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This is How We Care for One Another

Evaluating How Canopy Roots BCR Reimagines Safe Communities

August 2025

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Executive Summary

The Minneapolis Behavioral Crisis Response (BCR) service, operated by Canopy Roots, represents a transformative approach to public safety. Launched in December 2021, the program has grown from a pilot with two vans to a comprehensive, 24/7 operation with over 40 responders handling more than 10,000 annual calls. Minneapolis' choice to award its BCR contract to Canopy Roots—a local, majority Black-owned and woman-led mental health agency—reflected the community's demand for culturally responsive, trauma-informed care.

Importantly, Canopy Roots frames their work not as an alternative response but as an appropriate response to mental health-related community incidents. This reframing moves us beyond the traditional paradigm, in which police response is the default—and only—response, instead recognizing that when mental health is causing the crisis, someone with mental health expertise should lead the crisis response.

This report, the result of a 20-month developmental evaluation by the Minnesota Justice Research Center (MNJRC) in partnership with Canopy Roots, is the first comprehensive assessment of Minneapolis's emerging approach to BCR. In our study, we employed a collaborative, mixed-methods research design that prioritized community input and adaptive learning. Alongside in-depth analysis of organizational documents and training materials, national reports, and media coverage of BCR, our team analyzed nearly 11,000 call logs (a year's worth of Canopy Roots' responder contacts, from which we extracted a subsection of call narratives for further analysis), gathered and analyzed just over 500 community survey responses, and conducted 6 direct observation sessions (ridealongs with BCR teams). We further conducted and analyzed 36 stakeholder interviews and 1 focus group with BCR responders, Canopy Roots' staff and Community Advisory Board, community members, police officers, and other safety ecosystem partners.

The evaluation sought to answer Canopy Roots' research questions about the national BCR landscape, the Minneapolis BCR model, the needs of community members, BCR within the city's safety ecosystem, community member and other first responder perspectives of BCR, and how best to measure success and expand intentionally. We then offer recommendations to help Canopy Roots staff embed evaluative thinking into ongoing practice to facilitate iterative, community-informed learning.

Key Findings

1. **Mental health crisis response teams are transforming community safety across America.** With hundreds of programs now operating nationwide and emerging Substance Abuse and Mental Health Services Administration (SAMHSA) standards, the measurable results are clear: mental health crisis response results in fewer arrests and reduced police use of force, and it boasts strong public support and an excellent safety record. The challenge now is scaling these promising models.

2. **Canopy Roots BCR offers a comprehensive reimagining of crisis response that aligns with best practices.** Canopy Roots' cohesive model weaves together five trauma-informed guiding principles (non-threatening and unarmed presence, cultural

responsiveness, human dignity, self-determination, and barrier-free access) with 24/7 city-wide operations, tiered clinical oversight, and an evidence-based "Engage-Assess-Intervene" framework that aligns with national standards and best practices for trauma-informed crisis intervention.

3. **Canopy Roots BCR serves diverse residents with serious mental illness symptoms, revealing citywide community needs.** Responders are encountering individuals in states of paranoia and delusion, people struggling with coherent speech or basic hygiene, and those experiencing such intense agitation or despair that they pose a danger to themselves or others - visible manifestations of systemic challenges that extend beyond individual circumstances. In-depth analysis of call narratives identified six primary drivers of calls for assistance: mental health crises, welfare checks, substance use disorder, housing/basic needs, family/relationship conflicts, and safety/violence risk. BCR call data could contribute to a citywide needs assessment that could impact broader policy conversations, funding decisions, and community development efforts.

4. **BCR is perceived by other first responders as filling a critical gap in emergency response.** Other first responders at all levels—from police leadership to patrol officers, firefighters, and county agencies—voiced consistent and growing support for BCR teams, viewing Canopy Roots as filling a critical gap with their unique training and expertise. Some tensions and challenges persist around safety protocols, scope of authority, and system integration as collaborative efforts continue to develop.

5. **Community members strongly support BCR despite key awareness gaps.** While less than half of community members knew about BCR before being surveyed, once informed, support was overwhelming—91% backed unarmed alternatives to police response and 88% reported increased feelings of safety knowing the program exists. Direct experiences with BCR are consistently positive, with recipients and witnesses praising the program's compassionate, respectful approach despite some concerns around response time.

6. **Canopy Roots is well-positioned to pioneer new metrics that could capture BCR's complex contributions to community safety.** Many rubrics have been identified for assessing mobile crisis response programs. Most are based on law enforcement paradigms and include metrics such as the number of calls and response times. These are important metrics, but they cannot fully capture BCR's complex contributions to community safety. Canopy Roots is well-positioned to pioneer metrics such as presenting community needs, call outcomes, and community and system-level outcomes.

Recommendations

Our findings serve as a learning map, including a theory of change that shows how Canopy Roots' principles and services connect to outcomes for individuals, communities, and systems.

We recommend Canopy Roots continue and build on the following **strengths**:

1. Monitor national and local efforts
2. Solidify and operationalize a theory of change

3. Share innovative secondary trauma prevention models with other first responder agencies
4. Continue strong ecosystem collaboration

We recommend Canopy Roots consider the following possibilities for **growth**:

5. Move from ecosystem collaboration to integration
6. Enhance emergency response capability
7. Prioritize workforce retention and development

We recommend Canopy Roots invest in the following **improvements**:

8. Invest in a broad education campaign
9. Expand recipient feedback

Finally, we recommend Canopy Roots build on their **outcomes:**

10. Gather and share evidence of BCR's community safety impact
11. Bolster data collection practices and increase transparency

Canopy Roots' Behavioral Crisis Response program in Minneapolis represents a transformative approach to public safety that extends beyond traditional crisis intervention. Throughout this evaluation, the voices of responders, recipients, community members, and safety ecosystem partners have told a compelling story of a program that is reimagining how communities respond to human suffering.

By centering holistic definitions of safety, BCR creates space for human dignity even in moments of profound crisis. As Minneapolis continues evolving its public safety systems, the BCR program offers a compelling model worthy of continued investment, refinement, and expansion. The path forward is not without challenges, but the foundation is strong. BCR can continue growing as an essential component of a truly integrated community safety approach—one that recognizes that compassionate care is not merely an alternative to traditional public safety but an essential component of modern public safety.

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Chapter 1. *Background and Methods*

Why Minneapolis Behavioral Crisis Response: The Four Key Problems

Minneapolis stands at a critical juncture in re-imagining public safety. The murder of George Floyd in May 2020 exposed deep fractures in community trust toward the Minneapolis safety system. The watershed moment and subsequent inquiries into policing in the city prompted a necessary examination of city responses to behavioral crises amid the interconnected challenges of homelessness, substance use, and untreated mental illness.

The current system faces four fundamental problems: a profound crisis of trust in public safety institutions, escalating rates of homelessness and addiction alongside insufficient mental health resources, a problematic paradigm that prioritizes punishment rather than public health approaches, and the disproportionate impact of all three on BIPOC communities, which experience both over-policing and under-treatment.

Problem #1: A Crisis of Trust

The murder of George Floyd in Minneapolis catalyzed nationwide community efforts to critically evaluate public safety models and explore alternatives to traditional policing. This tragedy, along with numerous other police killings, exposed a fundamental lack of trust in the conventional safety system, especially among Black, Indigenous, and People of Color (BIPOC) communities, which have historically experienced over-policing and under-treatment for mental health concerns. In Minneapolis particularly, the incident shed light on a profound crisis of trust between law enforcement, city government, and the communities they serve (Morrissette, 2023, Minnesota Justice Research Center, 2021)., For many Minneapolis residents, especially those in BIPOC communities, Floyd's death wasn't an isolated incident but a visible manifestation of long-standing concerns. Surveys revealed that less than a quarter of Minneapolis residents believed police were held accountable for misconduct, (Jannetta, 2020) with Black Minnesotans consistently reporting significantly lower levels of trust in law enforcement compared to their white neighbors (Collins, 2021). In North Minneapolis and similar communities, residents frequently described a paradoxical experience of feeling simultaneously over-policed yet under-protected (Phelps et al., 2020). Many recounted stories of racial targeting and harassment during routine interactions with police, creating an environment where those most vulnerable often hesitated to call for help during crises.

Deepening the crisis of trust, data confirm that people with serious mental illness face dramatically higher risks of experiencing police use of force (11.6 times higher) and injury (10.7 times higher) compared to those without mental illness, with these disparities exceeding the racial disparities measured in the same cities. When these vulnerabilities overlap—when a person is both Black and experiencing mental health challenges—the statistical likelihood of experiencing harmful or fatal police encounters becomes devastatingly high, revealing an urgent need for comprehensive reforms to law enforcement responses to mental health crises (Laniyonu & Goff, 2021).

Problem #2: Connected Crises of Housing, Substance Use, and Mental Health

Minnesota faces a convergence of three escalating crises—rising homelessness, increasing substance use, and inadequate mental health treatment—that has resulted in more people experiencing severe mental health and substance use emergencies in public spaces.

In Minnesota, as of 2023, 33% of individuals who are unhoused are now living outside (Wilder Research, 2025) rather than in shelters, and the state experienced a 22% spike in opioid deaths from 2020 to 2021 (Minnesota Department of Health, 2024). National data in 2022 indicated that 15.4 million Americans are struggling with serious mental illness (SMI) . These interconnected challenges have created a visible public health crisis. The same 2022 national sample shows that young adults aged 18-25 years are particularly affected, with the highest prevalence of serious mental illness (11.6%) compared to adults aged 26-49 years (7.6%). The cyclical nature of these issues—wherein untreated mental illness leads to housing instability, homelessness drives substance use, and both contribute to increased police calls and emergency room visits—is exacerbated by treatment barriers (Substance Abuse and Mental Health Services Administration). In Minnesota, the Department of Health reports that 17% of those seeking help for mental health or substance disorder are delayed or denied care (Minnesota Department of Health, 2024; Dillon, et al., 2024).

This perfect storm has pushed mental health and addiction crises from behind closed doors into parks, streets, and public spaces, where between 21 and 38% of 911 calls are related to mental health, substance use, homelessness, and other quality of life concerns. Once-private struggles are, increasingly, visible parts of community life (Turner, 2022).

This perfect storm has pushed mental health and addiction crises from behind closed doors into parks, streets, and public spaces, where between 21 and 38% of 911 calls are related to mental health, substance use, homelessness, and other quality of life concerns. Once-private struggles are, increasingly, visible parts of community life.

Problem #3: Punishment Over Public Health

The increased visibility of homelessness, substance use disorders, and serious mental illness has created a complex mix of compassion and fear among Minneapolis residents. This tension reflects deeper challenges around SMI. Unlike temporary periods of sadness or anxiety, SMI encompasses persistent conditions like bipolar disorder or schizophrenia that make it challenging to maintain employment, sustain relationships, and handle routine responsibilities. Social stigma complicates these challenges, as mental illness remains one of the most stigmatized conditions in society, with persistent perceptions that people with SMI are dangerous and unpredictable (Albrecht et al., 1982; Corrigan & Penn, 1999; Tringo, 1970).As a result, the usual "solution" is to remove such people from public spaces and/or to punish them.

In other words, despite officers typically lacking adequate training for such situations, traditional law enforcement has become the primary response to mental health emergencies. Ill-equipped to do otherwise, police focus on the "removal" approach, thus criminalizing SMI.

The punishment paradigm extends systematically through quality-of-life enforcement —the enforcement of ordinances that effectively criminalize homelessness by prohibiting loitering, camping, sitting on sidewalks, and panhandling. Research shows these laws are often created or enforced in response to business and resident complaints rather than specific illegal behaviors (Robinson, 2017).

In December 2023, the City of Minneapolis declared unsheltered homelessness a public health emergency. However, patterns of response have focused primarily on displacement, or the clearing of encampments, which disrupts support networks without addressing the underlying mental health, substance use, and housing crises driving people into public spaces (Bell, 2025). Encampments present complex safety considerations—with both legitimate health and security concerns and community perceptions that may exceed actual documented risks (Cohen et al., 2019) . The "solution" of displacement usually exacerbates the problem: Evidence suggests that encampment clearings and involuntary displacement worsen health outcomes, increase hospitalizations, decrease access to treatment services, and contribute to deaths among people experiencing homelessness (Barocas, et al., 2023; Meehan et al., 2024).

Problem #4: Disproportionate Impact on BIPOC Communities

Despite Minnesota consistently ranking among the healthiest states in the nation, our BIPOC communities face disproportionate burdens across all three interconnected crises of homelessness, addiction, and mental health treatment barriers—a phenomenon economist Samuel Myers, Jr. calls "the Minnesota Paradox." Research shows that "measured by racial gaps in unemployment rates, wage and salary incomes, incarceration rates, arrest rates, homeownership rates, mortgage lending rates, test scores, reported child maltreatment rates, school disciplinary and suspension rates, and even drowning rates, African Americans are worse off in Minnesota than they are in virtually every other state in the nation" (Myers).

Despite Minnesota consistently ranking among the healthiest states in the nation, our BIPOC communities face disproportionate burdens across all three interconnected crises of homelessness, addiction, and mental health treatment barriers—a phenomenon economist Samuel Myers, Jr. calls "*the Minnesota Paradox.*"

There is an concerning overrepresentation of Native American, Black, and Hispanic/Latino people experiencing homelessness in both the Twin Cities metro and greater Minnesota. Home ownership inequities compound these challenges, as only 25.3% of Black households own homes versus 76.9% of white households—the largest gap in the nation—limiting wealth accumulation and access to stable housing that supports recovery.

Health disparities intersect with housing inequities in ways that threaten lives and wellbeing. African

American and American Indian populations are dying from drug overdose deaths at disproportionately high rates compared to whites (DeLaquil),while Black, Indigenous, and Hispanic/Latinx Minnesotans experience lower rates of optimal mental health care and worse outcomes compared to the statewide average. Minnesota's youth suicide rate already exceeds the national average, but disparities are severe here, too: American Indian youth face rates of death by suicide three times higher than other racial groups, and LGBTQ youth are five times more likely to attempt suicide than their peers (Division of Child and Family Health, 2021).

Stark disparities are exacerbated by systemic barriers, including limited behavioral health resources, a shortage of clinics accepting new patients and those using Medical Assistance, and cultural and language barriers that disproportionately affect underserved communities. As recently as February 2021,16.6% of adults in Minnesota reported being unable to get needed counseling or therapy, with groups preferring languages other than English facing particularly low rates of optimal care (National Association on Mental Illness, 2021). All this creates a cycle in which BIPOC communities bear disproportionate burdens of social challenges yet, instead of receiving adequate support or treatment, encounter heightened policing and criminalization of these very issues; again, we see that those most vulnerable are over-policed and under-supported (Phelps et al., 2020).

As Minneapolis seeks solutions, it must bear in mind these core and connected issues. Doing so is essential to developing more equitable and effective approaches to behavioral crisis response. Indeed, this is, in part, how the Minneapolis Behavioral Crisis Response team was conceived.

Minneapolis BCR Origin Story

Minneapolis's path to behavioral crisis response began as early as 2006, when the city first identified violence as a public health issue. Initially, its response involved focusing on youth violence prevention. The city expanded on this foundation in 2018 with the establishment of the Violence Prevention Fund to support community-driven strategies, signaling a shift toward addressing root causes of behavioral crises rather than just pursuing law enforcement (Jany, 2019).

The groundwork for police alternatives gained momentum in 2019 when Minneapolis officials formed a multi-departmental working group to analyze whether lower-priority 911 calls might be successfully diverted to other agencies. The working group's analysis of more than 70 call types identified five categories suitable for non-police response, with mental health and behavioral health calls standing out as both time-consuming for officers and high priority for diversion (Jany, 2019).

Following extensive community engagement, the city approved a pilot for an unarmed first responder team, and in 2021, Canopy Roots was selected to run the Behavioral Crisis Response (BCR) program. The choice of Canopy Roots—a local, majority Black-owned and woman-led mental health agency—reflected the community's demand for culturally responsive, trauma-informed care. Executive Director Candace Hanson explained the rationale: "When someone is a member of a historically marginalized group, when you have

She framed the BCR program as "*appropriate response* rather than alternative response," highlighting the fact that few mental health calls were suitable for police response in the first place

an authority figure coming at you from the stance of 'I'm the authority and I know what's best for you,' you don't tend to get very good outcomes." She framed the BCR program as "appropriate response rather than alternative response," highlighting the fact that few mental health calls were suitable for police response in the first place (Collins, 2024).

The program launched in December 2021. Today, more than 40 responders provide round-the-clock operations and respond to more than 10,000 calls annually. What began as a crisis-driven pilot with just two vans to its name has transformed into a core component of Minneapolis's reimagined public safety system (Crouch-Dodson et al., 2025). As of the spring of 2025, Canopy Roots has expanded its services with a pilot program in Brooklyn Center, MN and has launched a partnership with CIRCLE in Los Angeles, CA.

As the BCR program matured and explored its sustainability as an alternative to traditional police response for mental health crises, Canopy Roots recognized the need for rigorous evaluation. In the summer of 2023, staff at Canopy Roots contracted with the Minnesota Justice Research Center to conduct a 20-month developmental evaluation of the BCR program to better describe their practices, explore their impacts, and inform future development. The Minnesota Justice Research Center (MNJRC) is a nonpartisan, nonprofit organization dedicated to driving meaningful change in Minnesota's criminal legal system through rigorous and community-centered research, education, and policy development.

Research Methods: A Developmental Evaluation Design

Given the evolving nature of the BCR program and its community-centered approach, as well as its adaptive processes and emerging outcomes, the evaluation team at the MNJRC selected a developmental evaluation design. A developmental evaluation is an approach that supports innovation and adaptive learning in complex, evolving environments. Unlike traditional evaluation methods that assess whether predetermined outcomes were achieved, developmental evaluation helps organizations describe their approach and understand what's working, what's not, and why—all while they're still developing and refining their programs (Patton, 2010).

In the context of the BCR evaluation, this approach allowed researchers to work collaboratively with Canopy Roots staff to identify priority areas for inquiry, adapt research questions as new issues emerged, and focus on understanding how the program functions within Minneapolis's unique safety ecosystem.

Our developmental evaluation employed a convergent mixed-methods approach combining qualitative and quantitative techniques to understand BCR's implementation and impact. The evaluation was structured in two phases and prioritized the development of a collaborative learning framework.

Phase I: Collaborative Learning Structure

One key methodological tool employed during Phase I was a consensus-building workshop. The summer 2023 workshop's facilitators began with broad questions that were progressively refined through BCR responder and Canopy Roots leadership team input. They used the following questions to identify priority areas for BCR responders and determine appropriate data collection approaches: **What does success look like for the Minneapolis Behavioral Crisis Response teams? And how is the world different or better after you have done your work?**

Research Questions

In engaging with the collaborative learning structure and coming to consensus on the questions above, we developed the following research questions:

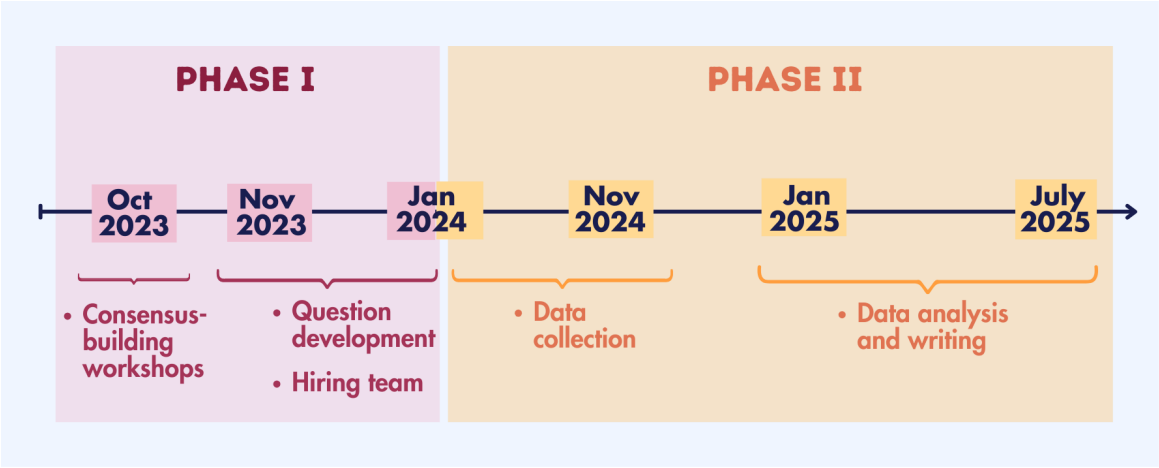
1. What is the standard for mental health first responders?
2. What is the Minneapolis BCR standard of practice?
3. Who is being served and what are the needs being presented on calls? (Emergent question)
4. How is BCR utilized and perceived within the Minneapolis safety ecosystem
5. How is BCR perceived by community members?
6. What are the appropriate metrics for measuring BCR's impact?

Research questions one, two, four, five, and six were developed in consensus with BCR responders. Through the nature of our developmental evaluation, research question three emerged from conversations with Canopy Roots leadership and staff, as well as early data collection from interviews with responders.

In broad strokes, this evaluation set out to explore the national BCR landscape; dig into and document the Minneapolis BCR model; explore call data to understand the needs of community members and identify how BCR fits in and stands out from the city's safety ecosystem; examine what people including community members and other first responders think about BCR; and to recommend to Canopy Roots how best to measure success and expand intentionally.

Phase II: Data Collection and Analysis

The second phase of our evaluation included data collection and analysis. Our research design used both primary and secondary sources of data to capture diverse stakeholder experiences and program outcomes across Minneapolis. Primary data collection[1] included four distinct approaches: a) semi-structured interviews, b) direct observations with BCR responders, c) a community survey, and d) one focus group.



1) For access to protocols used for primary data collection, reach out to the research team at info@mnjrc.org.

Data Collection

Semi-structured Interviews. Interviews formed our core qualitative component, involving 36 participants representing key stakeholder groups including BCR responders and Canopy Roots staff members (11), Canopy Roots leadership (6), staff from other appropriate response models operating nationally (3), community members who directly received or witnessed BCR services (5), the Minneapolis Police Department (5), and other critical safety ecosystem partners including from the Minneapolis Emergency Call Center or "MECC" (the city's 911 dispatch center), Minneapolis Fire Department, Hennepin County Behavioral Health, and Minneapolis Downtown Improvement Safety Ambassador Program (6).

Interview protocol was developed by MNJRC researchers and varied depending on role within the BCR and non-Canopy Roots status. Participants were identified through existing formal and informal networks, stakeholder referrals, and direct outreach. Interviews were conducted in-person and virtually, lasted approximately an hour, and included audio recording for accurate transcription. Researchers completed individual interview memos after each interview session. Interviewees were compensated for their time with $25 gift cards.

Direct Observations. The research team conducted 6 direct observation sessions through BCR ridealongs across different shifts, gaining firsthand insight into program operations and response protocols in real-world contexts. The MNJRC research team developed an observation protocol, and each researcher completed an observation memo after the completion of their ridealong experience.

Community Survey. To explore community perspectives and knowledge of BCR, the research team developed a large-scale, online survey. The survey included a brief explanation of the Minneapolis BCR approach (see Appendix A) and introduced Canopy Roots, then asked participants broadly about their perspectives on safety, pre-survey familiarity with BCR, personal experiences of BCR response, and their opinions about the Minneapolis BCR model for crisis response. The survey was distributed through various online channels and through an on-the-ground outreach strategy featuring 2 MNJRC community organizers working at various city-wide events (e.g., Open Streets) and within targeted neighborhoods, including Lowry Hill, Stevens Square, and Harrison, where BCR services are most frequently deployed.

The survey ultimately reached 519 valid respondents. Though the initial tally of responses was 878, with an 88% completion rate, analyses quickly revealed a large number were generated by "bots," or automated programs designed to simulate human behavior—nearly half the dataset. The level of sophistication of the bot responses was significant. Therefore, the research team cleaned the data by identifying responses with two or more "flags" that indicated non-human (or humans who do not live or work in or around Minneapolis) and removing them from the sample. Responses were flagged if they had a non-local zip code (beyond the Twin Cities metro area), non-local internet IP address, suspicious email addresses and time submission (e.g., several responses within seconds of each other with firstnamelastname123@gmail.com). A research intern then manually reviewed all the data with one or more flags to determine whether any appeared to be bots, specifically looking for A.I. generated short-answer responses alongside mismatches of names and emails (e.g., a response from someone named "Danny Biggs" with the email address "jxmseqngmbfjp@yahoo.com" would be flagged for further review).

The MNJRC team designed the survey protocol with the use of skip logic, meaning that residents receiving different questions based on their awareness of the BCR program. As a result, different questions had different sample sizes of respondents (or "Ns" in reference to percentages). Participants were entered into a drawing for a $50 gift card as an incentive to complete the survey.

Focus Group. Researchers conducted a focus group with the Canopy Roots Community Advisory Board. The research team designed a semi-structured focus group protocol, and 7 participants attended the group session.

Secondary data collection supplemented primary data collection. We reviewed Canopy Roots' organizational documentation about the BCR approach, BCR training materials, news coverage of the program, and existing research reports examining the broader Minneapolis safety ecosystem. Data were also collected from social media via the r/TwinCities and r/Minneapolis subreddits mentioning BCR on Reddit between October 2024 through March 2025, comprising 25 posts and their associated comments.

Finally, we conducted an extensive review of BCR "call logs"—call records spanning June 2023 through July 2024 that provided comprehensive quantitative data on service utilization patterns, response types, and operational metrics as recorded by responders after each call. During this one-year period, responders entered data for a total of 10,774 calls. The research team analyzed these call records to summarize whether contact was made, the recipient's presentation and demographics, what services were provided, and whether other agencies were involved. These call logs also provided a summary of the incident BCR responders were dispatched to and what happened on the call. We conducted further qualitative analysis of a subset of 729 call narratives.

Analytical Approach

We employed a mix of traditional qualitative coding with computational text analysis to examine the qualitative data. This process included initial data familiarization through multiple readings and group consultation, followed by thematic coding of all transcripts using a mixed-methods research software called "Dedoose." The research team employed both inductive action coding—that is, creating categories of codes using the data (e.g., "attending to basic needs" was a code that came out of the data)—and deductive coding based on our research questions—that is tagging qualitative data with predetermined categories (e.g., "community perspective"). Pattern recognition and thematic organization was supported by Anthropic's Claude A.I. for the large quantity of qualitative call log narratives (see Appendix B for detailed A.I. methodology). Quantitative analysis of survey data and program metrics was calculated in the Stata (v. 14) software package to produce descriptive statistics regarding response patterns and community perceptions.

To ensure our findings were trustworthy and accurate, we took several steps. We kept detailed records of how we collected and analyzed our data, and we had multiple researchers independently review the same information to check for consistency. We used the same survey questions and methods for all participants. We also cross-checked our results by comparing findings from different types of data sources, and we asked key participants and stakeholders to review our conclusions to confirm they accurately reflected their experiences.

Limitations and Validity Considerations

Key limitations include potential selection bias in stakeholder interviews and challenges reaching community members most impacted by crisis services. We addressed these through triangulation across multiple data sources—that is, identifying themes present from observation notes, interview transcripts, and training documents—and careful attention to the inclusion of diverse perspectives.

The use of A.I. in qualitative analysis raises important considerations regarding interpretive authority and the role of researcher positionality. While the A.I. tool we used was able to process large volumes of text efficiently, it lacks the contextual understanding and lived experience that a human analyst brings to qualitative research. To address this limitation, all A.I.-generated analyses were critically reviewed, refined, and contextualized based on the team's familiarity with the subject matter and qualitative research methodologies.

Chapter 2. *Evaluation Findings*

The National Landscape of Mental Health Response

The first question that emerged from the first phase of the evaluation was ***What is the standard for mental health first responders?*** The BCR responders and leadership at Canopy Roots' BCR expressed a desire to better understand how their model fits into a national landscape and aligns with (or contributes to) best practices in this emergent field.

In this section, we examine the emergence of national standards introduced by Substance Abuse and Mental Health Services Administration (SAMHSA), briefly summarize what is known nationally about variance in models, and present some emergent data on impacts and common challenges experienced in different cities across the country.

National standards

Recognizing the critical need for standardized approaches to crisis response, the Substance Abuse and Mental Health Services Administration (SAMHSA) released updated national guidelines in 2025, establishing the federal agency's most comprehensive crisis response standards to date. SAMHSA's Crisis Response Standards Framework represents a reimagining of how cities could respond to behavioral health emergencies, moving beyond fragmented, law enforcement-centered approaches toward integrated systems that prioritize therapeutic intervention and long-term recovery (Substance Abuse and Mental Health Services Administration, 2025). The framework establishes a foundational architecture built on three essential service elements:

1. Someone to Contact: Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support.
2. Someone to Respond: Services like mobile crisis teams deliver rapid, on-site interventions to de-escalate crises and connect individuals to other community-based supports that provide crisis prevention and postvention care.
3. A Safe Place for Help: Emergency and crisis stabilization services that support on-demand crisis care and crisis-related supports in a variety of community settings.

What distinguishes these standards is their holistic recognition that effective crisis response requires simultaneous development across multiple domains. SAMHSA offers guidelines around operational principles, standards for different configurations of mobile response teams, triaging of barrier-to-service levels, governance, financing, workforce development, technology integration, and community engagement. Finally, they offer recommendations for quality measurement and continuous improvement that span from individual service encounters to population-level impact assessments(Substance Abuse and Mental Health Services Administration, 2025).

What distinguishes these standards is their holistic recognition that effective crisis response requires simultaneous development across multiple domains.

Over 250 mental health crisis response teams now operate across the United States, including more than half of the country's largest cities (The Right Response). These programs vary widely based on local needs and resources—in Dayton, OH, trained mediators respond to neighbor disputes and trespassing calls; in Los Angeles, CA, outreach workers with lived experience handle calls about people experiencing homelessness; and in Anchorage, AK, clinicians and paramedics respond to mental health crises (Thompson, 2024;The Vera Institute of Justice, 2019) .

Across the country, mental health crisis response initiatives are showing encouraging outcomes as they develop and expand. In a study focused on the impact of the CAHOOTS program in Eugene and Springfield, OR, analysts reported a reduction in arrests and an increase in access to medical services (EMS response). This shift appears to stem from CAHOOTS' ability to respond to behavioral and mental health crises as health issues rather than criminal matters.

Public support has been notably favorable in areas where BCR has been assessed. In Durham, NC, for instance, 57% of residents reported an increased willingness to contact 911 due to the implementation of the city's HEART program (Thompson, 2024) Denver, CO's STAR team demonstrated significant impact through a 2022 analysis that revealed a 34% reduction in minor criminal activity within the neighborhoods they served (The Stanford Report, 2022)

Research from Columbia Heights, MN highlighted how deploying mental health professionals to emergency calls effectively decreased police use of force incidents. The Columbia Heights Police Department identified mental health as a contributing factor in approximately 30% of their use-of-force cases between 2018 and June 2021. While these situations typically involved minimal force—primarily handcuffing or securing individuals for ambulance transport—the department sought to minimize even these interventions. In 2022, the BCR program there facilitated interactions with over 300 people, achieving successful outcomes without force in 97% of these encounters. Additionally, 94% of cases were resolved without requiring medical holds, significantly decreasing the need for officer-assisted transports (Dispatch, 2024)

The safety record of alternative response teams has been impressive. Data consistently shows these teams rarely need police backup. In Eugene, OR's CAHOOTS program, only about 1% of their calls require police assistance. Similarly low rates are reported in Albuquerque, NM and Denver, CO. In Durham, NC, responders report feeling safe on 99% of calls, challenging assumptions that unarmed responders would be at high risk (Thompson, 2024) Research on

other outcomes, such as involuntary commitments, arrests, and police use of force, is ongoing in several cities including Durham, NC and Madison, WI.

The potential for growth is substantial—research using data from eight cities across the U.S. (including Minneapolis) suggests that 33-68% of current 911 calls could be handled without sending armed officers (Irwin & Pearl, 2020) The same report estimates that at least 25% of 911 calls in Minneapolis could be handled by community responders, and an additional 22% administratively. However, most BCR programs remain small in scope. A recent report found that only 1.7% of 911 calls in Minneapolis are being diverted to BCR (Alexander Heaton et al., 2024). In Albuquerque, NM, only 5% of police calls are being diverted; in Durham, NC, just 1%.

The potential for growth is substantial—research using data from eight cities across the U.S. (including Minneapolis) suggests that 33-68% of current 911 calls could be handled without sending armed officers.

Researchers indicate that a safety-first approach used by 911 dispatchers—that is, when dispatchers err on the side of caution when deciding whether to send police, EMTs, or mental health responders—may partially account for this low uptake rate. Dispatchers must make rapid assessments about whether a situation poses risks to unarmed mental health professionals, and the subjective nature of determining what constitutes "danger" often results in dispatching traditional law enforcement instead of specialized crisis responders. One researcher who studies 911 dispatch saw firsthand that operators had a "when in doubt, send [cops] out" mentality" (Thompson, 2024).

To address these challenges, some cities have implemented innovative solutions. One approach involves embedding mental health clinicians directly within 911 call centers to assist with real-time triage decisions. These professionals provide clinical expertise to help 911 dispatchers distinguish between situations requiring police response versus those appropriate for mental health intervention. Safety protocols are maintained but the decision-making becomes more nuanced.

Other jurisdictions have bypassed the 911 system entirely, recognizing that the safety-first culture of emergency dispatch may be incompatible with the implementation of mental health crisis response. Cities like Atlanta, GA have established alternative pathways using non-emergency lines such as 311, which helps address community reluctance to call 911 (particularly among communities of color, who are more likely to fear police involvement will escalate rather than de-escalate mental health crises) (Thompson, 2024).

Another barrier to the expansion of BCR programs is funding sustainability. Many programs launched using federal money from the pandemic-related American Rescue Plan, but that funding is now running out. Some have attempted to tap into Medicaid funding, but that pathway carries significant restrictions. Cities that have set aside money in their general funds struggle to grow these budgets amid fiscal constraints and competing priorities (Thompson, 2024).

Staffing is an equal challenge. Positions on these specialized teams require unique skills, often pay less than other first responder roles, and can easily lead to burnout, given the bind of limited resources and expanding need.

As research on outcomes like involuntary commitments and police use of force continues, cities acknowledge that BCR programs need to be integrated with broader health and social service systems to facilitate the simultaneous expansion of housing and mental health services. Despite these challenges, the potential impact on reducing unnecessary arrests, improving access to mental health care, and preventing tragic outcomes makes this work essential to reimagining public safety in American communities.

In sum, we see how SAMHSA's Crisis Response Standards Framework represents a reimagining of how we address public safety. From the hundreds of mental health crisis response teams now operating across the United States, we see promising outcomes including reduced arrests, decreased police use of force, and high rates of public support. Programs like CAHOOTS in Oregon and STAR in Colorado demonstrate that alternative responders can safely handle mental health crises, with less than 1% requiring police backup. However, significant challenges remain in scaling these programs. Today, most BCR programs handle only 1-5% of eligible 911 calls due to dispatcher safety protocols, funding issues, and staffing difficulties.

The Standard of Practice for Canopy Roots Behavioral Crisis Response: The "What" and "How"

The second research question posed by the MNJRC research team, in collaboration with Canopy Roots staff and leadership, was ***What is the Minneapolis BCR standard of practice?*** While responders and leadership demonstrated a deep understanding of their work and could articulate their practices, MNJRC's evaluation revealed that the BCR model and theory of change existed across multiple internal documents rather than in a single, cohesive framework. By exploring a "standard of practice," the research team set out to clarify and determine the "what" and "how" of Canopy Roots' behavioral crisis response.

A key function of developmental evaluation is to surface and synthesize underlying assumptions, theories of change, and operational models that guide program implementation. Canopy Roots' stated mission for BCR is to build safer communities through compassionate care. They do this through unarmed, trauma-informed, culturally affirming crisis response.

In the section that follows, we unpack the Canopy Roots BCR model by outlining their guiding principles, identifying critical operational elements, and describing key services of the BCR program that emerged through our evaluation process. We analyzed data from Canopy Roots staff interviews (both responders and leadership), internal organizational documents, ridealongs, and call data. Taken together, the principles create a foundation for the "what" of behavioral crisis response—the delivery of services—and the operational elements create a container for the "how" behavioral crisis response.

We find that Canopy Roots' Behavioral Crisis Response (BCR) program has established an approach to crisis response centered on five key trauma-informed principles: responding without weapons, embracing cultural responsiveness, affirming human dignity, supporting self-determination, and providing barrier-free access to services. In addition, the program's critical operational elements—its 24/7 coverage, clinical oversight, and robust support systems for staff well-being—enable responders to provide sophisticated crisis services ranging from de-escalation and emotional support to meeting basic needs and making appropriate referrals.

While still evolving, the Canopy Roots BCR program is an example of how crisis response can be reimagined around principles that support human flourishing, creating a **"canopy of care"** that addresses complex behavioral health needs in the community.

Trauma-informed principles

- Responding without weapons
- Embracing cultural responsiveness
- Affirming human dignity
- Supporting self-determination
- Providing barrier-free access to services

Critical operational elements

- 24/7 coverage
- Clinical oversight
- Robust support systems for staff well-being

Crisis services

Ranging from...

- De-escalation and emotional support

to

- Meeting basic needs and making appropriate referrals

Building A Foundation: Trauma-Informed Guiding Principles

The Power of Presence Without Force

The first principle that characterizes the Behavioral Crisis Response approach at Canopy Roots is responding in a non-threatening way without physical force. That is, at the heart of the BCR program is the commitment to respond without weapons, transforming how crisis situations unfold from the moment responders arrive. Responders are trained to understand, from the recipient's point of view, anything that might be perceived as threatening body language, tone of voice, and physical proximity, and to pay careful attention to what they do or don't carry in their hands or on their person. "The only thing that's the same," one responder said, comparing BCR to other first responders, "is that we carry the same radio, so we're dispatched by the same people. And that's the only thing that is the same. We are not armed. We're not carrying anything that can be considered as a weapon."

Unlike traditional police responses, which may escalate tension through the presence of badges, police uniforms, and weapons, interviews and internal documents show that Canopy Roots responders arrive as "guides and peers." As one responder described, it is about being "Somebody who is helping to resolve a situation without force... even just the temperament can help to create a sense of safety and calmness for an individual who really just needs to either be listened to or brought to a clinic or have resources provided to."

> Canopy Roots responders arrive as "guides and peers."

Another responder shared an example of this principle in practice. When arriving to a scene as backup to the Minneapolis Police Department who were already on-site, the responder recalled,

"the individual had threatened to cut himself, threatened to hang himself and the door was locked, the individual was clear he didn't want to deal with MPD... and I came in and my primary objective was to calm the person down and to ask for permission to have EMS take a look at his injury." This responder knew they needed to be present in a non-threatening way: "I was able to do that... was able to ask for the significant other of that person to be present [with the individual in crisis]. And they did agree for EMS to come in and take a look at the room. And then I just stepped back. And EMS took over. So, it's almost like a dance."

Indeed, research suggests that although many police officers are trained in de-escalation, the visible presence of armed, uniformed police and marked vehicles can intensify distress during mental health crises, particularly in Black and other communities of color where historical tensions with law enforcement have fostered distrust (DeSilver et al., 2020).

Culturally Responsive: Meeting People Where They Are

In addition to their unarmed presence, Canopy Roots demonstrates cultural responsiveness by tailoring its approach to diverse community contexts. BCR is not a one-size-fits-all model.

In our review of BCR training materials and internal documents, we found two fundamental tenets of this principle covered in BCR training. First, responders are taught to recognize that each client's community, culture, and perspective contains inherent strengths and resources—even when these assets aren't immediately visible. Second, they are encouraged to acknowledge that their own professional solutions and organizational culture may have limited relevance for individual clients' specific needs and circumstances. This cultural humility shapes how responders engage, ensuring they work with rather than impose upon the communities they serve.

First, responders are taught to recognize that each client's community, culture, and perspective contains inherent strengths and resources—even when these assets aren't immediately visible.

Again, interviews with responders revealed this nuanced approach in practice. Responders spoke about actively adapting their methods based on cultural considerations. "It's about being culturally responsive when you show up and [you're] using resources like translation services, language lines, and your colleagues," said one female responder who continued with the story of a Spanish-speaking service recipient who "didn't speak any English. My partner on that day spoke Spanish. So, we were able to coach her. She wouldn't go into the ambulance. So, we coached her. And the ambulance invited us in. So, we stayed with her."

Religious and gender customs also guide BCR interactions, as revealed in an interview with a responder who noted, for instance, "When visiting a devout Muslim woman who won't speak to men, they'll speak to my female partner instead.... I never enter a Muslim woman's bedroom without invitation. If they don't have their hijab on, I leave the room."

Cultural responsiveness extends to adapting communication styles for neurodiverse individuals and those with limited cognitive skills. One responder describes how she is trained to ask: "What is the best way for you to take information? Do you do well when you look at things or do you do well when you hear things? Or do you do well when you look at things and hear things?"

Perhaps most challenging, responders demonstrated cultural humility by putting the recipient's needs and preferences first, even when faced with racist or sexist comments or behaviors from community members. Three BCR responders who were women of color described their services being rejected because of their intersectional identities. One woman shared, "I have run into instances where people do not want to connect with me because I'm an African American woman." Another described how some recipients would only speak to a white or male colleague, hypothesizing that perhaps they could not see her, a woman of color, as a legitimate professional. Instead of taking offense, BCR staff described "stepping into the recipient's reality instead of forcing them into yours." This approach requires both a thick skin and practical skills—understanding of how one's identity might affect interactions while focusing on helping the person in crisis. A responder explains,

> *You get that one chance, you get one chance when you are encountering someone in a crisis, stressful or traumatic situation. Depending on how you decide to approach it or what words you decide to use, [that] is going to make or break that whole situation. And everyone needs to take their personal out of it. Forget what you learned, what you saw, what you heard, and deal with it in that moment at that time, because a lot of us swirl in this assumption and we're not accurate. There's no possible way to be accurate. And when we approach these situations with our previous experience or a learned behavior or something we grew up to know and to feel like we were right and we're never right. Mental illness is very different.*

These examples illustrate how BCR's cultural responsiveness operates as both a philosophical commitment and a practical methodology. By prioritizing client needs over professional comfort, adapting communication and interaction styles to individual circumstances, and maintaining focus on crisis resolution regardless of personal challenges, responders demonstrate that effective crisis intervention requires meeting people exactly where they are—culturally, linguistically, and emotionally.

Human Dignity: The Revolutionary Act of Seeing Humanity

A next recurring principle across responder interviews and throughout Canopy Roots materials and practice is the commitment to human dignity. In the words of one responder, "When a member in our community experiences a situation that breaks their ability to cope, the BCR will be the first to respond with dignity and respect fit for any human being." Responders intentionally work to center the full humanity of each person they encounter. Powerfully, another responder described "being radically present in a moment... with [the recipient]... looking at them through the lens of their own humanity." In practice, this is about acknowledging common human needs, from basic necessities such as food, water, and clothing to the need for privacy and the need to have one's difficulties be seen and acknowledged, even when those difficulties may be the result of delusion or hallucination.

"When a member in our community experiences a situation that breaks their ability to cope, the BCR will be the first to respond with dignity and respect fit for any human being."

BCR teams prioritize immediate physical needs—offering blankets, food, clothing, water, and bus tokens—in order to create bridges to trust. By prioritizing comfort and basic necessities before addressing complex mental health concerns, responders communicate that a person's right to dignity doesn't depend on their mental state, sobriety, or circumstances. This approach is an evidence-based standard practice for building trust, cooperation, and achieving successful crisis resolution (Ranjbar et al., 2020).

BCR teams also respond compassionately to situations of public undress. Public nudity often signals significant distress, whether from mental health crises, substance use, physical illness, environmental factors, or victimization (Remsberg, 2005). Many people, including first responders, are uncomfortable dealing with public nudity. BCR teams, on the other hand, respond and offer practical assistance, providing underwear, socks, t-shirts, shorts, and other clothing items, in addition to food and water. If the recipient isn't breaking any laws, they respect that person's own comfort level.

Privacy is related to the protection of dignity. Responders spoke with people in private settings or moved conversations away from public areas, following internal Canopy Roots policies that guide responders to "ensure privacy of community member whenever possible" and "ask or give options for alternative locations to offer privacy based on assessment of safety, client needs, and their expressed preferences."

The importance of this privacy protection is illustrated by one recipient's experience during a mental health crisis. When her case manager determined hospitalization was needed and called for EMS, police arrived first and spoke with her. Due to stigma and privacy concerns, the recipient feared what her neighbors might have thought if they saw her in an ambulance, so the police called BCR. The recipient only agreed to go to the hospital with BCR responders after they accommodated her request to pull around the back of her building to protect her privacy. She also appreciated that the van had tinted windows to protect her privacy while inside. These seemingly small gestures reinforced the larger message of unconditional respect and helped the responders adapt to the situation in a way that preserved the recipient's dignity.

We found, further, that responders validate the distress people are experiencing without dismissing it, even when they are responding to apparent delusions. For example, when a recipient reported "acid dripping from his ceiling," a responder did not contradict him, but validated "that his lived experience must be distressing." When another recipient was concerned about break-ins, responders checked windows with them and discussed practical solutions like installing cameras—despite knowing that this person was likely experiencing delusions. This validation acknowledges suffering without requiring reality-testing that might shame or alienate the person in crisis.

Responders do this, all while acknowledging the difficulty of engaging in this way. One responder was particularly candid:

> *And it's hard, right? You see all the homeless stuff happening and encampments and people in survival mode and just taking advantage of stuff and it's hard, right? You just—it's hard. You do get tired of seeing it, you do feel overwhelmed with it, but when you are in a position where you're responding*

> *or helping or addressing someone in that situation that you're overwhelmed with and you're so tired of seeing, you cannot treat that one person as if they are the issue. That's a person, we're gonna start there.*

The BCR principle of human dignity represents a fundamental shift from dehumanizing crisis response to one that affirms inherent worth, regardless of circumstances. By attending to basic needs, protecting privacy, and validating lived experiences—even apparent delusions—responders demonstrate that effective intervention begins with recognizing each person's full humanity. This commitment to dignity is both a philosophical stance and a practical strategy that builds trust, reduces harm, and creates meaningful connection during moments of profound vulnerability.

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Honoring Choice and Self-Determination

The importance of self-determination also emerged from BCR responder interviews, internal organizational documents, and ridealong observations. This philosophy stems from three core assumptions taught in Canopy Roots' foundational training: clients are the experts on their own situations, possess relevant past experiences that inform solutions, and have inherent resources and strengths—whether recognized or not.

This commitment to client autonomy permeates much of their service delivery. Canopy Roots responders consistently defer to client preferences on critical decisions, from transportation choices to hospitalization when there is no immediate danger assessed. As one responder put it, "In that moment, we're supporting them for whatever it is they feel like is best for their life, we're not telling them how they should live." Another noted:

> *I think it's genuineness, I think it's empowerment, I think it's a lack of a power differential, really meeting them where they're at and not trying to force them into anything but allowing them to make informed decisions. And I think it's really, in its most simplistic form, just a positive experience with a first-response entity. Cause a lot of our recipients have never had that.*

The practical application of this philosophy emerges clearly in Canopy Roots' documented interactions. For example, when a recipient declines hospital transport, responders respect that choice while maintaining support: "BCR offered recipient a ride to the hospital, but she declined, stating that she has things to pack. BCR requested she call back should she not be able to get a ride." Similarly, when clients refuse to discuss their crisis, responders honor those boundaries while offering alternative support: "BCR asked if recipient wanted to talk about what was happening. The recipient refused.... BCR advised him to call us back if he wanted to speak, BCR also provided him with emotional support and coping skills."

Like the others, putting this principle into practice involves challenges. For instance, one responder noted that it can be hard to make everyone in a situation happy while prioritizing recipients' agency: "From time to time when the business owners say, 'I wanted police to come and remove this person,' so, and then we have neighbors that say, you know, 'this individual is okay to be on

the sidewalk. They're not doing anything.' And then we have a set of neighbors say[ing], 'remove them.' So, you have those tensions there." Honoring the choice and self-determination of clients can, at times, conflict with the needs and preferences of others, though BCR responders seek to support all community members whenever possible.

Overall, BCR services represent a stark contrast, shifting from compliance-based to choice-centered crisis intervention.

Barrier-Free Accessibility

A fifth guiding principle of Canopy Roots' BCR service is their commitment to barrier-free service. Canopy Roots eliminates the traditional gatekeeping mechanisms that can prevent people from receiving timely help. Unlike many social services that require extensive paperwork, identification documents, and formal intake processes before providing assistance, BCR operates a model in which no prerequisites or qualifications need to be met—their service can be accessed directly through a 911 call.

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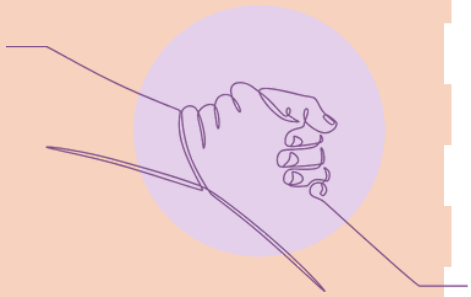

The BCR program recognizes that paperwork and identification requirements can be insurmountable barriers for many people in crisis—particularly those experiencing homelessness, severe mental health symptoms, or distrust of formal systems due to past negative experiences. In their stated purpose and scope, Canopy Roots notes, for example, that "Health records are not maintained by the BCR staff, as the service provided is not a true healthcare service. The purpose of the program not maintaining health records is to facilitate community trust and reduce barriers to community members accessing services." By eliminating these barriers, Canopy Roots creates a truly accessible "free public service" that "does not gather personal information or assign diagnoses" and "provides services regardless of legal status of the recipient or community members" truly meeting people where they are.

Furthermore, Canopy Roots' commitment to barrier-free access extends to how they connect people with other resources, or execute what responders call a "warm handoff." They actively work to smooth pathways to additional social services. As one responder explained, "We will transport to the Behavioral Health Center, and then that team will take over. The person doesn't have to tell their story over again." This approach minimizes the threshold to service and the re-traumatization that can occur when people must repeatedly explain their situation to access help.

Finally, BCR teams maintain physical accessibility through the use of vehicles with wheelchair accessibility and car seats. This allows the team to respond and transport individuals, regardless

of their age and mobility, to safe locations. Canopy Roots vans also provide plenty of space inside for assessment, safety planning, as resource delivery as needed—something one responder noted was "especially helpful in the cold weather here in Minnesota."

Importantly, putting these five principles together, Canopy Roots' BCR service strives to provide care that is non-threatening and unarmed, culturally responsive, humane, agentic, and barrier-free—but Canopy Roots never presents this approach as a finished success story. It is always positioned as an evolving practice adapting to face real-world constraints. Canopy Roots' commitment to being unarmed doesn't eliminate all safety concerns. Their cultural responsiveness encounters genuine cross-cultural tensions. Their person-centered approach operates within systems that often lack adequate resources. Yet it is the group's honest engagement with both ideals and realities that makes Canopy Root's BCR work so significant. They demonstrate that crisis response can be reimagined around principles—not as abstract concepts but as practical approaches that shape daily interactions. Through their continued work, BCR offers a glimpse of what community safety might look like when it is built around supporting human flourishing.

Set Up for Success: Critical Operational Elements

Having described the guiding principles that form the foundation for the BCR service, we next set out to explore the critical operational elements for any replication of this model. The BCR model is built upon a comprehensive operational structure that prioritizes continuous availability, clinical expertise, and responder well-being. By integrating these elements, Canopy Roots has created a sustainable framework for effective crisis response that distinguishes this work from other first response and delineates the necessary infrastructure for mental health first response.

Continuous Coverage and Clinical Oversight

First, BCR teams provide 24/7 coverage across the city. Their expansion to round-the-clock coverage was driven by demand, as evidenced by a rise in year-over-year average call responses after the new hours went into effect: Between July 2022 and July 2023, BCR averaged 574 responses per month, but between July 2023 and July 2024, they provided service 874 times per month.

BCR responders frequently mentioned their 24/7 city-wide coverage as a critical operational element but added that concerns remained about their ability to respond quickly to some crises. Location is one worry in a large urban area. Canopy Roots has one central location in northeast Minneapolis, yet responders are expected to serve the whole city at any given moment. Many mentioned that traffic patterns could be challenging, with one noting, "I can say there are times where I feel like we need to be, get there quicker and we're literally stuck in dead traffic." Interviewees pointed to the need to operate out of more locations throughout Minneapolis.

BCR responders frequently mentioned their 24/7 city-wide coverage as a critical operational element but added that concerns remained about their ability to respond quickly to some crises.

Connected to the perceptions of their efficiency as a 24/7 service, BCR responders' vehicles operate without any flashing lights or sirens, unlike other first responders. This design choice

supports their mission, as it differentiates BCR teams from other first responses that might trigger rather than de-escalate situations. At times, though, it can hamper recognition and slow response times. For example, several BCR responders discussed challenges accessing apartment buildings on calls when landlords did not perceive them as emergency responders. Responders proposed targeted solutions that might enhance their 24/7 city-wide emergency response capabilities while maintaining appropriate differentiation from police and EMS. Some wondered whether vehicle modifications like reflective tape and emergency vehicle designations might help: "I would not want sirens. I wouldn't want lights or sirens, but I would want... the van to be wrapped in reflective tape, just saying like 'emergency vehicle.'"

As Canopy Roots' 24/7 coverage and broad geographical reach represent a critical operational element, staff there and in other programs should continue to consider these issues and approaches.

Relatedly, Canopy Roots' BCR staff operate using tiered clinical oversight to ensure that responders always have a clinical supervisor to call for consultation, no matter the time of day. BCR is staffed by a team of mental health practitioners and mental health professionals, as defined by MN state statute (Minnesota Legislature, 2024). Clinical oversight is required by mental health licensing entities so that complex clinical and operational decisions are made with appropriate ethical, clinical, and safety considerations. The requirement that master's level professionals fill supervisory roles also establishes clinical standards while allowing for various levels of qualification among direct responders. This creates a balanced approach to staffing.

The tiered aspect of the model ensures that if one supervisor is off duty for any reason, a built-in backup provides responders 24/7 access to supervisory support over the phone or in person. Responders told our team in interviews that they appreciated this critical operational component. One called the supervisors "really good," and another elaborated on the help they provide to responders personally: "If you're unable to process a call and get through it mentally, you can reach out to one of the leads or supervisors [and they] will come and step in if need be.... When we feel like we can't help, that impacts us too. So, it feels really good when someone can just come and pick up where we left off, and we don't feel like 'now I left somebody in need of help.'" To make clinical oversight supervisors even more available, Canopy Roots has recently requested city funds to provide a vehicle dedicated to supervisory response.

Structures for Preventing Secondary Trauma

Research consistently demonstrates that traditional first responders experience high rates of employment-related fatigue and secondary trauma due to the frequency, type, and intensity of their exposure to traumatic events (Jones et al., 2024). Untreated stress and mental health challenges impact both physical health (including chronic health conditions and stress-related illnesses) and mental health outcomes over time, resulting in significant occupational costs such as decreased productivity and increased medical and mental health leaves. Ultimately, these factors contribute to widespread first-responder burnout (Antony et al., 2020; Wild et al., 2020).

A clear theme that emerged from our analysis of interviews and reviews of BCR call logs was the weight of crisis work

This is no surprise to behavioral crisis responders. A clear theme that emerged from our analysis of interviews and reviews of BCR call logs was the weight of crisis work. In one example, a responder described a call where a woman was taken to see her mother's remains after initially refusing to believe her mother had passed away. When the woman saw her mother's body, the responder recalled, she emitted "the absolute most heart-breaking, gut-wrenching scream that you could imagine." Moments like these stick with responders, and they test the resilience of even the most experienced staff.

Canopy Roots emerges from these interviews as an organization that works to address the risk of secondary trauma not just by relying on individual resilience-building strategies and post-incident interventions, but by integrating well-being considerations into organizational design and operating practices. A dominant theme from staff interviews centered on a parallel process wherein Canopy Roots works to relate to its responders with the same care, attention, and support that the responders provide to community members in crisis. Interviews revealed how this philosophy manifests in numerous tangible ways throughout the organization. From providing essential equipment like pen holders and quality flashlights for overnight shifts to maintaining open channels for processing difficult calls, employees consistently described feeling genuinely supported. The sentiment of one responder that "I can't say I've ever felt unsupported" was echoed across multiple interviews.

When it comes to mitigating risk for burnout and secondary trauma, Canopy Roots responder interviews and internal documents yield six recurring supports: ***institutionalized processing*** and support systems that normalize emotional processing as professional practice; ***multi-layered support networks*** that provide various levels of formal and informal assistance; ***sophisticated trauma*** prevention approaches that protect against secondary trauma exposure while maintaining support benefits; structural and organizational elements that ***embed recovery time*** and flexibility into standard operations; ***value alignment and shared purpose*** that create meaning and protection against burnout through mission coherence; and professional development and agency that includes frontline workers in organizational growth and decision-making.

Perhaps one of the most striking aspects of Canopy Roots' culture is the normalization of emotional processing. Weekly collective meetings serve as regular touchpoints where responders can discuss difficult cases in a safe space. The organization has created what employees describe as a "climate of being able to process" both difficult and rewarding calls. One staff member commented on having "lots of space to process calls" in as "mandatory critical incident stress debriefers." They summarized: "active listening" is "baked into our collectives."

This institutional commitment to processing difficult experiences is a departure from emergency service cultures that might emphasize a rapid return to service. By making debriefing routine rather than optional or available on demand, Canopy Roots has removed stigma that might otherwise prevent staff from seeking support. Responders found this crucial: "Some people can do these things and brush it off their shoulder, it's not a big deal. But every once in a while, you're going to get something that's gonna just hit the wrong way,

This institutional commitment to processing difficult experiences is a departure from emergency service cultures that might emphasize a rapid return to service

and we need to make sure that everybody is okay.... That is now part of the way the program is run, it's just an expectation that there is a debriefing."

The BCR model provides multiple avenues for processing and support, creating a continuous safety net for staff. One responder described:

> *We always check in with one another at work, and outside of work we have a community, in a way, of just reaching out and seeing if there's any way that we can support each other, or even it's just, like, processing through a call. We have collectives every week, which is also a really good space for that, where we can bring hard calls and talk about them with our peers. And those are really beneficial because not only can we hold space for that, but we can also provide support and give feedback and just validate, too, that, like, that was a messed-up call or that was really hard. And then, additionally, if we have just really intense calls, we always have the option to debrief with a supervisor or a lead that's on shift, and having that space to go through something and process it in the moment and trying to re-regulate and just do the best that we can with what we have at the moment.*

This operations approach aligns with the Substance Abuse and Mental Health Services Administration's (SAMHSA) recommendation for evidence-based approaches to prevent secondary traumatic stress in mental health staff (Substance Abuse and Mental Health Services Administration, 2023). As SAMHSA reminds us, all crisis work carries potential emotional impact; Canopy Roots creates a culture in which processing emotional responses is normalized as professional best practice rather a sign of personal weakness.

The BCR model further aligns with the SAMHSA model by going beyond basic debriefing to implement sophisticated approaches to the prevention of vicarious trauma. One poignant story about secondary trauma stood out in our research: After a particularly difficult DOA (Dead on Arrival) call, a supervisor offered the responders a break. Instead of taking a traditional break, however, the lead responder suggested to her partner: "Let's go down the river." Noting that "The smell of death is very powerful" and commenting that the age and decomposition of the body indicated no one knew the person was dead for weeks, she recognized her own and her partner's difficult feelings. When they found a blooming lilac tree by the river, the responder took a branch and smelled it—using the scent of the flowers to counteract the lingering sensory memory of death. She said: "I'm gonna take this lilac, and I'm gonna let it go down the river. And then, you can follow that if you choose." Both she and her co-responder participated in this impromptu ceremony, holding "a private moment" in which they spoke to the person who had passed and honored their humanity and importance.

A few participants pointed to the more routine BCR debrief protocol, which aims to prevent "contagious trauma" after stressful incidents:

> *The infrastructure of doing critical incident debriefs... Where they'll meet with two supervisors, two licensed mental health people... Because what we also don't want is, like, vicarious trauma to reach[...] into the other responders with details that we could probably avoid sharing in a bigger group.*

This approach aligns with evidence from the crisis intervention field warning that debriefing practices themselves can sometimes inadvertently propagate trauma among team members who weren't directly involved (Tend). By creating a tiered approach in which initial processing occurs in smaller groups with clinical supervision, the model balances the benefits of shared processing with protection from unnecessary secondary trauma exposure.

Several participants expressed similar views regarding how the BCR model goes beyond psychological support mechanisms to address staff well-being through intentional structural elements, such as the provision of a quiet recovery room in the office and careful schedule management. "We retain more employees," one staff member said, "because our work environment lets you come back and decompress better... And you're getting all these days off." This deliberate structuring of work schedules recognizes that the intensity of crisis work requires adequate recovery time to maintain effectiveness and prevent burnout. As this responder describes,

> *I feel very supported by the culture in terms of, like, caring for myself and my well-being... We are working on adding more PTO [paid time off] and things like that that help us care for ourselves. I feel like the values modeled by our leadership—that we all are individuals dealing with our own stuff, and being committed to the work doesn't mean that life stuff doesn't come out or that we don't have families or that we don't have personal things to take care of. And so I appreciate that we are approached with honesty and integrity and [that it's] recognized that the work is big and heavy.*

By prioritizing adequate time off and creating space for decompression between shifts, Canopy Roots' model demonstrates a sophisticated understanding of the SAMSHA model. Organizational policies and structures—not just individual self-care practices—are essential for maintaining workforce well-being in high-stress environments.

Staff Challenges and Growing Pains

Despite the overwhelmingly positive culture, a few responders acknowledged challenges. As Canopy Roots has grown, some have felt a shift toward more corporate structures. "The bigger it gets, the more growth, it becomes more corporate in my eyes," one employee observed, noting the addition of dedicated human resources and finance positions.

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There are also some ongoing struggles with benefits and recognition. A few employees mentioned desires for better health insurance, better retirement savings plans, and official recognition as first responders so that they could access loan forgiveness programs. The issue of finding coverage for scheduled time also emerged as a pain point for one responder, who found it stressful that responders needed to arrange for their own shift subs. Responders told the MNJRC researchers that they experienced moments of feeling unsupported, particularly around administrative decisions that seem disconnected from field realities. One responder described being "thrown under the bus" by management over a decision made in the field, highlighting occasional tensions between "those that do the work and those who do admin." Finally, a few responders suggested the creation of a work group to benchmark salaries against similar emergency response roles, such as police. EMTs, and other BCRs across the country, while also looking at healthcare benefits and paid time off policies to reduce burnout.

Alignment of Personal and Organizational Purpose

Despite the challenges, what emerges powerfully from these interviews is a sense of purpose and meaning. Multiple employees described their work not as a job but as a calling. "My job doesn't feel like my job, it feels like my purpose," emphasized one responder. More than half of the responders interviewed shared that the BCR model fosters well-being through explicit attention to shared purpose and organizational values, with one saying simply, "The value alignment drew me to BCR." Their stories suggest that this shared sense of purpose creates an important buffer against burnout and helps responders transcend hardships and frustrations. A staff member reflected:

> **No matter what I've done, no matter how tired I am... I feel privileged when I have a shift coming up with BCR, because I'm able to provide some solid resources and or make a solid plan.... This is my thing. This has healed me. I love waking up every day.**

This powerful testimony, from someone who joined Canopy Roots after the murder of George Floyd, illustrates how meaningful work within a values-aligned organization can be not only sustainable but actively healing for staff members.

> *When I go to work in the mornings—and I'm just gonna keep it real with you—I tend to think about all the people who go to work and just absolutely hate their job. Like, how much of a grind that would be on someone's mental wellness, right? My job doesn't feel like my job, it feels like my purpose. You see what I'm saying? So, when you walk in purpose and you're doing something in line with your purpose, it doesn't feel like work.*

The BCR model extends its supportive approach to professional development and staff agency in organizational decision-making. Staff members report opportunities to influence organizational direction and growth:

> *I have been given opportunities to kinda, like, help shape how, where we go and kind of, like, future growth opportunities. And so, I think there's a sense of, I kind of think about some of Canopy's values around trust and reliability and assuming good intentions.*

This support extends to professional development:

> *Right now I feel like I have everything that I need. I'm continuing to grow. And Canopy is supporting that growth. If there is not someone internally that is able to provide what I need, then we start to look externally.... And then if there's no one that can provide it that we can find, then we start to look at whether or not there's something we can develop because if I need it, maybe somebody else does. So that is the mindset here. ...I think it's very conducive to us growing.*

This approach contrasts with traditional organizational structures. As one staff member noted, "I've never worked for an organization that really has valued the input of the people who were actually doing the work." This comment highlights how rare genuine inclusion in organizational decision-making is for frontline workers while suggesting it may be crucial for crisis work environments to be sustainable workplaces.

The BCR model's multi-faceted approach offers important insights for crisis response organizations seeking to address workforce sustainability challenges through comprehensive institutional interventions rather than individual resilience-building alone. By addressing structural, psychological, and cultural factors simultaneously, the model provides a framework for sustainable crisis response that aligns with SAMSHA's recommendations for both service effectiveness and staff well-being over time.

BCR In Action: An Overview of Service Delivery

With an understanding of the guiding principles and operational structures necessary for the work, our research team sought to clarify the "what" of Canopy Roots' Behavioral Crisis Response: the delivery of services to those in crisis.

To better understand the Minneapolis BCR services, we conducted ridealong observations with BCR responders and conducted an in-depth analysis of Canopy Roots' internal call log—records spanning their first continuous year of 24/7 operations (from July 2023 through June 2024).

Canopy Roots' call log records are collected via an internal questionnaire that one responder completes on a tablet after each call. The data includes fields for responders to report information about the recipient, service(s) provided, and inter-agency collaboration on calls, and to write a detailed narrative description of the response. (Note that since the call logs come from completed BCR interactions, 911 calls not dispatched to BCR are excluded from this dataset.) In the first year of continuous operations, responders recorded a total of 10,774 call incidents, which we analyzed to better understand call patterns and the BCR model in practice.

The call log data show that BCR responders made contact with a recipient approximately 70% of the time.[2] The remaining 30% of the 10,774 calls were marked as "No Contact," most commonly because responders were unable to locate the intended recipient of their services. Among the 7,453 calls in which responders made contact and recorded service delivery information, responders logged the provision of one or more services to the recipient in almost 90%.

The most distinctive characteristic of BCR service delivery, according to Canopy Roots' categorizations, is the prevalence of crisis de-escalation, emotional support, and/or psychoeducation, which was provided on 65% of calls with recipient contact, reflecting the program's trauma-informed, relationship-centered approach. Safety-related assessments represent another cornerstone of BCR work, with responders performing suicide risk assessments and/or safety plans (26% of calls with contact), demonstrating their role as specialized crisis evaluators.

2) Corrections were made to the call logs if incorrectly tagged as "no contact" when call narrative revealed contact was indeed made.

BCR responders also connected individuals with supplies and/or services. One quarter (24%) of calls with contact resulted in supply hand-offs as well as more specific referrals or connections to community resources such as shelters, mental health supports, or treatment facilities. For example, in the first year of full operational services, responders provided supplies—most commonly water, snacks, bus tokens, and local resource guides—on over 1,600 calls. Another quarter of calls (24%) included BCR providing direct transportation services to safe locations (including to recipients' own homes or family members' residences) and/or "warm handoffs" to local service providers. (Note that responders can and often do provide more than one category of services on any given call.) These numbers illustrate the program's responsiveness to meeting recipients' immediate survival needs as well as initiating longer-term clinical interventions.

65% De-escalation, emotional support, and/or psychoeducation

26% Safety-related assessments (suicide risk assessments and safety plans)

24% Connection to supplies and services

24% Direct transportation and warm-hand-offs to services

These service delivery categories percentages sum over 100% because responders can (and often do) select more than one category of services provided.

As noted, each call log includes a narrative summary of the contact from the responder's perspective. It was outside the scope of our analysis to consider all 10,774 narratives. However, in reading hundreds of call narratives, we found the information rich in detail about the service model. Therefore, with the help of Anthropic's Claude AI, an advanced large language model, we analyzed a small subset of 729 BCR calls from the first month of 24/7 BCR services (July, 2023) - and calls from April and October 2024. This provided a window into the narrative detail of the calls but is not intended to be fully generalizable for all calls for service.

A note on methods: Recognizing the concerns regarding privacy and accuracy with AI, we first de-identified all open-ended call log narratives, or "description of calls," to protect responder and recipient confidentiality. Additionally, we selected program settings to ensure that any data we uploaded would not be used for AI model training. Using Anthropic's Claude AI, we developed an initial categorization framework. We then validated this categorization against human review, finding approximately 80% initial accuracy. Through an iterative refinement process—identifying errors and retraining our model—we improved categorization accuracy to approximately 95%.

Analysis of call narratives showed the more nuanced, relationship-based interventions that define BCR's crisis response services. Specifically, we found that the call categorizations fit into three stages of work: *engagement, assessment, and intervention.*

Engagement is the foundation of effective crisis response, establishing trust and creating a safe space for intervention. This initial connection forms the basis for all subsequent work. Through thoughtful, trauma-informed approaches, and using the guiding principles described above, the call narratives showed how crisis responders build rapport while reducing distress and creating conditions for collaborative problem-solving. Responders engage, establish rapport, and create safety through: ***De-escalation*** techniques using calm voices, appropriate physical distance, and non-threatening body language and ***Emotional support*** that validates feelings and normalizes reactions to crisis.

We also find that for some of the calls categorized as "no services provided" (roughly 10% of calls where responders make contact), meaningful engagement occurred but fell outside existing categorical boundaries.

For example, throughout the crisis response call logs, BCR responders demonstrate a commitment to recipient autonomy by offering multiple options and honoring recipients' decisions, even when, in crisis, they decline the various services regularly offered. The narratives show responders offering multiple pathways forward, such as giving recipients options between shelters, staying with friends, or returning to previous housing arrangements. On one call, "BCR offered to find recipient shelter, offered bus tokens, offered to drive him halfway to his house, as his house is in Alexandria. Recipient refused all help from BCR and disengaged." This choice-centered practice reflects and reinforces a fundamental respect for recipient autonomy. Canopy Roots might consider adding a category called providing options in order to document how responders respect autonomy and support self-determination.

Further, perhaps the most critically undocumented aspect of BCR work involves what one crisis responder called "seed planting"—the patient work of building trust with individuals who may be skeptical of help-seeking. This relationship-building approach recognizes that crisis intervention often plants seeds for future engagement rather than achieving immediate resolution, yet no existing service category captures this fundamental component of trauma-informed engagement.

Call narratives also revealed numerous instances in which responders invested significant time establishing rapport with individuals experiencing psychosis or acute distress, though immediate intervention was declined. Our research observed this in action on ridealongs, and responders told us in interviews that all interactions lay crucial groundwork for future engagement by familiarizing recipients with BCR services and demonstrating respect for their autonomy.

For example, a BCR team responded to a female recipient with a history of suicidal ideation:

> *Recipient appeared to be triggered by male responder and only spoke with female responder after some rapport building. BCR provided emotional support as recipient reported past trauma and her current life stressors. Recipient is houseless and just left a domestic violence situation. Recipient was labile and presented with rambling speech. BCR, recipient, and caller walked through options. Recipient denied being suicidal but stated that she did not care about herself. BCR offered to bring recipient to the hospital and recipient declined. BCR provided education on options for recipient and encouraged her to call back when she was ready. Recipient agreed and BCR departed.*

Again, such work fell outside the organization's service provision categories. We believe ***seed planting*** to build gradual trust and connections to systems of care should also be added to call log forms.

Assessment is the next critical stage of service delivery. As noted above, responders conduct safety-related assessments in about a quarter of the BCR calls. In practice, quickly evaluating complex circumstances requires both clinical expertise and intuitive understanding. Responders gather critical information about risk, resources, and needs while remaining attuned to the person's emotional state. Specifically, we find that Canopy Roots crisis responders gather critical information to inform care through ***Safety assessments***, which quickly evaluate immediate and potential risks and ***suicide assessments***, which involve direct, non-judgmental questions about thoughts, plans, and intent.

This call narrative provides a feel for what assessment looks like on the ground:

> *Responded to caller who was also the recipient. Recipient was observed to smell like alcohol. Recipient endorsed suicidal ideation, intent, and means. Recipient endorsed wanting to jump off the Lowry bridge and was located within walking distance to the Lowry bridge. Recipient was observed to be emotionally labile, oscillating between elation, sadness, and anger. Responders walked across Lowry Bridge and back with recipient per recipient's request to de-escalate immediate risk and restore self-efficacy and perceived ability to manage.*

In addition, but not clearly captured in the current call categories, the call narratives demonstrated responders conducting ***needs assessments*** to identify what the recipient requires for stabilization and support and ***strengths identification*** to leverage their existing resources and coping abilities. In another example from the call narratives:

> *Responders received a call for a recipient who was crying and talking to herself outside. Responders arrived and the recipient stated she was sad because her grandma passed away yesterday. Responders gave her emotional support and she responded well when responders were asking her questions and talking to her about good times and hobbies that she has. Responders asked if she was feeling safe and she stated that she was, just trying to process it. Responders safety planned with her to go on walks as she said that always helps, to get some coffee and do arts and crafts. Responders gave her psychoeducation about our agency and let her know if she needs emotional support to call and one of our teams will be out.*

Finally, the majority of crisis response calls involve some level of intervention. **Intervention** encompasses actions taken to address immediate needs and promote stability based on engagement and assessment findings. We saw how these actions balance immediate safety concerns with respect for the individual's autonomy and preferences. Effective interventions are tailored to the specific situation and draw on both clinical knowledge and community resources. Specifically, we observed crisis responders take action to address immediate needs and promote stability through: ***Provision of supplies*** including food, water, clothing, and bus tokens; ***Psychoeducation*** for recipients; ***Referrals and warm handoffs*** to appropriate community services; ***Safety planning*** with concrete steps to maintain well-being; and Transportation to safety or a referral as a component of care.

In the following example, almost all of these services are provided:

> *Responded to a call for assistance from police regarding male experiencing interpersonal conflict with his mother and wielding two knives with desire to complete suicide by cop. Responders made contact with recipient after police had recipient drop the knives. Recipient denied suicidal ideation, intent, and plan. Recipient reported he was "fed up with the bullshit" and was more angry at the situation he believes his mother placed him in. Recipient was able to reduce his anger and...he was able to collect his things, displayed future orientation by talking about going to work this evening, and was cooperative in leaving though did not want to be transported. Responders engaged recipient in safety planning. Responders also gave the recipient shelter resource referrals and bus tokens.*

In the intervention stage, we again find that the existing service categories fail to capture the substantial effort invested in supporting the concerned family members, friends, and community members who initiated calls. Several of the calls categorized as "no services provided" involved responders spending time reassuring concerned relatives and providing them with resources for future support ,even when the primary recipient declined assistance or was not present. For example, this call is listed as "not contact" and "no services provided":

> *BCR was dispatched to backup MPD regarding grandmother wanting granddaughter out of her home. Upon arrival, BCR was informed the granddaughter (recipient) would not interact through the locked bedroom door and had stolen grandmother's phone earlier in the day. BCR attempted contact with recip[i]ent but was unsuccessful. BCR did provide emotional support and guidance to grandmother regarding situation. BCR encouraged grandmother to call 911 if granddaughter leaves her room or becomes a threat. Caller advised BCR recipient is not a danger to self and no self harm concerns were present.*

Though the responder offered assistance and the recipient declined, the call shows that some services were provided to the grandmother. Therefore, Canopy Roots might consider adding a category to capture ***psychoeducation for community***.

Taken together, this service delivery we identified in the call logs and observed in practice—centered around engagement, assessment, and intervention—aligns with the well-established SAFER-R biopsychosocial model of crisis intervention that Canopy Roots uses to train its responders (Neal, 2024).

So, what does Canopy Roots' Behavioral Crisis Response approach actually look like? We find the Minneapolis BCR standard of practice represents a cohesive model that fundamentally reimagines crisis response by integrating trauma-informed guiding principles (non-threatening and unarmed presence, cultural responsiveness, human dignity, self-determination, and barrier-free access), robust operational elements (24/7 coverage city-wide with clinical oversight and comprehensive staff support systems), and evidence-based services organized around the Engage-Assess-Intervene framework.

Together, these three components create a seamless approach that moves beyond traditional emergency intervention to establish relationship-centered care that honors recipient autonomy, builds trust through "seed planting," and addresses both immediate crisis needs and long-term community healing. This integrated model demonstrates that effective crisis response requires not just clinical expertise but a fundamental commitment to seeing and honoring the full humanity of every person encountered, creating a sustainable "canopy of care" that transforms how communities respond to behavioral health crises.

Moving from Presentation to Presenting Needs of Community Members

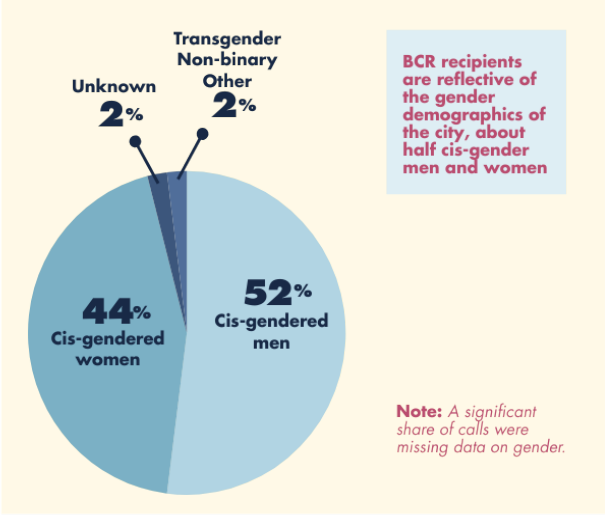
During our evaluation, a research question emerged from conversations with Canopy Roots' leadership and BCR staff: Who is being served and what are the needs being presented on calls? How can we better understand community need to align our growth and potential expansion?

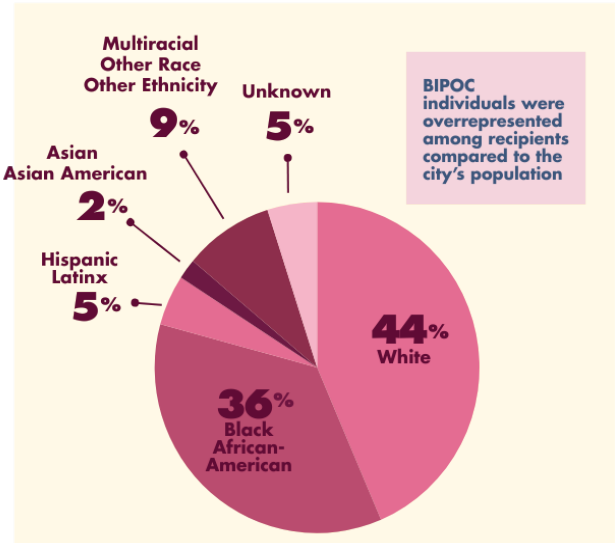
As we explored the "what" and "how" of Canopy Roots' BCR approach, we began to develop a deeper understanding of the "who" of crisis response, that is, who is calling 911 in crisis and what they are experiencing. This analysis can help Canopy Roots ensure responders are prepared to serve their communities and continually improve their standard of practice in response to evolving needs.

We turned again to internal data from BCR call logs to learn what they revealed about who BCR responders are serving and what recipients need. BCR call logs for calls in which responders make contact contain information about recipient characteristics, including responders' perceptions of the person's gender, race, age, risk of suicide, and presentation at the time of contact.

BCR Recipient Demographics

Overall, recipients were typically identified by responders as cis-gendered men (52% of calls) or women (44%), with another 2% recorded as transgender, non-binary, or other genders, and 2% listed as gender unknown (though note a significant share of call logs were missing gender data). BIPOC individuals were overrepresented among recipients compared to the city's population,[3] with 44% of recipients perceived to be White, 36% Black or African American, 5% Hispanic or Latino, 2% Asian or Asian American, and 14% as multiracial, other racial/ethnic groups, and unknown. The vast majority of recipients were adults (93%).





Canopy Roots employs a total of 14 racial categories in their data collection, with racial categories like Southeast Asian, South Asian, and Asian/Pacific Islander. In addition, responders can select multiple categories—a practice that, while potentially more inclusive and showing respect for the complexity of racial identity, creates significant challenges for demographic reporting and analysis. Further, the organization collects "perceived race" as reported by BCR responders, deliberately avoiding more intrusive personal questioning, aligning with Canopy Roots' commitment to removing barriers to care such as paperwork and identification requirements.

3) The demographic make-up of Minneapolis from 2024 census data is 62% white, 18% Black, 11% Hispanic or Latino, 5% Asian, and 10% two or more races and other racial groups.

This is to say, demographic challenges persist; it's difficult to provide clear demographic profiles of communities served, potentially complicating both internal program assessment and external inquiry or accountability metrics. If Canopy Roots seeks more actionable, population-specific insights, they may need to make that goal explicit and operationalize more structured data collec-tion strategies to capture recipients' race.[4]

Clinical Presentation of Recipients

Table 1. Recipient Presentation Data from Current Categorization

Recipient Presentation	Frequency	% of calls[5]	Examples of original descriptor code
None of these	751	12	
One or more presentations	5,573	88	
Mood & Affect	4,143	66	Anxiety Blunted affect Downcast affect Flat Affect
Orientation and Cognition	2,627	42	Apparent delusions Paranoia Tangential thoughts Dissociation
Behavioral or Speech	2,375	38	Psychomotor agitation Rigid body movements Tics Tremors Yelling
General Appearance	1,421	22	Poor hygiene/body care Poorly clothed Unclothed Disheveled
Risk of Harm	1,922	30	Endorsed recent substance use Homicidal Ideation Suicidal ideation (11%) Violent ideation
Total	6,324[6]		

4) For the purposes of reporting on racial demographics for this report we collapsed the categories to align with categories used by the 2020 U.S. Census, White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander, as well as of Hispanic/Latino origin. Additionally, we collapsed any who had selected more than one race into the "multiracial" category.
5) Percentages do not sum to 100% for sub-categories because recipients can demonstrate multiple descriptors.
6) Note that N here is 6,324 for any entry in this field because this question was added to the call logs during the year of data being analyzed. The full dataset for the year was 7,523 for all calls w/ contact.

When documenting a call, Canopy Roots' responders use the "recipient presentation" field to note the recipient's mood and affect, orientation and cognition, behaviors or speech patterns, general appearance, and risk of harm. These are clinical designations including things like dissociation, downcast affect, and echolalia. Responders select from a list of over 50 options (and often select more than one), tracking individual characteristics that, in aggregate, can serve as a rough guide to understanding broader patterns around community needs.

To enable our analysis, the MNJRC started by working to gain a high-level snapshot of recipient presentation. The research team worked with Canopy clinical staff to create a coding scheme that clustered all 50 options into 5 larger presentation categories. Table 1 shows the frequencies of calls in each of these categories and provides examples of the 50 options folded into each.

The presentation of recipients confirms that BCR is meeting its goals of responding to people in both acute and longer-term mental and behavioral health crises. **In 88% of the calls with completed recipient presentation information (N=6,324), responders indicated that the person presented with one or more features suggestive of mental health or behavioral health concerns.**

The most common were a cluster of characteristics we summarize as "mood and affect" concerns (66% of calls with contact), followed by "orientation and cognition" concerns (42% of calls with contact), then "behavior and speech" issues (38% of calls with contact). Roughly ***one-third of recipients (30% of calls with contact) were assessed as presenting some "risk of harm" to themselves or others,*** including apparent intoxication, suicidal ideation, and violent ideation; about ***1 in 10 (11%) recipients were evaluated as presenting with a risk of suicide***. Notably, the 30% of calls with recipients presenting some risk of harm includes a category called "endorsed recent substance use," which includes all possible risk of harm that may stem from a recipient using substances (from a skinned knee as a result of intoxication to death by overdose). Finally, recipients who showed significant concerns around "general appearance" (e.g., presenting in a state of undress) represented 22% of calls.

Presenting Needs of Minneapolis Community

The data above teases out recipients' individual clinical presentations as reported in responders' call logs. However, we sought to better understand potential trends in community-level issues driving calls to BCR. When crisis responders encounter someone who appears disheveled or is hungry, for instance, they're witnessing the visible manifestations of deeper, systemic challenges that extend beyond individual circumstances. That is, individual presentations often tell a story of community-wide issues: insufficient affordable housing, gaps in mental health services, neighborhood-level economic disinvestment, and the absence of accessible substance abuse treatment programs. BCR's perspective and data, therefore, can contribute to an informal but real-time

That is, individual presentations often tell a story of community-wide issues: insufficient affordable housing, gaps in mental health services, neighborhood-level economic disinvestment, and the absence of accessible substance abuse treatment programs

city-wide needs assessment that could impact broader policy conversations, funding decisions, and community development efforts. Such data could also serve as a tool for Canopy Roots to make decisions about the organization's intentional growth.

Recognizing that BCR responds to complex calls with multiple overlapping issues, such as mental illness combined with homelessness, we conducted this additional analysis using a systematic prioritization hierarchy.7 While this approach necessarily simplifies complex situations in which mental health, substance use, housing instability, and interpersonal conflicts intersect, it provides a structured framework for identifying patterns and trends in BCR service delivery. The methodology was designed to identify meaningful trends that could inform improvements in BCR's data collection and areas for potential growth. For example, if homelessness/basic needs were the most common primary driver for calls, we might recommend prioritizing the establishment of better partnerships with shelter referral programs.

An in-depth analysis of a subset of call narratives (N = 729) revealed six main themes that represent ***community needs driving calls:*** (1) ***Mental health crises***, (2) ***welfare checks***, (3) ***substance use crises,*** (4) ***housing/basic needs***, (5) ***family/relationship conflicts***, and (6) serious and imminent ***safety/violence risk***.

Aligned with the services provided data in the previous section, we found that most of BCR recipients' presenting needs were connected in some way to mental health crises. This theme revealed several distinct sub-themes, including psychotic symptoms, anxiety/panic, depression, and other behavioral health crises. Psychotic symptoms, which we defined as calls involving delusions, hallucinations, paranoia, or disorganized thinking, emerged as one of the most common subcategories.

In practice, the presenting need of psychotic symptoms would include cases like a 42-year-old who believed people were trying to electrocute him through the ceiling. This call was resolved through on-scene intervention. "Other behavioral crisis" would include a resident in a group home who displayed manic symptoms—a situation that was resolved without hospitalization.

The next theme of community need that emerged from the call narrative data was ***welfare checks***, defined by our research team as when a bystander or someone in a person's life is concerned for their wellbeing and/or feel the person's needs exceed their ability to help. Welfare checks were often initiated by concerned family/friends but also included public concern and provider requests.

One example of a call with a welfare check presenting need involved a request to BCR from an out-of-state family who had not heard from their 72-year-old relative in several days. This was unusual. Upon arrival, responders found the elder sitting in a chair in a hot apartment with no air conditioning during a heat wave. The recipient was oriented but somewhat confused and severely dehydrated. Though initially reluctant to accept help, the recipient was induced to drink water and allow BCR responders to conduct a basic assessment. When responders discovered the refri-

7) The prioritization hierarchy we used was: (1) Serious and imminent safety/violence risk including threats of violence toward others and/or suicidal ideation/plans/attempts, (2) Mental health crises, (3) Substance use crises, (5) housing/basic needs, (6) family/relationship conflicts, and (7) welfare checks. This technique forced mutually exclusive categories. For example, if a person was experiencing both a panic attack and threatening violence to another person, the call would be categorized under "safety/violence risk" rather than "other mental health symptoms."

gerator was empty and the recipient had not eaten in two days, due to being unable to shop, they provided immediate food and connected the elder to a senior services agency that arranged grocery delivery and ongoing case management. This case also illustrates how welfare checks often uncover unmet needs that might otherwise go untended.

This category in particular prompts questions about whether BCR might actually be poised to respond to a greater number of calls, specifically around welfare checks. This category of need consistently represents one of the top five problem nature codes responded to by law enforcement (see the City of Minneapolis dashboard for more details); it is worth investigating whether more of these calls could be directed to BCR.

When responders discovered the refrigerator was empty and the recipient had not eaten in two days, due to being unable to shop, they provided immediate food and connected the elder to a senior services agency that arranged grocery delivery and ongoing case management.

Substance use crises represented a third common presenting need. At the individual-level, substance use crises fit into the broad subcategory "risk of harm." However, in a more in-depth thematic analysis, substance use crises stood out as a distinct community-level driver of presenting need. Substance use crises predominantly involved alcohol intoxication but also included drug use and individuals actively seeking treatment.

In one such case, BCR was called to assist with a 38-year-old individual found heavily intoxicated on alcohol outside a convenience store. The caller reported the person was having difficulty standing and appeared disoriented. Upon arrival, BCR found the recipient slurring their words, unable to walk steadily, and periodically becoming tearful about a recent job loss. After determining the individual did not require immediate medical attention, responders listened. The recipient explained they had been attempting to access detox services for several days without success. BCR provided water, food, and arranged direct transportation to a detox facility with a confirmed bed. This call also illustrates that substance use calls often require concrete resource connection beyond immediate stabilization.

Next, ***housing or basic needs*** related to poverty emerged as a common reason for BCR engagement. Housing/basic needs calls primarily involved shelter needs and the provision of essentials (water, food, clothing) but also included resource connection and transportation assistance.

In this presenting need category, we see examples like a call from a passerby about a mother with two small children at a bus stop. The woman appeared distressed. BCR arrived to find a 29-year-old woman and her children, ages 3 and 5, who had fled a domestic violence situation the previous night. They had nowhere to stay. Though visibly anxious, the recipient's primary need was not mental health intervention but immediate shelter and safety. BCR provided snacks and water for the children while making calls to locate emergency family shelter. When no immediate shelter was available, BCR transported the family to a domestic violence organization that provided hotel vouchers and case management.

A fifth theme that emerged from the calls was ***family/relationship conflicts***. This may be a growth area for BCR, as it aligns with their values and responders are extremely well-placed to

provide timely and culturally competent help, connecting families to services that can be lasting. Family/relationship conflicts included domestic disputes, parent-child conflicts, and other family issues.

One example of this presenting need came when BCR responded to a mother-daughter conflict. Following an argument about cell phone use, a 16-year-old was reportedly becoming verbally aggressive toward her mother. Responders found both parties emotionally escalated, talking over each other, and unable to reach resolution, so they separated the two for a brief cool-down, then facilitated a structured conversation using active listening and conflict resolution techniques. By the end of this intervention, mother and daughter had agreed to specific household rules and a communication plan for handling future disagreements. Both expressed that a police response would have felt excessive and that they appreciated BCR's mediating approach.

Finally, the sixth main theme that characterized the presenting needs of community members was safety/violence risk. Calls related to safety/violence risk are often high-priority cases involving immediate potential harm, including threatening behavior and general public safety concern. While BCR is not dispatched to scenes involving threats of violence at the outset, BCR may respond to scenes that are not violent at first or when police call Canopy Roots for backup. These calls are often highly visible and garner media and public attention.

The following call log highlights this presenting need:

> *BCR was dispatched to back up police for a recipient who was verbally aggressive, grabbed a knife, sounded like a demon, and was having a mental health crisis. When BCR arrived squads on scene advised they were waiting for EMS as recipient had cut himself and requested assistance with de-escalation, BCR utilized OARs, recipient reported that he woke up today and everything was wrong, recipient would not elaborate, recipient was concerned that responders believed he was crazy, recipient stated he had autism and that rubbing his muscles helped, BCR encouraged recipient to utilize that skill as he found it helpful. Recipient reports he was anxious and was going to throw up, recipient proceeded to do so, BCR continued to work with recipient on identifying things that helped when he felt anxious and unsafe, recipient was able to deescalate momentarily. When EMS arrived recipient became verbally escalated again due to the advisement of going to the hospital, at this point BCR was unable to de-escalate and officers restrained recipient to assist EMS, officer's wrote a hold as recipient had cut himself prior to BCR a arrival. BCR spoke with mother who was present who advised she believed recipient had used a substance, BCR notified other responders, BCR provided emotional support and psychoeducation to mother, BCR encouraged mother to reach out to recipient's case manager and work with them on additional supports.*

As described in the individual-level analysis, the vast majority (88%) of calls had one or more presenting needs. This case example shows that community needs also overlap—while safety/violence risk was likely the most important need on this call in the moment, the recipient described a mental health diagnosis (autism) and substance use as underlying drivers for the crisis.

Taking a deep dive into a subsection of calls provided important insight for Canopy Roots on not just the presentation of those in crisis but their presenting needs. Canopy Roots serves demographically diverse residents, with BIPOC individuals overrepresented in the recipient population. The community members Canopy Roots responds to are experiencing serious and persistent mental health symptoms. Responders are encountering individuals in states of paranoia and delusion, people struggling with coherent speech or basic hygiene, and those experiencing such intense agitation or despair they pose danger to themselves or others. Many are in active psychotic episodes, suicidal crises, or substance-induced medical and mental health emergencies. And 88% of recipients present with one or more serious mental illness symptoms. Without proper intervention, such situations can escalate to emergency hospitalization and even tragedy. In-depth analysis of call narratives reveals six primary drivers of calls for assistance: mental health crises, welfare checks, substance use disorder, housing/basic needs, family/relationship conflicts, and safety/violence risk. Such BCR call data can and should contribute to a real-time, city-wide needs assessment that could impact policy conversations, funding decisions, and community development efforts.

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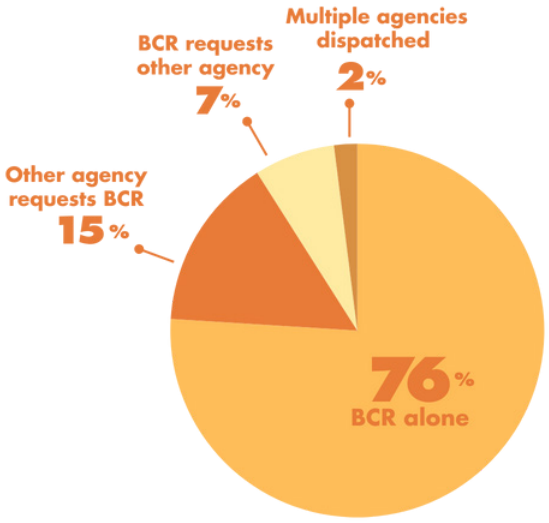
Collaboration in the Minneapolis Safety Ecosystem

The work of the Behavioral Crisis Response program is complex, and it is situated within an emergency or crisis response ecosystem. In many ways, the Minneapolis BCR program is a newcomer, so it is perhaps unsurprising that Canopy Roots responders were curious about how they are perceived by other first responders.

In terms of inter-agency collaboration across the public safety ecosystem, the call logs showed that the BCR responded independently in three-quarters (76%) of calls they responded to at some point.[8] In another 15%, another agency responded first and requested that the BCR support them as backup. And 2% of calls were recorded as calls with multiple agencies assigned by 911 dispatchers. Only in 7% of calls did BCR responders report calling in other agencies as backup. Most commonly, the MPD's assistance was requested by the BCR, but responders also received backup from EMS, Fire, and Animal Control. As documented in the call narratives, sometimes more than two agencies were on a scene together; for example, BCR, MPD, and EMS might all respond to a call requiring transporting a recipient to the hospital.



8) This question about cross-agency collaboration was only introduced in November 2023 so our N=4,976 for this variable.

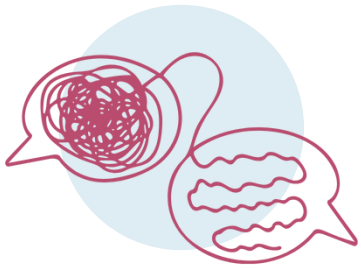
To understand the perspectives of others in the ecosystem more fully, we conducted interviews with representatives across the safety spectrum (see the Research Methods section for more detail). During the interviews, we focused on successful integration points, ongoing challenges, and suggestions for improvement.

We found that: 1) BCR is perceived as filling a critical gap in emergency response, 2) BCR is perceived as bringing unique training and knowledge to the field. 3) Interagency relationships have been uneven, evolving most readily with those who collaborate most frequently (911 and MPD) and 4) Other stakeholders asked about BCR report some remaining concerns regarding safety, availability, scope of authority, and system integration.

Filling a Critical Gap in Emergency Response

Stakeholders across the safety ecosystem consistently highlighted BCR's role in filling a critical void in emergency response. One MPD officer said, for instance:

> *And I just think there's just not enough [behavioral crisis responders]. There's not enough of them. I don't know if they're not paid enough or if there's just a shortage going into that profession or whether people in that line of work don't wanna have to do it sort of out in the field like that. I don't know what it is. They don't get enough credit. They're a lot more valuable than people are willing to acknowledge. And I think they're absolutely amazing.*



Another MPD officer pointed to provision gaps for people struggling with homelessness and behavioral health concerns:

> *It seems like Minneapolis has an unusually large demand for behavioral health emergencies. And I don't think you can measure that necessarily in proportion of calls or number of calls. It seems like the seriousness is also more severe. And I don't know why that is.... But it does seem both an unusually high volume of calls and then the sort of the seriousness or the level of care that's needed is unusually high.... I can tell you today, people absolutely, at least internally in the police department, absolutely want BCR to be available. They want more of it. I personally find it frustrating when BCR is criticized.... I think Minneapolis with Canopy has probably one of the best [BCR programs] in the country...*

Another Minneapolis safety community leader was emphatic in stating "*I couldn't imagine an ecosystem without BCR*" and affirmed that "The city did get it right" with its BCR contract for services through Canopy Roots. This sentiment was echoed by staff at the Hennepin County Behavioral Health Walk-in Center who, rather than suggesting modifications to the service, advocated, "If anything, expand it. Where are there gaps?"

Current challenges for first responders were clearly articulated by a leadership member of the Minneapolis Fire Department:

> *We know the system is broken and it's overloaded. It's frustrating because it happens on EMS calls too, where the only place you can take a person is to the emergency department. And they go in, and if the person isn't willing to get help at that time, or doesn't necessarily engage with what they're telling them, they'll spit them right back out.*

But significantly, those we interviewed returned to the idea that having BCR available better ensures that mental health issues "don't get criminalized" (as one leadership member of Hennepin County Behavioral Health put it) and that Canopy Roots addresses a longstanding concern about the intersection of mental health and criminal justice systems.

Bringing Unique Training and Knowledge

BCR's value lies in its specialized approach to behavioral health crises that traditional law enforcement is not primarily designed or trained to address. One 911 dispatch interviewee from the Minneapolis Emergency Communications Center noted that even with Crisis Intervention Team (CIT) training, police officers "would much rather go get the bad guy" than manage complex mental health situations. This perception was echoed by an MPD officer who said, "Even if it's just us and a couple of EMTs, we're not trained to appropriately deal with some of these emergencies, and we'll do it the best we can." The interviewee from 911 dispatch explained that the new response from police officers involved turning to BCR: "MPD will go, 'Yep, the knives are put away, the situation is calm, okay, now let's get the real professionals in.'" An employee at Hennepin County Behavioral Health agreed:

> *I think it's about lens. Police walk in from a place of safety and wrong and right and figuring out who did what, whereas a social worker, that's not the lens that you are walking into the environment with. Even the most helpful, the most well-informed and all-knowing of mental health police officers still walks into it with a lens of, like, safety first.*

Many first responders reflected on BCR's professional competency, praising responders, for instance for being "very competent, calm, and [keeping] their wits about them." These positive assessments highlight instances in which BCR staff demonstrated effective crisis management skills and emotional regulation under pressure–qualities essential for emergency response and found credible by other first responders.

Perhaps most encouraging, there are signs of mutual influence between these groups of safety stakeholders. BCR's approaches appear to be affecting police practice in subtle but meaningful ways. For example, one BCR team member noted "I've even seen officers now utilizing some of the skills...." This suggests a learning process wherein BCR's trauma-informed and mental health-centered approaches are beginning to influence traditional first responder tactics.

Perhaps most encouraging, there are signs of mutual influence between these groups of safety stakeholders.

More Interaction Leads to Better Relationships

Though initially met with skepticism, BCR has gradually built credibility among other agencies, with some uneven acceptance across departments. We found that the Minneapolis Police Department (MPD) and the staff at the 911 dispatch center have become supportive of BCR, while relationships with EMS and fire services have developed more slowly.

This operational evolution shows growing recognition of BCR's specialized value, with more police officers proactively requesting BCR assistance after identifying behavioral health components in calls. Early misunderstandings about BCR's purpose and capabilities have been replaced by a maturing partnership based in complementary expertise rather than competition.

Again, this uneven evolution appears to result from differing interaction rates between agencies. As one person from the fire department explained, *"We have 430 employees to educate on this service [BCR]. And it's gonna take a bit... We have 19 fire stations. We have 27 different rigs, three different shifts... 430 people that are trying to learn something new. And when you don't necessarily go to that type of call on a regular basis, people forget."* This evolution may continue now that the contract with Canopy Roots and BCR has recently moved from the Office of Neighborhood Safety to the Fire Department. Similarly, EMS has less interaction with BCR than does the MPD; a 911 dispatch staffer explains how that affects trust-building: *"We wanna keep the police out if we can, but we're working with the EMS to try to get them a little bit more trusting of our BCR staff."*

There is room to grow, as one responder explained. Law enforcement officers do, at times, still misunderstand BCR's function, with police sometimes calling BCR "to help with the transport," despite BCR not being "a transportation service." This misalignment leads to inappropriate referrals and potential conflicts.

In considering this, we see individual relationships have proven more significant than institutional policies in determining collaboration quality. BCR staff frequently praised specific MPD officers who model collaborative efforts: *"...he is the type of police officer that, if every cop was like him, nobody would ever complain about the police."* These person-to-person connections have created informal but effective working agreements. Another BCR responder described the emerging collaborative dynamic with a specific MPD officer:

> *He's real good at calling us in. Like, he'll recognize 'this is a mental health situation; I'm just gonna have the BCR come and meet me.' That's kind of how we were introduced and have that working relationships that I know, he knows when I call him for backup that it's serious, and I know when he calls me to come in for backup that it's a necessary call. Like, somebody needs something that I can provide help.*

This mutual recognition of expertise and appropriate roles represents significant movement from earlier tensions.

People at the Hennepin County Behavioral Health facility said that, as they've become familiar with BCR as a resource, they have become more comfortable, and vice versa. This partnership has moved from simple drop-offs to more engaged handoffs with collateral information sharing. They anticipate that as each group becomes more attuned to the other's capabilities, their hando-

ffs will naturally become more effective and impactful. However, they acknowledge they *"haven't necessarily collaborated enough to maybe dovetail that together,"* while emphasizing that true success *"really is about collaboration. We're just a small piece of that continuum, and we do need to partner and work collaboratively and together and cohesively to address this."*

Finally, BCR implementation has shown a strong safety record, which has slowly helped build trust among other system actors. A staff member at the 911 dispatch center stated, "I'm very proud... Because responders' safety is our most, our biggest thing and then civilian safety, but as far as, like, we've not had an injured BCR.... Because it was scary when you're first doing it [sending 911 calls to BCR]." Another added, "We've got a couple of close calls, but we've never had an issue."

Finally, BCR implementation has shown a strong safety record, which has slowly helped build trust among other system actors

Other First Responder Tension and Concerns

While the relationships between responders across the ecosystem have evolved, safety concerns regarding BCR's approach remain prevalent among the Minneapolis Police Department. As one responder indicated, *"people think that [BCR work is] inherently dangerous... because we're unarmed, a lot of times people are like... 'maybe you should carry mace.'"* This concern likely stems from experiences with unpredictable situations involving mental health crises, substance use, or other volatile scenarios.

However, this viewpoint stands in contrast with BCR's operational experience. As one responder put it, *"We've responded to now like 20,000 calls with zero injuries."* In fact, as noted above, data shows other agencies request BCR backup more than BCR requests other agencies' backup. Their safety record might suggest that their de-escalation techniques and non-confrontational approaches effectively reduce risks to responders and recipients. Despite this evidence, some other first responders maintain that *"a co-responder model would be better and safer,"* suggesting ongoing philosophical differences about appropriate crisis response models across first responders.

Some other agencies' responders expressed concern with work patterns, noting instances of BCR staff "suddenly becoming like unavailable or taking two hours to write up a call." This perception indicates that not all first responders are aware of (or agree with) the responder recovery time built into the BCR model. Whatever the cause, though, such concerns might affect the perceived reliability of BCR as reported by partners in the safety ecosystem.

Situations involving involuntary interventions are particularly challenging, because responders lack clear protocols for multi-agency cooperation: "If MPD asks us to back him up on the call, what's our role? And if we ask for MPD backup or EMS backup, what is it that we need?" This absence of formal frameworks leaves responders sometimes navigating complex boundary areas without protocol, especially when balancing voluntary engagement principles with public safety requirements in high-risk situations.

Finally, we find that occasional system integration problems hinder service delivery. Hospital coordination, for example, remains inconsistent, with responders indicating "we don't get to use

the ambulance bay at most hospitals," creating inefficiencies during critical situations.

In conclusion, the safety ecosystem in Minneapolis is constantly evolving. Over the course of our evaluation, we saw consistent support for BCR from other first responders at all levels, from leadership to beat cops, from firefighters to county agencies. Canopy Roots is perceived as filling a critical gap through its unique approach and capabilities. As time passes and agencies collaborate, inter-agency relationships continue to improve. Tensions and challenges remain around safety, scope of authority, and system integration as the work continues.

Community Perception of BCR

The team at Canopy Roots also wanted to better understand how BCR is perceived by the wider Minneapolis community, a concern that guided our fifth research question. In researching community perceptions, we find a complex picture of strong support and limited public awareness.

Survey data, interviews, ridealongs, and social media posts collectively indicated that Minneapolis residents conceptualize safety holistically—prioritizing community connections, economic stability, and freedom from fear over traditional law enforcement approaches. We find that less than half of community members surveyed were aware of BCR's existence, but those who were familiar and those who learned about BCR through our outreach and survey both expressed broad support for the model. Those with direct experience overwhelmingly praised the program's compassionate approach to mental health crises.

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Holistic Safety

In order to explore community perceptions of Canopy Roots and the Behavioral Crisis Response program, we began by surveying community members' conceptions of safety. In other words, because Canopy Roots' stated mission is to provide compassionate care to improve community safety, we set out to see what "safety" meant for residents of Minneapolis, especially those communities that more frequently receive BCR services (see the Research Methods section for more detail on survey design and distribution).

Safety is a high priority in the community. Nearly all respondents (95%, or 492 of 519)[9] ranked safety as "important" or "very important." When asked, in the same survey, to choose statements that best reflected their perceptions of safety, a holistic perspective resonated across the majority of respondents—respondents didn't coalesce around one single definition and most thought safety was many things. The highest agreement was with the statement "Safety is stability—economically, emotionally, physically, and socially," with 94%

Safety is a high priority

95%

ranked safety as
important
or
very important

9) A reminder that the survey contained some skip logic questions—that is depending on responses to certain questions respondents were asked more questions—and some residents didn't complete all questions on the survey.

of respondents reporting that this "strongly" or "somewhat" "reflects what safety is to me." Most respondents (between 84% and 93%) noted safety was about freedom, the absence of fear and violence, protection from harm, community closeness, freedom/liberation in body AND mind, and accountability for those who cause harm. The least frequently selected option—nevertheless selected by many residents (70%)—was that safety required an absence of lawlessness.

Answers to an optional open-ended prompt about other requirements for safety "missing from the choice above" bolstered this holistic and comprehensive conceptualization of safety, while underscoring the subjective and context-dependent nature of community members' perceptions of safety. For example, residents most often added details about physical environment factors (i.e., lighting, accessibility, infrastructure, and a quiet neighborhood; 18 mentions), then community and social factors (i.e., the presence of neighbors and the quality of community relationships; 14 mentions). Four respondents mentioned police presence as "missing" from the definitions of safety presented in the survey.

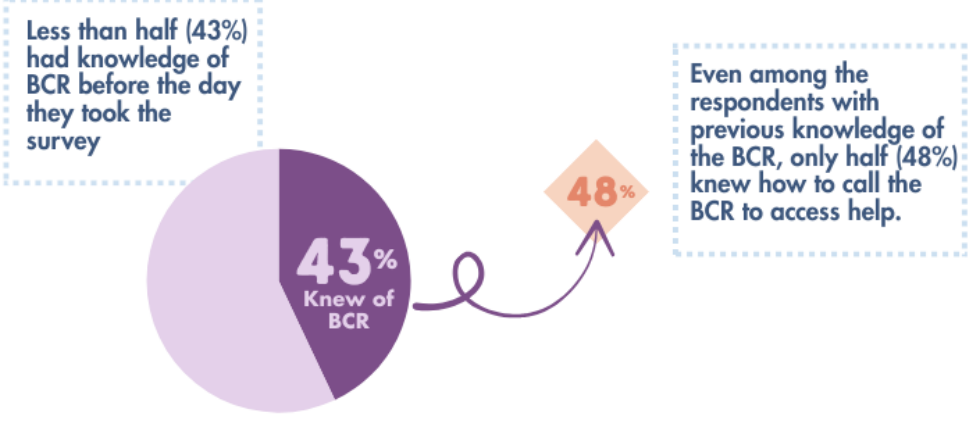
When we asked respondents how safe they currently felt in their neighborhoods, the majority (71%) reported feeling safe or very safe. Participants were able to select more than one reason for these feelings of safety, and their answers ranged from neighbor connections (73%) to personal resources (51%) and community-based organizations (36%). Only 28% of respondents noted that City of Minneapolis resources (e.g., 911) contribute to their sense of safety.

The degree of access to community resources, as well as neighborhood affluence, came up frequently (e.g., "[I am] blessed to live in an affluent area" and "I live in a well-resourced and wealthy neighborhood, and that contributes more to my sense of safety"). In addition, respondents spoke about personal strategies to increase their experiences of safety, such as having a dog, locking their doors, and/or living with a partner.

Thus, while creating safer communities is an important mission, the task of doing so cannot lie with the BCR program alone. Minneapolis residents have nuanced and holistic visions of safety, and their senses of safety depend on community-wide measures.

Lack of Information About the BCR

Less than half of the individuals surveyed (43%) knew BCR existed before the day they took the survey. From the group of people with existing knowledge of BCR, their previous information came from different (and sometimes multiple) sources; about half (45%) indicated that they had heard about the program from traditional media channels (e.g., newspaper, radio, and television), 35% through social media, and 45% from their community (e.g., family, friends). Importantly, even among the respondents with previous knowledge of the BCR, only half (48%) were confident they knew how to call the BCR to access help.



After a short explainer introducing the BCR in the survey, all participants were asked a series of factual questions about the BCR. After the information was shared, most participants (between 73% and 88%) understood that the BCR is dispatched by 911, run by Canopy Roots, free of charge, and in operation 24/7. As one participant summarized, BCR is "a non-violent, unarmed alternative to a police response that might be more appropriate for mental health non-violent situations."

However, some responses revealed lingering misconceptions, such as the service being part of the Minneapolis Police Department (13%), armed (3%), and a transportation service for those who need a free ride (5%). Some residents' optional open-ended comments suggested confusion around BCR availability, relationship with law enforcement, cost/fees for service, and ability to provide long-term support services.

Knowledge of the BCR was sometimes tangled up with points of confusion. For example, as one survey respondent explained, "Instead of calling the police, you would call BCR in the event of a mental health emergency and they would assist on the scene instead of police." In this response, we can see that even for an individual who understands what BCR does, they may not know that you call 911 for both BCR and police.

Expanding on the survey results, interviews with BCR responders revealed that community knowledge (or lack thereof) creates access barriers. Several responders reported direct resistance, for example, when attempting to reach clients in apartment buildings or areas that required access from landlords or others: "We have approached buildings where we couldn't get in, where there are men out front, and they're like 'no, this is our building.'" Another noted that the Minneapolis Fire Department has access to locks in large apartment buildings, whereas BCR just has "their uniform" and "people are... just like, 'I don't know who you are'" and are less likely to allow BCR entry to respond to people in crisis.

Critical gaps in community awareness and understanding have implications for BCR implementation that may impact program fidelity and outcomes.

Respondents Show Support For BCR

Despite gaps in awareness of BCR services, general opinions about a BCR model were overwhelmingly positive. Of the 429 respondents who completed the final battery of questions at the end of the survey, a full 91% reported they were "supportive" or "very supportive" of "unarmed alternatives to police approaches like BCR." Only 4% of survey respondents selected "unsupportive" or "very unsupportive." **Further, 87% indicated that knowing that the BCR program existed increased their feeling of safety and that they trusted the BCR to address a behavioral health crisis.** Considering this alongside the finding that only 28% of respondents reported that City of Minneapolis resources contributed to their sense of safety, we can see the potential for increased capacity by Canopy Roots via the City of Minneapolis to impact feelings of safety.

Participants had mixed perceptions of the importance of the various core operational design features of the BCR. Where respondents had the most consensus was around weapons (with 83% of respondents saying that BCR being unarmed was "very important" or "important") and 911 dispatch (with 81% agreeing it was important to have the BCR team dispatched through 911). Three-quarters of participants agreed it was important to have the BCR "paid for by public do-

> **These findings suggest that respondents strongly believe that BCR needs to be connected to city infrastructure—especially 911—but the majority prefer it not to be operated solely by the city.**

llars." Finally, 68% of respondents indicated that "being operated by an organization outside of Minneapolis city government" was important for effective BCR. These findings suggest that respondents strongly believe that BCR needs to be connected to city infrastructure—especially 911—but the majority prefer it not to be operated solely by the city.

Direct Recipients Praised Responders' Compassion and De-escalation Skills

Among our survey participants, 36 individuals (roughly 7% of the sample) told us they had been present when the BCR team responded to a crisis. Roughly one-third had made the call to BCR personally. These participants largely described their experiences with the BCR as "positive" or "very positive," with only 2 participants reporting a negative experience. The vast majority (82%) described BCR's response as "effective" or "very effective." Their responses highlighted responders' compassion, respect, and cultural sensitivity.

In addition, analysis of open-ended survey responses, interviews with individuals with direct BCR experience, and comments posted publicly to social media sites show that witnesses and recipients consistently—and in many cases fiercely—expressed gratitude for the BCR's approach, describing responders as "extremely friendly," "very helpful," and able to "connect emotionally" with people in crisis.

Social media sites such as Reddit/r/TwinCities, are filled with testimony about experiences with BCR. One BCR recipient described being "in a dark spot" and contemplating self-harm when they called 911. The BCR team's intervention marked "the day I started making a change for [the] better in my life." Similarly, a veteran expressed profound gratitude when BCR helped a friend who was experiencing suicidal thoughts:

> *So, my buddy had a pretty big mental health issue on Monday, and I couldn't get to him. We served together in Afghanistan. He's my best friend, and he was talking about killing himself. He was locked in a bathroom, and I called the cops and hoped for the best...It gets very sketchy with people like us. He's a registered gun owner so everybody knew he had access to firearms. I don't know what he had with him in the bathroom or how they got him out but it worked...They sent this behavior response team and [they] coaxed him out so he could get some help. Big ****ing shout out to you guys.*

Later the same person gave an update, "I saw my friend today. He looks good and healthy...I held off on posting this because **I wanted the focus to be on the real heros, my friend for getting help, and the response team for coaxing him out...My friend and those BCR team women are heros."**

Patience and compassion were noted by two interviewees who witnessed BCR interventions. More specifically, one observer watched from their apartment as BCR responders spent approximately 30 minutes with a man in crisis who was hitting himself. They noted the responders kept a respectful distance, provided water, and spent significant time with the man. Another individual

reported seeing BCR responders de-escalate a situation with someone stumbling through traffic: *"[911] sent BCR, who came in a little van and de-escalated the situation beautifully. The man got help."*

What stands out in the data is the relief expressed by those community members who acknowledge their need for safety options but fear police violence or criminalization. Respondents also appreciated BCR's respect for an individual's autonomy.

What stands out in the data is the relief expressed by those community members who acknowledge their need for safety options but fear police violence or criminalization.

For example, one single Black mom told us that she had called BCR when her teenage daughter was in extreme emotional distress. In the past, she said, "I really never have ever wanted to call the police, even when I was in danger, because even though my husband was awful to me, I didn't know if they would shoot him, to be honest, even when I was going through it." Now, with BCR as an option, this mother has reached out numerous times for help for her daughter. "I don't think it's an overreach to say [BCR] saved her life. Oh, I said I wasn't gonna cry. I really, I just I felt so grateful to have somebody else to call besides the police."

The veteran who responded above also said he was afraid to call the police to help his suicidal friend because police know that veterans often have weapons so they come into crisis situations "with guns drawn." He relayed, "I called the police and hoped for the best," fearing it could lead to an escalation or shooting incident. He was tremendously relieved to have BCR staff respond. Another person recalled calling 911 for a welfare check on their mother; they found the BCR team "nicer and more able to try to connect emotionally" than the police with whom they had previously interacted.

Direct Recipients Expressed Some Concern About Response Time

Among survey respondents who had witnessed or directly experienced a BCR response and rated the response time, over half (61%, 20 of 33 participants) rated the response time as fast or very fast. Eleven participants described the response as "moderate," and two as "slow." Open-ended survey responses also showed some concerns about response times. In one example, a caller reported that it took about 40 minutes for BCR responders to arrive after a 911 call about a person in crisis. Despite this wait time, though, this same observer was impressed with the amount of time the responders spent with the person in crisis once they arrived: "they seemed to be intentional and put in a lot of effort. It took them 40 minutes to show up. But they spent nearly that much time with him."

But another participant said BCR had "dropped the ball hard" when their employer called:

> *"A guy that was high off his rocker came in and had a panic attack in our entryway. Poor guy wanted us to call help and the crisis unit arrived 20 min after he had already run off and hopped on a bus to who knows where. When they did arrive, they were in no rush and were messing with their phone as they ambled in. I have hopes they'll do better as they get more established, but they failed that man."*

And a third said:

> *"I want to preface this comment by saying I think the Crisis Response teams are, at least in principle, a great idea and one that needs to be taken much farther than it has been. Minneapolis should have far more of them... BUT... I have now witnessed four response team responses. I live in Phillips. Two I called myself. Two my neighbors have called. The two times I called, the response time was 40 minutes each time. In both instances, [BCR] arrived, sat in the van for about 5 to 10 minutes, interacted with the person they had been called to help for under 5 minutes, then returned to the van for another stretch of time. I assume they were on the phone with someone during this time. In one of those instances, the person in crisis [PIC] took off running, and that was that. In the other, the PIC told the response team to fuck off, and they fucked off. He walked down the street but was later picked up in an ambulance because he overdosed.*
>
> *In both instances of my neighbors calling, the PICs were gone by the time they arrived. There's no need to compare response times to police response times. This isn't a contest or misery marathon. These are just anecdotes. Again, I think the idea is great. Take my money. But it seems to me (again, from witnessing this less than a handful of times) that Crisis Response has a long way to go before they are just keeping police away from people in crisis."*

Such mixed experiences highlight the tension between BCR's promise and operational realities.

In sum, we find that community members express strong foundational support for BCR. While less than half of residents knew about the program before taking the survey, an overwhelming majority expressed support for unarmed crisis response once informed, with most reporting that BCR's existence increased their sense of safety. Direct recipients of BCR services consistently praised responders' compassion and de-escalation skills, with particular appreciation from BIPOC communities and others who feared police violence, who described BCR as lifesaving. Response time concerns and access barriers due to limited community awareness are obstacles. The data suggests that BCR's core model aligns well with community values around holistic safety, but realizing its full potential requires addressing operational and outreach challenges.

The Right Metrics for Canopy Roots

The findings thus far have demonstrated the complexity and importance of Canopy Roots' Behavioral Crisis Response (BCR) approach. The BCR standard of practice builds on a foundation of five key trauma-informed principles with 24/7 coverage, clinical oversight, and robust support systems for staff wellbeing, allowing responders to provide sophisticated crisis services ranging from de-escalation and emotional support to meeting basic needs and making appropriate referrals. Call logs suggest that BCR staff are meeting the presenting needs of recipients of care. Interviews with other first responders suggest they play a unique and necessary role in the safety ecosystem. Community members support the model, and those who have experienced it have glowing reviews. All this begins to paint a picture of a program making real impact.

The final research question, therefore, frames up an inquiry about measurement—what are the right metrics to demonstrate BCR effectiveness? How should Canopy Roots measure its outcomes?

Traditional evaluations are often tied to concrete outcomes. An organization's staff will answer the "what's working" question by exploring whether the thing they hope to achieve is happening. However, when the outcome of interest is both systemic and holistic in nature—in the case of Canopy Roots, safer communities—it can be difficult to measure. Programs like Canopy Roots may struggle to determine their progress.

Many rubrics and metrics have been identified for mobile crisis response programs (Torres & Narayanan 2024). Most are based in similar paradigms as those employed by law enforcement. They include metrics such as number of calls, call types, response time, and call geography. These are important measures, but don't necessarily capture BCR's complex contributions to community safety. They are also limited by what data the 911 dispatch system collects. With the freedom to capture their own internal data, Canopy Roots has an opportunity to build metrics tailored to their unique model and mission.

Traditional evaluations are often tied to concrete outcomes. An organization's staff will answer the "what's working" question by exploring whether the thing they hope to achieve is happening. However, when the outcome of interest is both systemic and holistic in nature—in the case of Canopy Roots, safer communities—it can be difficult to measure.

Canopy's stated mission is to provide compassionate care to improve community safety.

Using the findings above, we can begin to define these goals. ***Compassionate care*** includes the guiding principles, operational elements, and specialized services used by BCR. ***Community safety*** is holistic, including protection from harm and reduced violence; emotional, physical, and mental stability; freedom in body and mind; and connections to a supportive community. From here, we can chart a path from the presenting needs of community members to the guiding principles and core techniques of BCR to the individual, community, and system-level impacts that ultimately improve community safety.

To answer our final research question, we analyzed internal training documents, external communication documents, interviews and observations with staff and key ecosystem actors, and survey data from community members to develop a theory of change and recommendation metrics that may help Canopy Roots staff better understand what compassionate care looks like and whether community members are feeling safe.

THEORY OF CHANGE

PRESENTING NEEDS

- Mental health crises
- Welfare checks
- Substance use crises
- Housing/basic needs
- Family/relationship conflicts
- Safety/violence risk

TRAUMA-INFORMED GUIDING PRINCIPLES

- Non-threatening/unarmed
- Culturally-responsive care
- Dignity and humanity
- Honoring choice
- Barrier-free access

SERVICES PROVIDED

Engagement

- De-escalation, emotional support, providing options, seed planting

Assessment

- Safety assess, suicide assess, needs assess, strengths identification

Intervention

- Supplies, psychoeducation for recipients, psychoeducational for community, referrals and warm handoffs, safety planning, and transportation

BCR

COMMUNITY/ SYSTEM IMPACTS

- Protection from harm
- Stable communities
- Freedom in body and mind
- Community connections

CALL OUTCOMES

- Resolved in community
- Local support activated
- Hold Called for Safety
- Medical issue/EMS backup
- Successful referral/handoff
- Attempted referral to services
- Right of refusal exercised
- Transport to safety/referral
- CPS, APS, MAARC report
- Unable to locate/no contact

MINNESOTA JUSTICE RESEARCH CENTER

The diagram above outlines our theory of change. We start by showing how Canopy Roots responds to the presenting needs of community members. Therefore, our first recommendation for a new metric involves the documentation, alongside "presentation," of recipients' "presenting needs." Such data will demonstrate how compassionate care is meeting community members where they are.

Metric #1: Capturing Presenting Needs of Community

We recommend creating a call log category to better document the systemic presenting needs of community members. Based on our analysis of presenting needs in a small subset of calls (see section III), Canopy Roots might consider including the following categories: mental health crises, welfare checks, substance use crises, housing/basic needs, family/relationship conflicts, and safety/violence risk.

This list should serve as a launching point for Canopy Roots staff to further explore and ultimately identify a full battery of presenting needs that both captures what needs responders are attending to and makes streamlines subcategory selection for responders in the field. For example, "safety/violence risk" may be too broad; responders may prefer to indicate suicide as a particular risk category.

As they work to design a system to document presenting needs, we recommend that Canopy Roots staff examine other response approaches across the country. For example, we identified Durham, North Carolina's version of BCR, HEART (Holistic Empathetic Assistance Response Teams), as a potential model. HEART's model and guiding principles strongly align with the BCR approach at Canopy Roots. The folks in Durham created a crisis response dashboard that gathers qualitative and quantitative data, including data on the safety of responders, in language that centers human dignity (City of Durham). HEART collects data on "call types" that aligns with the presenting needs of community members, whose top call categories are: "Trespass or Unwanted [person]," "HEART Follow-Up" (after another response), "Mental Health Crisis," "Non-urgent Welfare Check," and "HEART Assist" (with other responders).

Presenting needs categories will provide key data about what community needs are most prevalent, allow Canopy Roots to determine emergent training needs, highlight areas for possible expansion, and provide a de facto crisis needs assessment for the City of Minneapolis.

The theory of change moves from presenting needs to the trauma-informed guiding principles that buoy the services provided (as described in section II). The data on services provided is already collected and could be further analyzed to continue to explore the Canopy Roots model of BCR response.

Following the services provided, we identify several call outcomes—metrics that Canopy Roots does not currently measure systematically. These outcome categories stem from the services provided as recorded in call logs, and their regular use would help paint a clearer picture of the organization's impact (and its own needs). Therefore, our second metric recommendation is to expand the "call outcomes" category. This would also serve to increase public transparency of the work of a BCR responder.

Metric #2: Expand Call Outcomes

Call outcomes are often referred to as "call dispositions" in crisis response work. These are the codes that police units use to clear a call after they are done responding. The last primary police unit leaving the scene enters the call disposition. BCR responders are also required to enter disposition codes into the Minneapolis CAD (Computer Aided Dispatch) system.

However, on Canopy's own internal call logs, responders currently document only three call outcomes: "Contact Made/No Contact Made/Call Declined." If contact is made, "services provided" becomes the only way to determine the outcome of the call. If no contact is made, no services are selected (even if the responders intervened with a recipient's family). The addition of a more robust call outcome category is another metric that would help demonstrate how Canopy Roots is actually addressing community safety. It would also improve transparency, allowing Canopy Roots a more accessible way to report call completion to the community.

Reviewing a subset of 729 call narratives, we found that most BCR calls end in one of 10 following outcomes: 1) Crisis resolved in community, 2) Local support network activated 3) Hold called for safety of recipient or community (MPD), 4) Medical issue requiring EMS backup, 5) Referral to community resources (such as housing, mental health, food, or culturally specific supports), 6) Referral attempted but resource unavailable (e.g. no beds available at a shelter), 7) Right of refusal exercised, 8) Transport, 9) CPS, APS, MAARC report created (for thorough follow up safety assessment), and 10) Unable to locate/no contact.

As with the presenting needs categories above, this list should serve as a launching point for Canopy Roots staff to further explore and ultimately identify the full battery of call outcomes that capture how responders close a call and streamline the selection of subcategories for responders on a call. Ten categories are a lot, yet these recommended categories largely capture all call outcomes in one data subset. Furthermore, delineating between referral and referral attempted, for example, may support the City of Minneapolis in better understanding how to bolster the broader ecosystem of care.

Ultimately, this metric would allow Canopy to substantiate its impact while also demonstrating that some of the harder-to-measure work they do, such as "using a lens of human dignity," may indeed be measurable through a category like "right of refusal exercised." Such nuanced outcomes would not be possible in a large data system like the city's CAD system. But, internally, Canopy Roots could begin to demonstrate how their services link to specific individual outcomes for community members.

Metric #3: Storytelling with Community and System Level Outcomes

Finally, Canopy Roots should clarify, both internally and to the residents and leaders of Minneapolis, the broader impacts it strives for and how its principles, services, and individual outcomes can lead to broader change. Our final recommendation for a key metric involves clarifying community and system-level impacts while supporting the storytelling process when reporting out the work.

At the individual level, recipients are getting emotional support and connection to resources. These are concrete outcomes. But how does the BCR model achieve the broader mission of safer communities? Through the course of this evaluation, we found ample evidence that BCR contributes to community safety outcomes that align with the community's holistic definition of safety.

Recipient Feedback

To flesh out these system-level impacts, we relied on call narrative data and interviews with community members who have been the recipients of BCR care. This feedback process was challenging but critical. We recommend that Canopy Roots seek authentic feedback from behavioral crisis response recipients. This will help transform crisis services from provider-centered to person-centered care. Beyond supporting service improvement, collecting feedback from those who call BCR dignifies recipients' experiences by acknowledging their expertise about their own needs and recognizing them as partners in their recovery journey. Perhaps most importantly, prioritizing feedback—especially from marginalized populations often excluded from service design conversations—represents a commitment to equity, ensuring crisis response systems evolve to serve everyone with cultural responsiveness and genuine attention to diverse needs and experiences.

It can be difficult to gather such feedback. Community members engaging with BCR are in crisis and may not be in a position to provide feedback that reflects their experiences coherently. There are also power dynamics between professionals providing therapeutic support and community members, and these make voluntary feedback nuanced. Such challenges require thoughtful, trauma-informed approaches that balance the essential need for program improvement with the ethical imperative to protect those in vulnerable states.

When implemented effectively, feedback mechanisms elevate the voices of those directly experiencing services, revealing critical insights that technical metrics alone cannot capture. Stories and testimonials from recipients provide a deeper understanding of how BCR's trauma-informed principles translate into lived experiences of dignity, choice, and healing. They also demonstrate impact in ways that quantitative data cannot alone, showing how a single interaction can shift someone's willingness to seek help, trust emergency services, or feel belonging in their community.

Connection to Community-level Outcomes

We give examples of two types of community-level impact, showing how Canopy Roots might work to spotlight case examples from calls and feedback from recipients of care in order to focus on storytelling. Specifically, we examine what it might look like when BCR contributes to "protection from and reduced potential harm" and "increased neighbor connections and community closeness"—two components that our survey respondents identified as central to their understanding of community safety.

How Does BCR Contribute to Protection from Harm?

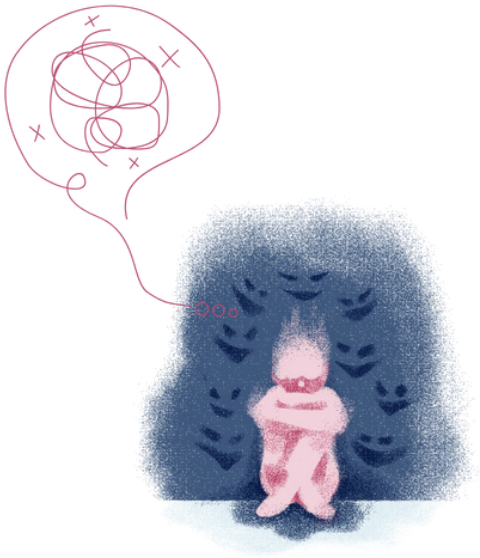
Protection from harm emerged as a fundamental component of safety in our community survey, reflecting residents' desire for crisis response that prevents escalation rather than creating additional risks and hardship. Traditional emergency responses to mental health crises have often increased harm through criminalization, use of force, or involuntary interactions that traumatize rather than heal. BCR's approach demonstrates how crisis intervention can actively reduce harm while maintaining community safety.

The following call narrative illustrates this:

Responded to a call for assistance from Minneapolis Police regarding black male experiencing interpersonal conflict with his mother and wielding two knives with desire to complete suicide by cop. Responders made contact with recipient after police had recipient drop the knives. Recipient denied suicidal ideation, intent, and plan. Recipient reported he was "fed up with the bullshit" and was more so angry at the situation he believes his mother placed him in. Recipient was able to reduce his anger and with police escort, he was able to collect his things, displayed future orientation by talking about going to work this evening, and was cooperative in leaving though did not want to be transported. Responders engaged recipient in safety planning. Responders also gave the recipient shelter resources and bus tokens.

In this example, BCR collaborated with the MPD to transform a high-risk crisis call (indeed, a dangerous scenario given documented disparities in police use of force against Black individuals). BCR's assessment revealed the recipient was experiencing dysregulation rather than suicidal intent—a critical distinction that guided their response. Using future-oriented safety planning, BCR successfully de-escalated the situation and co-regulated the recipient's nervous system while maintaining his dignity and autonomy. Canopy Roots responders were also able to meet the man's basic needs through resource referrals and bus tokens, key tools for building trust and honoring the recipient's choice to not accept a ride. **This approach achieved multiple harm-reduction outcomes: the individual's life was preserved without self-harm, criminalization, or use of force; the family and community were protected from potential violence, and the response demonstrated how mental health expertise can address systemic risks while maintaining public safety**.

In another example of the MPD requesting BCR backup, the following scenario unfolded:



PIC [person in crisis] reporting people are going to hurt him and he needs to harm them before they do anything to him. Recipient stated people have been trying to break into his home and he can hear their voices making threats. BCR educated recipient about his MH [mental health] diagnosis and symptoms related to his MH. Recipient stated what he's sharing isn't MH related and it's something real happening to him. Recipient appeared disoriented, anxious, paranoid and mania. Recipient stated the police took his pocket knife...Recipient stated he hasn't slept for three days because "these people" are trying to hurt and he wants to kill them. Recipient stated he's going to make it his priority to find these people and

> *kill them before they do anything to him. BCR and police tried engaging him in conversation but he couldn't focus and kept saying he will kill the people... Recipient willingly went with EMS to assess him.*

Traditionally, this scenario would result in arrest or forced psychiatric intervention. The person presented with multiple crisis indicators: sleep deprivation, disorientation, anxiety, paranoia, and mania, with auditory and persecutory delusions. BCR attempted psychoeducation about mental health symptoms, but the individual's fixed delusions prevented him from recognizing his experiences as illness-related, demonstrating the challenges of helping someone in acute psychosis. Despite unsuccessful attempts at de-escalation and the person's inability to focus during BCR intervention, responders' persistent therapeutic engagement and collaborative approach with police successfully reframed the situation from a criminal threat to a medical emergency. The breakthrough came when BCR guided the interaction toward voluntary medical assessment rather than forced intervention, resulting in the individual agreeing to go with EMS. This outcome demonstrates how specialized behavioral health responses can effectively address potentially dangerous mental health crises without resorting to arrest or forced holds, thereby reducing the criminalization of mental illness and maintaining community safety.

Together, these examples demonstrate that BCR's specialized behavioral health approach effectively enhances community safety during mental health crises by reducing criminalization and addressing potential risks to both individuals in crisis and community members.

How Does BCR Help Increase Neighbor Connections and Community Closeness?

Neighbor connections and community closeness emerged as key components of safety in our community survey. Informal support networks, we learned, increase residents' sense of safety.

The following case example, from an interview with the neighbor of a BCR recipient, highlights how BCR contributes to increased community closeness and neighbor connections: A Minneapolis resident was having a party when his upstairs neighbor began screaming. This person, who lived with developmental disability and mental illness, cohabitated with her mother, who had had a stroke and was unresponsive. The ambulance took the mom to the hospital, and EMS asked the neighbors to take care of the daughter, who would remain at home. The neighbors, worried that the woman was actively suicidal, felt this was beyond their skills. EMS thus called for BCR backup. When BCR arrived, one responder took the daughter to a private area to talk with her about her concerns and do an assessment, while the other stayed with the neighbors, involving all of them in creating an assessment and safety plan. Ultimately, BCR transported the daughter to the hospital for suicide assessment and prevention and made a safety plan with the neighbors for when she was discharged. Though the recipient's daughter passed away, she continues to live in place with a group of neighbors watching out for her. She is thriving.

This case exemplifies the BCR's unique ability to transform crisis into lasting community supports. Rather than leaving neighbors feeling helpless when confronted with mental health

emergencies, BCR addressed the immediate crisis and built a sustainable safety plan with the neighbors. This collaborative planning saw BCR actively foster the types of informal care networks that research shows are essential for both individual well-being and community resilience.

The long-term result—a thriving individual supported by engaged and informed neighbors—demonstrates how specialized behavioral health response both resolves immediate problems and weaves a stronger social fabric. This approach builds the neighborhood connections that prevent isolation, reduce future crises, and create the collective efficacy that residents identify as fundamental to community safety.

Metric Implementation Considerations

Several factors should be considered when implementing new metrics. First, Canopy Roots staff should balance comprehensiveness with practicality. When collecting new data on presenting needs and call outcomes, for instance, category sets must be calibrated so they are thorough enough to capture essential information while remaining feasible for responders in crisis field settings. This means responders should be involved in the determination, design, implementation, and refinement of new metrics.

Next, staff should prioritize recipient experience. Enhanced data collection should never come at the expense of recipient-centered care, a core part of Canopy Roots' mission. Documentation should be integrated into the helping process, and involving responders and recipient feedback in the design process will help center recipient needs. Finally, data collection must be supported with adequate resources. Expanded data collection and service enhancement require appropriate staffing, technology, training, and time. Under-resourced implementation may compromise both data quality and service delivery.

The recommended metrics framework moves toward evaluation approaches that authentically capture Canopy Roots' unique contributions to community safety. By systematically documenting presenting needs, expanding call outcome categories, and prioritizing storytelling through recipient feedback and community-level impacts, Canopy Roots can both refine their work and demonstrate how their trauma-informed, dignity-centered approach creates measurable change that extends far beyond individual crisis resolution. This is an opportunity to capture the ripple effects that build stronger, more connected neighborhoods.

Chapter 3: *A New Paradigm of Public Safety*

We designed this evaluation to help Canopy Roots surface, articulate, and refine their assumptions about how change happens in their work and how they contribute to the safety ecosystem in Minneapolis. Our goal was to offer recommendations that would help Canopy Roots embed evaluative thinking into ongoing practice, strengthening the organization's ability to reflect, learn, and adjust while navigating complexity and uncertainty.

Our findings serve as a learning map, including a theory of change that shows how Canopy Roots' principles and services connect to outcomes for individuals, communities, and systems. Based on the findings, we offer 12 recommendations below. **While we provide this guidance, Canopy Roots staff—as the experts of their own organization and work—must determine which directions to pursue based on their deep knowledge and this clearer picture of how their work creates change**.

We used a SOAR analysis to support Canopy Roots in their organizational development as they plan for what's next. A SOAR analysis (which focuses on strengths, opportunities, aspirations, and results) is a tool that aligns with Canopy Roots' own practices for building on strengths and community aspirations. SOAR also naturally guides organizational planning and decision-making by asking, "How do we build on what's working?" rather than "How do we fix what's broken?" This is exactly the mindset needed for Canopy Roots to navigate expansion opportunities while maintaining its core mission and values and noting that all growth requires sustainable investment.

Strengths: Where does Canopy Roots excel?

1. Monitor national and local efforts. As the landscape evolves, we recommend Canopy Roots maintain ongoing connections to both local and national developments in behavioral crisis response. This includes staying informed about the City of Minneapolis's dashboard and other local monitoring efforts, as well as emerging practices nationwide. Given Canopy Roots' expansion beyond Minneapolis, staying connected to these broader efforts and working to collaborate with organizations across the nation will be increasingly valuable. Appendix C offers a list of peer organizations and research institutions that have developed expertise in Behavioral Crisis Response.

2. Solidify and operationalize a theory of change. We found strong and clear evidence that Canopy Roots operationalizes clear guiding principles. For example, one of the characteristics that set Canopy Roots' approach apart is its deep attention to culturally responsive care that honors recipients' humanity and self-determination as both a principle and a practice. We recommend continuing to connect BCR practice with the trauma-informed principles that guide the work of the crisis responders and solidifying this into a theory of change. Creating a tangible rubric based on these guiding principles, organizational capacity, and other critical operational aspects will aid Canopy Roots with difficult decisions about where and how to grow and expand.

3. Share innovative secondary trauma prevention models with other first responder agencies. We recommend that Canopy Roots continue to document and share their successful approach to prevent responders' secondary trauma and burnout. The secondary trauma prevention strategies developed by Canopy Roots constitute a valuable framework that could shape practices across Police, Fire, EMS, and 911 Dispatch, bringing transformative value through reduced burnout, improved staff retention, enhanced service delivery, and improved community safety outcomes.

4. Continue strong ecosystem collaboration. We recommend that Canopy Roots continue its open, collaborative stance vis-à-vis the wider safety ecosystem. We found that Canopy Roots has become highly regarded for their skills and knowledge by the Minneapolis Police Department, Fire Department and 911 Dispatch. They are perceived as filling a critical gap in the safety system.

Opportunities: What are some possibilities for Canopy Roots' growth?

5. Move from ecosystem collaboration to integration: We recommend a continued focus on improving multi-agency collaboration across the safety ecosystem in Minneapolis and moving toward more formal integration, including via the establishment of cross-agency working groups. While BCR has built strong relationships with Police, EMS, Fire, and Hospitals, these connections

could benefit from a formal structure. As other first responders increasingly recognize BCR's specialized value, it creates an opportunity to move beyond ad hoc coordination toward system integration. We recommend establishing structured working groups to address specific integration challenges. For example, one group could develop formal protocols for BCR-hospital collaboration, including concrete issues like ambulance bay access and patient handoff procedures. Another might focus on standardizing multi-agency response protocols. Canopy Roots would further benefit by advocating for the City of Minneapolis to create formal policies governing multi-agency integration, ensuring that successful informal practices become official, embedded procedures. This shift from relationship-dependent coordination to policy-supported integration will make collaboration more predictable, efficient, and sustainable as BCR grows.

6. Enhance emergency response capability. Ensuring continuous, city-wide coverage means that the organization will have to address challenges related to response times and access. We recommend workshopping targeted solutions raised by responders like vehicle modifications (for example, reflective wrapping that would designate BCR vans as emergency vehicles) and precinct-based office distribution for better geographical coverage.

7. Prioritize workforce retention and development. Some responders, especially full-time staff, identify pay and healthcare benefits as areas for improving the employee experience. The organization's for-profit status also limits access to certain benefits like public service loan forgiveness and 403(b) retirement plans that nonprofit employees typically enjoy. Moving forward, BCR could benefit from benchmarking compensation against comparable emergency response roles and continuing to enhance benefit packages to support long-term retention.

Aspirations: What dreams might Canopy Roots consider?

When we asked Canopy Roots about their aspirations for the organization, one resounding answer was the desire to be seen and recognized as first responders and to have both peers and the public have some sense of their work and how it makes us all safer. To that end, we recommend:

8. Invest in a broad education campaign. When considering both our survey and interviews with community members, we strongly recommend that the City and Canopy Roots invest in an education campaign to inform the public about BCR services. Less than half of the people surveyed—people living in neighborhoods to which BCR regularly responds—had ever heard of BCR. Dedicated funding for a community education component that promotes BCR's guiding principles and model of crisis response while also providing mental health literacy and response system navigation training to community groups, schools, and neighborhood organizations will be crucial. We believe the findings from this report will help demonstrate support for this community outreach approach, increasing BCR visibility, building trust through non-crisis engagement, and potentially reducing crisis incidents through upstream intervention.

Additionally, we recommend considering targeted outreach to family-serving organizations including schools, foster/adoptive care programs, youth programs, family support agencies, and pediatric healthcare providers. Our call analysis revealed family/relationship conflicts as an emergent niche for BCR's response capabilities. While valuable resources like COPE provide family crisis services, BCR's unique positioning as an emergency response team dispatched through 911 allows its providers to address family behavioral health crises as they unfold in real-time.

9. Expand recipient feedback. Finally, we recommend that Canopy Roots invest in an expanded process to gather authentic feedback from recipients of care. Specifically, we recommend partnering with a community-based organization that has experience serving vulnerable populations to implement an anonymous feedback collection system for BCR service recipients. By engaging a neutral third party without direct service provision power, concerns about coercion and fear of service impacts are significantly reduced and recipients can speak freely. This external organization could manage all aspects of feedback collection—distributing anonymous paper surveys with prepaid return envelopes, hosting secure digital feedback forms, or conducting brief follow-up calls using only first names or assigned codes to maintain privacy. This system was used in Durham's HEART program to successfully collect recipients' critical feedback. HEART's partner organization also conducts listening sessions with specific populations, providing safe spaces for feedback while maintaining separation from direct service providers.

Results: How can Canopy Roots build on their outcomes?

10. Gather and share evidence of BCR's community safety impact. BCR has compelling stories of impact that, through broader visibility, can help build public understanding of and support for their services. We recommend leveraging the theory of change presented in this report to guide Canopy Roots' storytelling with stakeholders and the community. Regularly sharing de-identified success stories, community impact data, and public reports on call outcomes would help address community knowledge gaps, aligning awareness of with support for BCR. Enhanced transparency would also increase BCR visibility and build evidence for program expansion.

11. Bolster data collection practices and increase transparency. Our analysis of services provided highlighted a few areas where responders might collect better data. For each of these additions, we recommend careful consideration to balance comprehensive data collection with practicality in crisis field settings.

- **Missing services provided.** Specifically, we recommend Canopy consider the creation of new categories of services provided to better measure their work. These categories might be named "providing options," "seed planting," and "psychoeducation for community members."

- **New race categories.** Our analysis helped to demonstrate who the responders are serving. Over half (52%) of the community members served, based on responder reports of recipient race, are BIPOC. This underscores the need for some consideration of racial or cultural identity. However, the current categorization makes reporting on race unwieldy. We recommend Canopy Roots consider the utility of their current racial demographic categories and engage in another organization-wide consensus process to narrow the race fields and dig into the goal of collecting race data while establishing an approach that responders feel is practical and aligns with their commitment to culturally responsive care.

- **Presenting needs.** We recommend establishing a data collection process to measure the broader needs of community members, beyond individuals' clinical presentation. Based on our analysis of presenting needs for a small subset of calls, Canopy Roots might consider including the following categories in a new field called "Call Type" or

"Priority Issue": mental health crises, welfare checks, substance use crises, housing/basic needs, family/relationship conflicts, and safety/violence risk.

- **Call outcomes.** To better explore impact, we recommend BCR responders collect more expansive call outcome data, beyond contact/no contact. Canopy Roots could convene key staff to determine a full list of possible call outcomes, but we recommend including categories mentioned in the "Right Metrics" section of this report.

Conclusion

Canopy Roots' Behavioral Crisis Response (BCR) program in Minneapolis represents a transformative approach to public safety that extends beyond traditional crisis intervention. Throughout this evaluation, the voices of responders, recipients, community members, and safety ecosystem partners have told a compelling story of a program that is reimagining how communities respond to human suffering.

In the natural world, canopy roots—quite literally, roots in the canopy—represent a remarkable rainforest adaptation. Canopy roots extend not from the ground but from tree branches, gathering nutrients from the "canopy soil," organic matter that accumulates in tree branches. This creates a specialized ecosystem nested within the larger arboreal ecosystem, with each organism both influencing and being transformed by the presence of others.

Throughout this evaluation, the voices of responders, recipients, community members, and safety ecosystem partners have told a compelling story of a program that is reimagining how communities respond to human suffering.

The BCR program embodies this natural metaphor. BCR utilizes the existing infrastructure of traditional emergency response: the 911 dispatch network, communication systems, and institutional relationships with healthcare providers. Yet, what enriches this symbiotic relationship is BCR's ability to draw from resources beyond the existing first response system. It incorporates the lived experiences and cultural wisdom of BIPOC mental health practitioners, community insights, and knowledge from public health and mental health disciplines—perspectives that might otherwise remain untapped. This integration of diverse knowledge streams transforms BCR and the broader emergency response ecosystem, creating a more adaptive and responsive system for addressing community crises.

This integration of diverse knowledge streams transforms BCR and the broader emergency response ecosystem, creating a more adaptive and responsive system for addressing community crises.

This approach also nurtures trust between emergency services and communities that may have experienced trauma from past interactions. The presence of both traditional first response and BCR creates more options for addressing crises within the community, and trust for its approach grows as people see that calling 911 doesn't always mean a police response—sometimes it connects them to mental health professionals who can provide appropriate support.

The data demonstrate BCR's effectiveness: 91% of surveyed residents support this approach; 88% report increased feelings of safety knowing the program exists; and service outcomes show strong crisis resolution with minimal need for police intervention. These positive indicators reflect the program's skillful implementation of its guiding principles.

By centering holistic definitions of safety, BCR creates space for human dignity even in moments of profound crisis. As Minneapolis continues evolving its public safety systems, the BCR program offers a compelling model worthy of continued investment, refinement, and expansion. The path forward is not without challenges, but the foundation is strong. BCR can continue growing as an essential component of a truly integrated community safety approach—one that recognizes that compassionate care is not an alternative to but an essential component of public safety and an essential complement to traditional approaches.

By centering holistic definitions of safety, BCR creates space for human dignity even in moments of profound crisis.

Glossary of Terms

- **Alternative response:** A response to a mental health-related crisis/community incident deemed to be different from the "typical" response by a law enforcement team. Used to describe mobile mental health responses like Minneapolis' Behavioral Crisis Response.
- **Appropriate response:** A response to a mental health-related crisis/community incident that is person-centered and capable of managing mental health concerns. Used interchangeably and sometimes instead of "alternative response" to signal that the response is better suited to the crisis. Also used to describe mobile mental health responses like Minneapolis' Behavioral Crisis Response
- **BCR or "Behavioral Crisis Response":** The emergency response approach to behavioral and/or mental health crises in Minneapolis
- **Call Log/Call Narrative:** An internal dataset that contains all the information collected from the crisis calls to which Canopy Roots' BCR teams have responded.
- **Call outcomes:** A description of the result or outcome following a crisis call
- **Canopy Roots:** An innovative mental health organization offering culturally affirming, unarmed first responder services to people in crisis via 911.
- **Clinical presentation:** The manner or physical/visible/audible symptoms of a person in crisis, in which an individual's mental illness is presented (e.g., "slurred speech")
- **Culturally responsive/affirming:** Adjusting an approach to fit the unique background and culture of each individual and meeting them with empathy and openness in understanding both system-level and individual cultural influences
- **De-escalation:** A technique utilized by crisis responders to reduce the heightened emotional distress a recipient is experiencing
- **Developmental Evaluation:** An evaluation model that supports organizations in describing their approach and exploring outcomes and effectiveness while the organization is actively shifting, developing and refining their programs
- **Evaluative thinking:** A disciplined approach to inquiry and reflective practice that helps individuals and organizations make sound judgments using good evidence, as a matter of habit.
- **Future orientation:** The framework of having thoughts regarding upcoming events or recognition of forward thinking, as opposed to only present-time thinking
- **Holistic safety:** An approach to safety practices that acknowledges the variability in each person's own definition of what safety means
- **Mental Health Crisis Response:** An emergency response to a mental health crisis, in Minneapolis referred to as "behavioral crisis response" or BCR. These are alternative or appropriate responses

different from traditional law enforcement approaches to people experiencing crises connected to mental health struggles

- **Metrics:** Data utilized to provide further information or context to the evaluation process, sometimes called "measures" or measurements of key aspects of a process or program
- **Mixed-methods research design**: A combination of both qualitative and quantitative data analyses and designs
- **Presenting needs:** Community-level issues underlying individual clinical presentation. For example, when crisis responders encounter someone who appears disheveled or is hungry, they are witnessing the visible manifestations of deeper, systemic challenges that extend beyond individual circumstances, such as poverty.
- **Primary data:** Data collected directly by researchers from the main source (e.g., interviews)
- **Qualitative analysis:** Gathering non-numerical data (e.g., texual data, visual data from interviews or observations) and exploring patterns or themes.
- **Quantitative analysis:** Gathering numerical data and performing analyses to explore descriptives (like percents) and relationships between variables (e.g., statistical significance)
- **Respond*ents*:** Community members who responded to the survey distributed by the MNJRC research team to collect perspectives on BCR
- **Responder:** The individual who is sent out to respond to the behavioral and mental health crises, the staff of the BCR
- **Safety ecosystem:** The network of organizations whose primary purpose is to provide or ensure the safety of citizens (e.g., police, fire, EMS)
- **SAMHSA:** https://www.samhsa.gov/ The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation
- **Secondary data:** Data gathered, organized, and cleaned by researchers but collected from a different source (e.g. organizational documents)
- **Secondary trauma:** An event deemed to be traumatic due to the emotional distress caused that is indirectly experienced by someone (e.g., first responders experience secondary trauma responding to others in crisis)
- **Trauma-informed:** Practicing from a perspective that takes into account the significance and presence of trauma someone may have experienced
- **Use of force:** A law enforcement officer's strategy that employs the use of physical power or weapons

Appendices

Appendix A: BCR overview from survey

The following text was included in our community-facing survey to educate survey-takers with an overview of BCR in order to collect perspectives on the service from those who had never heard of it.

***Read or listen to the following overview carefully* to answer the questions that follow.**
Click above for an audio recording of the paragraph below if reading is not accessible for you.

When you call 911 in the City of Minneapolis, police can respond, the fire department can respond, emergency medical technicians (EMTs) can respond and, as of 2021, the ***Minneapolis Behavioral Crisis Response (BCR)*** *team can respond.*

The Minneapolis BCR team responds to people experiencing behavioral health crises (for example, if someone feels like they want to harm themselves) and they are of the first of their kind here. They are part of a growing movement of response teams across the country to use alternatives to police to assess needs and provide appropriate care to avoid the criminalization of behavioral or mental health crises.

The Minneapolis BCR provides ***unarmed*** *crisis intervention, de-escalation, and connections to support services. The Minneapolis BCR is operated by Canopy Roots, a local, Black-owned and women-led, mental health agency. The Minneapolis BCR team is comprised of culturally responsive, trauma-informed mental health practitioners. For example, the Minneapolis BCR vans do not have bright lights or sirens.*

The Minneapolis BCR team may call for backup from other first responders (for example, police or fire) in certain scenarios, such as if someone has a firearm or in the case of a medical emergency.

The Minneapolis BCR is run by Canopy Roots, LLC, and contracted through the City of Minneapolis. It is a public good that is available 24/7 (365 days a year) and provided free of charge for anyone in the city limits.

Appendix B: Details of Computer-Assisted Analysis to Understand System Drivers of Calls

Following best practices for transparent reporting of computer-assisted analysis, we maintained analytical control throughout the process, using AI as a tool for pattern recognition while retaining all interpretive decisions.[4] While we cannot provide definitive conclusions based on this AI analysis, we can identify meaningful trends with reasonable accuracy to help Canopy enhance their data collection and understand what drives calls in their system, ultimately revealing the underlying factors that generate demand for their services.

Process:

1. **Data Upload**: After completing all interview coding, we uploaded de-identified excerpts to Anthropic's Claude A.I. with privacy settings enabled to prevent data use in AI model training.
2. **Theme Identification**: We asked the AI to identify recurring themes, tensions, and notable patterns across the document set.
3. **Team Review**: Our team reviewed AI-generated themes, requested clarification on specific points, and guided areas needing deeper analysis.
4. **Collaborative Analysis**: The final analysis integrated both AI-identified patterns and our team's interpretive expertise.
5. **Technical Assistance**: Anthropic's Claude A.I. also assisted with grammar checking, APA formatting, and other time-consuming editorial tasks in the final report.

Use of AI in Call Log Analysis:

We developed a priority hierarchy to classify each call by its primary presenting issue, ensuring consistent categorization when multiple issues were present. For example, if someone was experiencing a panic attack while also threatening violence, the call would be categorized as "Threat of Violence" rather than "Mental Health Symptoms."

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4) Hutchison, A. J., Johnston, L. H., & Breckon, J. D. (2010). Using QSR-NVivo to facilitate the development of a grounded theory project: An account of a worked example. International Journal of Social Research Methodology, 13(4), 283-302. Doi: 10.1080/13645570902996301
Jackson, K., Paulus, T., & Woolf, N. H. (2018). The walking dead genealogy: Unsubstantiated criticisms of qualitative data analysis software (QDAS) and the failure to put them to rest. The Qualitative Report, 23(13), 74-91. doi: 10.46743/2160-3715/2018.3096
Paulus, T., Woods, M., Atkins, D. P., & Macklin, R. (2017). The discourse of QDAS: Reporting practices of ATLAS.ti and NVivo users with implications for best practices. International Journal of Social Research Methodology, 20(1), 35-47. Doi: 10.1080/13645579.2015.1102454
Kelley, S., Kelley, C., Solomon, B., & Wilkinson, A. (2025). Securely analyzing qualitative data with artificial intelligence. Child Trends. DOI: 10.56417/794r4275p

Priority Hierarchy:

1. Threats of violence toward others
2. Suicidal ideation/plans/attempts
3. Psychotic symptoms
4. Other mental health symptoms
5. Substance use crises
6. Housing/basic needs
7. Family/relationship conflicts
8. Welfare checks

Important Limitation: While each call was assigned a single primary category for analysis, many calls involved multiple overlapping issues. These findings represent a simplified view of complex situations where mental health, substance use, housing instability, and interpersonal conflicts often intersect.

Appendix C: National and Local Policy and Practice Guidance for Behavioral Crisis Response

City of Minneapolis

Policing Project, NYU School of Law. (n.d.). *Implementation of safe and thriving communities report: Proposal for technical assistance.* Reimagining public safety: Creating a system of holistic first response.

https://lims.minneapolismn.gov/Download/RCAV2/33294/Reimagining-Public-Safety-Implementing-the-Safe-and-Thriving-Communities-Report.pdfLeadership for a Networked World. (2023, July.). *Minneapolis safe and thriving communities report: A vision and action plan for the future of community safety and wellbeing.* Minneapolis, City of Lakes. https://lims.minneapolismn.gov/Download/RCAV2/31955/Minneapolis-Safe-and-Thriving-Communities-Report-and-Plan.pdf

National Sources

Crime and Justice Institute. (2024, May). *Behavioral Health Crisis Response Landscape Analysis.* https://www.cjinstitute.org/assets/sites/2/2024/05/AV-Crisis-Response-Report.pdf

National Behavioral Crisis Response Resource List

Transform 911 | Chicago, IL https://www.transform911.org/
Evidence-based 911 system evaluation and alternative development. Convenes experts to create policy recommendations for systemic emergency response change.

Dignity Best Practices | Washington, D.C. https://dignitybestpractices.org/
Cross-agency collaboration for crisis response. Unites clinicians, peers, mediators, first responders, and government leaders.

Georgetown Law Center for Innovations in Community Safety | Washington, D.C. https://www.law.georgetown.edu/cics/
Individual and systems-level interventions to reduce police overreliance and address criminal legal system disparities.

Government Performance Lab at Harvard Kennedy School | Cambridge, MA https://govlab.hks.harvard.edu/
Assists jurisdictions in developing 911 diversion programs using unarmed community responders and behavioral health professionals.

The Fourth Branch Institute (4BI) | Denver, CO https://www.4thbranch.org/
Supports communities implementing a "fourth branch" of emergency response. Provides community of practice and research.

The Futures Institute | Washington, D.C. https://www.futures-institute.org/
Community safety frameworks prioritizing innovative crisis management and preventative investments in violence root causes.

NYU Law Policing Project | New York, NY https://www.policingproject.org/
Comprehensive materials for police reform and alternative response implementation. Covers 30+ program areas, implementation guidance, and reference resources.

Effective Law Enforcement for All https://ele4a.org/minneapolis/ Mission is to educate and empower the public to engage with their police departments and municipal leaders to implement law enforcement practices that are safe and effective for police and the communities they serve

Safer Cities https://safercitiesresearch.com/
Coverage and analysis of innovative urban safety initiatives and reform efforts.

The Marshall Project https://www.themarshallproject.org/
Nonprofit news organization covering criminal justice with investigative journalism. Creates national urgency about system inequities.

Crime and Justice Institute (CJI)
https://www.cjinstitute.org/assets/sites/2/2024/05/AV-Crisis-Response-Report.pdf
Research on behavioral health crisis response landscape and state/federal regulations affecting local crisis response.

Global Law Enforcement and Public Health (GLEPHA) https://glepha.com/our-vision-mission/ Promotes research and practice at the intersection of law enforcement and public health.

Vera Institute | Redefining Public Safety Program https://www.vera.org/behavioral-health-crisis-alternatives Research on behavioral health crisis alternatives and literature reviews of police-based and community-based response models.

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