Crisis Intervention Teams and Mental Health Co-Responders

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Definition

Crisis Intervention Teams (CIT) and mental health co-responder models are specialized crisis-response approaches intended to improve police encounters with people experiencing mental illness, behavioural crisis, suicidal distress, substance-related crisis, or other acute states in which clinical knowledge and de-escalation may improve safety and disposition. The category contains two related but distinct models.

Crisis Intervention Team (CIT)

CIT generally refers to a police-based model in which selected officers receive enhanced training in recognizing signs and symptoms of mental illness, communicating with people in crisis, slowing and de-escalating encounters, assessing behavioural risk, understanding local mental health resources, using alternatives to arrest where appropriate, and connecting people with treatment or crisis services. The original Memphis-style model commonly includes approximately 40 hours of specialized training and is intended to function as more than a stand-alone course: it also relies on partnerships between police, mental health providers, advocates, emergency services, and community resources (Compton et al., 2014; Taheri, 2016).

Mental health co-responder

A co-responder model pairs or directly links police officers with a mental health professional during crisis response. The clinician may attend the scene with police, arrive as a secondary unit, provide remote consultation, assess mental state and immediate clinical needs, support de-escalation, advise on disposition, facilitate voluntary treatment, assist with involuntary mental-health processes where legally authorized, or connect the person with community services. Co-responder systems vary substantially in staffing, hours, whether the clinician rides with police, dispatch criteria, response time, authority, and whether the team is a primary or secondary response (Puntis et al., 2018; Shapiro et al., 2015).

This is not a single intervention

CIT training and co-response should not be treated as interchangeable. A CIT-trained patrol officer brings enhanced police crisis-response capability to an encounter, while a co-responder model adds real-time clinical expertise to the police response. Many jurisdictions combine the two, but their mechanisms and expected benefits differ.

How It Is Designed to Work

The intervention does not physically incapacitate a person. Its primary mechanism is to change the interaction: the response attempts to improve safety by increasing the probability that officers and clinicians can correctly recognize behavioural or psychiatric crisis, identify immediate risks, reduce unnecessary confrontation, slow the pace where circumstances allow, establish communication, reduce stimulation, build rapport, identify what the person is responding to or afraid of, negotiate voluntary cooperation, involve family or supports where appropriate, connect the person to clinical care, and avoid unnecessary arrest, force, or emergency-department use.

De-escalation is conditional, not magical

Crisis intervention works best when the responder has something tactically important: time. Communication can influence behaviour only if the encounter permits continued dialogue, sufficient distance, containment, reduced stimulation, repetition, reassessment, and opportunity for the person to process what is being said. A mental health professional cannot reliably "talk down" every person in crisis; acute psychosis, severe intoxication, delirium, extreme agitation, cognitive impairment, suicidal intent, fear, anger, or fixation may reduce the person's ability or willingness to engage.

Clinical expertise changes disposition

The clinician component can add capabilities that police generally do not possess to the same degree, including mental-status assessment, knowledge of psychiatric presentations, suicide-risk assessment, familiarity with treatment systems, access to clinical records in some programs, knowledge of medication and service history, direct referral pathways, and credibility with hospitals or community providers. This can change the outcome from arrest or emergency detention to voluntary care, community referral, crisis stabilization, family-supported resolution, or no further police action.

Evidence of Effectiveness

Overall assessment

Evidence strength: Moderate for improving officer knowledge, attitudes, and crisis-response skills; low-to-moderate for reducing force and arrest through CIT alone; moderate but heterogeneous for co-responder diversion and community-resolution outcomes.

The strongest consistent findings are that specialized mental-health response can improve officer knowledge, attitudes toward mental illness, confidence, recognition of crisis, referral to mental health services, and some disposition outcomes. Evidence that CIT training by itself reliably reduces arrest, use of force, officer injury, or subject injury is less consistent. Co-responder models appear more promising for reducing some forms of detention and increasing community-based resolution, but study quality and model heterogeneity remain important limitations (Taheri, 2016; Puntis et al., 2018; Marcus & Stergiopoulos, 2022).

CIT training: knowledge, attitudes, and skills

Compton and colleagues (Compton et al., 2014) found that CIT-trained officers demonstrated better knowledge of mental illness, attitudes toward people with mental illness, self-efficacy, and de-escalation-related skills than officers without CIT training. These are plausible mechanisms through which later encounter outcomes might improve, though improved knowledge and attitudes should not automatically be interpreted as proof of reduced force.

CIT and use of force

Compton and colleagues (Compton et al., 2014) examined actual encounters involving people officers suspected of having serious mental illness, substance-related problems, or developmental disability and found that CIT-trained officers showed differences in referral, arrest, and force-related decision-making, although effects depended on subject resistance and encounter characteristics. Taheri's systematic review and meta-analysis (Taheri, 2016) reached a more cautious conclusion: across the eligible quasi-experimental studies, CIT showed no statistically significant overall effect on arrest or police use of force, and evidence was insufficient to determine effects on officer injury. The central distinction is that CIT is better supported as a crisis-recognition, communication, and diversion model than as a proven force-reduction technology.

More recent use-of-force evidence

Willis and colleagues (Willis et al., 2023) add to more recent evidence suggesting that CIT may influence force decisions in some settings. However, the broader literature remains heterogeneous and does not support a universal claim that CIT training reliably prevents force across agencies or crisis types.

Co-Responder Evidence

Systematic review

Puntis and colleagues (Puntis et al., 2018) identified 26 eligible articles representing 23 studies of police–mental health co-response or "street triage," but no randomized controlled trials. Preliminary evidence suggested that co-response could reduce use of police detention powers and custody, improve immediate access to mental health assessment, and produce experiences perceived as less criminalizing by service users. The authors emphasized substantial variation in staffing, operating model, dispatch, clinical authority, and local mental health systems.

Comparative review of crisis-response models

Marcus and Stergiopoulos (Marcus & Stergiopoulos, 2022) reviewed police-led, co-responder, and non-police mental health crisis models and found little evidence that CIT alone consistently changes major police outcomes, while co-response models showed more promising diversion and service-use outcomes. The review is especially useful because it treats co-response as a system design issue, not simply a matter of officer training.

Canadian co-responder evidence

Kisely and colleagues [(Kisely et al., 2010)] evaluated a mobile crisis partnership involving mental health, police, and emergency health services in Nova Scotia and found improvements in aspects of service efficiency and crisis disposition. Lamanna and colleagues [(Lamanna et al., 2018)] examined Toronto's police–mental health co-response model and reported low arrest and injury rates, substantial use of mental-health pathways, and generally positive service-user experiences. Semple and colleagues [(Semple et al., 2021)] evaluated a community-based mobile crisis intervention team in a smaller Canadian police service and found evidence of improved crisis handling, including differences in apprehension and call-processing outcomes. These studies illustrate that co-response effects depend heavily on local system design and available destinations.

Multi-agency co-response

Every-Palmer and colleagues [(Every-Palmer et al., 2023)] compared police–ambulance–psychiatric co-response with usual emergency response in a study of 1,273 eligible callouts. Co-response was associated with faster resolution, more community-based outcomes, fewer emergency-department admissions, and reduced subsequent service use, though the study found no statistically significant difference in use of force. This pattern again suggests that the clearest benefits of co-response may appear in disposition and system utilization rather than guaranteed force reduction.

Injury and Safety Evidence

Direct injury evidence is limited

Unlike a baton, CEW, firearm, or police dog, CIT and co-response do not have an inherent injury mechanism. Their safety effect is indirect: they may reduce harm if they prevent unnecessary physical intervention, reduce escalation, facilitate voluntary cooperation, shorten restraint, avoid arrest, or help officers select an intervention better matched to the actual risk. The evidence base does not provide a reliable universal injury-reduction percentage.

Co-responder exposure to danger

Adding a clinician to a police encounter creates a separate safety question: when is it safe for the clinician to enter the scene? Many co-response models function as secondary response models precisely because mental health clinicians are not intended to replace police in circumstances involving an unresolved violent threat. Deploying an unarmed clinician into an active assault, uncontrolled edged-weapon incident, firearm threat, hostage situation, or other immediate lethal-threat environment may increase rather than reduce overall risk.

When Its Use May Be Appropriate

CIT or co-response is most useful where the encounter contains meaningful evidence of mental health crisis, suicidal behaviour, acute psychosis, severe emotional distress, disorganized behaviour, substance-related

behavioural crisis, developmental disability, welfare concerns, or repeated crisis-service involvement. It is especially valuable where officers have time, distance, containment, communication opportunity, and access to meaningful mental-health alternatives.

A clinician may add particular value where the scene is sufficiently safe for clinical engagement, the person is communicative, diagnosis or service history matters, voluntary treatment may be possible, suicide risk needs assessment, family or support networks can assist, repeated crisis contacts are occurring, or officers need help navigating community resources.

When Its Use May Be Inappropriate or Insufficient

Immediate violent assault

CIT and co-response are not substitutes for immediate protective action when a person is actively attempting to kill or seriously injure someone.

Scene not safe for clinician entry

A co-responder should not be conceptualized as someone who must be physically inserted between police and an armed or actively violent person. The clinician may instead remain staged, advise remotely, assist once containment is established, communicate from cover or distance, or engage after weapons are no longer immediately accessible.

Crisis caused by non-psychiatric medical conditions

Behaviour that appears psychiatric may result from head injury, hypoglycemia, delirium, seizure, intoxication, drug toxicity, infection, or another acute medical condition. Crisis response should therefore preserve the possibility that urgent medical care is more appropriate than psychiatric disposition.

No meaningful service alternative

CIT cannot divert someone to a service that does not exist or will not accept them. Program effectiveness therefore depends partly on crisis centres, hospitals, mobile services, community treatment, housing, addiction services, follow-up care, and the legal authority of participating agencies. This is one reason CIT should be understood as a system model, not simply a training package.

Relevance to Edged-Weapon Encounters

The presence of an edged weapon changes the crisis-response problem because it adds the possibility of rapid serious injury while preserving many of the same underlying mental-health, communication, and behavioural dynamics. CIT or co-response can be highly relevant, but its value depends heavily on whether officers can create time, distance, containment, and communication opportunity.

Potential role

A crisis-trained officer or mental health professional may help determine whether the person appears suicidal rather than assaultive, whether the weapon is being held defensively, symbolically, or aggressively, what the person is responding to, whether commands are being understood, whether a specific responder can establish rapport, whether family or a trusted support can assist, whether reducing stimulation could help, whether voluntary surrender is possible, and what clinical disposition may follow once the weapon is relinquished. In a contained incident, these capabilities may permit resolution without physical force.

Conditions favouring deployment

Crisis intervention is most plausible where the subject is contained, the edged weapon is not already being used against another person, officers have sufficient separation, there is cover or a physical barrier, access to third parties is controlled, the person can hear and process communication, officers can slow the encounter, and responders can tolerate a prolonged resolution. A barricaded suicidal person holding a knife therefore presents a very different crisis-response opportunity from a person actively chasing someone with the same knife.

Failure consequences

Crisis intervention does not mechanically prevent weapon use. A person who appears to be calming may still suddenly advance, self-harm, attack another person, attempt to escape containment, or stop responding to communication. The key operational question is therefore not merely whether this person can be de-escalated, but whether responders can safely allow time for de-escalation to work while preserving the ability to respond if behaviour changes.

Co-responder role in armed encounters

A mental health clinician can remain useful even where it is unsafe to place them directly beside the subject. Potential roles include advising the tactical team, providing known clinical history, identifying effective communication approaches, speaking from a protected position, supporting family communication, planning disposition, and assisting once the immediate weapon threat is resolved. “Co-response” does not have to mean co-location at contact distance.

Risk trade-off

For the subject, successful crisis intervention may provide the largest potential harm reduction of any intervention in the library because it can resolve an encounter without applying physical force at all. For police and third parties, the principal risk is allowing de-escalation efforts to substitute for necessary threat management when the subject has the immediate ability and intent to cause serious injury. The strongest edged-weapon application is therefore a contained, time-rich crisis in which responders can communicate without exposing others to immediate harm. The weakest application is an active or rapidly developing edged-weapon assault where there is no safe time for prolonged communication.

U.S. Legal Considerations

Mental illness is relevant but does not eliminate the threat analysis

Under *Graham v. Connor*, police force remains governed by objective reasonableness under the totality of circumstances. A person's apparent mental illness may be relevant to what officers reasonably understand about the behaviour, whether noncompliance is intentional, whether additional time or communication is feasible, and what tactics may reduce confrontation. Mental illness does not, however, require officers to ignore an immediate threat of death or serious bodily injury.

Deorle v. Rutherford

In *Deorle v. Rutherford*, the Ninth Circuit emphasized that officers dealing with an emotionally disturbed person should, where circumstances permit, take diminished capacity into account and use tactics appropriate to that reality. The case does not create a rule that officers must tolerate an imminent lethal assault.

City and County of San Francisco v. Sheehan

City and County of San Francisco v. Sheehan involved officers confronting a woman experiencing psychiatric crisis who threatened them with a knife. The Supreme Court did not establish a broad constitutional rule requiring officers to accommodate mental illness by foregoing otherwise reasonable protective force. The case illustrates the recurring tension between disability-sensitive crisis response and an immediate armed threat.

Americans with Disabilities Act

Police encounters involving mental-health disability may also implicate the Americans with Disabilities Act. Requirements are fact-specific and may depend on whether an accommodation is reasonable, whether officers have time to implement it, whether the scene presents an immediate safety threat, and the law of the relevant federal circuit. The existence of CIT or a co-responder may make some accommodations practically available, but there is no simple rule that a clinician must be summoned before police can act.

Ethical and Moral Considerations

Least-coercive resolution

The strongest ethical argument for CIT and co-response is that they can create a path to safety without arrest, physical force, injury, stigma, or unnecessary hospitalization.

Clinical crisis is not criminal culpability

Behaviour resulting from psychiatric crisis may require police involvement for safety, but that does not mean the most appropriate ultimate response is criminal enforcement.

Avoiding diagnostic assumptions

Responders should not assume unusual behaviour equals mental illness, nor use diagnosis to predict dangerousness automatically. Assessment should remain focused on observable behaviour, communication, immediate risk, known clinical information, and the person's needs.

Coercion remains possible

A mental-health response is not automatically non-coercive. Co-response can still result in involuntary detention, restraint, transport, hospitalization, or police force.

Equity and legitimacy

Service users often describe co-response as less criminalizing than standard police response (Puntis et al., 2018; Lamanna et al., 2018). That potential improvement in dignity and legitimacy is an important outcome even when it is not captured by arrest or force statistics.

Evidence Limitations

CIT and co-response are often discussed together despite being different interventions, CIT fidelity varies widely across programs, most outcome studies are observational or quasi-experimental, and officers who volunteer for CIT may differ systematically from non-CIT officers before training begins. Use-of-force events are relatively rare, making effects difficult to detect in most study designs, and co-responder programs vary substantially in staffing, hours, authority, dispatch, and clinical resources, with service-system capacity functioning as a major confounder. Many studies focus on immediate disposition rather than long-term outcomes, and reduced emergency-department transport is not automatically a better outcome unless appropriate alternative care is available. Few studies directly evaluate armed or edged-weapon encounters, clinician safety and thresholds for scene entry are poorly standardized in published research, and the strongest evidence concerns mental-health crisis generally rather than the subset of crises that become lethal-force encounters.

Bottom Line

CIT effectiveness

Strongest evidence for improving officer knowledge, attitudes, confidence, and crisis-response skills. Evidence that CIT alone reduces arrest or force is mixed and substantially weaker.

Co-responder effectiveness

Promising evidence for improved diversion, community resolution, reduced detention, and better service-user experience, but model heterogeneity and limited controlled research prevent a single universal effect estimate.

Use of force

Not reliably eliminated. Crisis-response specialization can improve options and decision-making, but studies do not establish that CIT or co-response will prevent force when behaviour creates an immediate safety threat.

Injury

No inherent injury mechanism. Potential safety benefits are indirect and arise when improved communication, assessment, and disposition avoid unnecessary physical intervention.

Edged-weapon relevance

Potentially very high in contained, time-rich incidents; limited in an immediate attack. The central value is creating or exploiting time, distance, containment, rapport, and clinical understanding–not physically stopping the weapon.

Risk-benefit assessment

The strongest use of CIT or co-response is a crisis where responders can safely slow the encounter and where mental-health expertise may change behaviour or disposition. Its weakest use is as a substitute for necessary protective action during an immediate violent assault or as justification for exposing an unprotected clinician to an uncontrolled lethal threat.

Core Peer-Reviewed Evidence

1. Taheri, S. A. (2016)

Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis.
Criminal Justice Policy Review, 27(1), 76–96.
DOI: 10.1177/0887403414556289

Citation key: `<span class="cite">(Taheri, 2016)</span>`

Priority: Essential CIT synthesis.

Key finding: No statistically significant overall effect on arrests or police use of force; insufficient evidence for officer injury effects.

Limitation: Small number of eligible studies, all quasi-experimental.

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2. Compton, M. T., Bakeman, R., Broussard, B., et al. (2014)

The Police-Based Crisis Intervention Team (CIT) Model: I. Effects on Officers' Knowledge, Attitudes, and Skills.

Psychiatric Services, 65(4), 517–522.
DOI: 10.1176/appi.ps.201300107

Citation key: `<span class="cite">(Compton et al., 2014)</span>`

Contribution: Evaluates the officer-level mechanisms through which CIT is expected to work.

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3. Compton, M. T., Bakeman, R., Broussard, B., et al. (2014)
The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest.
Psychiatric Services, 65(4), 523–529.
DOI: 10.1176/appi.ps.201300108

Citation key: `<span class="cite">(Compton et al., 2014)</span>`

Contribution: Field evidence on force and disposition in actual behavioural-crisis encounters.

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4. Willis, T., Kern, L. J., Hedden, B. J., Nelson, V., Comartin, E., & Kubiak, S. (2023)
The impact of Crisis Intervention Team (CIT) training on police use of force.
Journal of Offender Rehabilitation, 62(3), 157–173.
DOI: 10.1080/10509674.2023.2182863

Citation key: `<span class="cite">(Willis et al., 2023)</span>`

Priority: Important recent use-of-force evidence.

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5. Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015)
Co-responding police-mental health programs: A review.
Administration and Policy in Mental Health and Mental Health Services Research, 42(5), 606–620.
DOI: 10.1007/s10488-014-0594-9

Citation key: `<span class="cite">(Shapiro et al., 2015)</span>`

Priority: Foundational co-responder review.

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6. Puntis, S., Perfect, D., Kirubarajan, A., et al. (2018)

A systematic review of co-responder models of police mental health 'street' triage.

BMC Psychiatry, 18, 256.

DOI: 10.1186/s12888-018-1836-2

Citation key: `<span class="cite">(Puntis et al., 2018)</span>`

Key finding: Preliminary evidence of reduced police detention/custody and more acceptable service-user experiences; no randomized trials.

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7. Marcus, N., & Stergiopoulos, V. (2022)

Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models.

Health & Social Care in the Community, 30(5), 1665–1679.

DOI: 10.1111/hsc.13731

Citation key: `<span class="cite">(Marcus & Stergiopoulos, 2022)</span>`

Key value: Compares CIT, co-responder, and non-police models within the broader crisis system.

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8. Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018)

Co-responding police-mental health programmes: Service user experiences and outcomes in a large urban centre.

International Journal of Mental Health Nursing, 27(2), 891–900.

DOI: 10.1111/inm.12384

Citation key: `<span class="cite">(Lamanna et al., 2018)</span>`

Priority: High Canadian co-responder evidence.

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9. Kisely, S., Campbell, L. A., Peddle, S., et al. (2010)

A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia.

Canadian Journal of Psychiatry, 55(10), 662–668.

DOI: 10.1177/070674371005501005

Citation key: `<span class="cite">(Kisely et al., 2010)</span>`

Priority: High Canadian comparative evidence.

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10. Semple, T., Tomlin, M., Bennell, C., & Jenkins, B. (2021)

An Evaluation of a Community-Based Mobile Crisis Intervention Team in a Small Canadian Police Service.

Community Mental Health Journal, 57(3), 567–578.

DOI: 10.1007/s10597-020-00683-8

Citation key: `<span class="cite">(Semple et al., 2021)</span>`

Priority: High Canadian implementation evidence.

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11. Every-Palmer, S., Kim, A. H. M., Cloutman, L., & Kuehl, S. (2023)

Police, ambulance and psychiatric co-response versus usual care for mental health and suicide emergency callouts: A quasi-experimental study.

Australian & New Zealand Journal of Psychiatry, 57(4), 572–582.

DOI: 10.1177/00048674221109131

Citation key: `<span class="cite">(Every-Palmer et al., 2023)</span>`

Key findings: Faster resolution, more community-based care, fewer emergency-department admissions, and reduced subsequent service use; no statistically significant difference in use of force.

Evidence Rating

Officer knowledge / attitudes / skills: ★★★★★

Repeated studies support meaningful improvement after CIT training.

Diversion / referral: ★★★★☆

Generally favourable evidence, particularly where strong mental-health pathways exist.

Arrest reduction: ★★☆☆☆ to ★★★☆☆

Mixed; meta-analytic CIT evidence is not statistically conclusive.

Use-of-force reduction: ★★☆☆☆ to ★★★☆☆

Mixed for CIT; some promising newer and co-responder findings, but no universal effect.

Co-responder community resolution: ★★★★☆

Promising across multiple jurisdictions, though model heterogeneity remains substantial.

Emergency-department / detention reduction: ★★★☆☆ to ★★★★☆

Frequently favourable but not uniform across programs.

Injury reduction: ★★☆☆☆

Plausible and occasionally observed, but direct comparative evidence remains limited.

Edged-weapon-specific evidence: ★☆☆☆☆

Very little direct empirical research.

Overall confidence: Moderate.

Crisis Intervention Teams and mental health co-responder programs should be understood primarily as decision-making, communication, diversion, and system-navigation interventions rather than as force technologies. CIT training has strong evidence for improving officer knowledge, attitudes, confidence, and crisis-response skills, but considerably weaker evidence that training alone reliably reduces arrest or force. Co-responder models add real-time clinical expertise and show more consistent promise for community-based resolution, reduced detention, improved service-user experience, and more appropriate linkage to care, although program designs vary substantially and high-quality controlled research remains limited. In edged-weapon encounters, their value is greatest when officers can create time, distance, containment, and communication opportunity. A trained officer or clinician may help turn a suicidal or disorganized armed-person call into a voluntary surrender without force, but neither CIT nor co-response mechanically stops an attack. The central tactical requirement is therefore to preserve the conditions in which communication can work while maintaining the capacity to respond if the subject's behaviour changes.

References

Compton, M. T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., . . . Watson, A. C. (2014). The Police-Based Crisis Intervention Team (cit) Model: ii. Effects on Level of Force and Resolution, Referral, and Arrest. *Psychiatric Services*, *65*(4), 523–529. https://doi.org/10.1176/appi.ps.201300108

Every-Palmer, S., Kim, A. H. M., Cloutman, L., & Kuehl, S. (2023). Police, ambulance and psychiatric co-response versus usual care for mental health and suicide emergency callouts: a quasi-experimental study. *Australian & New Zealand Journal of Psychiatry*, *57*(4), 572–582. https://doi.org/10.1177/00048674221109131

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A Controlled Before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia. *The Canadian Journal of Psychiatry*, *55*(10), 662–668. https://doi.org/10.1177/070674371005501005

Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police–mental health programmes: Service user experiences and outcomes in a large urban centre. *International Journal of Mental Health Nursing*, *27*(2), 891–900. https://doi.org/10.1111/inm.12384

Marcus, N., & Stergiopoulos, V. (2022). Re-examining mental health crisis intervention: a rapid review comparing outcomes across police, co-responder and non-police models. *Health & Social Care in the Community*, *30*(5), 1665–1679. https://doi.org/10.1111/hsc.13731

Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., . . . Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry*, *18*(1), 256. https://doi.org/10.1186/s12888-018-1836-2

Semple, T., Jenkins, B., & Bennell, C. (2021). Injuries and deaths proximate to oleoresin capsicum spray deployment: a literature review. *The Police Journal: Theory, Practice and Principles*, *94*(2), 184–205. https://doi.org/10.1177/0032258X20926873

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding Police-Mental Health Programs: a Review. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 606–620. https://doi.org/10.1007/s10488-014-0594-9

Taheri, S. A. (2016). Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? a Systematic Review and Meta-Analysis. *Criminal Justice Policy Review*, *27*(1), 76–96. https://doi.org/10.1177/0887403414556289

Willis, T., Kern, L. J., Hedden, B. J., Nelson, V., Comartin, E., & Kubiak, S. (2023). The impact of Crisis Intervention Team (cit) training on police use of force. *Journal of Offender Rehabilitation*, *62*(3), 157–173. https://doi.org/10.1080/10509674.2023.2182863

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