MOBILE CRISIS TEAM/POLICE COLLABORATION EVALUATION

Dr. James Frank
Division of Criminal Justice
University of Cincinnati
P.O. Box 210389
Cincinnati, OH 45221-0389
Phone: 513/556-5832
Fax: 513/556-3303
E-Mail: james.frank@uc.edu

Dr. John Eck
Division of Criminal Justice
University of Cincinnati
P.O. Box 210389
Cincinnati, OH 45221-0389
Phone: 513/556-5833
Fax: 513/556-3303
E-Mail: john.eck@uc.edu

Shamir Ratansi
Division of Criminal Justice
University of Cincinnati
PO Box 210389
Cincinnati, Ohio 45221-0389
(513) 556-0857
E-Mail: Ratanss@email.uc.edu

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Executive Summary

Contact with mentally disordered citizens has long been a part of police work (Bittner 1967; Engel and Silver 2001). Police are routinely the first agency called to respond to situations involving the mentally ill. This is partly because they are always on duty and available, and partly because their job provides them with the authority to intervene in troublesome situations. The officer who responds must be able to recognize that mental illness is a factor, assess the situation, reduce contact with the criminal justice system, ensure safety for all involved and provide a resolution that is fair and dignified for people with mental illness.

Even though police are routinely involved in the handling of mentally disordered people, interactions involving these people remain particularly challenging. In an effort to improve the handling of police interactions with mentally disordered citizens, a number of different strategies have been used by cities and police agencies (e.g., better training for officers, mental health providers hired by police departments). The Cincinnati experience involves a collaboration between the local mental health system and the police. In this instance, when necessary, Code 9 calls involving mentally disordered individuals are handled by community health based crisis teams in coordination with the police department.

METHODOLOGY

The present study uses both quantitative and qualitative research methods to answer six research questions identified through discussions involving the Health Foundation, Hamilton County Community Mental Health Board, Mobile Crisis Team members, the Cincinnati Police Division and the research team.

1. Has the deployment of MCT resulted in greater citizen and officer safety?

2. Has the use of MCT decreased the use of criminal justice outcomes and increased psychiatric referrals?

3. Has the deployment of MCT reduced police time devoted to handling people with mental health problems?

4. Have repeat calls from and about individuals with mental health problems declined since involvement of MCT?

5. What are the police officers' and social workers' perceptions of the deployment of MCT?

6. Have police officers' attitudes towards the handling of mental health calls improved since the inception of MCT and are officers better able to identify and handle mental health calls?

The emphasis of this effort is on whether the collaboration has improved the handling of calls involving mentally impaired individuals, and whether the collaborative process provides a benefit to the Cincinnati Police Division and the local criminal justice system generally. This is not intended to minimize the important role mental health service providers perform in the delivery of services to mentally impaired individuals.

Data for this research project were collected from several different data sources using a variety of data retrieval strategies. First, data were collected from police division Form 316s. This report is primarily based on data collected from Form 316s that are to be completed by a police officer every time there is a call or police run involving a mentally impaired individual. Unfortunately, these forms are not completed on all such calls. The second data collection method was a survey of police officers. The third data source was MCT personnel surveys. Fourth, data were collected through interviews with MCT personnel. The fifth data set was Police Call Data.

FINDINGS

Has the deployment of MCT resulted in greater citizen and officer safety?

- Injuries to service providers and police officers are almost non-existent. In only a limited number of instances do clients suffer injuries after the police respond, and most of these client injuries are due to the use of chemical irritants by officers. Almost all of the patient injuries prior to police arrival involve some form of bodily harm as a result of an attempted suicide.

- Survey responses of MCT report that these individuals believe that a police presence lessens the potential danger of a call. In contrast, over 50 percent of the officers noted that having an MCT member present does not influence the dangerousness of a call.

Has the use of MCT decreased the use of criminal justice outcomes and increased psychiatric referrals?

- A police hold is signed in only a limited number of the examined Code 9 interactions, while a mental hold is the most common type of hold signed in these cases.

- Almost all of the mentally impaired individuals MCT members and the police encounter are initially transported to the hospital (96% of the situations). These findings are consistent across all districts for both time periods. Because the use of a criminal justice response is a rare event, it is difficult to find a decrease in the use of this dispositional alternative as a result of the police-MCT collaboration.

- One question on each of the MCT and officer survey addresses the issue of willingness to use a criminal justice response. MCT and police personnel say they are "just as likely" to use a criminal justice response when they work together as they are when they work alone. However, the specially trained MHRT officers note that they are "less likely" to use arrest or jail when they work with MCT members.

Has the deployment of MCT reduced police time devoted to handling people with mental health problems?

- Because of problems with the quality of the police call data we were unable to fully address this topic using this data source.

- The survey data indicate that MCT personnel believe it takes less time to handle a call when an officer is present, while police believe it takes longer. This finding is confirmed by comments from the MCT personnel to the open-ended survey items and in the face-to-face interviews, wherein they repeat that the police rush the assessment process when citizens are encountered.

Have repeat calls from and about individuals with mental health problems declined since involvement of MCT?

- Data on repeat calls were obtained through an analysis of the frequency of client names from the 316 Form. All clients whose name appeared more than once in the total number of calls for each district were counted as a repeat caller.

- All districts show an increase in the total number of Code 9 calls across the two time periods. Second, the number of repeat calls increased in all districts including those with MCT.

- District 4, which is the control group showed the lowest increase in the number of repeat calls from period one to period two. In addition, when compared to the total number of calls received in the second time period, District 4 was the only one to experience a decrease (-1.16%) in the number of repeat calls received.

- The frequency of repeat calls also fluctuated between (July-December 2001) and (July-December 2002). For District 5, the number of repeat callers who called two times increased from 50 percent in period one to 87.9 percent in period two. In contrast, for District 1 the number of callers who called two times in period one decreased from 87.5 percent to 56.3 percent in period two.

- The results from the analysis show that the only District with a reduction in their overall percentage of repeat calls was District 4, which has no direct MCT involvement.

What are the police officers' and social workers perceptions of the deployment of MCT?

Have police officers' attitudes towards the handling of mental health calls improved since the inception of MCT and are officers better able to identify and handle mental health calls?

Officer Perceptions of MCT/Police Collaboration

A random sample of officers from District 1, District 4, and District 5 who had responded to a Code 9 call in 2001 and 2002 were surveyed. Officer responses were categorized by the amount of training an officer received for Code 9 calls: Basic training; Advanced training and MHRT officers. In general, the responses of Basic and Advanced officers were quite similar, while some differences were observed between their responses and the MHRT officers.

- Over 65 percent of all officers surveyed believed that the handling of mentally ill clients was a moderate to small problem. All Basic trained officers believed that they were moderately to very well prepared in handling mentally ill clients. Only Additionally trained officers (11.5%) and MHRT officers (5.0%) stated that they were not well prepared.

- Over 70 percent of Basic and Advanced trained officers believed that having a member of MCT on a Code 9 call did not influence their response to a call. Forty-two percent of MHRT officers believed that MCT members did not influence their response to a Code 9 call.

- There was a general consensus amongst all officers, over 60 percent, that they preferred responding to a call involving a mentally ill individual alone or with another officer rather than a member of MCT. Less than 50 percent of Basic and Advanced trained officers believed that MCT personnel helped them in terms of arriving at a more appropriate resolution to a Code 9 call. Only a majority of MHRT officers, 57.9 percent, believed that a MCT member helped in resolving a Code 9 call.

- Advanced trained officers (61.9%) and MHRT officers (36.8%) believed that responding to a call with a MCT member made the response to the call more effective. Less than 20 percent of Basic trained officers felt that having a member of MCT improved the effectiveness of the response to a Code 9 call.

- Half of the Basic trained officers (50.0%) and the Advanced trained officers (52.4%) believed that working with MCT personnel would not likely improve the identification process of mentally ill individuals, while 68.4 percent of the MHRT officers felt the collaboration was likely to assist them in identifying mentally ill individuals. There was a general consensus amongst all officers, (over 60%) that the MCT collaboration has helped keep people with mental illness out of jail.

Do mental health service providers express greater satisfaction with the use of MCT?

MCT Member Perceptions of MCT/Police Collaboration

- Three fourths (75%) of the MCT personnel see the handling of Code 9 calls as problematic for the police. Respondents are divided on whether officers are "not well prepared" and are "moderately well prepared" to handle these incidents.

- MCT members do not believe that working with an officer influences how they handle or resolve calls and they do not prefer working with a police officer versus other mental health providers.

- Interview comments and responses to open-ended questions suggest that perceptions of effectiveness vary with the nature of the call, the individual officer dispatched to the call, and the individual client. This may account for the equivocal responses to whether working with the police improves effectiveness.

- A substantial majority of the MCT respondents believed that the police have become better able to identify people with mental illness, have become more effective generally, and are better at not using a criminal justice response as a result of participation in the collaboration.

INTRODUCTION AND PROJECT BACKGROUND

Since July 2001, the Hamilton County Community Mental Health Board and the Cincinnati Police Division have worked together to improve services to people experiencing mental health problems in Cincinnati. This effort was initially implemented in District 5. This involved a pilot project, funded by the Hamilton County Community Mental Health Board, in which the Mobile Crisis Team worked directly with police on mental health calls out of the Cincinnati Police Division's District 5. The Board applied for a grant from the Health Foundation of Greater Cincinnati to expand this Mobile Crisis Team/Cincinnati Police collaboration into District 1. As part of this grant, the Board and the Health Foundation determined that an evaluation should be conducted to determine the effectiveness of this collaboration. The Criminal Justice Research Center at the University of Cincinnati was asked to evaluate the program.

The primary questions we were asked to address were whether the collaboration has improved the handling of calls involving mentally impaired individuals, and whether the collaborative process provides a benefit to the Cincinnati Police Division and the local criminal justice system generally. The emphasis of this research effort is therefore on the intersection of the delivery of mental health services and the provision of criminal justice responses by the city police division. This report is not intended to minimize the role of mental health service providers in the treatment of mentally impaired individuals, which we believe is a separate issue from the effect of the collaboration on the use of criminal justice resources.

The specific research objectives include answering six questions identified through discussions involving the Health Foundation, Hamilton County Community

Mental Health Board, Mobile Crisis Team members, the Cincinnati Police Division and the research team. These research objectives are:

1. Has the deployment of MCT resulted in greater citizen and officer safety?
2. Has the use of MCT decreased the use of criminal justice outcomes and increased psychiatric referrals?
3. Has the deployment of MCT reduced police time devoted to handling people with mental health problems?
4. Have repeat calls from and about individuals with mental health problems declined since involvement of MCT?
5. What are the police officers' and social workers' perceptions of the deployment of MCT?
6. Have police officers' attitudes towards the handling of mental health calls improved since the inception of MCT and are officers better able to identify and handle mental health calls?

POLICING THE MENTALLY ILL: ISSUES, DEVELOPMENT AND CONTEXT

Contact with mentally disordered citizens has long been a part of police work (Bittner 1967; Engel and Silver 2001). Police are routinely the first agency called to respond to situations involving the mentally ill. This is partly because they are always on duty and available, and partly because their job provides them with the authority to intervene in troublesome situations. In general, the police encounter people with mental illness in one or more of the following situations: as a crime victim, crime witness, the subject of a nuisance, a possible offender, or as a danger to her/his self or others. The officer who responds must be able to recognize that mental illness is a factor, assess the situation, reduce contact with the criminal justice system, ensure safety for all involved and provide a resolution that is fair and dignified for people with mental illness.

In general, the deinstitutionalization movement increased the number of mentally ill individuals living within communities. This has been combined with changes in police practices (order maintenance and community policing) that encourage police to get involved in the handling of minor disorders and incivilities. On average, police activity data indicate that approximately seven percent of officer contacts involve people with mental illness (Deane, Steadman, Borum, Vesey and Morrissey 1998). Similarly, a recent survey of officers from a large metropolitan police department found that 89 percent of the officers had at least one contact with a mentally ill person during the past year (LaGrange 2000). Data from the Project on Policing Neighborhoods (Engel and Silver 2001) indicate that 3.6 percent of police-citizen contacts involve mentally impaired persons. Therefore, it is not surprising that the police are critical links in the referral process (Doyle and Delaney 1994).

Even though police are routinely involved in the handling of mentally disordered people, interactions involving these people remain particularly challenging. Officers believe they are inadequately trained to identify and intervene in cases of mental illness (Finn and Sullivan 1987). Historically, officers have been more inclined to arrest these individuals, as it is a response they may be more comfortable enacting. This may be especially true when other services are either not available or officers do not believe they are appropriate based on the observed behavior (Lamb and Weinberger 1998). Furthermore, there is some suggestion in the literature that officers found it more difficult to invoke the mental health system than the criminal justice system in the handling of these situations.

In an effort to improve the handling of police interactions with mentally disordered citizens, a number of different strategies have been used by cities and police agencies (e.g., better training for officers, mental health providers hired by police departments). These programs may be differentiated by who has primary responsibility for the handling of these calls. Namely, you can train officers to handle the calls, hire mental health professionals to render this service or conduct a collaborative effort. The Cincinnati experience involves a collaboration between the local mental health system and the police. In this instance, when necessary, Code 9 calls involving mentally disordered individuals are handled by community health based crisis teams in coordination with the police department.

METHODOLOGY

In this portion of the report, we first explain the evaluation design selected to determine the effects of the MCT/Police collaboration. Second, we discuss the various types of data collected during the study to address the aforementioned research questions. Third, and relatedly, we provide a detailed description of the methodologies used to collect the multiple types of data.

EVALUATION DESIGN

This research involves a quasi-experimental design to determine the effects of the Mobile Crisis Team and Cincinnati Police collaboration. The study includes an experimental and comparison group. The design scheme is presented in Table 1:

Table 1: EVALUATION DESIGN SCHEME

	TIME PERIODS	
District	JULY – DECEMBER 2001	JULY – DECEMBER 2002
5	MCT	MCT
1	No MCT	MCT

4	No MCT	No MCT

☐ MCT ☐ NO MCT

For the evaluation of District 5, the experiences of District 5 will be compared to the experience of District 1 and District 4 for the pre-expansion and post-expansion periods. For the pre-expansion period we would expect more positive outcomes for District 5 than the other two control districts. For the post-expansion period we would expect District 1 and 5 to have comparable performance but better than District 4. For the evaluation of the District 1 expansion we will have a before-after comparison for District 1 along with two control districts: District 5 is a control with MCT and District 4 is a control without MCT.

PROJECT DATA

Data for this research project were collected from several different data sources using a variety of data retrieval strategies. First, data were collected from police division Form 316s. Form 316s are filled out by police officers responding to a Code 9 call and include information on the client, person placing the call and the nature of and handling of the call. The second data collection method was a survey of police officers. These data are used to measure officer perceptions regarding the MCT/Police collaboration on issues such as effectiveness, danger, and identification. The third data source was MCT personnel surveys. Similar to the police survey, the MCT survey is used to measure MCT perceptions of the MCT/Police collaboration. Fourth, data were collected through interviews with MCT personnel. These data are used to develop a more complete understanding of what is involved in a typical Code 9 call and to allow MCT personnel to elaborate on the collaborative process. The fifth data set was Police Call Data. These data

were intended to be used to examine the time spent by police on mental health calls in all three study districts during pre and post period years.

Form 316

The University of Cincinnati Research Team collected all 316s from District 1, District 2, District 4, and District 5 for the years 2001 and 2002. Based upon the evaluation design scheme, and discussions at meetings with MCT and Hamilton County Mental Health Board members during the past year, the analysis was narrowed to District 1, District 5, and District 4 from July to December for the years 2001 and 2002.

The purpose of examining Form 316s was to collect the appropriate data fields needed to answer the first four questions established in the research objectives. The first information gathered from the form was the name and address of the client involved in the call. A limited amount of demographic information such as birth date, race, gender and marital status was also collected. Information on the person placing the call in terms of the reason for calling, time of call, and their relationship to the client was also recorded (see appendix A for data forms).

The bulk of the data used for analysis was related to the nature and handling of the call. Information was collected on who initially received the call, MCT involvement, type of hold signed (if any), where the client was transported and the initial disposition of the call by the police. Additional information was also recorded on whether drugs and alcohol were involved in the incident. Data were also gathered on whether any injuries were suffered by the patient, the person placing the call, the service provider or the police officer during the interaction. The extent of the injuries and whether the injuries occurred while in police presence was also recorded.

While Form 316 data are the best available data for examining the efforts of the police in handling calls involving mentally impaired persons there is also one caution that should be mentioned. Namely, it appears that officers do not complete these forms every time they interact with someone who may be suffering from a mental impairment. This is noted because the police call data and data records developed by MCT personnel contain more cases than appear in the Form 316s retrieved from the study districts. It appears from a review of these additional data sources that officers are more likely to complete a Form 316 when they transport a person to either the hospital or the Justice Center than when they handle the call at the scene. Also, there are number of calls in both the call data and MCT data files that indicate that the party was either not present or refused service when the police and/or MCT personnel arrived. Taken together, it appears that Form 316s therefore only represent a percentage of the calls involving mentally impaired persons. Thus, the findings presented herein should not be viewed as representing the complete "workload" of police and MCT members when it comes to handling these types of requests. At the same time, we are convinced that the findings and conclusions presented concerning the identified research questions would not be different if these service requests were included in the following analyses.

Table 2 provides information on the number of 316s completed by officers in the study districts as well as the number of calls with MCT involvement. Two important

Table 2: DATA COLLECTED FROM 316'S (N)

District	JULY – DECEMBER 2001			JULY – DECEMBER 2002		
	TOTAL	MCT	NO MCT	TOTAL	MCT	NO MCT
5	184	33	151	202	25	177
1	117	6	111	252	43	209
4	141	4	137	192	13	179

findings are apparent from the data contained in this table. First, the number of 316s completed by officers over the course of the project increased in each district, with this being most evident in District 1. It is possible that the absolute number of calls involving mentally impaired individuals increased during the study, though there is nothing in the data that would indicate that this was the case. The increase in the completion of Form 316s appears more likely to be related to a heightened awareness on the part of officers that they are required to complete these forms if they suspect that the service recipient suffers from some mental impairment. Additionally, working with MCT members may also have improved the ability of officers to identify citizens who are mentally impaired.

Second, the physical presence of MCT personnel in District 1 during the second time frame was accompanied by a substantial increase in the number of calls handled collaboratively by MCT and police officers. Specifically, there was over a 600 percent increase (6 to 43 Form 316 calls) handled by both a police officer and a MCT member. This trend was also evident in District 4, which did not have MCT personnel stationed in the District but still showed an increase of 200 percent in the number of calls that were handled collaboratively (from 4 to 13 Form 316 calls). The increase in collaborative responses in District 4 may have occurred as a result of an elevated awareness on the part of officers of the services MCT were providing. In contrast, MCT and police officer runs decreased in District 5. There is some indication that this may have come about due to the introduction of the collaboration in District 1 in the second time frame. Coupled with an increase in collaborative calls in District 4, the resources of MCT personnel were now spread across multiple Districts.

Officer Surveys

Surveys were administered to Cincinnati police officers from District 1, District 4, and District 5 in August 2003. The purpose of the survey was to collect information on officers' perceptions concerning interactions with mental health personnel and their influence in the handling of Code 9 calls. Officers were asked about whether they believe they spend more, less, or the same amount of time on these calls when they are accompanied by MCT members, whether working with MCT personnel has improved their ability to identify mentally impaired individuals, whether these calls pose dangers to them and whether they believe they are more or less effective in handling these calls with MCT. Additionally, responses of officers were compared amongst those who have received department-wide basic training, extended training in the handling of mentally impaired clients, and MHRT training.

A list of all officers and their allocated shift was obtained for District 1, District 4, and District 5. In order to maximize the number of officers in our sample who had experience handling a Code 9 call and were familiar with the work of MCT personnel, a random sample of officers who had recently completed a Form 316 during the study period was drawn for District 1 (50 officers), District 5 (50 officers) and District 4 (40 officers)[1]. In other words, the sample was not drawn from all patrol officers in these three districts, but only those individuals who had filled-out a Form 316. District 5 has 96 patrol officers and District 4 has 91 officers. (Unfortunately, we were unable to secure a listing for District 1).

[1] Only 40 officers were selected in District 4 because identified officers either transferred, retired, or were on furlough.

Prior to contacting officers, the Patrol Bureau Commander advised all three police districts that researchers would soon be conducting surveys and that all district personnel should cooperate. Following this memo, research staff contacted district sergeants to arrange roll call visits on shifts worked by officers in the sample. At the request of district sergeants it was agreed that the surveys would be delivered to each district and administered and collected by a district representative.

The packet given to officers included a survey and a letter from the principal investigator. The letter from the principal investigator thanked officers for cooperating in the study and assured confidentiality (see Appendix B), stating that all information would be presented in aggregate form and that no identifying information would be disclosed. Table 3 provides information on officer response rates. To better understand the

Table 3: Officer Survey Response Rates (N)

	District 1	District 5	District 4
Completed Surveys	24	24	21
Retired/Quit/Transferred	6	2	4
Not Completed	20	24	15
Response Rate (%)	54.5	50.0	58.3
Overall Response Rate - 53.1%			

distribution of officer perceptions, frequency distributions are presented separately for officers with basic training, officers who have attended police division training sessions on people with mental illness, and Mental Health Response Team (MHRT) officers.

MCT Personnel Surveys

Mobile Crisis Team members were also surveyed about their interactions with officers during the study period. These individuals were asked about their experiences in

handling calls with a police officer. Survey content resembled the police officer survey as an attempt was made to get perceptions from the "other side" in this cooperative work arrangement. MCT personnel were asked their opinions on relevant issues related to working with police officers in improving the handling of calls involving mentally impaired individuals (see Appendix C for MCT survey instrument).

A letter also accompanied MCT personnel surveys from the principal investigator stating that the survey was voluntary, confidential, and the information would be used in an aggregate form with information from other surveys. A representative from the research team was able to obtain a list of MCT personnel and their scheduled shifts. Surveys were then delivered to University Hospital and picked up once they were completed. A total of 12 surveys were collected (out of 14) from MCT personnel.

MCT Personnel Interviews

"Face to face" interviews were conducted with 14 members of MCT. A list of all personnel involved was obtained and interview schedules were set up with the assistance of the University Hospital staff. The interview process was voluntary and all participants were guaranteed confidentiality in regards to their responses. Participants were asked a series of questions related to their most recent Code 9 call. The primary purpose of the interview was to assist in a better understanding of Code 9 calls and to supplement the quantitative data already collected (Appendix D, MCT interview protocol).

Police Call Data

Police Call Data were secured for all districts for the years 2001 and 2002. All Code 9 calls were separated from the total number of calls for each year by District.

Each Code 9 call was then assigned a unique identifier composed of the day of occurrence and the address of the incident. A unique identifier was also created from the Form 316s based on the day of occurrence and the address of the incident. All identified calls from the Police Call Data and the 316s were than entered into a statistical program set up to match calls from each data source.

The primary goal of using the Call data was to track each call from origination through disposition. Further analysis after the matching procedure revealed overwhelming inconsistencies in the recording of the disposition time on Form 316. In the majority of cases the time on the 316 forms was identical to the time the call was initially received. In some cases the time recorded was when the officer arrived on the scene and only in a few cases was the time recorded at the end of the run. The Police Call Data therefore is not used for this project in addressing the issue of time allocated for calls. Only data regarding perceptions of time devoted to calls from the police and MCT surveys is used in meeting this research objective.

FINDINGS

1. Has the deployment of MCT resulted in greater citizen and officer safety?

Table 4 contains data from the 316s concerning the frequency of client and officer injuries in Code 9 calls. Specifically, Table 4 provides the number of injuries sustained by clients prior to and after arrival of the police and the number of injuries to police and service providers.

Injuries to service providers and police officers are almost non-existent. In only a limited number of instances do clients suffer injuries after the police respond, and most of these client injuries are due to the use of chemical irritants by officers. Almost all of

Table 4: INJURY TO PATIENTS IN CODE 9 CALLS (N)								
District	JULY – DECEMBER 2001				JULY – DECEMBER 2002			
	INJURY TO CLIENT BEFORE POLICE ARRIVAL	INJURY TO CLIENT AFTER POLICE ARRIVAL	INJURY TO SERVICE PROVIDER	INJURY TO POLICE OFFICER	INJURY TO CLIENT BEFORE POLICE ARRIVAL	INJURY TO CLIENT AFTER POLICE ARRIVAL	INJURY TO SERVICE PROVIDER	INJURY TO POLICE OFFICER
5	24	3	0	0	17	2	0	0
1	8	2	0	0	17	2	0	1
4	7	6	0	1	9	1	0	0

the patient injuries prior to police arrival involve some form of bodily harm as a result of an attempted suicide.

Table 5 provides data on the proportion of Code 9 calls that resulted in a reported injury to a client, service provider or an officer after the arrival of the police. As can be seen in the table, injuries occur in only a very limited proportion of the calls. While there is a decrease in the percent of calls involving an injury across all three districts, the actual frequency of calls with injuries is quite limited.

Table 5: INJURY TO PATIENTS IN CODE 9 CALLS (%)			
District	JULY – DECEMBER 2001	JULY – DECEMBER 2002	CHANGE
5	1.6	1.0	-.6
1	1.7	1.2	-.5
4	5.0	.5	-4.5

Several items on the police officer and MCT surveys asked respondents about their perceptions of dangerousness when it came to calls involving mentally ill persons. Table 6 contains the perceptions of the MCT members, while Table 7 displays the response frequencies for the police officers.

Table 6: MCT Perceptions of Danger

MCT Responses	
In comparison to the typical police call you handle, working with a police officer on mental health calls (Code 9) makes these calls:	
More dangerous than the typical call	0 (0.0)*
No more or less dangerous	4 (33.3)
Less dangerous than the typical call	8 (66.7)
In the normal situation, responding to a mental health call with a police officer has what effect on the potential danger the call poses?	
Increases the danger	0 (0.0)
Has no effect on the danger	0 (0.0)
Lessens the danger	12 (100)

* N (%)

Table 7: Officer Perceptions of Danger

Officer Responses	
In comparison to the typical police call, mental health calls (Code 9) are usually:	
More dangerous than the typical call	30 (43.5)*
No more or less dangerous	35 (50.7)
Less dangerous than the typical call	4 (5.8)
In the normal situation, responding to a mental health call with a MCT member has what effect if any on the potential danger the call poses?	
Increases the danger	14 (23.7)
Has no effect on the danger	30 (50.9)
Lessens the danger	15 (25.4)

*N (%)

Several key findings are evident in the tables. First, MCT members believe that a police presence lessens the potential danger. Second, slightly over 50 percent of the officers noted that having an MCT member present does not influence the dangerousness

of a call, while the remaining officers were fairly evenly split between increases danger and lessens danger.

2. Has the use of MCT decreased the use of criminal justice outcomes and increased psychiatric referrals?

One anticipated benefit of the collaboration is that the number of calls receiving a criminal justice disposition will decrease while the use of psychiatric referrals will increase. In order to address this issue we first present data on the number and type of holds signed on Code 9 calls. Next we examine where the person initially is transported when the police respond alone to a Code 9 call. Finally, we address where the person is transported in situations where the police and MCT both respond to a call.

Table 8: TYPE OF HOLD (N)

District	JULY – DECEMBER 2001				JULY – DECEMBER 2002			
	TOTAL NUMBER OF CALLS	MENTAL HOLD	POLICE HOLD	NO HOLD	TOTAL NUMBER OF CALLS	MENTAL HOLD	POLICE HOLD	NO HOLD
5	184	144	6	34	202	149	9	44
1	117	95	4	18	252	203	3	46
4	141	120	3	18	192	158	1	33

As can be seen in Table 8, the most common type of hold signed in each district across both time periods is a mental hold. The second most common situation involves no hold being signed. Finally, a police hold is signed in only a limited number of the Code 9 interactions.

The following tables examine the initial disposition of Code 9 calls using Form 316 data. More specifically, the first table displays the total number of calls handled by

the police without the assistance of Mobile Crisis Team members and the frequency with which they use a hospital, criminal justice or other mental health response during each of the two study periods. The second table provides the percent of these calls that result in the client being taken to a hospital.

Table 9: DISPOSITION OF CALL WITH NO MCT INVOLVEMENT (N)								
District	JULY – DECEMBER 2001				JULY – DECEMBER 2002			
	TOTAL NUMBER OF CALLS	HOSPITAL	CJ RESPONSE	OTHER	TOTAL NUMBER OF CALLS	HOSPITAL	CJ RESPONSE	OTHER
5	147	134	6	7	149	142	1	6
1	111	108	0	3	209	198	1	10
4	137	135	1	1	179	178	1	0

Table 10: DISPOSITION OF CALL TO HOSPITAL WITH NO MCT INVOLVEMENT (%)		
District	JULY – DECEMBER 2001	JULY – DECEMBER 2002
5	91.2	95.3
1	97.3	94.7
4	98.5	99.4

Two findings are evident from these tables. First, the use of a criminal justice response is a rare event. Because of the low proportion of cases where a criminal justice disposition occurs it is difficult to find a decrease in the use of this dispositional alternative. Second, almost all of the mentally impaired people the police encounter are initially transported to the hospital. These two findings are consistent across all districts for both time periods. It should be noted that the reduction in the percent of clients transported to the hospital from District 1 across the time periods occurs because officers were more likely to use an alternative to the hospital and jail, not because more clients

were taken to the Justice Center.

The following two tables provide the same information for situations where MCT personnel and police were involved in handling the Code 9 call. As can be seen in these tables, a criminal justice response is not utilized in any of the Code 9 situations. In almost all of the instances where MCT members are involved in the handling of the call, the client is transported to a hospital for services (95% of all calls). In fact, when all calls are examined 96 percent are initially disposed of with the client being taken to the hospital irrespective of whether the police act alone or with MCT members.

Table 11: DISPOSITION OF CALL WITH MCT INVOLVEMENT (N)

District	JULY – DECEMBER 2001				JULY – DECEMBER 2002			
	TOTAL NUMBER OF CALLS	HOSPITAL	CJ RESPONSE	OTHER	TOTAL NUMBER OF CALLS	HOSPITAL	CJ RESPONSE	OTHER
5	33	31	0	2	21	19	0	2
1	6	6	0	0	43	41	0	2
4	4	4	0	0	13	13	0	0

Table 12: DISPOSITION OF CALL TO HOSPITAL WITH MCT INVOLVEMENT (%)

District	JULY – DECEMBER 2001	JULY – DECEMBER 2002
5	94.0	90.5
1	100.0	95.3
4	100.0	100.0

Tables 13 and 14 address the issue of the willingness of participants to dispose a call using a criminal justice response. The following two tables provide the responses of each group of respondents to these questions. Two findings are evident in these tables.

Table 13: MCT Perceptions of Use of the Criminal Justice Dispositions

MCT Responses		
When you work with a police officer are you more or less likely to dispose of a call using a criminal justice response (arrest, jail) than when you work without a police officer?		
	More likely	2 (16.7)*
	Just as likely	8 (66.7)
	Less likely	2 (16.7)

*N (%)

Table 14: Police Officer Perceptions of the Use of Criminal Justice Dispositions

	Basic Training Officers	Additional Training Officers	MHRT Officer	Total
When you work with a MCT member are you more or less likely to dispose of a call using a criminal justice response (arrest, jail)?				
More likely	0 (0.0)*	0 (0.0)	0 (0.0)	0 (0.0)
Just as likely	10 (55.5)	13 (65.0)	8 (42.1)	31 (54.4)
Less likely	8 (45.5)	7 (35.0)	11 (57.9)	26 (45.6)

*N (%)

First, both MCT and police personnel say they are "just as likely" to use a criminal justice response when they work together as they are when they work alone. Second, the only time this is not the case is with the specially trained MHRT officers. A majority of these respondents note that they are "less likely" to use arrest or jail when they work with MCT members.

3. *Has the deployment of MCT reduced police time devoted to handling people with mental health problems?*

As noted in the Methods section, there were substantial questions concerning the accuracy of the call data and time data on the 316 forms once the data sets were matched. Because of the concerns about the quality of the time data, no analyses were performed using the call data.

One question on each of the survey instruments asked police and MCT respondents to offer their perceptions of whether it took more or less time to process a call when they both responded.

Table 15: MCT Perceptions of Time Spent Handling a Call

MCT Responses	
Is the amount of time you spend on a mental health call (Code 9) with a member of the police division:	
Greater than when you handle a call without a police officer	1 (8.3)*
The same as when you handle a call without a police officer	0 (0.0)
Less than when you handle a call without a police officer	11 (91.7)

* N (%)

Table 16: Police Perceptions of Time Spent Handling a Call

Officer Responses	Total
Is the amount of time you spend on a mental health call (Code 9) with a member of the MCT:	
Greater than when you handle a call alone	30 (50.8)*
The same as when you handle a call alone	15 (25.4)
Less than when you handle a call alone	14 (23.7)

* N (%)

In general, MCT personnel believe it takes less time to handle a call when an officer is present, while police believe it takes longer. This finding is confirmed by

comments from the MCT personnel to the open-ended survey items and in the face-to-face interviews. For instance several of the MCT personnel said that the "MCT alone response usually results in a more thorough assessment", and "police calls are rushed, because they want to get in and get out". Also MCT members in their interviews noted that if an officer is not present at the outset, then officer response time would influence the length of time spent on a call and often this meant that the call could have been handled faster without police presence.

4. Have repeat calls from and about individuals with mental health problems declined since involvement of MCT?

Data on repeat calls were obtained through an analysis of the frequency of client names from the 316 Form. All clients whose name appeared more than once in the total number of calls for each district were counted as a repeat caller. Table 17 compares the number of repeat calls in each of the three districts with and without MCT involvement.

Table 17: NUMBER OF REPEAT CALLS (N)

District	JULY – DECEMBER 2001		JULY – DECEMBER 2002		
	TOTAL NUMBER OF CALLS	REPEATS	TOTAL NUMBER OF CALLS	REPEATS	CHANGE
5	184	22	202	33	11
1	117	16	252	48	32
4	141	20	192	25	5

A total of 1088 calls were recorded. Column two presents the total number of calls for each District from July to December of 2001. The third column presents the total number of calls that were repeat calls during the 2001 time period. The same pattern is repeated in column 4 and 5 for July to December of 2002. Column six displays the change in the number of repeat calls from the first period to the second.

Table 18: REPEAT CALLS (%)			
District	JULY – DECEMBER 2001	JULY – DECEMBER 2002	
5	11.96	16.35	4.39
1	13.67	19.05	5.38
4	14.18	13.02	-1.16

Table 18 presents the percent of repeat calls for each district (number of repeat calls/by the total number of district calls during the allocated time frame). Column four presents the difference in percent of repeat calls from period one to period two. In an effort to explore further the incidence of repeat calls we examined whether repeat calls received on the same day as a first call were inflating our repeat call frequencies. Only one repeat call in District 5 fit within this criterion. No such calls in Districts 1 and 4 received on the same day as the first call.

Several findings are apparent from a review of Tables 17 and 18. First, the number of repeat calls increased in all districts including those with MCT. District 4, which is the control group showed the lowest increase in the total number of repeat calls from period one to period two. Because of the increase in the total number of calls in the second time period in District 4, this district was the only one to experience a decrease (-1.16%) in the number of repeat calls received.

To further explore differences in repeat calls within the Districts, we also examined the frequency with which repeat callers contacted the police. The results are presented in Table 19.

Table 19: Frequency of Repeat Calls

District 5 (July – December 2001)		**District 5 (July – December 2002)**	
Total Number of calls from 316's: 184		Total Number of calls from 316's: 202	
Repeats	22 (11.96)*	Repeats	33 (16.35)
Frequency		Frequency	
2	11 (50.0)	2	29 (87.9)
3	8 (36.4)	3	1 (3.0)
4	2 (9.1)	4	1 (3.0)
5	1 (4.5)	5	2 (6.1)
District 1 (July – December 2001)		**District 1 (July – December 2002)**	
Total Number of calls from 316's: 117		Total Number of calls from 316's: 252	
Repeats	16 (13.67)	Repeats	48 (19.05)
Frequency		Frequency	
2	14 (87.5)	2	27 (56.3)
3	1 (6.3)	3	10 (20.8)
4	0	4	8 (16.7)
5	1 (6.3)	5	1 (2.1)
		6	0
		7	1 (2.1)
		8	1 (2.1)
District 4 (July – December 2001)		**District 4 (July – December 2002)**	
Total Number of calls from 316's: 141		Total Number of calls from 316's: 192	
Repeats	20 (14.18)	Repeats	25 (13.2)
Frequency		Frequency	
2	16 (80.0)	2	16 (64.0)
3	4 (20.0)	3	6 (24.0)
4		4	1 (4.0)
5		5	2 (8.0)
6			

* N (%)

As can be seen in Table 19, the frequency of repeat calls also fluctuated across the two study periods (July-December 2001 and July-December 2002). For District 5, the number of repeat callers who called two times increased from 50 percent in period one to 87.9 percent in period two. In contrast, for District 1 the number of callers who called two times in period one decreased from 87.5 percent to 56.3 percent in period two. Surprisingly it appears that although District 5 had an overall increase in the number of repeat callers the actual frequency of repeat calls declined. In other words, there were fewer callers who were calling more than two times.

For District 1, the frequency of repeat calls increased in that there were now more repeat callers who called more than two times in the second period. For example the percentage of repeat callers who called 3 times increased from 6.3 percent in period one to 20.8 percent in period two. These results may help explain some of the increase in the overall percentage of repeat calls shown in Table 5.

One of the chief concerns related to the MCT/Police collaboration was a reduction in the number of calls pertaining to individuals with mental illness. The results from the analysis show that the only District with a reduction in their overall percentage of repeat calls was District 4, which has no direct MCT involvement. In terms of decreasing the frequency of repeat calls by repeat callers District 5 does show improvement with the involvement of MCT in the second time period.

Officer Perceptions of MCT/Police Collaboration

One means for examining the effectiveness of the MCT/Police collaboration is to gather information from street-level officers responsible for responding to Code 9 calls. This was accomplished by surveying a random sample of officers from District 1, District

4, and District 5 who had responded to a Code 9 call in 2001 and 2002. Survey items covered a range of topics including personal characteristics of the officers as well as officers' perceptions on safety, identification, training, time, and effectiveness related to the MCT/Police collaboration. A total of 69 officers returned completed surveys: District 1 (24), District 4 (21), and District 5 (24).

FINDINGS

First, sample characteristics are presented. Next, responses to questions that address officers attitudes towards the efficacy and appropriateness of the MCT/Police collaboration, officers preparedness in handling calls involving the mentally ill, training, identification issues, level of danger, and effectiveness in handling Code 9 calls are provided.

Sample Characteristics

Five characteristics of officers are presented in Table 20: officer gender, age, race, education, and length of service with the Cincinnati Police Division. Males account for at least 70 percent of the respondents in each sample (76.2% of the Basic training officers, 96.2% of the Advanced trained officers, and 73.7% of the MHRT officers). A majority of each category of officers is white (52.4% of the Basic training, 87.5% of the Advanced trained officers and 52.6% of the MHRT officers).

Officers in all three samples were similar in age, almost 50 percent in each category were between the ages of thirty and thirty-nine. Over 70 percent of the Basic and MHRT officers had been employed by the Cincinnati Police Division for less than five years. The length of employment for Advanced trained officers was more evenly

spread out with 46.2 percent being employed less than five years, 30.8 percent less then 10 years, and 23.1 percent less than fifteen years.

Table 20: Sample Characteristics

Variable	Basic Training Officers	Advanced Training	MHRT Officers
Gender			
Male	16 (76.2)*	25 (96.2)	14 (73.7)
Female	5 (23.8)	1 (3.8)	5 (26.3)
Age			
23-29	8 (38.1)	8 (30.8)	8 (40.0)
30-39	10 (47.6)	12 (46.2)	10 (50.0)
40-49	3 (14.3)	6 (23.1)	2 (10.0)
Ethnicity			
Caucasian	11 (52.4)	21 (87.5)	10 (52.6)
African American	10 (47.6)	2 (8.3)	8 (42.1)
Hispanic/Latino		1 (4.2)	
Other		0 (0.0)	1 (5.3)
Education			
High School/GED	2 (9.5)	0 (0.0)	3 (15.0)
Some College	10 (47.6)	13 (52.0)	7 (35.0)
Bachelor's Degree	8 (38.1)	10 (40.0)	7 (35.0)
Masters Degree	0 (0.0)	1 (4.0)	1 (5.0)
Other	1 (4.8)	0 (4.0)	2 (10.0)
Length of Employment			
1 – 5 years	16 (76.2)	12 (46.2)	14 (70.0)
6 – 10 years	3 (14.3)	8 (30.8)	3 (15.0)
11 – 15 years	2 (9.5)	6 (23.1)	3 (15.0)

* N (%)

A significant proportion of officers in all three samples had either attended college and/or received degrees. Surprisingly, over 90 percent of officers with Basic training had some college education. Overall, for all three samples less than 15 percent of the officers had only a high school diploma.

Perceptions of MCT/Police Collaboration

The following sections deal with specific issues related to the MCT/Police Collaboration. Specifically, issues addressed will include the efficacy and appropriateness of the MCT/Police collaboration, officer preparedness, perceptions on working with MCT members, and the overall opinions on the purpose of the MCT/Police collaboration.

Efficacy

Three survey items assessed officer beliefs about the efficacy of the MCT/Police collaboration. These items asked respondents to state whether they believed the statement was "true" or "false". Table 21 provides the responses to the survey items.

Table 21: Efficacy and Appropriateness of MCT/Police Collaboration

	Basic Training Officers	Advanced Training	MHRT Officers	Totals
Having an MCT member present at the scene of a Code 9 call does not influence my own response …				
True	13 (72.2)*	16 (76.2)	8 (42.1)	37 (63.8)
False	5 (27.8)	5 (23.8)	11 (57.9)	21 (36.2)
I prefer working with MCT personnel versus responding on my own or with other police officers when handling…				
True	7 (38.9)	8 (38.1)	6 (33.3)	21 (36.8)
False	11 (61.1)	13 (61.9)	12 (66.6)	36 (63.2)
I believe I am better able to arrive at a more appropriate resolution of the call when I respond with an MCT member.				
True	8 (44.4)	10 (47.6)	11 (57.9)	29 (50.0)
False	10 (55.6)	11 (52.4)	8 (42.1)	29 (50.0)

As can be seen in Table 21, officers with Basic training and officers with Advanced training had very similar responses to the questions. Over 70 percent of Basic and Advanced trained officers believed that having a member of MCT on a Code 9 call did not influence their response to a call. However, only 42.1 percent of MHRT officers believed that MCT members did not influence their response to a Code 9 call.

There was a general consensus amongst all officers, over 60 percent, that they preferred responding to a Code 9 call alone or with another officer rather than a member of MCT. Less than 50 percent of Basic and Advanced trained officers believed that MCT personnel helped them in terms of arriving at a more appropriate resolution to a Code 9 call. Only a majority of MHRT officers, 57.9 percent, believed that a MCT member helped in resolving a Code 9 call.

Preparedness

Table 22: Police Division Preparedness

	Basic Training Officers	Advanced Training	MHRT Officers	Totals
How big of a problem is the handling of people with mental illness for the police?				
Big Problem	5 (23.8)*	7 (26.9)	5 (25.0)	17 (25.4)
Moderate Problem	7 (33.3)	13 (50.0)	8 (40.0)	28 (41.8)
Small Problem	8 (38.1)	5 (19.2)	5 (25.0)	18 (26.9)
No Problem at all	1 (4.8)	1 (3.8)	2 (10.0)	4 (5.9)
How well are you prepared for handling people with mental illness that are involved in some crisis?				
Very well prepared	6 (28.6)	8 (30.8)	12 (60.0)	26 (38.8)
Moderately well prepared	15 (71.4)	15 (57.7)	7 (35.0)	37 (55.2)
Not well prepared		3 (11.5)	1 (5.0)	4 (5.9)

Two additional survey items assessed officer perceptions of their preparedness in handling calls involving the mentally ill. Officers were asked to state their level of agreement/disagreement with each of these two survey items. In terms of the scope of the problem there was general agreement amongst all officers. As can be seen in Table 22, over 65 percent of all officers surveyed believed that the handling of mentally ill clients was a moderate to small problem. Approximately 25 percent of all officers felt that handling mentally ill clients was a big problem. Interestingly, all Basic trained officers believed that they were moderately to very well prepared in handling mentally ill clients. Only Advanced trained officers (11.5%) and MHRT officers (5.0%) stated that they were not well prepared.

Effectiveness

Table 23: Perceptions of Effectiveness When Working With MCT

	Basic Training Officers	Advanced Training	MHRT Officers	Totals
I am less effective when handling Code 9 calls when I work with an MCT member.				
True	1 (5.6)*	3 (14.3)	3 (17.6)	7 (12.5)
False	17 (94.4)	18 (85.7)	14 (82.4)	49(87.5)
When responding to a mental health call with a MCT member do you believe you are:				
More effective than when responding alone	3 (16.7)	13 (61.9)	7 (36.8)	23 (39.7)
Neither more nor less effective	14 (77.8)	4 (19.0)	9 (47.4)	27 (46.6)
Less effective than when respondingalone	1 (5.6)	4 (19.0)	3 (15.8)	8 (13.8)

* N (%)

As can be seen in Table 23, over 80% of all officers in the sample agreed that having a member of MCT on a call did not reduce their effectiveness in the handling of a call. Officers were split though on whether the presence of an MCT member improved their effectiveness or had no effect. A majority of the Advanced trained officers (61.9%) believed MCT presence increases their effectiveness, while MHRT officers and Basic trained officers were not as likely to have this belief.

Training

Table 24: Training

Have you attended any police division training sessions that specifically taught you about handling people with mental illness	
Yes	48 (69.6)
No	21 (30.4)
The next three questions only pertain to the 48 officers who attended training sessions.	
If yes, were any of the presenters at these training sessions mental health service providers?	
Yes	44 (91.7)
No	4 (8.3)
In general, have these training sessions helped you to better identify people with mental illness?	
Have not been helpful at all	2 (4.2)
Have been somewhat helpful	21 (43.8)
Have been moderately helpful	16 (33.3)
Have been very helpful	9 (18.7)
In general, have these training sessions helped you to more effectively handle citizens with mental illness?	
Have not been helpful at all	5 (10.4)
Have been somewhat helpful	17 (35.4)
Have been moderately helpful	17 (35.4)
Have been very helpful	9 (18.7)

Table 24 shows that almost 70 percent of officers in the sample attended training sessions specifically aimed at improving the handling of individuals with mental illness. Over 90 percent of the officers reported that mental health service providers were present at these training sessions. The vast majority of officers (over 70%) noted that the training session have been somewhat to moderately helpful in improving the identification and handling of citizens with mental illness. Less than 11 percent of officers believed that the trainings were not helpful at all in improving the identification (4.2%) and handling of mentally ill clients (10.4%).

Benefits of the Collaboration

Three items on the survey focus on issues relating to the benefits of the MCT/Police collaboration in terms of identification, keeping people with mental illness out of jail and the overall purpose of the collaboration (Table 25).

Table 25: Overall opinions on MCT/Police Collaboration

	Basic Training Officers	Advanced Training	MHRT Officers	Totals
How likely is it that working with MCT personnel will improve your ability to identify mentally impaired individuals?				
Very likely	4 (22.2)	3 (14.3)	9 (47.4)	16 (27.6)
Somewhat likely	5 (27.8)	7 (33.3)	4 (21.0)	16 (27.6)
Not very likely	4 (22.2)	8 (38.1)	4 (21.0)	16 (27.6)
Not likely at all	5 (27.8)	3 (14.3)	2 (10.5)	10 (17.2)
Overall, the MCT has helped the police division to become more effective at keeping people with mental illness out of jail.				
True	11 (61.1)	13 (65.0)	12 (70.6)	36 (65.5)
False	7 (38.9)	7 (35.0)	5 (29.4)	19 (34.5)

Table 25: Overall opinions on MCT/Police Collaboration (continued..)

	Basic Training Officers	Advanced Training	MHRT Officers	Totals
What do you believe is the primary purpose of the MCT/police collaboration?				
Improve the handling of calls	10 (55.6)	9 (42.9)	13 (65.0)	32 (54.2)
Reduce liability	7 (38.9)	9 (42.9)	4 (20.0)	20 (33.9)
Unsure of why this collaboration came about		2 (9.5)		2 (3.4)
Other	1 (5.6)	1 (4.8)	3 (15.0)	5 (8.5)

* N (%)

Overall half of the Basic trained officers (50.0%) and the Advanced trained officers (52.4%) believed that working with MCT personnel would not likely improve the identification process of mentally ill individuals. In contrast, 68.4 percent of the MHRT officers felt that working with MCT was likely to assist them in identifying mentally ill individuals. There was a general consensus amongst all officers, (over 60%) that the MCT collaboration has helped keep people with mental illness out of jail. In general, less than 50 percent of the Advanced trained officers believed that the MCT/Police collaboration served the purpose of improving calls with mentally ill individuals. In comparison 65 percent of the MHRT officers believed that the MCT/Police collaboration was established to serve the primary purpose of improving Code 9 calls.

MCT Member Perceptions of MCT/Police Collaboration

MCT members were also surveyed in an effort to gather their perceptions of the effectiveness of the MCT/Police collaboration. The survey instrument closely resembled the officer survey with the major difference being that the mental health workers were asked about their working relationship with police officers. The survey was administered to fourteen individuals by leaving a copy at the end of the interview session. Because of the limited number of these surveys, one should be cautious in interpreting the reported percentages in the findings.

FINDINGS

The findings are presented in a manner that is consistent with the prior section containing officer perceptions of the collaboration. In other words, we first present responses to the questions on how problematic these calls are. Followed by issues on officer preparedness, the efficacy and appropriateness of the MCT/Police collaboration, working with police members, and the overall opinions on the purpose of the MCT/Police

Perceptions of MCT/Police Collaboration

We first report MCT member perceptions of the extent to which calls involving the mentally impaired pose a problem for police officers. This is followed by their perceptions on how well officers are prepared for this task.

As can be seen in Table 26, three fourths (75%) of the MCT personnel see the handling of these calls as problematic for the police. None of the respondents reported that calls of this nature were not a problem. The responses in Table 26 also indicate that the respondents are divided on whether officers are “not well prepared” and are “moderately well prepared” to handle these incidents.

Table 26: Police Division Preparedness

MCT Personnel		
How big of a problem is the handling of people with mental illness for the police?		
	Big Problem	2 (16.7)*
	Moderate Problem	7 (58.3)
	Small Problem	3 (25.0)
	No Problem at all	0 (0.0)
How well prepared do you believe the police are for handling people with mental illness that are involved in some crisis?		
	Very well prepared	0 (0.0)
	Moderately well prepared	6 (50.0)
	Not well prepared	6 (50.0)
	Not at all prepared	0 (0.0)

*N(%)

Three survey items focus on the mental health workers beliefs about their work relationship with police officers. These items asked respondents to state whether they believed the statement was "true" or "false". Table 27 provides the responses to these survey items.

Table 27: Efficacy and Appropriateness of MCT/Police Collaboration

MCT Personnel		
Having a police officer present at the scene of a Code 9 call does not influence my own response …	True	7 (58.3)
	False	5 (41.7)
I prefer working with police officers versus responding on my own or with other service providers…	True	3 (25.0)
	False	9 (75.0)
I believe I am better able to arrive at a more appropriate resolution of the call when I respond with a police officer	True	2 (16.7)
	False	10 (83.3)

*N (%)

The findings in Table 27 highlight two important perceptions of MCT members. First, they do not believe that working with an officer influences how they handle or resolve calls. Second, they do not prefer working with a police officer versus other mental health providers.

Effectiveness

Two additional survey items asked about whether MCT members believed they were more effective when working with police officers. The responses are reported in Table 28.

Table 28. Perceptions of Effectiveness When Working With the Police

MCT Personnel	
I am more effective when handling Code 9 calls when I work with a police officer.	
True	7 (58.3)*
False	5 (41.7)
When responding to a mental health call with a police officer do you believe you are	
More effective than when responding alone	3 (25.0)
Neither more nor less effective	7 (58.3)
Less effective than when responding alone	2 (16.7)

*N (%)

The responses to these two items appear somewhat contradictory. While a slight majority (58.3%) indicate that working with the police has made them more effective, a slight majority (58.3%) also report that work working with an officer has not influenced their effectiveness. Following the second item in Table 28, respondents were queried about their reasons for stating they were more or less effective. The responses suggest that perceptions of effectiveness vary with the nature of the call, the individual officer

dispatched to the call, and the individual client. The following comments are representative of the responses:

> "Depends on the situation, sometimes people hold it together better and other times they really act psychotic when the officer is present."
>
> "…patients are more honest without the police but if call was generated as 911 then we help police become more efficient."
>
> "…more effective due to having an MHRT officer on the scene to add his or her input."
>
> "More effective with the police because it lessens response time and makes it easier to get the patient safely to the hospital."

In addition, comments on the benefits and drawbacks of the collaboration also support this equivocal perception of effectiveness. Again the selected comments are representative of those received.

> "New officers do not have experience with mentally ill are more likely to use physical force."
>
> "MCT is too often connected to the police and many clients know that they may be arrested or taken to the hospital."
>
> "Joint response is only beneficial when the call is urgent, otherwise MCT alone is better to handle mental health calls."
>
> "Police are more educated on legal issues, safety is increased and police can provide history on patients to aid in assessment."

Benefits of the Collaboration

Three survey items address MCT member perceptions of the impact of the collaboration on officer behavior. One of the questions asks about the ability of officers to become "better at identifying people with mental illness", while another asks whether they believe officers have become "more effective at handling citizens with mental illness". The final item addresses their beliefs about whether the collaboration has made

the police more effective at "keeping people with mental illness out of jail" (see Table 28). In general, the responses indicate that MCT personnel believe that the collaboration has had a beneficial influence on officer handling of calls involving mentally impaired individuals. In response to each of these survey items, a substantial majority of the respondents indicated that police were better able to identify people with mental illness, had become more effective generally, and were better at not using a criminal justice response.

Table 29. Benefits of the Collaboration

MCT Personnel	
In general, do you believe the police officers you have worked with have become better at identifying people with mental illness?	
Have become much better	2 (16.7)
Have become somewhat better	9 (75.0)
Have become only slightly better	1 (8.3)
Have not become better at all	0 (0.0)
In general have these officers you have worked with become more effective at handling citizens with mental illness? They have become	
Much more effective	2 (16.7)
More effective	6 (50.0)
Only slightly more effective	4 (33.3)
Not become more effective	0 (0.0)
Overall, the MCT has helped the police division to become more effective at keeping people with mental illness out of jail.	
True	10 (83.3)
False	2 (16.7)

* N (%)

CONCLUSIONS

The findings presented herein provide support for the contention that *every program has some effects.* Two divergent conclusions can be drawn concerning the police-MCT collaboration depending on the issues being addressed and the data utilized. On the one hand, the findings of "no effects" have been interpreted as reflecting the objectives (safety, outcomes, time, and repeat calls) set forth by the Hamilton County Community Mental Health Board and the Health Foundation of Greater Cincinnati. On the other hand, findings from this evaluation do find "some effects" for the collaboration, which were not specified but nevertheless were consequences of the collaboration.

MCT/Police Collaboration Objectives

Form 316s were analyzed to address the primary objectives of the MCT/Police collaboration: safety, outcomes, time, and repeat calls. In general, the findings derived from the official police data do not support the collaboration. Specifically, Form 316 data suggests that injuries to clients, service providers and police officers are almost non-existent. In only a limited number of instances do clients suffer injuries after the police respond, and most of these client injuries are due to the use of chemical irritants by police personnel. Similarly, a police hold is signed in only a limited number of the examined Code 9 interactions, while a mental hold is a much more common response. This is true across all of the study districts for both time periods. In each instance, injuries and use of a criminal justice response are rare events in Code 9 calls. The limited variation in injuries and holds thus makes it very difficult to test the impact of the collaboration on the problem.

Results from the MCT and police personnel surveys however indicate that there are some benefits from the collaboration relative to these two issues. Survey responses of MCT members reveal that they believe a police presence lessens the potential danger of a call (for service providers), while police officers generally believed that having an MCT member present does not influence the dangerousness of a call. As to the willingness to use a criminal justice response, the specially trained MHRT officers note that they are "less likely" to use arrest or jail when they work with MCT members. Also, there was a general consensus among all types of officers (level of training) that the MCT collaboration helped keep people with mental illness out of jail.

When the effect of the MCT/Police collaboration on repeat calls is examined, the findings also reveal some inconsistencies. All districts showed an increase in the total number of Code 9 calls across the two time periods and the number of repeat calls also increased in all districts including those with MCT. Further analysis showed that when repeat calls were compared to the total number of calls in the second time frame only District 4 had a decrease in the percent of repeat calls.

In terms of the frequency of calls received, the number of callers who called two times in period one decreased from 87.5 percent to 56.3 percent in period two when MCT was stationed in District 1. District 4 also had a decline in callers who called two times (80% to 64%) but District 5 showed an increase (50% to 87.9%). What remains unknown is if calls from citizens that previously went directly to the hospital or other mental health service agency had migrated to the police call system because citizens knew that MCT members were available in the police Districts 1 and 5. If this is the case, then the

increase in the number of repeat calls in District 1 and 5 may have been inflated as a result of client service convenience (911 versus contacting the Hospital).

Due to limitations of the Police Call Data and Form 316s only police and MCT surveys were used to assess the time it takes to handle a Code 9 call. The results from both surveys supported the conclusion that a collaborative effort on a Code 9 call consumed more time. Police officers believed that the time spent on a Code 9 call was longer when they collaborated with an MCT member then when they acted alone or with another officer. MCT personnel, on the other hand, believed that they had less time to handle a call when an officer was present. MCT members noted that the police rush the assessment process when citizens are encountered. Conversely, police officers felt that MCT personnel spent too much time on assessment.

Differences in perceptions regarding time allocated a Code 9 call may directly be related to the primary purpose of each agency involved. In other words, there are profound differences in the objectives and training of MCT personnel and officers. While officers were more likely attempting to resolve the conflict quickly, MCT personnel were more likely to be focused on the underlying mental impairment of the client in an effort to arrive at a more long-term resolution of the problem.

Surveys of officers and MCT members as well as MCT personnel interviews were used to gather information concerning their perceptions of the effectiveness of the collaborative effort. Results from the police officer surveys showed that MHRT officers perceived the greatest benefit from the MCT/Police collaboration in comparison to the other officers in the sample. Specifically, a majority of MHRT officers believed that the presence of MCT helped in resolving a Code 9 call, that the collaboration was likely to

assist them in identifying mentally ill individuals, and that having mental health personnel present made their response more effective. At the same time, officers with Advanced training in handling mentally impaired individuals were generally less supportive of MCT than MHRT officers. Officers with only Basic training had the least favorable opinions on issues surrounding the handling of mentally ill clients and the MCT/Police collaboration in general.

MCT survey responses and interview comments were generally mixed as to the perceived benefits associated with handling calls with police personnel. These respondents suggested that the collaboration helped make the police division more effective when responding to Code 9 calls and that calls were less dangerous when an officer was present. Responses also indicate that a police presence was most helpful when a dangerous situation was encountered and an experienced officer responded. Overall, most MCT members suggested that the collaborative effort had improved police officer understanding of the issues surrounding the handling of mentally impaired citizens, that there was a more complete exchange of information between officers and service providers and that officers had become more supportive of social workers.

MCT personnel also voiced some negative effects as a result of participating in the collaboration. First, there was a concern that the officers were in a hurry to handle Code 9 calls and rushed MCT members during their assessment of the situation. Second, MCT members also noted that some citizens reacted negatively to the presence of the officer in a manner that made it more difficult to resolve the problem (became more aggressive and fearful of being arrested) and created confusion for the client as to the roles of the MCT and the police.

Interview comments and responses to open-ended questions suggest that perceptions of effectiveness vary with the nature of the call, the individual officer dispatched to the call, and the individual client. This may account for the equivocal responses to whether working with the police improves effectiveness.

Finally, both groups of respondents indicated that they preferred working alone. Namely, police preferred working with other police personnel and MCT members with other mental health service providers. In each instance these views were voiced by a substantial majority of the respondents. This is definitely problematic and suggests that both parties to the collaboration need to be better educated as to the roles and objectives of each in the handling of mentally impaired individuals.

Indirect Consequences of the Collaboration

First and foremost, a purposive social action such as the MCT/Police collaboration helped raise awareness about mental illness issues in the criminal justice system as well as society at large. Secondly, a key benefit of the MCT/Police collaboration is that it has facilitated an interaction between two divergent service providers. While no data is available on this issue the intensive interaction among participants may have produced benefits beyond the original goals of the collaboration.

For police officers, contact with MCT personnel and additional training may have sensitized officers to the need for more and better information concerning the handling of people with mental impairments. Additionally, officers voiced that they feel less alienated in interactions with mental health service providers and members of Psychiatric Emergency Services at the University Hospital. MCT personnel also noted that they have

benefited in gaining a better understanding of police officer concerns as well as developed lasting relationships with officers for future assistance on dangerous calls.

Future Implications

Numerous studies have found that persons with mental disorders are over represented in prisons and jails (Engel and Silver, 2001). In regards to this dilemma, it has been suggested that a possible source of the problem may be a disproportionate use of arrest by police officers to resolve encounters with mentally ill clients. The findings from this evaluation reveal that police officers overwhelmingly use appropriate means to handle situations involving mentally ill clients. The benefits gained from the MCT/Police collaboration and the creation of specialized Mental Health Response Team officers has further improved the handling of calls with mentally ill clients.

A program such as the MCT/Police collaboration is not carried out within a vacuum, rather, it is carried out within a larger social system – families, neighborhoods, hospitals, prisons, etc. The dilemma of a disproportionate number of mentally ill inmates in prison and jail still exists. It is therefore our belief that policy makers and program designers continue to explore additional avenues related to the well being of mentally ill citizens to further influence a comprehensive and ethically sound treatment agenda.

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APPENDIX A

Form 316 Information

Person Placing the Call:
Date of Call
Name, address, and telephone number
The relationship between the person placing the call and the patient

Patient:
Name and address
Demographic information on the patient (race, gender, and date of birth)

Officer Information
The unit that received the call
Officer handling the call
MCT Involvement

Nature of and Handling of the Call:
Type of Call
The reason provided for placing the call
The action, if any, being requested
The identification of the home organizations of all involved service providers
Criminal charge
Type of Hold signed
Person signing the Hold
Alcohol or drugs involved
The disposition of the call or, in other words, where the person is placed or referred
Whether any injuries were suffered by the patient or service people during the interaction. Also the extent of any injuries suffered

APPENDIX B

Police Officer Letter of Confidentiality

This survey is being conducted by the University of Cincinnati Center for Criminal Justice Research and the Division of Criminal Justice. The survey should take approximately 15 minutes to complete. It was designed to find out **your opinions** concerning the handling of citizens with mental illness and Cincinnati Police Division efforts to improve the handling of calls involving people who are mentally disordered. You will be asked questions about whether you believe you are effective when you respond to these calls, the training you have received relating to these types of calls, and efforts by local mental health service providers that you may have observed. **Your opinions are important to us.**

Your participation is voluntary. Your failure to participate will not influence your position with the police division.

The information you provide in your completed survey will only be used in combination with information from other surveys. Answers will be grouped for analysis. No attempt will be made to single out any individual responses. Only the researchers will see your completed survey. All information will be held in the strictest confidence.

Thank you for taking the time to complete the survey.

If you have any questions about the survey, please contact

Dr. James Frank
University of Cincinnati Division of Criminal Justice
556-5832

Dr. John Eck
University of Cincinnati Division of Criminal Justice
556-5833.

Police Officer Survey

The next several questions ask about your own perceptions of issues related to the handling of citizens that are mentally disordered.

General Perceptions

1. How big of a problem is the handling of people with mental illness for the police division? Would you say they pose a big problem, moderate problem, small problem or no problem at all?
    A. Big problem
    B. Moderate problem
    C. Small problem
    D. No problem at all

2. How well prepared are you for handling people with mental illness that are involved in some crisis? Would you say you are very well prepared, moderately well prepared, not well prepared, or not at all prepared?
    A. Very well prepared
    B. Moderately well prepared
    C. Not well prepared
    D. Not at all prepared

3. Have you attended any police division training sessions that specifically taught you about handling people with mental illnesses?

    Yes _____ No_____(if your answer is "no" go to question #7)

4. If yes, were any of the presenters at these training sessions mental health service providers?

    Yes _____ No_____

5. In general, have these training sessions helped you **to better identify** people with mental illnesses? Would you say they have not been helpful at all, have been somewhat helpful, have been moderately helpful, or have been very helpful?

    A. Have not been helpful at all
    B. Have been somewhat helpful
    C. Have been moderately helpful
    D. Have been very helpful

6. In general, have these training sessions helped you to **more effectively handle** citizens with mental illnesses? Would you say they have not been helpful at all, have been somewhat helpful, have been moderately helpful, or have been very helpful?

    A. Have not been helpful at all
    B. Have been somewhat helpful
    C. Have been moderately helpful
    D. Have been very helpful

7. How helpful is the psychiatric emergency services at the University Hospital in the handling of calls involving people with mental illness? Would you say emergency room personnel are very helpful, moderately helpful, not very helpful, or not helpful at all?

    A. Very helpful
    B. Moderately helpful
    C. Not very helpful
    D. Not helpful at all

8. In comparison to the typical police call, mental health calls (Code 9) are usually:

    A. More dangerous than the typical call
    B. Less dangerous than the typical call
    C. No more or less dangerous than the typical call

The next several questions ask about calls you may have handled with members of the Mobile Crisis Team (MCT)

9. Have you ever handled a call with a member of MCT?

    Yes_____ No_____ (If your answer is "No" go to question #21)

10. Is the amount of time you spend on a mental health call (Code 9) with a member of the MCT

    A. The same as when you handle a call alone (without a MCT member)
    B. Greater than when you handle a call alone (without a MCT member)
    C. Less than when you handle a call alone (without a MCT member)

11. How likely is it that working with MCT personnel will improve your ability to identify mentally impaired individuals?

    A. Very likely
    B. Somewhat likely
    C. Not very likely
    D. Not likely at all

12. In the normal situation, responding to a mental health call with a MCT member has what effect if any on the potential danger the call poses? Does it lessen the danger, increase the danger, or have no effect on the danger.

    A. Lessens the danger
    B. Increases the danger
    C. Has no effect on the danger

13. When responding to a mental health call with a MCT member do you believe you are:

    A. More effective than when responding alone or with another police officer
    B. Less effective than when responding alone or with another police officer
    C. Neither more nor less effective than when responding alone or with another police officer

14. When you work with an MCT member are you more or less likely to dispose of a call using a criminal justice response (arrest, jail)?

    A. More likely to use a criminal justice response
    B. Less likely to use a criminal justice response
    C. Just as likely to use a criminal justice response

15. What do you believe is the primary purpose of the MCT/police collaboration?

    A. Improve the handling of calls
    B. Reduce liability involved in handling these types of calls
    C. Unsure of why this collaboration came about
    D. Other_____

When responding to the next several questions please state whether you believe the statement is true or false as it applies to your own experiences in handling calls involving citizens with mental illness.

16. Having an MCT member present at the scene of a Code 9 call does not influence my own response to this type of call.
    True
    False

17. I prefer working with MCT personnel versus responding on my own or with other police officers when handling a call involving a person with mental illness.
    True
    False

18. I believe I am better able to arrive at a more appropriate resolution of the call when I respond with an MCT member.
    True
    False

19. I am less effective when handling Code 9 calls when I work with an MCT member.
    True
    False

20. Overall, the MCT has helped the police division to become more effective at keeping people with mental illness out of jail.
    True
    False

<u>Officer Demographic Information:</u> It is important that we collect some limited personal information. This information is being collected for academic purposes and will not be used to identify any officer.

21. How long have you been employed by CPD? _____

22. How old are you? _____

23. Are you a ____male or _____female?

24. What is your race?

    Caucasian _____
    African American _____
    Hispanic/Latino _____
    Asian _____
    Other _____

25. What is the highest year of education you completed?

    High School_____ Some College Classes_____ Bachelors_____
    Masters_____ Other_____

26. Are you one of the officers who have been specially trained and designated to handle Code 9 calls under the Federal settlement?

    Yes_____ No_____

27. Approximately how many Code 9 calls have you handled with a member of MCT in the last year? _____

28. Approximately how many Code 9 calls have you handled alone or with another police officer in the last year? _____

29. Approximately how many Code 9 calls do you handle in a typical month? _____

Optional Questions

What are the benefits, if any, to responding to a mental health call with an MCT member?

What are the negative aspects, if any, to responding to these calls with an MCT member?

APPENDIX C

MOBILE CRISIS TEAM SURVEY

The next several questions ask about your own perceptions of issues related to the handling of citizens that are mentally disordered that contact the police or the Mobile Crisis Team.

General Perceptions

1. How big of a problem is the handling of people with mental illness for the police division? Would you say they pose a big problem, moderate problem, small problem or no problem at all?

    a. Big problem
    b. Moderate problem
    c. Small problem
    d. No problem at all

2. How well prepared do you believe the police are for handling people with mental illness that are involved in some crisis? Would you say they are very well prepared, moderately well prepared, not well prepared, or not at all prepared?

    a. Very well prepared
    b. Moderately well prepared
    c. Not well prepared
    d. Not at all prepared

3. In general, do you believe the police officers you have worked with have become better at **identifying** people with mental illnesses? Would you say they have become much better, somewhat better, only slightly better or not better at all?

    a. Have become much better
    b. Have become somewhat better
    c. Have become only slightly better
    d. Have not become better at all

4. In general, have these officers you have worked with become more effective at **handling** citizens with mental illnesses? Would you say they have become much more effective, more effective, slightly more effective, or not more effective?

    a. Have become much more effective
    b. Have become more effective
    c. Have become only slightly more effective
    d. Have not become more effective

5. How helpful is the emergency room in the handling of calls involving people with mental illness? Would you say emergency room personnel are very helpful, moderately helpful, not very helpful, or not helpful at all?

    a. Very helpful
    b. Moderately helpful
    c. Not very helpful
    d. Not helpful at all

6. Is the amount of time you spend on a mental health call (Code 9) with a member of the police division

    a. The same as when you handle a call without a police officer
    b. Greater than when you handle a call without a police officer
    c. Less than when you handle a call without a police officer

7. In comparison to the typical police call you handle, working with a police officer on mental health calls (Code 9) makes these calls:

    a. More dangerous than the typical call
    b. Less dangerous than the typical call
    c. No more or less dangerous than the typical call

8. In the normal situation, responding to a mental health call with a police officer has what effect on the potential danger the call poses? Does it lessen the danger, increase the danger, or have no effect on the danger.

    a. Lessens the danger
    b. Increases the danger
    c. Has no effect on the danger

9. When responding to a mental health call with a police officer do you believe you are:

    a. More effective than when responding alone
    b. Less effective than when responding alone
    c. Neither more nor less effective than when responding alone

10. Why do you believe you are more or less effective when working with a police officer?

11. When you work with a police officer are you more or less likely to dispose of a call using a criminal justice response (arrest, jail) than when you work without a police officer?

    a. More likely to use a criminal justice response
    b. Less likely to use a criminal justice response
    c. Just as likely to use a criminal justice response

12. What do you believe is the purpose of the MCT/police collaboration?

When responding to the next several questions please state whether you believe the statement is true or false as it applies to your own experiences in handling calls involving citizens with mental illness.

13. Having a police officer present at the scene of a Code 9 call does not influence my own response to this type of call.
    True
    False

14. I prefer working with police officers versus responding on my own or with other service providers when handling a call involving a person with mental illness.
    True
    False

15. I believe I am better able to arrive at a more appropriate resolution of the call when I respond with a police officer.
    True
    False

16. I am more effective when handling Code 9 calls when I work with a police officer.
    True
    False

17. Overall, the MCT has helped the police division to become more effective at keeping people with mental illness out of jail.
    True
    False

18. What are the benefits, if any, to responding to a mental health call with a member of the Police Division?

19. What are the negative aspects, if any, to responding to these calls with a police officer?

<u>Other Demographic Information</u> It is important that we collect some limited personal information. This information is being collected for academic purposes and will not be used to identify any team member.

How long have you been employed by MCT? _____

What is your present assignment? _____

How old are you? _____

Are you a ____male or _____female?

What is the highest year of school you completed?

Ethnic origin?

Approximately how many Code 9 calls have you handled alone and with a Cincinnati police officer?

Alone _____

With a member of the Police Division_____

Approximately how many Code 9 calls do you handle in a typical month? _____

APPENDIX D

MCT INTERVIEW

Attitudes of Mobile Crisis Team Members Regarding the
Cincinnati Police Collaboration in Response to A Code 9 Call

Introduction (to be read verbatim to each officer and MCT member prior to in-person interview)

As you may know, the Division of Criminal Justice at the University of Cincinnati has been working on a project with the Cincinnati Police Department and the Hamilton County Mental Health Board examining the actions of the Mobile Crisis Team (MCT) on Code 9 calls. One of the things we would like to do is to spend a few minutes talking to you about the nature of these Code 9 calls and your perceptions of the interactions that occur as a result of this police/MCT collaboration.

Agreeing to this interview is strictly voluntary. Your choice about participating will have no impact on future aspects of your career. All responses that you provide will be kept strictly confidential. Nothing that you say will be attributed to you individually. The interviews are solely for our own use. They are intended to provide us with a better understanding of Code 9 calls and to supplement the quantitative data we have already collected regarding this collaborative effort between CPD and the MCT. Information from the interview responses will not appear in any reports.

I will be taking notes during the interview. I can assure you that your name, or any other form of identifying information will not appear in my notes. No one but team research members will have access to my notes.

1). Please summarize the events of your most recent Code 9 call.

2). What was the outcome of the call – what happened to the client?

3). How did you feel about the call knowing that the police would be there to assist you with the call? Why or why not?

4). Are your perceptions of the risk of physical confrontation altered as a result of the police being on the scene?

5). Do you think having the police present or knowing that they can be called helps or hinders in these types of calls?

6). Did the collaborative effort of the MCT and police working together make this type of call more efficient/faster or slower?

7). How do you feel about this collaborative effort with the police? Why?

8). What do you think are the main differences when MCT handles a call alone versus with the police?

9). What do you see as the biggest problem police officers or the police division has when handling these types of calls?