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Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness

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Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness

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In this study, we sampled sworn police officers from three law enforcement agencies ($n = 452$), each of which had different system responses to mentally ill people in crisis. One department relies on field assistance from a mobile mental health crisis team, a second has a team of officers specially trained in crisis intervention and management of mentally ill people in crisis, and a third has a team of in-house social workers to assist in responding to calls. Calls involving mentally ill people in crisis appear to be frequent and are perceived by most of the officers to pose a significant problem for the department; however, most officers reported feeling well prepared to handle these calls. Generally, officers from the jurisdiction with a specialized team of officers rated their program as being highly effective in meeting the needs of mentally ill people in crisis, keeping mentally ill people out of jail, minimizing the amount of time officers spend on these calls, and maintaining community safety. Officers from departments relying on a mobile crisis unit (MCU) and on police-based social workers both rated their programs as being moderately effective on each of these dimensions except for minimizing officer time on these calls where the MCU had significantly lower ratings.

Law enforcement personnel are routinely the first line of response for situations involving mentally ill people in crisis. In one large midwestern city, more than half of the officers had responded to at least one of these calls in the preceding month (Gillig, Dumaine, Stammer, Hillard, & Grubb, 1990), and nationally, on average, medium and large police departments estimate that about 7% of their contacts

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involve people with mental illness (Deane, Steadman, Borum, Vesey, & Morrissey, 1998). Given the frequency of these encounters, it is not surprising that police are a primary referral source for psychiatric emergency departments, providing up to a third of all mental health referrals (Doyle & Delaney, 1994; McNiel, Hatcher, Zeiner, Wolfe, & Myers, 1991; Meadows, Calder, & Van den Bos, 1994; Sales, 1991; Watson, Segal, & Newhill, 1993; and Way, Evans, & Banks, 1993).

However, emergency centers are not always available, expedient, or an appropriate form of disposition. Although most of these encounters are handled by informal disposition (Bittner, 1967; Green, 1997, Hanewicz, Fransway, & O'Neill, 1982; Teplin, 1984b), some of them, for a variety of reasons, result in arrest. Data from mental health consumers and their families suggest that most people with severe mental illnesses will experience at least one arrest and many will be arrested more than once (McFarland *et al.*, 1989). In one sample of 331 people with severe mental disorders, 20% reported being arrested or picked up by police for a crime at some time in the 4 month period before their hospital admission, most commonly for alcohol or drug offenses or crimes of public disorder (e.g., loitering or trespassing) (Borum, Swanson, Swartz, & Hiday, 1997).

Why are there so many arrests? In general, police officers tend to find these cases to be challenging and difficult to manage. They often feel inadequately trained to identify and intervene in cases involving mental illness, yet when called to respond, they are responsible to provide a disposition that both serves the needs of the individual and maintains order and safety in the community (Finn & Sullivan, 1987, 1989). Their options are often limited and sometimes they resort to arrest, even when a mental health disposition would be more appropriate (American Bar Association, 1986) because mental health system resources are inaccessible, unavailable, or viewed as hostile (Teplin, 1984a, 1984b; Teplin & Pruett, 1992).

In a survey of crisis response services in 69 U.S. communities, law enforcement personnel were found to play a critical role in responding to mental health crises in the community (Stroul, 1993). However, the survey found that although the relationship between the community and the police generally was positive, poor response time was a significant problem. Officers were frustrated by waiting for crisis staff; likewise crisis staff felt that they often had to wait excessively for police response, and that mental health calls received lesser priority. Even apart from response time, difficulties were noted in the officers' ability to handle mental health crises and in their understanding of the intervention process. Understanding and responding to these problems has increasingly become a priority for many law enforcement agencies.

Within the past 15 years, the dominant paradigm in American policing has shifted from a traditional enforcement model to a community policing model. This model places greater emphasis on order maintenance and non-emergency services, in addition to—and often as a part of—the fundamental mission of crime control (Moore, 1994). The implementation of this model is often seen in foot patrols, storefront stations, neighborhood crime prevention activities, and collaborations with other community agencies (Weisel & Eck, 1994). The impact of this transition has been so steady and pervasive that it has been referred to as a ''quiet revolution'' (Kelling, 1988). One implication of this shift has been that many agencies are re-considering their role in the community, particularly as it relates to more service-oriented calls. Although community policing initiatives vary widely by jurisdiction,

they seem uniformly to embrace two core tenets: (a) adoption of a ''problem-solving'' orientation to operational problems and (b) the use of community partnerships to accomplish operational objectives (Bureau of Justice Assistance, 1994). Agencies have begun to apply these principles in developing initiatives to improve the effectiveness of their response to mental health crises in the community (Borum, Deane, Steadman, & Morrissey, unpublished manuscript; Finn & Sullivan, 1989). Data from a national survey of police departments suggest that most of these programs conform generally to one of three models (Deane *et al.*, 1998):

1. *Police-based specialized police response*. These models involve sworn officers who have special mental health training who serve as the first-line police response to mental health crises in the community and who act as liaisons to the formal mental health system. The Memphis Crisis Intervention Team (CIT) program represents an example of this type of program.
2. *Police-based specialized mental health response*. In this model, mental health professionals (not sworn officers) are employed by the police department to provide on-site and telephone consultations to officers in the field. The Birmingham Community Service Officers provide an example of this approach.
3. *Mental-health-based specialized mental health response*. In this more traditional model, partnerships or cooperative agreements are developed between police and mobile mental health crisis teams that exist as part of the local community mental health services system and operate independently of the police department. The Knoxville program is one example of such a mobile crisis team approach.

These models appear to differ significantly in their organization, policies, and procedures. However, the extent to which they actually differ in practice, results, or costs and their adaptability to other jurisdictions is unknown at this time.

METHODS

Results from three law enforcement study sites are reported here; each representing a distinct approach for responding to incidents involving people with mental illness in crisis. The three sites are Birmingham, AL, Knoxville, TN, and Memphis, TN. These sites were selected based on results from mail survey to urban police departments ($n = 174$) inquiring about strategies that departments use to handle incidents involving people with mental illness (see Deane *et al.*, 1998). As noted above, based on the survey results and a follow-up meeting with representative programs, a typology was developed that classified these programs into three main models: (1) police-based specialized police response; (2) police-based specialized mental health response and; (3) mental-health-based specialized mental health response.

We then conducted a more detailed case-study evaluation with a single-case design and multiple units of analysis on each of the models. Three programs that reflect the typology and classification framework were selected. This evaluation effort was both descriptive and exploratory, with diverse data collection techniques used to gather empirical evidence to systematically investigate the operation and function of these programs. The three above-mentioned cities were selected and agreed to participate in the larger national evaluation of their specific programs.

The three innovative approaches include: (a) Birmingham's Community Service Officer (CSO) program, where incidents are handled by in-house mental health

specialists employed by the police department (this program represents the police-based specialized mental health response model); (b) Knoxville's mobile mental health crisis unit, where incidents are handled by community mental-health-based crisis teams in coordination with the police department (this program represents the mental-health-based specialized mental health response model); and; (c) the Memphis Crisis Intervention Team, which includes sworn officers with special training in mental health issues (this program represents the police-based specialized police response model).

Three sources of data were collected as part of the evaluation: key informant interviews from both the law enforcement and mental health systems, record reviews of representative cases, and a survey of patrol officers at each site. Only results from the patrol officer survey are used for the present study.

Measurement

The patrol officer survey was designed to measure officers' perceptions about handling incidents involving people who have mental illness. Perceptions of the local mental health system and the effectiveness of the department's specialized response to these types of call were also assessed.

Since there have been very few such police officer surveys conducted in the area of mental health (cf. Gillig *et al.*, 1990), our items were designed to be exploratory and descriptive and to focus on officers' perceptions regarding how these models worked in practice. Measures were designed for response based on a 4-point Likert-type scale ranging from ''1—not at all'' to ''4—very''. Open-ended questions were also included to gather more detailed information regarding personal experiences and disposition decisions for encounters involving people with mental illnesses.

The major domains covered on the questionnaire include officer preparation for handling incidents involving people with mental illness, perceived effectiveness of departmental specialized responses, perception of the magnitude of difficulty that people with mental illness pose for the department, and perceived helpfulness of the mental health system. We also gathered essential demographic information about the population and officers were asked to estimate the number of encounters with mentally ill people in crisis that they had had in the past month.

Officers were asked to rate the overall effectiveness of the department's program in responding to mentally ill people in crisis with regard to four specific objectives: meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing the amount of time officers spend on these types of calls, and maintaining community safety. In other studies of criminal justice diversion, program practitioners' ratings of perceived effectiveness have been found to correlate highly with program characteristics and objective measures of program success.

Sampling/Administration

We administered the officer questionnaire during roll call at the beginning of the shift in each of the three jurisdictions. To maximize the representativeness of our

sample, we attended each roll call in a 24 hour period so that officers on every shift and in every precinct or district were represented.

The resulting sample consists of a total of 452 officer responses from the three study sites. Fewer than five officers across all sites chose not to participate. The Birmingham Police Department (BPD) has a force consisting of 921 officers, with our sample representing 21% ($n = 190$). Memphis has the largest of three police departments with a total of 1,354. Our sample represents 15% of the MPD ($n = 207$). Knoxville's Police Department (KPD) has the smallest force, with a total of 395. Our sample represents 14% of the KPD ($n = 55$).

RESULTS

Sample Description

As noted in Table 1, the majority of the sample of 452 officers was male, with the total sample average at 89%. Knoxville had the highest percentage male at 93%. The mean age across samples was 32 years, with Knoxville having the younger respondents at an average age of 30. The age range for all three sites was 19–62. Officer rank was most likely to be Patrol Officer with an average across the three sites of 92.3%. Seven percent of the total sample held a rank of Sergeant or higher.

Overall, the majority of respondents were white/non-Hispanic at 55.4%; however that was not the case for all three sites. In Birmingham more than half of the respondents (54.8%) were African American. Officers responding to the survey had been with the police department an average of six years.

Officers also were asked to estimate the number of encounters they had with people with mental illness in crisis during the previous month. The average for the total sample was 6.4. Birmingham had the lowest average at 4, with Knoxville coming in second with a mean estimated average of 7. Memphis had the highest number of police encounters with mentally ill people in crisis with a total average of 9 in the previous month. However, when CIT officers were removed from the sample, the average number of encounters dropped to 8. CITs alone estimated an average of 12 encounters in the previous month. This is somewhat higher because the specialized function of the CIT is to handle these types of case, and CIT officers may also respond to calls where non-CITs are also on the scene, so there may be some redundancy in the estimates.

Therefore, the total sample shows a majority of white, male, patrol officers in their early thirties, with an average of 6 years on the force and an estimated average of six encounters in the previous month with mentally ill people in crisis.

Officer Perceptions

When officers were asked to rate the degree of problem that people with mental illness in crisis present for their department, there were no significant differences between the three sites with about half of the officers in each of the sites describing it as either a ''moderate'' or ''big'' problem (described hereafter as a ''significant problem''). Knoxville officers were least likely to note these cases as a

Table 1. Police Officer Sample Description by Site

Demographics	Birmingham $n = 190$	Knoxville $n = 55$	Memphis $n = 207$	Total $n = 452$
Mean age	33	30	32	32
Gender:				
% male	88.0	93.0	89.0	88.8
Race/ethnicity (%):				
white/non-Hispanic	44.6	89.0	56.2	55.4
African American	54.8	7.2	41.7	42.9
Asian	0.0	0.0	1.0	0.45
Hispanic	0.0	1.8	0.5	0.45
Other	0.5	1.8	0.5	0.68
Officer rank:				
Cadet	0.0	1.9	0.0	0.23
Patrol Officer	87.2	86.3	98.5	92.3
Sergeant	8.4	7.8	0.0	4.40
Lieutenant/higher	0.0	3.9	2.8	2.90
Mean number of years on the force	6.0	5.0	6.0	6.0
Mean number of encounters in last month with people who have mental illness in crisis[a]	4.0	7.0	9.0	6.4

[a] Memphis CIT Officers had a mean number of 12 encounters in the previous month with people who have mental illness. Non-CIT Officers averaged 8 encounters in the previous month.

significant problem for their department with 45.4% responding in these categories. Memphis non-CIT officers were most likely to perceive difficulties with 60% noting a significant problem.

Police officers in each of the sites were asked how well prepared they felt when handling people with mental illness in crisis. For these analyses we dichotomized responses into those reporting they were *well prepared* (i.e., those reporting that they felt ''moderately well prepared'' or ''very well prepared'') and those reporting that they were *not well prepared* (i.e., those reporting that they were ''not at all prepared'' or only ''somewhat prepared''). We performed one-way ANOVAs to determine whether officer responses differed by site and/or program (see Tables 2 and 3). Specific comparisons between sites/programs are indicated by Bonferroni-corrected t tests shown in the last column of each table.

In Birmingham, although more than half of the officers said they were well prepared, on average, they were significantly ($p < .05$) less likely to report feeling well prepared in these situations when compared to the other sites. In Knoxville, over three-fourths of the sample noted that they were well prepared and, most notably, the Memphis CIT officers were significantly more likely than their non-CIT counterparts on the Memphis force to indicate that they were well prepared, with all responding CITs checking this category (100% vs. 65.4% for non-CIT).

On the other hand, officers did not seem to feel quite as confident about the ability of their fellow officers when it came to handling these types of crisis calls. In every jurisdiction, officers on average rated the preparation of other officers as being lower than their own, although the rankings remained the same. In Knoxville, respondents reported that about two thirds of the other officers in the department were well prepared to handle these calls, whereas in Birmingham, that figure was just over a third. The Memphis CIT officers were the least likely to think

Table 2. Police Officer Perceptions by Program Site

% moderate to very[a]	Birmingham $n = 190$	Knoxville $n = 55$	Memphis non-CIT $n = 171$	Memphis CIT $n = 36$	Site differences Bon. alpha $p < .05$
Officer preparedness	52.1	78.1	65.4	100.0	B < K, M—C, M—N M—C > M—N
Other officer's preparedness	36.3	69.0	54.3	30.5	B, M—C < K, M—N
Scope of the problem of people with MI for the department	50.2	45.4	60.0	52.7	NS
MH system helpfulness	37.0	14.5	40.3	69.4	K < B, M—N M—C > B, K, M—N
Emergency room helpfulness	29.7	38.1	49.1	68.5	B < M—C, M—N M—C > K

Note. B = Birmingham, K = Knoxville, M—N = Memphis Non-CIT, M—C = Memphis CIT.
[a] This category represents the high end of the scale with moderately to very well prepared, moderate to a big problem, and moderately to very helpful.

Table 3. Police Officer Perceptions of Program Effectiveness by Program Site

% moderate to very effective	Birmingham $n = 189$	Knoxville $n = 55$	Memphis non-CIT $n = 171$	Memphis CIT $n = 36$	Site differences Bon. alpha $p < .05$
Meeting the needs of people with mental illness	39.7	52.7	70.7	88.8	M—C, M—N > B, K
Keeping people with mental illness out of jail	47.9	41.8	67.2	83.3	M—C, M—N > B, K
Minimizing the amount of time officers spend on these types of calls	20.6	7.3	53.8	72.2	M—C, M—N > B, K
Maintaining community safety	50.0	51.9	68.4	94.4	M—C, M—N > B, K M—C > M—N, B, K

Note. B = Birmingham, K = Knoxville, M—N = Memphis Non-CIT, M—C = Memphis CIT.

that other officers were well prepared. In fact, they were significantly less sanguine about the abilities of other officers than were their non-CIT counterparts (31% vs. 54%).

Since officers must frequently interact with the mental health system and emergency room when handling ''mental disturbance'' calls, we also investigated the officers' perceptions of how helpful these entities are in providing assistance to them in these circumstances. Knoxville officers reported that their mental health system was the least helpful, with only 15% viewing it as ''moderately'' or ''very'' helpful—a proportion which is significantly lower ($p < .05$) than the other sites. Memphis CIT officers (69.4%) were significantly more likely to rate the mental health system as being more helpful than were the Memphis non-CIT officers (40.3%) as well as the other sites. Concerning emergency room effectiveness, Birmingham officers were significantly less likely than Memphis officers to rate the

ER as moderately or very helpful, but no statistically significant difference was found between Birmingham and Knoxville. Once again, the difference in the percentages show that more Memphis CIT officers (68.5%) rated the ER as being helpful than did officers in the other sites.

Perceived Effectiveness

Officers were asked to rate their department's overall effectiveness in responding to crisis situations with people who have mental illness with regard to a number of specific program objectives: (a) meeting the needs of people with mental illness in crisis, (b) keeping people with mental illness out of jail, (c) minimizing the amount of time officers spend on these types of call, and (d) maintaining community safety. The overall results showed that the Memphis officer sample tended to respond more favorably on all program objectives (higher percentages responding to the ''moderately effective'' and ''very effective'' categories) than the other sites. However, in Memphis a subset of the respondents (CITs, $n = 36$) were those providing the speciality service that they were rating. When these officers were separated from the larger sample, the data revealed that they were indeed more likely as a group to rate their program as highly effective in accomplishing the objectives. However, even when examined apart, the non-CIT Memphis officers continue to rate their program as being significantly more effective than the other sites with regard to each of the four objectives. Birmingham and Knoxville were not significantly different from one another on perceived effectiveness variables.

When asked specifically about their department's specialized response to meeting the needs of people with mental illness in crisis, 74% of the total sample of officers from Memphis rated their program (CIT) as moderately or very effective. When CITs were removed from the sample, 71% of Memphis officers continued to rate the program as effective in meeting needs. Over half the officers (52.7%) in Knoxville and nearly 40% of the officers in Birmingham rated their program as moderately or very effective in meeting the needs of mentally ill people in crisis—proportions somewhat lower than those found among Memphis officers.

Next we asked about perceptions of the program's effectiveness in keeping people with mental illness out of jail. Memphis officers were again significantly more likely than the other sites to respond that their program was moderately or very effective (70.1%). Using this criterion, nearly half of the Birmingham officers (47.9%) felt as though their CSO program kept mentally ill people out of jail and 41.8% of the Knoxville sample noted that their partnership with the Mobile Crisis Unit (MCU) was moderately or very effective as a jail diversion technique.

When questioned as to whether their specialized response program minimized the amount of time patrol officers spent on these types of call, officers overall were less likely to perceive their programs as being highly effective in this area. Only 7.3% of the Knoxville officers reported that MCU was moderately or very effective, with Birmingham somewhat more likely to perceive the CSO program as effective (20.6%) and only slightly over half the total Memphis sample (53.8%) rating the CIT program moderately or very effective in this regard.

For maintaining community safety, about half of the officers from both Birmingham and Knoxville rated their programs as being effective. Memphis

officers were again more likely to rank their program highly on this objective, with 94.4% of the CIT and 68% of the non-CIT officers rating it as moderately or very effective.

DISCUSSION

In this sample of 452 police officers from three jurisdictions, we found that police encounters with mentally ill individuals in crisis were quite common. On average, these officers estimated that they had been involved in six encounters within the past month. In contrast to the findings of Gillig *et al*. (1990) in Cincinnati where only 60% of the officers had responded to a call involving a person with mental illness in the previous month, in our sample 92% reported at least one such encounter and 84% reported having more than one. Similarly, approximately half of the officers across jurisdictions perceive that people with mental illness in crisis pose a moderate or big problem for their department. Thus, these encounters are frequent and are perceived to present a significant operational problem. Taken together, these findings underscore the importance for law enforcement agencies of developing effective strategies for dealing with calls involving people with mental illness in crisis.

Each of the sites in the present study had already developed specialized programs or capacities to assist law enforcement in responding to psychiatric crises in the community, and each of the departments view these programs as a key part of their community policing initiatives. As noted above, these initiatives tend generally to take a problem-solving approach and to utilize community partnerships to address operational concerns. Within the community policing framework, many agencies have begun to focus more specifically on serving the needs of specialized populations, including those precipitating more service-oriented calls or those contributing primarily to public disorder. It is within this departmental context and philosophy that these programs operate.

Although encounters with mentally ill people in crisis are common and some departments have taken specific action to address these issues, questions have been raised generally about the level of training and preparation of law enforcement officers in responding to these calls (Murphy, 1986). In our sample, however, over half of the officers in each jurisdiction reported feeling well prepared to handle calls involving mentally ill people in crisis, although, notably, there was some variability between sites or program types. Those feeling most prepared were the specialized CIT officers in Memphis. This is not surprising given that these officers volunteer for this program and receive specialized training in managing these types of calls. Interestingly, the CITs reported feeling significantly better prepared than their non-CIT counterparts within the same department, suggesting that specialized training and preparation can improve officers' comfort and confidence in responding to mental health emergencies. In Knoxville, over three quarters of the officers felt well prepared to handle these calls, perhaps because they experience a lower volume, have a clear departmental directive mandating arrest for criminal offenses, have a less complex mental health infrastructure for after hours emergencies, and have become accustomed to handling many of these calls without assistance if the MCU is unavailable due to handling other calls—approximately 85% of the

Knoxville officers did not perceive the mental health system as being very helpful in responding to these calls. In Birmingham over half the officers felt well prepared, but the number was somewhat lower than in the other sites, perhaps because they have come to rely on their own in-house staff of social workers (CSOs) to handle these calls.

Officers' perceptions of the helpfulness of the mental health system and emergency room were somewhat lower and more variable. In Memphis, the CIT officers—who have the most contact with these personnel—tended to give the highest ratings. The psychiatric emergency service (The Med) in Memphis has a very strong partnership with the police department and is particularly responsive to CIT officers. The Med takes all police referrals and will provide for an appropriate disposition. The referral process has been streamlined so that officers typically spend less than 30 minutes processing a subject for evaluation. Thus, it is not surprising that the CIT officers find this system to be quite helpful in handling these calls. As noted above, Knoxville officers tended to give the lowest ratings to their mental health system and remarked frequently on difficulties with response time. The MCU that serves that department also serves a broader five-country area covering a considerable distance which often interferes with their ability to respond as quickly as they would like. Police officers, of course, are accustomed to immediate responses to requests for assistance. We are currently investigating officers' most frustrating experiences in handling mental disturbance calls and their suggestions for how the mental health system could be more responsive.

Finally, we inquired as to how effective the officers thought their programs were in accomplishing certain objectives: meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing the amount of time officers spend on these types of call, and maintaining community safety. Again, the Memphis CIT officers assigned the highest ratings across all objectives. However, most Memphis non-CIT officers also rated their program as being highly effective in accomplishing all four of the objectives. Knoxville and Birmingham showed comparable levels of perceived effectiveness for meeting the needs of mentally ill people in crisis, keeping mentally ill people out of jail, and maintaining community safety. The clearest difference was observed on the outcome about which officers have the most direct knowledge—whether the program helps to minimize the amount of time officers spend on these types of calls. Over half of the Memphis officers (CIT and non-CIT) rated their program as being highly effective in this regard, while about 20% of the Birmingham officers and 7% of Knoxville officers assigned this rating. The difficulties with MCU response time in Knoxville have already been noted, and in Birmingham sometimes officers must still be present since the CSOs are civilians and may require police presence for security. However, the difference between sites is most likely due to the efficiency and responsiveness of the psychiatric emergency service in Memphis where officers can always find immediate assistance and do not have to wait for the examination or disposition. Having such a "one stop drop off" center would appear to be a crucial element in reducing officer down time in responding to mentally ill people in crisis. Reducing down time may then reduce the likelihood that an officer would resort to arrest or non-action as a more time-efficient means of disposition. The importance of minimizing officer time should not be underestimated when developing speciality response programs.

Overall, these data present the views of law enforcement personnel in three jurisdictions, each having a distinct specialized response to calls involving mentally ill people in crisis. These calls appear to be frequent and are perceived by most of the officers to pose a significant problem for the department. Most of them feel well prepared to handle these calls, but some are less confident about the abilities of other officers in their department in this regard. Generally officers from a jurisdiction with a police-based, specialized police response capacity rated their program as being highly effective in meeting the needs of mentally ill people in crisis, keeping mentally ill people out of jail, minimizing the amount of time officers spend on these calls, and maintaining community safety. Officers from the police-based specialized mental health response program and the mental-health-based specialized mental health response program both rated their programs as being moderately effective on each of these dimensions except for minimizing officer time on these calls. Here, the mental-health-based specialized mental health response (MCU) had significantly lower ratings.

There were, of course, some limitations in the present study which warrant caution in the interpretation and generalizability of these results. First, we did not include as a comparison group a police department with no speciality program. While this would not necessarily affect the comparative ratings across sites, it is possible that the ratings in all sites may be inflated due to demand characteristics of the study. Given, however, that officers seemed quite willing to acknowledge the problems and shortcomings in their programs, it seems unlikely that demand characteristics would have significantly exaggerated ratings of perceived program effectiveness. Secondly, our study methodology was to conduct an intensive case study of three programs, each of which served as an example or prototype of their respective models. It may be that these results are more specific to features of the departments (e.g., funding, overall departmental quality) or jurisdictions (e.g., demographic composition, service infrastructures) sampled, than to the program type *per se*. Thus, generalization of these findings should be approached with caution.

Indeed, although each of these departments operate these programs as part of their community policing initiatives, mental health and social service infrastructures in each of these cities are somewhat different. From a community policing perspective, this would appear to be a key operational consideration for law enforcement agencies. The infrastructure of other services will affect the conceptualization of problem-solving approaches to mental disturbance calls and it most certainly affects the nature of the partnerships that need to be cultivated and developed to make the programs successful. Having a psychiatric drop off center would appear to be a crucial element here, as it minimizes officer down time and indirectly may affect other positive outcomes. In a national survey of police departments, those who had access to a drop off center were nearly twice as likely to perceive their response to these calls as being effective as those who did not have access to such a resource (Deane *et al.*, 1998). The use of in house social workers and mental health professionals may be more acceptable and less threatening to consumers, and may assist in relieving the burden of some more general service-oriented calls, but for crisis calls officers' presence may still be required for security, so those operational resources would still be occupied. Programs relying primarily or exclusively on outside assistance from the mental health system may be

frustrated by lengthy response times in a context where calls for assistance are typically answered immediately. The nature and quality of the partnership with the mental health agency as well as that agency's structure and resources would be key considerations for implementing this type of program. Thus, different types of programs may present a better fit for different types of community; however, the keys to success generally are consistent with the objectives of community policing, and these specialized responses should function well with that guiding philosophy for improving police responses to mentally ill people in crisis.

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REFERENCES

American Bar Association. (1986). *Criminal justice mental health standards*. Chicago, IL: Author.

Bittner, E. (1967). Police discretion in emergency apprehension of mentally ill persons. *Social Problems*, *14*, 278–292.

Borum, R., Swanson, J., Swartz, M., & Hiday, V. (1997). Substance abuse, violent behavior and police encounters among persons with severe mental disorder. *Journal of Contemporary Criminal Justice*, *13*, 236–250.

Bureau of Justice Assistance (BJA). (1994). *Understanding community policing: A framework for action*. Washington, DC: Author.

Deane, M., Steadman, H., Borum, R., Vesey, B., & Morrissey, J. (1998). Types of partnerships between mental health and law enforcement. In press in *Psychiatric Services*.

Doyle, H., & Delaney, W. (1994). Police referral of compulsory admissions: a comparison study. *Irish Journal of Psychological Medicine*, *11*, 116–119.

Finn, P., & Sullivan, M. (1987). *Police response to special populations*. U.S. Department of Justice, National Institute of Justice, Washington, DC.

Finn, P., & Sullivan, M. (1989). Police handling of the mentally ill: Sharing responsibility with the mental health system. *Journal of Criminal Justice*, *17*, 1–14.

Gillig, P. M., Dumaine, M., Stammer, J. W., Hillard, J. R., & Grubb, P. (1990). What do police officers really want from the mental health system. *Hospital and Community Psychiatry*, *41*, 663–665.

Green, T. (1997). Police as frontline mental health workers: the decision to arrest or refer to mental health agencies. *International Journal of Law and Psychiatry*, *20*, 469–486.

Hanewicz, W. B., Fransway, L. M., & O'Neill, M. W. (1982). Improving the linkages between community mental health and the police. *Journal of Police Science and Administration*, *10*, 218–223.

Kelling, G. (1988). *Perspectives on Policing: No. 1., Police and community: The quiet revolution*. Washington, DC: National Institute of Justice.

McFarland, B., Faulkner, L., Bloom, J., Hallaux, R., & Bray, J. (1989). Chronic mental illness and the criminal justice system. *Hospital and Community Psychiatry*, *40*, 718–723.

McNiel, D. E., Hatcher, C., Zeiner, H., Wolfe, H. L., & Myers, R. S. (1991). Characteristics of persons referred by police to the psychiatric emergency room. *Hospital and Community Psychiatry*, *42*, 425–427.

Meadows, G., Calder, G., & Van den Bos, H. (1994). Police referrals to a psychiatric hospital: indicators for referral and psychiatric outcome. *Australian & New Zealand Journal of Psychiatry*, *28*, 259–268.

Moore, M. (1994). Research synthesis and police implications. In D. Rosenbaum (Ed.), *The challenge of community policing: testing the promises* (pp. 285–299). Thousand Oaks, CA: Sage.

Murphy, G. (1986). *Improving the police response to the mentally disabled*. Washington, DC: Police Executive Research Forum.

Sales, G. N. (1991). A comparison of referrals by police and other sources to a psychiatric emergency service. *Hospital and Community Psychiatry*, *42*, 950–952.

Stroul, B. A. (1993). *Psychiatric crisis response systems: A descriptive study*. Rockville, MD: National Institute of Mental Health.

Teplin, L. (1984a). Criminalizing mental disorder: the comparative arrest rate of the mentally ill. *American Psychologist*, *39*, 794–803.

Teplin, L. (1984b). Managing disorder: police handling of the mentally ill. In L. A. Teplin (Ed.), *Mental health and criminal justice* (pp. 157–175). Beverly Hills, CA: Sage.

Teplin, L., & Pruett, N. (1992). Police as streetcorner psychiatrist: managing the mentally ill. *International Journal of Law and Psychiatry*, *15*, 139–156.

Watson, M. A., Segal, S. P., & Newhill, C. E. (1993). Police referral to psychiatric emergency services and its effect on disposition decisions. *Hospital and Community Psychiatry*, *44*, 1085–1090.

Way, B. B., Evans, M. E., & Banks, S. M. (1993). An analysis of police referrals to 10 psychiatric emergency rooms. *Bulletin of the American Academy of Psychiatry & the Law*, *21*(4), 389–397.

Weisel, D., & Eck, J. (1994). Toward a practical approach to organizational change: community policing initiatives in six cities. In D. Rosenbaum (Ed.), *The challenge of community policing: testing the promises* Thousand Oaks, CA: Sage.

