A Community-engaged Qualitative Study of Police Response to 911 Calls for Behavioral Health Crises

Jennifer L Hefner, PhD, MPH[1*], Pejmon Noghrehchi, MHM [1], Steve David, MSW[2], Shinjini Pandey, MS[3], Leah EM Bevis, PhD[3]

[1] Division of Health Services Management and Policy, College of Public Health, Ohio State University; Columbus, OH

[2] College of Social Work, The Ohio State University; Columbus, OH

[3] Department of Agricultural, Environmental, and Development Economics, College of Food, Agricultural & Envi. Sciences, The Ohio State University; Columbus, OH

Submitted 10 January 2025, revised 13 May 2025, accepted 30 June 2025

Hefner, J. L., Noghrehchi, P., David, S., Pandey, S., & Bevis, L. E. M. (2025). A community-engaged qualitative study of police response to 911 calls for behavioral health crises. *Progress in Community Health Partnerships*. (Forthcoming). 1 September 2025.

ABSTRACT

Background: Americans in a mental health or substance abuse crisis who call 911 for assistance are at increased risk for police violence. With the growing recognition that police are not trained behavioral health (BH) workers, cities across the country are searching for alternatives models of response to these 911 calls.

Objectives: To (1) describe community perceptions of 911 response to BH crisis calls, (2) explore community preferences for non-police models of response, and (3) engage a community advisory board in all study activities.

Methods: Using a community based participatory research (CBPR) approach, during 2023 in Columbus, Ohio we conducted 30 semi-structured interviews that were audio recorded, transcribed, and analyzed via qualitative methods.

Results: Four key themes emerged: (1) variation in responding officer demeanor across calls within the same neighborhood and even to the same address: "a *different cop can make all the difference";* (2) a pervasive reluctance to call the police during BH crises; (3) need for increased training in BH disorders and de-escalation; and (4) strong support for a non-police response program – "*medics for mental health.*"

Conclusions: As one of the first studies to explore community member perspectives on this issue, interviewees shared a preference for a non-police response program and made specific recommendations for its structure. While non-police response models have proliferated across the country, there is a need to engage the community in model development and impact studies using the methods of CBPR.

KEYWORDS: Mental Health, Police, qualitative, Community-Based Participatory Research,

Substance-Related Disorders, crises response

ACKNOWLEDGEMENTS

The authors would like to acknowledge the members of our Community Advisory Board for their active engagement with this project - Linda Jakes, Aaron Thomas, Monique Sneed, Malik Moore, Brian Stroh, Pamela Shields, and Jasmine Ayers. We would also like to thank the community members who trusted us with their stories.

FUNDING STATEMENT

This study was funded by the Robert Wood Johnson Foundation (grant 79711)

A Community-engaged Qualitative Study of Police Response to 911 Calls for Behavioral Health Crises

INTRODUCTION

In the past year a third of adult Americans had either a mental illness or substance use disorder (jointly referred to as behavioral health (BH) conditions).[1] Historically, the U.S. health care system has faced challenges effectively responding to BH crises.[2] Due to deinstitutionalization and the lack of availability of BH resources, local law enforcement agencies have become the default responders for BH crises.[3,4] Police as "street corner psychiatrists"[5] increased the rate of interactions between persons with BH conditions and the criminal justice system, with data suggesting that a person with an untreated BH condition is three times more likely to be incarcerated than treated in a BH care facility.[4] In addition to inappropriate incarcerations, there is a high risk of police violence during BH crises; between 2015 and 2024, nearly 20% of the victims of fatal police shootings were individuals experiencing BH issues.[6]

These facts expose a troubling reality: police officers acting as surrogate BH providers frequently contribute to the worsening of situations experienced by those in crisis.[7,8] This is partly rooted in the stigmatized views that police officers attribute to persons with BH conditions, characterizing them as "dangerous" or "volatile" individuals.[9–11] Such narratives are often used as the rationale for law enforcement personnel defaulting to traditional policing tactics, which can further escalate the crisis.[8] For example, police are trained that someone not following their commands is dangerous – yet people on stimulants may be physically unable to hear or follow direct orders.[12] It is equally important to recognize how non-BH factors, such as

race, socioeconomic status, and neighborhood of residence intersect and influence police response. For example, many suspect that Black persons with BH conditions face a heightened risk of negative encounters with police due to the compounding effects of structural racism.[13]

To mitigate the impact of these issues, law enforcement agencies developed Crisis Intervention Team (CIT) programs to educate police officers to respond to BH crises appropriately. While 17% of U.S. police agencies offer formal CIT programs, meta-analyses of outcome studies find little evidence of impact on crisis outcomes.[14,15] Many alternative response models, in addition to CITs, have sprouted across the U.S., including police/BH provider co-response, or, non-police response teams consisting of social workers, EMTs, community health workers, or a combination of those roles.[16] While the adoption of alternative models is expanding across the country, there is sparse rigorous effectiveness research.[14,15] As a precursor to conducting impact assessments on these police-centered or non-police models of crisis response, it is critical to understand the local context in which these response models are implemented.

Among the small number of U.S.-based studies that qualitatively explore stakeholder perceptions of the response to BH crises, only one interviewed impacted community members[17] the others focused on the perceptions of service providers[18] or the reflections of police officers on their ability to respond appropriately.[19] The historical exclusion of community members from developing, implementing, and evaluating BH crisis response models prompted calls for full community integration at all stages of response program development and evaluation.[8] To address this call, our study had the following aims: (1) describe community perceptions of 911 response, (2) explore community preferences for new models of response, (3) engage a community advisory board in all study activities. To our knowledge, this is one of the first

studies in a U.S. metropolitan city to examine perspectives of community members who have experienced a police response to a 911 call for a BH crisis.

METHODS

To achieve the study aims, we conducted a qualitative interview study following the community-based participatory research (CBPR) approach via collaborative engagement of a Community Advisory Board (CAB) as active members of the study team.[20,21] Below we present details on the study setting, the CAB, and the data collection and analysis process. Each step of this protocol was approved by the *Blinded for Review* University's Institutional Review Board, study id # 2021B0195.

Study Setting

The Columbus, Ohio Division of Police currently has three response models for handling 911 BH calls: traditional police response, a CIT-trained officer (mandatory for all new recruits since 2018), and the Mobile Crisis Response (MCR) program, which was launched as a pilot in June 2018. This co-response program pairs a BH provider with a CIT-trained police officer. Given the limited numbers of CIT-trained officers and the small MCR pilot program, the majority of BH calls to 911 receive a standard police officer response.

Community Advisory Board

Utilizing a CAB played an integral role in ensuring that our study team elevated the voices of community members throughout the project and provided the necessary structure to foster an authentic partnership that would benefit community members.[22] The six-member CAB includes the director of the county's BH assessment center, the executive director of a local mental health

treatment center, and four community members engaged in civic organizations working in the social services sector in Columbus. This board was convened unofficially before the academic study team applied for external funding for this project and thus, engaged in the grant development process. Potential board members were identified through collaboration with partner community organization, who also wrote letters of support for the grant application: the Columbus Division of Public Safety, Disability Rights Ohio, the Columbus Safety Collective, the YWCA Columbus, the Columbus City Council, Netcare Access – the county's BH crises services, and Cohear – a local community engagement and strategy company. Each year of the two-year grant period each CAB member was offered renumeration of $700 as a recognition of the personal time devoted to this project.

The academic team engaged with the CAB bi-monthly via Zoom to collaboratively finalize the data collection and recruitment materials and co-develop the formal recruitment process. In subsequent meetings, we developed a list of personal and work contacts who are engaged in community activism around police response, and the CAB made initial contacts and assisted with recruiting embedded community leaders who would agree to pass recruitment flyers to their contacts who may meet study inclusion criteria. The CAB has also provided critical feedback about results interpretation and has engaged in disseminating study findings in traditional academic outlets and local and national community forums.

Study Population and Recruitment

Study inclusion criteria was to have personal knowledge of at least one 911 BH call as a caller, recipient of the 911 response, bystander, or close family member of a caller, recipient, or bystander. Convenience and snowball sampling via email and flyers were used to recruit from

neighborhoods familiar to the CAB members.[24] CAB members and community contacts were critical in establishing a robust recruitment strategy to reach participants who met the inclusion criteria.[25] For example, initial brainstorming sessions with our CAB identified the name of a popular pastor who had engaged in police response advocacy in the community. A CAB member contacted this pastor, forwarded an email from study investigators introducing the study and describing the inclusion criteria, and requested his collaboration in recruitment. The paster then disseminated the recruitment flyer to potential eligible participants among his congregants.

Data Collection

Data was collected via a series of group and individual interviews starting in the spring of 2023 and continuing through the fall of that year. Two study team members (initials blinded for review - an expert in qualitative data collection) and a CAB member who specializes in leading community focus groups, conducted three, two-hour group interviews over Zoom with participants who met our inclusion criteria based on a short pre-interview screening survey hosted on Qualtrics (N = 5, 4, 3 across the three groups). We also conducted individual 20 to 30-minute phone interviews with 18 participants who either could not attend the scheduled group interview or responded to our recruitment materials after the initial group interviews. During these additional individual interviews, we reached thematic saturation.[26]

The interviews were recorded after informed consent was obtained and all audio files were transcribed to facilitate data analysis. Each participant received a $50 gift card as a thank you for their time and was provided with mental health resources identified by the CAB, if requested. Participant name, email, and phone number were recorded in a separate tracking file not linked to study data. The semi-structured interview guide included question prompts in three main sections

titled: (1) participant experiences with first responders during crisis calls, (2) participant experiences after the initial crisis call, how and where did it end?, and (3) what model of response does the community most prefer / trust? (See the supplemental material for the full guide). Study participants were not directly asked to report their demographic characteristics; an intentional choice made by the study team to preserve the anonymity and comfort of community members sharing very sensitive personal stories. General demographic categories of participants were inferred from their responses to open-ended questions (for example, one's role as a BH provider or a public library employee).

Data Analysis

This study employed rapid qualitative analysis (RQA) – a method to extract timely, policy relevant results from qualitative data.[27] This method has been validated against traditional thematic analysis with scholars concluding, *"this pragmatic method follows accepted scientific practices, is rigorous, and facilitates the collection of readily applied qualitative data."*[28] RQA utilizes a three-step process. First, the first and second authors (initials blinded for review) created a structured data extraction template based on the interview guide and used that template to summarize each audio-recorded interview. Verbatim quotes were also pasted into the template during this step. Next, the templated summaries were consolidated into matrices for visual display, to identify commonly occurring themes, and to allow comparison across groups of participants. Third, during a series of meetings, the coding team collaboratively and iteratively reviewed, discussed, and sorted the matrix data to identify commonly occurring themes and subthemes and representative quotes.

These initial results were shared with the CAB, who interpreted the results and suggested changes to the wording of themes and potential implications of findings based on their understanding of the topic area and the community. We then conducted a member-checking exercise by presenting our findings to the community in October 2024 at a downtown metropolitan library. All study participants received an invitation to attend. Additionally, CAB members sent invites to their colleagues and associates. The community meeting was a chance to discuss different interpretations of our findings and collect thoughts on our dissemination plans. While this meeting didn't result in any substantive adjustments to our analytic findings, there were small suggestions that helped us refine our results presentation.

RESULTS

The 30 study participants included people with BH conditions, family members and friends of people with BH conditions, public library employees and BH counselors who make these emergency calls as part of their daily job, community activists, an elected official, and neighborhood members who saw our recruitment flyer and had a story to share about experiences in their neighborhoods. Participants spanned age, race, and socio-economic status brackets, and most interviewees reported a long history of 911 calls for themselves and/or their family members.

The analysis revealed four key themes presented in Table 1 alongside representative quotes. Overall, we heard a consistent story of variation in the demeanor of responding police within the same neighborhood: this variation in officer demeanor was not about the operational process of responding to the call, i.e. what the officer does, but the level of emotional intelligence and attitude the officer brought to the situation. Relatedly, there was a pervasive reluctance to call the

police during BH crises and strong support for a non-police response. The following sections present details and representative quotes related to the four key themes.

***** *Insert Table 1* ****

Varied police demeanor across incidents within a neighborhood

Overall, we found that while it is *"dangerous to be black in any neighborhood,"* there was variation in police demeanor (i.e. attitude) across incidents within the same relatively homogenous neighborhood, and to repeated calls to the same address. Participants noted police demeanor (compassionate, helpful, aggressive, apathetic) then dictated the tone set during the encounter – *"a different cop can make all the difference."* A mother of a child with a chronic BH condition recounted the varied police responses she has encountered across the years while living in the same neighborhood. She has seen the police respond without force, even when a weapons threat was involved. But the variation in response was salient in her mind: *"They pick and choose [when to respond negatively]. You [responding officer] don't have to yell; you can just talk."*

Three subthemes emerged around the question of why there was variation in police demeanor within the same neighborhood: police burnout; BH stigma; and lack of police training in BH. Table 2 presents supportive quotations for each of these sub-themes.

***** *Insert Table 2* ****

Reluctance to call the police for mental health crises

Participants described a reluctance to call the police at both the individual and community level. When talking about personal reluctance, participants said things such as "*I will do everything I can to not have to call 911 ever*," and "*I don't call the police; I don't care for them."* Participants also highlighted a community-level reluctance to call 911 for support during these crises: *"A lot of our young people literally feel this way [no trust, will never call cops]. It's fear. It's fear of, 'are they gonna look at me as a suspect?' It's fear that something else is gonna happen other than what I am calling for help."*

For participants with repeated experiences calling 911 for themselves or loved ones, past traumatic experiences with police response inform this reluctance. For example, one participant shared the story of her call to the police about a woman having a substance abuse crisis in the street outside her home. The police response was negative and stigmatizing, resulting in her saying, "*that was the last time I called the police. I regret that choice, I don't know if that helped that woman in the moment but likely just created more harm."* Another participant described an informal response network he created comprised of friends and family: "*We are trying to think of ways to build a circle of resources so when these things happen, we can act quickly in situations where something other than arrests needs to happen. We know the potential violence that can happen when police show up."*

Police need increased training in BH disorders and de-escalation tactics

While recounting negative interactions with police, participants frequently mentioned the need for increased police training in both trauma-informed de-escalation techniques and the nuances of BH crises and treatment. For example, a mother who has called 911 for herself and her daughter said that officers usually do not act with empathy and understanding, and it makes her wonder about their training: "*In situations like this [a BH crisis], I don't know anything about their training. Do they really understand what's happening? There's a stigma surrounding mental health already, you know?"*

Regarding specific training elements, a participant with a job in quality assurance felt the precepts of his profession – a focus on providing a consistently high level of public service – could inform police training for BH crisis response. He noted that focusing on quality assurance training could result in a police response with a more consistent sense of engagement and urgency. Another participant suggested scenario-based training and psychiatric evaluations for police so that *"he [responding officer] can go into any situation and have confidence he can defuse the situation.*" Related to de-escalation skills was the suggestion that *"there needs to be better training on how to talk to people w/ compassion."*

Strong support for a non-police response

When answering the prompt 'suppose that you were in charge and could make one change that would make the 911 BH crisis response better, what would you do?', many participants noted the need to expand options for the type of responder, beyond, or in addition to, police or emergency medical personnel. A mother who had frequently called 911 during her daughter's BH crises said that "s*ometimes cops are not always needed. Sometimes we just need somebody to talk to."* This sentiment was articulated clearly by one participant who said: "*It's like sending, you know, a*

doctor to fix a damn leak. You don't need that. You need a plumber. So. When someone has a mental health crisis, you don't send an officer with guns. You send someone who's caring and understands."

There were five frequently mentioned subthemes related to the strong support participants voiced for a non-police response. These subthemes include that the non-police responders should be specialized BH providers with crisis training and that as a society we should treat those with BH crises like we treat physical health crises - *"medics for mental health."* Participants also discussed the need for changes to the 911 call center, including dispatcher training in BH crises and triage of calls to a BH-specific dispatch center. A final theme was that a non-police response would relieve the police and free their time to respond to crisis calls more in line with their public safety training. Table 3 presents representative quotes supporting each of these subthemes.

***** *Insert Table 3* ****

DISCUSSION

Overview of findings

Interviews with community members personally impacted by 911 response to BH crisis calls consistently noted variation in responding officer demeanor across calls within the same neighborhood and even to the same address. Additionally, due to the potential for a negative encounter with an apathetic or aggressive responding officer, our interviewees reported a pervasive reluctance to call the police during BH crises and strong support for a non-police response program. They suggested that this program include a 911 call center triage mechanism

to route BH calls to an operator with specific BH training, and non-police response teams consisting of trained BH crisis responders who collaborate with police when backup is needed.

Links to previously published literature

When discussing plausible reasons for differences in police response to crisis calls within the same neighborhood, interviewees cited policing burnout and BH stigma, two issues that are linked to police response outcomes. First, numerous studies have examined the causes and consequences of stress and eventual burnout among police officers. While estimates vary, studies have found moderate to high levels of operational stress and burnout among officers in the US.[29,30] Operational stressors such as workload, shift work schedule, on-the-job exposure to high-stress situations, and interpersonal stressors such as supervision, leadership, and co-worker relations have been linked to both on and off-the-job consequences,[31,32] negatively impacting officers' personal and professional lives.[33]

Second, the BH stigma noted by our participants is reflected in interviews of people with mental illness in Chicago, who also shared negative perceptions of police interactions and the expectation of being treated poorly.[11] These perceptions of stigma are supported by research that has shown negative stereotypes about individuals with mental illness are higher among police officers than in the general U.S. population.[9] In another study, officers reported perceiving situations involving a mentally ill individual as more dangerous, holding the description of the actual scenario constant.[10]

Another impactful finding from our study is the community's desire for non-police response options; our results here align with the only other study that we know of on this topic.[17] Community preference for non-police crisis response models parallels the observed trend of an

increasing number of cities across the U.S. piloting alternative, often non-police crisis response programs.[14,15] Our findings underscore the importance of integrating community members throughout the crisis response development process because the interviewees clearly identified what aspects of a non-response program as most important to them (BH training for 911 dispatch operators) and had ideas for how to safely implement such a program in their community (close collaboration with on-call officers as opposed to an independently operating BH team).

Dissemination of findings

Local dissemination of our findings is of critical importance to the study team. After a productive series of CAB meetings to develop a dissemination plan, the study team drafted a 2-page findings statement to give policy makers at the local and state level in advance of a series of briefing meetings the study team conducted in the spring of 2025 with the Columbus Chief of Police and her team, and the Columbus City Council.

Limitations

It is important to state that the perspective of Columbus residents, and specifically our convenience sample of residents, are not necessarily representative of people in other large U.S. cities. However, Columbus, with its history of racialized police violence,[34] is a microcosm of what is happening in cities across the country.[35] Additionally, finding common themes across diverse types of interviewees enhances the generalizability of the findings presented here. Another limitation of this study is that community members cannot distinguish a CIT trained officer from a traditionally trained officer – there are no external visual cues. Therefore, while there may be variation in officer actions based on this BH specific training, exploring that potential question was not possible given the anonymous data collection procedures.

Public Health Implications

Our findings related to the need for more police training in BH crises are particularly salient given the current national policy discussion around the culture of police accountability. A 2021 report by the Council on Criminal Justice Taskforce on Policing called on the federal government to promote trauma-informed policing that emphasizes de-escalation, procedural justice, and implicit bias training.[36] The participants in our interviews did not use those academic terms, but they noted the same needs based on their real-world encounters with police. Nationally, scholars have proposed a move beyond the traditional, 40-hour CIT classroom training, including extended CIT training via online video conferencing in which BH providers debrief complex cases with officers[37] or engaging local police in re-imagining a local care continuum for BH crises.[38]

Notably, however, many interviewees called not for more police training, but for an entirely non-police response to BH crises. Ours is the second study that we know of to elicit preferences for BH crisis response models in an impacted, U.S. community. A 2023 study in Georgia also found that among 4 models of specialized BH crisis response, impacted families most often preferred non-police response and were least likely to prefer "specialized police response",[17] implying a distrust in what police training can accomplish. One of our interviewees synthesized this sentiment:

> *"It feels to me that trying to train a subset of the police is working so hard upstream to change the attitude about what they're doing. It would be easier, I think, to train social workers to be police-like than to change police-like police to be social worker-like*."

Incorporating impacted communities into both the development and evaluation of these non-police response models is critical,[8] and this study is an important step toward that goal.

References

1. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2023:162. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

2. Lavoie JAA. Relative invisibility: an integrative review of carers' lived experiences of a family member's emergency mental health crisis. *Soc Work Ment Health*. 2018;16(5):601-626. doi:10.1080/15332985.2018.1467845

3. DeVylder JE, Anglin DM, Bowleg L, Fedina L, Link BG. Police Violence and Public Health. *Annu Rev Clin Psychol*. 2022;18(1):527-552. doi:10.1146/annurev-clinpsy-072720-020644

4. Taheri SA. Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis. *Crim Justice Policy Rev*. 2016;27(1):76-96. doi:10.1177/0887403414556289

5. Teplin LA, Pruett NS. Police as streetcorner psychiatrist: managing the mentally ill. *Int J Law Psychiatry*. 1992;15(2):139-156. doi:10.1016/0160-2527(92)90010-x

6. Washington Post. Police shootings database 2015-2024: Search by race, age, department. Washington Post. June 10, 2024. https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

7. Irwin A, Pearl B. The Community Responder Model. Center for American Progress. October 28, 2020. Accessed March 4, 2024. https://www.americanprogress.org/article/community-responder-model/

8. Spolum MM, Lopez WD, Watkins DC, Fleming PJ. Police Violence: Reducing the Harms of Policing Through Public Health–Informed Alternative Response Programs. *Am J Public Health*. 2023;113(S1):S37-S42. doi:10.2105/AJPH.2022.307107

9. Soomro S, Yanos PT. Predictors of Mental Health Stigma among Police Officers: the Role of Trauma and PTSD. *J Police Crim Psychol*. 2019;34(2):175-183. doi:10.1007/s11896-018-9285-x

10. Watson AC, Corrigan PW, Ottati V. Police officers' attitudes toward and decisions about persons with mental illness. *Psychiatr Serv Wash DC*. 2004;55(1):49-53. doi:10.1176/appi.ps.55.1.49

11. Watson AC, Angell B, Morabito MS, Robinson N. Defying negative expectations: dimensions of fair and respectful treatment by police officers as perceived by people with mental illness. *Adm Policy Ment Health*. 2008;35(6):449-457. doi:10.1007/s10488-008-0188-5

12. Centers for Disease Control and Prevention. A Stimulant Guide: Answers to Emerging Questions about Stimulants in the Context of the Overdose Epidemic in the United States. Published online 2022. https://www.cdc.gov/overdose-prevention/media/pdfs/2024/03/CDC-Stimulant-Guide.pdf

13. Shadravan SM, Edwards ML, Vinson SY. Dying at the Intersections: Police-Involved Killings of Black People With Mental Illness. *Psychiatr Serv*. 2021;72(6):623-625. doi:10.1176/appi.ps.202000942

14. Marcus N, Stergiopoulos V. Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. *Health Soc Care Community*. 2022;30(5):1665-1679. doi:10.1111/hsc.13731

15. Seo C, Kim B, Kruis NE. Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis. *J Crim Justice*. 2021;72:101752. doi:10.1016/j.jcrimjus.2020.101752

16. Balfour ME, Hahn Stephenson A, Delany-Brumsey A, Winsky J, Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatr Serv*. 2022;73(6):658-669. doi:10.1176/appi.ps.202000721

17. Pope LG, Patel A, Fu E, et al. Crisis Response Model Preferences of Mental Health Care Clients With Prior Misdemeanor Arrests and of Their Family and Friends. *Psychiatr Serv*. 2023;74(11):1163-1170. doi:10.1176/appi.ps.20220363

18. Bailey K, Paquet SR, Ray BR, Grommon E, Lowder EM, Sightes E. Barriers and facilitators to implementing an urban co-responding police-mental health team. *Health Justice*. 2018;6(1):21. doi:10.1186/s40352-018-0079-0

19. Richmond M, Gibbs JC. Police Perceptions of Training on Interactions with Persons with Mental Illness. *J Police Crim Psychol*. 2021;36(2):268-275. doi:10.1007/s11896-020-09409-8

20. Agency for Healthcare Research and Quality. *AHRQ Activities Using Community-Based Participatory Research to Address Health Care Disparities*. Agency for Healthcare Research and Quality; 2020:1-6. https://www.ahrq.gov/research/findings/factsheets/minority/cbprbrief/index.html

21. Jones N, Dotson K, Smith KD, Reynolds L, Key K, Hanna-Attisha M. The Impact of Community Engagement in the Design and Implementation of the Flint Registry. *Prog Community Health Partnersh Res Educ Action*. 2024;18(2):155-166.

22. Miller AB, Issa OM, Hahn E, Agalab NY, Abdi SM. Developing Advisory Boards within Community-based Participatory Approaches to Improve Mental Health among Refugee Communities. *Prog Community Health Partnersh Res Educ Action*. 2021;15(1):107-116. doi:10.1353/cpr.2021.0010

23. Florida RL, Mellander C. *Segregated City: The Geography of Economic Segregation in America's Metros*. Martin Propserity Institute, Rotman School of Management, University of Toronto; 2015. https://books.google.com/books?id=gSb7jgEACAAJ

24. Valerio MA, Rodriguez N, Winkler P, et al. Comparing two sampling methods to engage hard-to-reach communities in research priority setting. *BMC Med Res Methodol*. 2016;16(1):146. doi:10.1186/s12874-016-0242-z

25. Yuan NP, Mayer BM, Joshweseoma L, Clichee D, Teufel-Shone NI. Development of Guidelines to Improve the Effectiveness of Community Advisory Boards in Health Research. *Prog Community Health Partnersh Res Educ Action*. 2020;14(2):259-269. doi:10.1353/cpr.2020.0026

26. Patton MQ. *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. SAGE Publications; 2023. https://books.google.com/books?id=HXitEAAAQBAJ

27. Taylor B, Henshall C, Kenyon S, Litchfield I, Greenfield S. Can rapid approaches to qualitative analysis deliver timely, valid findings to clinical leaders? A mixed methods study comparing rapid and thematic analysis. *BMJ Open*. 2018;8(10):e019993. doi:10.1136/bmjopen-2017-019993

28. Lewinski AA, Crowley MJ, Miller C, et al. Applied Rapid Qualitative Analysis to Develop a Contextually Appropriate Intervention and Increase the Likelihood of Uptake. *Med Care*. 2021;59(Suppl 3):S242-S251. doi:10.1097/MLR.0000000000001553

29. McCarty WP, Aldirawi H, Dewald S, Palacios M. Burnout in blue: An analysis of the extent and primary predictors of burnout among law enforcement officers in the United States. *Police Q*. 2019;22(3):278-304. doi:10.1177/1098611119828038

30. Queirós C, Passos F, Bártolo A, Marques AJ, da Silva CF, Pereira A. Burnout and Stress Measurement in Police Officers: Literature Review and a Study With the Operational Police Stress Questionnaire. *Front Psychol*. 2020;11:587. doi:10.3389/fpsyg.2020.00587

31. Shane JM. Organizational stressors and police performance. *J Crim Justice*. 2010;38(4):807-818. doi:10.1016/j.jcrimjus.2010.05.008

32. Peterson SA, Wolkow AP, Lockley SW, et al. Associations between shift work characteristics, shift work schedules, sleep and burnout in North American police officers: a cross-sectional study. *BMJ Open*. 2019;9(11):e030302. doi:10.1136/bmjopen-2019-030302

33. El Sayed S, Sanford S, Kerley K. Understanding Workplace Stress Among Federal Law Enforcement Officers. *Am J Crim Justice*. 2019;44. doi:10.1007/s12103-019-09474-8

34. Matrix Consulting Group. *Report on the Police Division Operational Review: Columbus, Ohio*. Matrix Consulting Group; 2019. https://www.columbus.gov/WorkArea/DownloadAsset.aspx?id=2147511454

35. Sinyangwe S. Mapping Police Violence. Mapping Police Violence. May 25, 2024. https://mappingpoliceviolence.us/

36. Council on Criminal Justice. The Path to Progress: Five Priorities for Police Reform. Published online May 2021. https://counciloncj.foleon.com/policing/assessing-the-evidence/five-priorities

37. Crisanti AS, Earheart JA, Rosenbaum NA, Tinney M, Duhigg DJ. Beyond crisis intervention team (CIT) classroom training: Videoconference continuing education for law enforcement. *Int J Law Psychiatry*. 2019;62:104-110. doi:10.1016/j.ijlp.2018.12.003

38. Steadman HJ, Morrissette D. Police Responses to Persons With Mental Illness: Going Beyond CIT Training. *Psychiatr Serv Wash DC*. 2016;67(10):1054-1056. doi:10.1176/appi.ps.201600348

Table 1: Four key themes from interviews with 30 community members about police response to 911 calls for BH crises

Main themes	Representative quotes	
Varied police demeanor across incidents within a neighborhood, and to repeated calls from the same address.	*"A different cop can make all the difference."*	*"The mood they in. Or they work level. You never know what people go through."*
Reluctance to call the police for BH crises	*"I got to be honest, people don't want to call police. I don't want to call as well."*	*"We were trying to find out the best routes for care and the least violent routes for care. Without having to call the police."*
Police need increased training in BH disorders and de-escalation tactics	*"Without a high level of training they [police] don't have enough understanding of the nuances of the situation. So, all of that understanding of nuance comes from more education."*	*"I would also probably provide education to as many officers as possible to let them know that this is not black and white, and you can absolutely make a mental crisis so much worse by responding with force when somebody is not in their right, stable, form of mind."*
Strong support for a non-police response	*"I don't want the police to show up period. I would love for it to be a non-police response"*	*"It feels to me that trying to train a subset of the police is working so hard upstream to change the attitude about what they're doing. It would be easier, I think, to train social workers to be police-like than to change police-like police to be social worker-like."*

Table 2: Participants' proposed rationale for the varied police demeanor across incidents within a neighborhood and to repeated calls from the same address.

Why varied police demeanor?	Representative quotes	
Police burnout	*"I feel when we call 911 [for a mental health crisis] the officers are overwhelmed."*	"May*be I just got a person who was on the tail end of their shift?*"
BH stigma	"*They [responding officers] are just overreactive and stigmatized and treating mental health and substance use calls as criminals and dangerous people…They just are so afraid.*"	*"[responding officers were] nasty and judgmental, as if wasting their time."*
Lack of BH training	"S*ometimes you put trauma on top of trauma [with an aggressive police response] and that doesn't help situations. I am not going to say the officers aren't helpful, but they are kind of like 'what do you want us to do?*""	"*When I see apathy, or a lack of desire to help, there is some fear that they're going to do the wrong thing, and that they're going to be in trouble for it."*

Table 3: Subthemes on the benefits of non-police response to 911 calls for behavioral health (BH) crises.

Benefits of non-police response	Representative quotes	
Specialized BH providers with proper crises training	*"I think there should be at least two people there. People who are physically fit enough to handle a situation in case he did become aggressive. And then the police can be called if it is a situation like that."*	*"So if there were just a separate response unit closer to like a medic, what medics do for physical health, like medics for mental health. People who are trained and who can handle this situation that could escalate. I don't want to put a bunch of cardigan, clipboard social workers on these calls. They do need that kind of training if things go south. But when you show up with tanks, you get a different response than when you show up with kindness, and oftentimes they're showing up with tanks."*
Treat those with BH crises like we treat physical health crises	*"I just think if all of it [mental health crisis response] were pulled away from the police, it's like it's changing the whole paradigm of how we think of it. Like we call police for crimes, we don't have to call them for sick people. If I had somebody who is behaving weirdly because of diabetes*	*"We need to have people who are responding to mental health crises that are mental health professionals. I mean, that just makes sense to me,"*

	I wouldn't think to call the police."	
911 call center – triage to non police response	*"I don't know whether during the call if, if there needs to be a prompt of whether the individual has access to a firearm or weapon, and if so, then send someone [behavioral health provider] with the police. But if there are no weapons whatsoever, then I would think a mental health professional could probably handle that."*	*"I understand, you know, 9 1 1 is overwhelmed. They need to have a special unit just for mental health. Um, so that way whoever's answering the phone can talk to them, 'Hey, you know, what's going on? You know, are you doing okay? Um, do you have any weapons on you? Do you want me to send someone?' You know, just, just compassion"*
911 call center - BH training	*"I feel like somebody with the proper training [in the call center] would be able to cipher better when something really is an emergency. And you need to get some eyes out there and visibly verify that that person is okay, in a way that's not so aggressive that it's just adding more trauma to the already emotional state."*	*"I would probably treat incoming calls and, you know, concerns, try to have the dispatchers feel out the situation a little bit more."*
Non-police response would relieve the police	*"There are so many situations where people can do the job better than the police. And then that's one less thing that the police need to be involved with."*	*"[Non-police response] Should be a good solution for the pro-cop people too, because it's not fair to expect the cops to know how to handle mental health crises when it took me six years of school to learn how to."*

Community Member Focus Group Guide

INTRODUCTION TO THE FOCUS GROUP

First, let us THANK YOU for considering participation in our research project. I am (NAME) and I am a researcher from The Ohio State University. We are asking you to be part of a project we are doing to study community members' thoughts and feelings about how the city of Columbus responds to 911 calls about mental health crises.

You have been identified as someone who would provide invaluable information about these issues. We will email each participant a $50 gift card at the conclusion of the focus group.

The risks to you in this study are minimal. One potential risk is a breach of confidentiality because research team members cannot control what participants say outside of the focus group setting. To minimize this risk the focus group leader, (NAME), will provide instructions at the beginning of the group and again afterward to reinforce confidentiality. All audio recordings and transcripts will be stored in a password-protected folder on the secure University server, this is the safest way to store private data.

We have scheduled the next 90 minutes to discuss these topics with you. Before we begin the discussion, we need to take you through an informed consent process. In particular, let me make sure that you understand that:

a. Your participation is completely voluntary. If you do choose to talk with us, you may leave the focus group at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.
b. You can choose to skip or refuse to answer any questions.
c. We consider this discussion to be confidential. Your participation is confidential in the sense that your name will not be used in any reports or articles.

d. We would also like to record the interview for the purposes of data collection for our research. The recording will not be used to identify you in any way.
e. While we ask other group participants to keep the discussion in the group confidential, we cannot guarantee this. Please keep this in mind when choosing what to share in the group setting.

Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

For questions about your rights as someone taking part in this study, you may contact Ms. Sandra Meadows in the OSU Office of Responsible Research Practices at 1-614-688-4792 or 1-800-678-6251. You may call this number to discuss concerns or complaints about the study with someone who is not part of the research team. For questions, concerns, complaints, or if you feel you were harmed because of study participation, you may contact Jennifer L. Hefner, Principal Investigator at 614-363-5632.

Do you have any questions about our study or this focus group process?

Do you consent to participate in this study?

Section 1: Welcome and Introductory Questions

We are on a mission to collect your stories because we want to push Columbus city council to do better with 911 response, and we think they need to hear from you to do that. Before we dig into the discussion questions, I would like to go over a few guidelines for our time together:

- No right or wrong answers, only differing points of view
- We're tape recording, one person speaking at a time
- We're on a first-name basis and we won't use names in our reports
- You don't need to agree with others, but please listen respectfully as others share their views

- We ask that you silence your phones if possible. If you must take an urgent call, please just rejoin us as quickly as you can when it's done.
- My role as moderator will be to guide the discussion and allow you all to talk to each other.

Let's find out some more about each other by going around the Zoom boxes. Please tell us your name and where you live.

Next, we are going to talk about mental health crises and substance use crises quite a lot. To get on the same page about what we mean by 'mental health or substance crises,' here are some examples of mental health and substance crises that we see in the 911 call logs for Columbus:

- *A woman reporting that her daughter is off meds and behaving erratically*
- *A teenage girl warning 911 that her friend is depressed and emotional*
- *A man calling to say that he thinks his girlfriend is having a mental breakdown*
- *A caller who has taken drugs, and is now feeling paranoid and seeing things*
- *Parents calling because they can't control their child's erratic behavior and need help*
- *A young man calling in to say his sister went missing after threatening to kill herself"*
- *A caller saying that a man won't stop shouting on the street, probably on drugs*
- *A woman saying that her partner came home unbelievably drunk, and is getting violent*

Basically, we want to be clear that mental health crises and substance crises can look like a LOT of different things.

How have you been impacted by 911 response to a mental health or drug crises?

Prompt: Personally? In your family? In your neighborhood?

Section 2: Participant experiences with first responders during crisis calls

Tell me about police involvement in your community when responding to 911 calls about someone in a mental health crisis or substance use crisis?

Prompt: How do the police act in those situations?

Prompt: Is it always the same type of response, or does it depend? On what?

Prompt: Can you talk about a time you have seen or heard about? How did it go down?

Prompt: Did the police use any force? For example, did they put hands on anyone or use any weapons? Do you personally think it was needed?

What happened the specific time that you called 911? How was this the same or different from the police involvement we talked about in the last question?

Prompt: What information did the call taker ask for?

Prompt: Did they seem to understand the situation that was occurring?

Prompt: Who did they say would respond?

Has anyone here ever called 911 for a mental or substance use crisis, and somebody OTHER than police showed up? (For instance, a team with a Netcare social worker, paramedics on their own, some other sort of health service provider?) If so, tell us how that interaction went.

For people who have had that other responder experience --- How did that interaction differ from interactions with police only?

Prompt: Even if you have only had police respond with an ambulance, how did interactions differ between the police officer and the paramedics?

If anyone has a crisis incident that they have NOT yet shared about, please do share.

Prompt: In particular, does anyone recall a personal experience that went <u>differently</u> than what people have already shared?

Section 3: Participant experiences after the initial crisis call, how did it end?

Thinking about a time you have already talked about, in which you personally called for help during a mental health or drug crisis call, what happened to the person in crises in the end?

Prompt: Do you know if the person went to jail, Netcare, ED, or was left at home?

Prompt: Did they get on meds, did they get connected w/ a case worker, were they forcibly kept at the hospital against their will and lost their job?

Do you all think that what happens to the person in crisis at the end of the call can have an impact on his/her future health?

Prompt: What types of health impacts?

Prompt: Is drop-off at one place better than another, i.e. Netcare versus jail versus hospital?

Do you have any thoughts about how this interaction would have gone differently, or how it would have ended differently, if it had occurred in a different neighborhood?

Prompt --- will depend on the neighborhood. We could even name the other 2 neighborhoods… if east side "What if in Clintonville?" "What if in Hilltop?"

If you told me about one incident but there are others that you have personally witnessed, could you share about each of those times?

Prompt: Does anyone recall an experience that went differently than what people have already shared?

I am going to summarize what I have heard so far about how these calls for help during a crisis ended, and what happened after. Then I would like you all to tell me what I missed in this summary.

Section 4: What model of response do you all most prefer / trust?

Suppose you were in charge of the 911 mental health crisis response in Columbus — what would you change to make it better?"

Prompt: Non-police response?

Prompt: Police responding along with other folks?

Prompt: triage system that matches the type of response with the crisis situation's needs?

Have you heard about efforts to develop a different type of crisis response, without police officers? What are your thoughts on these discussions/plans?

What types of issues would be appropriate for trained crisis team responders to address without police?

Is there anything else we should know about our topic that we have not asked you yet?

CONCLUSION