight into how the pilot was functioning, and support the partner agencies in identifying and resolving potential operational challenges before implementation at-scale. This section presents analyses of the available CARE programmatic data and provides details on the events to which teams responded, locations, services provided, and related dispositions for those responses.

Data Collection and Analysis Overview

To support the implementation evaluation, Health Lab received five years of administrative data from OEMC, CFD, and CPD, as well as CARE Mental Health Crisis Clinician assessment data from CDPH.³² During data sharing negotiations between Health Lab and the CARE partners, the City determined that all data shared with Health Lab needed to be de-identified because elements of the CARE-related data include protected health information (PHI). The inclusion of PHI implicated both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Illinois Mental Health and Developmental Disabilities Confidentiality Act. To accommodate this, the Health Lab team developed and implemented a data hashing strategy³³ that allowed for the de-identification of individual data while preserving the ability to merge individual-specific information across administrative datasets. Due to these privacy and HIPAA regulations, identified administrative data were also not shared between the participating agencies.

With respect to the City's ability to capture CARE-specific program data, several challenges arose throughout the pilot period. The partners' data records management systems were not designed to systematically capture many elements of the events to which CARE teams responded. In many respects, this reflected the multi-agency nature of CARE. To take one example, only CARE "primary dispatches" (that is, dispatches occurring directly from 911 via OEMC) were available for analysis in OEMC's data. "CPD assist" and "self-dispatch" CARE events (described in more detail below) were not recorded in OEMC's CAD system. Again, these data challenges likely reflect the novel multi-agency implementation of the CARE intervention.

To compensate for the lack of data infrastructure needed to capture CARE-specific data in a formalized and systematic manner, partner agency staff met weekly to attempt to cross-identify CARE calls retroactively. While this was a helpful process throughout the pilot (and one in which Health Lab staff regularly participated), these retroactive identifications of CARE calls were not updated in the administrative data. This hindered our ability to identify confirmed CARE responses in the administrative datasets. Health Lab worked closely with agency staff to learn how each organization records and identifies CARE calls. Together we identified several strategies, including using vehicle numbers, incident/event numbers, call/patient dispositions, and corresponding dates and times. These approaches were helpful, though none allowed us to reliably identify the full universe of CARE responses in every instance.

In the end, our partners assisted the evaluation by assembling a separate dataset using CFD data which included all CARE responses during the pilot period. This separate data pull allowed us to pursue several questions we sought to answer about CARE responses during the pilot.³⁴ Many of the analyses below rely on this discrete dataset.

Analysis of CARE Programmatic Data

CARE Events Sept 2021-Oct 2023

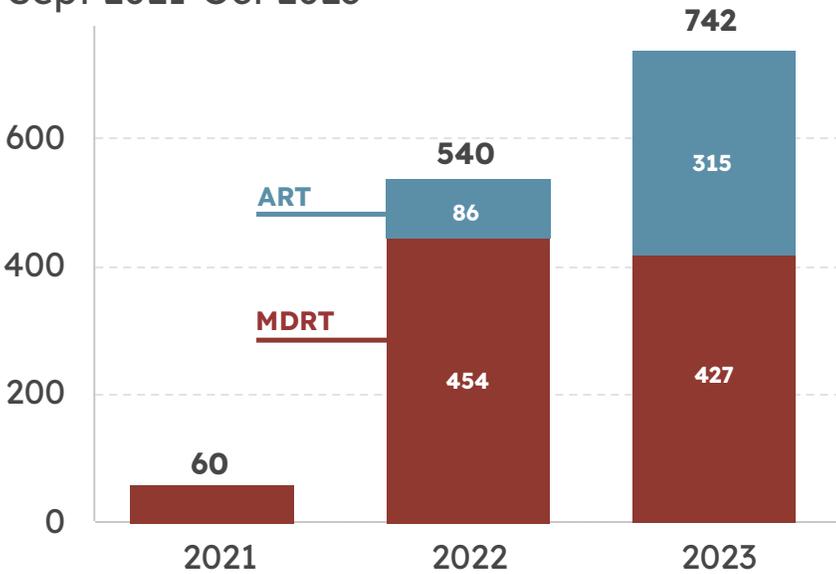


Figure 7. Number of CARE events throughout pilot period (Sept 2021 - Oct 2023) (data source: CFD)

During the CARE pilot from September 2021 through October 2023, CARE responded to **1,348** unique events and served **673** unique individuals.³⁵ MDRT units responded to 70% of events and ART units responded to 30% of events. Impacting this ratio is the fact that MDRT was the only active team model from September 2021 until June 2022, when ART was launched.

The CARE pilot operated for slightly over three months in 2021 (during which two MDRT units were operational), responding to a total of 60 calls for service. In 2022, which included the launch of ART units, CARE responded to 540 calls.

Finally, in 2023, after several expansions to the model—including: 1) broadening the eligible age-range to 12-65 (from 18-65); 2) dispatching to additional call types; and 3) launching the ORTs—CARE responded to 742 calls for service.

A CARE response can be initiated via three types of dispatches:

- **Primary Dispatch:** A primary dispatch refers to a call that comes in via 911, is designated CARE eligible by OEMC 911 professionals, and results in CARE being dispatched as the primary response to an event.
- **CPD Assist:** An assist refers to an instance in which another CPD unit reaches out to OEMC to request that the CARE team be dispatched to assist on scene.
- **Self-Dispatch:** A self-dispatch refers to an event in which the CARE team identifies an eligible call by listening to first responder dispatch radio calls and self-dispatches as a secondary unit to the primary response unit to offer their expertise and support.

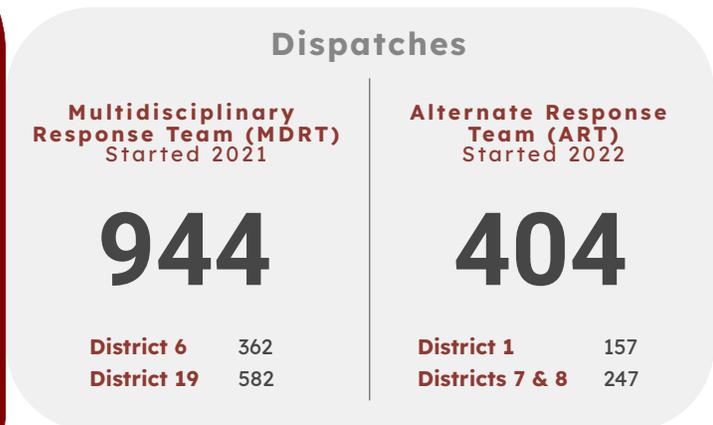


Figure 8. Number of calls responded to by CARE dispatch teams within pilot neighborhoods (data source: CFD)

Of the 1,348 unique events to which CARE teams responded, 1,209 events included specific recorded dispatch types. These include 587 self-dispatches, 401 CPD assists, and 221 primary dispatches, making self-dispatch the primary mechanism for dispatching CARE during the pilot, followed by CPD assists for the MDRT team and primary dispatches for the ART team. This is broken down in Figure 9, where we show totals split by each team.

If we limit the comparison to the period where both teams were active (i.e., between June 2022 – October 2023), MDRT had 683 dispatches (comprising 63% of total CARE dispatches) and ART had 404 (37% of total CARE dispatches).

Dispatch types

	Count*	%*
Self-dispatch	587	44%
CPD Assist/Request	401	30%
Primary	221	17%

*These figures do not include approximately 500 events where dispatch type was not recorded

CARE teams also perform follow-ups with individuals at 1, 7, and 30 days after an initial interaction. These interactions were not fully captured in the administrative data, and thus we could not specifically analyze these interactions.

While CARE teams can each respond to the five CARE-eligible call types, as shown in Figure 10 below, different CARE districts have different volumes of each of the five CARE-eligible call types.

Figure 9. Counts of dispatch types. Note: these counts are not mutually exclusive, as there are several incident/event numbers that are associated with multiple dispatch types. (data source: CFD)

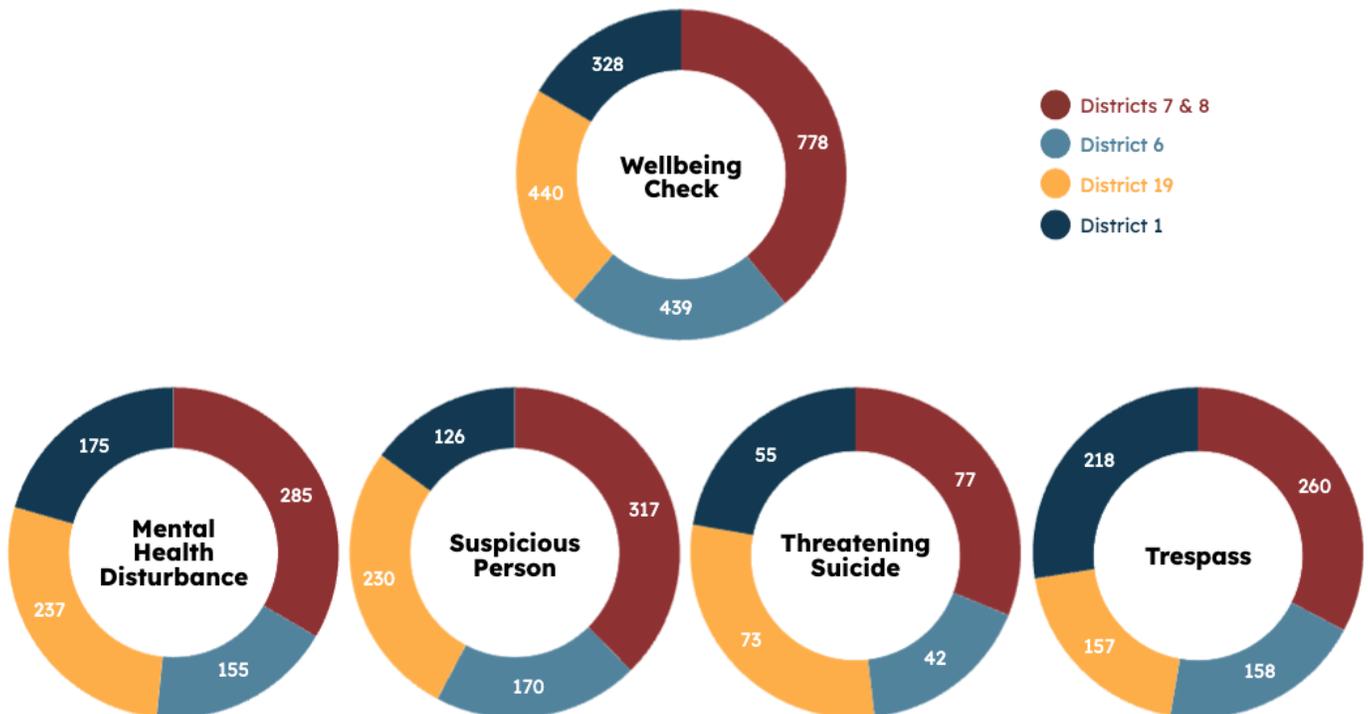


Figure 10. Average annual number of calls between Sept 2021 and Oct 2023 by call type within CARE pilot districts during CARE operating days and hours (Mon-Fri, 10:30 a.m. - 4:30 p.m.) (data source: OEMC)

As shown in Figure 11, the bulk of CARE events took place in north side and southwest side neighborhoods, the first neighborhoods in which CARE was launched.

Heat map of CARE events

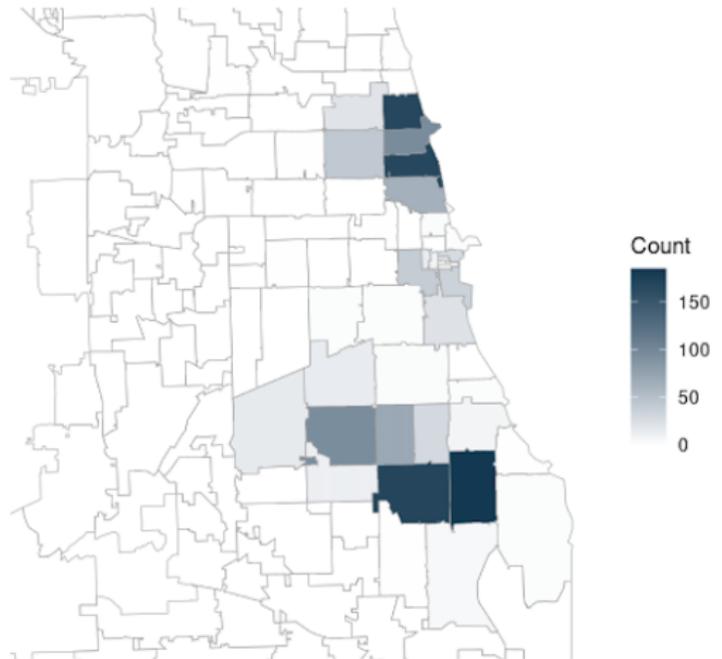


Figure 11. Heat map of CARE events; darker color indicates higher number of events (data source: CFD)

Where did CARE events occur?

	Count
Bus/Train	7
Shelter	13
Police/Fire	14
Medical facility	28
Indoor (Other)	49
Residential	140
Outdoor	147
Not indicated	1132

Figure 12. Distribution of where CARE events occurred/were recorded. Note: Counts shown here are not mutually exclusive, as there are several incident/event numbers that are associated with multiple locations (data source: CFD)

Location type was not recorded for the vast majority of CARE events. For those with a recorded location type, most CARE events took place in outdoor spaces and private residences (see Figure 12).

The average time CARE teams spent traveling to the scene of the event was **16 minutes**,³⁶ the median was **10 minutes**. For CARE teams, the average time spent on scene during calls was **61 minutes** and the median time on scene was **49 minutes**. When broken down by team type, ART units spent an average of 14 minutes traveling to the scene and 53 minutes on scene, whereas MDRT units spent an average of 17 minutes traveling to scene and 64 minutes on scene.³⁷

One hypothesis for some of the increased travel time over the course of the pilot is the possibility that when CARE expanded to the Loop, quite a bit more time was spent in heavy downtown traffic.

As shown in Figure 13a, over the course of the pilot, ART units experienced, on average, an **19% increase** in time spent traveling to scene and a **32% decrease** in time spent on scene. MDRT units experienced, on average, a **171% increase** in time spent traveling to scene and a **43% increase** in spent on scene. Median response times are provided for comparison in Figure 13b.

CARE Team Type	Average time to scene (mins)		Average time on scene (mins)	
	Pilot Start	Pilot End	Pilot Start	Pilot End
ART	12.3	14.6 (▲ 19%)	73.5	49.8 (▼ 32%)
MDRT	7.7	20.9 (▲ 171%)	49.8	71.4 (▲ 43%)

Figure 13a. Average response times between the beginning and end of the pilot period excluding zero-minute values. **Note:** Time-to-scene values only include incidents where CARE teams were able to locate the individual. (data source: CFD)

Green indicates an increase in time over the pilot period

Red indicates a decrease in time over the pilot period

CARE Team Type	Median time to scene (mins)		Median time on scene (mins)	
	Pilot Start	Pilot End	Pilot Start	Pilot End
ART	11.9	11.2 (▼ 6%)	72.4	45.5 (▼ 37%)
MDRT	2.3	11.6 (▲ 404%)	35.0	60.2 (▲ 72%)

Figure 13b. Median response times between the beginning and end of the pilot period excluding zero-minute values. **Note:** Time-to-scene values only include incidents where CARE teams were able to locate the individual (data source: CFD)

Green indicates an increase in time over the pilot period

Red indicates a decrease in time over the pilot period

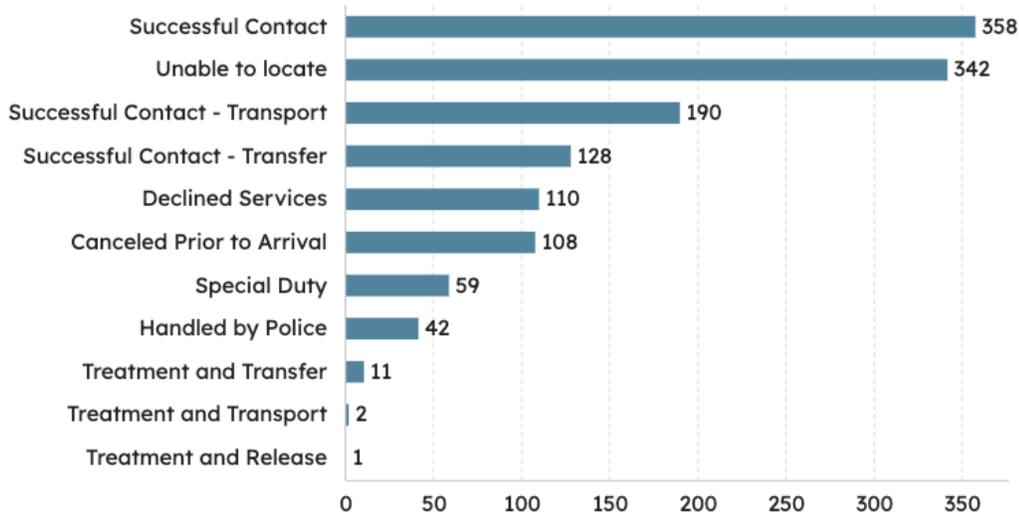
Importantly, average time to scene was far longer for events in which CARE teams were unable to locate an individual. When the response disposition (see Figure 15) indicated that the CARE team was unable to locate an individual, the average time to scene was approximately 45 minutes, compared to an average of 20 minutes to scene when the individual was able to be located. This suggests that CARE teams were not indicating that they had arrived on scene until they either located the individual or stopped searching.

For comparison purposes, Figure 14 below shows CPD response times recorded by OEMC for pertinent call types to which CARE teams might respond. CPD response times range from an average of 4.4 - 5.2 minutes of travel time to scene and 7.3 - 58.9 minutes on scene. Thus, CPD average travel time to scene is less than half that of the CARE team in most cases. This response-time gap reflects the reality that CPD has many more units available within districts (and even more granular patrol areas) than CARE, which had one unit to cover entire districts. Importantly, CARE team vehicles do not have lights or sirens,³⁷ which may have contributed to increased travel time; however, it is not clear, given the typical call priority assigned to pertinent CARE call types, whether traditional first responder units would have used lights and sirens for these calls.

CPD Call Types	Average time to scene (mins)	Median time to scene (mins)	Average time on scene (mins)	Median time on scene (mins)
Check Wellbeing	4.9	4.0	41.0	25.4
Mental Health Disturbance	5.1	3.9	57.0	33.0
Suspicious Person	4.8	3.8	36.1	22.1
Threatening Suicide	4.4	3.4	58.9	29.3
Criminal Trespassing	4.7	3.6	41.4	25.0

Figure 14. Average and median CPD response times for CARE call types (data source: OEMC)

Response Dispositions



The high incidence of "unable to locate" dispositions is likely due to a high number of responses to calls about individuals experiencing homelessness.

Figure 15. Call response results as reported by CARE teams. Note: Counts shown here are not mutually exclusive, as there are several incident/event numbers that are associated with multiple dispositions (data source: CFD)

Figure 15 shows the response dispositions recorded for CARE responses. When CARE teams arrive on-scene, three main contact outcomes can result: 1) **successful contact** (e.g., successfully locating and engaging with the individual which can result in treating on scene, transport to a hospital, or transfer to a different agency); 2) **declined services** (e.g., successfully locating the individual, but CARE services are declined); or 3) **the CARE team may be unable to find the individual** after arriving on scene.³⁸ Calls can also be cancelled for a variety of reasons before CARE arrives on-scene. "Special duty" was generally noted in cases where CARE teams had met with other agencies or community groups, or when they attended public events.

We also examined response disposition data for each CARE team type during the period where both were active (from June 2022 – October 2023). We calculate a “successful contact rate” by taking the total number of calls for service that had response dispositions indicating that a CARE team successfully contacted the individual³⁹ and dividing by the total number of calls for service by team. The successful contact rate for each team type was: **38% for MDRT** and **45% for ART** teams.

Clinician Assessments

Of the approximately 800 clients successfully contacted, 475 received a mental health assessment by CDPH clinicians. Clinicians determined which clients might benefit from a mental health assessment, and clients had to agree to an assessment. During these assessments, clinicians conducted pre- and post-interaction distress tests.

Subjective Units of Distress Scale (SUDs) Scores

Pre-screen score
(avg)

6.4

Post-screen score
(avg)

5.2

Out of **475** assessments conducted, **444** assessments were marked completed and analyzed

Analysis suggests that clients’ self-reported Subjective Units of Distress scores (SUDs) **decreased by 19%** on average post-interaction with CARE clinicians. Although we cannot conclusively determine a causal relationship, these results seem to suggest that interaction with Mental Health Crisis clinicians may bring tangible benefits to clients, including reductions in self-reported distress.

Additionally, **31% of assessed clients reported thoughts of self- or harm to others at some point in their lives** and **34% of clients reported use of alcohol or drugs not prescribed by a doctor**. Further, 30.5% of clients reported at least monthly alcohol use, and 24.5 % reported at least monthly drug use.

Figure 16. Average pre- and post-assessment Subjective Units of Distress Scale scores (data source: CDPH)

Importantly, many of these assessments were performed with police present (e.g., CIT officers on MDRT units), which may have led to underreporting, particularly for illegal activities such as illicit drug use or for responses such as homicidal or suicidal ideation that might occasion a coercive response.

Suicidality & Homicidality

	Yes	No
Ever struggled with suicidal/homicidal thoughts or actions	138	267
Having suicidal thoughts now	63	352
Had suicidal thoughts in the past week	78	331
Suicide attempt (ever)	69	331
Having homicidal thoughts now	22	390
Had homicidal thoughts in the past week	26	382
Homicide attempt (ever)	17	386

Figure 17. Self-reported suicidality and homicidality as assessed by CARE clinicians. Note: categories are not mutually exclusive (data source: CDPH)

Alcohol and Drug Use

	Alcohol	Drugs
Never	255	275
Monthly or less	42	22
2-4 times a month	28	11
2-3 times a week	13	20
4 or more times a week	29	36

Figure 18. Self-reported alcohol and drug use as assessed by CARE clinicians. Note: categories are not mutually exclusive (data source: CDPH)

Assessments identified 60% of individuals as currently involved in some sort of social service programming. As seen in Figure 19, many clients reported unmet basic needs, including for transportation, income, housing, and medical supports.

To help address these needs, CARE team staff provided clients with many forms of support and resources. These included distributing clothing, bus cards, food-related gift cards, snacks, water, and referrals to various community resources.

CARE Case Notes

We also analyzed case notes recorded by CARE team clinicians, paramedics, and officers after interacting with clients. The analysis included about 972 total case notes,⁴⁰ which were analyzed by examining frequently occurring key terms for symptomatic observations made by clinicians. CARE clients were particularly likely to express needs for housing and other basic resources. More than 130 clients stated that they were currently experiencing homelessness, and over 30 additional clients expressed that experiencing homelessness was imminent. Case notes also include clients' observed behavioral health symptoms (Fig. 20).

Roughly 40% of clients presented symptoms related to paranoia or schizophrenia, depression, anxiety, or substance use disorders.

Are clients' basic needs met?

	Yes	No
In services	266	153
Income	209	185
Health insurance	279	112
Transportation access	194	209
Housing security	262	144
Food security	295	105
Weather-appropriate clothes	344	60
Primary care doctor	210	172

Figure 19. Self-reported assessment of clients' basic needs as assessed by CARE clinicians (data source: CDPH)

Top 3 Symptomatic observations

	Count*	%**
Paranoia/Schizophrenia	187	20%
Depression/Anxiety/Bipolar	134	14%
Substance Use	68	7%

*These figures are not mutually exclusive, as most clients presented comorbid psychological symptoms.

**Denominator includes clients for whom no symptoms were recorded.

Figure 20. Symptomatic observations as recorded by clinicians (data source: CFD)

Time Series Analysis of Mental and Behavioral Health Calls⁴¹ by CARE District

District-level call volumes played an important role in the pilot site selection process. Throughout the city, behavioral and mental health calls occur at much higher rates in the late afternoon and less frequent between 3 a.m. – 7 a.m. The red boxes highlight the hours of operation of the CARE teams (10:30 a.m. - 4:30 p.m.).

Figures 21 and 22 suggest that the citywide time trends in behavioral and mental health calls align closely with those observed in the CARE pilot districts. However, as demonstrated in Figures 23-27, there is somewhat greater variance in the timing of these calls between each of the CARE pilot districts.

Heatmap of Behavioral & Mental Health Calls in Chicago

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	3645	3469	3062	2680	2247	1797	1523	1546	1816	2199	2137	2615	2758	2966	3280	3240	3391	3377	3587	3644	3786	3771	3845	3457
Mon	2989	2481	2212	1723	1521	1346	1345	1733	2310	2549	3162	3367	3341	3567	3793	3870	3932	3855	3910	3860	3612	3670	3538	3230
Tue	2687	2239	1859	1582	1397	1333	1418	1790	2341	2772	3148	3305	3331	3560	3723	3802	3917	3957	3721	3666	3636	3737	3613	3254
Wed	2727	2337	1964	1600	1404	1256	1472	1754	2312	2802	3132	3416	3393	3535	3786	3857	3916	3972	3782	3855	3717	3764	3602	3251
Thu	2728	2312	2037	1624	1423	1345	1332	1726	2200	2717	3190	3339	3381	3536	3748	3823	3925	3880	3687	3769	3733	3680	3714	3278
Fri	2880	2566	2212	1828	1565	1394	1450	1734	2352	2749	3124	3316	3496	3468	3718	3886	3930	3907	3858	3738	3838	3833	3993	3746
Sat	3425	3188	2851	2415	2030	1724	1454	1570	1887	2481	2155	2969	3172	3253	3393	3422	3558	3561	3552	3725	3733	3961	3980	3789

Figure 21. Heatmap of behavioral and mental health calls in Chicago (2019 - 2022) (data source: OEMC)

Heatmap of Behavioral & Mental Health Calls in CARE Districts

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	974	915	858	733	655	477	418	417	454	575	677	711	754	739	915	912	907	912	991	964	1001	1029	1027	912
Mon	807	688	605	488	417	391	374	456	664	663	819	911	850	965	1048	1076	1050	1036	1075	983	975	972	921	846
Tue	723	569	496	424	379	383	413	520	646	764	804	871	858	923	965	989	1015	1015	972	966	958	1046	981	839
Wed	739	642	514	436	418	361	366	496	651	803	835	855	936	923	982	1041	1077	1129	981	1017	988	950	942	935
Thu	744	633	596	493	414	364	378	473	630	763	812	870	862	951	968	1042	1113	1016	964	1030	997	1018	1017	915
Fri	772	696	589	482	405	380	372	482	606	744	812	867	956	921	973	1049	1052	1039	1084	1019	1046	1115	1088	1023
Sat	987	883	764	673	560	463	401	390	513	679	710	783	863	879	888	941	970	1004	987	1021	978	1072	1014	1067

Figure 22. Heatmap of behavioral and mental health calls in all CARE districts (2019 - 2022) (data source: OEMC)

Heatmap of Behavioral & Mental Health Calls in District 1

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	181	170	148	137	117	94	82	89	88	118	105	109	148	137	175	151	151	162	191	163	164	163	185	162
Mon	147	117	87	86	68	70	74	103	142	118	145	162	156	171	188	177	201	208	197	164	174	179	155	138
Tue	130	117	98	85	74	77	104	103	127	126	130	137	156	157	183	190	131	189	181	171	184	170	166	154
Wed	114	116	80	67	83	74	69	133	139	165	147	149	173	162	182	196	204	222	175	183	188	182	160	157
Thu	124	119	99	84	93	81	75	95	110	136	134	173	148	179	185	200	201	192	212	193	184	184	187	150
Fri	137	110	120	97	78	76	75	114	122	148	173	158	153	167	159	198	199	199	211	208	177	194	198	176
Sat	189	153	133	105	107	90	78	89	100	125	134	135	141	143	168	169	190	205	189	192	208	197	192	221

Figure 23. Heatmap of behavioral and mental health calls in District 1, which includes The Loop (2019 - 2022) (data source: OEMC)

Heatmap of Behavioral & Mental Health Calls in District 6

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	199	162	151	127	139	84	85	81	106	126	138	172	167	164	190	197	194	175	193	203	185	199	199	180
Mon	165	134	137	98	97	79	66	113	129	144	183	181	193	196	199	223	216	216	239	202	204	183	160	187
Tue	140	122	110	79	73	82	86	123	158	164	189	216	173	194	206	199	215	219	179	208	195	227	219	185
Wed	162	158	131	91	86	86	83	93	120	154	172	178	197	200	229	220	201	220	221	191	203	206	199	179
Thu	166	154	130	121	87	83	83	109	156	180	183	160	173	198	196	208	241	212	190	209	202	195	209	188
Fri	166	163	132	101	94	89	84	92	137	163	159	188	187	183	199	206	221	202	228	202	227	253	227	214
Sat	208	195	155	130	112	99	75	80	120	155	164	174	187	190	186	207	189	227	230	204	187	223	177	195

Figure 24. Heatmap of behavioral and mental health calls in District 6, which includes the neighborhoods of Auburn Gresham and Chatham (2019 - 2022) (data source: OEMC)

Heatmap of Behavioral & Mental Health Calls in Districts 7 & 8

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	389	383	351	289	244	193	167	148	150	216	284	274	280	279	346	346	349	355	347	369	385	403	406	367
Mon	305	273	247	199	170	141	141	140	240	251	319	341	310	375	424	423	379	376	395	376	364	375	397	343
Tue	317	234	200	177	140	145	141	188	225	315	313	323	344	349	353	376	390	386	386	368	354	423	374	324
Wed	295	255	204	201	154	141	137	161	253	308	338	337	354	358	380	399	393	441	361	401	370	362	371	384
Thu	284	240	242	196	149	120	153	164	230	261	304	323	335	365	367	414	416	382	346	388	387	403	395	374
Fri	281	277	213	190	157	141	137	164	228	273	311	335	412	359	372	375	415	403	396	361	409	390	400	414
Sat	401	339	298	268	219	173	163	131	180	246	276	298	350	355	345	363	356	353	355	374	363	400	394	417

Figure 25. Heatmap of behavioral and mental health calls in Districts 7 & 8, which include the neighborhoods of West Englewood, West Elsdon, Chicago Lawn, West Lawn, and Gage Park (2019 - 2022) (data source: OEMC)

Heatmap of Behavioral & Mental Health Calls in District 19

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	205	200	208	180	155	106	84	99	110	115	150	156	159	159	204	218	213	220	260	229	267	264	237	203
Mon	190	164	134	105	82	101	93	100	153	150	172	227	191	223	237	253	254	236	244	241	233	235	209	178
Tue	136	96	88	83	92	79	82	106	136	159	172	195	185	223	223	224	229	221	226	219	225	226	222	176
Wed	168	113	99	77	95	60	77	109	139	176	178	191	212	203	191	226	279	246	224	242	227	200	212	215
Thu	170	120	125	92	85	80	67	105	134	186	191	214	206	209	220	220	255	230	216	240	224	236	226	203
Fri	188	146	124	94	76	74	76	112	119	160	199	186	204	212	243	270	217	235	249	248	233	278	263	219
Sat	189	196	178	170	122	101	85	90	113	153	136	176	185	191	189	202	235	219	213	251	220	252	251	234

Figure 26. Heatmap of behavioral and mental health calls in District 19, which includes the neighborhoods of Uptown, North Center, and Lakeview (2019 - 2022) (data source: OEMC)

Heatmap of Overdose-related Calls in ORT District 11

	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
Sun	82	77	46	50	41	30	50	60	100	112	151	165	211	217	193	209	227	211	211	175	171	119	128	84
Mon	74	41	50	31	33	38	41	73	116	152	214	218	265	255	229	238	240	230	240	198	166	147	136	87
Tue	73	58	49	34	26	40	42	81	140	161	199	237	253	262	265	251	239	243	251	202	155	142	113	108
Wed	78	50	31	34	27	41	31	79	145	170	232	235	273	260	287	222	256	254	242	219	183	149	126	99
Thu	84	54	45	50	31	40	43	96	118	183	202	224	252	254	255	283	261	264	243	231	192	157	127	91
Fri	78	58	47	46	36	29	39	77	137	205	232	280	248	270	270	292	280	296	251	243	187	167	126	131
Sat	104	72	67	55	40	39	38	79	111	168	204	215	241	249	262	236	286	239	260	208	195	179	142	99

Figure 27. Heatmap of overdose-related CARE calls in District 11, which includes the neighborhoods of West Garfield Park, East Garfield Park, and Humboldt Park (2019 - 2022) (data source: OEMC)

V. Lessons Learned

Synopsis of Lessons Learned During the CARE Pilot

A central goal of Health Lab's implementation evaluation was to observe pilot operations and participate in planning and logistics meetings with CARE staff. Health Lab staff joined these meetings regularly, including bi-weekly leadership meetings (these consisted of senior level staff from each of the participating agencies who met regularly to discuss CARE operations), weekly CARE data calls, and others. Health Lab staff also led the technical assistance work associated with de-identification and data sharing. Additionally, in the earliest phase of the pilot, Health Lab embedded a staff member within OEMC to enable our research team to better understand the complexities of the pilot, dispatch, and data collection system. We sought, over the two-year pilot period, to gather operational insights and programmatic lessons to help inform the partners, particularly ahead of expansion, and to eventually offer insights to policymakers and practitioners implementing similar programs in other jurisdictions. Insights generated by our team (and, indeed, our CARE partners as well) include:

1. **Traditionally, implementing risk management strategies is often an internal process for agencies. The cross-agency CARE pilot, however, required the partners to work together to assess both internal risks (e.g., within agency) and external risks (e.g., from outside and among the partners between agencies generally).** This process required and received strong commitment from leadership, engagement in ongoing discussion and negotiation, and oftentimes acceptance of changes to longstanding agency practices.

Risk tolerance was a critical part of CARE conversations, particularly with respect to developing strategies to reduce the potential of violence during responses. In exchanges that we observed, CPD leadership felt a particular responsibility for the safety of the CARE team staff. They often expressed concern about the need for CPD officers involved in the MDRT units to take responsibility for the safety of their unarmed CFD and CDPH partners, neither of whom had received the field safety training police officers receive. However, these concerns seemed to abate over the course of the pilot. Among the CARE direct service teams themselves, members of each partner agency appeared to demonstrate growing appreciation for their partners and the unique skillsets and training brought by each agency and each team member.

Throughout the pilot, the CARE leadership partners demonstrated an ability to collaboratively assess risk, and to identify pathways toward resolution. Early in the pilot, the CARE teams received fewer eligible calls than anticipated. Upon closer examination, it appeared that calls were frequently being deemed ineligible for CARE because a crime was in progress; many such calls involved trespassing. For example, a manager from a local business would call 911 to report that someone who appeared to be experiencing a mental health crisis was refusing to leave the premises. The leadership group discussed the issue, eventually agreeing that, despite the question of trespassing, this was exactly the type of case to which everyone expected CARE to respond. They collectively decided to change policy and provide additional training to the requisite staff. This and similar processes led to the expansion of CARE-eligible call types described in Section 2.

2. **Agency culture, norms, values, and assumptions played vital roles in pilot implementation and decision-making.** Over the course of the CARE pilot, differences in these cultures, norms, values, and assumptions were evident in both leadership and direct service staff. In police and fire agencies, decision-making processes tend to be directly linked to hierarchical structure. In many situations, if a responding unit has a question while on a scene or at an event, they would consult a superior who would then make the decision. These processes are in place to ensure timely decision-making and delegation, as well as direct and clear lines of communication when challenges emerge.

These lines easily become muddled in a multi-agency collaboration such as CARE, when multiple agencies and personnel at different ranks seek to contribute their individual expertise in collaborating on decisions to advance the best interest of both involved personnel and clients. Each direct service staff member on the CARE team has a superior from their home agency. Since the supervisors all work for a different agency, they bring their agency's culture, norms, and values to interactions. It can be difficult to determine who has the final say on critical and fast-moving matters, such as whether the team can self-dispatch to an event or whether an emergency transport is necessary. Similarly, who determines the need for additional supports, such as police presence? These are just a few examples of a series of similar questions that have been considered.

Analogous processes in policy and procedure decision-making existed throughout the duration of the CARE pilot. For example, during 911 call review processes, agency representatives often expressed different perspectives regarding whether a particular policy change or adaptation should be made. As noted above, we found many instances in which the agencies were easily (or not so easily) able to come to consensus. Yet at other times, the agency with the strongest conviction or “voice” seemed to win. There were no clear indicators regarding who had final say; partners often had to quickly and carefully navigate such challenges. This was not a negative result; within many organizations, this is how decisions are made. However this did seem to be a clear departure from preexisting agency culture in many instances, and highlights the need to be cognizant of this dynamic for CARE and other similar cross-agency programs and pilots. This dynamic could also produce frustration when members of the team felt that they were not being heard or that their ideas and expertise were not being taken into consideration.

A similar example can be found in the “culture shock” or adjustment, particularly that was experienced by CDPH’s crisis clinicians as they worked within the more paramilitary cultures and structures of CPD and CFD (and perhaps vice versa). CDPH team members noted that working out of a CFD administrative building (where the CARE pilot was headquartered) highlighted the difference that these agencies’ hierarchical leadership structure created, and highlighted the challenges of navigating these structures. In team meetings, some agencies encouraged an environment of open dialogue, while others appeared to expect staff to listen and speak only when asked to do so. Staff also shared that some agencies instituted oversight systems that were more disciplinary in nature, which sometimes created tension when discussing topics like missed opportunities or mistakes.⁴² For some staff this created a fear of being disciplined if they made a mistake, which in turn led them to feeling less willing to try new approaches or to voluntarily engage in activities such as self-dispatching to a call.

One aspect of traditional first response is that partners on a responding police or paramedic unit must deeply trust one another to feel safe and supported. Trust and understanding are often built through intensive training—the same training—and time spent working together in the field developing shared experiences and a common language. This is intentional; field response training and systems are set up to create a level of trust and familiarity that allows one to anticipate and support a partner’s actions (or inactions).

With respect to CARE, these teams did not have the same levels of experience with one another and thus did not have pre-existing trust in each other during the early days of the pilot. Building such trust required time, and required shared interactions with each other and with clients in the field. Team members did not join CARE having received the same training; they also did not have years of experience working in the field together. Because the team members on CARE all had different areas of expertise and training, it took time to learn each other’s roles and develop a sense of teamwork, trust, and communication.

The partners planned trainings, including coordinated learning opportunities, role-playing and similar exercises, to address these concerns. At the pilot’s onset, there were no standardized and well-documented training programs designed to achieve these goals. To create effective trainings, partners were required to cobble together modules from disparate courses and training programs. The field would benefit from distinct training programs that can address common issues that arise within multidisciplinary teams.

3. Staffing decisions—including hiring, pay scales, and retention measures—are key to pilot development, program sustainability, and considerations for scaling. These require dedicated and stable funding. Out of necessity, the agencies took different approaches to staff the pilot. CDPH had funding to hire the crisis clinicians needed to staff the CARE teams. CFD did not have such funding; nor did it receive an additional budget allocation to hire paramedics to staff CARE. Instead, CFD detailed paramedics daily from a pool of pre-selected existing community paramedics. CPD fell somewhere in-between, using a combination of CIT officers who volunteered, as well as those who were detailed to CARE. The different approaches to staffing the pilot seemed to have a direct impact on program operations, as there were many days on which the pilot did not operate due to lack of staff availability. This included staff being on furlough, on vacation, needed elsewhere, or being injured—particularly for CFD and CPD staff, who were not able to be exclusively assigned to CARE. Another important factor in staff availability—described in more detail below—was the determination by the Illinois Department of Public Health (IDPH) that CFD paramedics could not staff different CARE team types.

Lost opportunities for additional remuneration posed another important challenge to hiring and staff retention. Police officers and paramedics generally have opportunities to earn overtime pay, such as by working an excess of hours, on holidays, or at special events. Those detailed to CARE did not have those opportunities due to agency policy as well as the pilot's shortened operational hours. In planning for program sustainability and scalability, such compensation disparities must be addressed.

4. 911 professionals are essential to the success of new forms of crisis response. It is important to recognize this workforce's critical gatekeeping role. They are relied on to use their best judgment to discern the optimal and most appropriate type of response. They also undergo high levels of review and quality assurance, whether or not they actively participate in a pilot such as CARE. These processes are necessary, given the impact 911 professionals' decisions can have on the lives of callers, responders, and others. In our experience, 911 professionals often worry that if they elect not to dispatch police and something goes wrong, they personally or their organizations may be held responsible if harm occurs.

In the CARE pilot, OEMC primarily played a behind-the-scenes, but nonetheless essential role. In the example about the lack of primary dispatches in early phases of the pilot, leadership came to realize that OEMC's 911 professional staff did not feel fully informed about the CARE pilot or its goals, and that they experienced some level of discomfort with dispatching calls to CARE generally. This was addressed in a few different ways. First, the CARE leadership team provided additional training about CARE and their role in the pilot. They also started to regularly share CARE “success stories,” to help demonstrate the effectiveness (and safety) of CARE responses.

It was also important for the 911 staff to build relationships and engage in trust-building with these new teams. They have spent years developing trust with and knowledge about police and other first responders' operations. They need intentional exposure to develop the same sense of familiarity and trust with this new workforce. In recognition of this, the CARE leadership team implemented roll call trainings where CARE leadership could introduce themselves and describe the pilot and its goals to the 911 staff. They scheduled informal meetings between OEMC staff and CARE responders so everyone could get to know each other and their respective responsibilities. Similar meetings and roll call trainings were held in police precincts within CARE pilot districts for the same reasons. One suggestion we offer for program sustainability and scalability is that leadership create more opportunities for interaction between CARE team members and 911 staff (and other first responders), including ride-alongs with CARE teams, observations of 911 staff, and other both formal and informal opportunities to interact with each other as a part of ongoing activities and trainings.

The success of pilots like CARE relies on the ability of the people answering 911 calls for service to have the support and resources required to appropriately identify, assess, triage, and send the right response at the right time—and to feel comfortable and that it's safe for on-scene responders to do so. This requires relationship and trust-building, additional training, and perhaps a degree of cultural change. It is important to involve these staff in early discussions about the pilot, to hear and address their concerns, and to engage them as critical partners in the planning process, day-to-day operations, and incident reviews.

It is also important to recognize the stress and pressure that they may experience given the nature of the pilot (and potentially its visibility), which is compounded by the excessive stress and low levels of occupational support 911 professionals generally receive both locally and nationally. 911 professionals do not often have access to occupational wellness supports, such as debriefing and counseling to help address trauma and other stressors experienced while managing difficult calls, and the compounding stress associated with long-term exposure to traumatic events. The stress they experience and worry they may have about making a mistake or an on-scene responder being harmed can have significant impacts on the success of these new forms of crisis response. It is noteworthy that CDPH clinical staff and leadership spent many hours providing such occupational wellness supports to OEMC staff during the pilot. For sustainability, these types of supports should be built into OEMC's (and other ECC)'s operational practices.

5. The regulatory and policy environment exerted major and unexpected influence on the pilot, particularly in the early days. Regulatory and policy issues occurred at the agency-, local-, and state-levels, impacting the timing of the pilot launch, day-to-day logistics and operations, and—likely—the overall volume of calls responded to during the pilot period.

A key challenge was especially pertinent to CARE team paramedics. IDPH is responsible for paramedic licensure in the state and requires that all policies involving paramedics be submitted to them for approval.⁴³ Thus in practice, every time a protocol, policy, or procedure involving CARE paramedics was developed or amended, this required approval by IDPH. For example, when protocols for the MDRT, ART, and ORT were drafted, they had to be sent to IDPH for review and approval. IDPH also had to review any amendments, such as when new call types were made eligible. Moreover, IDPH had to approve operational details, such as the design of CARE vehicles. The review periods, particularly at the beginning of the pilot, were lengthy, though over time CARE partners learned to anticipate IDPH requirements, with corresponding significant improvements in IDPH review times.

IDPH determinations significantly influenced pilot operations. For example, IDPH determined that paramedics could not be interchanged between team models (e.g., paramedics serving on MDRT units could not substitute in or also work on ARTs and vice versa). This impacted the fluidity of operations and sometimes prevented CARE teams from operating when needed paramedics were not available.

Other regulatory and policy impacts on CARE team operations are also noteworthy. Prior to the launch of CARE, each partner agency operated under their own standard operating procedures (SOPs). Prior to CARE, very few, if any, cross-agency SOPs existed. As a result, partners' SOPs that impacted the operation of the CARE teams often conflicted with each other. Many of these appeared mundane on their face, but turned out to create pressing issues requiring resolution before the pilot could move forward. Below we outline a few examples, and their impact on the pilot:

- **CARE uniforms:** CPD and CFD each have specific personnel uniform requirements, including detailed instructions for core uniforms, headwear, badges, outer garments, etc. Adopting uniforms for CARE staff required the partners to come to agreement on the form, function, and purposes of CARE uniforms. While most seemed to agree in principle that CARE uniforms should be differentiated from traditional first responder uniforms, each agency had to go through their own approval processes. However, CPD and CFD often had different policies regarding things like clothing type (e.g., sleeve length, collars, etc.), material, colorways, and logos/patches (e.g., where should logos be placed on the uniform). Agreement on uniforms was eventually reached, but negotiations led to delays in launching the pilot.

- **CARE vehicles and equipment:** Agreement on CARE vehicle requirements also proved difficult and time-consuming. The shared nature of the CARE vehicles—which were essentially sprinter vans—meant that its use requirements were not entirely in line with that of fire/EMS vehicles; nor were they completely aligned with police cruisers. CPD and CFD each have different vehicle regulations, including those related to models, features and functionality, safety protocols, transport regulations, and related training requirements. They also have different systems in place for purchasing and performing vehicle maintenance. CFD ultimately took responsibility for acquiring the CARE vehicles, but had to navigate many compliance issues, requiring much negotiation between the partners on safety features, ventilation, radio equipment, and even vehicle wrapping/logos.

Additional issues surfaced after CARE vans became operational. At first the vans didn't have seatbelts or speakers in the back. Lack of seatbelts created safety challenges because the MDRT units had three personnel, one of whom sat in the back. Similarly, CARE personnel sitting in the back had difficulty hearing radio transmissions. The CARE partners also had to figure out how to provide CARE vehicles with appropriate access to police and fire radio channels so that the teams could be dispatched to primary calls and listen in for assists and self-dispatches.

Again, navigating these changes required adaptation of existing agency protocols to suit the particular needs and use cases of the CARE teams. Addressing these complex and often conflicting policies took time and led to delays.

- **CARE staff schedules and breaks:** Each of the agencies' unions mandated different staff schedules and lunch break periods, creating several operational challenges. Following their agency's union requirements, CARE paramedics and officers started earlier in the day than CDPH's crisis clinicians, leading to delays in shift start times. Similarly, union requirements mandated different-length lunch breaks. This created obvious challenges for CARE teams when trying to conduct operations out of one van. As of this writing, this issue has not yet been resolved, but should no longer pose a challenge once CDPH becomes the sole agency responsible for CARE operations.

In summary, rather mundane issues greatly impacted the project timeline. While it's possible that some of these issues could have been identified and resolved prior to launching the pilot, the reality is that there was no roadmap in place for the involved agencies to navigate the complex cross-agency issues that arise in a multi-agency initiative such as CARE. We suspect that many jurisdictions attempting to launch similar cross-agency partnerships will experience similar challenges. Resolving these requires navigating multiple and often conflicting regulatory environments, highly varied timelines and staff bandwidth requirements, and some frustration. Staff and leadership from each of the CARE partner agencies demonstrated high levels of commitment and collaboration in identifying and resolving these challenges.

6. **Cross-agency partnerships like CARE often require establishing new policies and procedures, including those for capturing newly created operational information and programmatic data. The creation of data infrastructure, the ability to systematically capture programmatic data specific to these new teams and figuring out ways to appropriately share information between the participating agencies is vital for—and can have significant ramifications on—program operations, quality assurance and improvement, and the potential for evaluation.** This is particularly so for a program like CARE, where the partner agencies do not share the same records management or database systems, and have wide discrepancies in their data practices. Sharing data across agencies also presents numerous legal and privacy considerations, particularly when this involves PHI or other sensitive data. These considerations prevented—and continue to prevent—the CARE partner agencies from sharing data with each other (even when it is clear that they have access to the same information separately in their own agency's databases). This poses a variety of challenges, hindering efforts to comprehensively analyze programmatic data, and creates numerous hurdles for quality assurance and improvement activities.⁴⁴ We recommend that the partners collaborate closely to establish clear and practical data pathways for capturing CARE programmatic data that are at least on par with the data collected for standard response units, and incorporate the ability to capture additional behavioral health-related data required for a program like CARE.

During the pilot period, CARE was still very much in its formative stage. So, analysis and performance measures for this implementation evaluation are largely focused on logistics and service deployments rather than outcomes, agency performance metrics, or social impacts. Pilot operations were limited to a small number of neighborhoods (i.e., areas which were chosen for their high level of need), limited operational hours, and a small number of response teams. The partner agencies were enthusiastic about the program throughout the pilot period. In many respects, this was the first time these agencies partnered with each other in such a significant way. As is the nature of pilot programs, many operational, logistical, and regulatory obstacles surfaced over the two-year pilot period. CARE leadership and city policymakers learned from and adapted to these challenges, which in turn, led to programmatic changes over the course of the pilot.

Health Lab's implementation evaluation sought to capture as many details as possible about the operational logistics, detailed program activities, partner relationships and decision making, and descriptive program outputs over the two-year pilot period. We hope that these findings will help inform policymakers in Chicago—and, eventually, those in other jurisdictions—as CARE continues to grow toward implementation at-scale across Chicago.

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- 1 Viewpoints and opinions expressed within this document are those of the authors. They do not represent those of the City of Chicago Office of the Mayor, Chicago Department of Public Health, the Chicago Fire Department, the Chicago Police Department, the Office of Emergency Management and Communication, Illinois Department of Public Health (IDPH) EMS Region 11, nor those of The Joyce Foundation, Pritzker Pucker Family Foundation, Chicago CRED, Charles and Lynn Schusterman Family Philanthropies, the American Public Health Association, or the Centers for Disease Control and Prevention. The research reported in this publication was also supported by the National Institute on Drug Abuse of the National Institutes of Health under Award Number R21DA055639. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
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- 27 Throughout this document you will see reference to both neighborhoods and districts. Districts are a geographical reference utilized by CPD and OEMC for dispatch and operations. Most of the available data are organized at the district level. The analyses in this section will reference both districts and neighborhoods.
- 28 Districts 6 and 9.
- 29 Districts 7, 8, and 1.
- 30 District 11.
- 31 Shortened hours of response were partially due to the different staff schedules and lunch break periods driven by the divergent terms in each agency's collective bargaining agreements. These are discussed in more detail in Section V (5).
- 32 Health Lab did not receive any data on youth under the age of 18 or data related to sexual violence. Location data were limited to zip code and police district; event addresses were not shared due to privacy concerns. Additionally, Health Lab received slightly different administrative data timeframes from each agency, as outlined below:
- CDPH mental health assessment data ranging from September 2021-September 2023
 - CFD data from January 2019-December 2023
 - CPD data from January 2019-September 2023
 - OEMC data from May 2019-May 2023
- 33 Data hashing involves a process of converting text into a fixed-size, cryptographic string of alphanumeric characters (hash value) based on the contents of the data. The process of hashing transforms potential identifiers—such as name, address, or birthdate—into de-identified alphanumeric “strings.” For this analysis, individual names (and, in some cases, birthdates) were hashed. To accomplish this, Health Lab staff worked closely with data analysts from the city's agencies to implement the hashing strategy so that no Health Lab staff ever had access to identified data.
- 34 For example, our data did not include CARE-eligibility criteria (e.g., questions asked by 911 call takers used to assess the appropriateness of a CARE response, such as whether there were any violence concerns), limiting our ability to analyze the impact of eligibility determinations on CARE deployments.
- 35 Note: The data represented in Figure 6 do not include six CARE responses for which no date was recorded.
- 36 Time to scene calculations exclude instances where the difference between the time at which the **unit was notified by dispatch** and the **unit arrived on-scene** was zero minutes (“zero-minute values”). These exclusions account for approximately 14% of all calls. We suspect that this occurred when CARE staff accidentally (or by default) entered the same time for dispatch and arrival.
- 37 During the pilot, it was determined that CARE team vehicles were not intended to be classified as emergency response vehicles. As such, the request for CARE to be able to use lights and sirens was not approved by the Illinois Department of Public Health (IDPH), which is consistent with the National Association of EMS Physicians (NAEMSP) policy on use of lights and sirens in EMS: <https://naemsp.org/news/joint-statement-on-lights-siren-vehicle-operations-on-ems-responses/>.
- 38 Due to lack of data, we were not able to examine the response dispositions associated with each team model. Our partners did share with us, however, that the ORT model's low successful contact rate was a main consideration in the city discontinuing this model.
- 39 Successful contact events include: Successful Contact; Successful Contact - Transport; Successful Contact - Transfer; Declined Services; Treatment and Transfer; Treatment and Transport; and Treatment and Release.
- 40 Health Lab researchers conducted an analysis of 1,999 CARE case notes. After removing duplicative notes, cancelled calls, and notes deemed unintelligible due to the deidentification process, the final analysis included 972 case notes.
- 41 Includes the following call types: check well wellbeing (CHECWB), threatening suicide (THREAS), and disturbance with a mental health component (DISTME).
- 42 This was the case even when punitive actions were not being taken. Some team members reported that it nonetheless felt more like a punitive conversation than a learning opportunity.
- 43 IDPH has designated 11 EMS Regions under which all EMS services in the state are coordinated; Chicago is designated as EMS Region 11.
- 44 We note here that the partners did conduct biweekly quality assurance (QA) meetings, including call reviews, during the pilot period. Additionally, IDPH performed clinical QA reviews. However, these processes required a time-consuming and tedious approach whereby OEMC removed all identifiers from call audio ahead of each meeting.