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What can we expect of police in the face of deficient mental health systems? Qualitative insights from Chicago police officers

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Accessible summary

What is known on the subject?

- People with serious mental illnesses are overrepresented in the criminal justice system.
- Interventions such as Crisis Intervention Teams and Co-responder Teams may improve police officers' ability to provide effective response.
- There is still a gap in our knowledge of the nature of the situations officers are responding to and their perceptions of what is needed for effective response.

What this paper adds to existing knowledge?

- This paper provides insight into officer perceptions and experiences of the mental health-related calls they respond to involving youth, adults and families.
- Officers often refer to people in crisis as having "gone off meds" but also recognize more complex factors at the individual level (e.g., co-occurring issues), family level (challenges of caring for a loved one with mental illness) and community level (deficiencies in health and social resources to address long-term unmet needs).
- Deficiencies in the resources needed to address the unmet needs of people and their families frustrate officers' desires to make a difference and effect long-term outcomes.

What are the implications for practice?

- Findings underscore the need for cities and communities to develop alternatives to emergency departments which, in the long term, may provide the best hope for reducing the reliance on police as mental health interventionists. Formal collaborations between the law enforcement community and the mental health nursing community could be focused towards this end.
- Findings provoke the larger question of what should "count" as good police work in the face of deficient community health systems. Practitioners should consider the distinction between police effectiveness and "whole system" effectiveness. Police officers could be held to account for "principled encounters" that are resolved in ways that reduce immediate harm, avoid stigma and advance procedural justice, but the full impact of their effects is contingent on the capacity of the wider system to do its job.

- Mental health nurses are well positioned to assist with officer training and provide support to officers responding to mental health-related situations.

Abstract

Introduction: Data on fatal outcomes of police encounters, combined with evidence on the criminalization of people with mental illnesses, reveal a grave need to improve outcomes for individuals with mental illnesses who come into contact with police. Current efforts are hampered by a lack of in-depth knowledge about the nature of nature and context of these encounters.

Aim/Question: Building on previous findings from a larger study on the nature and outcomes of mental health-related encounters with police in Chicago, this paper examines officer perspectives on the unmet needs of individuals and their families and the ways in which the mental health and social system environment constrain officers' abilities to be responsive to them.

Methods: Findings are drawn from qualitative data produced through 36 "ride-alongs" with police officers. Field researchers conducted open-ended observations of police work during routine shifts and carried out interviews with officers—according to a ride-along question guide—during periods of inactivity or between calls for service to ask about experiences of mental health-related calls. Field notes describing their observations and ride-along interviews were analysed inductively using a combination of open and focused coding.

Results: Officers responded to a variety of mental health-related calls revealing complex, unmet needs at individual and family levels. A common theme related to officers' perceptions that "going off meds," combined with other situational factors, resulted in police being involved in behavioural health situations. The data also revealed broader aspects of the health and social system that, in officers' minds, constrain their ability to effect positive outcomes for people and their families, especially in the long term.

Discussion: Findings beg the larger question of what it is we, as a society, should expect of police in the handling of mental health-related calls, given their concerns with the wider health and social service system that they experience as deficient. At the same time, the view that "going off meds" is a common trigger of mental health-related events should be interpreted with care, as it may signal or perhaps serve as a shorthand for more complex health and social needs that could be obscured by a pharmacological or medicalized perspective on mental illness. This is an important area of future inquiry for research at the intersection of policing and mental health nursing.

Implications for practice: The contribution of police to the wellness and recovery of people and their families is constrained by the ability of the community health and social service system to do its job. A wave of new initiatives designed to enhance the interface between police and the medical community holds out hope for alleviating officers' concerns about whether they can work in tandem with the rest of the system to make a difference. For now, we suggest that what we can expect of police is to implement "principled encounters" that ensure public safety while achieving harm reduction, self-determination and the reduction of stigma. Mental health nurses are well positioned to assist with officer training and provide support to officers responding to mental health-related situations. However, the fields of policing and nursing practice may not yet fully understand the individual, family and community dynamics

driving calls for police service. The notion of "gone off meds" should be interrogated as a potential trope that obscures a whole-of-person approach and whole-system approach to mental health crisis response and care.

KEYWORDS
crisis intervention, mental illness, nursing, police

1 | INTRODUCTION

Half a century ago, researchers observed that frontline police officers regularly respond to events and situations with observed mental health components (Bittner, 1967a). Pioneering sociologies of police work portrayed this "social work" function within the broader ambit of keeping the peace and managing social problems, especially in urban contexts of structural disadvantage (Bittner, 1967b; Muir, 1977). In the late 1980s, scholars and practitioners renewed their attention towards this aspect of police work in the wake of preventable fatal outcomes resulting from officer encounters with people in crisis. This attention sharpened with mounting evidence that people affected by mental illnesses are disproportionately represented in the criminal justice system. Some use the term "criminalization" (Lamb & Weinberger, 2017; Slate et al., 2013; Teplin, 1983, 1984) to characterize the outcome of a decades-long process of dismantling state psychiatric institutions, inadequate investment in community-based resources and heightened involvement with police who serve as "gatekeepers" of the criminal justice system (Neusteter et al., 2019). Today, officers witness the effects of this resource vacuum in communities, and there is a growing perception that demands on police to respond to mental health issues have increased (Engel, 2015).

In efforts to improve the quality of police encounters, reduce the use of force and divert individuals from the criminal justice system, police agencies have implemented specialist programmes designed to elevate officers' understanding of mental illnesses and behavioural symptomologies. Crisis Intervention Team (CIT) programmes represent a flagship effort, nationally and globally, to effect positive changes in officers' knowledge, attitudes, decision-making and behaviour. Focused on more than just training, the CIT movement advances partnerships and collaboration across law enforcement, the behavioural health sector, advocacy groups and people with lived experience of mental illnesses. CIT can be considered an "evidence-based" intervention when it comes to improvements in officer knowledge, cognition and self-efficacy, and increasing linkages to psychiatric care (Watson et al., 2017). Other specialist programmes such as police co-responder models—composed of officers paired with clinicians—are beginning to show promise and further support that police–mental health partnerships can improve officer sensitivity to persons with mental illnesses and increase appropriate linkages to care (Puntis, et al., 2018). Programmes like CIT and co-responder initiatives represent police agencies' earnest efforts to address a "mental health crisis" at the population level (Rosenberg, 2019) brought on by social, legal, political and cultural forces beyond their control (Rosenberg, 2019). Deficient health and social infrastructures perpetuate this crisis and its underlying social determinants (Compton & Shim, 2015; Rosenberg, 2019).

Within this broader social context of policing in America, there is a gap in our knowledge about the nature of the mental health-related situations officers are responding to and their views of what is needed for effective response. This paper thus explores officer perceptions of and experiences with encounters they perceived to have mental health components. These experiences were shared in the context of "ride-alongs" during which Chicago-based field researchers accompanied CIT and non-CIT officers on routine patrol shifts at different times of day and night. Researchers elicited officer insights into the larger environment within which they worked (i.e., their district, neighbourhood and relevant hospital facilities). In community context, their comments illuminated their views of unmet behavioural health needs and the deficits in services and resources that shaped the environment of community mental health and what they as officers could do to affect it. Following an inductive analysis of these officer narratives, and building on prior findings from our larger study (Watson & Wood, 2017), we argue that it is important to take stock of what we can and should expect of police in the handling of mental health-related calls that warrant a whole-system approach.

2 | METHODS

This paper is based on qualitative data collected as part of a larger, externally funded study on the nature and outcomes of mental health-related calls in the city of Chicago, Illinois (2012–2016). This mixed-method study, approved by the University of Illinois Institutional Review Board, had the following three main aims: (a) estimate the relative impact of officers' CIT training status on immediate call resolutions; (b) determine the extent to which immediate call resolutions influenced mental health service utilization, engagement and recidivism; and (c) describe accessibility of mental health treatment for police to connect individuals with mental illnesses to psychiatric services through the perspectives and experiences of police officers, consumers and key stakeholders (police officials and receiving clinical personnel). Based on qualitative data gathered during 36 field observations, this paper relates to this third, descriptive aim.

In an earlier paper focused on a unique set of 31 field observations from the larger study, the central theme centred on the "grey zone" nature of the calls and the ways in which officers relied on their local knowledge of people and places to broker provisional solutions and negotiate peace with the people with whom they were intervening (Wood et al., 2017). That paper engaged with the sociological perspective of Egon Bittner who illuminated the peacekeeping function of police as they solved social problems, often in situations of social disadvantage (Bittner, 1967a, 1967b). In a second paper, the authors expanded on this line of inquiry related to the grey zone nature of mental health calls to describe and illuminate the fact that officers conducted hospital transports much more than they used arrest as a tool to resolve mental health-related encounters (Watson & Wood, 2017). To achieve this, the authors merged quantitative data from structured surveys with officers who described, among other things, how they resolved specific calls ($n = 428$) that they perceived as having a mental health component. Qualitative data from 21 in-depth officer interviews (collected as a separate piece of the largely study) comprised narrative accounts of calls they had experienced, how they handled them and why. Together, those findings illuminated the need for upstream diversion alternatives, earlier than point of arrest, because arrest was an option of last resort.

For this paper, our objectives were to extend and deepen the insights from the earlier datasets (qualitative observations, individual interviews and quantitative call resolution data) on officers' views of the social and medical complexities of mental health-related calls, and in particular, the officers' reliance on "going of meds" as a typical way that they characterized the origin of certain calls. During a study debrief and analytic discussion, two of the study investigators (authors on this paper) noted that family-related calls were a prominent feature in the observations as well as the narratives of the officers. This interest in the perceived medication adherence problem as well as the family dynamics of some calls focused on one aspect of the data analysis process. We were equally interested in expanding previous insight into what officers see as needed resources in the wider system of health and social services to address the issues they were observing. One aspect of this inquiry relates to officers' views of the quality and readiness of emergency department facilities in receiving mental health transports by police. In discussing the emerging themes from these data, the authors developed a broader interest in the question of what we can expect of police—i.e., what counts as effective police work—in the face of system-wide deficits in high-quality, accessible resources.

2.1 | Study site and methods

At the time of the study, Chicago's CIT programme had been operating for almost a decade. Approximately 18 per cent of the 13,000 Chicago Police Department (CPD) sworn personnel were CIT-trained. The Department had Memorandums of Understanding with 13 hospital emergency departments spread throughout the city that served as designated drop-off sites for officers to bring individuals needing emergency psychiatric assessment. In the years immediately preceding this research, the programme's infrastructure had deteriorated as new Superintendents focused on different priorities. The CIT Advisory Committee, comprised of representatives from partner city, mental health and advocacy agencies, was no longer active. The central unit at CPD responsible for the programme had shrunk from being a 12-member unit to a five-member unit that worked with NAMI Chicago and other partners to provide CIT trainings and coordinate the programme citywide. Also, at the time of the study, the current emergency communication centre staff had not been trained to identify CIT calls, nor were they consistently able to identify officers who were CIT-trained. Thus, both CIT-trained and non-CIT-trained officers were regularly responding to mental health-related calls.

The CIT programme was situated in a context of several decades of harsh cuts to mental health funding in the State of Illinois, with dramatic cuts totalling 32% of the mental health budget between FY 2009 and FY 2012 (Pan, 2013). During that same period, emergency room visits for people experiencing psychiatric crises increased by 19% (Thresholds, 2013). In 2012, the City of Chicago Department of Public Health closed six of its 12 mental health clinics, several of which served areas of the city with few other mental health service resources. Additionally, the fragile service system was further eroded due to a budget impasse that left Illinois without a fully appropriated budget from July 2015 through August 2017. Late or non-payment of state bills forced agencies serving vulnerable populations to limit their services, or for some, close altogether (Mendoza, 2018).

2.2 | Data collection

It is within this context of a faltering CIT programme and severely strained mental health system that our observations took place between March 2014 and September 2016. Most of the observations took place in 2015 ($n = 19$) and 2016 ($n = 15$). The consent process took place after each "roll call" and prior to the officer(s) entering into service with their police vehicles. The duration of the observations ranged from 2 to 7 hr, with the majority lasting approximately 4 hr. During each observation, a member of a Chicago-based research team accompanied one or more officers while on duty. A total of 57 officers were observed. Thirty-seven officers identified as male and 20 identified as female. Most officers were white/Caucasian ($n = 45$), 10 were African American, and 2 were Asian. Most research participants were at the rank of patrol officer at the time of the observations. Three officers were Sergeants, and one officer was a Lieutenant. Only 18 of the 57 participating officers were trained by the Chicago Police Department as part of the Crisis Intervention Team programme. The observations took place in 14 of Chicago's 22 police districts, across a range of shifts or "watches" to capture police work across various hours of the day and night.

The field observations were not limited to calls that had perceived mental health components on the part of the officers. All calls that the officers received, and to which they responded, were recorded in field notes. These included calls that came across the

radios as well as the encounters that officers initiated "on view" in the course of patrolling their areas. During instances where there was a purported mental health component to a call, the researchers probed officers about the nature of each situation and their assessment of it, in efforts to elicit officers' rationalizations for why they handled calls in the way that they did.

During quiet time or periods in between calls, the researchers took the opportunity to elicit officers' perspectives and experiences related to calls they perceived to have mental health components. Researchers' questions were based on a Ride-Along Interview Guide developed by the research team prior to going into the field. Depending on the rhythm and flow of the ride-along, including the service demands placed on officers while on patrol, the researchers had to be opportunistic in asking questions when and where they could without disrupting officers' activities. Researchers typically asked officers questions about the following topics: the demographics and characteristics of their districts; the most common calls that they respond to (generally and in relation to mental health); how often they thought they responded to mental health calls in their district; their experiences with resolving calls informally (no legal action); if they have arrested persons with mental illnesses and in what situations they would use arrest; perceptions of safety/danger during mental health-related calls; whether they experienced encounters with "regulars" (people they saw regularly); what officers thought about the hospitals to which they transported people in crisis; what they thought about community-based mental health resources, whether more were needed, and if so, what types of resources would help and what they thought of CIT training. They also had latitude to ask officers questions that emerged as officers told stories about calls they had handled or as follow-up questions to general issues that officers raised in relation to the nature of mental health-related encounters or their handling of such encounters. Sometimes, officers would drive by buildings or areas of the city that triggered memories they had about calls they perceived to have mental health components. After their ride-alongs, the researchers elaborated their jottings in the form of field notes.

2.3 | Data analysis

Another member of the research team led the qualitative analysis of the field notes that contained researchers' descriptions of the activities that took place during the shifts as well as the notes of the in-field interviews between the researcher(s) and officer(s). Working within ATLAS.ti, a qualitative analysis software, one of the authors treated each field note record as a "primary document" or data source. The analysis of the data followed a general inductive approach (Thomas, 2006) that honed in on a set of themes related to the complex nature of mental health-related calls experienced and perceived by police. The analytic process involved assigning code labels to capture specific themes as well as more general themes or categories. It was common for the analyst to apply more than one code to a given segment of the data to capture different meanings or issues (Hedlund-de Witt, 2013). Moving between the specific and general was an iterative rather than linear process as the analyst became increasingly immersed in the data (Benaquisto, 2008; Hedlund-de Witt, 2013).

The analyst jotted "memos" in ATLAS.ti to help flag and consolidate cross-cutting themes of relevance to this paper. One specific theme of interest for the objectives of this paper related to officers' suggestions for community resources which was assigned the code label "Community resource issues_suggestions." Another theme of interest centred on the source of calls for police service which included treatment providers or third parties, residential facilities/homes and families. Insights into calls from families were particularly rich in this dataset and was therefore a focus of attention in this area (labelled as "Calls received: Families") A theme with numerous dimensions related to issues observed during calls with perceived mental health components. Examples of specific code labels in this area include "Issues observed: Alcohol_drugs_co-occurring," "Issues observed: Homeless/hungry," and "Issues observed: Off meds" (this last code is an example of an in vivo code label, capturing the words or expressions of respondents). Aspects of serious mental illness (SMI) during the ride-along interviews and observations were also a focus, particularly suicide-related calls (coded as SMI-suicidal). Another main theme related to features of officer decision-making, including factors or circumstances that informed officers' decisions as well as how encounters ended (either in a real observed events or in the stories told by respondents). Specific codes of interest in this area included "Decision-making: Arresting/or not"; "Decision-making: Using coercion"; "Decision-making: Calming down_descalation_appeasing"); and "Decision-making: Transporting." A final main theme of interest related to officers' perceptions of and experiences with hospital facilities. The code labels of "Hospital service/resource issues" and "Hospital cycling" captured two aspects of this area. To capture officers' views of specific hospital facilities, specific code labels were developed to capture positive experiences, negative experiences and ambivalent experiences.

Data are presented in the form of extracts from field notes produced by different members of the field observation research team. These extracts were selected as emblematic illustrations of the main themes highlighted above. To protect the confidentiality of participants, police districts are assigned unique numeric identifiers, and each observation is assigned a random numeric identifier. Pseudonyms are also used in any references to people or hospital facilities.

3 | FINDINGS

Our research team observed officers responding to a wide range of calls that they perceived to have elements of mental disturbance or illness. These included calls about young people manifesting behavioural disturbances at schools, families struggling to support a loved one with mental illness, and people experiencing food insecurity or housing instability. It was not uncommon for behavioural disturbances to be accompanied by drug and alcohol use, which was unsurprising given prior research on co-morbidities in justice-involved

populations (Peters et al., 2015). The dataset revealed a range of instances, across observations, where officers described (based on their own perception, or information they were given) the person they were trying to help as having "gone off" medication. Below, we provide illustrative examples of different encounter situations and the complex needs presented in them.

3.1 | Young people in distress

It was common for officers to identify challenges related to mental health calls involving young people in crisis. Such challenges related in part to the capacity of schools to address the behavioural health issues displayed by their students. Across such calls, police were requested to quell a situation and keep people safe. The following field note recorded by a research team member captures a call that was taken during a ride-along at a school. It highlights the complexities surrounding the child's situation, and the reliance on the police (especially a CIT response) to help other school staff bring the situation to a close without harm.

> [An] MH call is dispatched and it is asking for assistance from a CIT officer. The call is at an elementary school and it involves a 9 year old child. Officer 1 radios the dispatcher and says that s/he will respond as CIT. The dispatcher tells Officer 1 that the school had to restrain the child. I tell Officer 1 that I find it interesting that a CIT officer was specifically requested, again. She says that "people who know about CIT will ask for it." We arrive at [the] Elementary School and see a squad car in front of the building. When we walk inside the building we are directed to a side room which is where the responding male officer, Jason, and a school staff worker are sitting at a table talking to the 9 year old, Black boy. The boy is seated with a lunch tray in front of him and is holding onto a hotdog. Jack asks the boy what is the problem. The boy says that no one likes him at school and that he is always teased. Jason asks the boy for the names of the kids that do not like him; however, the boy starts to cry and cannot respond because he is eating his hotdog. Jason then tells the boy that he cannot act out in school. The boy begins to heavily sob. Jason tells the boy to stand up because he is going to be taken to the hospital. The boy begins to tremble but listens to Jason's instructions as EMS place him on a chair and carry him to the ambulance. The staff worker tells Jason that the boy was touching the girls and got out of control. The staff worker tells Jason that he is a physical education instructor and works as a basketball coach. And because of his title, he is the only one who is allowed to put a hand on the boy. He says that he did have to restrain the boy by putting his arms around him—in order to calm the boy. The principal tells Officer 1 that the boy has mental issues and that he really needs help. She adds that the boy's mother is involved with the child but that nothing seems to work so they are forced to send the boy to the hospital when he gets out of control. For a brief moment Jason, Officer 1 and I converse outside the school. Jason tells Officer 1 that he has dealt with the boy before and that "this is typical."
>
> (Obs. 8, Dist. 33)

In the above situation, transport to hospital was deemed to be the only viable tool to help the boy (who was previously known by police), at least in the short term. When it comes to calls originating from schools, sometimes officers attributed such crises to lack of medication adherence. During a ride-along, a researcher noted,

> I ask [the officer] to tell me about her experiences with some of these [mental health-related] calls. She says that it seems that many of the calls that she hears about, even if she isn't assigned the call, seem to be to the schools in the area. I ask if these calls stem from behavioral issues or acting out in the schools or mental health crises. She says that in many cases it is kids not taking their medication and then having problems in the school.
>
> (Obs. 34, Dist. 66)

In other situations, family members themselves call the police because they are feeling unable to manage a child's behaviour in the home environment. In the following case, the officer perceives that non-compliance with medication is an issue (as with the prior school-based call) but also suggests that families can lack the support and knowledge they need to manage mental illness.

> Officer 1 recalled several mental health calls he's responded to involving children. He said that, in his experience as a police officer, parent caretakers (often mothers) of children with mental illness are exhausted and preoccupied with keeping other children in the house safe. He noted that another issue is that children who are non-compliant with meds often go unreported due to parental guilt. Officer 1 said that oftentimes cultural barriers and opinions towards mental health form barriers to recognizing and treating mental illness, especially with children.
>
> (Obs. 42, Dist. 88)

Across the observations, officers' references to people going "off meds" were a common theme. This theme was revealed in a previous quantitative analysis of call resolution data where 300 officers provided data through a structured survey on 428 calls perceived to have a mental health component. In that data, officers indicated that in 200

calls (46.7%), they had gathered information that the call subject was taking prescription medication and that in 108 of those cases (25.2%), their information suggested that call subjects had gone off their medication (Watson & Wood, 2017).

3.2 | Families in distress

Family-related situations generally involved a behaviour management issue for which police were called to address. The above-referenced study on 428 mental health-related incidents revealed that private homes represented the most common call location (146 cases or 34.1% of calls) (Watson & Wood, 2017). Upon arrival to a scene, officers glean information from family members. In some cases, they report that a family member is affected by a serious mental illness such as schizophrenia or bi-polar disorder. In other cases, there may or may not be a purported clinical diagnosis. In the following situation, the officers knew the family from a prior encounter(s). The child was displaying aggressive behaviour, and the family was in conflict stemming from their choice to discipline him for poor performance in school.

> [The officer]… told me a story about a kid who was 14 years old but looked like he was 19. "Kind of like that movie with Sandra Bullock, same mentality. He was very slow and had bipolar." The officer said that by the time he got to the scene, the kid had ripped a gate of its hinges. He was saying that he was sick of his family, and was upset because his parents wouldn't let him play football until his grades improved. Some of the officers had dealt with the kid before and had a relationship with him. They sat him on the couch and calm[ed] him down by explaining that he couldn't play football at all if he was in the hospital. The officer pointed out that the mother meant well, but if the kid was off his meds, there was nothing they could do.
>
> (Obs. 12, Dist. 27)

In the above instance, the responding officer took on a counselling role, informed by their prior knowledge of the young person and their family situation. Stepping in to help families can serve as a source of frustration for officers. During the following observation, an officer expresses the view that they are performing a role that should ordinarily be filled by parents:

> Officer 2 said she typically responds to more mental health calls for juveniles, originating from home disputes more often than from school. Officer 1 and Officer 2 agree that "incapable parents" want society to deal with their children's issues and needs rather than working on it themselves.
>
> (Obs. 11, Dist. 55)

An officer working a different district expressed a similar perception that the police were stepping in to address preventable family issues:

> Officer 6 said that most of his mental health calls involve teenagers who are unmedicated and without any mental health care. He labeled these incidents as an issue of parents [that] "relinquish responsibility" and do not address their children's mental health needs until they fear for their family's safety, at which point they call 911.
>
> (Obs. 13, Dist. 65)

As revealed in these field note excerpts, officers may be required to assist with families as holistic social units that are struggling to support or manage mental illness. As part of these holistic contexts, drug and alcohol use can co-occur alongside behavioural disturbance, generating complex situations for officers to interpret and manage.

3.3 | Co-occurring substance use issues

Family units involving adults in conflict represent a group or class of calls to which officers responded. Typically, such incidents involved families experiencing a dispute or stressor that prompted someone to call for the police. In the following excerpt, two officers were describing common types of calls they experienced, indicating that "domestics" were a routine event. The dynamics of such calls may not be apparent until they arrive. The following field note reveals that behavioural health concerns may be prevalent in more than one family member:

> Officer 1… told me it can be a difficult situation because they can respond to a call and it could be one of several situations. For example, one person could have MI [mental illness] but both use drugs and the one is using the drugs to cope with symptoms and they are fighting over who smoked the last rock or they respond to a call and they have everything under the sun.
>
> (Obs. 99, Dist. 77)

The previous analysis of 428 mental health-related calls revealed that officers perceived subjects as having alcohol problems in 31.1% of cases and drug problems in 25% of cases (Watson & Wood, 2017). During a ride-along, a researcher recorded a call where the officers were dispatched to assist the emergency medical services (EMS) address an issue where a friend of the call subject reported a co-occurring issue with alcohol:

> We are dispatched a call to assist EMS in helping a difficult person get into an ambulance. We arrived on scene and another squad was already present. The

> man was already on the stretcher on the way down. Officer 5 spoke with a female friend of the subject and she told Officer 5 that he has mental health problems but is treated poorly at the hospital because he has alcohol issues. The female friend is visibly upset and Officer 5 provided emotional support while the male officer congregated behind the ambulance with the EMTs. The officer filled out a study card [describing the possibility of a follow-up interview with the call subject] and gave it to the woman. She agreed to have the subject contact the study once he was out of the hospital. I asked Officer 5 if she knew what caused the call or why the man did not want to go the hospital. Officer 5 told me that she did not ask because she's found it is best not to press the issue once it has already been handled. (I called the number listed on the card on [a date] in April, 2016) to recruit the subject. The women answered to inform me the man committed suicide that morning at the ["Green line transit stop]."
>
> (Obs. 18, Dist. 73)

Tragically, the man involved in the above intervention by EMS and police ultimately ended his own life. His friend insinuated that he had not received the high-quality support he needed to address both his mental health and alcohol use issues. Hospital transportation was a short-term option and likely the only available option in the minds of EMS and the police.

3.4 | Chronic vulnerability

During an observation, the researcher asked the two officers about their experiences with handling calls informally. This sparked a conversation about people they had encountered repeatedly (often referred to as "regulars"). One officer provided an example of an encounter with a regular who had been allegedly causing a disturbance at a currency exchange. S/he explained, "Usually she puts up when she needs to go to the hospital but that day she was coherent enough so we decided to just bring her home" (Obs. 28, Dist. 62). In their field notes, the researcher reports the officer saying,

> [T]his reminds me of a woman who is kind of a nuisance. She is in and out of the hospital and when we first encountered her we didn't know who she was and we tried to lock her up. The bosses said no and told us she is kind of 'un-arrestable' and the hospital just kicks her right out. It's like, what do you do with this person?" I asked how often do they think she has police contact? Officer 2 said, "every day because she's out there everyday. Sometimes it's as easy as picking her up but she's a prime example because the hospital doesn't want anything to do with her." Officer 3 added, "the other issue is that she is into crack which doesn't help. She has accused me of raping her three different times. It is difficult when interacting with some of these people because when you mix crack and alcohol they may appear to have mental illness but they don't…or they may have all of the above."
>
> (Obs. 28, Dist. 62)

Here, the officer highlights the challenge of discerning what to do when issues of mental illness and drug use co-occur.

When officers decide how to intervene with "regulars," they draw from what they know about that person's propensity (or not) to be violent. Officers can also draw from their knowledge of similar types of situations or prototypical cases. One researcher recorded, "I ask the officers, what types of contacts do they have with homeless people who have a mental illness? Officer 1 says impeding the flow of traffic, aggressive panhandlers, screaming at cars, or they have gone into a restaurant and go into the bathroom to bathe themselves. Officer 2 states for the most part they are peaceful and cooperative" (Obs. 35, Dist. 66).

It is not uncommon for officer to be dispatched to calls involving suicide attempts or threats (Watson & Wood, 2017). Obviously, such calls are iconic crisis moments, where options are limited to hospital transportation and, where possible, de-escalation and persuasion.

3.5 | Suicide risks

During a ride-along, the researcher observed a suicide call that came across the radio:

> …. a threatening suicide call comes in over the radio. This call is not dispatched to us, but we decide to go as back up. The computer reads "Ex-Fiance, 40-year-old male, had heart surgery, threatening to kill himself and has locked himself in his apartment." Upon our arrival, there is already a squad car and firetruck parked in the middle of the street. The CFD [Chicago Fire Department] personnel, who is in basketball shorts, tells us that the subject was dead on arrival.
>
> (Obs. 37, Dist. 66)

Typically, police coordinate with CFD or EMS in such events, or police arrived after the call has been handled:

> …we drove to St. Jean's Hospital for some food and a break. As we were preparing to leave, a call was dispatched to us over the radio; a man had drunk a toxic substance, thought to be windshield wiper fluid, at Riverfront Hospital. When we arrived on the scene, the man was already being checked on in a CFD ambulance. He was a Caucasian Eastern European male

> and looked as if he were in his 50's. His mother was with him in the ambulance. The paramedics gave the officers a thumbs up and the man said he was fine. Officer 2 told me to go inside with Officer 3, who was gathering information from the nurse working on the subject. She told us that he had come to the hospital with his mother for an intake, and had been depressed because he was kicked out of his girlfriend's house. She explained that during the intake, he divulged that he had drunk windshield wiper fluid around 10 am. The nurse immediately called EMS because they could not medically provide for him at Riverfront Hospital.... The officers handed over the job to EMS and we left them to finish their work.
>
> (Obs. 15, Dist. 33)

In a case like this, several first responders intervened in a situation that displayed complex needs that were addressed in a temporary way through conveyance to hospital. This instance is one reflection of a wide variety of situations that display not only unmet mental health-related needs, but other health and social needs as well that escalated to the point of crisis. Many officers are reflective about the complexity of health and social issues that they observe, and as a result are thoughtful about their role and what they can do in the face of limited tools and resources. In the next section, we shed light on officers' views of the resources available to them.

3.6 | System deficits and inconsistencies

Across the sample, perceptions of the staff, services and efficiency of hospitals were varied. Officers reported diverse experiences of specific hospital receiving facilities with respect to geographic accessibility, ease of handover to hospital staff and the quality of the hospital experience, including treatment by staff of the individual in crisis. Yet, field researchers observed various instances where families in crisis expected or assumed that transportation to hospital—via the police—would be the solution at hand. During the observations, officers referenced specific hospitals that they have transported people to for psychiatric care. This expectation can generate frustration among officers because they observe deeper, more chronic unmet needs. The following officers implied that police can be used as a taxi service:

> Throughout the conversation [the officers] kept reiterating that they wished facilities would keep consumers longer or something to keep those from going right back out on the street unsupervised. They said a lot of times they are a more-or-less just a free ambulance ride. They explained many people do not want to call EMS because it will cost them or the organization money.
>
> (Obs. 21, Dist. 65)

Where officers do provide transports to hospitals, they are not always certain such visits will yield long-term benefits to individuals in crisis. Indeed, there was a general perception across the observations that hospitals provided very temporary relief to long-term issues:

> Officer 1 says that he doesn't know they have effective solutions to these [mental health-related] calls and that he feels like in many ways, they are "passing the buck" onto the hospitals. He goes on to say that he does not know what an alternative would be for the system they have now. In regards to people where they really cannot intervene, Officer 1 says that there needs to be some "onus on the person" to get help themselves and stick with their treatment. He says, "I don't know how it gets much better." Officer 2 says that in some ways he feels like the response is effective and in other ways not. Officer 1 chimes in with agreement and says that in many ways the response now is an "immediate bandaid" and we clearly don't have the resources to address some of the problems.
>
> (Obs. 94, Dist. 33)

Another officer describes a "never ending cycle" of hospital transport, noting that repeat transports for the same people affect hospital staff and their relationship with police:

> Officer 1 said St. Jane Hospital staff do not like the police because they repeatedly bring the same patients day after day who already have mental illness diagnoses. Officer 1 said the hospital gives them medications for one day and releases the call subject within 4–24 hours. It's a never ending cycle that causes police and hospital staff frustration. Both officers said they often have repeat calls with the same call subjects. Officer 2 said there are not enough mental health institutions, while Officer 1 said there are none.
>
> (Obs. 83, Dist. 77)

Across the sample, officers reported inconsistent experiences with the efficiency of the handover process and the quality of staff treatment and services. Beginning with a story about a suicidal man they were transporting to hospital, the following officers suggest that the quality of hospital services can vary seasonally. They also note their concerns about safety issues, especially in waiting room contexts, and the ability of hospitals to manage them. Such concerns are exacerbated when there are long waiting periods.

> Officer 5 began another story about a time they respond to a call about a man making suicidal threats to his girlfriend. They arrived at the scene and the man was fairly calm so the officers decided to take

him to St. Harold's Hospital. However, on the way he took his shoelace and tried to hang himself in the car… [Officer 5] continued and said one of the issues [with] St. Harold's is they just watch them for three days then let them go. I asked what she thought of the admission process? Officer 5 said okay, here's the routine: "EMS goes to the nearest hospital and, for example, this call goes to Simons Hospital. Then the person gets put into a wheelchair and sits in the triage waiting room – suicidal or whatever, they could be volatile." She said some of the time it is like this and other times they are brought to a room right away. Officer 6 chimed in, "I think it's just based on staff too. There is no rhyme or reason for how things are done". Officer 5 concluded, "for the most part, they are okay but during the summertime when there are more people it is definitely a problem. Not so much at Manion Hospital but at George Hospital we wait a lot."

(Obs. 18, Dist. 73)

Even where hospital staff do the best they can, officers reflected on the suitability of hospitals as resources for people affected by co-occurring needs such as housing instability or alcohol and drug use. In the following excerpt, the officers expressed their desire for an alternative to the designated hospital receiving facility that they use in their district. When hospital staff are overwhelmed, efforts to address these chronic needs may be further compromised:

Officer 1 added "I wish there was another hospital to utilize other than Edison Park".

I ask Officer 1 if he thinks hospitals are effective?

Officer 1, "No, but they can be. This particular hospital is understaffed and overwhelmed."

Officer 2 added, "we have St. Christian and St. James hospitals. St. Christian is a little better but it's farther away and St. James just isn't there yet. Without any mental health clinics or homeless shelters we get overwhelmed dealing with that demographic. A lot of them just hang out at the library. Even people going through withdrawal or alcohol withdrawal we don't have anywhere to bring them other than St. Jane."

(Obs. 99, Dist. 77)

The physical state and repair of hospitals influenced officers' assessments of the quality of the hospital experiences for patients. Coupled with concerns that hospitals provide temporary quick fixes to the issues at hand, some officers held the view that more alternatives to hospitals were needed:

I asked if there were any other resources in the district that he has accessed?

He told me his main mental health facility is St. Jane. Hunterdon South will sometimes take them but the district wants the officers to take them to St. Jane which is so dirty and a shithole. I asked him to tell me more about St. Jane. He said, "…The people are dynamite but the facility is a dark dirty shithole… Everyone is on some form of meds, nobody has long term care, and everything is a short term patch. We cannot spend the resources to get them physically, mentally better but we'll give them a patch before their next rock, drink, blow, Xanax, whatever they're going to take until the next lunar eclipse or whatever sets them off."

(Obs. 23, Dist. 39)

In light of these comments, it is unsurprising that officers expressed preferences for specific hospital facilities. These preferences were shaped in part by how they perceived the efficiency of the drop-off process:

I wondered aloud if she would be comfortable with linking consumers to other services? She responded, "it would be nice to have a place that does want to help and take them and not make the situation worse. Like St. Jane Hospital takes forever and makes us wait for them, in the waiting room with other people around. They are not helpful – even if we are fighting with someone, they will not help. St. Christian Hospital is really good. They take them right away and are helpful. If we have someone who is combative they will come out and help us take them from the wagon." The officer elaborated on her views of St. Jane Hospital, "St. Jane…we dread going there and we have to get an approval from a supervisor to bring someone to St. Christian. St. Jane is in the neighboring district and that is why we utilize them the most."

(Obs. 21, Dist. 65)

3.7 | Looking beyond hospitals

During their observations, researchers asked officers about their knowledge and perceptions related to resources other than hospitals. When asked whether they had any experiences linking people to other services, an officer cynically stated "no, by the time we get involved it's either jail or the hospital" (Obs. 8, Dist. 23). A different officer expressed a similar level of defeat in terms of the limits of what police can do in relation to mental health issues:

> … [T]hroughout the ride along, [the officer] questioned again why are we studying officers when mental health issues should be solved before police became involved. I reiterated the purpose of the study but she felt there would never be any new resources or facilities' because of the lack of money.
>
> (Obs. 10, Dist. 55)

Some officers did, however, reflect on possible alternatives and expressed wishes for something more and different. An officer expressed the view that resources outside of hospital settings need to be responsive to co-occurring issues:

> A conversation is brought up about criteria for hospital admissions and the lack of knowledge of other resources or solutions within the community. Both officers discuss that it seems like people only know the hospital and do not know how to access other resources to solve problems. Officer 1 comments on the subject. "There seems to be lack of awareness in the community of other programs - most problems are just solved by sending people to the hospital". Officer 2 adds his thoughts: "people don't see the big picture - a lot of the calls we respond to like domestics and robberies stem from people with mental health issues not getting help and are self-medicating with alcohol. I think if we just focus on some [of] these issues there will be less calls".
>
> (Obs. 14, Dist. 23)

Programmes that address such needs must, however, be timely and responsive. In the following excerpt, an officer relays their attempt to get someone help, but their efforts were thwarted:

> Officer tells me about a call that she responded to a couple of weeks ago that involved a missing person. She says that she happened to be at a gas station when she randomly came across the missing male. Officer 1 says that the male told her that he has schizophrenia and has not taken his medication. Officer 1 decided to take him to 4909 Division for some type of mental health service/treatment. However, staff workers refused to see/treat the male and told Officer 1 that they can set up an appointment but that the earliest a doctor can see him will be until three months. Officer 1 tells me that she was upset because even though the male was not in a crisis, he was in need of care. She says that she could not imagine how the male was going to cope for three entire months. Officer 1 says that she did not know what else to do for the man—she took him home.
>
> (Obs. 17, Dist. 72)

3.8 | The need for follow-up and long-term solutions

Even with accessible hospital services that are responsive in a crisis, officers indicated that follow-up services are important. In the following excerpt, an officer links the notion of follow-up with the need to support people with medication adherence:

> Officer 1 says that it is "complex" – going to the hospital, some intervention can be done, but there is no support to follow through and maintain "normalcy." He says that after leaving the hospital, people aren't taking their meds. He says that they take care of the problem for the night and "make them happy," but that this is "only as effective as the person lets it be."
>
> (Obs. 22, Dist. 88)

One officer provided a creative suggestion for clinician-driven outreach programme that supports people with their medication regime. The researcher noted, "Sergeant 2 and Officer 1 suggested that a doctor or nurse practitioner travel throughout each district to dispense medication to avoid costly hospital transports for prisoners in lockup as well as adults with mental illness in the community." (Obs. 97, Dist. 77).

Some officers were also reflective about the need for long-term resources to address kids' needs, including the possibility of finding alternatives to medication:

> Officer 2 asks me if she wants me to give her opinion (in regards to mental health needs in the city). She says, "Open up some type of counseling center for kids who are disturbed." She continues, High Schools only get so involved, especially on [a certain side of Chicago]. It would be nice to have somewhere to refer them to before they become more serious cases. Officer 1 agrees and says that they can only bring people to the hospital but if you were able to refer people to services "you could nip the problem in the bud"…. Officer 2 goes on hypothetically speaking about a teen center for "border line kids", emphasizing the need for some sort of counseling before heavily medicating someone.
>
> (Obs. 35, Dist. 66)

Given their experiences with family-related calls, certain officers reflected on the need for family-focused resources. They expressed different views about what such resources could look like. A field researcher asked an officer, "do you think it would useful to share information with Social Workers or other resources?" They replied, "No, I think you really need to get to the families. Their social workers can't find them resources because there aren't any resources anywhere. It just becomes a bad onion" (Obs. 3, Dist. 39). Another expressed the need for a follow-up mechanism:

> Officer 1… often stated that most people do not want help and when the police are involved they are having their worst five minutes so not much could be done. He felt the best way to affect change would be to put a follow up system in place. He said a lot of the time nothing happens after they make contact with a person. If there was a system that would allow an officer to fill out form on somebody and then, once things have settled a bit, follow up on them, he thought their interactions would be more effective.
>
> (Obs. 2, Dist. 55)

An officer in a different district also expressed the need for follow-up, arguing for social workers to lead follow-up efforts. In the following excerpt, the researcher asks the following of the officer: "Magic wand scenario, what kinds of resources would you like to have when responding to mental health calls?"

> He replied, "more mental health centers and training. I like the idea of having someone follow up directly or us being able to document a call and having a social worker follow up. I would also like to see better information sharing with hospitals. We drop them off and they just stick them and make them go to sleep. We need to be better all around but some hospitals are better than others."
>
> (Obs. 5, Dist. 39)

A different officer expressed the need for follow-up in terms of an "extended response":

> Without any prompts, Officer 2 shared his ideas for mental healthcare change right at the beginning. He would like to see an "extended response" of doctors, nurses, and/or mental health professionals available at the scene of mental health crisis calls. Officer 1 proposed that a Mobile Mental Health unit separate from Chicago Police Department assist police when needed.
>
> (Obs. 17, Dist. 39)

One officer emphasized the need for long-term follow-up that addresses medication adherence issues, including potential alternatives to placing people on medication. This suggestion was grounded in an example of a specific call, where a mother claimed that her son's medication was not helping. Because of this, the police were called to intervene:

> Officer 2 tells me a story about a call they responded to because it was in their beat (neither officer is CIT trained). A mother called on her adult son because he was breaking things in the house. Officer 2 says that they arrived on this occasion and found that the house was "destroyed." Officer 2 says that in past (and future) calls to this house, the son usually takes off, but on this occasion he stayed out in the yard. The mother told Officer 2 that the meds her son was on for his "panic attacks" were not working and she wants to sign him into the hospital. Officer 2 says that he was able to talk with him and convince him to go to the hospital. He says that this man was not violent toward the police, despite breaking items in the house. I ask what the outcome of this call was, and he says that they were able to take him to the hospital and they evaluated him and then released him. He says that they have subsequently responded to the house. He says that when you meet this man, "you'd never know there was something wrong with him." I ask him what he thinks would help in a situation such as this. Officer 2 responds saying that particularly with ongoing problems he thinks that people need to be admitted to the hospital and they need to actually keep them or "give them more options" about what to do in the long-term. He says that he thinks that these options need to be presented to families to provide more long-term solutions. Officer 2 says that the hospitals are not going to keep them because that will cost them more money, but that families need options if medications aren't working for people.
>
> (Obs. 4, Dist. 40)

Overall, our observations revealed that in the face of deficient resource environments, officers work to keep the peace, prevent further harm and ensure safety while balancing the wishes and self-determination of people and their families. Transportation is a commonly used option, but officers are reflective about the limits of emergency hospitalization and have witnessed repeat, cyclical hospital use. Where transports are requested by callers or families or deemed appropriate by police, unsurprisingly, officers prefer that the individuals go voluntarily or that family members sign them in. Officers recognize the complex health and social issues present in individual and family-based situations but perceive that there are little to no resources available for addressing such needs holistically and over the long term. In the next section, we reflect on what this all means for what we can expect of police officers and how we frame notions of police effectiveness in contexts of resource vacuums. We also comment on new developments that have the potential to address such vacuums, such as programmes serving to enrich or extend CIT programmes as well as efforts to build out programming in hospital settings or as follow-up components to hospitalization.

4 | DISCUSSION: WHAT CAN WE EXPECT OF POLICE?

The themes emerging from our field observations illuminate the variety of mental health-related situations to which officers are

asked to respond. While officers often mentioned someone "going off their meds" as the cause of the need for police response, they also discussed family conflict, substance use, lack of housing, knowledge and cultural barriers to accessing care, and "incapable" or overwhelmed parents. Officers described the strategies they used to de-escalate situations, including familiarity with individuals they had previously assisted. They expressed frustration with hospital emergency departments and the overall inadequacy of mental health system resources. They were thoughtful about what resources are needed to better address the needs of individuals and families impacted by mental illnesses, suggesting community resources to address people's needs well before police are called on to be involved, mobile mental health units capable of responding to mental health crisis (instead of police) and clinician follow-up after a police contact to assist individuals with accessing and engaging with services. These themes underline the extent to which we are asking officers to provide solutions, albeit temporary, to complex problems exacerbated (if not created) by a mental health service system vacuum.

4.1 | Distinguishing police effectiveness from "whole of system" effectiveness

In the context of inadequate mental health resources, the frequency of the need for police response to mental health-related situations may be higher and the options they have to provide effective resolution constrained. This leads us to consider how we frame effectiveness of police response to mental health-related situations and what we can reasonably expect of police. The literature on CIT and other strategies to improve police response to mental health-related events in the community suggests that we can improve officer attitudes, knowledge, skills and disposition decisions (Watson et al., 2017). Such improvements speak to both the quality of the interaction and immediate outcomes of police interventions. Thus, effectiveness of police response might best be assessed in terms of the extent to which they implement what we might depict as "principled encounters" acting within the confines of what they are able to control in the limited scope of the encounter. These principles include providing procedurally just treatment, reducing harm, supporting self-determination, ensuring safety and redirecting people to appropriate mental health services whenever possible. In practice, this involves treating people with dignity, respect and concern; using de-escalation skills to calm a person in crisis and help them feel safe; and connecting people to mental health services whenever possible. However, the full impact of these efforts is contingent on the capacity of the mental health system to do its job. As officers are well aware, improved long-term outcomes at the individual, system and community level will only be achieved with a coordinated and rich array of community-based resources. It is important to note that fully implemented CIT programmes (and other police mental health collaboration models) understand this and work with partners to develop the mental health system resources (Usher et al., 2019).

4.2 | Alternatives to emergency departments

The overreliance on law enforcement to respond to mental health issues and the inadequacy of hospital emergency departments as crisis receiving centres are not unique to Chicago or even the United States. As communities struggle to address these issues, several promising developments have emerged that are very consistent with officer suggestions. Some involve creating alternatives to the emergency department that individuals and families can access themselves and to which police officers can transport. For example, the Crisis Response Center (CRC) in Tucson, Arizona, provides crisis evaluation, urgent care and observation for up to 24 hr. It has a "no refusal" policy and can be accessed via self-referral, police transport, ambulance, mobile crisis team or emergency department transfer. Balfour et al. (2017) report the CRC is able to discharge 60%–70% of patients to the community and 85% of patients indicate they are satisfied with the service.

Another alternative to emergency departments is the living room model, which is an outpatient, voluntary programme for individuals experiencing emotional distress. The setting is generally furnished like a home and staffed with mental health clinicians, a nurse and certified peer specialists. Heyland and Johnson (2017) examined 30-day outcomes for individuals utilizing a living room-based service and found that 94% had no emergency department visits in the month following the initial visit to the service. Additionally, a study examining the experiences of individuals who utilized living room services found that compared to their experiences in emergency departments, clients found the living room to provide a safe, helpful and non-judgemental oasis (Shattell et al., 2014).

4.3 | Community-based interventions

Other promising developments involve sending clinicians into the community to provide crisis intervention. This may involve co-responder teams that pair a clinician (a nurse with a police officer to respond to mental health crisis calls and/or conduct follow-up engagement and linkage; or mobile crisis teams comprised of clinicians (or a clinician and a certified peer specialist) to provide crisis intervention and linkage to care; Watson et al., 2019). Available data on both co-responder and mobile crisis teams suggest they can reduce emergency department transports and increase connections to community mental health care (Murphy, et al., 2015; Puntis et al., 2018). Another promising strategy involves utilizing peer providers to offer support following a police contact. In Lincoln, Nebraska, the police department has partnered with a community-based peer support programme called the Respond, Empower, Advocate, and Listen (REAL) programme that assists individuals following a police encounter. Following officer referral, a peer provider makes contact with the individual within 48 hr and offers assistance in connecting to care (Bonkiewicz, et al., 2018). Data from the programme suggest that individuals referred to the programme had fewer mental health

calls for service and emergency custodies than those not referred to the programme.

4.4 | Strengthening the interface between police and mental health nurses

We were struck by how often officers described situations in terms of a person having "gone off their meds." This was often the officer's perception, but they also noted that family members explained the situation in those terms as well. Interestingly, officers generally went on to describe encounters in ways that suggest family conflict, housing instability, substance use and other situational factors significantly contributed to the reason for the police call. Thus, it seems that "gone off their meds" is an oversimplified shorthand term for complex situations that need to be further interrogated as it may inhibit a whole-of-person approach and whole-system approach to mental health crisis response and care.

The themes that emerged suggest a role for mental health nurses in supporting increased police effectiveness in providing "principled encounters" and whole-system effectiveness in meeting the needs of individuals experiencing mental health crises. Strengthening partnerships with mental health nursing can inform officer training and facilitate linkages to mental health care. Nurses can provide on scene or telephone assistance to assist officers in understanding the medical and social complexity of the mental health crisis situations they encounter and the options officers have for providing procedurally just response and effective resolution. Mental health nurses can also provide insight into the underlying dynamics of medication adherence issues. At the whole-system level, enhancing partnerships between mental health nursing and law enforcement can expand the mechanisms for connecting people to care and support that meets their needs and reduces further police involvement. For example, they can work to develop non-ED crisis triage centres, mobile crisis teams and follow-up linkage services.

5 | CONCLUSION

Building on the argument that officers are generally reconciled to brokering temporary solutions to chronic vulnerabilities (Wood & Watson, 2017), this paper raises broader questions about what to expect of police in contexts of resource vacuums, what should be conceptualized as good police work and types of resource investments needed to support their efforts. We suggest that in the absence of structural efforts to invest in community mental health, our conception of effective policing may best be anchored to a framework of "principled encounters," where officers display a commitment to reducing harm and protecting public safety while respecting the self-determination and agency of people and families affected by mental illness. We conclude that it is important to advance granular field-based research on the everyday world of police to illuminate how health and social systems constrain what they can do and what they think is possible. Shedding light on the everyday world of policing will help researchers and policymakers understand the impact of resource vacuums on officers' hopes of making a difference.

Emergency department alternatives and mobile crisis teams hold promise for alleviating the burden on police officers and providing more effective crisis care for individuals in the community. The officers in our study clearly saw the need to develop such resources. We argue that we must push for expanding the capacity of mental health systems to support non-ED and non-law enforcement interventions and study the emerging models that look promising. If we do not, officers will continue to be reconciled to providing short-term solutions to system-level problems. Partnerships between the law enforcement sector and the mental health nursing community should be harnessed in furtherance of such solutions.

6 | RELEVANCE STATEMENT

There is great potential for the mental health nursing sector and the law enforcement sector to work closely together to assess mental health crisis responses and to advance system-wide approaches to addressing the needs of young people, adults and families living with mental illnesses. The findings reported in this paper have relevance to partnerships between mental health nursing and law enforcement and for the development of more capable mental health systems that may ultimately rely less on police as mental health interventionists. A better understanding of police officer perspectives on mental health-related events they respond to and the resources they think are needed can inform mental health nursing interventions, advocacy and law enforcement–public health partnerships.

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CONFLICT OF INTEREST

Dr. Watson has worked as a consultant to the City of Chicago Police Department on research that is not part of this study.

ETHICAL STATEMENT

This research was approved by the Human Subjects Institutional Review Board at the University of Illinois at Chicago.

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