Published in final edited form as:

Behav Sci Law. 2017 September ; 35(5-6): 442–455. doi:10.1002/bsl.2324.

Everyday police work during mental health encounters: A study of call resolutions in Chicago and their implications for diversion

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Abstract

In recent decades, there has been sustained attention on police responses to persons experiencing mental health crises. The Crisis Intervention Team (CIT) model has been a seminal effort to improve safety, reduce arrests and enhance the use of emergency psychiatric assessment. With CIT well-established, new discussions have emerged around how to further enhance the police-public health interface, including diversion from hospital emergency departments. In this context, this paper takes stock of current police practices, utilizing descriptive data on 428 mental health-related calls addressed by Chicago Police over 3 years triangulated with insights from 21 in-depth officer interviews. During these calls, hospital transports were conducted more often than arrests. Moreover, informal interventions - without any legal action or hospitalization - were used most often, speaking to the “gray zone” (Wood, Watson & Fulambarker, 2017) nature of mental health-related encounters. Taken together, the data reveal the need for non-crisis diversion options that address chronic vulnerabilities.

Keywords

police; mental health; Crisis Intervention Teams; diversion

Introduction

In recent decades, there has been sustained attention on police responses to persons experiencing mental health crises and the need to improve safety in these encounters (Cochran, Deane & Borum, 2000; Steadman & Morrisette, 2016). Additionally, there is wide acknowledgement of the overrepresentation of persons with mental illnesses in jails and prisons, and the need to divert them from the criminal justice system at the earliest point possible, ideally at the initial point of contact with the police (Heilbrun, et al 2012; Munetz & Griffin, 2006).

The Crisis Intervention Team (CIT) model, arguably the most well-known strategy to improve police response to persons experiencing mental health disturbances or illnesses, is being implemented widely in the United States, with backing from the President’s Task Force on 21st Century Policing Final Report (2015) and the International Association of

Chiefs of Police (IACP). CIT has traditionally been discussed as a strategy to improve safety and divert individuals from arrest. However, as agencies gain experience implementing the model, and officers become adept at transporting people to hospital emergency departments for psychiatric evaluation, discussions about the need to divert *from* emergency departments have emerged as well (McKenna, Furness, Oakes & Brown, 2015).

At the same time, there is a re-emerging understanding of the “gray zone” nature of mental health-related encounters, where neither arrest nor transport to an emergency department for emergency psychiatric evaluation are indicated or considered as options (Wood, Watson, & Fulambarker, 2017). Thus, the actions (or inaction) officers selected to resolve gray zone encounters would not represent “diversion”, because formal or legal actions are not deemed relevant as dispositional options. Borrowing from emerging discussions related to police response to persons with substance use disorders (Charlier, 2015; Knopf, 2017), we might conceptualize officers’ actions that fall short of diversion as “deflections” when officers attempt to link individuals to treatment and other resources, or use other informal strategies to resolve the presenting problem and reduce the likelihood of future police contact.

In this paper, we briefly examine the literature on the extent and nature of police encounters with persons with mental illnesses and discuss the re-emerging literature on gray zone interactions and the CIT model. We then triangulate descriptive quantitative and in-depth qualitative interview data from a study of police encounters with persons with mental illnesses and Chicago’s CIT program to examine how officers consider the complexities of mental health related encounters and choose among limited deflection or diversion options. We also explore officers’ perspectives on the need for alternatives to existing options. Taken together, our quantitative and qualitative findings reveal a need to expand our conception of diversion while exploring a broader array of gray zone intervention options that address chronic vulnerabilities of individuals and families over the long-term.

Police-led Diversion in Context

A recent review of studies estimated that six to 10 percent of all police contacts with the public in the U.S. involve persons with serious mental illnesses (Livingston, 2016). The evidence on whether mental illness increases the likelihood of arrest is equivocal (Teplin 1985, Engel & Silver, 2001). However, a recent study estimates the prevalence of serious mental illness in jails at 14.5% for men and 31.0% for women (Steadman, Robbins, Case, Osher & Samuals, 2009) and estimates for prisons range from six to 14 % for men and women combined (Prins, 2014). Given that the prevalence of serious mental illness in the general population is estimated to be four percent (Center for Behavioral Health Statistics and Quality, 2016), it is clear that persons with serious mental illnesses are overrepresented in jails and prisons. Furthermore, analyses of police involved shootings conducted by the Treatment Advocacy Center (Fuller, Lamb, Biasotti & Snook, 2015) and the Washington Post (Lowery et al., 2015) estimate that at least one in four individuals fatally shot by police had a serious mental illness.

Fortunately, most police contacts with persons with mental illnesses (or the public in general) do not involve major crimes or violence that would necessitate arrest or use of force

(Draine et al., 2002; Fisher et al., 2006; Swanson, McGinty, Fazel, & Mays, 2015), nor do they often meet the legal criteria of “emergency apprehension” for psychiatric evaluation and treatment (Bittner, 1967a; Green, 1997; Teplin, 1986; Teplin & Pruett, 1992; Watson et al., 2010). Rather, they more often comprise an array of lower intensity and less formal interactions in which officers serve a peacekeeping or problem solving role, providing what we have described previously as “provisional solutions to chronic vulnerability” (Wood & Watson, 2017). These “provisional solutions” or “deflections” have the potential to reduce the likelihood of future police contact, arrest and transport situations. They also may provide opportunities to establish trust and build positive rapport that may pay forward in the event of subsequent police interactions.

The Crisis Intervention Team model is considered a “Best Practice” approach to improve police response to individuals experiencing mental health crises (Watson & Fulambarker, 2012). It was developed in Memphis, TN following the tragic shooting of a man in crisis by a Memphis police officer. The stated goals of the model are to improve safety in police encounters with persons with mental illnesses and divert individuals away from the criminal justice system to mental health services when appropriate (Compton, Broussard, Munetz, Oliva & Watson, 2011). The CIT model includes collaboration between police, emergency communications, mental health and other service providers, advocates, persons with mental illnesses and their family members; changes in policies and protocols; and a designated drop off site where police can bring individuals in need of emergency psychiatric treatment. The most well-known element of the model is the 40 hour training for a select group of officers who volunteer to become CIT officers. The training includes content on signs and symptoms of mental illnesses, co-occurring disorders, psychiatric medications, legal criteria for emergency apprehension, and de-escalation skills. Throughout the training, officers have opportunities to interact with panels of persons with mental illnesses, family members, and service providers. Many CIT trainings also include site visits to mental health providers in the community.

While at face value, it appears that the model primarily addresses situations in which immediate use of force and/or arrest/divert decisions are in play (in part due to those being documented elements of police calls), the model is a holistic organizational and community intervention. If implemented well, the model is designed to ultimately shift agency culture and encourage officers to take advantage of gray zone situations to develop relationships and identify opportunities to steer individuals toward supports and services before crises occur. In light of this long-term agenda for CIT and diversion more generally, more research is needed to quantify the varied (crisis and non-crisis) nature and outcomes of mental health encounters and explore the kinds of everyday reasoning behind officers’ intervention decisions.

This mixed methods study, which takes place within the Chicago Police Department, combines longitudinal outcome data with explanatory qualitative data in an attempt to address this gap. Here, we triangulate descriptive quantitative data on police calls with qualitative data from officer interviews to illuminate the variation and complexities of mental health related encounters and how officers consider their response options. Although the Chicago Police have an established CIT program, this study examines encounter

resolutions on the part of both CIT and non-CIT officers. This reflects the reality that in most departments, routine mental health-related calls are handled, at least in the first instance, by a range of patrol officers with varying levels of specialized training. Relatedly, it has been suggested that CIT training need not be mandatory for all officers in an organization in order for a larger cultural shift to occur in the direction of improved de-escalation and diversion practices (Wood and Watson, 2017).

Research Design and Methods

Data reported on here are from a large, five year multi-method study of Chicago Police Department's (CPD) CIT program and more broadly, police officer responses to situations involving persons with mental illnesses. The overall study aims to examine immediate and longer term outcomes of mental health related encounters in the context of the CIT program and varied mental health service accessibility across the city. The quantitative component of the study involves a longitudinal assessment of health and justice-related outcomes of individuals with mental illnesses involved in encounters with police. The qualitative component seeks to understand the ways in which such encounters are resolved by police, including the situational and community-level factors influencing officers' decision-making. Here, we utilize data from officer reports on specific mental health related calls and in-depth interviews with officers to examine how officers consider the complexities of these encounters and choose among limited intervention options and their perspectives on needed alternatives. All study activities have been approved by the Principal Investigator's University Institutional Review Board.

The setting for this study consisted of all 22 Chicago police districts. The city of Chicago covers an area of 228.5 square miles with a population of approximately 2.9 million residents. It is divided into 22 police districts, each containing 9–15 beats. As of late 2011, the Chicago Police Department (CPD) had 12,244 sworn officers.

Quantitative Data on Specific Mental Health Calls

Data were collected on encounters with persons that officers perceived to have a mental illness and/or to be experiencing a mental health crisis, based on responding officer observations or information gathered at the scene. From July 2013 until September 2016, members of the research team visited all 22 Chicago police districts and the public transit unit. Over a six week period in each district, team members addressed roll call briefings on each watch six times to provide information on the study and to request that officers participate if they respond to a mental health related call. Team members met officers as they came in from their watch to follow up and complete a researcher administered survey if they had responded to a mental health related call with an adult. Officers were provided study information cards to give call subjects that also included a tear off card for the officer to complete with information about the call subject. These cards were forwarded to the CIT unit at CPD headquarters. CIT Unit staff let the research team know when cards were received so we could follow up with any officers we missed coming in from shifts. Additionally, letters were sent out from CPD to call subjects with information about the study and how to participate in the call subject arm.

The officer survey included questions about the nature of the call, location, subject behavior and risks noted, information gathered, strategies used, call resolution and officer and subject demographics. Officers completed the survey for each mental health call they identified, but only completed the officer demographic questions once.

Police Officer Interview Data

Officers who participated in the quantitative portion of the study were asked if they were willing to be contacted at a later date for a longer interview. Contact information was obtained from those indicating willingness. From that pool of 125 individuals, 21 officers with varied demographic characteristics and geographic patrol assignments were interviewed between July 2015 and September 2016. Ten of these officers were CIT trained, and all but 4 officers were male. Most officers (n=15) were Caucasian, while 3 officers were African American and 3 were Asian or Indian. Overall, the sample of officers worked in 18 different police districts.

The individual semi-structured interviews with the officers (approximately one hour each in length) were designed to elicit narrative accounts of mental health-related encounters they experienced and the ways in which they handled them. In particular, respondents were asked to recount different situations involving the use of arrest, hospital transport and informal actions including resolving on scene. For each story, the interviewer elicited details about the situation and the factors that influenced the officer's decision (or collective decision with other officers) of how to act. Various issues emerged in these narratives related to the nature of the call, history (or not) of police involvement with the individual or complainant, as well as the officer's general approach or sensibility in the handling of mental health-related calls.

Overall, the officers provided considerable detail on how they informally assessed situations for signs of behavioral health vulnerability. The interviews also provided insight into how officers gathered and considered information from others on scene (including complainants) on the nature of the behavioral disturbance and any risks or threats posed. Officers were also asked to reflect on the kinds of community resources, services or referrals that might benefit or enhance their own efforts to respond to calls in the future (a "magic wand" type of question). In general, the interviews provided sufficient flexibility for officers to reflect in general on their experiences with, and perceptions of, mental health-related calls and their situational decision-making.

All interviews were audio-recorded and transcribed. The transcripts were imported into ATLAS.ti, a software program that facilitates the management, coding, analysis and visual display of qualitative data. A member of the research team coded the data using code labels including, but not limited to, "alternative MH facilities", "family issues", "medication adherence issues", "situational information – behavioral signs or not" and "situational information – info from others". Themes cutting across the interviews began to emerge early on in the coding process, and these were shared with the research team. For instance, the interviews as a whole revealed a general proclivity for using tactics of persuasion, negotiation and de-escalation during mental health-related encounters, and using arrest judiciously in a limited number of circumstances. It was also common in the narratives for officers to refer to individuals who had gone off their medications. As a means of depicting

different cross-cutting themes and relationships in the data, a conceptual “network” diagram was drawn in ATLAS.ti. This diagram assisted in identifying quantitative data points from the call encounter surveys that could complement or triangulate the qualitative findings. The qualitative excerpts below were chosen to illuminate and expand upon different insights from the quantitative data. Efforts were made as well to select quotes from a range of different officers in the sample.

Results

Quantitative call data

Here we report on data provided by 300 officers for 428 calls identified as involving a person with mental illness that they responded to from July, 2013 through to September, 2016. In terms of demographics, see Table 1. The majority of police participants were male (241, 80.3%), white (214, 72.3) and at the rank of police officer (271, 90.4). The mean years of experience was 14.8 (SD 12.4). Eighty-one (27.0%) were CIT trained.

Officers provided data on 428 calls involving persons they perceived as having a mental illness and/or experiencing a mental health crisis based on their own observations or information provided. Demographics of the call subjects and characteristics of the calls are provided in Table 2. Two thirds of the call subjects were male, and two thirds were African American. Most were between the ages of 20–60 years old (note, calls involving juveniles were not included in the study). By inclusion in the study, all calls involved someone the officer believed to have a mental illness or be experiencing a mental health crisis. Officers perceived most call subjects (347, 81.1%) to have a serious mental illness, and almost one third as having an alcohol problem. One fourth of the call subjects were perceived to have a drug problem, while one fifth were perceived to have an intellectual or developmental disability. In almost half (200, 46.7%) of the calls, officers gathered information that the call subject was prescribed psychiatric medication, in more than half of those (n=108) that the subject had gone off the medication; in almost a quarter (or 10 and 11 % of all calls respectively) each the subject was taking medication (n= 45) or the officer did not know (n=47). Officers indicated that they or their colleagues had dealt with 150 (35%) of the call subjects before.

Approximately two thirds (279, 65.2%) of the calls were dispatch initiated. Most of the remaining third were on view or officer initiated. However, in three cases, the subject walked into the police station and asked for assistance and 16 had some other call origin listed. In terms of location of calls, the most frequent was a private home (146, 34.1%) followed by on the street or in a public park (134, 31.3%), a business (74, 17.3%), a government facility (26, 6.1%) and public transportation (22, 5.1). Notably, 13 (3.0%) calls were at a mental health agency and seven (1.6%) were at a hospital (e.g. subject would not leave emergency department when discharged).

In just over half the calls (221, 51.6%), someone on scene requested a specific resolution. Family members were the most frequent requesters (n=66, 29.9% of requests), followed by business owners (n= 48). Most often, the requested resolution was to transport the subject to

the hospital (141, 32.9%), however, arrest (19, 4.4%), removal from property (38, 8.9%) and a number of “other” outcomes (23, 5.4%) were also requested.

Officers reported they resolved 192 (44.9%) of the calls by transporting the subject to the hospital, 34 (7.9%) by referring the subject to some type of mental health or social service, 25 (5.8%) by arresting the subject, 150 (35.0%) by resolving on scene-no action taken, and 46 (10.7%) by resolving with some “other” action (46, 10.7%), over half (n=25) of which also included on-scene resolutions. Of all calls, nine (2.1%) call subjects were both transported and arrested. Note that both outcomes are possible because a charge can be delayed until after a medical evaluation. Among the 46 coded as “other resolution,” 21 involved the officer giving the subject a ride somewhere and five involved releasing the subject to a family member. There were also a handful of creative solutions described, including convincing the subject to leave for a hair appointment to give her mother some space, giving the subject \$2 for a prescription, and buying coffee for a subject who claimed someone stole his coffee.

Considering the most serious offense charged, among the 25 calls resolved with arrests, 10 included charges for violent offenses (aggravated assault, assault, battery, domestic violence), five were for trespassing or loitering, two for criminal damage to property, two for reckless conduct, one for retail theft and four for outstanding warrants. Officers indicated that in the 403 calls in which an arrest was not made, there was a potentially chargeable offense in 129 or 32%. Potential charges ranged from violent offenses (aggravated assault, aggravated battery, battery, domestic violence) to criminal damage to property to drinking alcohol on the public way. Of the 129 calls with potentially chargeable offenses, 55 (46.2%) were transported to the hospital; 8 (6.2%) referred to other services, 51 (39.5%) resolved on scene, and 15 (11.6%) had some other outcome.

We also asked officers to respond to a series of items to indicate whether they observed specific signs of behavioral vulnerability and risk. As displayed in Table 3, officers noted a variety of behavioral signs of mental illness as well as behavioral risks.

Overall, the quantitative data reveal several aspects of routine mental health calls and the ways in which they are resolved by police officers. In what follows, we draw from the qualitative interviews to expand upon and contextualize these main findings. We also share some insight from officers on the kinds of services and resources that would benefit the police in addressing mental health incidents.

Qualitative Insights

As noted above, approximately one quarter of calls involved persons who went off their medication, indicating a common factor triggering police involvement. Additionally, the most frequent location of origin for calls was private residences (n=146, 34.1%), while family members were the most common source of specific resolution requests (n=66, 29.9% of requests). The following story of a call contains these elements. It relates to a criminal incident at a private residence where the family requested not to press charges:

Family called... He's a regular. And he was breaking stuff in the house... and the family called. And it was a male adult, and then the whole house was all females...

And we didn't take him to the hospital or anything. We just talked with him... [T]he family didn't want him arrested or anything. They just wanted him to calm down... In that case we got him to calm down and the family was happy with that and so there was nothing. We didn't take him into custody, and we didn't take him to a hospital. But the mom said he was off his meds and he needs to take his meds, and that was it. We got him to calm down.

(nonCITofficer17)

The call resolution data further revealed that transports to hospitals were more frequent than arrests (44.9% versus 5.8% respectively). Although the officers chose to resolve the above situation simply through on-scene de-escalation, officers told other stories where mental health transports were the preferred option in addressing medication adherence issues. When asked about the benefits of repeated hospital transports, one officer emphasized the importance of hitting the "reset" button, even if this has to be done repeatedly with the same individual:

It's just the roller coaster. You know, they'll have good days and bad days, and on their bad days they might be at the hospital a lot, you know, as the bad days stack up over a year, but if they don't have an outlet to go and kinda hit the reset button to get back on their medication, I don't know what they would do then.... The benefit is, I guess, just kinda getting 'em back on track, no matter how many times you have to do that.

(nonCITofficer1)

The value of the reset button offered by hospital transports may partly explain why the use of arrest was a relatively uncommon disposition in the call data (only 5.8% of incidents). Overall, the interview respondents expressed a general preference for minimizing the use of arrest where mental health disturbance was clearly manifest. In the following exchange with the interviewer, one officer expressed the importance of carefully determining the need for treatment.

Officer: ... you can arrest someone who has mental health issues but who is medicated and knows exactly what they did and then we would process them like we would process anyone else or this situation where you're going to arrest someone and obviously, they're not in the right state of mind.

Interviewer: Right.

Interviewee: Our general orders are they should get the mental health treatment.

Interviewer: Right.

Interviewee: ... it's kind of borderline then I mean we have people, you know, that try to act crazy but you can tell they're not so it's kind of a gray area where you try to make your best decision, best judgment, but you know, if they're obviously needing of help, we try to just bring them.

Interviewer: Take them over to the hospital?

Interviewee: Yeah, release them without charging and send them to the hospital.
(CITofficer2)

Although mental health transports constituted nearly half of the call outcomes, officers also relied significantly on informal strategies to resolve calls on-scene. Across the interview sample, officers provided accounts of various acts of persuasion and de-escalation. When asked to recall specific situations that were handled informally and on the scene, one officer replied,

That's 90 percent of it. A lot of it is where you go to somebody – a disturbance. Somebody's yelling, somebody's getting very loud and obnoxious out on the street, in the hallways, somewhere. So you respond.... Go talk to the person and they need help, they really need help. But they're still with it. They're still alert and oriented times three. They know who they are, where they are, what they're doing in a sense... Just heard him out, just listened to him. Just told him, "People are complaining. I can't force you to go to the hospital. If you need any help, there's plenty of places to get some help." And just to keep it down...

(nonCITofficer5)

The importance of de-escalation and persuasion was emphasized in various ways by officers in the sample, not only as a normative priority (the right thing to go), but as the best means of securing compliance. In describing their communication style during mental health encounters or other situations involving trauma, another officer replied,

Me, personally, what I found to be most of the time very effective is I like – as much as possible, I like to reduce images and impressions of force... like I want to come to the person in as much a gentle way as possible, and I'm not ready to hurt you. Like I'm not here to jump on you and grab you, and handcuff you, and to Taser you.... If I can get the person, and so that kind of leads into the second thing, which is if I can get the person to talk, that's ideal as well because I can hear what's in their mind, what are their motivations. So gentle, no force, listening...

(CITofficer7)

One officer reflected on their repeat interactions with a woman who stops taking her medication. As the officer put it, "Tina's always around...She gets medicated, she gets treated, and she's good. She gets cleaned up, and then she just loses it." In explaining how the officer manages Tina's behavior, the officer recounts a simple, but creative solution to keeping the situation under control:

[S]he'll see you, she'll talk with you, she'll ask you, you know, "Can you get me a cup of coffee?" And you just might as well do it because then you don't want to get her all riled up. And then when she's off her meds CTA [Chicago Transportation Authority] calls and you know who it is. You try to calm her down or have her move to another station... I mean, you have to go and buy her another cup of coffee. That's all she wants. She's playing the kid a little bit....

(nonCITqualPO014)

When asked to describe Tina's behavior while off medication, the officer explained, "[j]ust belligerent, ignorant. She'll call anybody anything at any time, any place, anywhere. Worst language – you've seen the movie the exorcist?" The officer explained that police have taken Tina to the hospital in the past and that such a decision is contingent on the level of (usually verbal) aggression displayed.

As the story of Tina illustrates, knowing the histories and behavioral patterns of particular individuals ("regulars") provides officers with an experienced and nuanced understanding of how to secure compliance and resolve calls. Officers told stories of routine intervention tactics they developed through repeat exposure to similar situations and similar individuals. During an interview, one officer recalls what they have learned over time about how to manage a particular individual:

There is [a] guy by the name of [Rudy Peabody]... He likes to hang out by Channel 7 and Channel 2, and he is very mean. He is very – he appears violent. He's a bit mad all the time. He doesn't attack anybody...He's very, very angry. He will not let us put a finger on him. He freaks out, but verbally he'll leave. It's weird with him...[W]e'll tell him, "Hey, you got to go." "Don't you tell me I got to go, mother f'er, blah, blah, blah, blah, blah." But yet he'll pack up his stuff every time and he leaves... He's put out a big time fight, but he listens and he leaves. Weird.

(nonCITofficer10)

Although officers relayed stories about calls they resolved on the street or in public settings, it was common for them to describe situations involving families that called for help to deal with a loved one. The prevalence of this family-related theme corresponds to the call data which revealed that mental-health calls originated over a third of the time from private residences. In their narratives officers highlighted family issues and forms of dysfunction, noting the lack of capacity in some cases to address the complex needs of loved ones in people's care. The following officer recalls the desperation of one family struggling to support a young adult son with a history of mental illness:

There was one that I would constantly go to, and the gentleman in [his] probably early 20s who had been dealing with mental illness his whole life. And he didn't have a job. He was living at home, but he was pretty much comatose. And we would constantly get called. And the family just were in desperate need of resources. They just didn't know how to deal with it anymore.... He was self-medicating, and when he was self-medicating through illegal drugs...

(CITofficer15)

In the above situation, the police chose hospital transport as the best course of action. Not unlike the previous comment about the value of hospitals in hitting the "reset" button, hospitals can be, without question, the best resolution in officers' minds. Notwithstanding, officers recognize the relatively short-term or remedial value of hospitalization. When asked about needed improvements to mental health issues in the community, an officer noted concern about follow-up care:

Well, it's just the follow-up. We take 'em there [a hospital]. Once we release them to the mental facility we don't know what happens to 'em. Obviously it's not

working because they're right back on the street doing the same thing. So there's a disconnect between the follow through and the resources.

(CITofficer20)

A different officer expressed a similar concern related to the "revolving door" problem:

... I feel like sending them to the hospitals, per se, are just revolving doors, it seems like. Because you see them, because you see them there, and they come back. And then it's the same issues over again... I think if there was more things like a specific clinic within at least one district, or close, maybe two districts in the city. Or police districts can share one, or something. I would think they'd truly get the help that they need...

(nonCITqual13)

When asked to share ideas about alternative mental health resources, alternatives to hospital emergency rooms (ERs) were considered. One officer suggested it would be helpful to bring people to a location that is separate from standard ER settings. The officer suggests that in ER settings, "they [call subjects] always feel betrayed, like you brought 'em to the hospital and they just gonna stick 'em with needles, strap 'em to the bed, and fill 'em with medication, which usually happens, but can we do it in a different way, you know?" (CITofficer9). When asked to further describe such a place, the officer said,

Just a nicer area, somebody who have – and I know that this does not exist – have the patience to actually listen to them, listen to their rant or whatever, their complaint, because some – in mental illness, I find out that what they're saying may not be true for that situation, but in some instances, there is some truth in there. You have to look at the whole – there is some truth somewhere in there, but to be able to distinguish that and put them in present time may be difficult, but if you're a trained person, I think you can do that because I can almost do that, and I'm not even trained.

(CITqualofficer9)

A different officer discussed the value of having a resource that police can directly link individuals to outside of police and ER settings:

[I]t would be nice to have at each area or something like that, somebody that you can go to that you're not waiting you know, for six hours to get out there and speak with the person, somebody you can bring them to... Our first thing is secure the person and then take them either to hospital or a police station. But...something that's reachable quickly instead of, oh you got a call here you got a call here. I get tired of making all these phone calls...I think somebody more available that we can pass that onto so we're not tied down on something we're not getting anywhere in. Believe it or not... [the] police department isn't looking to arrest everybody. We're not. I mean, me personally I'm not.

(nonCITofficer19)

The above excerpts contain different, but complementary perspectives on the potential value of mental health services beyond ER settings. While one officer suggested that non-

emergency settings may appear less coercive to call subjects, there was a broader interest in the potential of alternative mental health resources that could be accessible to officers in the field. Beyond the need for alternative mental health resources, one officer discussed the need to better track repeat calls or “problem houses”, with a view to improving follow-up care:

Yeah, maybe something like – Like I said, especially with repeat callers, or, quote-unquote, “problem houses,” is what people call them, maybe some kind of follow up. Maybe someone in the station who’s dedicated to just keep information – not information, but, you know – on people who call regularly who happen to reside in the district. Let’s say, take example, for that person that I just described, the [“Pastor”]. If someone who is a mental health professional who was maybe located in the district. “Oh, you know, it’s the Pastor. Who’s going over there?” Give them information for maybe someone new who doesn’t know, “listen, this is what he takes,” or, “this is the hospital he likes to go to.” Something like that. That would be nice.

(CITofficer8)

Although this discussion does not mine the breadth and depth of qualitative insights provided by officers, it serves to complement the quantitative data in characterizing police work as multi-faceted and nuanced in the handling of mental health encounters. We now turn to a brief assessment of the implications of these findings for the debates surrounding diversion.

Discussion

Although this paper does not do justice to the depth of officer experiences and perspectives that emerged in the interviews, it shows – in concert with the descriptive quantitative data – that everyday police work involves a gamut of interventions, the least central of which is the use of arrest. This can be partly attributed to the “gray zone” nature of police mental health encounters, where serious criminal behavior is typically not at play (Wood, Watson and Fulambarker, 2017). Moreover, the call resolution data reveal that officers make significant use of hospital transportations to address the mental health needs of call subjects. In this light, the data suggest that the CIT vision of diverting individuals from criminal justice involvement is being advanced. Furthermore, the use of transportation is not limited to CIT officers, given that only just over a quarter of the call resolution data came from officers with CIT training.

Of further interest is the fact that officers resorted commonly to resolutions that involved neither the use of arrest nor the use of hospital transportation. It is clear from the call resolution data that officers resort routinely to settling mental health-related disturbances on scene and through various informal and creative solutions. The qualitative data provide some insight into officers’ tendencies to choose persuasion and de-escalation techniques over formal, coercive interventions. As reported previously (Wood, Watson and Fulambarker, 2017), officers make careful situational judgements of how to act, drawing from their assessment of behaviors on scene, coupled with information they have gathered about

individuals and families, especially over time. Officers make holistic appraisals of how best to secure compliance, satisfy resolution requests and address imminent mental health needs.

Recognizing the contemporary landscape of police work in the management of mental health vulnerabilities, the data here imply the need to re-visit the ways in which “diversion” is conceptualized. A broadening of this conception, moving beyond notions of diverting from arrest, may be in order, given the national commitment to de-criminalizing mental illness. Although there is no room to be complacent about strides made in ameliorating the policing of vulnerable populations, it is important, we argue to explore opportunities for enhancing the interface points between police and the behavioral health system.

Although further studies are warranted beyond the Chicago context, there is evidence to suggest that police are now disposed to linking individuals in crisis to emergency hospital facilities. Although there remain opportunities to strengthen relationships between police and particular hospital facilities, concerted efforts should be made to consider post-ER mental health engagement and follow-up. This long-term view on consumer engagement is particularly critical given the extent to which medication mis-adherence is a factor surrounding calls to police. In some such cases, families are experiencing the dire consequences of individuals who no longer can, or wish to take their medication. It is not uncommon, therefore, for police calls for service to involve officers engaging with families more broadly, and not just individual call subjects.

In addition to post-ER engagement, it is therefore important to explore opportunities for interventions with families as providers of care for members experiencing chronic illness, some of whom are affected by co-morbidities including substance use. This whole-of-family perspective may shed light on alternative mental health resources that might sustain engagement in care – and adherence to medication when indicated, thereby diminishing the chances that situations could escalate into mental health crises and psychiatric hospitalization. Including but beyond the family context, it would seem beneficial to police to have increased, direct access to mental health resources that could address mental health disturbances in ways that are less coercive and potentially stigmatizing than emergency psychiatric facilities. Ideally, these resources should be available to individuals and families prior to the need for police involvement. Unfortunately, in the years preceding and during the study period, community mental health services in Chicago consistently shrank.

Continued research is required, however, in tracking call resolution outcomes in both Chicago and beyond. The call resolution data collected here contained a relatively small number of incidents, largely because this data was manually collected as part of a funded research study. Official police data on the nature of mental health encounters and their immediate outcomes are very limited, with gaps and missing data points. As such, national progress needs to be made in improving police data systems in ways that capture the gamut of situations handled by police, and the range of formal and informal actions deployed to keep the peace and address public health. Such conversations about data systems should be supplemented by more open conversations about the gray zone nature of police work, and the need to strengthen the law enforcement-public health interface in the management of both crisis *and* non-crisis situations.

Conclusion

Public demand for police interventions during mental health related disturbances shows no signs of slowing down. The police will continue to serve as the front line of mental health service delivery for as long as the social determinants of mental health remain unaddressed and community mental health services are under-resourced. The study discussed here, however, suggests there is room for cautious optimism in the enhancement of police decision-making. Although police still hold a place in the population's imagination as crime fighters, their role in the management of mental health-calls is particularly nuanced and complex. Our analysis of a sample of mental health call resolutions in the Chicago Police Department reveal that police are disinclined to use legal action, and considerably more inclined to transport individuals for hospital psychiatric assessments. Moreover, police routinely resort to on-scene call resolutions involving an array of informal tactics. Our qualitative data reveal an emphasis on de-escalation and the strategic value of persuasion in securing compliance. Both situational and historical knowledge accumulated by officers informs the ways in which they balance imminent issues of safety and call subject health.

Taken together, our quantitative and qualitative findings underscore the need to reflect critically on our existing conceptions of diversion, and the ways in which community mental health could be further advanced through additional forms of service interface with police. Relatedly, diversion from arrests to emergency hospitalization should be considered the first step, not the last, in improving society's responses to people affected by mental illness. This paper was intended to provide some additional empirical and conceptual grounds upon which the Crisis Intervention Team agenda, within the broader landscape of criminal justice diversion, could be further advanced.

Acknowledgements:

This work was supported by the National Institute of Mental Health [grant number NIMH R01MH096744]. These data were provided by and belong to the Chicago Police Department. Any further use of these data must be approved by the Chicago Police Department. Points of view or opinions contained in this document are those of the author and do not necessarily represent the official position or policies of the Chicago Police Department.

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Table 1.**Officer Characteristics (n=300)**

Gender	Frequency (%)
Male	241 (80.3)
Female	57 (19.0)
Race/Ethnicity	
White/Caucasian	214 (72.3)
Black/African American	65 (21.7)
Asian	11 (3.7)
Other	3 (1.0)
Hispanic/Latino	61 (20.3)
Rank	
Police Officer	271 (90.4)
Field Training Officer	9 (3.0)
Sgt/Lt	14 (4.6)
CIT Trained	
Yes	81 (27.0)
No	217 (72.3)
Age 23–61 years old	Mean 41.9 (SD 8.4)
Years experience 1–38	Mean 14.8 (12.4)

Table 2

Call Subject and Call Characteristics

CALL SUBJECT information		Number (%)	CALL CHARACTERISTICS	Number (%)
Gender			Call Origination	
	Male	280 (65.4)	Dispatch Initiated	279 (65.2)
	Female	142 (33.6)	On view/Officer initiated	130 (30.4)
	Transgender	2 (0.5)	Subject walked into station	3 (.07)
	UNK	2 (0.5)	Other	16 (3.7)
Race/Ethnicity			Call Location	
	Black/African American	281 (65.7)	Private Home	146 (34.1)
	White/Caucasian	135 (33.5)	Street/Public Park	134 (31.3)
	Asian	4 (0.9)	Business	74 (17.3)
	Native Hawaiian/PI	2 (0.5)	Government Facility	26 (6.1)
	Other/UNK	6 (1.4)	Public transportation	22 (5.1)
	Hispanic/Latino	49 (11.4)	Mental Health Agency	13 (3.0)
Age			Hospital	7 (1.6)
	<20	17 (4.0)	Other	6 (1.4)
	20–39	196 (45.8)	Someone requested resolution	
	40–59	184 (43.0)	yes	221 (51.6)
	>=60	30 (7.0)	Who requested resolution	
Officer perceived subject as having			Family member	66 (15.4)
	Serious mental illness	347 (81.1)	Clinician	18 (4.2)
	Alcohol problem	133 (31.1)	Business owner	48 (11.2)
	Drug Problem	107 (25.0)	Subject	41 (9.6)
	ID/DD	92 (21.5)	Security/Police	33 (7.7)
Gathered information about med			Community member	5 (1.2)
	Currently prescribed meds	200 (46.7)	Other	9 (2.1)
	Currently taking meds	45 (10.5)	What resolution requested	
	Currently off meds	108 (25.2)	Hospital transport	141 (32.9)
	Don't know	47 (11.0)	Arrest	19 (4.4)
Have dealt with subject before			Removal from Property	38 (8.9)
	Yes	150 (35.0)	Other	23 (5.4)
	No	269 (62.9)	Actual Call Outcome	
	Don't know	8 (1.9)	Arrest	25 (5.8)
			Transport to Hospital	192 (44.9)
			Referred to services	34 (7.9)
			Resolved on Scene	150 (35.0)
			Other	46 (10.7)

Table 3.

Behavioral signs of vulnerability/crisis and risk

Behavioral Signs of Vulnerability	Number (%)	Behavioral Risks	Number (%)
Sad or depressed	182 (42.5)	Suicide Attempt	21 (4.9)
Hearing voices	88 (20.6)	Suicide Threat	50 (11.7)
Paranoia	221 (51.6)	Thoughts of Suicide	63 (14.7)
Odd or unfounded beliefs	183 (42.8)	Possession of weapon	26 (6.1)
Under influence of alcohol	95 (22.2)	Threat of harm to others	102 (23.8)
Under influence of drugs	53 (12.4)	Threat of harm to police	56 (13.1)
Excessive energy	191 (44.6)	Unable to care for self	166 (38.8)
Talking extremely rapidly	202 (63.1)		
Anxious/panicky	270 (63.1)		
Confused thinking	272 (63.6)		
Verbally abusive	140 (32.7)		
Damaging property	54 (12.6)		

Note: Number of calls (%) that the officer indicated “yes” behavioral sign/risk was observed