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FINAL REPORT

Police Response to Emotionally Disturbed Persons: Analyzing New Models of Police Interactions with the Mental Health System.

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Background

Police have always been key front line responders for mental health emergencies. They have been labeled variously as "gatekeepers," street corner psychiatrists and social workers (Cumming, Cumming and Edell, 1965; Bittner, 1967; Sheridan and Teplin, 1981; Teplin, 1986; Teplin and Pruett, 1992; and Borum, Deane, Steadman, and Morrissey, in press). Empirical analyses of these law enforcement - mental health system interactions have focused mainly on street level interactions with persons who are possibly mentally ill (Sheridan and Teplin, 1981, Teplin, 1984a,1984b) and on interactions with emergency room staff, where police often bring people for psychiatric evaluation. (Steadman, Morrissey, Braff, and Monahan, 1986; Steadman, Braff, and Morrissey, 1988; Watson, Segal, and Newhill, 1993; Way, Evans, and Banks, 1993). More recently, data on an innovative police-based diversion program (Lamb, Shaner, Elliot, DeCuir, and Foltz, 1995) have also been added to the literature.

While analyses of police - mental health system interactions have been very informative, they have not systematically examined a number of recently developed initiatives that have evolved under the concept of "pre-booking" diversion programs, i.e. avoiding arrest by having police officers make direct referrals to community-based mental health and substance abuse programs (Steadman, Barbera, and Dennis, 1994; Steadman, Morris and Dennis, 1995; Deane, Steadman, Borum, Veysey, and Morrissey, In Press). Further, prior studies have not considered how contemporary police-mental health interactions work within emerging models of community policing. (Ruiz, Vazquez, Vazquez, 1973; Meacham and Acey, 1974; Zealberg, Christie, Puckett, et al., 1992; Geller, Fisher and McDermeit, 1995, Borum et al. in press)

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 law enforcement agencies are re-considering their role in the community, particularly as it relates to more service-oriented calls.

In practice however, community policing has been variously defined by police departments asserting to operate under the increasingly popular banner. It has yet to be fully developed across the country, in part because police departments vary in size and in the social and economic characteristics of the populations that they police and in additional resources needed to implement such a program (Skogan and Harnett, 1997). Although community policing initiatives vary widely by jurisdiction, they seem uniformly to embrace two of the core tenets: (1) adoption of a "problem-solving" orientation to operational problems and (2) 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, in press; Finn & Sullivan, 1987, 1989).

Under the rubric of community policing, newer pre-booking diversion initiatives tend to use innovative training and practices by police departments to avoid detention in local jails by arranging for community-based mental health and substance abuse services as alternatives. One example of this practice includes providing specialized training to police officers with a

curriculum developed by local mental health professionals, often in collaboration with family or consumer groups (i.e., local Alliance for the Mentally Ill) and law enforcement personnel. Another key element to many pre-booking diversion programs is a designated mental health triage or "drop-off" center where police can transport all persons thought to be in need of emergency mental health services, usually under a no-refusal policy (Deane et al., in press). No criminal charges are filed and the triage center provides an appropriate treatment disposition.

The data reported here examine three program sites: Birmingham AL, Knoxville, TN, and Memphis, TN. These sites were selected based on results from a mail survey to urban police departments inquiring about strategies that departments use to handle incidents involving people with mental illness. 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 innovative approaches examined include two innovative pre-booking diversion programs and one traditional mobile mental health crisis response team: 1) 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; 2) 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; 3) 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.

A primary focus of this study was to examine the extent to which use of a pre-booking diversion program is associated with a "specialized" response (i.e., as opposed to a general dispatcher call) and with reductions in the arrest of people with mental illness. Secondly, we were interested in how police officers perceived the specialized response used by their department and in what factors might be associated with their differential effectiveness ratings. As part of the descriptive nature of the study, we also wanted to document the types of incidents that occurred commonly and which incidents were more likely to result in police use of physical force and/or arrest.

The Programs

Birmingham, AL

In 1976, the Birmingham Police Department participated in a pilot project initiated by the University of Alabama to provide the police with a team of in-house civilian social workers. It was proposed that these Community Services Officers (CSOs) would be available 24-hours a day to provide on-site assistance in mental health related crises. The pilot was so successful that for the past 20 years the CSO team has been funded by the city and is currently based within the police department.

The CSOs assist police officers in mental health emergencies by providing crisis

intervention, as well as some follow-up assistance to individuals. CSOs are civilian police employees with professional training in social work or related fields. They dress in plainclothes rather than uniforms, drive unmarked cars and carry police radios. They are not "sworn" police officers, do not carry weapons, and do not have the authority of arrest.

Newly hired CSOs participate in a six-week training program of classroom and field instruction. Since April of 1993, there have been six to eight CSOs working within the Birmingham Police Department: one masters-level Social Worker in a senior position and the rest with Bachelors degrees in Social Work or related fields. They are housed in each of the four major city police precincts and operate Monday through Friday on the 8:00 a.m. - 4:30 p.m. day shift and on the 1:30 p.m. - 10:00 evening shift. Twenty-four hour coverage is provided by CSOs rotating on-call duty during weekends, holidays and off-shift hours. In addition to mental health emergencies, the CSOs attend to various social service types of calls, which include domestic violence, transportation, shelter needs or other requests for general assistance. In 1997, the CSOs answered a total of 2,189 calls. The most frequent request (731) was for assistance with mental health-related situations. Currently the CSO program is receiving attention from many jurisdictions in the states and abroad, that are in search of a similar type of program for handling calls of a "social services" nature. The most recent addition is Reno, Nevada which recently adopted a CSO program.

Memphis, TN.

The Memphis Police Department's Crisis Intervention Team (CIT), is a police-based program with specially trained officers and is probably the most visible pre-booking diversion program in the U.S. (Dupont and Cochran, 1998, Borum, Deane, Steadman and Morrissey, in

press). Additional CIT programs, based on the Memphis model, have been developed in Waterloo, IA, Portland, OR, Albuquerque, NM, and Seattle, WA. San Jose, CA will be implementing CIT in January 1999 and numerous other departments are in the early planning phases of implementation[1].

In 1987, following a police shooting incident involving a mentally ill person, under the aegis of the Memphis mayor's office, the Police Department formed a partnership with the Memphis Chapter of the Alliance for the Mentally Ill, the University of Memphis and the University of Tennessee, to develop a specialized unit within the Police Department to manage community crises, and to intervene with mentally ill people in a safe, effective and professional manner. As part of their charge, the mayor's office requested that this be a collaborative community effort which tapped community resources. Accordingly, memorandums of Agreement were signed among participants indicating that services would be provided voluntary and at no expense to the City of Memphis. The Memphis Police Department responded to this directive by developing a cadre of specially-trained officers known as the Crisis Intervention Team (CIT). The Memphis CIT officers are trained to immediately transport individuals they suspect of having mental illness to the UT psychiatric emergency service, after the situation has been assessed and diffused. Some fewer calls end with the individual being transported directly to the local inpatient Crisis Stabilization Unit.

Currently, the CIT is composed of 130 patrol officers, covering four overlapping shifts in each precinct. The program operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" calls in addition to their regularly assigned patrol duties. After being selected into the CIT program, police officers receive 40-hours of specialized training from mental health providers, family advocates and mental health

consumer groups providing information about mental illness and techniques for intervening in a crisis. CIT officers are issued CIT medallions which provide immediate identification to other officers/citizens as to these individuals' role in the crisis situation. When the CIT officer arrives on the scene, she/he is the designated officer in charge. This program provides 24-hour, on-site service which during 1997, responded to 6,940 mental disturbance calls and made 3,261 transports.

Within the Memphis community mental health services system, but separate from the police department's CIT program, there is a community mobile mental health crisis team based out of the Midtown Mental Health Center. Only occasionally does this team work in tandem with CIT officers.

Knoxville, TN.

In 1991, the state of Tennessee mandated, and financially supported through grant funds, the establishment of mental health Mobile Crisis Units (MCU) based throughout the state. In Knoxville this Unit was designated to serve a five-county area with a population of 475,000. In addition to responding to calls in the community, the unit also handles telephone calls and referrals from the jail, since the jail does not have an in-patient mental health program.

When this study began, the MCU was composed of nine individuals who worked in two-person teams, typically pairing one Bachelor's level member with either a Master's level Social Worker or registered nurse serving as team leader. Twenty-four hour coverage was provided by day, evening, night and weekend team leaders. During the first quarter of 1996, the Unit responded to a total of 1,943 situations including 1,053 telephone calls and 890 field contacts. Jails made 16% of the referrals to the Unit, 14% came from emergency rooms, 14% were self

referrals, and 13% were referred by police. Knoxville's MCU was selected for comparison with the Memphis CIT program, since both could be examined under the same state-wide managed care initiative.

Methods

Phase I (Pre-NIJ Funding) — Police Department Mail Survey

Prior to NIJ funding we conducted a survey of urban police departments in the 194 U.S. cities with populations of 100,000 or more was conducted in 1996[2]. Completed survey's were received for 174 departments (90%) in 42 states. The survey was exploratory and gathered information regarding existing specialized response programs that were primarily designed to manage crisis calls with people with mental illnesses that were also based within the police department or at least partnering with them. The survey specifically requested background information on the police department and locale, information about police-mental health professional interactions (with regard to whether a department has any policies or procedures designed to divert into treatment or provide crisis assistance to persons thought to be mentally ill who might otherwise be arrested), availability of departmental training to all line officers in managing mentally ill persons, and whether the department employs specially trained mental health officers/deputies.

Departments were asked to rate on a five-point Likert scale the perceived overall effectiveness of the department to respond to a person with a mental illness who is in crisis. This perceived effectiveness scale was used as a "first cut" and cost-effective measure to identify exceptional programs[3].

To identify existing specialized response strategies we asked departments: 1) Does your

department have special mental health officers/deputies who are employees of your department?; 2) Does your department provide on-site emergency psychiatric evaluation of mentally ill persons?; 3) Does your department have other collaborations with emergency mental health services? A follow-up, open-ended question provided more specific accounts of the departments' crisis response and many department's attached additional information and literature about special programs. We then examined the responses for similarities across departments and combined the similar strategies into categories. This procedure yielded three primary police-mental health response strategies.

Phase II — Site Level Analysis

After the categorization of the primary existing models, one example of each type was selected for further in-depth study. For each site three data sources were collected: 1) key informant interviews with law enforcement and mental health personnel; 2) a survey of patrol officers from each site and; 3) two types of record reviews of representative cases.

I. Key Informant Interviews

Informal semi-structured interviews were conducted with key law enforcement and mental health personnel at each of the three program sites for exploratory information gathering. Key informant were persons that had a significant administrative decision-making role with the program, was instrumental in carrying out the daily operations of the program, or had a key stakeholder in the community. These data assisted in development of the officer survey and the record reviews. The interviews were conducted with: chiefs of police, program coordinators, patrol officers, specialized response personnel, communications personnel, Directors of Mental

Health, emergency room personnel, and members of the local Alliance for the Mentally Ill. A total of 30 open-ended interviews were conducted across the three sites.

II. Police Officer Survey

The patrol officer survey was designed to measure officers' perceptions about handling incidents involving people who have mental illness. Perceptions of the department's effectiveness and the specialized response programs were also assessed. Key factors toward determining a disposition were examined as well, such as whether to arrest, release, or decide upon some other disposition.

Since there have been very few such police officer surveys conducted in the area of mental health (c.f. Gillig, et. al, 1990), our items were designed to be 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 have 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 (Steadman et al., 1994, Steadman and Veysey, 1997).

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).

III. Record Reviews

Two types of records were used to gather information at each site: 1) police dispatch calls and; 2) incident reports from the specialized response .

a. *Police Dispatch Calls*

At each site we examined approximately 100 dispatch files which were consecutive "mental disturbance" calls, to determine the frequency with which the specialized response team

was called to the scene of the incident and to determine how often the incident ended in arrest.

All three sites use the Computer Aided Dispatch (CAD) system; however, a different method of data collection was needed at each site to determine the frequency of specialized response. For Birmingham each dispatch call was cross-checked with special CSO incident reports. Knoxville cross-checks were conducted by collecting dispatch data from the police department and then matching each call, by date and address of incident, with Mobile Crisis Unit incident logbooks. The MCU files do note if the call was a police referral, thus we tried to match police referrals by date and incident time. Memphis cross-checks included collecting dispatch calls and matching officer identification numbers, first to see if any of the officers were CIT, and then matching with CIT statistics reports to determine if a CIT officer was dispatched initially or was eventually on scene. Each CIT officer fills out an incident "stat sheet", which is promptly filed with the CIT coordinator.

b. *Specialized Response Incident Reports*.

Our second type of record review involved the collection of 100 incident reports from mental health disturbance calls in each of the three sites (n=300). The second sample was necessary because only 28% and 40% of the "mental disturbance" calls in Birmingham and Knoxville, respectively, were either the CSO or MCU and we were interested in examining the outcomes of cases across the three programs and these were not sufficient cases without drawing a targeted sample of specialized responses. From the specialized response incident reports, we gathered detailed information concerning the nature of the call and how it was handled by the specialized response personnel. Incident data included subject demographics, behaviors, and symptoms as well as the response time, intervention, and disposition provided by the specialized response. Dispositions were later classified into four mutually exclusive categories: 1) Arrest

(criminal charges were filed) ; 2) Treatment (a broad category including psychiatric hospitalization detox, psychiatric ER evaluation, general hospital admission for medical purpose); 3) On scene resolution (incident resolved on the scene and/or crisis intervention provided at the scene) and; 4) Referral (subject was referred to a mental health specialist). We also collected information as to whether the individual was transported by the specialized unit and where the subject was taken.

Results

I. Police Department Mail Survey

a. *A Typology of Police/Mental Health Crisis Response*

For the 174 police departments in our study, 7 percent of all police contacts, both investigations and complaints, involved persons believed to be mentally ill.

Over half of the departments (55%) indicated they had "no specialized response" for handling these types of incidents. Three basic strategies[4] were used by the 78 departments that did have a specialized response:

Police-based specialized police response (n=6; 8%)

(1) This strategy involves sworn officers who have special mental health training to provide crisis intervention services and to act as liaisons to the formal mental health system.

Police-based specialized mental health response (n=20; 25%)

(2) In this strategy mental health consultants are hired by the police department. The consultants are not sworn officers, but they provide on-site and telephone consultations to officers in the field.

Mental Health-based specialized mental health response (n=52; 67%)

(3) This strategy uses mobile mental health crisis teams. The teams are part

of the local community mental health services system and have developed a special relationship with the police department to respond to the special needs at the site of an incident.

b. *Perceived Effectiveness by Model Type*

When perceived effectiveness ratings were examined by the type of specialized response model, no significant relationships were found between the models.

[Exhibit 1]

Results also showed that 50% of those programs that indicated a Police-based mental health response (eg. teams of trained social workers) (n=20) rated their response higher on the effectiveness scale, with "very effective," whereas only 20-35% of the other model types (including no response) indicated "very effective."

Another important strategy, often used in conjunction with specialized response, appears to be the use of a crisis "drop-off center" where police officers can literally transfer mentally ill persons in crisis to mental health staff and thus reduce their down time. Indeed when we examined perceived effectiveness with the existence of a "drop off" center, we found that those with the center were significantly more likely to perceive that their programs were highly effective (χ^2 =21.689 df=1 p<.0001). Crisis drop-off centers were used by 68% of all departments surveyed.

II. Police Officer Perceptions:

The majority of the sample, 89% was male. The mean age across samples was 32 years. 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%. 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 were asked to estimate the number of encounters they have had with people with mental illness in crisis during the last month. The average for the total sample was 6.4. Birmingham had the lowest average at four, with Knoxville coming in second with a mean estimated average of seven. Memphis had the highest number of police encounters with mentally ill people in crisis with a total average of nine in the last month. However, when CIT officers were removed from the sample, the average number of encounters dropped to eight. CITs alone estimate an average of 12 encounters in the last month. This is somewhat higher because the specialized function of the CIT is to handle these types of cases, and CIT officers may also respond to calls where non-CITs are also on the scene.

[Exhibit 2]

When officers were asked to rate the degree of problems 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").

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"). 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).

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.

[Exhibit 3]

a. Perceived Effectiveness

Officer's 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: (1) meeting the needs of people with mental illness in crisis, (2) keeping people with mental illness out of jail, (3) minimizing the amount of time officers spend on these types of calls, and (4) 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. When Memphis CIT officers were separated from other Memphis officers, 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 programs effectiveness 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 that patrol officers spent on the these types of calls, 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.

[Exhibit 4]

b. Key Factors in Determining Disposition

Officers were asked in an open-ended format to list or describe the key factors that they consider when deciding upon a disposition for an individual in a mental health crisis. Based on the multiple response categories we were able to pool responses into the top three key factors used in this often difficult decision making process. Once again we separated the Memphis department into non-CIT and CIT responses expecting differing results due to the differences in the amount of training and types of calls that CIT specifically receive. However, our results showed a unified Memphis department in terms of the top three key factors used to decide whether to arrest, release, or to provide some other disposition. Therefore, with the two Memphis groups re-combined the top three key factors that police officers listed in order included: 1) danger to self and others (78.0); 2) degree of subject impairment (30.0) and; 3) medication adherence (19.0). Birmingham (57.3) and Knoxville (73.1) police officers were also

more likely to note the dangerousness criteria first when making their disposition decision. The second key factor mentioned most for both sites was "the seriousness of the crime." However, on the third key factor, it was apparent that structural reasoning came in to the decision process, with Birmingham officers (22.0) more likely to note the "degree of impairment of the subject" and Knoxville officers (25.0) choosing the "availability of alternative placements."

When we considered the degree of overlap (possible combinations of factors used in making determinations about disposition), we basically found what we expected and more confirmation for the above findings. We were able to group all possible responses into 6 categories of deciding factors: 1) factors involving the subject specifically; 2) officer safety; 3) factors involving specialized response; 4) issues surrounding crime/violence; 5) mental health and substance abuse issues and; 6) other miscellaneous. Factors involving the "subject" included such concerns as: danger to self or others, degree of contact with reality, degree of cooperation, availability of a responsible person to care for the subject and the subject's ability to care for self. Officer safety is self explanatory and specialized response issues included: availability and response time — "if the team could get there in a reasonable amount of time, they'd wait, otherwise plan "two" might come into play". When considering crime issues as a factor, these would involve the seriousness of the crime, violence, weapons, escalation of the problem, and prior criminal contacts. Mental health/substance abuse included systemic reasoning and individual concerns: medication adherence, intoxication, and if currently in treatment, as well as opinion of the specialized response team or availability of a mental health disposition or alternative placement. Other included factors that we were unable to categorize or individual comments, such as: time, location of the incident, how far to the nearest hospital.

Overlap between these six categories can be explained as: 44% of the total sample only

noting decisions based on "subject " characteristics, 20% used both the combination of subject and crime concerns, and 8.4% of the total sample noted factors involving subject, crime and mental health and substance abuse. Memphis (11.3%) was more likely to consider factors involving subject and mental health issues in combination, which confirms the above findings as well.

[Exhibit 5]

III. Case Disposition and On-Scene Response

As seen in Exhibit 6, there was a notable difference across the three sites in the proportion of mental disturbance calls eliciting a specialized response. The differences appear to be partially related to the program structure, especially the availability in Memphis of a crisis triage center with a "no-refusal" policy for police cases, and partially related to staffing patterns.

[Exhibit 6]

In Knoxville, where the Mobile Crisis Unit was on the scene in 40% of the 100 cases examined, our interview data and police survey suggested that lengthy response times from the MCU posed a significant barrier to police utilization of that service. The MCU is responsible for covering five counties, including the city of Knoxville. Police often expressed frustration and concern about these delays, and frequently made disposition decisions (jail, detox, ER, or drop off "somewhere") without calling the MCU. In Birmingham, where 28% of the mental disturbance calls had a specialized response, there were only six CSO's for a police force of 921 officers, severely restricting their availability. This is especially true on weekends and nights when none of the CSOs are on duty and only one is on call. In Memphis, where there were 130 CIT officers for a police force of 1,354, the specialized response (CIT) was utilized in 95% of the 97 mental disturbance calls.

The next set of questions focused on the dispositions provided by specialized response personnel. As seen in Exhibit 7, for the total sample, 34.7% of the mental health incidents were resolved on-scene. Referrals to mental health specialists (ie., case managers, mental health centers or outpatient treatment) were made in 13% of all incidents and 45.7% were immediately transported to a treatment facility (psychiatric emergency room, general hospital ER, detox, or other psychiatric facility) or admitted for hospitalization. For the entire sample only 6.7% of the incidents resulted in arrest.

[Exhibit 7]

The disposition and program type were significantly related ($\chi^2 = 142.397$ df=6 $p<.0001$). The Birmingham CSOs tended to resolve most incidents on-scene (64%). Knoxville's Mobile Crisis Unit tended to refer subjects to mental health specialists as the predominant disposition (36%). The Memphis police-based CIT program resolved incidents on-scene less often than other programs (23%), yet they were more likely to transport to or place subjects into some type of mental health treatment (75%) than the other program sites.

Since all three programs are designed to divert persons suspected of having mental illness, whenever possible, from jail to the mental health services, one way to measure their relative effectiveness as true jail-diversion programs is to examine arrest records from the calls specifically related to mental illness. Indeed, Exhibit 7 shows that all three programs have relatively low rates of arrest for these types of calls (Teplin, 1986; Green, 1997) with those from Memphis, particularly low at 2%. This figure when compared to the 6.1% figure in Exhibit 6 for all mental disturbance calls resulting in arrest, reflects differences in the two samples. All 100 of the incident reports (Exhibit 7) had a CIT officer on-scene, however in the dispatch data set only 95% had the specialized CIT response. The calls involving the Knoxville police and the Mobile

Crisis Unit, also resulted in low arrest rates at 5% and the rate for Birmingham's CSO unit was only 13%.

IV. Program Response Times

Response time was examined for each of the program sites as a key variable of effectiveness. A common criticism of crisis programs is the amount of time it takes to respond to the emergency and how long the police officer must wait for additional help. When assessing response time for the three sites, the mean response time for our Birmingham sample was 23 minutes, with a maximum response time of 2 hours and 25 minutes. Knoxville's MCU mean response time was 33 minutes with a maximum of 3 hours, and the Memphis CIT mean time only 5 minutes with a maximum response time of 24 minutes. We found that 61 percent of the CIT calls were responded to within 0-5 minutes and 94 percent of all crisis calls within 0-10 minutes. The Birmingham CSOs were able to respond as quickly as 0-5 minutes in 13 % of the cases we examined, with nearly 50 % of the calls responded to in up to 15 minutes. The Knoxville Mobile Crisis Unit had the slowest response time, with a five county area to cover and few staff, the MCU responded to calls within 0-5 minutes in only 2.3% of the calls in our sample. They responded in up to 15 minutes in 22.3 percent of the calls. The officer survey and the key informant interviews illuminated the fact that lengthy response time was one of the largest complaints held by officers and consumers of services. Measuring a lengthy response time as anything over 40 minutes, 15% of the Birmingham calls were over this limit and 22% of the Knoxville calls were. None of the Memphis response times took over 40 minutes.

[Exhibit 8]

V. Arrest Charges

Across all three sites specialized response very few of the incidents actually ended in arrest (6.7%). When examining the types of arrest charges (n=19) that occurred in our sample, they split into two categories: 1) violent crimes such as aggravated assault and assault and battery (n=8) and; 2) minor offenses such as disorderly conduct, public intoxication, probation violation and traffic infractions (n=7). The rest of the charges (n=4) could be categorized into other crimes against person: harassment, menacing and verbal assault and property crimes: criminal mischief, tampering, trespassing and forgery. One case involved arson. These types of charges are not unusual for these types of incidents (Borum, Swanson, Swartz and Hiday, 1997; Green, 1997; Wolfe, Diamond, Helminiak,1997).

[Exhibit 9]

VI. Police Use of Physical Force

Police use of physical force was examined to further assess the descriptive nature of these types of calls and to gain more understanding as to whether force was used frequently with this population and whether force varied by type of incident and finally by program site. The results show that overall there were differences in the use of force by program site and that force was primarily used when there was a threat or perceived threat of violence. However, Knoxville police officers tended to be more likely to use physical force overall. When an incident involved the threat or fear of violence, Knoxville police used force in 14 out of 28 cases (50%). Under the same circumstances, Birmingham police used force in 3 of 19 incidents (16.0%) and the Memphis CIT used force in 2 out of 36 incidents that involved a threat of violence (5.6%).

[Exhibits 10, 11]

Discussion

Based on how the two pre-booking diversion programs and the traditional mobile mental health crisis team performed and were viewed by police officers in the three cities, there is strong reason to believe that specialized programs can succeed in improving outcomes for mentally ill people in crisis. In particular, these programs appear to hold promise for diverting mentally ill people from jail, keeping them in the community, and facilitating access to treatment. Across all three sites, only 6.7 % of the "mental disturbance" calls resulted in arrest - a rate which is only one third of that reported by Sheridan and Teplin (1981) for non-specialized police contacts with persons who were apparently mentally ill. In fact, our finding of the Memphis Crisis Intervention Team arrest rate at 2% is exactly comparable to that reported by Lamb et al. (1995) in their examination of the Los Angeles System Wide Mental Assessment Response Team (SMART), which further reinforces that a specialized response lowers the inappropriate use of arrest. Furthermore, in the present study, in over half of these encounters mentally ill subjects were either transported or referred directly to treatment resources, and in another third, officers were able to intervene and resolve the incident at the scene in a way that facilitated resolution of the crisis and allowed subjects to maintain their tenure in the community.

Each of these programs appears to have some particular strengths. The Memphis CIT program has apparently made the most positive impressions on the officers. Even when CIT officers are separated out from the larger Memphis sample, the remaining Memphis officers show a high regard for CIT on all program objectives. From our observations, and the open-ended questions on the officer survey, there appear to be two major reasons for the positive perceptions. The first is that the CIT program is police-based. The second is that the mental health infrastructure is also police friendly, and has a drop-off point with a "no-refusal" policy.

Police officers know they can count on CIT officers to appropriately handle a crisis and that they will not be expected to spend an enormous amount of down-time with the subject for a mental health evaluation.

The CIT program also has the most active procedures for linking people with mental illness into mental health treatment resources. Seventy-five percent of the "mental disturbance" cases in Memphis resulted in a "treatment" disposition, usually through transportation to the psychiatric emergency center. Certainly, not all of these people became engaged in effective, appropriate treatment, but a disposition that results in direct transport to a mental health treatment setting rather than transport to a jail is a very positive option for most people.

For the other innovative, police-based program (Birmingham's CSO program) there were also many positive features. The CSO officers appear to be particularly active and adept at on-scene crisis intervention. They were able to resolve almost two thirds of "mental disturbance" calls on scene without the necessity of further transportation or use of coercive procedures to facilitate treatment. With the immediate crisis resolved, this option allows most people with mental illness to remain safely in the community with available supports. On balance, their slim staffing pattern (six CSO's for a police force of 921 officers and four precinct areas), and limited response capability on nights and weekends may extend their response times and potentially limit the extent to which they are utilized. They were present on site for only 28% of all mental disturbance calls compared to 95% of Memphis mental disturbance calls having a CIT officer on-scene.

In Knoxville, the collaboration between the police and the MCU allowed people with mental illness to be linked into treatment resources through transport or referral in about three quarters of the cases, with very few incidents (5%) resulting in arrest. Of course, one of the key

concerns expressed about the MCU in this study was that response times were excessive and impractical. This led officers not to use the MCU as often as they otherwise might have, and forced them to consider alternate dispositions, although the MCU was on-scene in 40% of our sample of mental disturbance calls.

Thus, overall, these specialized programs appear to contribute to improved dispositions for those people with mental illness who may come into contact with the criminal justice system during a time of crisis. The success of these individual programs, in the broader view, appear linked to two overarching factors. The first is the existence of a psychiatric triage or drop off center where police can transport individuals in crisis. Because this reduces officer down time, it is an attractive dispositional alternative and immediately places the person in crisis within the purview of the mental health system as opposed to the criminal justice system. In our earlier national survey of police departments, those who had access to such a facility were twice as likely to rate their response to these calls as being effective as those who did not (Borum, et al., in press; Deane et al., in press).

The second factor is the centrality of community partnerships. Each of these departments view these programs as part of their community policing initiatives. A core component of this policing philosophy is that police agencies should join with the community in solving problems (Borum, et al. in press; BJA, 1994). The CIT program provides perhaps the clearest example of how this philosophy of police operations is applied to improve care for people with mental illness when they are most in need of assistance. The CIT program exists as a collaboration between the criminal justice system, local mental health professionals (both treatment providers and academics) and family advocates, in this case, the Memphis Alliance for the Mentally Ill (AMI).

The CIT program was created in response to an unfortunate encounter between a mentally ill individual who burglarized a residence and the Memphis Police Department who ended a complex apprehension situation by fatally shooting the mentally ill person. Subsequently, a new police chief with a community policing philosophy, the local AMI branch advocating for more humane alternatives, and a mental health community willing to create a new 40-hour police training curriculum and to teach it without charge once a year, all came together to design and implement this new model. Currently, they all continue to collaborate with the CIT program.

Our data strongly suggest that collaborations between criminal justice, mental health and the advocacy community when combined with essential elements in the organization of services, (e.g., a centralized crisis triage center specifically for police referrals), represent a major advance in reducing the inappropriate use of US jails to house persons with acute symptoms of mental illness. Given the overall findings from our case-studies, we believe that the Memphis CIT program and the Birmingham CSO program merit further in-depth examination. It would be informative to study the differences of these model as they relate to other communities, jurisdictions, and state laws. Most importantly, it is necessary to understand whether performances similar to those reported in this report are sustained. Also being diverted from jail is not the same as being linked effectively to integrated mental health services. Clearly then, further work is needed to build upon the promise of these innovative models.

Endnotes:

1. The Memphis Police Department and Mental Health system provide an annual training for new CIT personnel. This training is open to other interested participants — such as police department and/or mental health personnel from other jurisdictions. The training is 40 hours, however, Memphis has had to extend the training to 3 weeks to accommodate the growing number of participants.

2.This research was funded by NIMH. The survey instrument and list of participating police departments are provided in the Appendix.

3. See Steadman, Barbera, and Dennis (1994) which report that program ratings of perceived effectiveness correlate highly with program characteristics and objective measures of program success.

4. These strategies appear to differ substantially in their organization, policies, and procedures. The extent to which they actually do in practice will require on site observation. This type of investigation will be the next phase of the present study.

Exhibit 1

Police/Mental Health Crisis Response Model by Effectiveness Rating

Crisis Response Model	Frequency (n=174)	% (n=174)	% Moderate to Very Effective ^
*Police-Based Police Response	6	3.4	66.7
*Police-Based Mental Health Response	**20	11.5	70.0
+Mental Health-Based Mental Health Response (Mobile Crisis Teams)	52	29.8	82.0
No Specialized Response	96	55.2	69.8

^No difference in perceived effectiveness by model type.

*Includes programs that may use additional services as a secondary response.

**(8 MH Team programs: teams of social workers. 12 depts. have MH police-staff only - such as staff psychologist)

+ MCT category includes only those programs that rely solely on MCT.

Exhibit 2
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	.45
Hispanic	0.0	1.8	0.5	.45
Other	0.5	1.8	0.5	.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**	4.0	7.0	9.0	6.4

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

Exhibit 3
Police Officer Perceptions by Program Site

% Moderate to Very*	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

Abbreviation Key: B = Birmingham, K = Knoxville, M-N = Memphis Non-CIT M-C = Memphis CIT
* 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.

Exhibit 4
Police Department Effectiveness in Handling People with Mental Illness in Crises by Program Type

% 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

Abbreviation key: B= Birmingham, K=Knoxville, M-N - Memphis Non-CIT Officers, M-C= Memphis - CIT

Exhibit 5
Key Factors that Police Officers Consider in Deciding Disposition by Site

Top 3 Responses %	MEMPHIS CIT (n=36)	MEMPHIS NON-CIT (n=167)	BIRMINGHAM (n=150)	KNOXVILLE (n=52)	TOTAL % Across Sites (n=405)
1	Danger to Self or Others (75.0)	Danger to Self or Others (78.4)	Danger to Self or Others (57.3)	Danger to Self or Others (73.1)	Danger to Self or Others (70.0)
2	Degree of Subject Impairment (36.0)	Degree of Subject Impairment (28.1)	Seriousness of the Crime (28.0)	Seriousness of the Crime (27.0)	Degree of Subject Impairment (25.2)
3	Medication Adherence (25.0)	Medication Adherence (17.4)	Degree of Subject Impairment (22.0)	Availability of Alternative Placements (25.0)	Violence, aggression and Hostility (17.0)

Column percentages do not sum to 100% because multiple responses are possible and these are the top three of 21 possible categories.

Exhibit 6
"Mental Disturbance" Calls of Specialized Response: On-Scene and Arrest Disposition

Site	Mental Disturbance Calls	(%) Specialized Response On-Scene	(%) Arrested
Birmingham, AL (CSO)	100	28.0	13.0
Knoxville, TN (MCT)	100	40.0	5.0
Memphis, TN (CIT)	97	95.0	6.1

Exhibit 7
Disposition of Specialized Response Cases by Site

Initial Disposition	Birmingham (CSO) (n=100)	Knoxville (MCU) (n=100)	Memphis (CIT) (n=100)	Total (n=300)
Taken to Treatment Location	20.0	42.0	75.0	45.7
Resolved On-Scene	64.0	17.0	23.0	34.7
Referred	3.0	36.0	0.0	13.0
Arrested	13.0	5.0	2.0	6.7
Total	100.0	100.0	100.0	100.0

$\chi^2 = 142.397$ df = 6 $p<.0001$
Birmingham: Community Service Officers
Knoxville: Mobile Crisis Unit
Memphis: Crisis Intervention Team

Exhibit 8
Response Times for Crisis Calls by Program Site

Response Times	Birmingham CSO % (n=78)	Knoxville MCU % (n=88)	Memphis CIT % (n=79)
0-5 minutes	13.0	2.3	61.0
6-10 minutes	15.4	6.0	33.0
11-15 minutes	21.0	14.0	5.1
16-20 minutes	15.4	23.0	0.0
21-40 minutes	21.0	34.0	1.3
41-60 minutes	9.0	15.0	0.0
61+ minutes	6.4	7.0	0.0

Mean Response Time and Ranges:
Birmingham CSO: mean: 23 min — range: 0-145 min
Knoxville MCU: mean: 33 min — range: 0-180 min
Memphis CIT: mean: 5 min — range: 0-24 min

Exhibit 9
Types of Charges Resulting in Arrest

Charges	Frequency n=19	(%) with Charge
Violent: Aggravated Assault, Assault and Battery	8	42.1
Potentially Violent: Arson	1	5.3
Other Crimes Against Person: Harassment, Menacing, and Verbal Assault	2	10.5
Property: Criminal Mischief, Tampering, and Destruction, Trespassing, and Forged Check	1	5.3
Minor: Disorderly Conduct, Probation Violation, Public Intoxication, Traffic	7	36.8

Multiple criminal charges possible -- up to three charges per incident may have been reported.
Charges in this table are ordered by seriousness.

Exhibit 10
Police use of Physical Force by Site

Use of Force (%)	Birmingham n=97	Knoxville n=96	Memphis n=84	Total n=277
No	88.7	79.2	95.2	87.4
Yes	11.3	20.8	4.8	12.6
Total	100.0	100.0	100.0	100.0

χ^2=10.709 df=2 p<.005

Exhibit 11
Police Use of Force Under Threat of Violence by Program Site

Use of Force (%)	Birmingham (CSO) (n=19)	Knoxville (MCU) (n=28)	Memphis (CIT) (n=36)	Total (n=83)
No Use of Force	84.2	50.0	94.4	77.1
Use of Force	15.8	50.0	5.6	23.0

χ^2=18.329 df=2 p<.0001 contingency coefficient = .425 p<.0001

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Appendix

City of Police Department
(Participants in Police Department Mail Survey)

1. ABILENE
2. AKRON
3. ALBANY
4. ALBUQUERQUE
5. ALEXANDRIA
6. ALLENTOWN
7. AMARILLO
8. AMHERST
9. ANAHEIM
10 ANCHORAGE
11. ANN ARBOR
12. ARLINGTON
13. ATLANTA
14. AURORA
15. AUSTIN
16. BAKERSFIELD
17. BALTIMORE
18. BATON ROUGE
19. BEAUMONT
20. BERKELEY
21. BIRMINGHAM
22. BOISE
23. BOSTON
24. BRIDGEPORT
25. CEDAR RAPIDS
26. CHESAPEAKE
27. CHICAGO
28. CHULA VISTA
29. CINCINNATI
30. COLORADO SPRINGS
31. COLUMBUS, GA
32. COLUMBUS, OH
33. CONCORD
34. CORPUS CHRISTI
35. DALLAS
36. DAYTON
37. DENVER
38. DES MOINES
39. DETROIT
40. DURHAM
41. EL PASO
42. ELIZABETH
43. ELMONTE
44. ESCONDIDO
45. EUGENE
46. EVANSVILLE
47. FLINT
48 FORT WAYNE
49 FORT WORTH
50. FREMONT
51. FT LAUDERDALE
52. FULLERTON
53. GARDEN GROVE
54. GARLAND
55. GLENDALE, AZ
56. GLENDALE, CA
57. HAMPTON
58. HARTFORD
59. HAYWARD
60. HEMPSTEAD
61. HIALEAH
62. HOLLYWOOD
63. HONOLULU
64. HOUSTON
65. HUNTINGTON BEACH
66. HUNTSVILLE
67. INDEPENDENCE
68. INDIANAPOLIS
69. INGLEWOOD
70. IRVINE
71. IRVING
72 JACKSON
73. JERSEY CITY
74. KANSAS CITY, KA
75. KANSAS CITY, MO
76. KNOXVILLE
77. LAKEWOOD
78. LANSING
79. LAREDO
80. LEXINGTON
81. LINCOLN
82. LITTLE ROCK
83. LONG BEACH
84. LOS ANGELES
85. LOUISVILLE
86. LOWELL
87. LUBBOCK
88. MACON
89. MADISON
90. MEMPHIS
91. MESA
92. MESQUITE
93. MIAMI
94. MILWAUKEE
95. MINNEAPOLIS
96. MOBILE
97. MODESTO
98. MONTGOMERY
99. NASHVILLE
100. NEW HAVEN
101. NEW YORK CITY
102. NEWARK

103. NEWPORT NEWS
104. NORFOLK
105. OAKLAND
106. OCEANSIDE
107. OKLAHOMA CITY
108. OMAHA
109. ONTARIO
110. ORANGE
111. ORLANDO
112. OVERLAND PARK
113. OXNARD
114. PASADENA, CA.
115. PASADENA, TX
116. PATERSON
117. PEORIA
118. PHILADELPHIA
119. PHOENIX
120. PITTSBURGH
121. PLANO
122. POMONA
123. PORTLAND
124. PORTSMOUTH
125. PROVIDENCE
126. RALEIGH
127. RENO
128. RICHMOND
129. RIVERSIDE
130. ROCHESTER
131. ROCKFORD
132. SACRAMENTO
133. SALEM
134. SALINAS
135. SALT LAKE CITY
136. SAN ANTONIO
137. SAN BERNARDINO
138. SAN DIEGO
139. SAN FRANCISCO
140. SAN JOSE
141. SANTA ROSA
142. SAVANNAH
143. SCOTTSDALE
144. SEATTLE
145. SIMI VALLEY
146. SIOUX FALLS
147. SMITHTOWN
148. SOUTH BEND
149. SPOKANE
150. SPRINGFIELD, IL
151. SPRINGFIELD, MO
152. ST LOUIS
153. ST PAUL
154. ST PETERSBURG
155. STERLING HGTS
156. STOCKTON
157. SUNNYVALE
158. SYRACUSE
159. TACOMA
160. TALLAHASSEE
161. TAMPA
162. TEMPE
163. TOLEDO
164. TOPEKA
165. TUCSON
166. TULSA
167. VIRGINIA BEACH
168. WACO
169. WASHINGTON
170. WATERBURY
171. WICHITA
172. WINSTON-SALEM
173. WORCESTER
174. YONKERS

POLICE MENTAL HEALTH DIVERSION PROGRAMS SURVEY

Name of Person Completing Form: _____

Title: _____

Address: _____ _____

_____

City: _____ Sate: _____ Zip: _____

Today's Date: _____ /_____ / _____ Telephone #: (_____) _____

SECTION I: BACKGROUND INFORMATION

1. Estimated city population: _____
2. Number of sworn officers: _____
3. Estimated number of arrests in 1995: _____
4. Estimated percentage of police contacts that involve persons with mental illnesses: _____%
5. Do you have any community policing initiatives currently underway? 1□ Yes 0 □ No

SECTION II: POLICE MENTAL HEALTH DIVERSION

	Yes 1	No 0
1. Does your jurisdiction have any policies, procedures or formal arrangements that are specifically designed to divert or provide specialized crisis assistance to persons with mental illness into treatment who would otherwise be arrested?	□	□

	Yes 1	No 0
2. Does your department provide training to officers in managing person with acute mental illnesses?	□	□
Does your department have special mental health officers/deputies who are employees of your department?	□	□
Does your department have any arrangements with local mental health agencies to provide:		
a. telephone consultations during incidents involving persons with mental illness	□	□
b. involuntary hospitalization for persons with mental illness?	□	□
c. provision of on-site mobile emergency psychiatric evaluation of mentally ill citizens?	□	□
d. availability of a crisis center for police to drop off patients?	□	□
e. other collaborations with emergency mental health services?	□	□
If yes, please specify: _____	□	□
_____	□	□

3. Using the following scale, please rate the overall effectiveness of your department's ability to respond to a person with mental illness who are in crisis *(circle one)*.

1	2	3	4	5
Not al all Effective	Barely Effective	Somewhat Effective	Moderately Effective	Very Effective

4. ☐ Yes, I would like to receive a copy of the survey report.

Thank you very much for your time. Please return this form in the stamped, self-addressed envelope to ***Policy Research Associates, 262 Delaware Avenue, Delmar, New York 12054.*** *If you have any questions, please call Bonita Veysey, Ph.D. at (518) 439-7415 ext. 230.*

3/96

Police Response to Emotionally Disturbed Persons

Section I: Memphis Police Chief Interview

Date / / Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____

What is your official position or job title: _____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

The CIT program has established national recognition as a unique police response to persons with mental illnesses. We would like to ask you a few specific questions about the situation here in Memphis:

1a. Relative to other problems that a police department might experience, how big of a problem would you say emotionally disturbed persons (EDP's) are for the Memphis Police Department?

1b. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

2. What do you feel are the keys elements for effective police response to EDP's (ie., what do you need to do your job well?)

3. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

4. Overall, how well prepared are the CIT officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:** (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

6. How helpful is the mental health system in providing assistance to your officers when they are handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

7. What could the mental health system do to be more responsive to your needs as a police department?

8. What do you think the "non-CIT" patrol officer's attitudes are toward the CIT officers?

9. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)
   Yes ___ No___

10. What was the most difficult part of applying the CIT program in Memphis?

11. What would be the most difficult part of the program to transfer to other jurisdictions?

12. What advice would you have for other department who are thinking of implementing a CIT program?

13. In what ways do you think the CIT program in Memphis is different than that in other cities like Portland or Albequerque?

14. What do you think could be done in Memphis to make police response to emotionally disturbed persons better?

Thank you for your time

Police Response to Emotionally Disturbed Persons

Section II: Police Manager/ CIT Coordinator Interview

Date / / Form ID# **Memphis** City Code 04

Background Information

For our records, who is your employer?_____
What is your official position or job title: _____
How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

The CIT program in Memphis has established national recognition as a unique police response to persons with mental illnesses. First of all, let me make sure that I know the way the program operates. My understanding is:

Some Probes:
Step by Step way the system works:

When might a CIT call the mobile crisis unit?
Do non-CIT patrol officers call Mobile Crisis directly?
When might a patrol officer call Mobile Crisis directly?
How big of a problem were EDP's prior to the CIT program?
How were EDP's handled prior to the CIT program?

1. Please describe your professional responsibilities:

2. Relative to other police department problems, how big of a problem are EDP's for the Memphis Police Department?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

3. About how many police calls for Emotionally Disturbed Persons have you had in the last month: (estimate) _____

4 About how many hours of training do CIT officers receive for handling emotionally disturbed persons? _____

5. About how many hours of continuing education do CIT officers receive for handling emotionally disturbed persons? _____

6. Can you describe some of the training procedures to us?

7. Overall, how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

9. Overall, how well prepared is the Mobile Crisis Team to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

10. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:** (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

11. How helpful is the mental health system in providing assistance to you when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

12. Do you have access to specialized on-site assistance from mobile mental health crisis for emotionally disturbed person cases?

Yes ___ No___

13. How satisfied are you with their response time?

1	2	3	4
Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very satisfied

14. How helpful is the ER in providing assistance to you when handling emotionally disturbed persons?

1	2	3	4
Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very satisfied

15. How easy is it to get an EDP admitted to a hospital when it is necessary?

press). Additional CIT programs, based on the Memphis model, have been developed in Waterloo, IA, Portland, OR, Albuquerque, NM, and Seattle, WA. San Jose, CA will be implementing CIT in January 1999 and numerous other departments are in the early planning phases of implementation[1].

In 1987, following a police shooting incident involving a mentally ill person, under the aegis of the Memphis mayor's office, the Police Department formed a partnership with the Memphis Chapter of the Alliance for the Mentally Ill, the University of Memphis and the University of Tennessee, to develop a specialized unit within the Police Department to manage community crises, and to intervene with mentally ill people in a safe, effective and professional manner. As part of their charge, the mayor's office requested that this be a collaborative community effort which tapped community resources. Accordingly, memorandums of Agreement were signed among participants indicating that services would be provided voluntary and at no expense to the City of Memphis. The Memphis Police Department responded to this directive by developing a cadre of specially-trained officers known as the Crisis Intervention Team (CIT). The Memphis CIT officers are trained to immediately transport individuals they suspect of having mental illness to the UT psychiatric emergency service, after the situation has been assessed and diffused. Some fewer calls end with the individual being transported directly to the local inpatient Crisis Stabilization Unit.

Currently, the CIT is composed of 130 patrol officers, covering four overlapping shifts in each precinct. The program operates on a generalist-specialist model, so that CIT officers provide a specialized response to "mental disturbance" calls in addition to their regularly assigned patrol duties. After being selected into the CIT program, police officers receive 40-hours of specialized training from mental health providers, family advocates and mental health

20. Do you believe that the CIT program would work well as "model" of crisis response to emotionally disturbed persons for other police departments? (why or why not?)

Yes ___ No___

21. What was the most difficult part of applying the CIT program in Memphis?

22. What would be the most difficult part of the program to transfer to other jurisdictions?

23. What advice would you have for other department who are thinking of implementing a CIT program?

24. In what ways do you think the CIT program in Memphis is different than that in other cities like Portland or Albequerque?

25. In setting up/operating an appropriate program, who are the key players in the community?

26. Do you believe that managed care is changing any of this in Memphis? If so, how?

Police Response to Emotionally Disturbed Persons

Section III: Mobile Mental Health Crisis Team Director Interview

Date / / Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____

What is your official position or job title: _____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to examine the Memphis Police Department's CIT program. We would also like to understand how they interface with the mental health system. We would like to ask you some questions about your program and also find out about your experience with the CIT program.

1. Please describe your professional responsibilities:

2. So that we can understand how your program works, could you please describe for us how you operate, what types of calls you receive and how you might respond?

Probes:
Does Mobile Crisis go to the jail for calls?
Do they conduct pre-certification for TennCare?
Respite?
How are they Funded?
Where do your referrals come from?

3. About how many crisis calls for emotionally disturbed persons have you had in the last month: (can estimate) _____

4. Do you ever receive calls for assistance from the Memphis Police Department's CIT's?
Yes___ No____

5. Overall how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Overall, how well prepared are "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Overall, how well prepared is the Mobile Crisis Unit to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:**
(circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

9. Do you ever request CIT assistance? (If not, skip next question)

1	2	3	4

Never Rarely Sometimes Often

10. How often would you estimate that you request CIT assistance per month? (#) _____

11. How helpful is the law enforcement system in providing assistance to mobile crisis when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

12. How satisfied are you with their response time?

1	2	3	4
Not at all satisfied	Somewhat satisfied	Moderately satisfied	Very satisfied

13. How helpful is the ER in providing assistance when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

14. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Please answer the following questions to the best of your ability:

15. When the Mobile Crisis team encounters a person who currently appears to be showing signs of serious mental illness, but who has done something for which s/he could be legally charged with a crime, generally, how does mobile crisis respond?

16. What do you feel are the key elements for effective police response to EDP's (ie., what do you need to do your job well?)

17. What could the mental health system do to be more responsive to the needs of the CIT officers?

18. Do you believe that the CIT program would work well as a model of crisis response to emotionally disturbed persons for other police departments?

Yes ___ No___

19. What would be the most difficult component of the program to transfer to other jurisdictions?

20. In setting up/operating an appropriate police/mental health response program, who are the key players in the community?

21. How do you believe the CIT program fits into the mental health system?

22. How is the relationship between the CIT officers and the mental health system?

1	2	3	4
Not at all good	Somewhat good	Moderately good	Very good

23. Do you believe that managed care in Memphis is changing how you do your job? If so, how?

Police Response to Emotionally Disturbed Persons

Section IV: Mental Health Center Director Interview

Date ___/___/___ Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____
What is your official position or job title: _____
How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to examine the Memphis Police Department's CIT program. We would also like to understand how they interface with the mental health system. We would like to ask you some questions about the mental health system in Memphis and also find out about your experience with the CIT program.

1. Please describe your professional responsibilities:

2. How do you believe the CIT program fits into the mental health system?

3. Overall, how well prepared are the CIT officers when handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

4. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. Overall, how well prepared is the Mobile Crisis Unit to handle EDP's who may be charged with an offense?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:** (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

7. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

8. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Please answer the following questions to the best of your ability:

9. What do you feel are the key elements to effective Police/Mental Health response to EDP's (ie.,what would help the police department and mental health professionals do their job well)

10. What could the mental health system do to be more responsive to the needs of the CIT officers?

11. What could the CIT officers do to be more responsive to the needs of those in the Mental Health system?

12. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments?

Yes ___ No___

13. What would be the most difficult part of the program to transfer to other jurisdictions?

14. In setting up/operating an appropriate Police/Mental Health response program, who are the key players in the community?

15. Do you believe that managed care is changing the way in which crisis situations are handled in Memphis? If so, how?

Police Response to Emotionally Disturbed Persons

Section V. Psychiatric Emergency Room Director Interview

Date / / Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____
What is your official position or job title: _____
How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to understand how the Memphis Police Department's CIT program works and how it might be useful to other places in the U.S. We would also like to understand how they interface with the mental health system and use the psychiatric emergency room for crisis situations. We would like to ask you some questions about the ER and about your experience with the Memphis Police Department and the CIT officers in particular.

1. Could you describe for us your professional responsibilities?

2. Could you describe for us the way in which police referrals are handled at the MED?

3. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

4. Is there any specific funding for police cases?

Yes ____ No ____

5. How does your staff handle persons who are referred with dual diagnosis?

6. Overall how well prepared are CIT officers when handing emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

8. Relative to other police department problems, how big of a problem are emotionally disturbed persons (EDP's) for the Memphis Police Department?

9. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

10. What do you feel are the key elements to effective police response to EDP's (ie., what would they need to do their job well?)

11. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:** (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

12. How do you think the mobile mental health crisis team responds to persons with mental illnesses in your community?

13. In your opinion, what could be done to improve the CIT response to persons with mental illness in crisis?

14. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)

Yes ___ No___

15. What would be the most difficult part of the program to transfer to other jurisdictions?

16. In setting up/operating an appropriate crisis response program, who are the key players in the community?

17. Do you believe that managed care is changing the way in which crisis situations are handled in Memphis? If so, how?

18. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary?

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Police Response to Emotionally Disturbed Persons

Section VI: Psychiatric Emergency Room Staff Interview

Date ___/___/___ Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____

What is your official position or job title: _____

How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

We are here to understand how the Memphis Police Department's CIT program works and how it might be useful to other places in the U.S. We would also like to understand how they interface with the mental health system and use the psychiatric emergency room for crisis situations. We would like to ask you some questions about the MED and your experience with the Memphis Police Department and the CIT officers in particular.

1. Please describe your professional responsibilities

2. Could you describe for us the way in which police referrals are handled at the ER?

3. How helpful is the ER in providing assistance to the CIT officers when handling emotionally disturbed persons?

1	2	3	4
Not at all helpful	Somewhat helpful	Moderately helpful	Very helpful

4. How does the ER staff handle persons who are referred with dual diagnosis?

5. Overall, how well prepared are the CIT officers when handing emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Overall, how well prepared are the "non-CIT" patrol officers to handle EDP's in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

7. Relative to other police department problems, in your opinion, how big of a problem are emotionally disturbed persons (EDP's) for the Memphis Police Department?

8. Can you put a number on that for us?

1	2	3	4
Not at all	Somewhat	Moderate	Significant

9. What do you feel are the key elements to effective police response to EDP's (ie., what would they need to do their job well?)

10. **How effective do you believe the Memphis CIT Program is for handling "emotionally disturbed persons in crisis" in accomplishing the following objectives:** (circle one for each answer)

Allowing police officers to do what their job should be?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Meeting the needs of emotionally disturbed persons in crisis?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Keeping emotionally disturbed persons out of jail?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

Reducing the amount of time the officers spend on these types of calls?

1	2	3	4
Not at all Effective	Somewhat Effective	Moderately Effective	Highly Effective

11. How do you think the mobile mental health crisis team responds to persons with mental illnesses in your community?

12. In your opinion, what could be done to improve the CIT response to persons with mental illness in crisis?

13. Do you believe that the CIT program would work well as a "model" of crisis response to emotionally disturbed persons for other police departments? (Why or why not?)

Yes ___ No___

14. What would be the most difficult part of the program to transfer to other jurisdictions?

15. In setting up/operating an appropriate crisis response program, who are the key players in the community?

16. Do you believe that managed care is changing the way in which crisis situations are handled in Memphis? If so, how?

17. How easy is it to get an emotionally disturbed person admitted to a hospital when it is necessary

1	2	3	4
Not at all easy	Somewhat easy	Moderately easy	Very easy

Police Response to Emotionally Disturbed Persons

Section VII: AMI Representative Interview

Date / / Form ID# **Memphis** City Code 03

Background Information

For our records, who is your employer?_____
What is your official position or job title: _____
How long have you been with your current agency: _____yrs. _____mos.

How long have you been in your current position: _____yrs. _____mos.

What is your involvement in the CIT program?

Interview

1. We are here to understand how the Memphis Police Department's CIT program works and how it might useful to other places in the U.S. We would like to ask you some questions about AMI's role with the CIT program and to gain some understanding of how AMI thinks the program works.

   Our understanding of AMI's role in the CIT program is this:

   Do we have this right? Is there anything else we should we know?

2. What kind of a relationship would you say that AMI has with the Memphis Police Department?

1	2	3	4
Not at all good	Somewhat good	Moderately good	Very good

3. Are there any specific training needs for police officers that you feel would improve the department's response to people with severe mental illness?

4. Overall how well prepared are the CIT officers are in handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

5. Overall how well prepared are the "non-CIT" patrol officers in handling emotionally disturbed persons in crisis?

1	2	3	4
Not at all prepared	Somewhat prepared	Moderately prepared	Very well prepared

6. Can you recall any serious incidents regarding a person with mental illness and a CIT officer? (If yes, examples)

POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESS IN CRISIS
Patrol Officer Survey

Date ___/___/___ Form ID# ___ ___ ___ ___ Roll Call Shift Time: _____

Please circle the number:

1. How well prepared do <u>you</u> feel when handling people with mental illness in crisis?

1 Not at all prepared | 2 Somewhat prepared | 3 Moderately well prepared | 4 Very well prepared

2. Overall, how well prepared do you think the other patrol officers in the police department are to handle people with mental illness in crisis? (In Memphis, non-CIT patrol officers)

1 Not at all prepared | 2 Somewhat prepared | 3 Moderately well prepared | 4 Very well prepared

3. Overall, how effective do you believe your department's response to handling people with mental illness in crisis is in accomplishing the following objectives:
(circle one for each answer)

a. Meeting the needs of people with mental illness in crisis?
1 Not at all Effective | 2 Somewhat Effective | 3 Moderately Effective | 4 Very Effective

b. Keeping people with mental illness out of jail?
1 Not at all Effective | 2 Somewhat Effective | 3 Moderately Effective | 4 Very Effective

c. Minimizing the amount of time officers spend on these types of calls?
1 Not at all Effective | 2 Somewhat Effective | 3 Moderately Effective | 4 Very Effective

d. Maintaining community safety?
1 Not at all Effective | 2 Somewhat Effective | 3 Moderately Effective | 4 Very Effective

4. Relative to other problems the department faces, how big of a problem are people with mental illness in crisis for the Birmingham Police Department?

1 Not at all a problem | 2 Somewhat of a problem | 3 A moderate problem | 4 A big problem

5. About how many encounters with mentally ill people in crisis have you had in the past month:
___ ___

6. How helpful is the mental health system in providing assistance to you when you are handling people with mental illness in crisis?

1 Not at all helpful | 2 Somewhat helpful | 3 Moderately helpful | 4 Very helpful

7. How effective is the emergency room in providing assistance to you when you are handling people with mental illness in crisis?

1 Not at all helpful | 2 Somewhat helpful | 3 Moderately helpful | 4 Very helpful

8. Have you ever called a CSO for assistance?

1 Yes | 0 No *(if no, skip to #10)*

(If Yes to #8, please answer)

9. About how many calls for CSO back-up have you had in the past month? _____ _____

(over)

Please answer the following questions briefly to the best of your ability.

8. **When you encounter a person who currently appears to be showing signs of serious mental illness, list or describe the key factors that you consider in deciding whether to arrest, to release, or to provide some other disposition?**

9. **What could the mental health system do to be more responsive to police officers in responding to calls involving emotionally disturbed people in crisis?**

10. **What would help you or your department enhance your effectiveness in providing an appropriate response to people with mental illness in crisis?**

11. **What is the single most difficult or frustrating factor you encounter when you attempt to respond to calls involving people with mental illness in crisis?**

Please fill out background information (this remains confidential and seen only by the research team)

12. Age: ___ ___			
13. Race/Ethnicity:	1 ☐ White (Non-Hispanic) 2 ☐ African American	3 ☐ Asian 4 ☐ Hispanic	5 ☐ Other (specify:_____)
14. Gender:	1 ☐ Male 2 ☐ Female		
15. Officer Rank	_____		
15. Number of Years in the Police Department	___ ___		
16. Department Precinct	_____		

POLICE/MOBILE MENTAL HEALTH CRISIS RESPONSE PROJECT

Disposition Coding Form - Memphis, TN

Date Coded ___ ___ / ___ ___ / ___ ___ Case ID# 3 ___ ___ ___ Coder: ___ ___

SUBJECT DEMOGRAPHICS

1. Age ___ ___
   (Code 99 for Don't Know)

2. Sex: 1 ☐ Male
   0 ☐ Female
   9 ☐ Don't Know

3. Race: 1 ☐ African American 4 ☐ White
   2 ☐ Asian 7 ☐ Other: _____
   3 ☐ Hispanic 9 ☐ Don't Know

---

4. Date of Incident: ___ ___/___ ___/___ ___

5. Time of Incident: ___ ___ : ___ ___ *(military time)*

6. Precinct: ___ ☐
   1 = N 5 = Central
   2 = S 6 = Downtown
   3 = E 7 = Public
   4 = W Housing
   9 = Don't Know

---

7. Call initially dispatched to: Patrol Officer: 0 ☐ No 1 ☐ Yes MCU: 0 ☐ No 1 ☐ Yes CIT: 0 ☐ No 1 ☐ Yes

8. CIT called by Patrol Officer: 0 ☐ No
   1 ☐ Yes Time called: ___ ___ : ___ ___ *(military time)* Time arrived: ___ ___ : ___ ___ *(military time)*

9. MCU called: 0 ☐ No ***(skip to #11)***
   1 ☐ Yes Time called: ___ ___ : ___ ___ *(military time)* Time arrived: ___ ___ : ___ ___ *(military time)*

10. MCU called by: 1 ☐ CIT
    2 ☐ Patrol officer

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11. Nature of Incident *(check all that apply)*

- ☐ Disorderly/disruptive behavior
- ☐ Neglect of self -care
- ☐ Public intoxication
- ☐ Interfering with business
- ☐ Trespassing
- ☐ Nuisance (loitering, panhandling)
- ☐ Destruction of property
- ☐ Theft/other property crime
- ☐ Alcohol or drug offense
- ☐ Suicide threat or attempt
- ☐ Threat of violence to others
- ☐ Battery/violence toward another person
- ☐ Other (Please specify: _____)
- ☐ No information

11a. Threats/Violence For each relationship category, code whether this person was involved in the incident and whether the subject threatened or was violent towards that person.

0 = Involved, but no threat or violence
1 = Threat only
2 = Violence
3 = Don't know whether threat / violence
8 = Not involved in incident
9 = Don't know whether involved

_____Partner/spouse
_____Boyfriend/girlfriend
_____Parent
_____Sibling
_____Other family member
_____Friend/acquaintance
_____Police officer
_____Business owner
_____Other stranger

12. Weapons Involvement

Did subject use/brandish a weapon?
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If YES :

Type of weapon *(check all that apply)*
☐ Knife ☐ Rifle
☐ Gun ☐ Other (specify_____)

Did the weapon cause injury to target?
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

Did the weapon cause injury to subject?
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

13. Complainant Relationship *(check one)*

01 ☐ Partner/spouse
02 ☐ Boyfriend/girlfriend
03 ☐ Parent
04 ☐ Sibling
05 ☐ Friend/acquaintance
06 ☐ Business owner
07 ☐ Other family member
08 ☐ Police observation
77 ☐ Other stranger
99 ☐ Don't Know

14. Location of Incident *(check one)*

1 ☐ Subject's home
2 ☐ Other home
3 ☐ Street
4 ☐ Bar
5 ☐ Subjects workplace
6 ☐ Other commercial or business
7 ☐ Other location (Please specify:_____)
9 ☐ No information

15. Medication Adherence *(check one)*

1 ☐ Subject (or Other) reports that subject has not been prescribed psychotropic medication
2 ☐ Subject (or Other) reports that subject has been taking prescribed psychotropic medication as prescribed (Please specify medication:_____)
3 ☐ Subject (or Other) reports recent nonadherence with prescribed psychotropic medication (Please specify medication:_____)
4 ☐ Subject (or Other) reports subject has been prescribed psychotropic medication but no information about medication adherence
9 ☐ No information concerning prescribed psychotropic medication

16. Symptoms Evident at Time of Incident *(check all that apply)*

- ☐ Disorientation/confusion
- ☐ Delusions (specify if known:_____)
- ☐ Hallucinations (specify if known: _____)
- ☐ Disorganized speech (freq. derailment, incoherence)
- ☐ Disorganized or bizarre behavior
- ☐ Manic (elevated/expansive mood, inflated self-esteem, pressured speech, flight of ideas, distractable)
- ☐ Depressed (sadness, loss of interest in activities, loss of energy, feelings of worthlessness)
- ☐ Unusually scared or frightened
- ☐ Belligerent or uncooperative (angry or hostile)
- ☐ No information

17. Prior Contacts *(check all that apply)*

Known person (from prior police contacts)
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

Repeat call (w/in 24 hrs.)
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

18. Drug/Alcohol Involvement

Evidence of acute intoxication
1 ☐ Yes 0 ☐ No 9 ☐ Don't Know

If YES:
1 ☐ Alcohol
2 ☐ Other drug (specify:_____)
9 ☐ Don't Know

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19. Incident injuries:

Were there any injuries during incident to: *(check all that apply)*

☐ Subject
☐ Family members
☐ Patrol officers
☐ CIT
☐ Mental health staff
☐ Other citizens

If YES, by whom:(_____)

Did the police use physical force on the subject during the encounter?

0 ☐ No
1 ☐ Yes (please specify: _____)
9 ☐ Don't Know

Did the police draw or threaten to use any weapons during the encounter?

0 ☐ No
1 ☐ Yes (please specify: _____)
9 ☐ Don't Know

Did the police actually use any weapons during the encounter?

0 ☐ No
1 ☐ Yes (please specify: _____)
9 ☐ Don't Know

---

20. Initial Disposition: *(check all that apply)*

☐ No Action/resolved on scene
☐ On-scene crisis intervention
☐ Police notified case manager or mental health center
☐ Outpatient / Case management referral
☐ Transport

If YES, where to:

01 ☐ Psychiatric ER (MED in MPH)
02 ☐ Other psychiatric facility
03 ☐ Hospital (general/ER)
04 ☐ Detox
05 ☐ Residence
06 ☐ Home/other
07 ☐ Shelter/emergency housing
08 ☐ Police department/jail
77 ☐ Other
99 ☐ Don't Know

☐ Admission to hospital for Medical (non-psychiatric) reasons
☐ Admission to psychiatric hospital or unit

If YES:

Legal Status of Psychiatric Admission

1 ☐ Voluntary 2 ☐ Involuntary/pre-commitment hold (or detention) 9 ☐ Don't Know

Facility

Name: _____ ☐☐

☐ Admitted to Detox
☐ Arrested

If YES:

Most Serious Charges (3) _____ ☐☐
_____ ☐☐
_____ ☐☐

☐ Other (specify: _____)

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21. Incident Description: (Please give us a brief synopsis of the incident (who did what to whom). Include information that helps to give a better understanding of the incident (i.e., relevant quotes).

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