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New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises

Training, emergency response options, and data reporting are key areas for improvement, says Pew study

Overview

Every year, millions of 911 calls involve a person experiencing an emergency related to a mental health or substance use disorder—situations often referred to as behavioral health crises.[1] How these calls are handled can determine whether the incident ends safely, the person in crisis is arrested, or the person is connected to appropriate care.

The call-takers and dispatchers answering these emergency calls make critical assessments of the health and safety of those involved in each call, decide whether help is needed, and, if it is, determine whether it should be led by law enforcement officers, emergency medical services, or more specialized field responses (if available).

The important role 911 plays in behavioral health emergencies has drawn increased national attention in recent years, with new ideas emerging on how call centers and emergency responses can be more effective.[2] But there is a relative lack of information about how call centers manage these emergencies, including how calls are assessed, what dispatch options are available, and how data on calls and outcomes is collected and shared. Those unknowns are fueled by the disjointed nature of the system, comprising more than 5,000 separate 911 call centers, each with its own standards for training staff, call-handling and dispatch protocols, and data management and reporting systems.[3]

To better understand how behavioral health crisis calls are currently handled by 911, The Pew Charitable Trusts sent a questionnaire to 233 call centers across the country. The results reflect the responding 37 agencies and their jurisdictions and cannot be considered nationally representative. However, key insights emerged from this analysis that provide a rare look into behavioral health crisis system resources for 911 call centers in diverse communities across 27 states in the U.S. Those themes include:

1. **Few responding call centers have staff with behavioral health crisis training to inform how they navigate 911 calls and dispatch responses.** Experts have recommended that call-takers and dispatchers—collectively known as telecommunicators—should receive specialized training to handle behavioral health crisis calls.[4] Some call centers have started to enlist behavioral health clinicians, either on staff or on call, to whom telecommunicators can transfer calls or whom they can ask for their guidance. Yet, while many law enforcement agencies have taken steps to improve officer responses to mental health emergencies, most responding call centers indicated their telecommunicators have not received specialized behavioral health crisis training. And few respondents used behavioral health clinicians to aid in addressing incoming crisis calls.

2. **Respondents indicated they had limited options to dispatch specialized responses to crisis calls.** Most responding 911 call centers had crisis intervention trained law enforcement officers available to dispatch to at least some calls. But less than half said more comprehensive mobile crisis response teams (MCTs)—which include police officers, clinicians, social workers, and other field responders—were available in their area. Most respondents also did not know whether their emergency medical technicians (EMTs) or fire personnel were trained in crisis intervention, even though these responders frequently must handle mental health and substance use-related emergencies.[5]

3. **Some respondents did not indicate that their 911 call center and service area had any specialized resources to address mental health or substance use-related emergencies.** Seven of the 37 responding centers said they didn't have or weren't aware of having access to behavioral health clinicians; crisis-trained 911 telecommunicators, law enforcement, fire personnel, or EMTs; or specialized response options such as MCTs. This suggests that how 911 responds to a behavioral health crisis depends on where it is occurring. Most of these responding call centers without specialized resources served primarily rural areas, meaning that disparities may be greater in these types of communities.

4. **While most respondents record calls as mental health and/or substance use-related in their electronic data management system, few reported on these statistics internally or publicly.** How this data is entered and updated varies by call center, and software can limit usability of the data. The lack of consistent coding and data sharing suggests many administrators and policymakers do not have the information necessary to understand the scope of behavioral health crises in their communities, how they are being addressed, potential disparities based on race or location, and where opportunities might exist for improvements and needed investment. It also highlights the difficulty in painting a national picture of the scope of emergency calls related to mental health and substance use.

5. **Many respondents recognized the need to improve 911's responses to behavioral health emergencies, and either are working to improve their systems or expressed a desire to do so.** Several respondents mentioned wanting to strengthen their behavioral health responses, but also pointed to various impediments to improvement, including budget constraints, access to training, availability of appropriate health services and transportation to those facilities, and staffing shortages and turnover.

To develop best practices for these emergencies—including possible alternatives to arrest or other criminal justice responses—it is crucial to identify, understand, and address crisis response system deficits. [6] While Pew's research presents only a snapshot of 911 crisis services in a small number of communities across the country, the findings suggest a need to better understand the challenges call centers face in addressing mental health and substance use-related emergencies, and to develop policy solutions tailored to the unique circumstances of each call center and its service area.

Currently, a number of reform efforts are in progress to transform behavioral health crisis responses. These include federal legislation to support the creation of a national crisis-specific call number (988), state funding to expand community crisis response options, and development of model frameworks for community crisis response systems.[7] Integrating the perspectives of 911 center employees into these discussions would provide valuable input into recommended improvements and be critical to their successful implementation.

About the research

Pew collaborated with the National Emergency Number Association (NENA)—a professional organization with more than 16,000 members focused on improving 911 policy, technology, operations, and education—to develop and distribute an online questionnaire to 911 call centers.[8] Researchers asked center representatives to provide information on the multiple steps of handling behavioral health crisis emergencies; considering these stages of call-handling and dispatch, researchers collected information about how call centers identify, respond to, and track and report on these crisis contacts.[9] (See Figure 1.)

Figure 1

Handling Behavioral Health Crisis Calls Is a Multistep, Multiagency Process

Stages of responding to a 911 crisis call

Behavioral Crisis Event

A person is experiencing an emergency due to mental health and/or substance use issue.

911 Contact

911 call centers can be contacted in various ways, including phone, text, email, or other electronic exchange.

This contact may come from the affected individual or other individuals, police officers, crisis centers, or other sources.

Telecommunicator Response

Telecommunicators process information from the caller.

May include using a script to identify behavioral health crisis calls and/or input from behavioral health clinician on staff.

Telecommunicator Dispatch Decision

Decision on how to handle the call could depend on resources.

May include sending crisis-trained field responders or mobile crisis response team, and/or involving a behavioral health clinician.

Outcome of Behavioral Health Crisis Event

Outcome could depend on dispatch decision.

May include connection to treatment services, hospitalization, arrest, or the situation may be resolved without further action.

To select call centers to send the questionnaire to, NENA provided a random sample of its members; Pew augmented this with additional call centers in states not represented in the NENA sample to ensure questionnaires would be sent to at least one center in every state. From this, 233 were selected to create a sample that approximated the racial demographics of states and maximized service area coverage.

Representatives from 37 call centers in 27 states completed the questionnaire; these answers were used for the analysis. (See Figure 2.) The response rate (16%) is not surprising given the nature of 911 operations, where call centers are often understaffed.[10] Over three-quarters (76%; 28 of 37 respondents) were in regions where 75% or more of the population is White; the remaining nine 911 service areas were classified as not predominantly White for analysis. The responses represented 16 rural, 15 urban clusters, and six urbanized service areas; see the methodology for more information about these classifications, as well as the research process generally.

Figure 2

Location of Questionnaire Respondents

37 911 call centers in 27 states answered the questionnaire
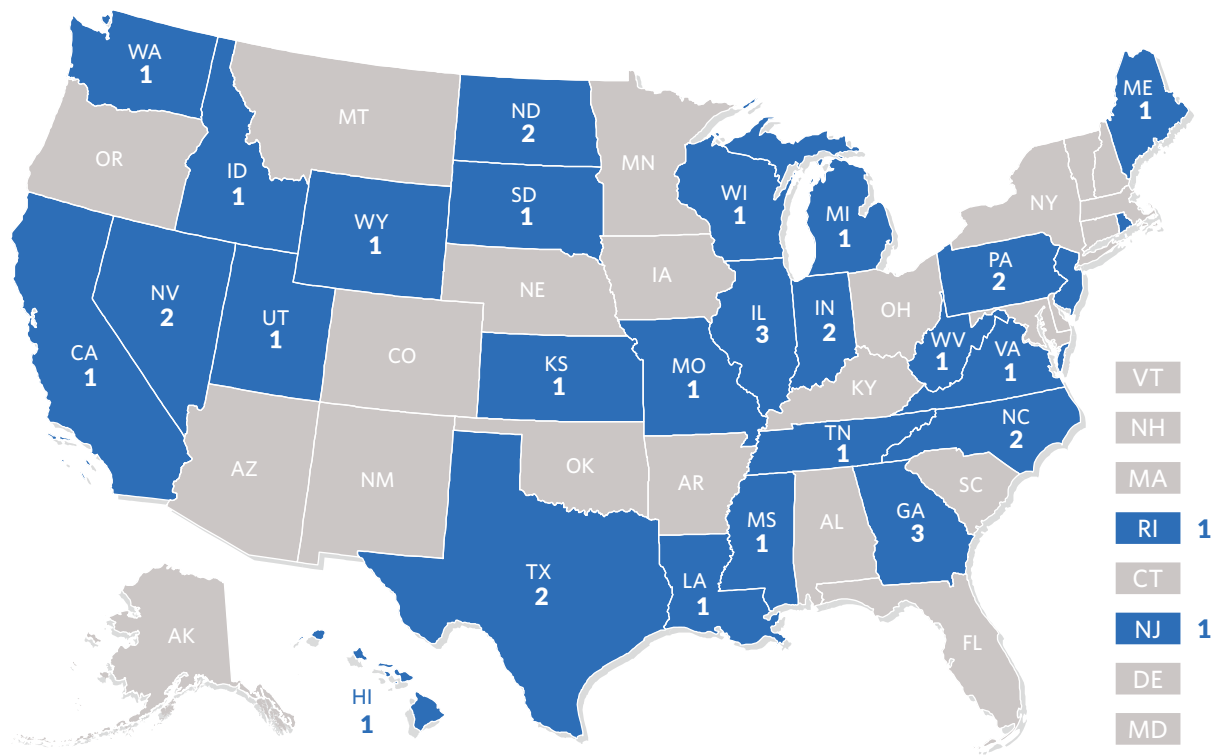
Note: Completed responses were received from 911 call centers in blue shaded states. Numerals represent number of responding 911 call centers in each state. Gray states had no responding call centers.

Source: Pew analysis of questionnaire responses

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Crisis-specific resources for 911 call centers

Most 911 centers in the study don't use standardized tools to identify calls related to a person in behavioral health crisis

There is no national standard protocol for emergency call-taking; instead, there are several different proprietary systems in use around the country, as well as locally developed methods of identifying whether a caller is in behavioral health crisis.[11]

Centers responding to the questionnaire varied in their methods of identifying whether a call is related to behavioral health. Slightly less than half (17 respondents) said they used scripts from the International Academy of Emergency Dispatch or another emergency medical dispatch protocol.

However, several respondents indicated they do not have a script to identify behavioral health crises. A respondent from an urbanized cluster service area explained, "We do not follow a script or questionnaire. [These calls are determined] by listening to the caller and identifying their needs." Urban and urbanized cluster areas were more likely to use a specific question set related to behavioral health (57%; 12 of 21 respondents) when compared with rural localities (31%; five of 16 respondents).

Despite these inconsistencies, representatives from centers with and without scripts acknowledged in their open-ended answers the importance of training and/or experience in identifying these types of calls. "Recognizing a mental health crisis comes with experience," explained one supervisor in an urban cluster area that recently began using a scripted protocol, while a 911 director from a rural area without a script noted "there are general key questions, and the call-taker asks questions based off of training."

Current high rates of turnover among telecommunicators may mean that in 911 call centers that rely on the experience of call-takers and dispatchers, lack of access to clinicians and standardized protocols may be particularly challenging.[12]

Most 911 telecommunicators in the sample have not received specialized crisis training

The past three decades have seen an increase in education and training programs to improve law enforcement's interaction with people who have mental health and substance use disorders.[13] Crisis intervention team (CIT) training is one of the best known and most utilized programs. Launched in 1988 following the death of a man with mental illness during a police encounter in Memphis, Tennessee, CIT training has since been associated with reduced use of emergency services, arrests, and instances of police use of force in some jurisdictions, and the training has been adopted by many law enforcement agencies across the U.S.

A version for other groups of field responders, including 911 call center employees, has been recommended as a way to provide them with key information about behavioral health crises.[14]

Researchers asked respondents if their call-takers and dispatchers had taken CIT training specifically, as well as whether they had received other training related to mental health or substance use-related crises. Roughly two-thirds of respondents indicated their call-takers and dispatchers had not received specialized behavioral health crisis training (25 out of 37).[15] Of the 12 localities with training, all indicated they were CIT-trained; in two of these, telecommunicators also received additional unspecified behavioral health training.

Roughly the same share of rural respondents (five of 16) and those in urban or urbanized clusters (seven of 21) indicated they had crisis-trained telecommunicators. And even where the training was offered to call-takers and dispatchers, not all have been able to participate; some respondents noted problems with staff turnover and

a limited availability of training, which may contribute to inconsistent practices. Eleven of 28 centers serving predominantly White regions had crisis-trained telecommunicators, compared with one of the nine centers serving populations that were not predominantly White. (See Figure 3.)
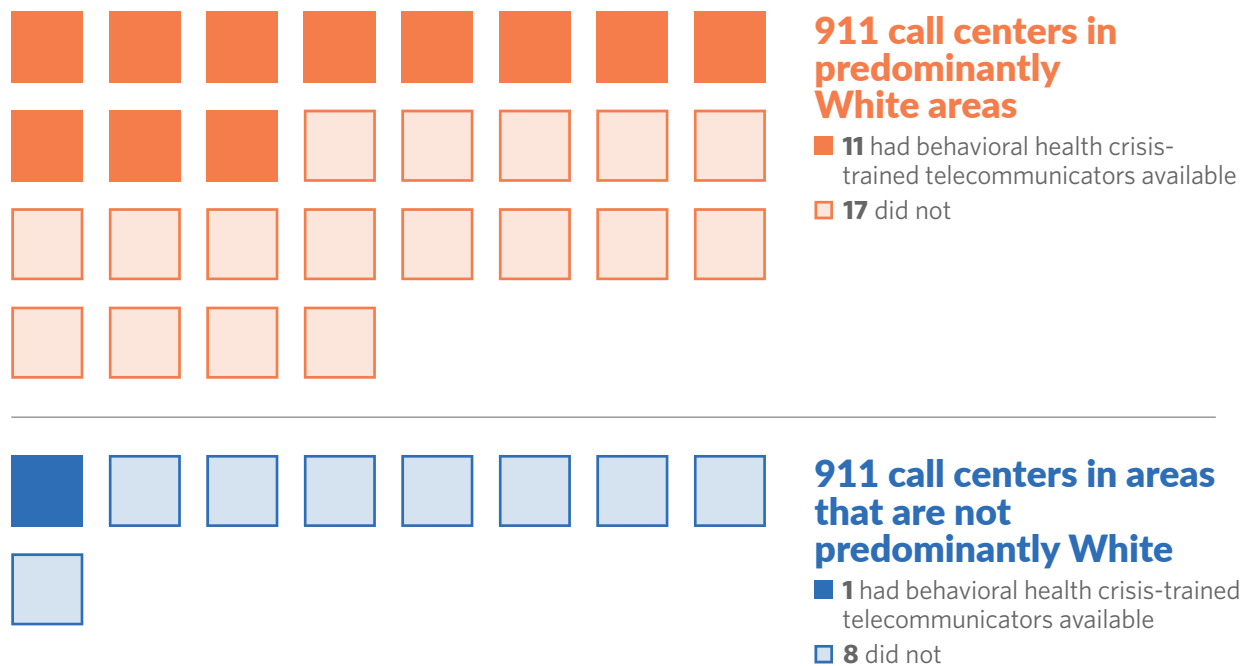
Among those who indicated a desire for 911 center staff to be trained in CIT or other behavioral health crisis response, barriers included:

- Staffing: "Access to training is difficult with high staff turnover."
- Time: "The 40-hour course is a lot of time to dedicate to this type of training along with our other requirements."
- Funding: "Budgetary restraints keep us from going to trainings that require extensive travel."
- Awareness: "[I] honestly did not know there is a training geared to [center] personnel."

Figure 3

Most Responding 911 Call Centers Indicated Their Telecommunicators Did Not Have Behavioral Health Crisis Training

Respondents in predominantly White areas more likely to have been trained

911 call centers in predominantly White areas

■ **11** had behavioral health crisis-trained telecommunicators available

□ **17** did not

911 call centers in areas that are not predominantly White

■ **1** had behavioral health crisis-trained telecommunicators available

□ **8** did not

Source: Pew analysis of questionnaire responses

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Most responding centers do not have access to behavioral health clinicians to assist with crisis calls

Recently, some 911 centers have begun utilizing clinicians to guide call assessment, work with the caller to try to stabilize the situation, and help make connections to care and treatment alternatives that could reduce the likelihood of people entering the criminal legal system.[16]
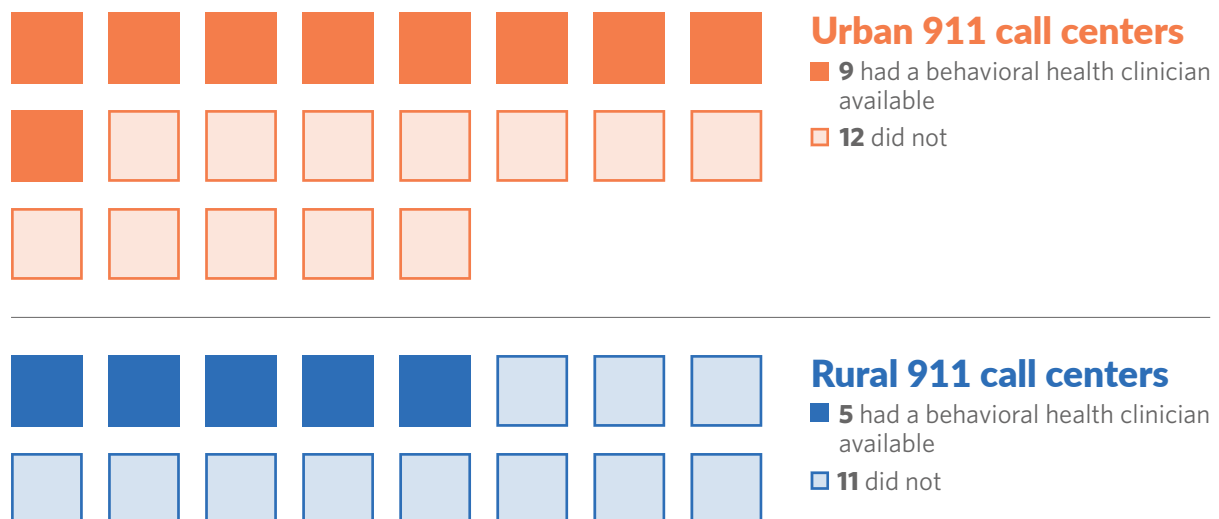
Among the respondents, 14 reported having access to behavioral health clinicians in the community or on staff, compared with 23 indicating they did not. (See Figure 4.) Among centers serving rural areas, less than one-third (five of 16) indicated clinician access, compared with almost half (nine of 21) of respondents in regions considered urban clusters and urbanized. In terms of access by racial demographics, this was roughly proportionate: 11 of 28 centers with predominantly White service areas had access to a behavioral health clinician (39%), compared with three of nine of those in areas not predominantly White (33%). There was variability in terms of the type of clinical access, ranging from an embedded clinician, to round-the-clock availability through a crisis line, to only during a clinic's regular hours. Several respondents indicated that a clinician could be made available after dispatch, but not to help with triaging calls. Having this type of support could also benefit 911 center employees, as research indicates this work exposes individuals to stress and trauma that can lead to mental health challenges, including post-traumatic stress disorder.[17]

About half of respondents (18 of 37) said that they did not have telecommunicators with behavioral health crisis training and also did not have access to a clinician, indicating a lack of individuals with specialized training to handle calls involving people in crisis.

Figure 4

Most 911 Call Centers in the Study Didn't Have Access to Behavioral Health Clinicians

Rural service areas were more likely to lack this resource

Urban 911 call centers

■ **9** had a behavioral health clinician available

□ **12** did not

Rural 911 call centers

■ **5** had a behavioral health clinician available

□ **11** did not

Source: Pew analysis of questionnaire responses

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Crisis-specific field response resources

Fewer respondents had access to crisis-specific field response options other than crisis-trained law enforcement officers

Almost two-thirds of respondents (24 out of 37) indicated CIT-trained law enforcement officers were available to dispatch during a behavioral health crisis at least some of the time.

Although these officers are an important resource for crisis response, the unique nature of these emergencies and their impacts on individuals and communities have led to expert recommendations that additional and/or alternative response options are necessary.[18] Still, the majority of respondents reported a lack of additional response options or awareness of training among other potential responders. (See Figure 5.) Less than 1 in 5 respondents noted that they had access to CIT-trained EMTs or fire department personnel; most (23 for each category) indicated they did not know whether these groups had crisis-trained field responders.

Although research has shown that mobile crisis response teams made up of crisis-trained law enforcement and people with clinical expertise can be effective in reducing arrests, hospitalizations, and medical costs, only about 2 in 5 (15 of 37) respondents said they had this resource available.[19] Just 1 in 3 (five of 16) 911 centers serving rural areas indicated access to a mobile team, as compared with almost half (10 of 21) of respondents in urban cluster or urbanized areas. By demographics of the service area, it was roughly a third for each: 12 of the 28 respondents serving predominantly White areas had access to crisis teams, compared with three of nine in jurisdictions that were not predominantly White.

As with other crisis-related resources, 911 call centers reported a range of availability for field responders. Several noted that they have 24/7 access to crisis care professionals. Others, however, could access their MCT only during business hours or had to share with other counties. As explained by a supervisor in a rural area, "Our MCT is available only during business hours. The response time can vary depending on the day and the number of requests."
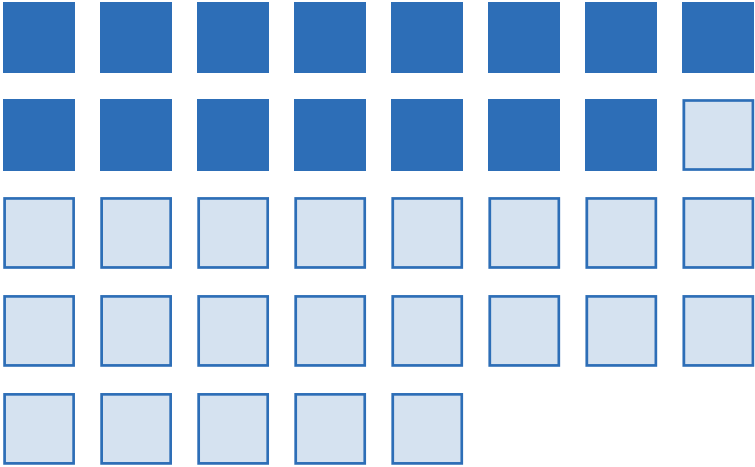
Figure 5

Most of the 37 911 Call Centers in the Study Had Crisis-Trained Law Enforcement Available to Respond to Crisis Calls

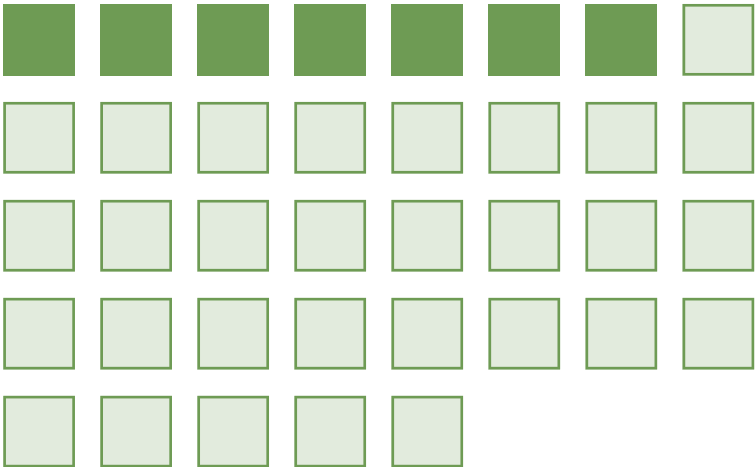Fewer had crisis teams or other non-law enforcement options

Crisis-trained law enforcement

■ **24** call centers had access

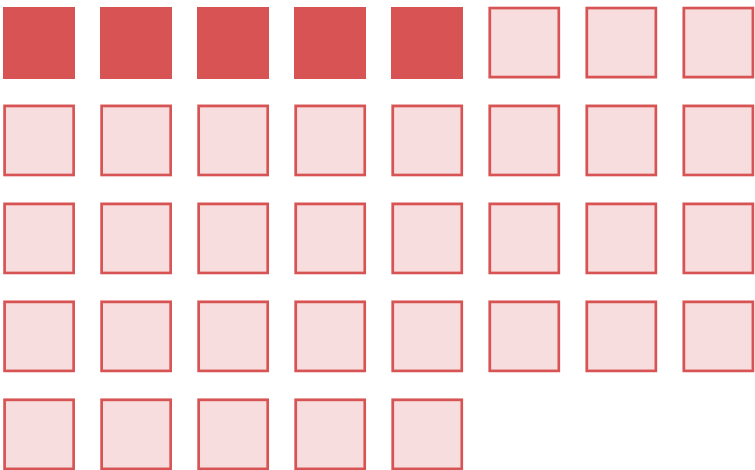☐ **13** call centers did not have or know of access
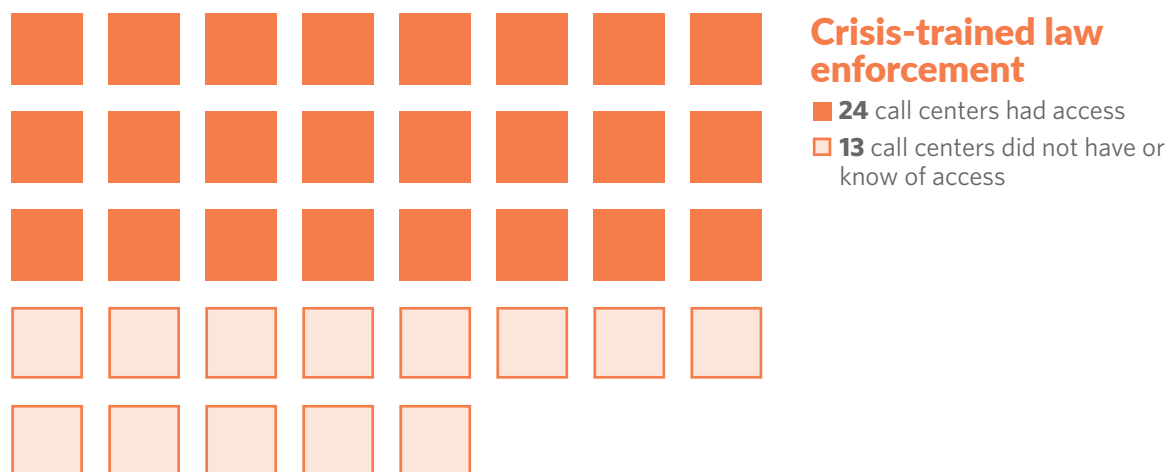
Mobile crisis team

- **15** call centers had access
- **22** call centers did not have or know of access

Crisis-trained emergency medical technicians

- **7** call centers had access
- **30** call centers did not have or know of access

Crisis-trained fire department personnel

- **5** call centers had access
- **32** call centers did not have or know of access

Source: Pew analysis of questionnaire responses

Respondents described a variety of other available field response options. Nine sites noted using hospitals or emergency rooms, four sites mentioned detoxification treatment facilities and crisis stabilization centers, and three identified other facilities such as shelters. Several indicated dispatch options that connected people with treatment services, and some noted the availability of a crisis or suicide hotline. However, even where these resources are available, complications can arise in practice, such as varying availability of CIT-trained officers when they are on duty. One deputy director noted, "work shift hours for [the] CIT team can be a challenge, depending on who and how many are on shift."

Roughly 1 in 5 respondents reported having virtually no crisis-related resources

Seven of the 37 911 call centers in the study indicated they didn't have or weren't aware of CIT-trained dispatchers, call-takers, law enforcement officers, fire department personnel, and EMTs—*and* didn't have or weren't aware of the availability of mobile crisis teams, behavioral health clinicians, or additional dispatch or field response options. While this is a small, nonrepresentative sample, it is still both surprising and concerning that this large a share of the respondents do not have or do not know whether they have access to various crisis response resources, which could make handling these emergencies difficult. One dispatcher working in an area without these services explained, "officers have to transfer these [people] either voluntarily or involuntarily to the hospital in the next county over. We do not have a hospital in our county anymore."

This group included four of 16 rural, two of 15 urban cluster, and one of six urbanized areas; they served four predominantly White service areas and three that were not predominantly White. Because the ability to respond to the questionnaire may be linked to agency capacity, this could suggest that those that did not respond have even more limited capabilities, although more research is needed.

Data collection and reporting on 911 crisis-related calls

Most responding 911 centers indicated that crisis calls are recorded in their systems, but methods varied

To better evaluate individual behavioral health outcomes and measure system progress, it is important for jurisdictions to document call data and provide metrics on their emergency response systems.[20]

More than 3 in 4 responding call centers (28 of 37) indicated that they record whether a call is related to a behavioral health crisis in their computer-aided dispatch (CAD) or other data management system. Many utilize dispatch codes when classifying and handling calls.[21] Although these codes may vary between localities, they typically include information on the emergency, such as "domestic violence," "assault with a weapon," "mental health-related," etc.

However, some methods of recording this data might be of limited use when attempting to understand the scope and nature of these calls. Some respondents noted relying on crime codes, such as the National Incident-Based Reporting System or Uniform Crime Reporting, which may not provide adequate information related to behavioral health crises. Others indicated that a call is mental health or substance use-related in a narrative text field.

Research has shown that dispatch codes can affect officer decisions upon arrival and could mean the difference between an officer assuming the person poses an immediate public safety threat or the officer understanding it is a situation that could be de-escalated.[22] For example, the code "suspected suicide" has been associated with a higher likelihood of being transported to treatment compared with other designations such as "calls for assistance" or "suspicious person."

Despite that, some respondents indicated that they have limited categories available to their telecommunicators, which could lead to inaccuracy in call details. For example, a dispatcher from an urban cluster service area wrote, "This county would list the call as a suicide, but there is not a category for mental health." In some cases, a call is identified as being crisis-related in the narrative notes of the call, which can make extracting standardized data on 911 utilization for behavioral health crisis calls difficult, further affecting the ability to analyze information about these calls. Another respondent described software limitations, remarking that "Our system does not have a mental health flag on [people] so we have to mark them as 'use caution.'" This designation could cause an officer to respond in a way that increases rather than decreases potential conflict.[23] It also can be inappropriately stigmatizing, as mental illness alone does not increase the risk of violent behavior.[24]

What are some challenges telecommunicators face in updating records to incorporate new crisis information?

- "If they are transported by ambulance to a medical facility, we will not know the disposition [final outcome] of the call."

- "The only challenge is remembering what needs to be done. We have checks and balances procedure[s] in place to ensure that this gets entered as needed."

- "This relies solely on the staff involved to input everything into each record. If they forget this step, then the information has the potential to be lost or delayed."

Less than half of respondents update call information or record the outcome of behavioral health crisis calls
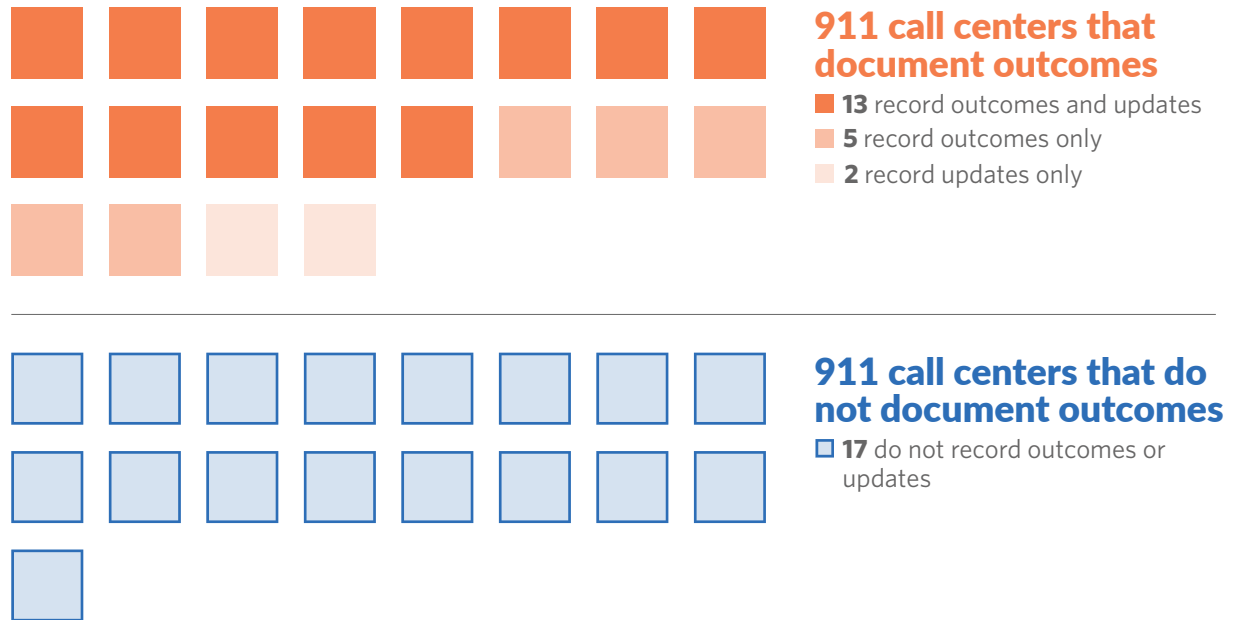
Many researchers and policymakers are interested in the number of 911 calls related to mental health and substance use-related crises, and how much of officers' time these calls consume.[25] Estimating this requires accurate and up-to-date data. Yet, only about 2 in 5 (15 of 37) of those in the study said they update records to reflect whether a call is crisis-related if it was not originally indicated as such. Respondents identified challenges in updating records in several categories: system inadequacy, like a need to overwrite existing codes or lack of an appropriate code; reliance on busy staff to remember to update; and not receiving updated information from field responders. One call center representative explained there are "[HIPAA] rules that prevent information to be disseminated." It is worth noting that health privacy laws allow communication between emergency service providers as necessary for treatment, which may indicate a need for additional training around these rules to improve crisis response.[26]

Just under half of the respondents (18 of 37) said that the outcome of behavioral health calls (for example, if the person is brought to a hospital) is recorded in the CAD or other system. (See Figure 6.) Most of the respondents either recorded both updates and outcomes (13) or recorded neither (17). Many indicated the responding officer is responsible for entering this information, but in others the responding unit contacts dispatch, which enters the information. Several indicated the outcomes were entered into the narrative notes of each call only. All of these patterns were roughly the same when comparing call centers serving rural and urban areas.

Figure 6

Less than Half of Respondents Updated Records or Documented Outcomes of Crisis Calls in Their Data Management System

About half of responding 911 call centers recorded neither outcomes nor updates

911 call centers that document outcomes

■ **13** record outcomes and updates
■ **5** record outcomes only
□ **2** record updates only

911 call centers that do not document outcomes

□ **17** do not record outcomes or updates

Source: Pew analysis of questionnaire responses

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No respondents said they report on crisis calls externally to policymakers or the community, and few said they reported on this data at all

Only 1 in 6 (6 of 37) of the responding call centers indicated they reported data on behavioral health crisis calls. Of these, none indicated the information was made available in a publicly accessible format, while four noted that the reports were shared internally only and state agencies could access them. This lack of reporting by most respondents means that policymakers and community members in their service areas may not have a clear picture of the volume of behavioral health crisis calls to 911, which could inform whether more resources are needed. Even those working in the 911 center may be unaware of the data or where it goes, as one dispatcher indicated: "Internal reports, then it gets sent to the state. After that, I do not know."

Behavioral health crisis response challenges and opportunities

While there is growing evidence of the benefits of specialized training and staffing to handle mental health and substance use-related emergencies, a lack of resources has been identified as a barrier to successful outcomes in some jurisdictions.[27] Several responses to open-ended answers in the questionnaire described similar challenges in addressing behavioral health crisis calls, including limited field response options, staffing shortages and turnover, and a lack of training. One respondent described the conflict in even securing transportation for those in crisis:

"There is always a struggle between who is responsible for transport of MH [individuals experiencing a mental health emergency]. EMS [Emergency Medical Services] does not feel it is their responsibility to provide transport when the patient is capable of being transported without an ambulance. Almost all of the ambulances here are volunteer personnel, this means they are leaving work to run a call and when they can't provide anything except transport, they feel like the system is being abused. Law enforcement, although paid, isn't keen on providing transport either as it removes them from their patrol area, for anywhere from 2-5 or more hours."

Despite these complex challenges, multiple respondents also indicated a personal and/or organizational desire for improvement. Some expressed an eagerness for more training, while others described new protocols and response options recently instituted or in development in their service area. (See Figure 7.)

Figure 7

Several Respondents Shared Planned Improvements for Their Service Area's Behavioral Crisis Response System

Some 911 call centers are already trying to enhance their ability to address these emergencies

"We are in the **process of upgrading** to a new call-taking software that will assist in more consistent script-like questions."

"We are **establishing a protocol** to dispatch CIT trained personnel on mental health related incidents."

"Currently we are **developing a response** plan to send CIT trained units on appropriate calls."

"[Our] county health department **recently established a QRT [Quick Response Team]**. This team is staffed with a recovery coach, law enforcement, and representatives from faith-based organizations."

Source: Pew analysis of questionnaire responses

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Conclusion

Despite the limited scope of Pew's questionnaire, the 37 respondents in this study highlighted several key themes regarding behavioral health crisis calls to 911, including disparities in availability of specially trained staff, lack of available resources to respond to calls, and inconsistent data collection and limited reporting.

Respondents discussed difficulties with making response decisions on crisis calls because of a lack of access to trained mental health clinicians in call centers and non-law enforcement crisis response options, particularly in rural areas. Several respondents also noted a lack of access to training for dispatchers.

More research is needed with additional 911 call centers to gain additional insights into these challenges and develop solutions that improve 911 efficiency, expand services for those in crisis, and improve outcomes. Emergency call center employees, with their specific expertise, should be involved in local, state, and federal efforts to develop and sustain long-term system reforms and the development of improved responses to behavioral health crisis calls.

External reviewers

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Acknowledgments

Appendix

Methodology

This report presents Pew analysis of questionnaire responses from directors, administrators, telecommunicators, and other representatives of 37 911 call centers; in the field, these are also referred to as Public Safety Answering Points (PSAPs), and this was the language used in the questionnaire instrument. Working with the National Emergency Number Association (NENA), researchers collected data via online survey in March 2021.

Sampling frame

This study used a nonprobability sampling technique, in which emergency service areas were chosen based on availability and characteristics. NENA first selected a random sample of 376 of its members in 46 states and provided Pew with their basic contact information. To ensure every state was included in the final sample, Pew researchers added missing states' service area information accessed through official websites (Hawaii, North Dakota, New Hampshire, and South Dakota). The final sampling frame consisted of 432 unique PSAPs in 50 states.

Sample refinement

Using the sampling frame, researchers reduced the number of cases with the goal of including roughly 200 service areas total. First, 911 call center area population coverage (service area resident population divided by census state population) and the number of unique service areas per state were considered. The cases associated with the largest state population coverage—responsible for more than 5% of residents—were automatically included in the study sample (n = 29). Additionally, all PSAPs in any state with less than 5% population coverage when all were combined (n = 104), in any state with three or fewer service areas total (n = 3), or both (n = 17) were chosen. The 80 remaining cases were selected with the primary goal of geographic diversity, ensuring that each state had at least three call centers in the sample, and that those PSAPs were roughly representative of the state in terms of race based on census data.

The final nonrandom sample consisted of 233 unique 911 call centers in 50 states. Because the responses are based on a nonprobability sample, they should not be generalized to call centers outside of the report. See Figure 8 for a visual breakdown of the sample refinement.

Figure 8
233 911 Call Centers Were Selected for the Final Sample

Nonprobability sampling breakdown
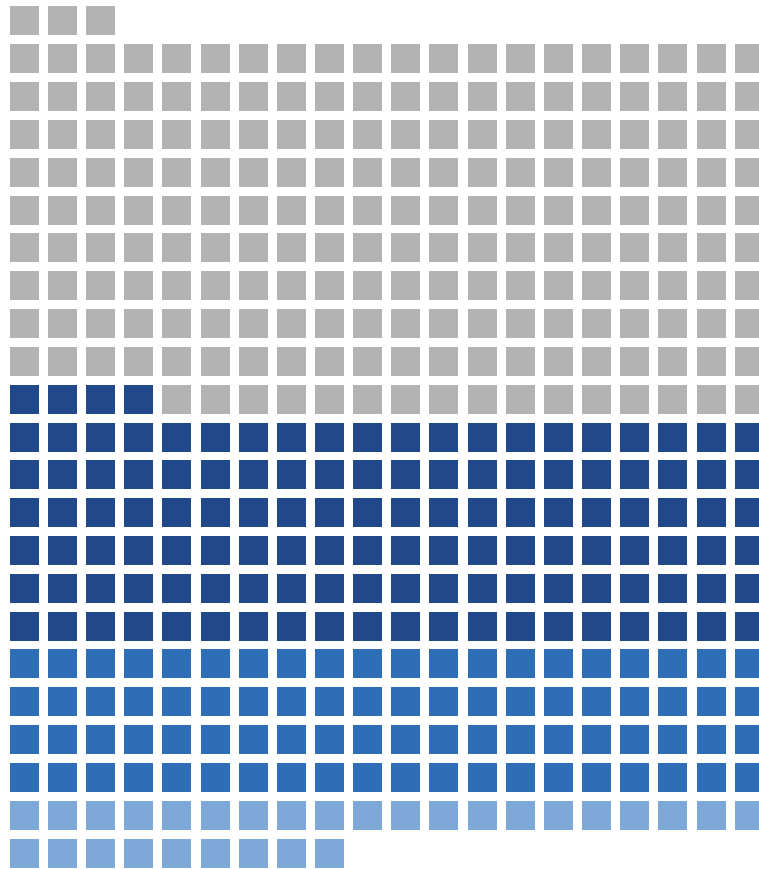
432 911 call centers in sampling frame

233 911 call centers in final sample

- **124** in states with less than 5% total state population coverage and/or 3 or fewer service areas
- **80** selected to ensure each state has at least 3 representative cases
- **29** covering over 5% of the state population individually

Source: Sample of 911 call centers from NENA database, official state websites

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Questionnaire responses

All questionnaires were administered via Qualtrics XM, a web-based survey platform, with at least one email and/or one phone call follow-up for those that did not respond or complete the survey.[28] In instances where contact information provided by NENA was outdated, Pew researchers searched publicly available websites and databases and contacted PSAPs via telephone to obtain updated contact information. Respondents were told their responses would not be presented in an identifiable manner; for this reason, actual PSAP jurisdictions are not included in the publication, and quotes exclude information that could be used to identify the service area. A total of 37 out of 233 911 call centers contacted submitted completed data (a 16% response rate).

Researchers used NVivo software to code service area characteristics, yes/no, and open-ended data into themes.[29] Areas were categorized as "predominantly White" or "not predominantly White" and "rural," "urban," or "urbanized clusters" based on census data for analysis. Predominantly White areas have a resident population over 75% White (n = 28); below 75% is considered not predominantly White (n = 9). As defined by the census, urban areas are those with 50,000 or more people (n = 6), urban clusters consist of 2,500-50,000 residents (n = 15), and rural areas are those not in an urban or urbanized cluster (n = 16). This analysis used census designations to assign these categories; however, it is possible that some call centers are responsible for multiple localities that could include more than one of these classifications.

9-1-1 and Behavioral Health Questionnaire

Introduction

You are being asked to voluntarily complete a questionnaire about 9-1-1 calls to your PSAP (Public Safety Answering Point) involving people experiencing crises related to mental health issues (including suicidality), drug use, or both. The Pew Charitable Trusts, a nonpartisan, nongovernmental independent nonprofit organization, recently launched an initiative to improve services and outcomes for people experiencing crises related to mental health (including suicidality) and/or drug use. This is an issue that is garnering increasing national attention, particularly related to development of alternatives to justice system responses.

The purpose of this questionnaire is to learn more about responses to 9-1-1 calls related to people experiencing crises as a result of mental health issues, drug use or both. We know that 9-1-1 plays a vital role in outcomes for these individuals, and your information will be tremendously valuable.

Your PSAP will not be identified in any published results. At the end of the questionnaire, you will be given the opportunity to share your contact information so that we might follow up with you regarding your responses. Sharing your name and contact information is optional and will be kept confidential. If you have any questions regarding this questionnaire, please contact Tracy Velázquez, research manager, at tvelazquez@pewtrusts.org. Thank you.

You can save and return to this questionnaire at any point until it is submitted. Please click the button below to begin the questionnaire.

9-1-1 and Behavioral Health Questionnaire

1. Let's begin with what happens when your PSAP receives a 9-1-1 call. Please describe how 9-1-1 call takers in your PSAP identify calls that may be related to individuals experiencing a crisis related to mental health issues (including suicidality), drug use, or both. When responding, consider tools like questionnaires or scripts, for example. (If 9-1-1 call takers in your PSAP DO NOT use a script or questionnaire to help identify calls related to mental health (including suicidality) or substance use crises, please indicate this as well.)

2. Let's consider the types of training that 9-1-1 personnel receive. We're most interested in Crisis Intervention Training, often referred to as CIT. CIT curriculum trains personnel to understand common signs and symptoms of mental illnesses and co-occurring disorders, recognize when those signs and symptoms represent a crisis situation, and safely de-escalate individuals experiencing behavioral health crises.

   Have dispatchers received 9-1-1/dispatch Crisis Intervention Training (CIT)?
   >   a. Yes
   >   b. No

   2a. If yes, please describe whether CIT is mandatory for dispatchers, and whether all or only some have received training. Please tell us about any other training (such as topics/materials included and length of course(s)) that dispatchers in your PSAP receive regarding 9-1-1/dispatch for calls involving people experiencing a crisis related to mental health, substance use or both.

3. Have call takers received 9-1-1/dispatch Crisis Intervention Training (CIT)?
    a. Yes
    b. No

    3a. If yes, please describe whether CIT is mandatory for call takers, and whether all or only some have received training. Please tell us about any other training that call takers in your PSAP receive regarding 9-1-1/dispatch.

4. We would also like to understand what kind of training, if any, the field responders in your PSAP service area have received for calls related to people experiencing crisis related to mental health issues (including suicidality), drug use, or both.
    Regarding law enforcement, please tell us whether officers with Crisis Intervention Training (CIT) are available. If CIT trained law enforcement officers are not available, please indicate that in your response below.

5. Regarding fire (except EMTs, which are asked about below), please tell us whether fire department personnel with Crisis Intervention Training (CIT) are available. If CIT trained fire personnel are NOT available, please indicate that in your response below.

6. Regarding Emergency Medical Technicians (EMTs), please tell us whether EMTs with Crisis Intervention Training (CIT) are available. If CIT trained EMTs are NOT available, please indicate that in your response below.

7. Please provide any additional information related to dispatching crisis-intervention trained (CIT) field responders. For example, consider their availability to respond to all calls, gaps in coverage, etc.

8. Now we would like to know about what information your PSAP collects regarding 9-1-1 calls involving people experiencing crises related to mental health issues (including suicidality), drug use, or both, and what happens to that information.
    Does your Computer Aided Dispatch (CAD) and/or Record Management System (RMS) record whether a 9-1-1 call involves someone experiencing a crisis related to mental health issues (including suicidality), drug use, or both? When answering, please consider things such as a specific code or codes, whether the call is identified as part of a broader category, listed as a separate field, in a text/notes field of the record, etc.
    a. Yes
    b. No
    8a. If yes, please describe how your CAD and/or RMS records whether a 9-1-1 call involves someone experiencing a crisis related to mental health issues (including suicidality), drug use, or both. When answering, please consider things such as a specific code or codes, whether the call is identified as part of a broader category, listed as a separate field, in a text/notes field of the record, etc.

9. Does your PSAP report on 9-1-1 calls involving people experiencing a crisis related to mental health issues (including suicidality), drug use, or both? For example, internal reports, report to the county commission or an interagency council, state agency, etc.
    a. Yes
    b. No
    9a. If yes, please describe how and to whom your PSAP reports data on 9-1-1 calls involving people experiencing a crisis related to mental health issues (including suicidality), drug use, or both. For example, internal reports, report to the county commission or an interagency council, state agency, etc.

10. Does your PSAP update records to reflect calls that were not originally recorded in the Computer Aided Dispatch (CAD) and/or Record Management System (RMS) as involving a person experiencing a crisis related to a mental health issue (including suicidality), drug use, or both. For example, if a call is updated to reflect a behavioral health crisis, where and how that update recorded?

        a. Yes

        b. No

10a. If yes, please describe how your records are updated. For example, who is responsible for updating the record, where the information is added in the system, etc.

11. Please describe any challenges that your PSAP experiences when appropriately updating records to reflect a call being identified later as involving a person experiencing a mental health (including suicidality) or substance use crisis. For example, inconsistency in obtaining updated information, software challenges, etc.

12. Does your PSAP document outcomes of calls involving a person experiencing a crisis related to mental health (including suicidality), substance use, or both, in your Computer Aided Dispatch (CAD) and/or Record Management System (RMS)? For example, the person was brought to a crisis center or detox facility.

        a. Yes

        b. No

12a. If yes, please describe how outcomes of calls involving a person experiencing a mental health (including suicidality) or substance use crisis are entered into your CAD and/or RMS. For example, consider who enters the information, where the outcome is recorded, etc.

13. Let's consider the availability of trained individuals, resources, and protocols to respond to calls involving a person experiencing a crisis related to mental health issues (including suicidality), drug use, or both – other than law enforcement, fire, and EMT.

Some PSAP service areas have mobile crisis response/intervention teams. We're interested in yours, if you have one. These teams generally include trained and/or licensed professionals that can provide assessment, evaluation, face-to-face intervention, and assistance to stabilize the situation.

Does your PSAP service area have one or more mobile crisis response/intervention teams?

        a. Yes

        b. No

13a. If yes, please tell us about your mobile crisis response/intervention teams. When describing, please consider things like the times it is available for responding, the adequacy of the number of teams for responding to calls, gaps in coverage, etc.

14. Some PSAPs have access to behavioral health clinicians who can assist with identifying and/or responding to calls related to people experiencing mental health issues (including suicidality), drug use, or both. A behavioral health clinician is a person licensed in areas such as social work, nursing or medicine with the knowledge and ability to assess mental health issues (including suicidality), drug use, or both. Does your PSAP have access to behavioral health clinicians?

        a. Yes

        b. No

14a. If your PSAP has access to behavioral health clinicians, please describe the nature of this access. For example, round-the-clock or on call staff, contract with health facility, etc.

15. Some PSAP service areas have additional dispatch and response options (other than any of those discussed previously). We're interested in yours, if any exist. These options may be non-governmental responders, co-responders, a separate system for responding to these calls, etc.
    Please describe any additional dispatch and response options that are available in your PSAP service area for calls involving people experiencing a crisis related to mental health (including suicidality), drug use, or both. If your PSAP DOES NOT have any additional dispatch and response options, please indicate that as well.

16. Please tell about any additional resources that are available in your PSAP service area for field responders to use for people experiencing a crisis related to mental health (including suicidality), drug use, or both. For example, behavioral health crisis stabilization centers, detox facilities, hospital emergency room, etc. If there are NO additional resources available in your PSAP service area, please note that as well.

17. Please share any other information regarding your PSAP's responses to calls involving people experiencing a crisis related to mental health (including suicidality), drug use, or both in the following area. For example, challenges, innovations, protocols for responding to mental health and/or drug use crisis calls, etc.

18. Please share any other thoughts on issues impacting your PSAP's capacity to address calls involving people experiencing a crisis related to mental health issues (including suicidality), drug use, or both (for example, access to training, staff turnover, budget issues, etc.):

Information about your PSAP

19. What is your PSAP's service area?
    - a. County
    - b. City:
    - c. Multi-jurisdictional
    - d. Other:

20. What is your position at your PSAP?

21. May we contact you regarding your questionnaire responses?
    - a. Yes
    - b. No

22. If yes, please fill in contact info:
    - a. First Name
    - b. Last Name
    - c. PSAP Name
    - d. Email
    - e. Best phone number to reach you
    - f. State
    - g. County/Region

Endnotes

1   E. Westervelt, "Mental Health and Police Violence: How Crisis Intervention Teams Are Failing," NPR, Sept. 18, 2020, https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing; Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response" (National Council for Behavioral Health, 2021), https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56.

2   H. Swan et al., "Reimagining America's Crisis Response System for Vulnerable Populations: Knowledge Gaps and Areas for Investment" (Abt Associates, 2020), https://www.abtassociates.com/files/insights/white-papers/2020/crisis-response_knowledge-gaps-wp_v2.pdf; S.R. Neusteter et al., "Understanding Police Enforcement: A Multicity 911 Analysis" (Vera Institute of Justice, 2020), https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf.

3   National Emergency Number Association, "9-1-1 Statistics," accessed July 15, 2021, https://www.nena.org/page/911Statistics; Neusteter et al., "Understanding Police Enforcement."

4   Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "Roadmap to the Ideal Crisis System"; Neusteter et al., "Understanding Police Enforcement."

5   Manatt Health, "Communities in Crisis: Local Responses to Behavioral Health Challenges" (Robert Wood Johnson Foundation, 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441220/subassets/rwjf441220_1.

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7   Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "Roadmap to the Ideal Crisis System"; K. Houghton, "In Montana, Crisis Support Teams Offer Alternatives to Policing Mental Health," NPR, June 10, 2021, https://www.npr.org/sections/health-shots/2021/06/10/1004744348/in-montana-crisis-support-teams-offer-alternatives-to-policing-mental-health; National Suicide Hotline Designation Act of 2020, S.2661, (Senate Committee of Commerce, Science, and Transportation, Oct. 17, 2020), https://www.congress.gov/bill/116th-congress/senate-bill/2661/text?q=%7B%22search%22%3A%5B%22National+Suicide+Hotline+Designation+Act+of+2019%22%5D%7D&r=2&s=1.

8   National Emergency Number Association, "About NENA," accessed July 15, 2021, https://www.nena.org/page/AboutNENA.

9   Neusteter et al., "Understanding Police Enforcement."

10 Ibid.

11 Ibid.

12 C. Scott, "911 Has Its Own Emergency: Not Enough Call Takers and Dispatchers," KDVR, May 24, 2021, https://kdvr.com/news/local/not-enough-911-call-takers-and-dispatchers/.

13 Swan et al., "Reimagining America's Crisis Response System"; R. Dupont, S. Cochran, and S. Pillsbury, "Crisis Intervention Team Core Elements" (The University of Memphis CIT Center, 2007), http://www.cit.memphis.edu/information_files/CoreElements.pdf; Scott, "911 Has Its Own Emergency."

14 Dupont, Cochran, and Pillsbury, "Crisis Intervention Team Core Elements."

15 Although Pew asked 911 call centers about call-taker and dispatcher CIT training and other types of training separately, all respondents that said call-takers were trained also indicated dispatchers were trained, while all respondents without trained call-takers also did not have trained dispatchers.

16 Neusteter et al., "Understanding Police Enforcement"; R.L. Scott, "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction," *Psychiatric Services* 51, no. 9 (2000): 1153-56, https://pubmed.ncbi.nlm.nih.gov/10970919/.

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23 Ibid.

24 M. Varshney et al., "Violence and Mental Illness: What Is the True Story?," *Journal of Epidemiology and Community Health* 70, no. 3 (2016): 223-25, https://jech.bmj.com/content/70/3/223.short.

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28 Qualtrics, "Qualtrics" (2020), https://www.qualtrics.com.

29 QSR International, "NVivo," accessed July 20, 2021, https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home.

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