



## Justice Insights Series: Research Briefs for Policy and Practice

# Can a Police-Clinician Partnership Reduce Repeat Mental Health Crisis Calls? Evidence from a Suburban-Rural County

### Key Takeaways

- Adding a clinician to an existing crisis intervention team (CIT) response did not produce a detectable reduction in repeat police contacts.
- Getting people connected is not the same as keeping them connected. Only 41 percent of treatment participants completed the services clinicians recommended, while roughly 22 percent received no subsequent services.
- This test of co-response was small but demanding. Every officer had already received 40 hours of crisis-intervention training, so the experiment tested whether a clinician added benefits beyond CIT. With only 104 participants available for the full 12-month analysis, the study may not have been large enough to detect modest effects.

### Why This Matters

Police are usually the first to arrive when someone is experiencing a mental health crisis. In one department, mental health calls made up only about 2 percent of all calls but took far more time than other calls. Because state law required officers to remain with at-risk individuals until they could be placed in a mental health facility, calls requiring emergency custody could take officers up to six hours to clear. Furthermore, the prevalence of repeat calls for service suggested that available responses did not address the underlying problems.

Earlier studies found that co-response models—in which police and mental health clinicians work together on crisis calls—can reduce arrests and detentions of people with mental illness. Other studies found that this approach can increase referrals to community mental health services and reduce the amount of time police spend on mental health calls.

Most prior research came from larger urban jurisdictions, used weaker study designs, and rarely tracked participants' subsequent police contacts. This study addressed those gaps through a randomized controlled trial in a suburban-rural US police department, following participants' subsequent police contacts for a full year.

### How the Study Worked

To determine whether adding a clinician produces benefits beyond an already specialized police response, researchers conducted a randomized controlled trial in which police shifts were assigned to one of two conditions: the department's existing response by CIT-trained officers or a co-response model that added a mental health clinician after officers secured the scene. Researchers used an "intent-to-treat" approach in which each participant was counted in the group they were assigned to even if they dropped out of treatment, reflecting how the program would likely work in the real world. The program ran in a suburban-rural county in the Southeastern United States from 2016 to 2019. In this version of the model, officers responded first and secured the scene, then called a mental health clinician who was available by phone 24/7 and could arrive on site within an hour. Researchers used police records to count each participant's total calls for service and

their mental health-specific calls during the 12 months after they entered the study. They also used clinician records to document how much service each person received, and they held three rounds of focus groups with officers, command staff, and clinicians.

## What Was Learned

- **No drop in repeat police contacts.** Treatment participants averaged 5.23 calls for service over the year, compared to 4.74 for the control group, and the difference was not statistically significant. Mental health-specific calls were also similar (1.12 versus 1.57 per person).
- **Low service uptake.** Only 28 of 69 treatment participants (about 41 percent) received the full recommended services, and 15 participants (about 22 percent) received none. Participants who engaged in services received about 41 hours on average, compared with about 1.3 hours among those who did not continue in treatment.
- **Officers valued the program.** In focus groups, officers described the clinician as a useful extra resource that helped de-escalate situations and reduced their workload, especially regarding the long waits tied to emergency custody.
- **Testing against an already specialized response.** Every officer was already trained in crisis intervention—a program that teaches officers to recognize and calm mental health crises—so the control group also received a skilled response, which may help explain why adding a clinician showed no extra effect.

## What This Means in Practice

This study does not show that co-response is ineffective. It shows that, in this setting, **researchers could not detect an additional reduction in repeat police contacts when a clinician is added to an already CIT-trained police response.** The relatively small sample also limited the study's ability to identify modest effects. The researchers caution that repeat calls may be an imperfect measure of success because a more positive experience with police could conceivably make someone more willing to seek help again. Just as important, the study highlights an implementation challenge: a successful handoff during a crisis does not guarantee sustained engagement with treatment. Fewer than half of treatment participants completed the services clinicians recommended. The researchers therefore point to follow-up and care coordination, such as help with referrals and appointment reminders, as potentially important parts of an effective co-response model.

For suburban and rural agencies, the secondary-response model may still offer a practical way to make scarce clinical expertise available without maintaining a clinician on every patrol response. But the findings suggest that the connection after the crisis may matter as much as the clinician's presence during it.

### Source article

Yang, S.-M., Gill, C. E., Lu, Y.-F., Azam, M., & Kanewske, L. C. (2024). A police-clinician co-response team to people with mental illness in a suburban-rural community: A randomized controlled trial. *Journal of Experimental Criminology*. <https://doi.org/10.1007/s11292-023-09603-8>

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