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The "Gray Zone" of Police Work During Mental Health Encounters: Findings From an Observational Study in Chicago

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Abstract

Although improving police responses to mental health crises has received significant policy attention, most encounters between police and persons with mental illnesses do not involve major crimes or violence nor do they rise to the level of emergency apprehension. Here, we report on field observations of police officers handling mental health-related encounters in Chicago. Findings confirm these encounters often occur in the "gray zone," where the problems at hand do not call for formal or legalistic interventions. In examining how police resolved such situations, we observed three core features of police work: (a) accepting temporary solutions to chronic vulnerability, (b) using local knowledge to guide decision making, and (c) negotiating peace with complainants and call subjects. Findings imply the need to advance field-based studies using systematic social observations of gray zone decision making within and across distinct geographic and place-based contexts. Policy implications for supporting police interventions are also discussed.

Keywords

police, mental health encounters, crisis intervention, peacekeeping

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Introduction

Although police performance is traditionally assessed in terms of clearance rates and crime reduction, patrol officers have long functioned as "incidental"[1] mental health interventionists (Matthews & Rowland, 1954). Over 90% of officers on patrol have an average of six encounters with individuals in crisis each month (Cordner, 2006), and 7% to 10% of all police encounters involve people affected by mental illness (Borum, Deane, Steadman, & Morrissey, 1998; Franz & Borum, 2011; Hails & Borum, 2003; Watson et al., 2010). For vulnerable citizens who may not otherwise seek or be able to access help, the police operate as a last resort "intercept" (Munetz & Griffin, 2006), making critical decisions about how to resolve encounters and whether to initiate formal interventions by criminal justice, behavioral health, or social services.

Police decisions of how best to intervene are complex because mental illness is often accompanied by substance use, physical health vulnerabilities, and homelessness (Draine, Salzer, Culhane, & Hadley, 2002). Co-occurring substance use disorders are highly prevalent among criminal justice system involved persons with mental illnesses (Slate, Buffington-Vollum, & Johnson, 2013), with figures as high as 75% for jail populations (Abram & Teplin, 1991; National GAINS Center, 2002). Experiences of homelessness are also common for justice-involved persons living with mental illnesses or comorbid disorders (DiPietro & Klingenmaier, 2013; James & Glaze, 2006; Markowitz, 2006; National Health Care for the Homeless Council, 2013; Slate et al., 2013). With deinstitutionalization from state psychiatric hospitals all but complete (Slate et al., 2013), the health intervention role of police is both salient and controversial, especially given a series of high-profile tragedies involving fatal shootings by officers (Goodman, 2015; Reuters, 2015; Santos & Goode, 2014; The Associated Press, 2015).

In addition to concerns about the misuse of force in the handling of mental health-related encounters, much of the literature has focused on the "criminalization" of those whose needs would be better served by behavioral health and social services (Slate et al., 2013; Teplin, 1983, 1984). In efforts to reduce criminalization—and the rates of arrest leading to this—both researchers and practitioners have advocated for interventions using specially trained personnel with knowledge on how to recognize mental illness, de-escalate potentially volatile encounters, and make the best possible use of health referrals or transports to resolve situations. The most popular intervention models are the Crisis Intervention Team (CIT) model, which includes police officers with specialized mental health training (Hartford, Carey, & Mendonca, 2006; Schaefer Morabito & Socia, 2015; Steadman, Deane, Borum, & Morrissey, 2000; Watson, Morabito, Draine, & Ottati, 2008; Watson et al., 2010) and coresponse arrangements (Hails & Borum, 2003; Victoria Auditor-General, 2009; Wilson-Bates, 2008) where health professionals such as psychiatric nurses or social workers assist police through telephone consultations or by responding at the scene (for a review, see Wood, Swanson, Burris, & Gilbert, 2011). Overall, such efforts to

improve the crisis response capacity of police have been shown to reduce officer injury and increase the number of transports for psychiatric assessment (Dupont & Cochran, 2000; Steadman et al., 2000).

Although improved crisis intervention has been the focus of policy attention, researchers have pointed out that most of the interactions officers have with persons affected by mental illnesses do not involve major crimes or violence (Draine et al., 2002; Fisher et al., 2006; Swanson, McGinty, Fazel, & Mays, 2015) nor do they often meet the legal criteria of emergency apprehension (Bittner, 1967a; Green, 1997; Teplin, 1986; Teplin & Pruett, 1992; Watson et al., 2010). Rather, police encounter people whose mental health needs are unmet due to a lack of service initiation or sustained engagement outside of crisis situations. Evans' conception of the "gray zone" (2013; see also Wood & Beierschmitt, 2014) captures this amorphous category of unengaged or under-engaged individuals who fall through service cracks.

Faced with what Punch (1979) also described as the "gray area" of "secret social service" work (p. 102), officers function as "peacekeepers" (Banton, 1964; Bittner, 1967a, 1967b, 1970, 1990; Reiner, 2015), handling matters without invoking the law, or using the civil commitment system (Watson, Ottati, Draine, & Morabito, 2011; Watson et al., 2010). In this light, current research and policy efforts may overlook the vast array of lower intensity and less formal interactions and their potential not only to prevent future arrest or transport situations but also to establish trust and build positive rapport that may pay forward to subsequent interactions. In short, it is time to take a 21st-century look at the broader context of police interactions with persons affected by mental illnesses and their implications for advancing practice in this area.

Nested in the aforementioned conception of policing as peacekeeping, this article reports on field observations of police officers handling mental health-related encounters in Chicago, Illinois. Over a period of 18 months, 31 ride-alongs were conducted in 11 police districts at different times of the day and night in order to capture the variety of mental health-related situations they addressed. Our emphasis was on describing and understanding the ways in which officers resolved such situations. Engaging with Bittner's previous research on police decision making during mental health encounters (1967a), as well as Morabito's extension of his insights (Morabito, 2007), we identify various contextual factors influencing officers' decisions of how to intervene. Our observations illuminated a range of situations that did not—in the minds of officers—call for formal interventions including arrest or transportation for psychiatric evaluation. Although officers chose to transport individuals to psychiatric facilities in certain situations, they were mostly preoccupied with resolving gray zone situations involving low visibility decisions (Goldstein, 1960) about the management of chronic vulnerability rather than imminent danger. In this light, this study focuses more broadly on police decision making rather

than discretion which is more narrowly concerned with whether to invoke the law or not (Roberg, Novak, & Cordner, 2009).

Policing as Peacekeeping

Bittner (1990) once characterized police work as “Florence Nightingale in Pursuit of Willie Sutton.” Officers spend much of their time responding to situations that not only require some level of competence in health or social work but also require the capacity to exercise nonnegotiable force, should compliance not be achieved through other means. This is not to suggest that police are a substitute for nurses or social workers. Rather, they often respond to situations requiring care-taking skills, while attuned to the potential for danger (Sknolnick, 1966), and being ready to respond by invoking the law or using force. In reality though, police rarely need to follow through with formal action. As Banton (1964) put it, “the most striking thing about patrol work is the high proportion of cases in which policemen do *not* enforce the law” (p. 127). Bittner (1990) similarly remarked that “when one looks at what policemen actually do, one finds that criminal law enforcement is something that most of them do with the frequency located somewhere between virtually never and very rarely” (p. 240).

Other pioneers in the sociology of police work (Muir, 1977; Wilson, 1968) also observed police to be performing a multitude of tasks that can be described as “dirty work” (Westley, 1970). Such tasks are often performed in especially depressed areas of cities characterized by high levels of poverty, low levels of employment, and other characteristics of social disorganization (Goldstein, 1977); areas Bittner describes as “skid row” (Bittner, 1967b; see also Huey, 2007). In such contexts, “the police most frequently care for those who cannot care for themselves: the destitute, inebriated, the addicted, the mentally ill, the senile, the alien, the physically disabled, and the very young” (Goldstein, 1977, p. 25). With respect to mental illness, efforts to enhance the professionalism of police during encounters date as far back as the 1950s (Matthews & Rowland, 1954), but the “dirty work” function of police did not receive much attention until the combined effects of mental health deinstitutionalization (Slate et al., 2013), and criminal justice re-institutionalization (Wood et al., 2011) became apparent.

In the ensuing years since the classic observational studies of police, changes in the laws governing civil commitment—based on a commitment to the protection of liberty—have resulted in stringent conditions (i.e., dangerousness and incompetence) for the use of involuntary detention, confinement, and treatment (Petrila & Swanson, 2010; Wood et al., 2011). This changed legal environment, combined with the deinstitutionalization of state psychiatric hospitals (Manderscheid, Atay, & Crider, 2009) and tremendous gaps in community-based health resources (Starr, 1982; Wood et al., 2011) influenced what Bittner would describe as the “structural determinants” of police work, by

which is meant the "typical situations that policemen perceive as *demand conditions* for actions without arrest" (Bittner, 1967b, p. 701). Arguably, the second half of the 20th century brought with it an increased pressure on police to resolve encounters with a growing proportion of people in the community affected by mental illness.

With the disturbing realization that more people with mental illnesses are institutionalized in correctional facilities than in mental health facilities, the role of police in the process of criminalization has been the subject of scrutiny for the latter part of the 20th century (Abramson, 1972; Lamb, Weinberger, & DeCuir, 2002; Teplin, 1983, 1984). Teplin's (1984) large-scale observational study of police encounters in the early 1980s highlighted this issue, finding that while formal police action is rare, persons considered suspects by police were more likely to be arrested if they had a mental illness than suspects that did not. Data from this study indicated that when officers arrested persons with mental illnesses, it was often due to lack of other viable options to resolve situations (Teplin & Pruett, 1992). Officers also frequently employed informal means to manage the behavior of persons affected by mental illnesses in the community, acting as Teplin and Pruett (1992) termed "street corner psychiatrists" as they addressed "gray zone" issues. A larger study using systematic observation methods found that police were NOT more likely to arrest suspects affected by mental illness, and that in fact mental illness played a protective role (Engel & Silver, 2001). This study controlled for a number of factors known to impact arrest for which Teplin's study was not able to control. Regardless, concerns about the criminalization of persons with mental illnesses as a result of inappropriate arrests have been maintained.

In response to criminalization concerns and spurred on by a series of tragic encounters ending in officer-involved fatal shootings, researchers and practitioners developed a "first generation" (Epperson et al., 2011) wave of reforms to improve the immediate outcomes of police encounters. The most prominent services intervention is the CIT model, which has emerged as a best practice approach to improving police response to mental health crises. It has the goals of reducing use of force and injuries and diverting individuals from arrest to appropriate mental health services (Cotton & Coleman, 2010; Hails & Borum, 2003; Hartford et al., 2006; Steadman et al., 2000; Watson et al., 2008). To date, approximately 2,700 agencies in the United States and elsewhere are implementing CIT programs (University of Memphis CIT Center, 2015). While there is significant variation among programs and a randomized trial has yet to be conducted, there is limited evidence that CIT can be an effective approach to improving officer knowledge and attitudes, reducing use of force in encounters, and increasing linkages to mental health services (Dupont & Cochran, 2000; Steadman et al., 2000). The evidence of the impact of CIT on arrests is less consistent (Steadman et al., 2000; Teller, Munetz, Gil, & Ritter, 2006; Watson et al., 2008, 2011, 2010). The CIT model emphasizes collaboration across

stakeholders and encourages officers to develop relationships with providers and community members (including persons with mental illnesses). However, research on CIT has not examined this element as closely, instead focusing on mental health crisis incident outcomes.

In this larger reform context, the study reported here set out to examine the range of situational and community-level factors influencing the immediate outcomes of mental health-related police encounters. Although the influence of CIT training was a focus of the larger multimethod study, our field observations took place with many officers, two thirds of whom were not CIT-trained. This provided an opportunity to examine the nature of police patrol work and officer decision making more generally and to revisit some of the core findings of sociological studies mentioned previously. In line with that prior body of work, we found that officers function primarily as peacekeepers, addressing situations of chronic vulnerability—the "gray zone" problems—with a preference for informal, provisional solutions. This finding confirms the importance of a peacekeeping conception of police work while illuminating a broader horizon of possibilities for situating police work within cross-systems efforts to improve gray zone services and supports, and ultimately, long-term mental health outcomes.

Method

This article reports on findings of ride-alongs with police officers in Chicago, which at the time of writing reflects a period of 18 months. This research forms part of an on-going mixed method study of the Chicago Police Department's CIT program and short- and long-term outcomes of police encounters with people affected by mental illnesses. Beyond the field observations reported here, there are other study design components, including individual interviews with police and consumers as well as a longitudinal quantitative assessment of health and justice-related outcomes of consumers involved in encounters with police. All study procedures were approved by Chicago Police Department and the institutional review board of the second author's academic institution. No restrictions were placed on the reporting of findings.

The qualitative component discussed here seeks to understand the nature of encounters police have with persons affected by mental illness and the ways in which such encounters are resolved by police, including the situational and community-level factors, or "horizons of context" (Morabito, 2007) influencing officers' decision making. Such factors include availability and accessibility of community mental health resources, officers' historical knowledge of individuals and their circumstances, as well as officers' knowledge of the spaces and places of the encounters and the demands or preferences of stakeholders in those areas.

A total of 31 ride-alongs with officers were conducted in 11 police districts between July 2013 and December 2014. Observations occurred over three different watches. First watch occurs around midnight (9:00 p.m.–5:30 a.m.

and 10:30 p.m.–7:00 a.m.), second watch takes place during the day (5:30 a.m.–1:30 p.m. and 7:00 a.m.–3:00 p.m.), while third watch covers evenings (2:00 p.m.–10:00 p.m. and 3:30 p.m.–11:30 p.m.). A total number of 11 first watch, 10 second watch, and 10 third watch observations were undertaken with officers patrolling either alone or in pairs. The research team consisted of four observers who conducted ride-alongs independently. Based on considerations of researcher safety, combined with the fact that most patrolling in this city occurs in cars rather than on foot, our observations were primarily of motor patrols, with the exception of two walk along observations with officers assigned to the public transit unit. In total, 53 officers were observed over approximately 120 hours. A total of 15 (28%) were CIT-trained, and males ($n = 37$) outnumbered female ($n = 16$) officers (70% and 30%, respectively). The dominant race of officers was White (83%), followed by African American ($n = 5$ or 9%). One quarter of the sample (26%) was Hispanic. Years of experience range from less than 1 week to 27 years.

Researchers were instructed to conduct open-ended observations of both reactive (citizen-initiated) and proactive (officer-initiated) encounters. Although the focus of the observations was on the resolution of mental health-related situations, the researchers observed police work across a broad variety of situations (e.g., traffic violations, neighborhood disputes, property crime, and gun shots fired). During periods of time where officers were on proactive patrol, or in transit to calls for service, researchers took opportunities to query them on their general experiences with mental-health related calls, including questions about the nature and frequency of such calls and the impact of mental health service accessibility on call resolution.

In line with ethnographic convention, all researchers took jottings in the field that captured the details of each encounter, including physical descriptions of individuals at the scene (i.e., complainants, witnesses, bystanders, alleged subject of the complaint, and other responding officers), along with the interactions (including conversations) between the police and the parties at the scene. Following the resolution of each encounter (if it was convenient for officers), observers usually asked the police follow-up questions about the particular situation and the immediate outcome. Throughout the observations, all efforts were made to capture key terms and phrases verbatim. Following the ride-alongs, researchers developed the jottings into elaborated field notes.

Analysis

The field notes generated from the observations constituted the data set for this article. Team members met regularly through web conferencing to reflect on key insights developing in the observations ($n = 7$, 1-hour meetings). These meetings provided a group forum for moving iteratively between the descriptive data and abstract understandings of what was being observed (see Janesick, 2004).

One of the authors—the lead qualitative analyst not involved in the field work—reviewed the field notes and led discussions with the team on emergent themes. These reflection meetings helped to guide a detailed coding of the data using *ATLAS.ti*, software that facilitates the process of qualitative analysis. Each field note was redacted and labeled according to date, district and watch prior to being imported into *ATLAS.ti* as a data or hermeneutic unit.

The coding and analysis process followed three main steps. A process of "open coding" was performed on all field notes. This involved generating code labels inductively until an extensive code list was established. The second key phase involved merging codes to form larger or higher level codes while validating or refining specific subcodes within those categories (Benaquisto, 2008). The third phase centered on the development of conceptual ("nodal") relationships using the network management software within *ATLAS.ti*. A network provides a visual illustration of relationships among main codes and their constituent subcodes. The resultant network diagram furnished a preliminary structure for the article. The analyst reread text segments organized by code label to identify illustrative quotes and more nuanced analytic themes. During a final analytic process—known as abduction (Thornberg & Charmaz, 2014)—the central themes of the article were elaborated and refined in dialogue with the classic sociological literature on police work.

The data presented here consisted of excerpts from researchers' field dairies. Officers' names are replaced with basic code labels (i.e., Officer 1 = O1). Each text segment is tagged with a reference to the date of the observation and the watch during which the observation took place. All references to landmarks and facilities are also redacted. Police District numbers have been altered.

The "Gray Zone" of Police Work During Mental Health-Related Encounters

The field excerpts highlighted in this section reveal the extent and plurality of gray zone encounters during a typical shift on patrol. When criminal or disorderly behavior is at issue, it is often that which is nonviolent and nonthreatening. Most calls involved responses to people regarded as being disruptive or acting in ways that made others feel uncomfortable. Calls for service often related to disputes among neighbors, or within families who felt incapable of handling a loved one with mental illness. Lack of medication adherence, both within family contexts and during street-level encounters, was a common topic of conversation between researchers and officers. Experiences of homelessness were also prevalent features of police encounters. Officers certainly did respond to emergency situations, ranging from families at their wit's end, individuals contemplating suicide, and service providers enlisting police to transport a person for psychiatric assessment. In this section, we recount examples of such situations while illustrating three core features of police work that cut across

them: (a) accepting temporary solutions to chronic vulnerability, (b) using local knowledge to guide decision making, and (c) negotiating peace with complainants and call subjects.

Accepting Provisional Solutions to Chronic Vulnerability

The police we observed exercised "psychiatric first aid" (Bittner, 1967a, p. 288) in the face of what Muir (1977) describes as the "paradox of dispossession," whereby "the less one has, the less one has to lose". That is, for individuals lacking in the means to subsist, with little or no family resources, of poor health, and with few skills, the prospect of losing liberties (e.g., through confinement) would be largely ineffective in achieving compliance with behavioral norms. It was rather more likely that the prospect of detention and confinement would furnish a place of subsistence, warmth, and shelter (Muir, 1977). Officers consider arrest as a solution, but recognize that it, along with incarceration, "are relatively impotent in their effects" (Bittner, 1967b, p. 714).

In the following story, told by an officer, the police negotiated with a woman that they encounter regularly in the course of resolving complaints about her disruptive behavior. Officers' experience with this woman from past encounters produced rather detailed guidance on how to handle the situation in subsequent encounters. In Morabito's terms (2007; building from Bittner's work, 1967a), there was a "temporal horizon" to this encounter, whereby the officers drew from their prior knowledge of the individual and her behavior as well as past police efforts to achieve compliance:

> We initially drove around a bit and I had an opportunity to ask the officers some questions about mental health related calls ... There are a number of people they feel have "mental problems" that they encounter pretty regularly. There is a woman that regularly causes disturbances at a McDonalds. She talks to customers and sometimes knocks things over or "gets in their face." She is usually pretty cooperative when police come and ask her to leave. O1 explained that if there are just two or three officers there, she calms down and cooperates. But if more show up, she gets pretty agitated. The officers indicated they think sometimes she is off her meds ... The officers felt she really needs some follow up services to make sure she has meds etc ... They did not see her as a threat or major problem and seemed resigned to regularly getting called to calm her down and move her along. At one point, we drove by the McDonalds. The woman (African American probably in her 50s) was sitting on a bus stop bench in front. O2 waved to her. She smiled and waved back, then stated "I have some stick ups to do." O1 commented—"We may get a call about her later." (District A, Third watch)

This example is illustrative of officers developing a regularized pattern (Bittner, 1967a, p. 290) of encountering individuals whom they knew from

experience were affected by some form of mental illness. Despite their lack of clinical knowledge, officers' commonsense understanding of an individual's vulnerability guided their approaches to the situation. Through experience, the officers have developed an understanding of how to safely gain the cooperation of the woman described earlier that is consistent with research that suggests that the risk of injuries to officers and call subjects increases when more than two officers are dispatched to a scene (Ruiz & Miller, 2004). One officer's account of a "regular" (a person that police encounter regularly) also illustrates the effect of the temporal horizon, whereby the choice of dispositional alternatives is guided by knowledge they have accrued about an individual's behavioral patterns. Moreover, such knowledge informs a generalized approach to similar categories of people and behavior. In this case, the officer emphasizes the importance of ending the encounter on good terms, which in a way pays forward to future encounters.

> The officer ... tells me about a regular that he sees around pretty often; he has three fingers. He says that he has three fingers, but he will shake your hand with those three fingers. He [the officer] laughs saying that he [the individual] remembers everything, like if he (the officer) was about to go to on vacation, the next time the subject saw him he would ask how his vacation was. He [the officer] says that he never forgets anything, that "he's crazy, but he's funny." He stops and says "he's not right, but he's funny." He laughs again and says that he tries to take that attitude with everyone. That he and his partner "always try to leave them with a smile." He says that it helps them later. He says that while the call subject sets the precedent for how they are going to approach the situation, they still try to joke around with them or make them smile and to "find common ground." (District B, Second watch)

During patrol on a first watch observation, officers recounted the story of a man who they, and others in the area, knew as nonthreatening, but in great need of health and social services. In the following account by the researcher, the officers explain their frustration with the absence of means to assist the individual. In this instance of a gray zone problem, hospitalization was not a lawful option, yet the officers expressed compassion with the individual's chronic condition:

> They decide we should drive by a gas station where a homeless man with mental illness lives ... O2 says that he is a "fixture" at that corner and that he will just yell and stomp his feet at no one in particular. I ask if people know who he is or if they often get calls from people about him. O1 says that no one calls on him; they know who he is. She says that the guy that works at the gas station will let him come in and get coffee, but that they do not usually talk with him because he is not causing any trouble. O2 says that this is "a perfect example of what's wrong with the

> system." I ask how so and he says that he "fell through the cracks." He goes on to say that this man will not sign himself into the hospital and that there is nothing they can do because he is not a danger to himself or others. He says he "just knows he needs help." (District C, First watch)

In the aforementioned examples, officers appeared resigned to the fact that there are limited options for them in keeping the public peace while assisting the very individuals that are threatening that peace. To that end, they choose provisional remedies that draw, wherever possible, on the knowledge they have accrued about individuals and their particular circumstances—commonly referred to as "regulars." We now elaborate on the importance of this local knowledge in tailoring their interventions.

Using Local Knowledge to Guide Decision Making

Through the stories they told, officers revealed a place-based or area knowledge (Bittner, 1970) reflected in detailed descriptions of the people (and sometimes their families) in the contexts of their communities. In Morabito's terms (2007), this knowledge forms part of the "scenic horizon" of police work, as illustrated in the following field excerpt:

> As we are driving, [the officer] points out different places where things have happened in the past or are known to be dangerous areas. She says in the middle/southern part of the district it is more dangerous because there are a lot of "drunks" and "mentals[2]" in the area ... She tells the story of a family that are "all straight up alcoholics" and they are always "cussing each other out." ... [S]he says that many of the people dealing with mental illness are also probably dealing with other "underlying stuff," such as a history of rape, prostitution, sexual abuse, "a lot of different stuff." She says that a lot of time the calls are for other circumstances, but then certain things "take them into that." (District B, First watch)

In his analysis of what he depicted as "methodical police work" in "skid row" areas, Bittner argued that universal standards or rules of professional and responsible interventions need to be balanced against the particular factors which were inherent in the local circumstances surrounding any given problem. In particular, his observations of how officers handled problems were informed by this area knowledge (Bittner, 1970). "As a general rule," he explains,

> the skid-row patrolman possesses an immensely detailed factual knowledge of his beat. He knows, and knows a great deal about, a large number of residents ... Though there are always some threads missing in the fabric of information, it is continuously woven and mended even as it is being used. New facts, however, are

> added to the texture, not in terms of structured categories but in terms of adjoining known realities. (Bittner, 1967b, pp. 707–708)

> O1 mentions that the district has its fair share of mental health calls. He asks me if I have encountered Reverend [subject name]. I say that I have not and ask if he is a local. "You could say that," O1 says. He says that Reverend [subject name] is someone he has encountered a number of times. He "gets excited" and should be on meds, but O1 does not think he is. I ask if the man is actually a reverend, and O1 says he is not sure and does not know if he is actually affiliated with any church, but that is what people call him . . . O1 reiterates that Reverend [subject name] is "very excitable." He is "not a bad guy" but can seem aggressive to others. He hangs out at the Dunkin Donuts at [location] . . . O1 says that for a lot of mental health calls officers will call the wagon, but with the reverend O1 likes to take a less "violent" and "aggressive" approach, so he puts him in the back of his car when possible. He took the reverend to [hospital]. The staff knows the reverend there as they have had trouble with him before . . . O1 says he tries to take the reverend and all "mentally challenged" people somewhere they can get help . . . He is "one of our regulars," O1 says. (District D, Second watch)

While local knowledge drawn from both the temporal and scenic horizons is used by police to tailor their interventions, this knowledge also accumulates in the form of general guidance on how to act in a similar class of cases. In this example, the officer describes an element of the scenic horizon, a deficit in gray zone health resources which—in his experience of similar cases—limits their dispositional options. Moreover, since gray zone resources, such as housing or community-based care, cannot be coerced, they must rely on peoples' willingness to seek help voluntarily:

> O1 notes that their beat is small because it used to be a "hell hole," he says that the beats were drawn smaller in rough areas. After a while, I ask about what they think the issue is with mental health services. O1 says that there is no money to be spent on facilities. He says that there are "certain individuals that don't belong on the street." He says that they need to be housed long term, but the hospitals have just "turned them loose." O2 says that they need a place to take them to be dropped off, a facility that is maybe not a hospital. O1 says that hospitals are a "temporary fix" and that taking people there repeatedly is a "waste of hospital resources." He says that there are many people that are unwilling to get help. He says that there is a man that walks around and has many bibles with him. O2 chimes in that "[subject nickname]" is another example of someone that doesn't want help. O2 says that she was working the desk once and "[subject nickname]" came in and took all of his clothes off. They took him to the hospital and have done this other times, but most of the time he refuses help. O2 says that some people are "mental to the point that they don't think they are mental." O2 says that no one wants to go to the hospital "except drunks." (District E, Third watch)

The development of local knowledge over time also informs officers' understanding of the normative standards of different areas, another element in the scenic horizon (Morabito, 2007). Officers use this knowledge to gauge community expectations of how they should act, if at all:

> O1 says that on some streets ... they get a lot more calls because people who aren't usually in the area see people talking to themselves and then call the police. He says that on the less busy streets where there are regulars, the neighbors know people and just leave them alone and don't call the police. He explains that the comfort level with people is different if you aren't used to seeing them. (District F, Second watch)

When police are dispatched to a scene, they must reconcile the demands of callers or complainants with the needs of the individual whose behavior is at issue. In what follows, we describe officers' efforts to integrate order maintenance concerns with concerns about individuals' vulnerabilities.

Negotiating Peace With Complainants and Call Subjects

It is typical for health or social service providers to call the police when there is a concern about an unpredictable or potentially dangerous situation. This danger could present itself in the midst of delivering routine health services, and in such cases, it is the police with the authority and capacity to "overpower resistance to an attempted solution in the native habitat of the problem" (Bittner, 1970, p. 40). In the following situation described by an observer, an emergency facility has called the police to handle a person who is refusing to leave the premises. In attempts to resolve the situation, the officers engage in "psychiatric first aid" which is an attempt to interact with the individual, understand their circumstance, and offer advice in order to achieve "a phase of relative safety and normalcy" (Bittner, 1967a, p. 288). In this particular incident, elements of the immediate situation, described by Morabito as the "manipulative horizon" (2007), govern the officer's decision making. Of particular relevance is the absence of criminal behavior, and more generally the absence of grounds to coerce a solution:

> We get dispatched to [hospital] where there is a man that has been released from the ER but he is being belligerent and will not leave. When we arrive the man is standing in between the two sliding doors in the foyer area of the ER with a security guard. He walks right out to talk to us when we get there. The man is African American and probably in his mid-50's, he has a bit of a speech impediment and might have a developmental disability. O1 asks him what is going on and the man explains that he is just hungry and needs somewhere to stay. O1 asks him for his ID and asks him where he usually stays and if he has a caseworker. He says that

> he does have a caseworker but he cannot call tonight. O1 explains that he cannot stay at the hospital and that he needs to leave. The officer asks again if he knows where he is going to stay tonight and the man starts talking about something that happened on the train (which is how he ended up in the hospital – someone from the CTA [transportation authority] called and had him transported). O1 asks again if he knows where he is going to stay and he does not respond. The officer asks him if he knows where the police station is and he goes on to explain that he can walk there and that the van will come and take him to the shelter if he wants ... As we get back into the car, O1 explains that the man has probably survived many years on the street and that he will find his way tonight. He reiterates to me that they would have taken him themselves to the shelter or the station if I had not been with them. He says that in this case, you just have to listen to what the person wants because there is nothing they can do (because he hasn't committed a crime) and he seemed to want to go to the train, so that's what he should do. He also says again that he thinks that the man will be just fine because he has survived all this time and he seems to be pretty well with it. (District G, First watch)

A common category of mental health-related calls originates from families who lack the resources to support members with mental illness over the long term. In some cases, mental health crises emerge from a lack of medication adherence and a family's inability to handle a situation. In essence, the police are called in to fill a deficit in community capacity or gray zone resources at the family level. Although a family may wish for a person to be taken away, officers must manage a legal gray area, where the criteria for emergency apprehension are not met:

> I asked them if they get many mental health related calls on their watch. O1 ... indicated that she responds to about 30 per month, which is 1–2 per shift. O2 indicated agreement. O1 indicated many are domestic related. They have some regular domestic calls—often one of the parties shows signs of a mental illness. Many involve a person who is behaving in a way that bothers family or the neighbors-basically annoying them or creating a nuisance. "They want us to take the person away. They don't understand we can't lock someone up just for being a nuisance. We can't make them go to the hospital unless they are a danger to themselves or others ... Often, there is not much we can do. They are not really criminal, not in crisis." O1 indicated that they (call subjects with mental illness) are rarely violent-but they can be. (District F, First watch)

In the aforementioned example, the officer laments, "there is not much we can do" given the narrow emergency apprehension criteria and the lack of other options. Officers must then choose between doing nothing and acting alternatively, such as persuading a family to initiate an involuntary commitment petition. In the following example, an officer explains their reasoning in such a

scenario, dubious of a family's intentions and resigned to the fact that the remedy is temporary:

> O1 says sometimes families call—often they are—"bogus calls." He explains that the family gets tired of the person so they call and they say the person is off his or her meds. "They will say the person was doing all sorts of stuff-but when we are there, the person is perfectly calm." O1 indicates they will take the person to [hospital] and have the family complete the petition-"since we didn't see anything." O1 states the person is usually only there for few hours. "I guess that gives the family a break." (District D, Third watch)

This officer, and many others we spoke with, believes he cannot complete a petition for involuntary emergency psychiatric evaluation based on second-hand information. However, state law and departmental policy both allow for this.

In this section, we illuminated the gray area of police work with people affected by mental illness. In particular, we demonstrated officers' preference for informal call resolutions which is informed by different "horizons of context" (Morabito, 2007). This is not to suggest that officers do not invoke the law and use either arrest or transportation for emergency psychiatric assessment as methods of resolution. Rather, arrest is viewed as ineffective in a range of gray situations, where the "paradox of dispossession" presents itself. Further, the use of civil law to support transportation to a psychiatric facility is limited by the stringency of its requirements. Within this legal context, officers function mainly as the peacekeepers described in classic sociological research on police work. It appears that the most important tool at the disposal of police is the local knowledge they accrue over time about the circumstances of individual people and places. This knowledge provides the basis for informed situational judgments of how to act. Such judgments generate temporary solutions to what officers recognize as chronic states of vulnerability. In line with what early police sociologies have told us, "policing cannot deliver peace if deep social cleavages militate against it" (Reiner, 2015, p. 24). In the next section, we examine the implications of these findings for theory and practice.

Discussion and Implications

Building on findings from early field studies of officers on patrol, especially the work of Bittner (Banton, 1964; Bittner, 1967b, 1970) and relating to Morabito's conceptualization of "horizons of context" (2007), we moved beyond a narrow conception of policing as law enforcement to one centered more broadly on policing as peacekeeping. Based on this conception, our empirical observations illuminate three core features of police decision making in the handling of gray zone mental health encounters. The first is that officers are faced with choosing among a set of temporary remedies, fueled by the acceptance that the people in

greatest need of help (people who are poor, sick, unemployable, hopeless) are the most difficult to assist due to structural conditions that perpetuate their vulnerability. This feature echoes Muir's observation about the "paradox of the dispossessed" (Muir, 1977), whereby those with the fewest bonds to social institutions have the least commitment to comply with social norms and the directives of authorities.

A second feature is that officers rely on a "situated" (Thacher, 2008) or "particularized" knowledge (Bittner, 1967b) of people and places in determining intervention options. The more officers know about a patrol area, its structural conditions, and gray zone resources (scenic horizon), and the more they are aware of a person's circumstances and history (temporal horizon), the greater their assumed predictive capacity and confidence in bringing an encounter to a peaceful close. Third, and in relation to the immediate circumstances and (sometimes competing) demands on police (manipulative horizon), officers pay careful attention to negotiating peace with both complainants or callers and call subjects. This resolution of interests often occurs within a gray area that exists between the restricted options of invoking criminal law (arrest) and using civil law as grounds for emergency apprehension. In many cases, officers choose not to coerce a solution, but to align interests in the negotiation of peace (Bittner, 1967a).

Taken together, the aforementioned three features of police decision making reinforce the classic concept of police as "all-purpose and terminal remedial agents" (Bittner, 1967b, p. 702) furnishing "provisional solutions to long-range problems" (Bittner, 1990, p. 280). When it comes to mental health-related encounters, police navigate horizons of context with the tools to implement only provisional solutions. We suggest that this remedial character of police work does not stem from a lack of commitment to the problem of mental health, but to the absence of family- and community-level gray zone resources available to address the structural conditions of vulnerability and mitigate the risks of crisis situations.

The widespread dissemination of CITs across the United States and beyond signifies the growing acceptance of police as mental health interventionists. However, we have tried to demonstrate that the gamut of mental health encounters experienced by officers extends well beyond crisis incidents to a range of situations involving chronic vulnerability. In this light, the work that police do in this gray zone is not sufficiently recognized and valued by researchers, policymakers, and potentially police officers as well. As Bittner (1990) puts it,

> [f]earing the role of the nurse or, worse yet, the role of the social worker, the policeman combines resentment against what he has to do day in, day out with the necessity of doing it. And in the course of it he misses his true vocation. (p. 263)

Future research on this true vocation should, therefore, delve more carefully and systematically into the nature of gray zone encounters, the horizons of

context shaping police decision making, and the proximate and long-term outcomes of such decisions for public safety and public health. In the ensuing years since Bittner's groundbreaking insights, some conceptual and methodological developments create new opportunities for measuring the mental health-related aspects of the police craft. For instance, the subfield of place-based criminology (Weisburd, Bernasco, & Bruinsma, 2009; Weisburd, Groff, & Yang, 2012) and tools from the geospatial sciences can help in quantifying and visualizing the location and geographic clustering of mental health-related calls (citation redacted; see also Hibdon & Groff, 2014 on mapping emergency medical services call data) in relation to community attributes (e.g., crime rates and sociodemographics) and travel distance to gray zone resources (e.g., behavioral health treatment, homeless outreach, and peer specialists). Geospatial techniques, therefore, allow for a comparison of the scenic horizons governing gray zone police work within and across police districts.

Within this place-based framework, it is important to further isolate and quantify the factors influencing gray zone decision making and intervention outcomes. Systemic social observation techniques developed by Mastrofski et al. (Mastrofski & Parks, 1990; Mastrofski, Parks, & McCluskey, 2010; Mastrofski, Snipes, & Supina, 1996) and more recently Schulenberg (2014, 2016) provide critical guidance in this area. In her Canadian study, for example, Schulenberg (2016) coded field observations of police interventions along the domains of encounter characteristics (e.g., offense type and presence of bystanders), citizen characteristics (e.g., prior criminal record), situational factors (e.g., uncooperative), and officer actions (e.g., well-being check and referral).

Spatial analyses of community attributes including mental health resources could both inform and complement systematic social observations designed to explore spatial variation in police decision making. Moreover, observations which record the precise location of encounters could generate the data for a geospatial analysis of police decision making according to the nature (e.g., public and private) and type of place (e.g., sidewalk, park, healthcare provider, and residence) in which encounters occur. For example, existing research suggests that police perceive a narrowing of their dispositional options when incidents are particularly public in nature and exposed to onlookers or citizen demands for action (Cooper, McLearen, & Zapf, 2004; Patch & Arrigo, 1999; Teplin, 1983; Teplin & Pruett, 1992). With advancements in geospatial techniques and systematic social observation, there are opportunities to advance a more nuanced understanding of police decision making during mental health encounters.

From a policy perspective, our findings imply the need to more fully recognize gray zone policing. From the broader perspective of policing as peacekeeping, the specialized knowledge gained through CIT training would be understood as an important complement to police local knowledge in decision making. Good police decision making during gray zone situations, however, remains largely unrecognized in police performance management structures because

such situations do not rise to crises and require officially recorded actions. As noted earlier, programs like CIT have led to reductions in police use of force during mental health-related encounters and have increased mental health referrals and transports, but much of what happens during gray zone encounters remains invisible.

One means of rendering gray zone policing more visible is improved police data capture (Centre for Addiction and Mental Health, 2010; Cotton & Coleman, 2010; Victoria Police, 2007; Wilson-Bates, 2008). Systematic social observations can serve this data function, but only as a temporary component of research studies. Current CIT and police mental health co-response programs are beginning to address this data gap through the capture of encounter-related information by police and triage lines (Council of State Governments, 2016). Such practices, combined with initiatives to train dispatchers in identifying mental health-related calls could help build the digital infrastructure needed to capture gray zone encounters and their dispositional outcomes. On the platform of enhanced police data capture, data linkage across police justice and health sectors would provide the basis for evaluating long-term individual and system-level outcomes, such as future incarcerations, emergency hospital utilization, and police time spent on mental health encounters (Wood & Watson, 2016).

Geospatial analyses of police mental health encounters and their dispositional outcomes can also assist policymakers in identifying districts and neighborhoods with deficits in gray zone resources such as nonemergency mental health facilities, treatment programs, outreach services, and family engagement services for those caring for people affected by mental illness. This place-based perspective could inform efforts to facilitate police access to existing gray zone resources or improving the accessibility of such services to individuals and their families. It could also inform new investments in place-based programming, such as mobile co-response teams, that could be deployed to spaces and places with disproportionately high rates of mental health-related police encounters.

Conclusion

To date, the literature on officer encounters with people affected by mental disturbance or illness has honed in on the troubling, and in some cases, tragic implications of the police authority to invoke the criminal law as well as the capacity of officers to use force during encounters. This unique legal authority, combined with coercive capacity, can result and has resulted in tragic consequences for ill individuals involved in acts of crime or disorder.

While it is important to examine these high profile and tragic encounters in order to learn how to reduce their frequency, this focus misses most of what police officers do in terms of addressing concerns about persons affected by mental illnesses in the community. From a research perspective, this qualitative study both illuminated and reaffirmed the existence of various contextual factors

shaping police decision making in the gray zone of mental health disturbance. Taking our cue from Bittner's early insights (1967a) and Morabito's extension of them (2007), we suggest that the existing emphasis on crisis intervention fails to recognize the complex peacekeeping function of police in contemporary cities.

From a research perspective, our findings highlight the need for advancing field-based research on police decision making that takes advantage of developments in geospatial analysis and systematic social observations to measure the nature and outcomes and gray zone work. From a policy perspective, we advocate a broader lens through which to view the challenges facing police in the handling of mental health-related situations. Although efforts to improve the crisis response capacity of police are essential, future policy efforts should focus on ways to enhance access to noncrisis resources as options for police to use in mitigating the gray zone problems that confront them daily. Finally, as we move into a new era of policing refocused on building police–community relations (President's Task Force on 21st Century Policing, 2015), we must understand, support, and create accountability structures that illuminate the gray zone of policing and define the tenets of good peacekeeping in furtherance of better outcomes for people affected by mental illness.

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Notes

1. On the "incidental" function of laws and law enforcement practices in relation to public health, see Burris et al. (2010).
2. In Chicago, mental health-related calls are often dispatched with the code "disturbance mental." Thus, the common shorthand officers use for persons who are the subjects of these calls and the calls themselves are "mentals." While this term may be offensive to

some, it is the common term used. Similarly, calls dispatched as "disturbance domestic" are often referred to as "domestics."

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Anjali J. Fulambarker is an assistant professor at the Simmons College School of Social Work. Her research explores criminal legal systems responses to intimate partner violence; specifically factors that influence police response. She is interested in exploring more effective and transformative alternatives to traditional criminal legal responses in order to improve long-term outcomes for survivors.