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Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices

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EXECUTIVE SUMMARY

Police officers are often the first point of contact for people living with mental health issues. The rationale for police to intervene in the lives of persons with mental illness (PMI)¹ stems from two common law principles: power and authority of police to protect the safety of the community, and the *parens patriae* doctrine which grants state protection for citizens with disabilities such as the acutely mentally ill (Finn & Stalans, 2002; Lamb, Weinberger, & DeCuir, 2002; Teplin, 2000). Many police officers have expressed concern about the difficulties they encounter in providing assistance to this population and have indicated that they do not feel adequately trained or would like additional training in effective response (Watson & Angell, 2007). Studies indicate that these interactions can be incredibly time consuming and frustrating for both police and persons with mental illness (Durbin, Lin, & Zaslavska, 2010). Efforts to improve police officers' abilities to respond to persons with mental illness are being initiated in jurisdictions globally. These efforts include crisis intervention teams, mobile mental health cars, and a range of educational programs.

The US has been a forerunner in the development of police-led and co-response² models which have spread rapidly across the US and other western jurisdictions. Many of these efforts have incorporated the perspectives of multiple stakeholders into planning and implementing interventions, but minimal investment has been dedicated to evaluations for effectiveness. These programs would benefit from both rigorous evaluation and a well-developed understanding of interactions between police officers and persons with mental illness. Law enforcement agencies would also benefit from knowledge of “what’s working” in other jurisdictions with similar environmental characteristics. This knowledge can help isolate the essential components of effective police response that can be disseminated alone, or as components of a more extensive program.

The overall objective of this paper is thus twofold. I begin with a preliminary review of the literature addressing the nature, prevalence and dynamic of interactions between persons with mental illness and law enforcement. This includes the intersections between mental illness, substance abuse and homelessness, which are particularly relevant to policing. The latter half of the paper will be dedicated to law enforcement responses, focusing on programs that have the specific goal of improving response and treatment access. The jurisdictions studied for this review will be predominantly Canada and the United States, and to a lesser extent, Australia and the United Kingdom. There appears to be considerable

¹ Persons with mentally illness will be occasionally referred to as PMI throughout this document.

² Collaborative response, police and mental health.

convergence in attitude amongst all four jurisdictions around the importance of police in effectively managing persons in crisis.

Despite the increasing number of programs to improve the interactions of police with persons with mental illness, good evaluations are limited. As well, the objectives of such programs are often vague and difficult to measure. Generally, it appears that effective programs have reduced arrest rates, reduced injuries to both persons with mental illness (PMI) and police, reduced response times, increased coordination with mental health services and increased appropriate referrals to hospital and various community-based agencies. However programs have generally not reduced recidivism, unless the referral is to more than regular mental health services and includes cognitive behavioural training and stable housing.

I. Mental Illness and the Criminal Justice System

The greatly increased presence of the mentally ill in the criminal justice system (CJS) is a global problem. Mental health professionals, law enforcement officials, and policy makers have become more concerned about the number of persons with mental illness in custody, as well as the treatment provided to these persons (Lamb, Weinberger, & Gross, 2004). Police officers are often the first responders to individuals in crisis; they make the critical decision of who gets arrested, who gets medical service and who gets released (Canada, Angell, & Watson, 2010). This role has earned law enforcement officials the moniker of “psychiatrists in blue” (Menziés, 1987) because they often operate as gatekeepers into the mental health system (Durbin et al., 2010; Lamb et al., 2002; Matheson et al., 2005).

Until recent decades, many people suffering from chronic, severe and disabling mental disorders were interned in public psychiatric hospitals (Wood, Swanson, Burris, & Gilbert, 2011). Beginning in the 1960s, a process of deinstitutionalization took place, whereby, large numbers of people diagnosed with mental illness were released from hospitals in the community without an adequate community treatment infrastructure (Abigail, Vincent, & Scott, 2008; Borum, 2000). That said, an increase in persons with mental illness living in the community does not serve to sufficiently explain their disproportionate representation in the criminal justice system.

A need exists to clearly understand the intricate factors surrounding police/PMI encounters. In what follows, I consider the prevalence and nature of police contact and some well-documented reasons for the criminalization of mental illness. Within this broader discussion, I review the conflicting literature surrounding the intersections between mental illness, violence, homelessness and substance abuse. Understanding the

complexities of this dynamic interaction will set the tone for considering the essential elements of effective response.

PREVALENCE AND NATURE OF POLICE/PMI CONTACT

There is little doubt that contact between police and those with mental illness has increased as more individuals suffering from mental illness are residing in the community rather than in hospital. As well, certain types of mental disability, such as FASD and brain trauma, as well as substance abuse, are becoming more prevalent. Persons with mental illness are more likely than their non-mentally ill counterparts to have contact with police as victims, given their vulnerability. Individuals with a serious psychiatric diagnosis (such as schizophrenia) are at especially high risk of criminal victimization (Marley & Buila, 2001). Where calls for service involve a person with mental illness as the “offender”, research suggests that the majority of those contacts involve less serious offences and contact-generating nuisance behaviour. In a study of police/PMI contact in Indiana, Wells and Schafer (2006) found that only 1% of the calls for service were for a serious crime. In contrast, 87% of the calls fell into the category of “general order maintenance” or “other, including contacts while on patrol.” Studies from the US, Canada and the United Kingdom suggest that PMI are arrested and jailed for minor offences at a higher rate than the general population (Crocker, Hartford, & Heslop, 2009; Hoch, Hartford, Heslop, & Stitt, 2009; Schellenberg, Wasylenski, Webster, & Goering, 1992).

The assertion of ever-increasing police/PMI contact is widespread, but the empirical bases are not well-established and studies have produced disparate results. Crocker et al. (2009) conducted a large-scale study using the administrative database of the London Police Service (LPS) in Ontario and estimated that interactions with persons with serious mental illness constituted about 3 percent of all police-citizen contacts from 2000 to 2005. This likely represents an underestimation because the analyses excluded individuals who were identified by the initial algorithm as being in the possible and probable categories of mental illness.

Cotton (2004) surveyed three police forces in Ontario and British Columbia and found that 25.7% of officers had contact with a person with mental illness at least once per week and 75.7% had contact at least once per month. In a study conducted by Brink et al. (2011, p. 8) to assess how people with mental illness perceive police officers, numerous and recent contacts were common amongst participants, with 21% of survey participants and 37% of interview participants reporting more than 25 interactions during their lifetime. In a study conducted in the US, it was estimated that up to 7 percent of monthly police contacts involve a person with serious mental illness (Borum, Williams Deane, Steadman, &

Morrissey, 1998). In contrast, a study of the Vancouver Police Department finds that 31% of calls for service involve at least one mentally ill person; in some areas of the city, the proportion is almost half (Wilson-Bates, 2008). It is possible; however, that Vancouver is unique in this regard and so it would be unwise to generalize from these figures (Government of Canada, 2010).

Studies investigating contact prevalence rates reflect differences in operational definitions of “mental illness” (identification of individuals as “emotionally disturbed persons” at dispatch, officer perception, or police reports) as well as differences in data collection (police databases, self-report surveys). Consequently, the rate of police contacts with PMI remains largely unknown.

When police/PMI interactions do occur, they can be particularly challenging. Reuland, Schwarzfeld, and Draper (2009, p. v.) summarize some of the distinct characteristics of police/PMI encounters. They:

- often take much more time than other calls for service,
- require officers to have special training and skills,
- may depend on the availability of community mental health resources for successful outcomes,
- typically involve repeated contact with the same individuals who have unresolved mental health needs,
- are mostly in response to a person with mental illness committing a minor or “nuisance” offense,
- occasionally involve volatile situations, risking the safety of all involved

Most people with a mental illness do not commit crime; however, encounters with police are common among this population. Rates of contact are mediated by the extent of victimization experienced by persons with a mental illness, as well as the nature of the behaviour of persons with mental illness and societal reactions to that behaviour. The criminalization of mental illness is particularly relevant to our understanding of the role of law enforcement.

THE CRIMINALIZATION OF MENTAL ILLNESS

It is often suggested that persons with mental illness end up in the criminal justice system for a number of factors other than their criminal behaviour, thus effectively criminalizing the mentally ill. It is suggested that the criminalization of persons with mental illness may stem from homelessness and poverty; community disorganization; poorly funded community-based programs; hospital emergency room bed shortages; more formal and

rigid criteria for civil commitment; and a belief by law enforcement personnel that they can deal with deviant behaviour more quickly and efficiently within the criminal justice system than in the mental health system (Brink et al., 2011; Lamb et al., 2004; Reuland, 2004; Teplin, 2000).

Some have suggested that fewer psychiatric hospital beds have resulted in more mentally ill persons being arrested. The rapid and considerable reduction in hospital beds in the US since the mid-1900s is staggering. Occupied state beds were reduced from 339 per 100,000 to 20 per 100,000 on any given day (Lamb et al., 2004). Moreover, in the early 1960s the average length of stay was about 6 months and by the early 1990s it had declined to 15 days (Markowitz, 2006). This experience is echoed in the Canadian context, although the decline has not been so dramatic. Combined days of care in psychiatric beds in both psychiatric hospitals and general hospitals decreased by 38.4%, from 463.6 per 1000 in 1985-86 to 285.6 per 1000 population in 1998-99 (Sealy & Whitehead, 2004). For many persons suffering from mental illness, community care might be a positive experience and serve to increase independence and stability through employment and social integration. Unfortunately, community-based supports to people leaving institutions appear to be limited in access and availability. In British Columbia, for example, the Riverview Redevelopment Project announced the transfer of all patients from the largest provincial psychiatric institution (Riverview Psychiatric Hospital) to smaller tertiary or other supported living arrangements (Jamer & Morrow, 2008). However, deinstitutionalization in BC has taken place in the context of severe housing shortages and little has been done to supplement services that provide important supports to assist people in gaining access to the housing, income and education (Jamer & Morrow, 2008). In the year 1994-95, the operating cost of BC psychiatric hospitals and psychiatric units in hospitals was 424 million dollars. By 1998-99, this cost dropped to 234 million dollars (Sealy & Whitehead, 2004). Despite efforts toward increased community-based treatment, patients are often stabilized (medicated) and then discharged from the hospital with no provision for aftercare or follow-up treatment (Lamb, 1992; Markowitz, 2006).

It has been suggested that the arrest rate for PMI is higher than for non-mentally ill counterparts, but how much of that is attributed to increased rates of criminal behaviour and how much is attributed to the “criminalization of mental illness” remains unclear. In the opinion of Lamb and Weinberger (1998), criminalization of mental illness refers to PMI who are arrested and prosecuted for minor offences instead of being placed in the mental health system. Accordingly, criminalization is used to describe the tendency to involve individuals with mental illnesses in the criminal justice system, under circumstances in which other non-mentally ill individuals would not be involved (Cotton, 2004).

This phenomenon may be reflected in practices such as “mercy booking.” In some instances, arrest may be the most efficient and pragmatic disposition option, and the only way to keep the person with mental illness off the street and safe from harm (Wells & Schafer, 2006). The practice of “mercy booking” has been regarded as a major cause of criminalization (Lamb et al., 2002; Markowitz, 2006). In this framework, it is not the mental illness that is seen as the primary cause of offending, but rather externally-imposed changes and deficiencies in the management of mental illness (Fisher, Silver, & Wolff, 2006). This conceptual model is guided by the belief that reconnecting individuals with mental health services will reduce risk for arrest. Citing a *Research Brief* from the Soros Foundation, William H. Fisher et al. (2006) succinctly articulate the early criminalization argument:

Mentally ill offenders are often arrested and detained because community-based treatment programs are nonexistent, filled to capacity, or inconveniently located. Police report that they often arrest the mentally ill when treatment alternatives are unavailable (p.4).

Supporters of the criminalization hypothesis have referred to the numerous studies that find that persons with mental illness are overrepresented in prisons and jails (Fazel & Danesh, 2002; Lamb & Weinberger, 1998; Teplin, 2000). Although suggestive, the disproportionate number of inmates with mental illness does not necessarily indicate that police inappropriately use arrest to handle PMI encounters. A study of police-citizen encounters in twenty-four police departments finds that other factors predict the likelihood of arrest including the influence of drugs, noncompliance, fighting with officers or others, and the seriousness of the offense (Engel & Silver, 2001). Accordingly, PMI are more likely than the general population to exhibit arrest-generating behaviour.

William H. Fisher et al. (2006) also advocate for reconceptualising beyond the criminalization hypothesis. Fisher, Packer, Simon, and Smith (2000) sought to test the criminalization hypothesis by comparing the prevalence of mental illness among jail detainees from two systems with different levels of community based services. Based on the criminalization hypothesis, one would expect that the jail that operated in one of the best funded community mental health systems would house fewer individuals with mental illness. However, no difference was observed in rates of severe mental illness among individuals received by the two jails over the same six-month period. While diverting PMI from the criminal justice system into mental health services is a worthy endeavour, empirical support for the idea that mental health service will itself reduce recidivism, appears weak at best (William H. Fisher et al., 2006).

Skeem, Manchak, and Peterson (2011) echo this sentiment, suggesting that the criminalization framework may apply to only a very small subgroup of offenders with mental illness. The programs that will be the most effective in reducing recidivism are those that target needs closely related to criminality. Since serious mental illness is not a criminogenic need for this population, programs need to target stronger risk factors for crime (Skeem et al., 2011). While risk factors for criminality are largely the same for persons with and without serious mental illness (Hiday, 2006), suggestions are made that this population's disproportionate risk may be based on their having *more* general risk factors for recidivism (Skeem et al., 2011, p. 117). Persons with mental illness are at greater risk of being poor and living in "settings that are rife with illicit substances, unemployment, crime, victimization, family breakdown, homelessness, health burdens, and a heavy concentration of other marginalized citizens" (Fisher & Drake, 2007, p. 546 as cited in Skeem et al., 2011). The relationship between serious mental illness and social factors such as substance use and homelessness have not been sufficiently accounted for in service planning, research and policy (Draine, Salzer, Culhane, & Hadley, 2002).

HOMELESSNESS, SUBSTANCE USE AND MENTAL ILLNESS

Studies estimate that approximately one-third of homeless persons meet the diagnostic criteria for a major mental disorder (Shlay & Rossi, 1992). Homelessness is considered to be an important pathway to crime and incarceration among the mentally ill population (Lamb & Weinberger, 2001; McCarthy & Hagan, 1991). Surveys of jail inmates indicates that those with mental disorder were more likely than their counterparts to be homeless at the time of arrest and in the year before their arrest (McCarthy & Hagan, 1991). A study of psychiatric emergency service in San Francisco found that homeless patients were more likely than other patients to have multiple episodes of service and to be hospitalized after an emergency department visit (McNiel & Binder, 2005).

A recent BC study used a randomized controlled trial design to study the effectiveness of housing as a means of reducing crime among individuals who meet criteria for current homelessness and the presence of a mental disorder, and who had previous involvement with the justice system. In comparison to the treatment as usual group, the treatment group (those who received secure housing) had a significantly lower rate of convicted offenses in the post period even in the absence of mandatory mental health treatment (Somers, Rezansoff, Moniruzzaman, Palepu, & Patterson, 2013). The study underscores the importance of providing adequate housing and supports to persons living with mental illness. While mental illness may not be a direct predictor of homelessness, Draine et al. (2002, para.8) claim that it is a risk factor for poverty:

If persons with mental illness are not poor to begin with, they are likely to become poor, and poverty factors become salient in explaining common outcomes, such as quality of life, social and occupational functioning, general health, and psychiatric symptoms.

Mentally ill and homeless persons often reside in shelters and single-occupancy hotels in more “social disorganized” areas with more fragmented families, racial diversity and economic disadvantage (Markowitz, 2006). According to social disorganization theory, these structural characteristics weaken social cohesion and may result in increased crime (Sampson & Groves, 1989). Draine et al. (2002) stress that poverty moderates the relationship between mental illness and other social problems through factors such as lack of education, problems with employment, substance abuse and low likelihood of prosocial attachments. Accordingly, “persons with mental illness experience social problems more frequently because they live in a world in which these problems are endemic, not just because they are mentally ill” (Draine et al., 2002, para. 3). Somers et al. (2013) echo the sentiment that poverty, social marginalization, unemployment are indirect pathways to crime and incarceration for persons suffering from mental illness.

In a comparison of distributions of offenders with and without mental illness, Peterson, Skeem, Hart, Vidal, and Keith (2010) discover more commonalities than differences. Regardless of psychiatric status, most patterns of offending for both subgroups were driven by hostility, disinhibition and emotional reactivity. Substance abuse was an important secondary driver, particularly for persons with mental illness (Peterson et al., 2010). Stuart and Arboleda-Flórez (2001) reinforce the crucial role of substance use in their findings that less than 3% of violent offenses are attributable to people with a diagnosis which is a non-substance-use disorder.

Evidence also strongly supports adverse effects of substance abuse on the course of severe mental illness. Some of the consequences of substance abuse for mental health patients include increased symptom severity, medication noncompliance, disruptive behaviours, increased hospitalization and decreased social functioning (RachBeisel, Scott, & Dixon, 1999). J. A. Swartz and Lurigio (2007, p. 582) explain that substance use provides multiple pathways into the criminal justice system, including the commission of income-generating crimes, increased nuisance offenses due to exacerbation of psychiatric symptoms, and the fact that the possession of many drugs is an offense in its own right. This is particularly problematic since prevalence studies indicate that persons with mental illness have significantly higher rates of substance use than the general population (Graham et al., 2001; J. Scott, 1993).

In a study conducted by Abram and Teplin (1991), 80% of subjects with any severe lifetime disorder, met criteria for either two or three other disorders which almost always included substance abuse. More specifically, drug use disorders occurred nearly twice as often among the schizophrenic detainees as among the non-disordered detainees. Similarly, drug abuse among persons with depressive disorders was 50% higher than among persons who were not severely mentally ill (Abram & Teplin, 1991).

The rates of dual-diagnosis are particularly important because evidence suggests that the link between mental illness and violence is mediated by substance use. In the following section, I present a review of the long-debated relationship between violence and mental illness.

MENTAL ILLNESS AND VIOLENCE

In general, it is falsely assumed that mentally ill persons are more likely than non-mentally ill persons to be dangerous (Lipson, Turner, & Kasper, 2010). The assumption that people with mental illness are dangerous has played a role in the development of civil commitment laws and has contributed to social rejection and stigma. While the topic has been long-debated, the precise link remains unclear. Mulvey (1994) asserts that there does appear to be a link between mental illness and violence despite earlier contradictory findings. However, the link appears to be small and there is no consistent body of evidence indicating the relative strength of this association in comparison to other risk factors such as socioeconomic status and history of violence (Mulvey, 1994).

It is important to differentiate between mental illnesses when considering violence propensity. While a direct link between mental illness and violence has not been established, research has shown that people with schizophrenia have a higher risk of committing homicide than those with other serious mental illnesses (Schanda, 2005). Nielssen and Large (2010) point out that the chances of committing murder and becoming involved in the CJS can be reduced by ensuring that these individuals receive early and appropriate treatment. In their study, Nielssen and Large (2010) demonstrate that the rate ratio of homicide in the first episode of psychosis prior to treatment was 15.5 times the annual rate of homicide after treatment for psychosis. The study underscores the importance of early intervention in preventing homicide.

A finding that is striking and consistent in the literature is the increased risk of violence involvement for those with substance abuse and dependence (Kraanen, Scholing, & Emmelkamp, 2012; Salloum, Daley, Cornelius, Kirisci, & Thase, 1996; Smith & Hucker, 1994; M. S. Swartz et al., 1998). In a study involving involuntarily-admitted patients with

severe mental illness, respondents with both noncompliance and substance abuse problems were more than twice as likely to commit violent acts, while those individuals with either of these problems alone had no greater risk of violence (M. S. Swartz et al., 1998). The results suggest that the co-occurrence of substance abuse with medication noncompliance may explain much of the observed relationship of comorbidity with violence among the severely mentally ill.

From a review of studies from eight countries, Hiday (2006) finds that in all cases the risk of violence is higher, double or more, for those with substance use disorders than those with severe mental disorder.

In studies involving the role of other types of mental illnesses (schizophrenia, affective disorder or anxiety disorders) a link to violence has been small or nonexistent. However, risk factors that exist in those without mental illness also exist in those with schizophrenia, with strong predictors being substance abuse and history of violence (Walsh, Buchanan, & Fahy, 2002).

While mental illness is not a direct predictor of violence, there are interacting variables that serve to increase the likelihood of volatile confrontations between police and persons with mental illness. Ruiz and Miller (2004, p. 361) claim that five main catalysts exist that foster physical confrontations between police officers and persons with mental illness:

1. *Fear on the part of the person with mental illness ... because it involves placing them in the hands of unfamiliar police officers*
2. *The reluctance of the person in the mental health crisis to cooperate with or comply with police orders*
3. *Fear due to the police uniform or the overpowering attitude of the police*
4. *Lack of understanding or empathy by police officers for the plight of persons with mental illness*
5. *Fear that police officers harbour for persons with mental illness*

The precarious nature of interactions between police and person with mental illness requires unique considerations in order to minimize risk of violence and injury, and improve outcomes. The co-occurrence of homelessness, mental illness, substance use and violence represents a complicated issue and the availability of integrated services will be critical for effective community treatment (Hiday, 2006; Kraanen et al., 2012; MacPhail & Verdun-Jones, 2013; McNiel & Binder, 2005).

Minimizing criminal justice involvement among persons with mental illness has become a major focus of policy makers and service providers. Support and inter-agency collaboration has led to various interventions evolving over the past ten to fifteen years to

help divert arrestees with mental illness to an appropriate array of mental health services (William H. Fisher et al., 2006). Prominent program advances specific to law enforcement will serve as the focus for the subsequent sections.

II. Specialized Intervention Programs

In response to the many challenges discussed earlier with respect to mental illness, police-led and co-response³ intervention models have begun to spread globally. Although program outcomes have not always been clearly specified for every initiative, the most common ones are:

1. Reducing the risk of injury to police and PMI when dealing with mental health related incidents;
2. Improving awareness amongst front line police of the risks involved in the interaction between police and PMI;
3. Improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents, and;
4. Reducing the time taken by police in the handover of PMI into the health care system;
5. Reduced arrests through diverting PMI to the health-care system, and thus less penetration into the justice system;
6. Reduced recidivism;
7. Improved therapeutic outcomes

Data from a survey of 174 cities in the United States with populations of 100,000 or more revealed that 78 police departments had a specialized response for persons with mental illness (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Where specialized programs exist, they appear generally to conform to one of three models (Hails & Borum, 2003, p. 54):

1. ***Police-based specialized police response:*** These models involve sworn officers who have special mental health training, serving as the first-line police response to mental health crises in the community and acting as liaisons to the formal mental health system.
2. ***Police-based mental health response:*** In this model, mental health professionals (not sworn officers) are employed by the police department to provide on-site and telephone consultations to officers in the field.

³ Co-response: joint mental health and police response (Reuland et al., 2009).

3. ***Mental-health-based specialized mental health response:*** In this more traditional model, partnerships or cooperative agreements are developed between police and mobile mental health crisis teams (MCTs) that exist as part of the local community mental health services system and operate independently of the police department.

In what follows, I describe some of the major police-led and co-response programs operating in the US, Canada, Australia and the U.K. The majority of the programs selected for discussion can be categorized by the Hails and Borum (2003) typology. Unfortunately, there is no empirically supportable way to define a “best practice” in police/PMI interactions at the current time. Unfortunately most programs have not clearly identified specific outcome objectives but a number of studies/reports highlight programs that have potential to lead the way. I begin with the US, which has been a forerunner in the development of crisis models.

UNITED STATES

The structure of policing in the US is localized, multi-layered and somewhat fragmented (Wood et al. (2011)). Under the federalist system, powers are distributed across the federal and state levels of government. One barrier to widespread program implementation in the US is the sheer volume of police departments. Recent census data indicates that there are approximately 18,000 state and local law enforcement agencies in the US, about half of which have fewer than 10 sworn personnel (Reuland, Draper, & Norton, 2013). A branch of each state’s government oversees the administration of mental health services. States vary with respect to the laws that govern police powers to take someone into custody for emergency mental health evaluation (Reuland et al., 2013). While country-wide consistency is unlikely, some suggest that state-level policy makers need to be promoting and supporting state-wide coordinated responses at the local level (Reuland et al., 2013). Part of this pursuit involves deciphering promising strategies that can be tailored to jurisdictional needs.

I will provide a brief review of three of the most prominent crisis response models originating in the US. An empirical comparison of the three models will also be presented. I have chosen the three models for discussion because some form of empirical assessment has been used to evaluate the program. While I acknowledge that hundreds of other programs are now in existence, most of them have a program design which reflects the foundational elements of the “big three.”

Crisis Intervention Team (CIT) Model

The most well-known and specialized model for responding to persons with mental illness is the Crisis Intervention Team (CIT) (Canada et al., 2010; Hails & Borum, 2003; Wells & Schafer, 2006; Wood et al., 2011). This model falls under the category of police-based specialized police response. The CIT model was born out of the recognition that mental health issues were an all-too-frequent factor in violent encounters between the police and the public. The three core elements of the CIT model are intense training, partnership between police and mental health community resources and the adoption of a new role for CIT-trained officers. Details of the core elements can be found in *Appendix B* of this paper. The model was launched in 1988 by the Memphis Police Department and by 2006, over 70 police departments in the United States had adapted the model and formed their own CIT program (Teller, Munetz, Gil, & Ritter, 2006). CIT is considered by many to be the most rapidly expanding and promising partnership between law enforcement and mental health professionals (Compton, Bahora, Watson, & Oliva, 2008). The explicit mission of the Memphis Police Department with respect to CIT is as follows:

The Crisis Intervention Team (CIT) program is a community partnership working with mental health consumers and family members. Our goal is to set a standard of excellence for our officers with respect to treatment of individuals with mental illness. This is done by establishing individual responsibility for each event and overall accountability for the results. Officers will be provided with the best quality training available, they will be part of a specialized team which can respond to a crisis at any time and they will work with the community to resolve each situation in a manner that shows concern for the citizen's well-being.⁴

Other CIT programs based on the Memphis model have been developed in Portland, Albuquerque and Seattle (Steadman, Deane, Borum, & Morrissey, 2000), and there are now over 400 CIT programs operating across the nation (Canada, Angell, & Watson, 2012).

Empirical evaluations of the success of CIT are limited. However, the information available suggests that CIT may be an effective model for servicing PMI in the community. Steadman et al. (2000) reports that the Memphis model actively links PMI with mental health resources, with 75% of the mental health disturbance calls resulting in a treatment disposition, usually through transportation to the psychiatric emergency centre. The study also reported lower arrest rates for PMI and rapid response times.

Wells and Schafer (2006) administered pre- and post- training testing to assess newly trained CIT officers' perceptions in Indiana. They report that training appeared to improve officers' ability to identify individuals with mental illnesses and respond appropriately; their knowledge of local treatments and services; and their comfort in interactions and

⁴ The official site of the Memphis Police Department:
<http://www.memphispolice.org/crisis%20intervention.htm>.

with patients and their family members. Furthermore, officers felt an increased sense of confidence; were able to identify common stereotypes and stigma; and reduce behaviour based on these detrimental attitudes in interactions with PMI (Compton et al., 2008). The San Jose, California Police Department's CIT program reported a 32% decrease in officer injuries in the year following implementation (Reuland et al., 2009). The Memphis, Tennessee Police Department's CIT program reported that during the first four years, the rate of referrals by law enforcement to the psychiatric emergency service increased by 42% (Reuland et al., 2009).

Research indicates that CIT training has a significant effect on increasing referral to services and decreasing "contact only" encounters among officers who have a positive view of mental health service availability and familiarity with mental health (Watson et al., 2010). While the Memphis model does not require officers to function as quasi-mental health personnel, many of the CIT officers establish relationships with citizens in the community. In fact, they are often personally requested by citizens and their families when problems arise (Peck, 2003).

On a systems level, CIT, in comparison to other pre-and post-diversion programs, may have a lower arrest rate. This is unsurprising given that the diversion associated with CIT occurs at prebooking (Compton et al., 2008). While a reduced rate of arrest might simply be the result of an increased understanding and recognition of the symptoms of mental illness for greatest effectiveness, prebooking diversion models such as CIT require accessible non-jail options such as the centralized single entry drop-off site in Memphis. The potential for success of CIT will likely vary with local contexts, such as relationship between police and mental health services, availability of funding, and state laws that might govern disorderly behaviour and civil commitment (Wells & Schafer, 2006). Nonetheless, findings suggest that CIT training holds the potential to change the nature of interactions between police officers and persons with mental illness.

Some U.S. jurisdictions have implemented models based on the mental health care sector, which involve teams such as mobile crisis teams, consisting of mental health workers who provide first response assistance to officers (Wood et al., 2011). One such model is Knoxville's Mobile Mental Health Crisis Unit.

Knoxville's Mobile Mental Health Crisis Unit

The Knoxville MCU was established in 1991 and consists of civilian mental health professionals who provide 24-hour coverage, responding to calls to assist at the scene and offering telephone consultation (Wood et al., 2011). In a study of major models of police

response, the collaboration between the police and MCU allowed persons with mental illness to be linked to treatment through transport or referral in approximately 75% of the cases with only 5% of incidents resulting in arrest (Steadman et al., 2000).

With this model, there are cooperative agreements between police and mental health services, but the two remain institutionally separate. Hence, Knoxville MCU falls under the mental-health-based specialized mental health response model (Hails & Borum, 2003). A variation of the co-response is an arrangement where police departments *employ* a mental health professional who assists officers either on-site or via telephone (Hails & Borum, 2003). Birmingham, Alabama established a program that corresponds to this approach.

Birmingham, Alabama: Correctional Service Officer (CSO) Program

In 1976, the Crisis Intervention Taskforce in Birmingham developed a Community Service Officer (CSO) unit in the Birmingham Police Department. The unit responds to all problems on the social work spectrum, including elder abuse, domestic violence and mental illness (Council of State Governments, 2002), thereby linking the department and the community. University Hospital has been designated as the centralized location for police drop-offs, which helps to eliminate confusion in co-ordinating follow-up services. The CSO has developed a manual/ reference guide for sergeants, and new recruits attend a 12-hour block of training on persons with mental illness and crisis intervention (Council of State Governments, 2002). The CSOs are based in each of the major city police precincts and are available Monday through Friday from 8 a.m. to 10 p.m. Twenty-four-hour coverage is also provided by CSOs rotating on-call duty during weekends, holidays, and off-shift hours (Steadman et al., 2000). The department sets out their missions with respect to the CSO unit (Burnett et al., 2002):

Our objective is to stabilize a crisis, attempt to prevent future crises, and enhance our client's well-being. The CSOs network and maintain professional relationships with community resources and strive to provide exemplary crisis intervention services.

CSO unit is staffed by six social workers who are housed within the department and report to the chief. The social workers are not sworn officers, nor do they carry weapons or have authority to arrest. They dress in plain clothes, carry police radios and drive in unmarked cars. Compton and Kotwicki (2007) note that separating the CSO staff from the police department may create several challenges. The CSO staffers have an understanding of mental health issues, but limited safety or legal knowledge. This disparity may lead to “unsafe aggressive circumstances, limited authority, or even a “hierarchy” within the department in which CSO staff are viewed to be less important because they cannot make

arrests or carry weapons” (Compton & Kotwicki, 2007, p. 50). Evaluations of program effectiveness are limited, but it is clear that the program has some positive features. In one study, police were able to resolve almost 2/3 of the mental disturbance calls on the scene without the necessity of further transportation or coercive measures (Steadman et al., 2000). The CSO unit would like to survey people who use the program’s resources so that the department can evaluate its success in responding to community needs (Council of State Governments, 2002).

Comparing the “Big Three”: Evidence in favour of CIT

Steadman et al. (2000) compared the three major models of police response representing distinct approaches to police handling of persons with mental illness: Birmingham, Alabama; and Knoxville and Memphis Tennessee. At each site, records were examined for approximately 100 police dispatch calls for “emotionally disturbed persons” as well as 100 incidents at each site that involved a specialized response. The study objective was to determine how often the specialized professionals responded and how often they were able to resolve cases without arrest. One of the primary concerns expressed about the Knoxville MCU was that *response times were excessive and impractical*. Officers expressed concern and frustration about the delays and may have decided to incarcerate persons or transport them to other services without requesting the unit (Compton & Kotwicki, 2007). The Knoxville MCU was on scene in 40% of the 100 cases.

In Birmingham, only 28% of the calls received a specialized response. At the time of the study, there were *only six CSOs for a police force of 921*⁵, severely restricting the availability of specialized officers. This lack of availability was particularly problematic on weekends and evenings when none of the CSOs were on duty, and only one was on call.

The proportion of calls resulting in specialized response in Memphis was significantly higher than the other two cities: *95% of the 97 mental health service calls* were responded to by crisis intervention team officers. In this study, the Memphis CIT was the most active in linking people with mental illness to mental health resources. The high ratio of specialized officers and capacity for immediate response gives the Memphis CIT program a distinct advantage.

The Police Executive Research Forum (PERF) discovered that agencies’ rationale for choosing CIT is that it is efficient and realistic. A respondent from Houston Police Department commented (Reuland, 2004):

⁵ According to the Council of State Governments *Local Program Examples Database*, this number of trained officers (6) has not changed: http://consensusproject.org/program_examples.

It makes sense to focus on the first responders. It's the first few seconds of these interactions between law enforcement and people with mental illness that determines if it's going to be a bad or good situation. It's good to de-escalate a situation at the beginning. By providing training to people in all divisions and shifts, we have coverage everywhere. Calling into a specialized central team would take too long, and there is a lot of down time associated with centralized units (p.17).

The Memphis Police Department⁶ echoes this sentiment:

A response to mentally ill crisis events must be immediate. The National Alliance on Mental Illness/Memphis and the Memphis Police Department agree that an "immediate response" is preferable to that of specialized mental health workers on call or a mobile crisis van response. By offering an immediate humane and calm approach, CIT officers reduce the likelihood of physical confrontations and enhance better patient care.

An important reason for agencies to choose CIT is the importance of police in controlling potentially violent situations. Specialized officers are crucial to getting mental health expertise in a situation that is unsafe for clinicians (Steadman et al., 2001). This is not to say that mental-health-based response models do not have merit; joint police/mental health response has many positive elements such as expert support. Still, excessive response times and limited availability of specialized personnel stand out as primary limitations. Wood et al. (2011) assert that there is no definitive evidence that all CIT programs have decreased the number of arrests of PMI overall, with one study showing no difference in numbers between CIT- and non-CIT- trained officers. Nonetheless, the available evidence shows promise for CIT in providing immediate and appropriate care to PMI in our communities. Dupont and Cochran (2000) suggest that CIT implementation is associated with decreased use of high-intensity police units such as Special Weapons and Tactics (SWAT) and lower rates of officer injury. Donohue and Andrews (2013) have also cited reduction in police downtime through waiting in hospitals, jail diversion, and improvements in consumer treatment and medication use. These findings have not been replicated in all studies, which suggest more work is needed to identify the disparity.

CANADA

Like the US, the delivery of both policing and mental health services in Canada is both varied and complex. It is thus not surprising that there are a variety of response models that are employed across the country.

⁶ The Official Site of the Memphis Police Department:
<http://www.memphispolice.org/Crisis%20Intervention.htm>.

Police-Based Specialized Response

The CIT model has been adopted in Canada but it is not common. The Ontario Provincial Police (OPP) provide a modified 20-hour CIT curriculum to front-line officers and are working towards the goal of having 25% of their officers trained (Wood et al., 2011).

In British Columbia, the Royal Canadian Mounted Police (RCMP) Lower Mainland Division adopted an enhanced version of CIT (Wood et al., 2011). In this case, a 40-hour training module is provided to police but also integrates components for many other first responders including dispatchers, paramedics, ER nurses, social workers, and addictions counsellors (RCMP, 2013). While initially established in the Lower Mainland, it is now a provincial program.⁷

While the Vancouver Police Department (VPD) does not use the traditional U.S CIT model, their training program for “first responders” is based on a 40-hour CIT training. Although the Memphis CIT model suggest that 25% of officers be trained in mental health, the VPD has a goal having 100% of officers trained due to the extraordinarily high percentage of police/PMI contacts in Vancouver (Wilson-Bates, 2008). The VPD have yet to evaluate this course, but claim it is “based on best practices” because it follows the CIT model (Coleman & Cotton, 2010).

Co-response Models

⁷ The syllabus for the BC-CIT training includes (Coleman & Cotton, 2010) :

- B.C. Mental Health Act - Role of Police, Physicians & BCAS;
- Criminal Prosecution of the Mentally Ill;
- Developmental Delay & Fetal Alcohol Spectrum Disorder;
- Mental Health Disorders & Common Medications;
- Early Psychosis Intervention EPI;
- Risk Assessment for First Responders;
- Complexity of Addictions; ☒ Excited Delirium and Restraint;
- Posttraumatic Stress Disorder – Compassion Fatigue;
- B.C. Schizophrenia Society (BCSS) Interactive Client & Family Panel;
- Adult Guardianship Act & Community Resources;
- Victim Precipitated Homicide “ Suicide by Cop;”
- Health Authorities and the Police: Disclosure Issues;
- Crisis Communications Skills;
- EDP Simulations with Ralston Studio Actors;
- Stand Up for Mental Health – an anti-stigma through client comedy troop; and Cultural Awareness and Implications.

While CIT is the principal response model in the US, joint response and mobile health crisis teams in particular are more common in Canada. Many police services operating a joint police-mental health response have multiple layers to their training which includes an “in-house” component.

Calgary Police Service mental health training has three levels. The first is an online course based on *Calgary Police Service Officer’s Guide to Dealing with Emotionally Disturbed Behavior* (Coleman & Cotton, 2010). The second level is called the Mental Health Interdiction program that extends from the classroom, into a hands-on practice which incorporates psychiatric and forensic nurses.

At the final level, the Homeless Unit of the Police and Crisis Team (PACT) is a strategic community partnership between Calgary Police and Alberta Health Services to link PMI who may be homeless and committing relatively minor offences with services rather than arresting and prosecuting them PACT is a fairly new program with operations starting in early 2010 as a three-year pilot funded by the Safe Communities Initiative. The goal of PACT, as described by the Calgary Chief of Police, Rick Hanson, is (Alberta Health Services, 2010):

to reach out to folks with mental illness or addictions, who are in most cases homeless, and may come to our attention after committing a minor, non-violent crime...We want to have something in our toolkit to work with this vulnerable population, and to get them linked up with agencies who can give them the help they need, while keeping them out of the justice system. They will still be held accountable to the law, however, the main focus will be on finding them the appropriate help, and alternative sentencing will be considered.

While evaluations of PACT are in preliminary stages, the evidence so far suggests promising results. In a presentation prepared for the Human Services and Justice Coordinating Committee, 73% success was reported in linking clients with appropriate services (Partridge & Schneider, 2011). The data also suggested that 1 year prior to PACT, 43% of clients used ER/Urgent care. Of these, 68% had no usage for 3 months following discharge. The Calgary Police Department and Alberta Health Services claim to be in “on-going program evaluation” but the details of such evaluations does not appear to be readily or publicly available.

PACT is a critical part of the Vulnerable Persons Unit (VPU), whose primary function is to co-ordinate with homelessness, addiction and mental health serving sectors (Alberta Health Services, 2010). The members of this team acknowledge the complexity of mental illness and the need for creative solutions through inter-agency collaboration.

In eastern Canada, Halifax Regional Police (HRP) has a training matrix with four levels of training/education. The training was developed between HRP and the joint response Halifax Regional Mental Health Mobile Crisis Team (MHMCT). The official goal of the MHMCT is to “provide intervention and short term crisis management for children, youth and adults experiencing a mental health crisis” (Capital Health, 2007). The team offers telephone crisis service 24/7 anywhere within the Capital Health District and mobile crisis response from 1:00 p.m. to 1:00 a.m. daily to most communities in Halifax Regional Municipality.

The first of four levels of HPR training is the basic training (100-level). The training lasts for three days and some of the objectives include an introduction to broad categories of mental illness, to increase confidence, comfort and awareness in responding and resolving EDP calls, and gain familiarity with Involuntary Patient Treatment Act (IPTA) and the role of the MHMCT. The 200-level training includes online training program called *Recognition of Emotionally Disturbed Persons*, which was developed in conjunction with the Dalhousie University Department of Psychiatry. This training is offered for three hours on four separate days throughout the year. The 300-level training is 40-hour CIT training, which is provided at least twice per year. Finally, the 400-level training is advanced training for MHMCT officers (300-level is a prerequisite) and involves one week of Capital Health Mental Health Orientation (Coleman & Cotton, 2010). Thus, Halifax has both a CIT and co-response component.

The Vancouver Police Department (VPD) provides co-response through partnership with the Vancouver Coastal Health Authority- Mental Health Emergency Services (Wood et al., 2011). Car 87 provides a 20-hour-a-day mobile response by a team consisting of a plain clothes officer and a registered nurse or psychiatric nurse (Wilson-Bates, 2008). Car 87 has been in operation for almost 30 years in Vancouver and is seen as a vital part of the police response to mentally ill people in need of assistance (Wilson-Bates, 2008). The police and nurse work as a team to assess, manage and decide on the most appropriate course of action during a mental health crisis. Car 87 outcomes information is not available.

Crisis Outreach and Support Team (COAST) is a widely known co-response model that originated in Hamilton, Ontario. The COAST team consists of team consisting of child and youth crisis workers, mental health workers, nurses, social workers and plain-clothes police officers (COAST, 2011). The crisis line is managed by a mental health worker who plays a triage role and makes preliminary assessments. Once the triage worker collects information, the next step, if necessary, is outreach. Between 8am and 1am, the outreach mobile unit is able to go to the crisis situation (COAST, 2011). The goal is to help the

individual/family in the environment of choice, and also to provide a follow-up plan. Clients requiring follow-up will receive assistance from the support team within 24 hours of the crisis situation. Many individuals with mental illnesses are repeat users of the ER and this “revolving door” is often because follow-up after discharge is consistently low. A commitment to immediate follow-up sets COAST apart from other co-response models we have discussed. In 2006, COAST incorporated CIT training to better enable officers to identify symptoms and provide appropriate care. The program goals are as follows (COAST, 2011):

- To assist individuals with a serious mental illness in acute distress or crisis to remain and be treated or supported in the environment of their choice.
- To support caregivers, including family members, in managing acute psychiatric problems and crisis through education and problem solving approaches.
- To link individuals during and following a crisis with the necessary community resources and support systems, including peer support in order to prevent further crises.
- To offer these interventions and supports anywhere within the region.
- To be a resource for other communities within the Central-West Health District interested in developing similar programs.

The Kaiser Foundation, an organization dedicated to reducing harm and preventing substance use and addictions, awarded COAST an award for excellence in Mental Health and Substance Abuse Programming in 2009 (Wood et al., 2011). Other co-response models can be found in Toronto, Ontario and Edmonton, Alberta (Cotton & Coleman, 2010). Contact information for the Canadian programs cited in this report can be found in *Appendix B*.

An Ontario-based survey administered by the Centre for Addiction and Mental Health (CAMH, 2010) found that most services (84%) provided training to front-line officers. The most common arrangement for on-site response was a mobile mental health team (62%) and much less common (30%) was specialized officer response (as in the CIT model). Despite the widespread adoption of one of these approaches actual use of on-site responses was quite low, with about half of respondents saying they implemented the response in less than 25% of encounters (CAMH, 2010). Some of the factors that may influence the use of on-site response include timely availability of specialized officers or mobile mental health teams, officer awareness of options, and assessment of need.

The results of this section suggest that empirical evaluations need to be prioritized and programs need to be tailored to jurisdictional needs. The various models are clearly an improvement from the perspective of people working in the system(s), and are more responsive to client needs, but there is little to support the suggestion that they reduce

recidivism or decrease injuries. This is not necessarily a reflection of faulty programs, but may be due, at least in part, to minimal recording of important variables and a lack of clear objectives. Empirical evaluations are virtually non-existent in the Canadian context for pre-arrest diversion programs. These are crucial if we are to improve police response to persons with mental illness.

AUSTRALIA

Australia consists of six states: Queensland, New South Wales (NSW), Victoria, Tasmania, South Australia and Western Australia, and two territories, the Australian Capital Territory and the Northern Territory. The country has a federalist structure, under which police and health services are largely the remit of states and territories (Donohue & Andrews, 2013). In fact, each state has its own police service (there are no municipal-level police organizations) (Wood et al., 2011). As such, each police organization has responsibility for providing services to both major metropolises and smaller jurisdictions with unique needs. As such, it is less fragmented than policing in Canada, given lack of municipal forces and fewer state police services. Approximately one-third of Australia's population reside in NSW. The NSW Police Force is 150 years old- the oldest and largest policing jurisdiction in Australia (Donohue & Andrews, 2013) . This force is responsible for some monumental advances in serving PMI through police-led programs.

Police-Based Specialized Response

In 2008, the New South Wales Police Force (NSWPF) began implementation of a pilot project called the Mental Health Intervention Team (MHIT), adapted from the CIT model. The aims of the MHIT program included (NSW Police Force, 2011):

1. Reducing the risk of injury to police and mental health consumers when dealing with mental health related incidents;
2. Improving awareness amongst front line police of the risks involved in the interaction between police and mental health consumers;
3. Improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents, and;
4. Reducing the time taken by police in the handover of mental health consumers into the health care system

In consultation with various mental health authorities, the NSW Police Force developed a four-day intensive training package. Some of the educational tools include identifying symptoms and behaviours which indicate mental illness, communication strategies, risk assessment, de-escalation, information about the Mental Health Act and the Memorandum of Understanding between the NSWPF, Ambulance Service and Department of Health (NSW

Police Force, 2011). Officers who complete the training are formally designated as Mental Health Intervention Officers and they wear a badge over the name place on their uniform.

The four-day intensive training is only one of many facets of the MHIT model. MHIT is also involved in a range of government policy development and coordination duties; for example, they are a standing member on the NSW Mental Health Senior Office Group and the NSW and Commonwealth Suicide Prevention Committees (Donohue & Andrews, 2013). In addition MHIT is active in the research community. Valuing evidence-based research, the team manages four university-affiliated research projects and continue involvement in longitudinal research projects (Donohue & Andrews, 2013).

NSW has invested in ongoing independent evaluations of the MHIT program, and the results are promising. The results of a rigorous evaluation at 2-year follow-up indicated that MHIT successfully achieved each of the four aims, to a greater or lesser extent (Herrington, Clifford, Lawrence, Ryle, & Pope, 2009). The evaluation reported a “reduction in the incidence of injury to mental health consumers; an increased understanding of de-escalation techniques among trained officers; improved confidence when attending a mental health related events; improved inter-agency collaboration through the LPCs; and a reduction in the amount of time spent on schedule 1 and convey schedule calls⁸, and waiting at hospitals.”

Despite the glowing appraisal, the MHIT is not without challenges and recommendations. Donohue and Andrews (2013) discuss some of the primary external challenges which impact the MHIT capacity.

1. Ongoing police role in lengthy and inappropriate transport of persons from community settings in remote and regional NSW. This issue needs to be addressed at the legislative policy level by amending the Mental Health Act (2007).
2. Ambulance Service NSW has a legislated responsibility to transport involuntary persons for the purpose of assessment. It is police experience that ambulance services do not use the full flexibility provided for in their authorizing legislation when it comes to involuntary transportations.
3. Lack of response from mental health services when it comes to frequent presenters (defined as a person who police detain under the powers in the Mental Health Act three or more times per year). These individuals are seen by health as “complex cases, treatment resistant, behaviourally hard to manage, clinically complex, and noncompliant” (p. 97). For all of these reasons they require ongoing case management. However, mental health services do not have the resources, and possibly not the skills, to provide the type of case management that this non-compliant group of clients’ needs.
4. The adverse impact of drug and alcohol abuse on police resources. An illegal drug consumption spike tends to correlate with an increase in the number of mental health events police attend.

⁸ Refer to calls involving persons with mental illness who need transport to hospital or psychiatric facility.

5. Challenge to ensure inter-agency collaboration at a local level. Addressing this challenge requires better accountability measures via policy and performance audits.

Since the implementation of the pilot program, the NSWPF has trained over 300 officers and aims to have 10% of all operational officers trained by 2015. MHIT shows promise of being a leader not only in effective response but also in the value of rigorous program evaluation and evidence-based research.

Co-response Models

Victoria has the second largest state population in Australia with approximately 5.6 million people. The Victoria Police is a centralised state-wide armed force of about 11, 250 sworn officers (Thomas, 2013) and incorporates five regions totalling 339 police stations across the state (Godfredson, Ogloff, Thomas, & Luebbers, 2010). According to a large-scale survey incorporating the views of 3,534 police respondents, participants estimated that approximately 20 percent of people with whom they had contact in a week, were mentally ill (Godfredson, Thomas, Ogloff, & Luebbers, 2011). The Office of Police Integrity (2012, p. 18) boldly claims that “the over-representation of mentally ill persons in fatal police shootings was a systematic and collective failure by Victoria Police during the 1990s”. Fortunately, promising reform efforts are underway.

Crisis Assessment and Treatment services (CAT), alternatively referred to as Crisis Assessment and Treatment Teams, are a service provided by the Victoria Department of Health (Wood et al., 2011). CAT is a community-based outreach service for assessing and treating persons with mental illness. The role of CAT services are to (Springvale Monash Legal Service Inc., 2007):

- Receive referrals from triage and attend situations where individuals are in the acute stage of their mental illness or in psychiatric crisis;
- Conduct initial assessment of problems;
- Develop and implement crisis management plans for/with the individual;
- Provide further short-term treatment and support during the acute stage of the crisis;
- Facilitate all public psychiatric inpatient admission; and
- Facilitate referral to other service providers.

CATs provide an alternative to hospitalization, providing intensive support in homes and on-site support to selected ER departments. They are not designed to be a mobile emergency response service resembling those discussed in the Canadian context. While

CATs are expected to prioritize referrals from police, in practice, police have found CATs to be unresponsive, especially with respect to response time required to arrive at the scene (Wood et al., 2011).

With the goal of strengthening the collaborative response of Victoria Police, CATs and ambulance services, PACER (Police, Ambulance, and Crisis Assessment Team Early Response) was developed in 2007 (Office of Police Integrity, 2012). The PACER response involves operational police and mental health clinicians working together. The team uses an unmarked vehicle but contrary to the North American context, the officers wear their uniform, with the aim being to try to build positive relationships with uniformed officers (Denhem, n.d.). The PACER training is provided to all operational police over six months and principles are also to be applied to pre-services and other training. The training is scrutinized by an Expert Panel including members of Forensicare⁹ and mental health support agencies (Denhem, n.d.).

An evaluation using data from 2009-2011 suggests that the PACER model demonstrated more effective and efficient outcomes for the person in crisis and the emergency agencies involved (Allen Consulting Group Ltd., 2012). More specifically, on site activity was recorded in 78% of cases where PACER was requested. Of the on-site activity, 82% of cases resulted in PACER providing a mental health assessment. PACER also showed improved results for timeliness to mental health assessment and services. For the majority of PACER cases involving section 10¹⁰, mental health assistance was provided in less than one hour. In the comparator site, persons suffering from a mental health crisis waited nearly three hours on average. Another important outcome is the significant reduction in the use of emergency departments. Almost 30% of PACER cases resulted in transportation directly to a psychiatric facility (as opposed to ER), compared to only 15% for the comparator site (Allen Consulting Group Ltd., 2012).

As Cotton and Coleman (2010) have noted similarly in regards to the Canadian context, the Police Federation of Australia (PFA) calls for more thinking and research into the unique challenges of rural and remote areas which tend to have fewer mental health services. It may be that models such as PACER are not suitable or feasible in rural parts of Australia, and it may be more appropriate to ensure that all or most police officers are trained in mental health issues. Nonetheless, it is clear that Australia is demonstrating innovation and creativity, providing evidence-based research, and emphasizing co-operation and collaboration. In Australia, state governments attempt to align their strategic direction

⁹Forensicare is the name for the Victorian Institute of Forensic Mental Health, which is responsible for providing adult forensic mental health services in Victoria. For more information visit <http://www.forensicare.vic.gov.au/>.

¹⁰ Section 10 of the *Mental Health Act 1986* outlines "Apprehension of mentally ill in certain circumstances".

with the vision for mental health service delivery at the national level. The ‘whole-of-government’ approach is aimed at breaking organizational silos and creating interagency collaboration within and beyond crisis response. *The Roadmap for National Mental Health Reform 2012-2022* (2012) includes:

the shared intents and goals of Commonwealth, State and Territory governments to develop better mental health services and support across all relevant government portfolios, including mental health, health, education, early childhood, child protection, youth, employment and workplace relations, housing and homelessness, police and the justice system.

Evidence of this broader perspective can also be found in the United Kingdom.

UNITED KINGDOM

In 2007, the Secretary State of Justice called for an independent review to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion. The findings of the review are published in *The Bradley Report* (UK Department of Health, 2009).

Lord Bradley indicates that interventions as early as possible in the CJS would provide the best opportunity for improving how persons with mental illness are managed. He found that the police play a crucial role in supporting effective interventions early on in the criminal justice pathway as the first point of contact, but was “surprised to discover that the police stage is currently the least developed in the offender pathway in terms of engagement with health and social services, as intervention generally occurs further along the pathway at the court and sentencing stages” (UK Department of Health, 2009, p. 34). In contrast to the pre-arrest/pre-bookings schemes discussed previously in this paper, the police custody liaison schemes, that are the most common approaches found in the UK, take effect once an arrest has been made.

Diversion & Liaison Schemes

Lord Bradley (as cited in National Police Improvement Agency, 2010) identifies four main scheme types operating in the UK:

1. **Assessment:** focuses on identifying and assessing people at an early stage through the police or courts to minimise the needs for assessment in remand or prison.

2. Liaison: offers advice and support to those with mental illness or learning disabilities and to other agencies, and may also be involved in supporting a person through the criminal justice process.
3. Diversion: focuses on increasing the identification of mental illness or learning disabilities and accelerating transfer to hospital or secure health facilities where assessed as appropriate.
4. Panel: brings together a range of agencies including police, health, social care, and probation to agree on a coordinated package of care.

Liaison services are typically found in police stations where diversion tends to occur in court (D. Scott, McGilloway, Dempster, Browne, & Donnelly, n.d.). One example of a liaison scheme is the CPN Police Liaison Service in Central London, which is run by Community Psychiatric Nurses (Wood et al., 2011). The goal of the CPNs is to divert minor offenders, who would otherwise receive no mental health services, out of custody and into appropriate care. Unlike the other models discussed, the CPN takes effect once an arrest has already been made. CPNs are linked to Community Mental Health Teams consisting of nurses, doctors, and social workers who assist with community based care (Wood, Swanson, Burris, & Gilbert, 2010). Similarly, a police liaison scheme operating in Belfast, Northern Ireland (NI), is devoted to providing a timely mental health screening and assessment of persons in conflict with the law (Wood et al., 2010)

The NI scheme shares some features in common with the CPN police liaison scheme in that the service delivers rapid screening and mental health assessment at the earliest point of contact with the CJS and a mechanism for appropriate referral. The NI service is unique in that the nurses also co-ordinate follow-up care and provide on-going advice to the offenders, police and health care professionals (McGilloway & Donnelly, 2004).

An appraisal of the effectiveness of the liaison scheme revealed promising results. The service appeared able to detect and assess most offenders with significant levels of mental disorder. Important to note, mental illness among many of the detainees went undetected by Custody Sergeants and Forensic Medical Officers but was identified accurately by the Community Mental Health Nurses¹¹ (CMHNs) who also achieved success in linking PMIs to health and social services (McGilloway & Donnelly, 2004). Ninety-one percent of all detainees were judged to have a mental health problem and health improvements were recorded for those linked to service and follow-up. Key stakeholders also expressed that the scheme played a pioneering role in developing and facilitating liaison between

¹¹ The Northern Ireland liaison service is provided by two Community Mental Health Nurses; similar to the Community Psychiatric Nurses in the London liaison service.

psychiatric services and the CJS. The Criminal Justice Inspection has argued that this scheme, which is limited to Belfast, should be extended to all of Northern Ireland.

While it does not technically classify as diversion, it is also worth noting that a neighbourhood policing philosophy has been emphasized in the UK, which involves “officers working locally and visibly in their neighbourhoods, with active participation of community members, to understand neighbourhood concerns and address local priorities through new initiatives” (Wood et al., 2011, p. 28). Safer Neighbourhoods Teams were developed to support this focus and consist of police, community support officers, special constables, and local authority neighbourhood wardens. According to the *Bradley Report* (2009), these teams are the ideal forum for looking at mental health issues and the early identification of people at risk.

Similar to the wider conceptual thinking demonstrated in the Australian context, the UK appears to be envisioning an all-stages conception emphasizing early-intervention and early-identification before reaching a crisis stage. Lord Bradley calls for more emphasis on diversion *prior* to arrest- thus, police need to be seen as a central step along the diversionary pathway (UK Department of Health, 2009).

III. Discussion and Conclusion

The need to improve the way in which police respond to and manage PMI is widely recognized. However determining the most effective strategy is hampered by the lack of empirical evaluations of the different programs. In turn, the failure of most programs to clearly articulate the expected outcomes of the programs makes empirical evaluations very difficult, such that a cost-benefit analysis of the different approaches is not possible.

Summary of the research:

It is clear that appropriately trained police officers, in coordination with mental health staff and access to mental health programs and services can make progress in relation to each of the possible outcomes identified earlier in this paper:

1. Reducing the risk of injury to police and PMI when dealing with mental health related incidents;
2. Improving awareness amongst front line police of the risks involved in the interaction between police and PMI;
3. Improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents, and;
4. Reducing the time taken by police in the handover of PMI into the health care system,

5. Reduced arrests through diverting PMI to the health care system, and thus less penetration into the justice system
6. Reduced recidivism (only where the referral or diversion is to a service which includes cognitive behavioural training and preferably housing)
7. Improved mental health outcomes

More generally, some guidance has been developed in the literature which should be implemented by all services or detachments. According to Cotton and Coleman (2006) there is a central tenet which is incumbent for all police services:

Each organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which PMI are treated with the same degree of respect as other members of society.

In *Contemporary Policing Guidelines for Working with the Mental Health System*, Cotton and Coleman (2006) outline ten principles and respective rationales as a starting point for police programs and services related to mental illness. Below, I summarize a few of the guiding principles¹²:

- Each organization should have one or more identified personnel who are responsible for issues related to mental illness in the community.
- Each organization should identify and develop a relationship with a primary contact person within the local mental health system.
- Each organization should have a clearly defined policy and procedure by which personnel can access mental health expertise on a case-by-case basis.
- Each police service should have available a directory or other print material that provides descriptive and contact information for mental health agencies in the area for both employees as well as PMI and their families.

These principles could serve as a guiding structure for police organizations to ensure that people with mental illness are dealt with compassionately and with dignity. The issue of which pre-arrest diversion model (if any) to select for a given department is a more complex question.

SELECTING AN APPROPRIATE MODEL

The model that a police agency will choose to adopt will depend on a number of factors including demographics, geography, hospital/ service locations as well as prevalence of PMI/police contact. As mentioned, the CIT model has some significant advantages because it trains more first-responders. The result is the response is more immediate, matters can

¹² For access to the full document, visit pmhl.ca.

be de-escalated, appropriate referrals made, and officers make use of community contacts to link offenders to supports (not just in mental health services). However, this requires a significant investment in training, which may not be warranted in communities where there are fewer police/PMI contacts. Even within a police department, choices might be made to train a majority of officers who are policing a highly disorganized neighbourhood, but fewer if any who police more stable neighbourhoods, leaving them to rely on back up from trained officers. There is some evidence to suggest that mobile crisis teams are extremely effective in smaller disorganized areas where distance/travel time is minimal. The primary issue associated with mobile crisis teams such as Knoxville MCU is that wait times were excessive and impractical.

In order to better understand program effectiveness, police departments need to create clear objectives for the initiative they select. Articulating clearly the expected goals, as opposed to more generic and rhetorical statements about "improving response" will be helpful in communicating the expected outcomes to both front-line officers and the public. Setting clear goals will also aid in program evaluation and identifying gaps in service delivery. As previously mentioned, some of the specific outcomes which the initiatives could expect to achieve might include:

- Reducing the risk of injury to police and PMI when dealing with mental health related incidents;
- Improving awareness amongst front line police of the risks involved in the interaction between police and PMI;
- Improved collaboration with other government and non-government agencies;
- Reducing the time taken by police in the handover of PMI into the health care system;
- Reduced arrests through diverting PMI to the health-care system, and thus less penetration into the justice system;
- Reduced recidivism;
- Improved therapeutic outcomes such as increased access to sustainable mental health treatment

CLOSING COMMENTS

The interventions reviewed in this compendium provide for a broad conception of the police role in servicing persons with mental illness. Police services can look to other national and international jurisdictional practices to gain insight about 'what's working.' At the same time, the need to tailor interventions suited to community context is critical. Also essential is research-informed policy and practice which involves improved data collection methods and rigorous program evaluation. Instead of shifting the contemporary police

role to *de facto* mental health workers, Wood et al. (2011) suggest that police need to have functional links with various agencies in the health sector that allow them to 'broker' individuals into the systems that have the capacity to manage them.

The Council of State Governments (2002) have identified what is arguably the most important challenge of all: co-operation between the two-key stakeholders: the criminal justice system and mental health system. The communities that have successfully improved their response to PMI, began by acknowledging and tackling this key challenge. It is important that police departments engage in dialogue with the hospitals and service providers in their respective jurisdictions. It would be helpful for police officers to be educated about the role and duties of mental health practitioners and vice-versa. Health authorities may complain that police are clogging up regular health-care facilities, but police may complain that they have nowhere else to take people who have an immediate mental health crisis- both of which are legitimate complaints from separate systems working hard to fulfill their respective mandates. In order to establish effective and sustainable collaboration, we must eliminate some of the "ought to" attitude in relation to the policies and practices of both the CJS and health system. This will begin with engagement, open dialogue and a willingness to be *partners* in effectively and proactively managing PMI in the community.

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VI. Appendices

APPENDIX A: CONTACT INFORMATION FOR U.S. PROGRAMS CITED IN THIS REPORT

Agency/Organization	Program Title	Type of Response	Contact Information
Memphis Police Department Memphis, Tennessee	Memphis Crisis Intervention Team (CIT)	Police-led; involves intense officer training for selected CIT officers	Coordinator Crisis Intervention Team Memphis Police Department 201 Poplar Ave. Memphis, TN 38103 Phone: (901) 576-5735
Birmingham Police Department Birmingham, Alabama	Community Service Officer (CSO) Unit	Police-Based Mental Health Response; police department employs CSOs to provide specialized response	Senior Community Service Officer Birmingham Police Department 1710 First Avenue North Birmingham, AL 35203 Phone: (205) 254-2793 Fax: (205) 254-1703
Knoxville Police Department Knoxville, Tennessee	Knoxville Mobile Crisis Unit (MCU)	Mental-health-based specialized mental health response model; MCU responds to police calls to assist on scene or via telephone	Don Green Deputy Chief of Police Knoxville Police Department 800 Howard Baker Jr. Avenue Knoxville, TN dgreen@cityofknoxville.org (865) 215 - 7229

APPENDIX B: CONTACT INFORMATION FOR CANADIAN POLICE PROGRAMS

Agency/Organization	Program Title	Contact Information
Toronto Police Service	Mobile Crisis Intervention Team (MCIT)	Mailing Address: 40 College Street, Toronto, Ontario, M5G 2J3 Main Number (Mental Health): 416-808-0132
Chatham-Kent Police Service	HELP Team	Headquarters: P.O. Box 366 24 Third Street, Chatham, Ontario, N7M 5K5 Tel: 519-436-6600
Ottawa Police Service	Mental Health Unit (MHU)	Tel: 613-236-1222, ext. 5115. Email: mentalhealth@ottawapolice.ca
Hamilton-Wentworth Regional Police	Crisis Outreach and Support Team (COAST)	Tel: 905-546-4925 Email: coasthamilton.ca/hamilton.php
Halifax Regional Police Service	Mental Health Mobile Crisis Team (MHMCT)	Mailing Address: Halifax Regional Police, 1975 Gottingen Street, Halifax, Nova Scotia, B3J 2H1 Tel: 902-490- 5016
Vancouver Police Department	CIT Program, Crisis Negotiator Team and Car 87	Mailing Address: 3585 Graveley St. Vancouver, B.C. Canada V5K 5J5 Tel: 3-1-1 Outside Vancouver or are unable to reach 3-1-1, phone: (604) 873-7000

APPENDIX C: CRISIS INTERVENTION TEAM MODEL- THREE CORE ELEMENTS

Information adapted from Reuland (2004), Wood et al. (2011) and the Local Program Example Database provided by the *Council of State Governments* at http://consensusproject.org/program_examples and the official site of the Memphis Police Department at <http://www.memphispolice.org/crisis%20intervention.htm>.

Core Element	Details
Training	<ul style="list-style-type: none"> ▪ 40- hour training curriculum for CIT officers; dispatchers also receive training ▪ Trainers include local mental health service providers, people with mental illness and their families, police department personnel and attorneys ▪ Practical experiences include role-play exercises, visits to mental health facilities, and dialogue with people with mental illness, videotapes and virtual reality/computerized simulations of mental illness symptoms ▪ Some advanced training topics include recognizing symptoms of mental illness, co-occurring disorders, history of mental health, psychiatric medications, community resources, legal issues concerning police liability, less lethal weapon training, suicide prevention and the role of family and other supports in treatment and recovery
Mental Health Partnerships	<ul style="list-style-type: none"> ▪ Single point of entry, no refusal policy and streamlined intake for police ▪ Mental health professionals are available to support the police responder by telephone or dispatch ▪ The Memphis Police department is partnered with the University of Tennessee psychiatric services, which serve as the centralized drop-off facility for people who need emergency evaluations ▪ Another example is Multnomah County, Oregon which has a crisis triage center located within the Providence Medical Center, which functions as a one stop centralized crisis service for law enforcement officers
Police Roles	<ul style="list-style-type: none"> ▪ Officers volunteer to become CIT officers and are specially selected ▪ Agency works hard to make CIT officers feel like a team through the use of special pins, ceremonies, awards and monetary rewards for their commitment to CIT ▪ Although they are not mental health professionals, CIT officers conduct an initial mental health assessment at the scene; this role is particularly unique for law enforcement ▪ Once on the scene of a mental health call, the designated CIT

officer is in charge, regardless of the rank of other officers present*