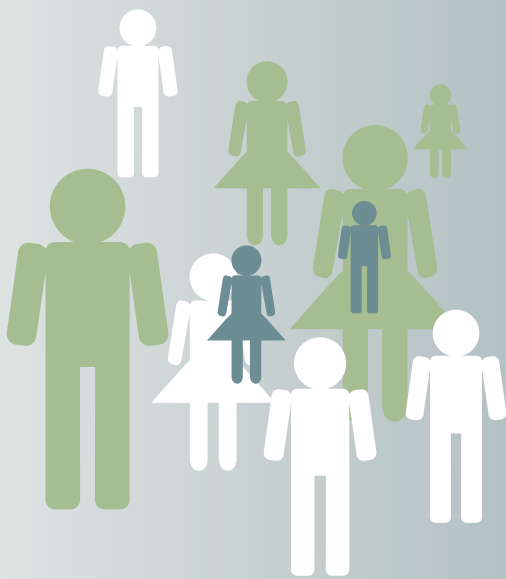


POLICE INTERVENTIONS WITH PERSONS AFFECTED BY MENTAL ILLNESSES

A critical review of global thinking and practice



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Introduction¹

Mental illness and substance abuse disorders constitute a global public health problem of enormous proportions. International epidemiological studies estimate that nearly 25% of the world's population suffers from a diagnosable psychiatric or addiction disorder at some time in their lives, and mental illnesses are the leading cause of disability in the United States (US), Canada, and Europe (World Health Organization [WHO], 2001). In the US, approximately 6% of adults at any given time meet criteria for a serious mental illness that interferes with at least one important activity of daily living (Kessler et al., 1996). Moreover, mental health and substance abuse problems often overlap, as nearly 30% of people with a mental illness also have an addiction disorder (Regier et al., 1990).

Until recent decades, large numbers of people who suffered from chronic, severe, and disabling mental illnesses such as schizophrenia and bipolar disorder were interned in public psychiatric hospitals for lengthy periods—often against their will and sometimes for life. In the US, by the middle of the 20th century approximately 500,000 people were confined to public mental hospitals and receiving mainly custodial care (Appelbaum, 1994). Beginning in the 1960s, however, a massive process of ‘deinstitutionalization’ unfolded and today there are fewer than 50,000 people in these institutions (Manderscheid, Atay, & Crider, 2009). Shortly after the ‘deinstitutionalization period,’ the US embarked on a quite different project of social control through incarceration. Between 1982 and 2007, the population of prisons and jails rose from 612,000 to 2.3 million (Pew Charitable Trusts, 2009). The increase in people held in correctional institutions has been accompanied by a similar rise in the number of people living in the community on probation and parole, now more than 5.1 million (Pew Charitable Trusts, 2009). To an unfortunate extent, ‘deinstitutionalization’ from the mental health system led to ‘reinstitutionalization’ through criminal justice. Indeed, there are now more people with serious mental disorders to be found in the largest US city jails than in any psychiatric hospital (Frank & McGuire, in press; Torrey, 1995).

The historic demise of ‘the asylum’ was driven by a combination of legal and fiscal reforms, advances in pharmacotherapy, and a shift in therapeutic ideology in favor of community-based care and recovery for people with psychiatric disabilities. However, the closing of large public mental hospitals proved far easier than replacing them with an effective system of care and support in the community. The promise of definitive treatment or cure with better medications ‘just around the corner’ remains elusive. Persons with ongoing, disabling psychiatric conditions now reside in every community. A small, but visible, proportion of persons with serious mental illnesses revolve in and out of acute psychiatric hospitals, are chronically unemployed, are sometimes homeless, and are frequently involved with the police and the criminal justice system.

Developing and implementing cost-effective interventions to improve the lives of people with serious mental illnesses in the community remains a challenge for multiple, interfacing service systems, from public health to social welfare to law enforcement, the courts, and corrections. This monograph aims to shed light on one key component of these systems—*policing*—and specifically the role of police officers in the community as front-line workers who often come into contact with persons with mental illnesses and must respond to their needs with whatever tools lie at hand. We focus on the contexts of the US, Canada, Australia and the United Kingdom (UK), all of which are experiencing similar core challenges facing policing in the 21st century, especially in relation to providing effective responses to persons with mental illnesses.¹

There are numerous questions that face the field: How do police manage their multiple, and sometimes conflicting roles in their encounters with persons with mental illnesses? To what extent are police organizations ‘accepting’ and trying to manage this unsought role? What are the current and forward-looking models of training and support for police officers in this work? How effective are these approaches—particularly in times of severe fiscal constraint in public

¹ For recent reviews of developments outside of the English-speaking world, especially in Central, Western and Eastern Europe as well as China, see Moore (and 2010) and Lo and Wang (2010) in a recent special issue of *Police Practice and Research* devoted to the topic of policing and mental illness.

systems—and what evidence is lacking in order to develop better and more cost-effective interventions in the future? We address these questions in this monograph and argue that there is a considerable convergence in thinking around the importance of police in more effectively managing encounters with persons in crisis. Police-led and co-response (police and mental health) crisis intervention models are especially dominant, and have diffused across the globe with great speed.

The intersection between serious mental illness and substance abuse is particularly important to policing, insofar as alcohol and drug use contribute to criminal and otherwise problematic behavior of persons with mental illnesses, and thereby complicates officers' decision-making in many encounters with mentally disordered individuals in the community. Indeed there is a substantial overlap between serious mental illness and substance abuse, and the two types of maladies are related in complicated ways in their causation, expression and treatment. In combination, psychopathology and abuse of alcohol and illicit drugs markedly increase the risk of violence and other criminal behavior. Acute pharmacological effects of alcohol and drugs, such as cocaine, can increase violence risk directly, but also indirectly by exacerbating psychiatric symptoms such as excessive threat perception. Substance use disorders are associated with treatment non-adherence and disengagement, which may contribute additionally to increased risk for violence. There is some evidence that mentally disordered offenders are more likely than their non-mentally-ill counterparts to have been under the influence of drugs at the time of arrest, and to have been arrested for a violent offense (Ditton, 1999). However, criminogenic mechanisms underlying violence in seriously mentally ill offenders with co-morbid drug abuse disorders have been little studied (Volavka & Swanson, 2010).

Even without violence, intoxication at the time of an encounter can make it harder for a police officer to recognize mental illness, or to find an alternative to arrest. Substance abuse treatment facilities may resist taking on a person with mental illness, while mental health units may not want a person who is under the influence of drugs or alcohol (Tepelin, 2000). Depending on an officer's attitudes or departmental policies, possession or sale of drugs may preclude any alternatives to arrest. Where there are integrated treatment systems in place (Mueser, Noordsy, Drake, & Fox., 2003), the officer's initial determination may be less important, but

despite some evidence of effectiveness, such systems remain rare (Desai et al., 2006; Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998).

Police today encounter persons with serious mental illnesses in a range of circumstances and settings—whether in a dangerous health crisis, an escalated domestic argument, a drug arrest, the scene of a minor public disturbance or a serious violent crime, in an urban encampment of the homeless, or in a hospital emergency department. In these and many other situations, police are in fact functioning not only as public safety officers, but social workers, emergency health care responders, triage decision-makers, inter-agency liaisons, and providers of transportation and other services. Police can take people to jail, but for offenders with mental illnesses, police may also open a gateway to therapeutic alternatives in the community.

Along these lines, there are currents of thinking that call for a broader conceptualization of the police role, one that imagines possible points of intervention along a policing continuum, beginning with early prevention opportunities and ending with appropriate systems of assessment and referral at the police custody stage. Focusing purely on suspects or offenders can also be too limiting as we suggest in our expanded conceptual model (see below), given that police encounter a range of persons in need of health assistance, be they victims, witnesses, missing persons, or others who are affected by mental illnesses. Within this broader conception the police role in assisting persons in need expands, but this need not mean that police deviate from their central functions. Rather, at the core of what police can do at different points along this continuum rests an infrastructure of linkages between police, the mental health sector, and other parts of the health care system that address mental health and co-morbid conditions. Developing and sustaining such an infrastructure is a complex challenge. Whether or not police organizations can or wish to think and act in such broad terms depends on a range of factors, including police philosophy, political and government structure, resources, and community needs and conditions, all of which arise throughout different discussions in this review.

The high prevalence of psychiatric and substance use comorbidity specifically in the population that is likely to encounter the police and the criminal justice system calls for greater recognition of the relationship between 'mental health law' and drug control law, and suggests the advantages of integrating mental health and substance abuse

recognition, triage, and treatment capacities throughout the criminal justice and health systems (Chapman, Desai, & Falzer, 2006; Teplin, 1990). Thinking about substance abuse and mental illness together in this context—i.e., as intertwined public health problems at the interface with the criminal justice system—makes sense even beyond the issue of co-morbidity. Strategies for prevention, treatment, and overcoming barriers to service access for both problems, and thereby reducing risk of relapse and recidivism, follow many of the same logical pathways and confront similar challenges (Burriss et al., 2004; DeBeck et al., 2008). This monograph, however, takes the system as we find it, and so concentrates primarily on how police identify and manage a person as mentally ill, without doing sufficient justice to the challenge of addressing co-morbid conditions. This is as much a limitation of the monograph as it is of the systems of response, and should be dealt with in future research.

The central point of this monograph is that police organizations should not be uncritically accepting of existing models for intervening with persons with mental illnesses without first engaging in what we describe as a problem-

oriented approach (H. Goldstein, 1990) to the design and testing of localized interventions. We draw from, and build upon, developments in criminological thinking to elaborate this point. This approach involves the following core steps: problem identification and analysis; spatial analysis (understanding the geographic distribution of mental health- and co-morbid-related incidents and problems in local areas); resource mapping and analysis of organizational linkages or 'nexus' arrangements; and the development and evaluation of tailored interventions that take inspiration from a global pool of ideas.

In what follows, we examine key challenges associated with implementing these steps, such as the need for police, health practitioners, and academic partners to collaborate in developing better and more integrated data collection systems to track health-related outcomes. We suggest, drawing from Reuland's (2010) terms that this 'process-oriented' approach to the design and testing of interventions is more desirable than a 'model replication' approach because it helps expand the evidence needed to advance global thinking and local practice.



The police role in democratic societies: A socio-legal perspective

The general public and police themselves tend to think of police primarily as enforcers of criminal law, but historically police practice has always incorporated a broader mission of population security, health, and good order (Carroll, 2002). Today, the police continue to provide a variety of services to citizens that have little to do with criminal behavior and the need for law enforcement. Police respond to innumerable public requests for mundane assistance and remain the “major emergency arm of the community in times of personal and public crisis” (Reiss, 1971, p. 1).

While police may initiate a larger criminal justice response to a problem, this is not exclusively what they do, nor is it often an appropriate response to the range of situations and behaviors which they are tasked to handle. In addressing such issues as drug use, loitering youths, soliciting prostitutes, injured animals, and noisy gatherings, police might just as easily act *outside* of the criminal justice system, avoiding its use altogether (Reiss, 1971). In most or all cases of disorderly behavior for instance, a violation of some law can be deemed to have occurred, but in many situations an officer will handle the matter informally by, for example, instructing the person or group in question to cease and desist or “go home and sober up” (Wilson, 1978, p. 17).

The widest array of police services are often performed in especially depressed areas of cities characterized by high levels of poverty, low levels of employment, and other characteristics of social disorganization (H. Goldstein, 1977). In such contexts, “the police most frequently care for those who cannot care for themselves: the destitute, inebriated, the addicted, the mentally ill, the senile, the alien, the physically disabled, and the very young” (H. Goldstein, 1977, p. 25). In such matters, partnering with other agencies may be a better option than applying the tools of criminal law (DeBeck et al., 2008). Indeed, while the police officer is capable of applying the tools of the criminal law, she or he may choose not to do so some, or perhaps even most of the time.

The fact that an officer *may* apply the law—i.e., has special access to the law as a resource—serves to frame every encoun-

ter between a police officer and a citizen. If an officer decides not to enforce a law in any given situation, the citizen or group involved is generally aware that a ‘softer’ disposition has been granted and that the potential to escalate up the pyramid of enforcement is ever present (Shearing & Leon, 1977, p. 339). At the same time, encounters between citizens and the police are shaped by the fact that officers have the ability and right to use force (Bittner, 1990; Reiss, 1971). Within a ‘modern’ conception of the state, the public police are granted a monopoly on the right to exercise force by the state, within the state’s boundaries, and in relation to a wide variety of persons and locations (Klockars, 1985, Chapter 1).

Equipped with the authority to enforce the law and exercise coercion, police perform their duties both reactively and proactively. They deal with matters brought to their attention by citizens. Oftentimes, police receive calls about criminal events that have already happened, and more often they receive calls about non-criminal matters (Reiss, 1971, p. 64). They also intervene in people’s lives, not because they have been requested to, but because they take the initiative to do so (Reiss, 1971). Police may for instance stop and question (and possibly frisk) individuals that appear troublesome or otherwise appear useful to a criminal investigation.

When it comes to what police officers actually spend their time doing on a daily basis, sociological studies have uniformly shown that much more work is carried out doing order maintenance and peacekeeping than enforcing the law. A considerable portion of an officer’s time is spent undertaking service functions (e.g., assisting injured persons), gathering information (e.g., asking questions), filling out paperwork (Ericson & Haggerty, 1997), patrolling, and, through their visible presence, providing ‘reassurance’ (Innes, 2004). Yet, despite the fact that police spend very little of their time doing what the public may perceive as ‘real police work’ and conducting arrests, they are nonetheless measured and evaluated as if this were the case. Police organizations are judged by others, and themselves, in terms of their effectiveness in crime control (Manning, 1977, p. 348; White, 2007).

In sum, police can be differentiated from other agents of order maintenance due to both their access to law enforcement and physical force as special resources (Shearing & Leon, 1977, p. 341). With these resources, officer decision-making is shaped by formal and informal sets of rules that are applied to address the unique situational conditions encountered by officers. The challenge for policing from a health perspective is that the authority to wield force and to assign people at least the provisional status of ‘criminal’ may have the effect of obscuring, if not delegitimizing, an explicit health and social welfare role for police. If the descriptions and stories of police work that constitute the self-understanding of the police officer’s role do not include therapeutic or social work themes, they are not likely to be enacted in practice (Shearing & Ericson, 1991). The intervention models we review in this monograph reflect organizations’ attempts to re-shape this self-understanding, and ultimately officers’ practices on the ground. Before this review, we outline the factors that can influence what officers choose to do with respect to persons with mental illnesses, and why.

Legal factors shaping police encounters with persons with mental illnesses

When it comes to encounters with persons affected by mental illnesses, both criminal law and what may be considered ‘mental health law’ determine what is enforceable and when official coercion may be warranted. Both sets of laws guide police in their interventions with persons with mental illnesses, as the type of response varies with circumstances and behaviors involved.

The term ‘mental health law’ frequently is used as a catchall for the variety of statutes, cases, and administrative decisions that have an impact on persons with mental illnesses. However, while many scholars and practitioners have considered mental health law to be separate from, rather than part of public health law (and some decry such a separation as discriminatory ‘mental health exceptionalism’), the laws that apply in many jurisdictions to persons with mental illnesses are mostly rooted in common legal principles which may apply equally to general public health issues (Petrila & Swanson, in press).

The legal criteria for detaining, confining, and involuntarily treating persons with mental illnesses bear similarities in many developed countries yet vary considerably within common parameters. Fistein, Holland, Clare, and Gunn

(2009) systematically reviewed mental health legislation in 32 diverse Commonwealth jurisdictions, coding the permutations of criteria for involuntary intervention among persons with mental illnesses: diagnosis, risk, incapacity, treatability, and exclusions for various characteristics and problems such as criminal behavior, substance abuse, intellectual disability, and personality disorder. These authors found significant variation across countries and deviation from standards derived from the Universal Declaration of Human Rights. However, with some exceptions, trends in reform of mental health acts across Commonwealth nations have moved towards the use of general tests of capacity and treatability, treatment in the interests of health rather than safety, and regular reviews of treatment orders (Fistein et al., 2009; Szmukler & Dawson, 2006). A related trend has seen a shift in the focus of mental health law away from a preoccupation with safeguarding individual rights *per se* (e.g., the right to refuse treatment) and towards a concern with helping people gain access to needed treatment and services in the community (Carney, 2003).

Two core legal principles underlie the laws that guide police interventions with respect to persons with mental illnesses across the countries covered in this review. First, police have a public protection mandate; they have the duty to provide for the public’s safety and welfare. Second, police have a duty under the doctrine of *parens patrie*—the state as ‘parent’—to help those in need, including the disabled who are unable to care for themselves (Lamb, Weinberger & DeCuir., 2002; Teplin & Pruett, 1992). Police therefore have the statutory authority to apprehend, in emergency situations, persons who pose a threat to themselves or others, or who, by virtue of a mental illness, are unable to provide for their basic needs or protect themselves from harm from others (Bittner, 1967; Teplin & Pruett, 1992). In short, police possess both a legal mandate and authority to intervene in the lives of persons affected by mental illnesses in certain situations. Below we examine the legal contexts of the US, Canada, Australia, and the UK.

United States

In the US, a body of laws—statutes and case law in state and federal courts—has evolved over several decades with specific reference to mental health conditions; a few of these laws affect police work directly, while others do not. At the interface with criminal law, contemporary mental-health-related laws address a range of issues such as the requirement for competency to stand trial when the criminally accused

may be impaired by psychiatric illnesses, questions of criminal culpability, and the defense of ‘not guilty by reason of insanity.’ Insofar as such laws are applied in the process of criminal adjudication—i.e., after a person has been detained and charged with a crime—they fall mostly outside the scope of day-to-day police work (exceptions include the role of police in providing evidence or testimony in some criminal proceedings).

In contrast, the body of civil laws around involuntary treatment arguably has more salience to police encounters with many persons with mental illnesses. Within the US Constitution’s framework of liberty protections, states have enacted laws that define in practice the boundaries around the individual’s right to refuse intervention and treatment, the specific conditions under which such a right can be abridged by the state, and the due process protections for persons who are subjected to involuntary detention and custody as the consequence of a mental health condition and given treatment against their will.

Police become involved in applying these laws insofar as they are authorized to detain and transport individuals who meet certain criteria by exhibiting dangerous or incapacitating symptoms of mental illness. Police may also apply these laws as they exercise discretion in deciding whether to arrest and charge criminal suspects who are impaired by mental illnesses. In some cases, even when a crime has been committed police may transport a person with mental illness to a treatment facility to be evaluated for involuntary civil commitment rather than filing criminal charges. In many states, such action may be initiated by an order for ‘emergency custody’ or ‘temporary detention’ issued from a judicial authority such as a magistrate. That the detaining police officer must have probable cause to believe civil commitment criteria are present—i.e., dangerousness or incompetence due to mental illness—is legally analogous to the requirement of probable cause for arrest on suspicion that a crime has been committed.

One illustrative state law that often involves police in detaining individuals who are experiencing a mental health crisis is Virginia’s emergency custody statute (Code of Virginia § 37.2-808). In Virginia, an emergency custody order is to be issued by a magistrate when there is “...probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious

physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.”

The role of the police officer may be to initially set in motion the petition process for an emergency custody order. However, when the order is issued, the officer’s role is then to take the person with mental illness into custody and transport him or her to a treatment facility for evaluation of criteria for temporary detention, which may, in turn lead to a longer period of involuntary civil commitment following a court hearing. Specifically, the Virginia law states that “the magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation.”

Generally speaking, then, in the US police officers at their discretion detain and charge criminal suspects experiencing mental illness notwithstanding their mental health status, except in three kinds of scenarios: (1) the individual is manifestly in need of emergency medical or psychiatric treatment; (2) the individual is mentally incapacitated and thus unable to survive safely in the community without care (and there is no guardian available); and (3) the individual poses a danger to self or others (i.e., a more or less ‘imminent’ threat, depending on jurisdictional definition). In each of these scenarios, police may exercise detention authority under civil statutes and transport the person to a hospital emergency department or mental health care facility—and they may do so whether or not the person is also suspected of (and may be charged with) committing a crime.

Canada

Canadian mental health law, crafted at the provincial level, is similar in spirit to its US neighbor. In certain situations, police officers can take a person in their custody to a location where they will be examined by a physician. In the Ontario context, and in accordance with section 17 of the Mental Health Act, such situations emerge “[w]here a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person’ (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself, (b) has behaved or is behaving violently

towards another person or has caused or is causing another person to fear bodily harm from him or her, or (c) has shown or is showing a lack of competence to care for himself or herself, and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in, (d) serious bodily harm to the person, (e) serious bodily harm to another person, or (f) serious physical impairment of the person” (Ontario Mental Health Act, 1990). While section 16 of the Act provides for a justice of the peace—based on information brought to them—to prescribe an order for examination by a physician, section 17 allows officers to arrange for such an examination where “it would be dangerous to proceed under section 16” (Ontario Mental Health Act, 1990).

British Columbia’s Mental Health Act has more expansive criteria regarding the conditions for civil commitment than the country as a whole. According to section 28(1), “[a] police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person (a) is acting in a manner likely to endanger that person’s own safety or the safety of others, and (b) is apparently a person with a mental disorder²” (British Columbia Mental Health Act, 1996). While the Act does not provide specific information on diagnostics, it is not presumed that officers have the capacity or professional authority to provide accurate diagnoses. Rather, it is assumed that police will draw from their own commonsense and experience in the field to determine whether an individual isn’t acting within a normal range of behaviors (British Columbia Ministry of Health, 2005, p. 188). The term ‘safety’ in this legislation is meant to be interpreted broadly and is not limited to the prospect of physical violence. It could be the case, for example, that a person’s safety is threatened because they are being exposed to extreme cold weather, or it could be that they are living in a state of self-neglect (p. 13).

Once an officer takes an individual to a physician (often-times located at a hospital), the physician will determine whether the involuntary admission criteria have been satisfied. If such criteria have been satisfied, he or she will issue a Medical Certificate, which grants authority to an officer to transport the individual to a designated facility and to admit the person for examination and treatment for a period of up to 48 hours. At that point, it is possible for a second Medical Certificate to be written in order to extend the period of involuntary admission for an additional month (British Columbia Ministry of Health, 2005, pp. 12-13).

Australia

In Australia, mental health law is established at the state and territorial levels. There is similarity across these jurisdictions in the authority they grant officers to apprehend and transport persons in situations where a person is: (1) deemed to be mentally ill or disordered; (2) at large, having been detained in accordance with a Mental Health Act; (3) refusing or failing to comply with a treatment order; and/or (4) deemed to benefit more from a health intervention (e.g. transport to a hospital) than through other legal interventions (e.g., arrest) (Clifford, 2010). In the State of Victoria, for example, section 10(1) of the Mental Health Act³ stipulates that police can apprehend persons who appear to be mentally ill if (a) “the person has recently attempted suicide or tried to cause serious bodily harm to themselves or another person [and/or] (b) [t]he person is likely, by act or neglect, to attempt suicide or to cause serious bodily harm to themselves or another person” (Victoria Auditor-General, 2009, p. 2).

Similar to the Canadian context, officers in Victoria are not required or authorized to provide clinical diagnoses, but may apprehend a person “if, having regard to the behavior and appearance of the person, the person appears to the member of the police force to be mentally ill⁴” (Victoria Mental Health Act, 1986, s. 10(1A)). Once an officer has

² The British Columbia Mental Health Act refers to ‘disorder’ as ‘a disorder of the mind that requires treatment and seriously impairs the person’s ability (a) to react appropriately to the person’s environment, or (b) to associate with others’ (British Columbia Ministry of Health, 2005, p. 188).

³ This Act is currently under review by the Victorian Government in light of new developments including the implementation of the Victoria Charter of Human Rights and Responsibilities Act 2006 which stipulates, among other things, that public authorities like police must safeguard particular rights, including “protection from torture and cruel, inhuman or degrading treatment” (Victoria Auditor-General, 2009, p. 6).

⁴ ‘Mental illness’ is referred to in the legislation as “a medical condition that is characterized by a significant disturbance of thought, mood, perception or memory” (Victoria Mental Health Act, 1986, s. 8(1A)).

apprehended a person they are required—as soon as possible—to arrange for the person to be examined by a registered medical practitioner or assessed by a mental health practitioner. Following the application of involuntary treatment criteria, the mental health practitioner may advise the police officer to either arrange for an examination by a registered medical practitioner or to release the individual (Victoria Mental Health Act, 1986). The mental health practitioner may also complete an ‘authority to transport the person to an approved mental health service’ (Victoria Mental Health Act, 1986, s.10 (5b)).

United Kingdom

The United Kingdom’s Mental Health Act (a national piece of legislation) was recently amended with some key changes, including a more encompassing definition of mental disorder, which now refers to “any disorder or disability of the mind” (UK Mental Health Act, 2007). While the new (2007) and previous (1983) versions of the Act emphasize the importance of basing decisions to detain and treat on a sound clinical judgment, the new Act specifies that a personality disorder is a mental disorder that can be assessed and/or treated (UK Department of Health, 2009, p. 11).

The Act governs the transport to, and treatment of persons within police custody. Section 136 in particular provides for police to transport persons with mental disorder to a “place of safety” which can be a police station, a local mental health facility, a psychiatric unit, or an emergency room. In the new version of the Act, police can transport persons from one place of safety to another, although the general guidance is that police custody suites should be used as a last resort (UK Department of Health, 2009, pp. 45, 46; for a critical examination of Section 136 and its use see Docking, Grace & Bucke., 2008).

Another notable amendment to the Act is the introduction of supervised community treatment powers, which replace previous supervised aftercare powers. With the new powers, persons who have been discharged after a period of compulsory detention in hospital may be subject to a Community Treatment Order whereby they are required to adhere to specific conditions, such as remaining on their medication. If persons do not comply, they can be conveyed to hospital

for compulsory treatment—in essence an out-patient—without going through the process of re-admission (Lawton-Smith, Dawson & Bruns, 2008). Community Treatment Orders (civil law) are to be distinguished from Community Orders (criminal law), which have been in effect since April 2005 as the vehicle for community sentences. These Orders, which can be issued by magistrates and judges seeking alternatives to a prison sanction, specify requirements such as drug and alcohol treatment, mental health treatment, and supervision (Seymour & Rutherford, 2008).

While the transport of persons to places of safety is governed by mental health law in the UK, the treatment of persons while in custody is in part governed by UK criminal law. The Police and Criminal Evidence Act 1984 (PACE) stipulates that the police must request an ‘Appropriate Adult’ in situations where a custody officer suspects there are problems with a person’s mental state or capacity. An Appropriate Adult is meant to represent the best interests of the person in custody and to ensure that he or she understands their rights and is aware of how the custody process works. In the case of juveniles, such a person is often a parent or guardian, but others can fill the role such as third parties who are trained to act in this role (Criminal Justice Inspection Northern Ireland, 2010, p. 16; Moore, 2010; for a critical review of the use of Appropriate Adults see UK Department of Health, 2009, p. 42).

PACE also stipulates that persons in custody suffering from physical and/or mental health problems must receive clinical attention, and if necessary, provision of care by health professionals. The provision of such services, which is the responsibility of each police organization, can be provided according to different service delivery arrangements, including the use of a Forensic Medical Examiner (FME)⁵, the provision of privately provided services, the use of custody nurses, or police liaison schemes (as discussed later in this paper) (UK Department of Health, 2009, p. 47).

At a wider level of crime and disorder policy in the United Kingdom there is a strong emphasis on the management of anti-social behavior, which the Home Office (2010) defines as “any aggressive, intimidating or destructive activity that damages or destroys another person’s quality of life.” In advancing this agenda, the Anti-Social Behavior Order

⁵ Forensic Medical Examiners or Forensic Physicians (previously referred to as Police Surgeons) have traditionally been responsible for providing health care to detainees in police custody within England and Wales. They tend to be General Practitioners working in police custody suites on a part-time basis (Payne-James, Anderson, Green & Johnston, 2009).

(ASBO) was established by the Crime and Disorder Act 1998 and subsequently enhanced in England and Wales by the Anti-social Behavior Act 2003.⁶ It was designed to deal with minor and persistent behavior that would have previously not been subject to regulation and punishment (BBC News, 2010). Such behavior includes acts by a person that “caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as himself” (UK Department of Health, 2009, p. 37). An ASBO, which is a civil court order, can set restrictions on where a person can go, with whom they can associate, and what they can do. If out of compliance with the conditions of this court order, which is in place for a minimum of two years, the individual is criminally liable and can receive a punishment of up to five years in prison. Alternatively, adults could receive a penalty of up to 5000 pounds or young people can receive fines of various amounts (Hampshire Police, 2009).⁷

In a recent review of diversionary practices for offenders with mental illnesses and disability in the UK (see below), it was argued that the behaviors targeted by this legislation “can be indicative of a mental health problem” and as such, there has likely been the perverse effect of bringing persons with mental disorders into contact with the legal system, especially as it is difficult for such persons to comply with the conditions of their order (UK Department of Health, 2009, p. 37). A Home Office review of ASBOs found that in 60% of cases of ASBOs issued, the individual involved had one of several mitigating conditions, such as mental distress or addiction (UK Department of Health, 2009, p. 37).

In the UK officers also have at their disposal Penalty Notices for Disorder (PND) under the Criminal Justice and Police Act 2001. They can be applied to a range of behaviors including “alcohol abuse, exhibiting distress or alarming behavior, any one of which can also be indicative of mental health crises” (UK Department of Health, 2009, p. 37).

In summary, police officers working in the countries reviewed here encounter persons with mental disorders or illnesses in various situations, each of which can be guided by the application of mental health, criminal, or civil law depending on aspects of the behavior concerned.

The question of whether police, in any given instance, decide to use their legal authority to effectively route persons with mental illnesses into the treatment system versus the criminal justice system depends on a number of factors, such as the perceived burden and opportunity cost to the officer, as well as the perceived capacity, responsiveness, and effectiveness of the mental health service system.

Extra-legal factors shaping police encounters with persons with mental illness

Discretion is an inevitable feature of policing, especially lower down on the organizational hierarchy. Police decisions on the street are of low visibility (J. Goldstein, 1960) and nearly impossible to render visible by distant police managers (Wilson, 1978). In theory, police are to arrest all those who have violated the law, yet in practice police cannot observe all offenses, and when they do, they must interpret laws in relation to situational factors and systems-level issues (including resource availability) as well as public opinion. Full enforcement of the law at all times in all places is neither practical nor politically desirable (Wilson, 1978, p. 7). The lowest ranking officer—the patrol officer—is charged with enforcing laws that are especially ambiguous, such as those dealing with disorderly conduct.

When it comes to assisting persons affected by mental illnesses, the police serve as gatekeepers to both the criminal justice and mental health systems. This is because they have the authority to construct a situation as either one calling for a treatment resolution or as one requiring a criminal justice solution, and in the latter case the existence of a legal violation can take precedence over characteristics of the situation (Lamb et al., 2002, p. 1266). When a major crime has been committed, for example, an officer has little choice but to arrest the individual. Ideally in such cases the individual would receive a psychiatric assessment, and possibly receive treatment while in custody.

⁶ Other related legislation governing anti-social behavior exists in Scotland and Northern Ireland.

⁷ The ASBOs are currently under criticism by Home Secretary Theresa May who is calling for a review of the legislation, arguing that dispositions for disorderly behavior should be ‘rehabilitative and restorative’ instead of ‘criminalizing’, adding that “[w]e need a complete change in emphasis, with people and communities working together to stop bad behavior escalating” (BBC News, 2010).

When it comes to minor offenses, officers have a wider discretionary space that is more apt to be influenced by other variables. While a person may have a mental illness, this may not be apparent to the officer depending on his or her training and experience. The officer may also interpret the person's behavior as having been influenced by the consumption of drugs or alcohol. In such cases the nature and manifestations of the person's condition might be misunderstood by the officer (Lamb et al., 2002, p. 1267). An officer will make a dispositional decision based on his or her best knowledge of the situation, but his or her knowledge may be flawed and the chosen disposition may be inappropriate.

Sometimes officers arrest persons with serious mental illnesses for only minor violations, because they see no other viable options—for example, in situations where the individual needs some level of care but would likely not be admitted to a psychiatric hospital or receive adequate mental health services if allowed to remain in the community. This action is referred to as 'mercy booking;' jails may be the only facilities available to provide psychiatric treatment (Lamb et al., 2002). While charging a person for a minor offense can contribute to criminalization, it can also provide a channel to the mental health system in certain jurisdictions; at the court level the person charged may be required to be assessed for fitness to stand trial or she or he may be assigned, in the Canadian context for example, to mandatory treatment as provided in the Criminal Code (Cotton & Coleman, 2010).

Even if an officer decides hospitalization is most appropriate, the process of referral can be frustrating and time-consuming. Officers can spend lengthy periods in emergency departments or hospital waiting rooms, during which time they are unable to perform other duties. As well, mental health professionals may not necessarily agree with an officer's assessment of a person's condition. This situation may result in either the hospital's refusal to admit the individual or a decision to release the individual quickly (Lamb et al., 2002, p. 1267; Steadman et al., 2001). Co-occurring substance abuse may also complicate referral (Teplin, 2000).

Bittner (1967) argued that officers tend to use arrest as a last resort once they have made the determination that no other viable options exist. Arrest, he explained, is a "residual resource, the use of which is determined largely by the absence of other alternatives" (p. 278). His early research on use of civil commitment laws found that officers were reluctant to use this option unless there was a serious threat to personal

or public safety (e.g., suicidal tendencies). The psychiatric condition of a citizen, while relevant to what a police officer thinks and does, is not a real 'police problem' unless the behavior poses 'external troubles' in the form of dangerous and life-threatening behavior, threat to property, or disruption of order in a public place (p. 279).

In a more contemporary context, taking into account the advent of deinstitutionalization, increased stringency of civil commitment criteria, and loss of resources in community treatment, Teplin and Pruett (1992) set out to understand officers' 'decision-making normative framework' (p. 139). Their study was based on observations of nearly 1400 police-citizen encounters (of all types) in Chicago. Arguing that police officers function as 'streetcorner psychiatrists,' the authors sought to understand the 'decision rules' that guide three main dispositional alternatives: (1) hospitalization, (2) arrest, and (3) informal disposition.

Out of 2,122 individuals (including suspects as well as non-suspects) who were observed in interactions with the police, 85 individuals were reported as manifesting signs of mental disorder. The researchers found that while officers generally tended to handle cases informally, they were almost twice as likely to arrest the suspects who appeared to be mentally ill (see also Teplin, 1984a).

Teplin and Pruett (1992) argued that officers resorted to arrest more often when encountering persons with mental illnesses because they perceived that it was the only means available to gain control in many situations. For instance, in cases where a person may not be ill enough to meet the criteria for hospitalization, but is being disruptive in a public space, officers can use arrest to stop the behavior and possibly prevent a future call for service from 'decent people' who may eventually become annoyed (Teplin & Pruett, 1992, p. 147). Arrest is also a viable alternative in situations involving a person who either has a pending criminal charge or who may be deemed 'too dangerous' by a local hospital (p. 148).

Teplin and Pruett (1992, pp. 144-145) also found that officers were aware of resource limitations in the health care sector. Psychiatric placements were of limited availability and community-based mental health centers (often housed in private hospitals and designed to replace state hospitals) had strict admission criteria. Officers were aware, for instance, that citizens would need to manifest delusional or suicidal behavior in order to be admitted. At the same time, if persons suffered from alcoholism or other addictions

they would not meet the standards for admission. Persons that have been drinking, for instance, may be deemed too disruptive to be among other patients. Furthermore, such facilities were disinclined to take persons who were deemed dangerous, even if they exhibited a serious mental health disorder, due to the potential threat they posed to hospital staff. Those with pending criminal charges, regardless of severity, were also denied admission.

At the same time, people with psychiatric diagnoses may not be willingly accepted by detoxification centers. Ironically then, jail may be the only viable option for persons with dual diagnoses or multiple impairments (Teplin & Pruett, 1992, p. 149). The structure of the health care system may therefore create service delivery gaps that disadvantage those with complex needs. As a result, the criminal justice system can become a wide 'net' for clients that 'fall through the cracks' of health care (p. 150).

Menzies' (1987) analysis of police decision-making in the Canadian context (Toronto) revealed the importance of the overall system structure in shaping dispositional alternatives. Teplin and Pruett's (1992) study highlighted the separation between the mental health and criminal justice systems; officers choose either hospitalization or arrest as formal alternatives or they may choose both in sequence (if the first choice fails). By comparison, Menzies study explored the ways in which police officers participate in the "dual application of judicial and therapeutic interventions" (p. 429). This dual role is enabled by a service delivery structure that connects the mental health and criminal justice systems via pre-trial forensic clinics that provide psychiatric assessment for persons in conflict with the law. Such clinics allow police to first arrest an offender and then recommend them for a forensic assessment (Menzies, 1987, p. 431). The individuals that are eligible for such interventions are those that officers deem to be 'dangerous'. Menzies' larger argument was that police play a powerful role as 'forensic gatekeepers,' central to which is the construction of 'dangerousness' which shapes the subsequent decisions of both criminal justice and mental health actors as they decide on the 'institutional careers' of defendants.

Subsequent research has challenged Teplin and Pruett's (1992) finding that police are more likely to arrest persons with mental illnesses than those without mental illnesses, as well as their argument that police practice in this regard contributes to 'criminalization'. Teplin and Pruett's analysis

of arrest rates failed to control for a range of explanatory covariates, such as the severity of the offense, the presence of substance abuse, community priorities, and police organizational directives (Morabito, 2007, p. 1583). When Engel and Silver (2001) controlled for a range of situational, suspect, and legal variables (i.e., race, homelessness, alcohol and drug use, number of bystanders, public or private location of encounter, evidence of disorderly or criminal behavior, seriousness of offense, and presence of a weapon), they found that police actually arrested persons with mental illnesses less frequently than those without mental illnesses. This methodological and empirical challenge suggests, therefore, that the phenomenon of criminalization is not necessarily, or at least exclusively, the result of officers making inappropriate arrest decisions based on the presence of mental illnesses (Morabito, 2007).

Drawing from a vast sociological and criminal justice literature on police discretion, Morabito (2007) argued that decisions are only very partially formed in relation to a subject's perceived state of mental health. Bittner's early work (1967) alerted readers to a range of situational variables, which are not exclusive to encounters with persons with mental illnesses, that shape police decisions. In particular, he argued that police decisions are shaped by three contextual variables, or what he terms 'horizons of context': scenic, temporal, and manipulative. The scenic horizon centers on community characteristics, and consists of known resources (e.g., relatives) in the background setting of the encounter, which an officer may deploy in resolving the situation. The temporal horizon relates to characteristics of the offender, including what is known about how the problem has manifested and been managed in the past (e.g., previous psychiatric treatment).

The manipulative horizon refers to characteristics of the incident at hand, including practical considerations that apply in the moment of the encounter (e.g., the probability that a treatment center will take over the matter swiftly) (Bittner, 1967, p. 283; Morabito, 2007). In general, the more severe the offense committed, the less latitude the officer has in handling the problem. Officers also tend to respect the wishes of the victims at hand who may or may not know the offender and who may or may not want to press charges. Furthermore, it has long been known that a citizen's demeanor can significantly influence the course of action an officer might take (Black & Reiss, 1967). Disrespect, resistance, or other

behaviors that challenges the authority of an officer may mean the difference between informal resolution/referral and arrest (Morabito, 2007, p. 1585).

In sum, Morabito (2007) argued that the existing literature on police interactions with persons with mental illnesses 'may be oversimplifying discretion' (p. 1586). While it is indisputable that persons with mental illnesses are disproportionately represented in the criminal justice system, existing explanations for criminalization may place undue emphasis on elements of the manipulative horizon at the risk of neglecting scenic and temporal variables. According to Morabito, it is therefore important to develop measures of all three horizons and to relate these to criminal justice involvement outcomes (p. 1586).

Police make difficult choices in complex circumstances, and the guidance provided to them in making such decisions is broad rather than specific. Legal rules provide general directives, but it is often non-legal rules of thumb that guide officers as they assess the nuances of a given situation. Officers undertake quick assessments of the individuals they encounter based on the knowledge at their disposal. At the same time, they filter all sorts of knowledge about the community in which they are working, including the availability of health and other resources, a factor which can either serve to limit or expand the set of options an officer believes is at his or her disposal. In very practical terms, officers must decide upon an expedient course of action for each type of encounter, one which does not pose a heavy burden on an officer's time and his or her ability to fulfill other core functions.



Police interventions: Theories and practices across countries

In the following review we find some commonalities in the types of interventions developed, but also important differences. In the US, Canada and Australia, a considerable focus of attention has been on interventions aimed at persons with severe mental illnesses who have been engaged in minor offending. Such interventions occur at either pre-arrest or pre-booking points (Sainsbury Centre for Mental Health, 2009a, p. 13; Lattimore, Broner, Sherman, Frisman, & Shafer, 2003). For the purposes of comparison across countries, we review such specialist police models under two broad categories⁸ (Reuland, Schwarzfeld, & Draper, 2009; Reuland, 2010):

Police-based response (training of officers to respond to crises as well as link to the mental health system)

Co-response (mental health and police partners jointly respond at a scene)

These two categories are distinguished primarily by whom (which lead actor) arrives and responds to the scene of a mental health crisis. Among these approaches are numerous variations to which we cannot do justice. The examples we provide here are therefore meant to be illustrative rather than exhaustive.

In the context of the UK, police custody schemes have dominated thinking and practice. At the same time, however, conceptual advances have been made in thinking more broadly about intervention points at which police can get involved along the criminal justice pathway, beginning with points at which police can be preventive in their assistance, not only with offenders, but with others whom they encounter in their various roles, including victims, witnesses, missing persons, and other persons including those in states

of neglect. A similarly broad conceptual focus can be found in Australia, particularly in the thinking of the police from the state of Victoria. In what follows, we review examples of thinking and practice from the above countries, beginning with the US, which has been a forerunner in the development of crisis response models.

United States

The structure of policing in the US is distinctly localized, multi-layered, and some would say fragmented, compared to what is found in other countries discussed in this review. America has a federalist system, whereby powers are distributed across the federal and state levels of government. States in turn have the ability to create and oversee local government. Based on the Tenth Amendment to the US Constitution, the power to establish police organizations is located at the state level, but in practice, police agencies, and their administration, have developed in various forms, with various responsibilities, at federal, state, and municipal levels of government. Like American government more generally, the organization and administration of policing is de-centralized. This is to ensure that no single agency of government is too powerful, and also that police organizations are responsive and accountable to their local constituents (Gaines & Kappeler, 2008, pp. 7-8; Roberg, Novak, & Cordner, 2009, p. 12).

As of 2004, there were 17,876 police agencies at the state and local levels across the country. Seventy-nine of these consist of 1,000 or more full-time sworn personnel. At the other end of the spectrum, there were 2,202 agencies with one or two full-time personnel and over 3,200 with only two to four full time personnel. Indeed the bulk of police organizations at

⁸Some commentators have used several categories to depict interventions (e.g., police-based police response, police-based mental health response, mental-health-based mental health response, and the reception center model) (see Adelman, 2003; Lamb et al., 2002; National Council of State Governments; Schwarzfeld, Reuland & Plotkin, 2008). Our review draws on Reuland and colleagues' (2009) simpler distinction between models where police are the lead agency in a crisis intervention and models where police co-respond at a scene in partnership with health professionals. While there are variations within these broad categories, for the purpose of this review these two simpler categories allow for ease of comparison across countries.

state and local levels employ 99 or less full-time personnel (16,777 out 17,876) (Roberg, 2009, p. 13). These organizations span a country with over 309 million inhabitants.

Police-based response

The Crisis Intervention Team (CIT) approach is the most popular intervention model in the US and has gained widespread interest across the world. Crisis Intervention Teams were designed with the goal of improving officers' abilities to address crisis situations effectively and efficiently. The assumption is that if officers have greater awareness of mental health issues and how they manifest behaviorally, and learn the subtleties of de-escalation (ensuring that the encounter does not become more tense or hostile), they are better positioned to use force less. Being able to manage a situation without resorting to force helps ensure the safety of an encounter (both for the officer and the citizen involved), and creates more of an opportunity for officers to choose a disposition that serves the mental health needs of the individual concerned. There is a central emphasis on diversion – reducing arrests and increasing referrals to treatment – in order to stem the tide of criminalization, while at the same time ensuring that no injuries occur during an incident.

The CIT model was originally developed by the Memphis Police Department in 1988 in the wake of an incident involving police shooting a man with schizophrenia. Since then, variations of the CIT model have been implemented in over 400 programs in medium and large cities across the US. Operating at the pre-booking stage of the 'offender pathway' (UK Department of Health, 2009), specially trained officers are dispatched as first responders and as links to the mental health system. Officers volunteer for this role, receiving 40 hours of training on mental health disorders, substance abuse, de-escalation techniques, and the law, which is delivered by mental health professionals, advocates, and others with specialized expertise in the area. With this extensive training, the assumption is that officers will be best placed to make an appropriate disposition, whether it is transport to a hospital, referral to mental health treatment services, or arrest. Dispatchers are trained to call CIT officers to incidents involving mental disturbance. Once at a scene, de-escalation and negotiation are preferred as key tactics in an officer's handling of an encounter.

Inter-agency arrangements, which are pivotal to the functioning of CIT, vary across cities. In the Memphis context, the police department has a 'no refusal' agreement with

the University of Memphis Medical Center's psychiatric emergency department. With this agreement, police referrals are accepted swiftly, while officer waiting time is kept to a minimum (Oliva & Compton, 2008; Hartford, Carey & Mendonca, 2006; Schwarzfeld et al., 2008; Steadman, Williams Deane, Borum, & Morrissey, 2000; Watson, Morabito, Draine, & Ottati, 2008). Multnomah County, Oregon has a crisis triage center located within the Providence Medical Center, which functions as a 'one stop centralized crisis service for law enforcement officers', (Steadman et al., 2001, p. 220). This center provides a variety of functions, such as responding to a 24-hour crisis line, providing on-site crisis intervention assistance and mobile outreach, and delivering detoxification and mental health treatment. Like the Memphis program, the triage center accepts referrals by police officers based on a no-refusal policy (Steadman et al., 2001).

There are three essential elements of the CIT model, which have resonated with police jurisdictions across the country as well as internationally. The first element is the comprehensive police training program which is designed to positively shape officers' awareness, knowledge, and confidence. The second element is a strong link between the police and mental health resources in the community. In some jurisdictions, the most important link is the establishment of a centralized site, where police can transfer citizens for assessment. In Memphis, the 'no-refusal' policy with the crisis center of the University of Tennessee psychiatric services is essential. Police can be confident that their referrals are accepted and generally officers do not have to wait any longer than 30 minutes during the transfer process.

The third element of CIT consists of a shift away from a traditional, reactive model of policing— one which, as Simon (1997) described, 'governs through crime'— to one which is more community oriented and based in a public health understanding of mental illnesses, their causes, and their treatments (Watson et al., 2008). In some jurisdictions, police departments have opted for a Comprehensive Advanced Response model, which involves providing the specialized training to all first response officers (National Council of State Governments, 2002).

The Memphis approach has been taken up in numerous other jurisdictions, both in the US and worldwide (as discussed below in both the Canadian and Australian contexts). Other cities in the US using this approach include Albuquerque, Portland, and Seattle (Steadman et al., 2001). There are over 1000 programs operating worldwide (CIT International, 2011).

Co-response

Other jurisdictions have implemented models based in the mental health care sector, which involve teams such as mobile crisis teams (consisting of professional mental health workers) or assertive community treatment teams (Wolff, Diamond & Helminiak, 1997) and provide first-response assistance to officers. Here there are cooperative agreements between police and mental health services, but the two services remain institutionally separate (Hails & Borum, 2003; Hartford, Carey, & Mendoca, 2006). Examples include Knoxville's Mobile Mental Health Crisis Unit or the Psychiatric Emergency Response Team (PERT) (Sainsbury Centre for Mental Health, 2009a). Established in 1991, the Knoxville MCU consists of civilian mental health professionals (including those with social work or nursing backgrounds) who provide 24-hour coverage, responding to calls to assist at a scene and offering telephone consultation. The team also accepts referrals from jail due to the absence of jail-based mental health treatment (Steadman et al., 2000).

A variation of this co-response approach is where a police organization employs a mental health professional who assists first-response officers either on site or via telephone (Hails & Borum, 2003). One example of this approach is the Community Service Officer (CSO) program from Birmingham, Alabama established in 1976 (Steadman, Morrissey, Deane, & Borum, 1999). Here, CSOs are social workers or other professionals from relevant fields who are hired by police and who co-respond at critical incidents (Sainsbury Centre for Mental Health, 2009). The CSOs provide 24-hour coverage and are available to respond to a range of calls requiring social assistance, including family violence incidents, or situations requiring transportation (Steadman et al., 1999; Steadman et al., 2000). Reviews of both police-based and co-response models have shown promising results, all of which are highlighted in a review by Reuland and colleagues (2009). Some research has shown that the number of injuries to officers decreased, as in the cases of CIT programs in San Jose, California (Reuland, 2004) and Memphis, Tennessee (Dupont & Cochrane, 2000). Jurisdictions with specialized responses have also been found to have more transports to mental health services (both voluntary and involuntary) than those without such programs in place (Dupont & Cochrane, 2000; Steadman et al., 2000; Teller, Munetz, Gil, & Ritter, 2006). Specialized responses have also been proven to generate cost savings. While diversion serves to increase mental health treatment costs, studies

have shown that criminal justice expenses, including the use of SWAT services have decreased (Bower & Petit, 2001; Teplin, 1984b).

The traditional performance culture in policing—centered on statistics such as arrest rates and response times—has made it challenging for both researchers and practitioners to evaluate specialized police-based responses; police are not accustomed to measuring public health outcomes. It has been rather more straightforward to evaluate the impacts of officer characteristics and training on outcomes such as the ability of officers to appropriately identify mental illnesses in the citizens they encounter, the feeling of confidence officers have in their ability to handle such encounters, and the time officers spend handling a situation (Borum, Deane, Steadman, & Morrissey, 1998; Compton, Esterberg, McGee, Kotwicky, & Olivia, 2006; Watson et al., 2008). Researchers have found, for instance, that CIT training improves the knowledge and confidence of officers, although there is evidence that knowledge can decay over time (Compton & Chien, 2008; Watson et al., 2008).

Data on arrest outcomes have been mixed. Steadman and colleagues (2000), having examined arrest outcomes for different types of crisis interventions, found that arrest rates across these programs were lower than those generally found across the country. The CIT program yielded a higher success rate compared to the other programs evaluated in terms of the percentage of cases in which officers brought citizens to a treatment facility. Steadman and colleagues (2000) suggest that a key explanation for this result was the existence of a 'no-refusal' policy with emergency services in the Memphis program they evaluated (Sainsbury Centre for Mental Health, 2009a, pp. 13-14). There is however no definitive evidence suggesting that all CIT programs have decreased the number of arrests of persons with mental illnesses overall, with one study showing no difference in such numbers between CIT-trained and non-CIT-trained officers in Akron, Ohio (Teller, Munetz, Gil, & Ritter, 2006).

Watson and colleagues (2008) noted that there have not been robust studies on CIT's implementation, including various factors influencing adherence to the model. They have gone so far as to suggest the need for expanding the conceptualization and scope of CIT evaluations in order to take into account a range of factors at the levels of the community (e.g., levels of social disorganization), the police organization (e.g., the presence of 'champions' of the approach), and the

mental health system (e.g., availability of services) that can influence both CIT's implementation as well as the achievement of outcomes, such as reduced arrest, increased safety during encounters, and better linkages to mental health services. It is unclear whether the training component of CIT, for example, is the ultimate key to getting such outcomes as opposed to, say, developing efficient and sustainable service delivery partnerships with the health care sector (see also Hails & Borum, 2003; Tucker, Hasselt & Russell, 2008). It is therefore important to explore "the rival hypothesis that the availability and ease of linkage to mental health treatment is the principal mechanism for affecting these outcomes" (Watson et al., 2008, p. 362).

Watson and colleagues' (2008) view is substantiated by a prior study by Sellers, Sullivan Veysey and Shane (2005), which compared the attitudes and practices of police officers from one police organization that did not have a specialized response (Newark) with officers who worked in three other organizations that did have a specialized model. The researchers found that officers from Newark had similar views about their own confidence as well as their organization's effectiveness compared to the other three agencies. Newark's officers had a slightly lower arrest rate than officers from the other organizations. What likely explained this finding was Newark's well established interagency relationships, which would not necessarily have benefited from the introduction of a specialist program (Sellers, Sullivan, Veysey, & Shane, 2005, p. 656).⁹

As will be seen in the Canadian and Australian contexts described below, the above US innovations have been highly influential and taken up in different jurisdictions to suit local circumstances. While there are many variations of these police-based and co-response models in both the US and these other countries, they all rest on elements of specialized training, inter-agency partnerships, and a community policing orientation.

Canada

Canada has a federalist government structure, which provides constitutionally delegated authority to its ten provinces and three territories. There is some variation across the systems and laws of health care and policing of the different provinces. Police organizations can be found at municipal, provincial, and federal levels, but not all provinces have their own police service. There are approximately 230 police services across the country, with about 45% of these numbering less than 25 officers. The Royal Canadian Mounted Police (RCMP)¹⁰ (the national police service) is the largest with over 17,000 officers (Cotton & Coleman, 2010). There are 12 police services with over 1000 members, such as the Vancouver Police Department, which has 389 civilian employees and 1327 sworn members (Vancouver Police Department, 2010) serving the third largest metropolitan area in the country (following Toronto and Montreal).

While Canada has a large land mass (second in the world behind Russia and ahead of the United States, which is third), it has a relatively small population (33.3 million compared to 307 million in the US). While the majority of Canadians live in areas with a population of 10,000 or more, some live in areas so remote that mental health or substance abuse services may be a day away by car (assuming they are accessible at all). This situation obviously poses challenges for both police and mental health professionals in providing access to services (Cotton & Coleman, 2010).

During the ten-year period between 1992 and 2002, there were eleven instances nation-wide of persons with mental illnesses being fatally wounded by police (Cotton & Coleman, 2010). One example was the case of Lester Donaldson, a man suffering from Schizophrenia, who was shot fatally by Toronto Police in 1998 (for recent examples see Kennedy, 2010). This event resulted in a Coroner's Inquest and marked a new wave in legislative review and the development of new service delivery arrangements (Cotton & Coleman, 2010). Similar to what is found in the US, the interventions that have developed in Canada have the core objectives of reducing instances of criminalization, diverting persons with mental illnesses away from the criminal justice system, and providing linkages to needed services and supports.

⁹ For other recent reviews of CIT see Watson et al., (2010) and Morabito et al. (in press).

¹⁰ The RCMP plays distinct roles in different parts of the country. Similar to the Australian Federal Police, the RCMP has a federal law enforcement mandate, but it can also serve as a contracted police service to provinces and territories that do not have their own service as well as to municipalities who choose to hire the services of the RCMP rather than establish their own local service (Cotton & Coleman, 2010).

Police-based response

Parts of Canada have tailored the CIT, including the Ontario Provincial Police (OPP), which provides a modified 20-hour CIT curriculum to front-line officers and is working toward the goal of having 25% of its officers trained over the next five years. The OPP's policy is that dispatchers call upon a CIT-trained officer to respond to a crisis situation. If such an officer is not available, a regular officer will go to the scene and, if needed, call upon the CIT officer for support (Ontario Provincial Police, 2009).

In British Columbia, the RCMP's Lower Mainland Division adopted an enhanced version of CIT. Centered on the need for 'cross-training,' a 40-hour training module (based on the Memphis model) is available not only to municipal and transit police, but also to other first responders including dispatchers, paramedics, and psychiatric emergency liaison nurses. The expansion of mental health training to agencies other than police has also been initiated by British Columbia's Ministry of Public Safety and Solicitor General which arranged for the Canadian Mental Health Association (CMHA) (Burnaby Branch) to provide Mental Illness First Aid Training to sheriff services and community corrections officers over the past several years. During 2007-2008 the CMHA BC's Mental Health and Police enhancement project involved the delivery of this training to first responders in various BC communities (Hall & Weaver, 2008).

Similar to the US context, some police agencies in Canada strive to offer all of their first response officers training in mental illnesses. Cotton and Coleman note that this objective has been difficult to achieve in the Toronto Police, which is a large service. This ambitious and obviously expensive objective may however be much more feasible in smaller police departments, and indeed may be essential. In small or remote areas, mental health resources may not be readily available in a crisis situation, suggesting the need for most or all police to have mental health awareness and training. Whereas the Toronto Police and the Belleville Police (both in Ontario) both have an Advanced Patrol Model, Toronto has over 5000 officers, while Belleville has approximately 85-90 first responders that receive mental health training every year (Cotton & Coleman, 2010).

In contrast to the Advanced Patrol Model, some Canadian police utilize designated mental health officers. Aspects of this specialist function can vary depending on the size of the jurisdiction. Such officers may arrive at a scene to assist

other first responders or they may be called to provide first response capacity upon request. They tend to assist with the case management of persons with mental illnesses who come into frequent contact with the police. They may also serve policy development roles and liaise with mental health agencies (Cotton & Coleman, 2010).

Co-response

Similar to the US, some Canadian jurisdictions utilize a co-response model involving police and a mental health worker (nurse, social worker or other professional) arriving jointly to a scene. The team may be called directly by a dispatcher or it may be called in by other first responders. Having a mental health worker present is meant to increase the accuracy of the assessment of the person in crisis and to ensure an efficient and appropriate referral of the person to needed services. The officer's role centers on ensuring the safety of the interaction, and if necessary, apprehending the person in accordance with the Mental Health Act. This approach is common in Canada's larger centers and in some smaller jurisdictions one can find variations, such as using telephone consultation with a mental health worker (Cotton & Coleman, 2010).

One version of this approach in Vancouver, British Columbia involves a partnership between the Vancouver Police Department (VPD) and the Vancouver Coastal Health Authority - Mental Health Emergency Services (MHES). Referred to as Car 87, the program has been in operation for nearly 30 years. The car provides a 20-hour-a-day mobile response by a team consisting of a plainclothes police officer and a Registered Nurse or Registered Psychiatric Nurse. A Psychiatric Nurse responds to telephone requests that are called in by a range of parties including emergency services, mental health agencies, and families. The nurse provides a triage service but does not provide crisis counseling. He or she decides whether to link the caller to appropriate services or to dispatch Car 87. Once on the scene, the officer-nurse team conducts an assessment and decides how to handle the situation. When required, the team will call for a psychiatrist to come to the scene and conduct an assessment. The psychiatrist may issue a Medical Certificate (Dubey, 2006; Wilson-Bates, 2008). It is worth noting that the Vancouver police have also cooperated in the implementation of public health approaches to substance abuse, including cooperation with the city's supervised injection facility (DeBeck et al., 2008).

POLICE INTERVENTIONS WITH PERSONS AFFECTED BY MENTAL ILLNESSES

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The city of Hamilton, Ontario is widely known for its Crisis Outreach and Support Team (COAST), which is similar to Vancouver's approach but more extensive. This program was piloted in 1997 and instituted permanently in 2001. The COAST teams are composed of plainclothes police officers, mental health workers, social workers, nurses, and child and youth crisis workers. COAST workers are mobilized through a crisis telephone line (available 24 hours a day, 7 days a week) that is managed by a mental health worker who plays a triage role and makes preliminary assessments. Depending on the nature of the call, she or he may decide to provide telephone support or arrange for a mobile visit. In the latter situation, an outreach mobile unit (working between 8 a.m. and 1 a.m.), consisting of a mental health worker and a plainclothes police officer, will be dispatched to the scene in an unmarked police car (no doubt a symbolic move to reduce any levels of intimidation associated with the arrival of a marked police car).

A management plan is developed, aimed at addressing the immediate situation, and if necessary, a follow-up plan is created involving, for example, referrals to community mental health service agencies. Clients are always offered support services in a crisis situation, and if the consumers choose to use supports or follow-up interventions, a support team from COAST will respond within 24 hours of the initial crisis. This program is designed to provide continuous support or follow-up until the person's difficulties have been addressed or the person has engaged with relevant community services.

COAST provides expertise in mental illness (e.g., attention deficit disorder, depression, suicide, and self-injury) and addiction to children and youth as well as to adults (COAST, 2010). COAST will respond to alerts from mental health agencies with concerns that a given client will need support during times that agencies are closed. COAST also has agreements with different service providers who have committed to accepting referrals (Dubey, 2006).

In 2006, COAST incorporated CIT training to better enable officers to identify situations and provide appropriate responses (Kaiser Foundation, 2010). The Kaiser Foundation, a national organization devoted to improving responses to persons with mental health problems and addictions, awarded COAST an award for Excellence in Mental Health and Substance Abuse Programming (<http://www.kaiser-foundation.ca/awards/winners.php>). Other co-response

models can be found in Toronto (Ontario), Edmonton (Alberta), and Halifax (Nova Scotia) (Cotton & Coleman, 2010; Dubey, 2006).

As we will see in our discussion of Australia, Cotton (cited in Dubey, 2006) noted that such team approaches depend on a rich inter-locking of resources that are most readily available in higher density areas. Therefore, it may be more feasible in smaller jurisdictions to develop agreements between police and other service providers such as emergency departments and mental health agencies. Indeed, in some communities, such agreements have been developed. In a small town in northeastern British Columbia, Dawson Creek, the RCMP liaises with the local mental health center in tailoring responses to individual cases. Because Dawson Creek is so small (less than 12,000 people and 7.98 square miles), RCMP officers are more likely to know and be familiar with a person's situation than officers in larger jurisdictions. When an RCMP officer(s) responds to a call for service, and the individual is perceived as having a mental health problem, the officer will contact the local mental health service. In situations where violence is a concern, the RCMP will escort the individual to a hospital for assessment. At this point, the officer(s) informs the physician of known previous mental health-related contacts with the individual. Where violence is not a factor, a mental health team takes over responsibility for the situation (Adelman, 2003).

The attending physician at the emergency department always consults with the mental health center (a separate entity) to determine whether the patient has history of previous contact/service. If the patient is not known by the mental health center, staff from the center will provide an assessment, and if the staff is aware of the individual's case, they will provide consultation to the emergency department. Instead of the police, an outreach mental health team may be the first point of contact in some cases. Following an assessment of the situation, the team may contact the RCMP if necessary (Adelman, 2003).

A recent Ontario-based survey of municipal police and the Ontario Provincial Police administered by the Centre for Addiction and Mental Health (CAMH, 2010) found that 62% of responding agencies have formal arrangements in place where mobile mental health teams would provide on-site assistance. Less than 30% of services had a specialized police-based response model in place. In terms of implementation of such approaches, an interesting gap emerged.

Actual usage of on-site responses was low. Approximately half of survey respondents argued that they used their response arrangement in less than 25% of situations. This figure was lower in regards to use of police-based responses. As well, a surprisingly small number of agencies had agreements in place supporting transfer of care to hospitals, community crisis services, or withdrawal management programs following an event (CAMH, 2010, pp. 38-39).

In explaining the possible factors contributing to low usage of on-site responses, the authors of the CAMH report speculated that the “timely availability of specialized officer or mobile mental health team’ may play a role” (CAMH, 2010, p. 40). Also, officers may not be fully aware of response options. It could be the case that in a significant number of situations, a crisis response is not deemed necessary on the part of the officer on the scene, or the officer chooses another, perhaps more expedient approach to handling the encounter (CAMH, 2010).

Cotton and Coleman (2010) noted that despite the number and diversity of interventions in Canada, the scientific evidence regarding their effectiveness is limited. There is considerable anecdotal support on the part of police for the idea that Canadian police/mental health partnerships have accomplished objectives in relation to “improved communication, better disposition of cases, more client-centered solutions, better appreciation of the roles of each of the professional groups, more selected and efficient use of emergency room resources, an overall reduced tendency to criminalize and stigmatize mental illness and greater awareness of mental illness in communities” (Cotton & Coleman, 2010, p. 311). Yet, a robust body of qualitative and quantitative research remains lacking to substantiate such claims (pp. 310-311).

As one exception, one study of policing interventions conducted by the London Police (Ontario) examined the effectiveness of a service agreement between the police and the London Mental Health Crisis Service in which the mental health service would attend a crisis situation when requested by police on the scene. According to this study, after a twelve month period, the police were involved in 26% fewer encounters with persons with mental illnesses and the number of occurrences involving persons with mental illnesses decreased by 25% (Cotton & Coleman, 2010, p. 310). As we will discuss toward the end of this paper, such studies are rare due in large part to inadequacies in baseline data collection, both at the police level and system-wide, which makes it challenging to assess whether police-based and co-response models achieve various criminal justice and public health outcomes.

As is the case with Canada, Australia has been equally inspired by developments in the US. At the same time though, differences can be found in regards to the ways in which the police role is conceptualized. One answer to the question of how, and at what points, police are thought to make a difference in the lives of persons affected by mental illnesses can be found in Australia’s ‘whole of government’ framework and the broad understanding of ‘prevention’ to which it aspires.

Australia

Similar to Canada, Australia is a vast country with a relatively small population (2.4 million), the bulk of which resides in or around urban centers such as Sydney, Melbourne, Brisbane, and Perth. The country consists of six states, Queensland, New South Wales, Victoria, Tasmania, South Australia, and Western Australia, and two territories, the Australian Capital Territory (ACT) and the Northern Territory. Each state, in addition to the Northern Territory, contains its own police service (there are no municipal-level police organizations) and the ACT (home of the nation’s capital, Canberra) receives its policing services from the Australian Federal Police. This structure is, therefore, much more centralized than what is found in the US.

Due to their state- or territory-based structure, each police organization has responsibility for providing services that are appropriate to various smaller jurisdictions with unique needs and characteristics. Australia is the land of contrasts, consisting of big, urban centers with large and diverse populations, small to medium cities or regions, and rural and remote bush areas (Fleming & O’Reilly, 2009, p. 72).

In terms of mental health priorities, and their intersection with criminal justice operations, a national agenda for Australia is articulated in such plans at the National Mental Health Policy 2008 (Commonwealth of Australia, 2009). As will be discussed later in this section, state governments (with Victoria as an example) attempt to align their own strategic direction with the normative vision for mental health service delivery established at the national level. This emerges from the ‘whole of government’ orientation of the country. At the same time, Australian jurisdictions have taken up and tailored US innovations, including the CIT model. One such example can be found in the state of New South Wales (NSW).

Police-based response

At the start of 2008, the New South Wales Police Service, in partnership with organizations including the NSW Department of Health, began implementation of a pilot program called the Mental Health Intervention Team (MHIT) adapted from the CIT model. In support of this program, NSW Health temporarily transferred a mental health clinician to assist with program design, development of MHIT training, and coordination between the program and health service providers (New South Wales Police, 2010). The pilot program involved the provision of special mental health training to front line officers in three select Local Area Commands.¹¹ The training, provided by a Mental Health Intervention Team Command (represented by a Commander and Corporate Spokesperson), was designed to help officers improve their ability to respond effectively to individuals displaying signs of mental illness (Herrington, Clifford, Lawrence, Ryle, & Pope, 2009).

The training package, developed in consultation with mental health professionals, contains a four day curriculum and, in the spirit of the original CIT model, teaches officers to recognize signs of mental illness and provides them with communication and de-escalation strategies as well as tools for managing a crisis situation. Officers are also trained on the state's Mental Health Act as well as the NSW Emergency Mental Health Memorandum of Understanding between the police, the Ambulance Service, and NSW Health (NSW Police, 2010) which "commits agencies involved to work in co-operation to promote a safe and coordinated system of care and transport, and clearly defines the roles of each of the agencies at major points of the process from initial contact through assessment, care and follow up" (NSW Health, Ambulance Service of New South Wales, & NSW Police Force, 2007; see also Clifford, 2010 on the use of Memorandums of Understanding in Australia). Officers who complete the training are formally designated as Mental Health Intervention Officers, and wear a special badge over the name plate on their uniform (NSW Police, 2010).

The MHIT program has four primary objectives:

"Reducing the risk of injury to police and mental health consumers when dealing with mental health related incidents;

Improving awareness amongst front line police of the risks involved in the interaction between police and mental health consumers;

Improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents, and;

Reducing the time taken by police in the handover of mental health consumers into the health care system" (NSW Police, 2010).

A two-year evaluation of the MHIT program found an increase in the extent to which officers used de-escalation techniques. Overall, officers noted that they perceived that their understanding of mental health issues increased and as such felt more confident in their abilities to manage an encounter effectively. Interviews with NSW Health staff confirmed this finding. In general, staff reported an improved level of understanding among police, demonstrated when they would transfer persons with mental illnesses into their care (Herrington, 2009, pp. 3-4).

During incidents in which the Mental Health Act was applied, there was an increased use of de-escalation techniques in cases where an MHIT trained officer was present. While noting that use of force is generally rare during encounters, Herrington and colleagues (2009) found no difference in the use of force between MHIT trained officers and their non-MHIT trained colleagues (p. 3). There was also no difference between MHIT-trained officers and non-MHIT-trained officers in the degree to which police were injured during encounters. These findings are not surprising when related to the incidence of injury and the rate at which injuries are the result of self-harm as opposed to officer-inflicted use of force. Following an analysis of Mental Health Act events captured in the NSW Police case management system (COPS – Computer Operational Policing System) for the periods July 2007, July 2008, and July 2009, the research-

¹¹ Local Area Commands (LACs) are the NSW equivalent of 'local police' jurisdictions serviced by generalist community policing officers and supported by specialist units when required. There are numerous LAC's within each police 'region' (e.g., Central Metropolitan Region) (see http://www.police.nsw.gov.au/about_us/structure/operations_command/local_area_commands).

ers found that the majority of injuries were self-inflicted (Herrington, Clifford, Lawrence, Ryle, & Pope, 2009, p. 33). Herrington and colleagues explained that “our data show that police use of force and sustaining of (non-self inflicted) injuries during mental health-related events is mercifully rare and, as such, it is difficult to identify a *rate* of this and compare pre- and post-training periods, with the small numbers meaning that one event will have a disproportionate impact” (p. 34).

Relationships between police and health workers or representatives were found to have improved in quality since the implementation of the program. However, this effect was observed across MHIT and non-MHIT sites, suggesting that the enhanced quality of relationships could not be attributed to the training in and of itself (Herrington et al., 2009, p. 55).

Herrington and colleagues (2009) also examined other questions related to the effectiveness of the program, such as whether officers were less likely to transport persons with mental illness using police vehicles (a practice which is deemed as a last resort according to inter-agency guidelines). The data revealed that police continued to use their vehicles for transport in 75% of cases (only a quarter of which involved use of force) (p. 4).

The research team noted that there may be challenges in implementing the MHIT program across the service in terms of the additional requirements placed on the MHIT Command. As well, the distinct challenges of rural and remote areas would need special consideration during the dissemination of the program. Such challenges include the long distance between such areas and needed services as well as the small number of police officers providing coverage at any given time. In crisis situations, therefore, individual police officers may have no choice but to de-escalate situations on their own, knowing that timely assistance may not be forthcoming. Herrington and colleagues (2009, p. 67), therefore, suggest that during implementation of the program, it would be important to ensure that a higher proportion of officers working in such areas are MHIT-trained.

There are also challenges related to the interface between such rural areas and the organizations that serve them, which are usually based in larger centers. The facilities that tend to service smaller areas may be limited in their capacity to help after hours and may even refuse admission if the person conveyed by the police is deemed a security threat. It may therefore take a considerably long period of time for

police to hand over such a patient, as officers are required to maintain the person in custody until the safety of the situation has been guaranteed (Herrington et al., pp. 67-68). The authors concluded that “[i]f the ultimate aim of the MHIT is to remove police from such activities, and quicken handover times to NSW Health, then there is a need to work closely with NSW Health Area Services in these [rural] areas to achieve a mutually satisfactory compromise” (p. 68).

Since the implementation of its pilot program, the NSW Police has trained over 300 police officers and aims to have 10% of all operational officers trained by the year 2015. NSW Health has also agreed to support the transfer of a mental health clinician for another three years (NSW Police, 2010).

Similar to Canada and the US, Australia has also experimented with co-response schemes, an example of which is the Police, Ambulance, and Crisis Assessment Team Early Response (PACER) initiative in the state of Victoria. It builds on the work of Crisis Assessment and Treatment services teams based in the health sector.

Co-response

Crisis Assessment and Treatment services (CAT), alternatively referred to as Crisis Assessment and Treatment Teams, has been in existence for over 15 years. CATs are a service provided by the Victorian Department of Health. They assist with short-term assessment and choice of treatment interventions for persons in crisis. While their services are available 24-hours per day, they are not designed as a mobile emergency response service and do not have adequate staffing to perform such a function. CATs provide an alternative to hospitalization, providing in many cases intensive support to people in their homes. They also provide on-site support to selected hospital emergency departments. CAT staff consists of health professionals with backgrounds in medicine, nursing, social work, occupational therapy, and psychology (Victoria Auditor-General, 2009, p. 3; Victoria Department of Health, 2010). CAT services are commonly found in metropolitan areas, while in rural areas such services tend to be absorbed within the functions of other mental health teams (Victoria Auditor-General, 2009, p. 4).

Based on existing protocols, CAT services are intended to prioritize referrals from police, although research by the state’s Auditor-General has found that in practice, police have found CATs to be unresponsive, especially in relation to the response times required for CATs to get to a scene. In

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theory, however, CATs can assist in providing assessments at a variety of locations such as a person's home, an Emergency Department, or a police station (Victoria Auditor-General, 2009, p. 4).

The PACER project was designed to strengthen the collaborative operational response of Victoria Police, the CATs, and ambulance services and to test the premise that a dual- or co-response function by these agencies would best meet the needs of persons with mental disorders in crisis. There were several specific aims, including reducing the number of Mental Health Act apprehensions, de-escalating situations more effectively, and ensuring that responding staff have more ready access to mental health database information which could assist with expanding referral options (Victoria Auditor-General, 2009, p. 19).

The initial PACER trial occurred between September and December 2007. The PACER team consisted of one police officer and a CAT clinician who worked seven days a week between 2 p.m. and 10 p.m. Unlike the Canadian COAST model, the PACER team does not provide a primary response function in the sense that it can be accessed directly by a public hotline. Rather, the PACER team is described as a 'secondary response unit' for ambulance crew or police who are allowed to call PACER for assistance. The PACER team can provide various forms of assistance to police or ambulance crew. They can provide a clinical assessment on-site, provide referral options on-site or via phone, and serve other consultative roles over the phone such as providing guidance on de-escalation tactics or the best means of transport. The CAT clinician and the police officer have very clear and distinguishable roles. While the clinician provides the assessment, checks medical records, and explores referral options, the officer checks police databases and ensures the safety of the scene (Victoria Auditor-General, 2009, p. 19).

The initial three-month assessment of PACER showed that out of a total of 279 requests for assistance, 68% of these involved assessments conducted on site, and 55% involved citizens who met the criteria for a Mental Health Act apprehension. In 47% of the responses, the PACER team was able

to free the initial responder (police or ambulance) to resume duty for other functions. In only 4% of cases was coercion, such as handcuffs or capsicum spray, required to manage the situation. In 90% of cases, a clinical diagnosis of mental disorder or illness was made by the CAT team member (Victoria Auditor-General, 2009). The Auditor-General's report notes that "[s]taff believe that the PACER model improved resource use and interagency communication, but most importantly, it created a more person-centered response, where restrictive interventions can be avoided" (p. 18). The PACER program is continuing with the financial support of the Department of Health, and once a 12-month evaluation is completed, the Auditor General recommends further innovation in regards to addressing the unique operational challenges associated with rural and regional areas (Victoria Auditor-General, 2009; Victoria Police, 2010b).

Echoing Herrington and colleagues' (2009) call for more thinking and research on the unique challenges of rural and remote areas, the Police Federation of Australia (PFA)¹² has been vocal about the obstacles that police face in providing an effective response. Noting that a lack of mental health resources has served to place an undue burden on police, the PFA has stated that providing effective police responses in remote and rural areas is particularly challenging. The amount of distance that police must travel to handle a call is "in some instances many thousands of kilometers but in all cases inappropriate for the job and undignified for the patient" (Burgess (Chief Executive Officer of the PFA), undated, p. 2). The problem of distance is exacerbated by the fact that remote areas tend to have fewer mental health service resources than urban areas (PFA, 2005). As Cotton and Coleman (2010) noted similarly in regards to the Canadian context, it may be the case that in remote and rural parts of Australia, a model such as PACER is neither desirable nor feasible, and that it may be more appropriate to ensure that all or most police in such areas are trained in mental health issues, and that comprehensive inter-agency protocols are in place.

In the wider context of the above initiatives is a state and national level emphasis on providing a 'whole of govern-

¹² The Police Federation of Australia (PFA) was formed in 1997. It brought together the police unions from all Australian state and territory police organizations, and as such provides a powerful collective voice for police workers across the country. In addition to addressing industrial issues, the PFA conducts work on police professional development, conducts research (including with university partners), and plays a national lobbying role (Fleming, Marks & Wood, 2006, p. 79)

ment' response to persons affected by mental illnesses, as illustrated in the case of Victoria. In this state, Victoria Police have argued that while improving the crisis intervention role for police is essential, it is important to conceive of what police can do in a broader way, and in alignment with national priorities and objectives.

Beyond crisis intervention

Victoria Police (VicPol) has chosen a broad strategic focus, which encompasses various aspects of service delivery and interagency coordination beyond the area of crisis response. It is an expression of a 'whole of government' approach, similar to the 'joined up government'¹³ orientation in the UK (see below), aimed at breaking down organizational silos across public sector entities (see Rhodes, 2006).

VicPol's Business Plan 2006/2007 (Victoria Police, 2006) cites the improvement of police responses to persons with mental disorders as one of its priority areas, which aligns with similar priorities at the state level, including those contained in the Victorian Justice Mental Health Strategy (Victoria Department of Justice, 2010). As will be discussed further, these state-level developments both reinforce and complement a national agenda expressed in the National Mental Health Policy 2008, which is committed, among other things, to "ensur[ing] that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community" (Commonwealth of Australia, 2009, p. 2). Following a review of its service delivery arrangements, VicPol developed a Mental Health Strategy, released in 2007, which was designed to improve the ways in which the organization assists persons experiencing, or affected by mental illnesses. A central focus of this strategy was the development of agency partnerships (Victoria Police, 2007).

Prior to the development of its Strategy document, VicPol did not specify targets or outcomes in relation to the provision of services for persons with mental disorders.¹⁴ Traditionally,

VicPol, like other police agencies, sets organizational targets in relation to such achievements as reduced crime, number of successful prosecutions, or reduction in the number of repeat young offenders (see for example, Victoria Police, 2010a). In its strategic directions paper titled 'Peace of Mind: Providing Policing Services to People With, or Affected by, Mental Disorders', VicPol notes that because there are no specified outcomes in relation to encounters between police and persons with mental disorders, there is no routine system for collecting data on the nature of such encounters and their outcomes (Victoria Police, 2007, p. 7). As well, VicPol's review of its own practices revealed that officers were not clear on precisely their role. As such, both practice and innovation has varied across police regions and localized Police Service Areas.¹⁵

In line with a 'whole of government' orientation, VicPol has developed new policing objectives that are meant to align with broader social and public health priorities articulated in other government reports.¹⁶ For Victoria Police, these broader priorities can be broken down in terms of service delivery outcomes and social outcomes (Victoria Police, 2007, p. 8). Examples of service delivery outcomes include improving access to services, linking service delivery, and prioritizing prevention and early intervention. Examples of social outcomes include the enhancement of social integration, better support of disadvantaged groups, and a decreased prevalence of mental disorders.

The policing-specific outcomes established by VicPol are meant to reflect the fact that there are limits as to what police can do to help influence produce mental health outcomes (Victoria Police, 2007). While VicPol recognizes its contribution to wider government outcomes, it does not see itself as a *de facto* public health agency, but rather as an agency required to manage mental health-related events appropriately (e.g., respecting rights, communicating in an accessible manner, minimizing use of force), while making sure to avoid criminalization where possible (e.g., referring

¹³ According to Rhodes (2006, p. 22), 'joined-up' government in the United Kingdom contains two features: "horizontal co-ordination of central departments and agencies and vertical coordination of subnational bodies, irrespective of whether they are part of the government, the voluntary or the private sectors."

¹⁵ The State of Victoria is divided into four police regions (Western, Eastern, North West Metro, and Southern Metro). Each region is further broken down into dozens of Police Service Areas (PSA's).

¹⁶ Such reports include: A Fairer Victoria (Government of Victoria, 2005), the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003), and the Victorian Health Promotion Foundation Strategic Priorities 2006-2009 (Victorian Health Promotion Foundation, 2006).

to health services, including those deemed 'at risk', helping to respond effectively to persons with complex needs (which include dual diagnosis), and helping individuals access care directly from the health sector, rather than seeking care through the criminal justice system) (Victoria Police, 2007). At the same time, VicPol articulates what one might describe as a 'minimalist' view of their role (Marks & Wood, 2010), emphasizing their 'core functions' and the need to intervene only when their unique authority and capacities are required.

The Peace of Mind report noted that there are a variety of contexts in which police encounter persons with mental disabilities, and that it is important to broaden discussions of what police can do (from a minimalist perspective) to promote the outcomes above. The report noted that during consultations with stakeholders (which informed their review), it was common for participants to focus narrowly on the roles played by police in crisis situations or when they encounter offenders with mental disorders. When the writers/researchers broadened the discussion to include non-crisis encounters, or encounters with victims with mental disabilities, for example, the larger problem of what can be done was re-framed. The key problem identified by stakeholders was not about police capacity as first responders, although it was suggested that police would benefit from a greater awareness of symptoms and an understanding of response strategies. The larger concern centered on the ways in which police were able to mobilize mental health resources, and similarly the ability of such services to respond to police calls for help. In other words, the problem was not simply about police *per se*, but rather about the connections and interface points between police and mental health units (Victoria Police, 2007, p. 9).

In this light, VicPol distinguished between a primary and a secondary response capacity, which ties back to their understanding of their core function. The Peace of Mind report argued that, ideally, a mental health agency should take the lead role in responding to incidents, with police in a secondary role. The police should only assume a primary role if they are needed to protect the individual (who becomes violent) or others from harm if an offense has been committed. In other words, the police should only be involved if a *policing* role is required. This perspective is consistent with Victoria mental health law, wherein "[p]olice power to intervene for mental health purposes is limited to crisis situ-

ations to apprehend someone who has harmed themselves or others or is judged at imminent risk of doing so" (Victoria Police, 2007, p. 10).

Notwithstanding this circumscribed power of apprehension, there are various points at which police can 'broker' individuals to mental health and other resources in the community, and such individuals need not be limited to suspects or offenders. Australia's mental health service priorities, both at the national level and within the context of Victoria, focus on improving health and other social outcomes not simply to suspects or offenders, but also to all those who are affected by mental disabilities. Given that police are involved in numerous types of situations where disability may be an issue, they have the opportunity to assist with the mental health of not only suspects, but also victims, witnesses, missing persons, or simply everyday people requiring assistance. In other words, police can assist in non-crisis situations, and with a range of individuals with whom they encounter in the course of discharging service, order and crime control functions (Victoria Police, 2007, p. 17).

The subject of the police role being more preventive in encounters where mental disorders might be present (i.e., identifying problems before they escalate) is controversial in police circles because it can be understood as involving a more maximalist role for police, taking on greater responsibility for problems that may not call for their unique authority and capacity. Yet, the writers of Peace of Mind noted that police already play a preventive role in a range of circumstances. For example, when responding to family violence incidents VicPol officers are already required to identify a range of risk factors present, such as the expression of suicidal threats or the presence of delusional behavior. As well, they are able to identify instances of repeat disorderly behavior and explore the reasons behind these behavioral patterns (Victoria Police, 2007, p. 18). Both examples represent a 'problem-oriented policing' orientation (exploring opportunities for addressing the 'root causes' of widespread problems) to which we will return in the last section of this monograph. In such cases, however, the police capacity to intervene in the lives of persons 'at risk' or involved in recidivist offending is constrained by both criminal and mental health law. At best, police can recommend to citizens various treatment or other services, unless of course such individuals present a threat to the safety of themselves or others (at which point Section 10 of the Mental Health Act comes in to play) (p. 18).

As part of this preventive role, police may encounter individuals who may show early signs of a mental illness or who are manifesting co-occurring disorders or complex needs (e.g., depression combined with alcohol abuse). In such situations the emphasis is on the connectivity between police and a range of other social services including substance abuse treatment, counseling, mental health, and even housing services. The Victoria Department of Human Services, for example, developed a strategy in 2006, which centered on improving the conditions for family members with a parent suffering from mental illness (Victoria Department of Human Services, 2009). As part of this strategy, police are required, in the course of their routine encounters, to both identify and respond (e.g., referrals or notifications) to situations where parental mental illness is present (Victoria Police, 2007, pp. 18, 52).

While stressing prevention, VicPol also discovered the need to enhance the training and capacity of its police members in the handling of crisis situations.¹⁷ To this end it has recently enhanced its officer training which now consists of a two-day program that is mandatory for all operational officers, and some senior officers, once every six months (Government of Victoria, 2010). The new training program responds both to its own internal review as well as to recommendations made by the Office of Police Integrity (OPI) in its Review of Fatal Shootings by Victoria Police (Office of Police Integrity, 2005).¹⁸ The program gives officers tools to identify mental illnesses as well as signs of alcohol or drug abuse. This training is led by police, with the participation of a person with bi-polar disorder who comes to speak to officers about their experiences of mental illness (Donovan, 2010).

The extensive Peace of Mind report consists of over 60 directions for Victoria Police, all of which were approved for implementation beginning in April 2007. To date, over 80%

of these recommendations have been implemented. While it is not possible to cover all of the report's directions in this monograph, in general terms they fall under three broad areas of reform: 'Improving our knowledge and information', 'strengthening our internal and external partnerships', and 'updating police training' (Victoria Police, 2010b). As indicated above, VicPol has enhanced its training of operational officers.

A variety of knowledge and information initiatives have been implemented, such as the establishment of a Mental Health Knowledge Bank, an intranet portal that police members can access for information on such areas as state and local protocols, initiatives occurring locally, statistics, and research. The Victoria Police Manual has also been updated with rules and guidelines for assisting officers as they respond to persons with mental disorders. A protocol between VicPol and the Department of Health, aimed at clarifying the roles and responsibilities of the police and health partners, is also currently being developed (Victoria Department of Justice, 2010, p. 25; Victoria Police, 2010b). As part of its efforts to strengthen internal and external partnerships, VicPol has appointed 120 Mental Health and Disability Liaison Officers operating at local service area levels. Such officers carry an explicit mental health portfolio and serve as liaisons to the corporate level and externally. Together the officers serve as a network through which information can be disseminated and advice or feedback can be sought (Victoria Police, 2010b). As well, VicPol has participated in the PACER initiative discussed above.

In short, Australia has been ripe with innovation, both in the adoption and evaluation of crisis response programs and in the articulation of broader conceptual thinking around the range of roles police could play in contributing to better mental health outcomes among the population. This broader thinking can also be found in the UK.

¹⁷ A review of fatal uses of force by Victoria Police between November 1982 and February 2007 revealed a significantly disproportionate number of victims suffering from Axis 1 disorders, including psychosis and schizophrenia, compared to rates of such conditions in the general population (Kestic, Thomas, & Ogloff, 2010). Out of the 48 shootings studied, 42 shootings involved persons who had previous contact with the mental health and criminal justice systems, and approximately 40% of the cases involved persons with a drug or alcohol addiction (Kestic et al., 2010; Rose, 2010).

¹⁸ The Director of the OPI stated, "I have come to the view that Victoria Police officers' knowledge and understanding of people suffering from a mental disorder is, generally speaking, limited. It follows that the management of people with a mental disorder who come to the notice of Victoria Police could be improved and there is an urgent need for officers to develop skills in identifying, communicating with and managing people who are presenting with the symptoms of mental disorder." (Office of Police Integrity, 2005, p. 39).

United Kingdom

The United Kingdom, consisting of the countries of England, Northern Ireland, Scotland and Wales, has three key types of policing arrangements, all of which are overseen by the Home Office, responsible for issues of immigration, security and order across Britain. England and Wales have forty-three police forces and Scotland has eight regional services. The Police Service of Northern Ireland (PSNI), a national police service, was created in 2001, replacing the previous Royal Ulster Constabulary which had been in operation since 1922 (Sainsbury Centre for Mental Health, 2008; Mawby & Wright, 2005; London Metropolitan Police, 2010). With the exception of PSNI and some specialist police forces, British officers (including those in the London Metropolitan Police) are generally not armed, although do carry extendable batons, a factor that should be considered when comparing Britain with the other national policing contexts discussed here.

The London Metropolitan Police (the Met) was established in 1829 by Sir Robert Peel, and today employs over 33,000 officers responsible for policing a population of 7.2 million over 620 square miles. As part of their regular policing services, England and Wales also provide a unique second-tier service in the form of Police Community Support Officers (PCSO's), 4,700 of which work for the Met. The mission of PCSO's is community engagement; officers provide visibility and reassurance to the public, address disorder and minor offences, link with community partners and provide support to Met officers.

The PCSO's are one component of an overall 'neighborhood policing' philosophy that emphasizes officers working locally and visibly in their neighborhoods, with active participation of community members, to understand neighborhood concerns and address local priorities through new initiatives. To support this focus, England and Wales established a Neighborhood Policing Programme (NPP) in 2005 following an earlier pilot program (Mason, 2008). As part of this there are Safer Neighborhood Teams which consist of the police, the PCSOs and local neighborhood wardens/ambassadors (established by local authorities, who provide a visible presence in communities and assist with vulnerable populations) (UK Department of Health, 2009, p. 34). The teams work with local agencies and groups to devise tailored solutions to local problems.

The UK has long been committed to diverting offenders with mental disorders (MDO's) from the criminal justice system and at different points along the criminal justice pathway, from the pre-arrest stage to other stages of decision-making. Several key guidance documents have advanced this emphasis, including The Home Office Circular 66/90 Provision for Mentally Disordered Offenders (Home Office, 1990) which stressed that the criminal justice system should not be used as a channel for gaining access to treatment. A subsequent Home Office Circular added that inter-agency partnerships are important "as the means of making the most effective use of resources and of developing arrangements so that the treatment and care needs of mentally disordered people are met whether or not criminal proceedings are taken" (Home Office, 1995, p. 4).

The Reed Report (UK Department of Health and Home Office, 1992) was also released during the early 1990s following a review of services for offenders with mental disorders. It reinforced the argument that the health needs of offenders should be met by health and social services, and that such services should be provided, as much as possible, in the community and in close proximity to one's home or family (Chiswick, 1992, p. 1449). The report advocated for the diversion, as much as possible, of minor offenders with mental health and other complex needs (Pakes & Winstone, 2009, p. 158). It further stressed the need for multi-agency arrangements and an increase in community-based facilities in order to enhance rehabilitation and assist individuals with living independently (Chiswick, 1992, p. 1449).

Over the last two decades, diversion schemes have emerged across the UK, and operate at courts, police stations, or prisons as institutional points of diversion. Such schemes are known by several names: court diversion or criminal justice diversion and liaison schemes (CJLDs) or Mentally Disordered Offender (MDO) schemes, and they vary across all key dimensions—resources, structure, processes, objectives, target groups—partly to support local conditions and partly due to the absence of a national framework or standardized model (UK Department of Health, 2009; Pakes & Winstone, 2009; Sainsbury Centre for Mental Health, 2009a). Court-based schemes significantly outnumber those taking place at police stations, and have received the bulk of public and scholarly attention (James, 2000; McGilloway & Donnelly, 2004; Pakes & Winstone, 2009). As of 2008, for instance, out of 19 diversion and liaison schemes operating in Greater

London, only three were based at police stations (Nacro, 2008). In England and Wales more broadly, McGilloway and Donnelly (2004) note the existence of 40 police liaison schemes compared to 150 such schemes at the court level.

Our discussion here will center on the police station level, although there are some common challenges across the police and court-based initiatives (see Nacro, 2009¹⁹ for a recent directory of liaison schemes across England and Wales). Notably, both police and court-based schemes have declined in number over the years, despite a national commitment to country-wide implementation (Pakes & Winstone, 2009). Notwithstanding, the new Bradley Report (see discussion below) takes stock of the state of diversion across the criminal justice system, and makes various recommendations for renewing the country's commitment and advancing the diversionary agenda, with a special emphasis on bolstering police-based schemes (UK Department of Health, 2009).

Police custody liaison schemes

In contrast to the pre-arrest/pre-booking schemes discussed previously in this paper, the police custody liaison schemes take effect once an arrest has been made. One example of such a scheme is the CPN Police Liaison Service in Central London, which is run by Community Psychiatric Nurses (CPNs) (Nacro, 2009, p. 5). James (2000) published an early study of this program based on its first 31 months in operation and found some promising results. CPNs are linked to Community Mental Health Teams, which consist of nurses, doctors, and social workers who assist with the community-based care of individuals. Such teams have grown over the last four decades as a means of serving individuals who would have previously received treatment in hospital settings (Burns, 2004). 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 (James, 2000).

The initial scheme studied by James covered three police stations and has since expanded to two additional locations (Nacro, 2009). The pilot started with one CPN working across the three sites, and this grew to two CPNs in the second year. The scheme operated initially for five days per

week and then expanded to seven days per week. The CPNs were tasked with screening cases of persons in custody at the three stations (persons in 'custody suites')²⁰ and responding to referrals, which would come from custody sergeants or Forensic Medical Examiners (FMEs). Once a CPN receives a referral, he or she gathers background information on the case, and then conducts a history and mental state examination, which is carried out by conducting a semi-structured interview and completing a Global Assessment Scale. The CPN uses this information to develop a diagnosis, and then determines what would be the most appropriate means of addressing the needs of the offender, such as referral to a community agency or a hospital, and then makes the necessary referrals by contacting appropriate mental health professionals (James, 2000).

In studying this scheme, James (2000) was interested in finding out whether it was successful in identifying and helping persons who would otherwise not have been referred within the criminal justice process. He also wanted to determine whether the functions performed by the CPNs at the police station level served to leverage existing police and health resources effectively and whether they were duplicative of the work carried out by court-based diversion schemes. After 31 months in operation and the assessment of 710 cases, James found that most referrals came from custody sergeants (85%), demonstrating a good use of existing police resources leveraged by the existence of the CPNs. The remainder of the referrals came from the FME (4%), with 8% of assessments resulting from CPN screenings. The rest of the referrals came from social workers on duty at the police stations (James, 2000, p. 537).

Most individuals referred for assessment were male (80%) and without jobs (88.3%); almost half had no permanent housing (28.2% lived on the streets, 18.5% were in temporary accommodations; and only 53.2% had a fixed address). Over half had received psychiatric care (72.7% had previous contact with psychiatrists and 57.3% had previous psychiatric admissions). In 61% of cases, the individual concerned had previous convictions, 31% of which involved violent criminal offending. In 42.4% of cases, individuals were diagnosed with schizophrenia (James, 2000, pp. 537-540).

¹⁹ Nacro stands for The National Association for the Care and Resettlement of Offenders, a charitable organization in the UK.

²⁰ This amounts to a 'targeted' screening, as there weren't/aren't sufficient resources to screen every case coming into police custody (James, 2000, p. 550).

Based on the work of the CPNs, 31% of all individuals referred were admitted to psychiatric hospitals, with 91% gaining admission on the same day as the assessment. Another 44% referred to community agencies (local community mental health team, mental health homelessness team, psychiatric outpatients, or social services). Thirty-two percent of these referrals were to community-based services while 62% were to health or social agencies (James, 2000, p. 540). James adds that “[t]he take-up of these referrals was not audited, but the fact that the CPNs were able to initiate them is a measure of the potential of their role” (p. 551).

James (2000) also found that the work of the police scheme was not duplicative of the diversion taking place at the court level. Over the first 31 months of the CPN program, referrals at the stations increased by 400%, and the numbers of referrals occurring at the court level stayed at similar levels both before and after the police scheme was implemented. Over that time, 85% of referred individuals were released unconditionally by the police and 6% were given bail, which suggests that the offenders diverted at the police station level would not have engaged in serious enough behavior to reach the court level (and hence to reach the court diversion scheme). In fact, 60% of cases referred at the police station level involved summary offenses, compared to 22% of court-based referrals (James, 2000, pp. 551-552). James explained that there is a real opportunity to avert more serious offending behavior by diverting people early and at the police stage:

Police station cases were significantly more likely to be still (at least nominally) under the case of psychiatric services, to be on medication, and to have contacts with a CPN or social worker. They were significantly less likely to have criminal convictions. There is a possibility that ‘early intervention’ at this stage, at the police station, might be able to prevent a progression to further offending before eventual inception into psychiatric care (James, 2000, p. 552).

McGilloway and Donnelly (2004) evaluated a police liaison scheme in Belfast, and also found promising results, although they argued that the scheme could achieve even

greater results if there were enhancements to mental health services. The Belfast scheme, operating in the city’s largest police department, began operations in 1998. It was established to provide a timely mental health screening and assessment of persons in conflict with the law at the ‘point of arrest’ stage. Based on an assessment provided, the scheme, led by two Community Mental Health Nurses (CMHNs) arranges for referrals to health and social services (McGilloway & Donnelly, 2004, p. 264). According to a report prepared by the Criminal Justice Inspection Northern Ireland (2010, p. 18), the nurses are effective in making placements to health services due in part to their relationships with colleagues in Belfast hospitals.

In addition to screening referrals from magistrates, custody sergeants and Forensic Medical Officers,²¹ the CMHNs undertake screenings of all of the cases of persons detained in police custody, drawing from information contained in their Custody Record Forms (CRF). During this screening the nurses focus in particular on whether there are signs of mental illness or learning disability. They also take note of whether the individual was engaged in violent or ‘odd’ crimes or other troubling behaviors including self-harm. If an individual shows signs of mental illness, disability, and/or odd behavior, then he or she is subject to a psychiatric assessment (requiring the consent of the individual), which is performed with the use of various instruments including a Learning Disability Questionnaire, an Assessment of Risk Form and a Brief Psychiatric Rating Scale. The findings of this assessment are compiled in a report, which is accessible to the arresting officer, the court, and the individual’s attorney (McGilloway & Donnelly, 2004, pp. 264-266).

McGilloway and Donnelly (2004) examined the outcomes of the screenings over the first 18 months of the scheme’s implementation. They found that 16% of the CRF screenings identified individuals with one or more of the criteria for assessment (e.g., violent or odd behavior). It was only possible for the CMHNs to undertake assessments of 48% of this group, as the rest either refused to be assessed or the nurses were not on duty to carry out the assessment. Of the assessments carried out, most were completed (83%) within

²¹ Forensic Medical Officers (FMOs) are analogous to Forensic Medical Examiners. They supervise health care among detainees in police custody and determine whether offenders have sufficient capacity to be questioned by police. The FMO can also arrange for an assessment to determine whether detention under a Mental Health Order is appropriate (under a Mental Health Order a person can be transported to a place of safety and be held for up to 72 hours if he or she appears to be ‘in immediate need of care or control’) (Criminal Justice Inspection Northern Ireland, 2010, pp. 11, 17).

24 hours following arrest, and 48% resulted from nurse screenings of the CRFs (McGilloway & Donnelly, 2004, p. 267), meaning that there was a significant number of cases that would not otherwise have been captured through regular referral channels (e.g., custody sergeants, magistrates), a stated goal of the CRF screening process (p. 264).

Similar to the observations of James' (2000) London study discussed above—as well as a study conducted by Riordan, Wix, and Humphreys (2000) on a 'Diversion at the Point of Arrest' scheme in South Birmingham—McGilloway and Donnelly (2004) found that the bulk of assessed persons were male and 18% were homeless. Forty-four percent had previously been inpatients in psychiatric facilities. Ninety-one percent of assessed cases were deemed to be suffering from forms of mental illness including clinical depression, alcohol and drug abuse, and schizophrenia. The majority of assessed clients had a history of criminal behavior, a third of which involved property offenses such as theft, and 20% of which involved personal offenses, including but not limited to homicide. Fifteen percent (or 59) of those who were assessed were 're-presenters', having been through the scheme before (McGilloway & Donnelly, 2004, pp. 267-268).

Examples of recommendations provided by the CMHN's included referrals to General Practitioners (in 35% of cases), addiction services (in 23% of cases), and Community Mental Health Teams (in 12% of cases). In 79% of cases, the CMHN's provided 'educational advice and support' (McGilloway & Donnelly, 2004, p. 269). In only 10% of cases were individuals recommended psychiatric hospitalization or hospital assessment. Of the 312 assessed persons that the researchers were able to track at the court stage (in terms of dispositions received), 46% received bail to the community and 27% received custody. Most of the remainder was hospitalized or diverted (released without charge or released with a requirement to reappear or report back to the police station) (p. 268).

In their final analysis, McGilloway and Donnelly (2004) concluded that the CMHNs play a significant role in identifying persons with mental illnesses and complex needs, and that due to their training and background can recognize people in need more readily than criminal justice personnel, and can do so early on in an offender's pathway. This conclusion is consistent with Riordan and colleagues' (2000) broader support for such schemes due to their potential to intervene early and channel persons toward appropriate

forms of care and support. The Criminal Justice Inspection (2010, p. 18) has argued that this scheme, which is currently limited to Belfast, should be extended across Northern Ireland.

An 'all stages' conception

The Sainsbury Centre for Mental Health (2009a) set out to take stock of what we know about diversion programs while conducting its own study of 16 schemes, three of which occur at the police station level. In addition, the Department of Health recently released its exhaustive 'review of people with mental health problems or learning disabilities in the criminal justice system' written by Lord Bradley. Both the Sainsbury Centre and Lord Bradley took note of the patchwork system that currently exists as well a need to deepen the UK's efforts in institutionalizing diversion to match the spirit of police and guidance documents that have been released over the past 20 years.

These two reports also share a vision for what the Sainsbury Centre (Sainsbury Centre for Mental Health, 2009b) described as an 'all-stages' approach to diversion which encapsulates various points along the offender pathway. These are points at which components of the criminal justice system can link individuals to appropriate mental health care. The police play a pivotal role along this pathway. The 'all-stages' conception imagines 'early intervention' as occurring at the prevention, pre-arrest, and point-of-arrest stages. At the prevention stage, service providers such as faith-based organizations, substance abuse programs, and social services can assist with the provision of basic support in areas such as housing, employment, and advocacy, while at the pre-arrest stage, the police, Community Support Officers, and others can assist in identifying individuals in need before they reach a crisis stage and referring them to appropriate health-care services. Efforts at the point-of-arrest-stage include the police custody schemes discussed above as well as other efforts at the police level to be effective in the handling of offenders with mental illnesses (e.g., being adequately trained in mental health awareness and ensuring that 'appropriate adults' who can help arrestees are indeed appropriate and available) (Sainsbury Centre for Mental Health, 2009b).

In a similar vein, Lord Bradley expressed concern that court-based schemes have been unduly emphasized at the expense of other points in the system, especially at the police stage, that could contribute to early intervention. From this system-wide point of view, he sees the police as a central

step along the diversionary pathway, arguing that “there is a strong case for ensuring that screening and assessment take place at the earliest possible opportunity—at the police station. This is not only to inform the police in their assessment and handling of an individual, but also to inform charging and prosecution decisions by the police and Crown Prosecution Service (CPS) and further decisions at subsequent stages of the criminal justice system” (UK Department of Health, 2009, p. 132).

Even before the arrest stage, Lord Bradley argued that police can play an early intervention role, which should be well supported by the UK’s existing emphasis on neighborhood policing. In particular, he suggested that Local Safer Neighborhood Teams should be positioned to identify people involved in minor offending or anti-social behavior who may need assistance to address mental health conditions. These teams could provide referrals or work in partnership with local agencies to address needs (UK Department of Health, 2009, p. 36).

Lord Bradley further noted that police in the UK, with a few exceptions, are generally not trained well in mental health awareness and that this training needs to be enhanced. He also noted that officers’ awareness of local services, to which they can refer offenders, is generally inadequate. He argued that both Community Support Officers as well as regular police officers should partner with local mental health services in the development and delivery of mental health training (UK Department of Health, 2009, pp. 36-37).

In advancing the diversionary agenda in the UK, Lord Bradley recommended that a National Programme Board be established, which would involve all key stakeholders from various sectors of government and be charged with a national approach that would improve outcomes for individuals with mental health and disability issues. One of the tasks of this Board would be to oversee the creation of a nation-wide model for Criminal Justice Mental Health Teams, which would be charged with tasks such as screening and assessment, liaising with community services, and managing information about a person’s case throughout the criminal justice pathway. The Teams would cover both police and court locations (UK Department of Health, 2009, pp. 130-131). The UK Government is currently acting on Lord Bradley’s various recommendations (UK Ministry of Justice, 2009).

Similar to the ‘whole of government’ approach found in Australia, this ‘all-stages’ conception serves to broaden the roles of police in assisting and diverting persons with mental illnesses beyond the crisis intervention stage. In integrating the crisis response frameworks (police-based and co-response models) with this larger preventive conception, one can imagine a conceptual model that encompasses points along the policing continuum at which police (and their partners) can play different roles in diverting individuals into appropriate systems of health care, including both mental health services as well as other programs that address co-occurring disorders including substance abuse. Before we elaborate on this conceptual model we briefly summarize the key similarities and differences across the interventions reviewed in this paper.



Key similarities and differences across interventions

While the countries we have examined vary in terms of political organization and policing structure, there is considerable convergence at the level of innovation, especially in regards to pre-arrest and pre-booking crisis intervention schemes. The US has been undoubtedly very influential in the development and diffusion of models, as seen in the degree to which the police-based crisis response and co-response models developed in the US have been taken up and adapted to circumstances in countries including Canada and Australia. Even in Britain, where police custody schemes have dominated thinking and practice, the need for enhancing police response capacity, as has been advanced in the US, is strongly acknowledged.

At the pre-arrest/pre-booking stage, two core features of interventions can be discerned across the police-led and co-response initiatives reviewed here. The first is the enhancement of police awareness and training in relation to both identifying the signs and symptoms of mental illnesses and co-occurring disorders as well as responding appropriately to persons in crisis to avoid their unnecessary involvement in the criminal justice system. A second core feature of pre-booking/pre-arrest interventions is the establishment of inter-agency arrangements which can ensure that persons with mental illnesses receive appropriate and continuous care from the health sector. The intent is for officers on the ground to be adequately supported by arrangements that allow for the swift transfer of persons under their charge to appropriate treatment or emergency facilities. Such arrangements can come in various forms, including protocols with medical triage centers.

Recent work has been done in the US to establish an inventory of 'essential elements' required for effective crisis response programs, including but not limited to collaborative planning and program implementation structures, training of officers, dispatcher protocols, safe and appropriate trans-

portation arrangements, information exchange between police and their health partners, and extensive police organizational support of such specialized programs (Schwarzfeld et al., 2008; Reuland, 2010). Agreement on such essential elements can form the basis of future research designed to compare programs across sites, both in terms of related outcomes as well as in terms of fidelity to each element within program locales (Compton, Bahora, Watson, & Oliva, 2008, p. 54). As we discuss further in the next section, while further comparative research is important for strengthening both thinking and practice in this area, individual studies to date have had some flaws and limitations, an issue which Compton and colleagues raised in regards to the popularity and diffusion of the CIT model. They stated that "research is crucial, especially considering that CIT is uncritically being touted as a model program and being adopted rapidly and broadly" (p. 53).

The innovations reviewed here are not limited to the pre-booking/pre-arrest stages of intervention. The UK is unique in the attention it has given to issues of police management of persons while in police custody. Police-based liaison or diversion schemes are common in the UK, although not as numerous as schemes based at the court level. Improving the level and quality of assessment for mental health and co-occurring disorders while persons are in custody is a central concern of such programs. Similar to the crisis response interventions seen in the US, Canada, and Australia, an essential element of police custody schemes is the existence of strong and sustainable links to the health care sector to improve not only appropriate referrals in the first instance, but also to ensure continued follow-up and care.

Tracking the progress of individuals diverted from custody over the long-term has proven to be especially challenging, given that individuals may not, on their own, comply with continued conditions of treatment including routine visits

to doctors and remaining on medication. In the UK context, McGilloway and Donnelly's (2004) review of police custody diversion found that given the extent to which assessed persons had previous experience with psychiatric care, there are obvious problems with their continuous engagement of mainstream services and a lack of success with such services in preventing offending. Effective and sustained interventions by the health care system are made especially challenging, they argued, due to the presence of complex needs or dual diagnoses which "require a more flexible, co-ordinated and integrated service response" (p. 273).

Conceptualizing points of intervention along the policing continuum

In the UK and Australia in particular, there have been explicit attempts by police, policy-makers, advocates, and researchers to broaden our conceptualization of what police can do to make a difference in the lives of persons with or affected by mental illnesses.²² Many of the models reviewed above focus on the crisis response capacity of police which, in the eyes of some, is too limiting a view of how police, in various roles and in the variety of situations they are asked to handle, can contribute to better mental health outcomes for the individuals they serve. As Cordner (2006, p. 2) wrote, current police interventions "have been targeted almost exclusively at improved handling of individual incidents. Little attention has been devoted to developing or implementing a comprehensive and preventive approach to the issue." Can police indeed play a more expansive, preventive role beyond the effective handling of persons in crisis or while in custody?

Victoria Police in Australia and the Sainsbury Centre for Mental Health in the UK have articulated an understanding of the police role that acknowledges the various points at

which front-line staff, or other personnel, come into contact with persons affected by mental illnesses, either as persons 'at risk' or in crisis. Some citizens that police encounter may not be experiencing mental illnesses themselves, but may be affected by family members who are in crisis or in need of better long term care. Other persons may be victims of crime who are mentally distressed, or it could be that certain missing persons are experiencing a mental health crisis. As well, everyday people who are simply requesting police assistance may show signs of mental illness. In theory, then, it is not simply suspects or offenders with mental illnesses that police can help in the course of their daily routines, which (as we discussed earlier) often do not involve crime control or law enforcement functions.

Possible points of police intervention could therefore be conceptualized along a continuum, one end of which involves police playing a preventive role, identifying persons at risk of entering into crisis situations, or identifying persons with family members who may be in crisis but may or may not have come into conflict with the law. The other end of the spectrum involves police arranging for appropriate assessments of mental illness and co-occurring disorders once a person has been arrested. When a crime has already been committed, the custody stage represents a final point at which police can channel persons into appropriate systems of care, whether this involves community-based mental health treatment, substance abuse programs, or psychiatric hospitalization. In the middle of this continuum is the crisis intervention stage, where police play crucial roles in determining which criminal justice-based or health-based responses will best contribute to public safety as well as to long-term mental health outcomes for the individual concerned. This continuum is captured in Table 1 on the opposite page.

²² This attempt at more broadly re-framing the debate appears to have occurred to a lesser extent in Canada and the US, with of course some exceptions (see for example the Canadian Association of Chiefs of Police, 2006 and Cordner, 2006 respectively).

Table 1: Intervention points along the policing continuum ²³

Persons affected by mental health problems	Prevention	Pre-Arrest	Point of arrest (including transport and custody)
	<ul style="list-style-type: none"> ● Referral/notification to relevant agency or service ● Community-based prevention program 		
Person at risk (of victimization or offending)	<ul style="list-style-type: none"> ● Referral to agency or program ● Community-based prevention program 		
Complainant or witness	<ul style="list-style-type: none"> ● Referral to relevant agency or service 		
Missing person	<ul style="list-style-type: none"> ● Referral to agency or program ● Community-based prevention program 		
Victim	<ul style="list-style-type: none"> ● Referral to agency or program ● Community-based prevention program 		
Person involved in disorderly conduct (with minor or serious behavioral disturbance)		<ul style="list-style-type: none"> ● Diversion/referral Crisis Intervention ● Appropriate use of anti-social behavior/disorder laws ● Community-based prevention program 	<ul style="list-style-type: none"> ● Appropriate transport vehicle (with police car as a last resort) ● Assessment and liaison/referral while in police custody ● Appropriate and swift handover at psychiatric facility
Suspect/offender involved in personal or property crime (with minor or serious behavioral disturbance)		<ul style="list-style-type: none"> ● Diversion/referral ● Crisis Intervention ● Community-based prevention program 	<ul style="list-style-type: none"> ● Appropriate transport vehicle (with police car as a last resort) ● Assessment and liaison/referral while in police custody ● Appropriate and swift handover at psychiatric facility

This table works to de-center the offender/suspect as the primary or exclusive focus of intervention. For instance, officers may encounter a person in a state of neglect (e.g., a child or aging parent of a person with mental illness or a person with mental illness not properly cared for in their family situation). In such cases, police may be able to refer this individual to appropriate social services. If the problem of neglect is widespread in a community, officers may be able to work collaboratively with community agencies and groups to develop a focused community-based program.

As another example, officers may also routinely encounter persons who appear to be at risk of becoming either victims or offenders as a result of mental illness and/or co-occurring disorders. Armed with the appropriate knowledge of health and social services, police may be able to refer such indi-

viduals to needed systems of support and care. Victims and witnesses may also show signs of emotional distress, which, if spotted by police, could be appropriately handled through referral mechanisms.

The broader conception of the police role as encapsulated in the above table does not imply that officers become *de facto* mental health workers providing direct mental health services. Rather, it suggests that police, at all of these points along the continuum, would need have functional links with various agencies and programs in the health sector that allow them to ‘broker’ individuals to the systems that have the capacity to manage them. Such linkages would need to be seamless and efficient so that police do not deviate from their core functions of law enforcement, public safety, and order maintenance. As well, individual police officers would

²³ This table was inspired by, and draws from, conceptual models developed by Victoria Police (2010b), Australia, the Sainsbury Centre for Mental Health (2009b), UK, the UK Department of Health (The ‘Bradley Report’ (2009)), and Cordner (2006).

need to have strong and trusting relationships with the community members they serve so that referrals, or the offer of community-based prevention programs, would be accepted voluntarily (as they would need to be) and with gratitude. Police would need to be ‘procedurally just’ (Tyler, 2004) in their encounters with suspects, offenders, victims, vulnerable persons, and others they encounter, acting in ways that are fair and respectful and that give ‘voice’ to those in need. Without police relating appropriately and sensitively to those they encounter, ensuring legitimacy with the public, prevention work is difficult, and officers’ suggestions for help may be met with defiance. Legally, as previously reviewed, police cannot coerce persons into getting assistance unless of course they have reached a point of crisis that is jeopardizing their own safety and that of the public.

The degree to which a police organization wishes to embrace this broader conception of their role along this continuum undoubtedly depends on the characteristics of the jurisdiction in which they operate and more broadly on broader government policies. In the UK, the existence of a neighborhood policing program, supported by Community Support Officers provides both an ideological and structural framework within which police can work with communities to develop community-based prevention programs that address behaviors that would not otherwise be the subject of effective referral or diversion in crisis-based intervention schemes. The ‘whole of government’ orientation of Australia, combined with the rather simple organizational structure of policing in the country, may be more conducive to the advancement of this broader view at different levels of policy and practice. Victoria Police, for example, has explicitly aligned itself with government agendas—as encompassed in various strategic documents—at the federal level. It is also rather more straightforward for the country to have a national focus on community policing and partnerships as strategic pillars in policing at the state level. Cross-sector partnerships are obviously essential to fulfilling a whole-of-government vision, and this is no less the case with respect to the criminal justice-mental health interface. In contrast, the multi-layered jurisdictional nature of the US may prove challenging to the alignment of mental health and criminal justice priorities across all levels of government. Developing and testing interventions that suit the needs of communities may necessarily be highly localized in nature, focusing on cities, parts of cities or county-level priorities and circumstances.

The need to think and act locally was of course borne out in previous discussions about differences in urban and rural areas. Mental and physical health infrastructures in terms of availability, accessibility, and resources tend to vary considerably across urban and rural areas. This might mean that police do not have the health resources to engage in early prevention and must necessarily limit what they do to a crisis intervention role. On the other hand, rural and remote areas can also be highly conducive to community-based, partnership policing because the citizen/officer ratio is lower, and officers have the opportunity to get to know the citizens they serve as well as the agencies and services that operate in their area.

Parts of urban cities that may be plagued with dual diagnosis issues due, for example, to the spatial overlay of drug markets, poverty, and homelessness, may pose such a strain on police resources that doing anything other than crisis response is impractical. At the same time though, such areas may be (ironically) resource rich, with numerous community-based groups, treatment facilities, and services that could potentially work along the prevention continuum with police, provided there were concerted efforts at the city level to make this happen.

Taken together, the interventions reviewed in this monograph provide for a broad conception of the police role articulated here. The notion of a policing continuum simply provides a framework within which police and their health partners can think about what can be done and how. The framework implies that a comprehensive approach to the advancement of population-level mental health on the part of the police would entail both working at all stages of this continuum and being able to track outcomes along the way. At the same time, the need to design and tailor interventions suited to community contexts is essential. For example, it may not be necessary or practical in some contexts to work at all levels of this continuum or to devote highly limited policing resources to persons in need beyond offenders who pose a public safety threat. What we argue in the next section however, is that extensive problem analysis and ‘research-informed policy and practice’ (Rueland et al., 2009) is more essential to the design and evaluation of innovations than the (uncritical) diffusion of models (see Compton et al., 2008) that may not properly suit the needs and conditions of particular jurisdictions.



Recommendations for future research and practice: A problem-oriented, place-based perspective

In what follows we argue for what Reuland (2010) describes as a ‘process-oriented’ versus a ‘model replication’ approach to the development and testing of police interventions designed to balance the needs of public safety with the improvement of population-level mental health. In particular, we draw from and build upon current thinking in three related strands of criminology: evidence-based policing (Sherman, 1998), place-based criminology (Weisburd, Bernasco, & Bruinsma, 2008), and Problem-Oriented Policing (H. Goldstein, 1990).

A growing body of research designed to prove ‘what works’ in policing has shown that interventions, which are generic and unfocused (i.e., not responding to the particularities of certain problems, or not targeted to the spaces and places where problems cluster, such as city blocks or neighborhoods) do not reduce crime and disorder (Weisburd & Eck, 2004). Developments in place-based criminology suggest that problems of crime and deviance have often been examined at geographical levels of analysis that are too macro (e.g., entire cities or states), and that it is important to move down the ‘cone of resolution’ (Brantingham, Dyreson, & Brantingham, 1976) in order to capture the micro-spatial dynamics of criminal activity (i.e. the highly localized social and environmental conditions that generate risky behavior). Problem-Oriented Policing (POP) is based on the proposition that the police role is to help solve social problems and not simply to enforce the law. As such, it is vital for police to understand the nature and patterns of the problems they confront, to do extensive analysis of such problems, to design interventions that focus on problem resolution, and to evaluate whether or not such interventions work.

While these criminological strands have been applied primarily to problems of crime and disorder, we suggest they can be fruitfully applied to the problem of mental illness and more broadly, to the risky and unhealthy behaviors that police confront on a routine basis. In other words, mental illness and co-morbid conditions (including substance abuse) constitute a large category of social problems that the police are tasked to handle. Understanding how exactly those prob-

lems manifest, and in what spaces and places they cluster, is fundamental to effective problem identification, analysis, and intervention. We comment here on the essential elements of a problem-oriented perspective. In so doing we note areas of weakness in current research, based on the countries reviewed here, that need to be addressed if police organizations and their health partners want to both tailor interventions to the needs of their constituents while evaluating the effectiveness of such interventions along desired outcomes.

Problem identification and analysis

In reviewing developments in the countries discussed here we found that there is often a basic lack of data collection taking place in police organizations in regards to the nature and prevalence of mental health problems they encounter in the course of their daily routines, especially as regards to suspects/offenders, witnesses, victims, or others, as well as the outcomes of such encounters. This is in large part due to the fact that police performance has not traditionally been assessed in relation to health effects and associated processes including criminalization. This issue appeared to be universal across the jurisdictions reviewed here, and it seems equally problematic across the interface of police and mental health systems. Shared data collection and analysis—necessary for system-wide approaches and evaluations—is especially challenging within cross-sector partnerships.

Cotton and Coleman (2010) identified this issue in relation to the Canadian context. They stated that the lack of national standards for police data collection presents a significant obstacle to developing an evidence base for police interventions. Specifically, the nature and frequency of police interactions with persons with mental illnesses is not uniformly captured by Canadian police (Centre for Addiction and Mental Health, 2010; Cotton & Coleman, 2010). Recent research for the Vancouver Police Department (VPD) and the Vancouver Police Board encountered this weakness in attempting to track trends in the incidence of calls to the VPD for service involving persons with mental illnesses (Wilson-Bates, 2008).

The ways in which data are currently captured by police make it rather difficult to identify the precise nature of mental health-related problems that police encounter. In the Vancouver context, for example, data generated from the VPD's Computer Aided Dispatch (CAD) system only sheds partial light, and sometimes this light can obscure the true nature of calls. When a person phones 9-1-1, the operator must decide how the incident will be recorded for the purpose of dispatch. The operator must choose from over 100 incident types the one that most accurately describes the nature of the occurrence. While there are some incident types that are specifically mental health related, such as a suicidal person, there are many generic categories of behavior that may or may not involve a person experiencing a mental health problem. The operator is making a decision based on limited information, and this in turn limits the knowledge available to the responding officer prior to arriving at the scene. Wilson-Bates provided the example of a person being reported to be walking down a street in rush hour screaming obscenities. This incident could be coded differently as 'a person annoying,' 'disturbance,' 'noise complaint,' or 'suspicious person' (Wilson-Bates, 2008, p. 6).

A recent report by the Centre for Addiction and Mental Health (CAMH; 2010) also noted problems with the quality and uniformity of Canadian police data on both the nature and number of officer contacts with persons with mental illnesses. In collecting data on both encounters as well as diversion practices, CAMH relied on a survey that they administered to police services across the province. This survey was pivotal because "there is no standardized central data source in Ontario on police encounters with persons with mental health concerns" (CAMH, 2010, p. 34). In terms of future research, the report authors suggested that it is important to re-visit the reporting practices of police organizations with a view to developing standards in this area. Cotton and Coleman (2010) also pointed to the weak evidence base surrounding the nature and extent of victimization of persons with mental illnesses.

Victoria Police in Australia found that there was limited data on both the nature of encounters between officers and citizens with behavioral disorders as well as the outcomes of such encounters. As such, it was difficult to assess the organization's effectiveness and determine opportunities for

improvement. There were no databases designed to capture mental health information relevant to an incident, although aspects of such an incident could be recorded in several different databases, which were not focused on mental health considerations. In short, the knowledge management system of the police had not traditionally been centered on gathering mental health-specific information, nor has an information infrastructure been in place to link relevant bits of information from different databases (Victoria Police, 2007, p. 33).²⁴

From a Problem-Oriented Policing perspective, it is important for police to first improve the ways in which they gather basic data on the nature and outcomes of encounters involving persons affected by mental illnesses. One means of addressing this limitation, suggested by Cordner (2006), is to undertake a study where police officers and dispatchers are asked to record incidents involving persons with mental illnesses or emotional disturbances for a certain period of time to establish a trend. In the Vancouver context, Wilson-Bates (2008, p. 9) took this kind of approach, where she developed a simple card for certain officers to complete and submit at the end of their shifts over a selected period of time. For every incident, the officer circled 'yes' or 'no' in relation to whether it involved one or more persons "whose mental health was a contributing factor in police attendance."

There are a variety of questions that police departments can ask themselves in trying to get a handle on the nature and distribution of local problems. Apart from knowing the frequency of different types of incidents they experience during certain periods, they can also collect data (as researchers have done in existing studies) on how often they use different dispositions (e.g., referral, arrest) for different types of incidents. The presence of other co-morbid conditions or diagnoses could also be captured, such as the number of individuals who are homeless (see Laird, 2007) or who abuse alcohol or other substances. Even data on other characteristics of persons with mental illnesses, such as gender and age, could be routinely captured by police to assist in the analysis of trends (see the work by Hunter, Boyce, & Penfold, 2007 and Hunter, Boyce, & Smith, 2008 who focused on experiences and outcomes for women in diversion schemes). Police can also take advantage of data collected by other agencies to assist with system-wide identification and analysis of

²⁴ Victoria Police is currently developing improvements for linking databases and modifying the ways in which data is recorded (Victoria Police, 2007, p. 33).

problems and trends. Such data include court outcomes, emergency department data on people diagnosed with a mental disorder as well as data on at-risk populations (e.g. indigenous people, children) (Victoria Police, 2007p. 36).²⁵

Spatial analysis

Place-based thinking (Weisburd et al., 2008) and more broadly environmental criminology dovetail with ecological approaches to health that seek to understand where persons with mental illnesses, or those who engage in risky behaviors such as substance abuse, cluster and why (Burriss, 2002). Areas where clusters are found could include particular blocks or neighborhoods or even 'micro-places' like clinics, groups homes, and shelters. Certain days of the week might also contain more incidents of some behaviors, as might certain months of the year (Cordner, 2006). Current developments in geographic software and spatial analysis allow police, both alone and/or in conjunction with research partners to geographically map where (and even during what time periods) mental health and dual diagnosis-related incidents and problems are concentrated, which gives police a very clear indication of where to focus their limited resources. The Philadelphia Police, for example, have taken this spatial approach to the policing of violence (Ratcliffe, Taniguchi, Groff, & Wood, in press).

With the appropriate systems of data collection in place (as discussed above) police might discover a spatial overlay of issues (Cordner, 2006, p. 6). For instance, they might find that high rates of mental disturbance are concentrated in areas with high rates of homelessness (as others have already found – see Wilson-Bates [2008] on the Vancouver context). Or, illegal drug markets or even alcohol outlets might be operating in areas where there are high rates of mental disorder and substance abuse co-morbidity. In such areas, it would be important to assess current police order maintenance and drug enforcement strategies to determine whether police may be enabling the criminalization of persons with co-occurring disorders (i.e., through targeted drug enforcement sweeps) rather than channeling persons in need into appropriate systems of care.

Police agencies in the US and elsewhere routinely engage in 'crime mapping', often facilitated by the work of crime analysts who geocode police data to produce spatial representations of crime patterns and trends. With better and more systematic data on mental health-related incidents and encounters, including that which captures co-morbid conditions, police can generate a deeper spatial understanding of problems which can in turn inform their analysis of why and how such problems occur and what interventions might best address them.

Resource mapping and analysis of 'nexus' arrangements

While not often an explicit component of problem-oriented thinking, we suggest that equally central to localized problem mapping and analysis is a focus on the size (resources), location, and arrangement of local police and mental health, substance abuse, and other resources. Understanding the nature and distribution of local problems compared to available resources can give police a realistic idea of what collaborative arrangements might be possible. It could be that a community is resource rich and that a rather elaborate partnership model for referral and diversion could be established. Or, it could be that simple protocols around specific processes, such as swift handovers to emergency department personnel, are all that is conceivable within a resource-limited environment. Knowing the distribution of both mental health as well as other health resources that address co-morbid disorders is especially critical, given that mental health-specific services are not traditionally well linked to, or coordinated with programs such as substance abuse treatment.

The resources available in a community constitute what Morabito (2007), drawing from Bittner (1967), described as an important part of the 'scenic horizon' perceived by officers (see discussion at the outset of this paper). If mental health resources are not readily available, especially within a reasonable radius of where an officer is working, or if officers perceive such resources are inadequate or difficult to negotiate, they will tend to prefer non-mental health dispositions

²⁵ According to Victoria Police, approximately 50% of missing persons have a mental illness and 11% (and possibly more) of family violence reports indicate the presence of mental health factors in one of the parties involved (Victoria Police, 2010).

(Morabito, 2007, p. 1584; see also Cotton, 2004 and Wilson-Bates, 2008). It is therefore vital to understand this aspect of the scenic horizon before developing and testing a given intervention.

A deeper level of resource analysis is especially important in not only grasping the quantity of police and health resources and their existing links but also the quality of such links. The term ‘nexus’ refers to a linking or binding, and there may be numerous nexus arrangements in operation, ranging from informal codes of practice to more formalized collaborative service delivery arrangements. Without understanding the nature and depth of such nexus arrangements, it is difficult to determine the kinds of interventions along the policing continuum that might be possible in a given area.

Knowing a community’s system of resources and nexus arrangements can therefore allow police to know what they have to work with and how they can move forward to develop shared solutions. One means of undertaking this resource mapping and analysis is Rapid Policy Assessment and Response (RPAR, 2004), a community participatory rapid assessment method that explicitly addresses laws and law enforcement practices. This approach focuses in part on creating a ‘power map’ that is “a picture showing the *formal* and *informal organizations* that wield influence over (or “govern”)” conditions and behaviors (RPAR, 2004, p. 2). It sees police, along with other groups and organizations, as distinct ‘nodes’ that address aspects of particular social problems (Shearing, 2001; Wood & Shearing, 2007). A component of the RPAR approach is a textual description of internal nodal characteristics. Emphasis is placed on nodal level material *resources* (e.g., money, equipment), *mentalities* (i.e., ways of thinking about or ‘making up’ a problem), and *tools of influence* (e.g., legal levers that induce compliance), and the regulatory logics they embody (e.g., coercion, rehabilitation).

Added to the RPAR power maps are ‘influence connections’ or relationships of influence among the nodes/organizations on the maps. Within a participatory action research framework, organization representatives are asked to comment on which nodes they influence, and conversely, which nodes influence their actions. A defining feature of the RPAR methodology is that it consists of a set of practical tools for nodal and power mapping that can be used by practitioners and community stakeholders. The usual vehicle for doing RPAR

is a Community Action Board (CAB) where participants are trained as researchers who can collect data in simple ways to feed into the power maps. Once they make these maps, they work deliberatively to assess them, identify power blockages, and identify laws, policies, and practices, which they could reasonably change in order to create new nexus arrangements and make the best use of nodal resources in a system. The RPAR method has been used at the city level to foster collective strategies to improve access to services and reduce the negative effects of policing on populations of concern (Sobeyko et al., 2006; Vyshemirskaya et al., 2008).

Problem identification and analysis, combined with a resource mapping and analysis, are therefore central to the design and tailoring of interventions that suit community needs and conditions. The framework of the policing continuum introduced previously can serve to guide the generation of ideas for interventions to try and test.

Designing and testing interventions

This problem-oriented perspective is supported by a recent discussion by Schwarzfeld and colleagues (2008) on the needed elements involved in designing and implementing an effective police-based response to persons with mental illnesses. They suggested that interventions must be tailored to the nature of the problems in a given community and that community partners—in the form of what they propose to be a planning committee—must lead the planning, coordination, and evaluation of new specialist responses. They stated that,

“[a]s a critical first step in the design process, the planning committee should develop a detailed understanding of the problems in its jurisdiction and identify all contributing factors...It should look at law enforcement data on calls for service, beat boundaries, feedback from officers, community survey data, and other sources of information. To enhance their understanding of root causes and available resources, committee members also should examine factors such as the community’s inpatient and outpatient treatment options, crisis response services, ancillary services such as housing and substance abuse treatment, population, and geography.” (Schwarzfeld et al., 2008, p.2)

In exploring the full potential of Problem-Oriented Policing (POP), Tilley (2010, p. 188) brought in the analogy between criminal justice and public health, suggesting that POP is “the crime and disorder counterpart to scientific medicine and health improvement...” He noted that in historical terms, the public health field has been farther along than the criminal justice field in advancing evidence-based practice based on collaborative research partnerships. Just as health researchers have worked closely with clinicians to develop and test health solutions, so too, he argued, should criminal justice researchers work closely with police to develop and test solutions to crime and disorder. Of course, there have been some notable criminological exceptions to this contention, and there appears to be a groundswell of research devoted to combining research and ‘clinical’ work. We suggest that this thinking needs to be applied across the fields of policing/criminal justice and public health so that health solutions can become an important focus of POP.

Following the logic of POP, the identification and analysis of problems leads to the identification of concrete outcomes against which the success of an intervention can be measured. The analysis of resources and nexus arrangements provides the basis for determining procedural and infrastructural elements of an intervention which themselves need to be measured by clear process-level indicators. Researchers have noted, however, that evaluations of interventions in the real world are incredibly challenging, both at outcome and process levels. The nature of interventions may change over time,

and continuous fidelity to a model may not always be guaranteed (Compton, Bahora, Watson, & Oliva, 2008; Watson et al., 2008). Determining whether a particular intervention is more desirable than another requires the use of control groups, which have tended to be absent in research to date (Hartford et al., 2006; Sainsbury Centre for Mental Health, 2009a; Tucker, Van Hasselt, & Russell, 2008; Watson et al., 2008; Winstone & Pakes, 2009). Longitudinal designs, which are central to tracking long-term outcomes, have also been rare (see an exception with Lattimore et al., 2003). It would seem that strong research collaborations between police, health agencies, and academics are now, more than ever, required to develop the most robust evaluation designs that can help build up the evidence base in this field.

Another evaluation challenge relates to comparing interventions across jurisdictional contexts, and especially country contexts. If true comparisons are to be made across country contexts like the US, Canada, the UK, and Australia, it is important for the future to identify variables that can be consistently and reliably measured (Hartford et al., 2006). Yet, it may be virtually impossible to fully compare interventions across contexts that differ politically, legally and philosophically, except along generic lines (e.g., trends in persons diverted from the criminal justice system). Perhaps the best lessons to be learned from international, comparative research come in the form of a pool of ideas that can shape global conceptual developments while inspiring local practice.



Conclusion

In the course of their daily routines, police officers encounter persons suffering from, or affected by, mental illnesses. The intervening decades since deinstitutionalization have witnessed an unacceptable increase in the numbers of persons with mental illnesses that have been left without appropriate systems of care and support. The unintended criminalization of such persons has grown over time and become a widespread concern of crisis proportions across the globe. Deinstitutionalization has amounted to a reinstitutionalization of persons through the criminal justice system.

The need for police to better manage persons with, or affected by, mental illnesses has been recognized for some time. The US has seen a flurry of innovation centered on the development of police-based and co-response models designed to improve the knowledge and capacity of officers in the management of situations with persons in crisis. Other countries have followed the lead of the US, taking up approaches developed in the US and adapting them to local circumstances. US-based models, especially the Crisis Intervention Team approach has diffused (and some would say uncritically) across the globe with great speed. Essentially, there is a consensus in thinking across the US, Canada, Australia, and the UK, on the need for police to be more aware about mental illnesses, and more knowledgeable about how to address citizens' needs, for various reasons, including ensuring the safety of encounters and diverting persons in need of care to systems that can provide this for them.

Our review further discovered that the crisis intervention role may be too narrow a conceptualization of what police can do to contribute to the health of persons suffering from mental illnesses and co-morbid disorders. In this paper we developed a conceptual framework, inspired by and drawing from what we have found, that sees the police having opportunities to make a difference at various points along a continuum of service delivery. There are opportunities to reduce criminalization at the police custody stage, as was discovered in the UK context, but there are also ways of being more preventive, assisting persons before they might reach crisis points, and working collaboratively with community agencies to develop community-based programming. Police interventions need not focus simply on serious manifestations of mental illness; they could potentially assist persons with chronic, but more minor behavioral disturbances. Furthermore, suspects and offenders need not be the only focus. Police routinely encounter victims, witnesses, missing persons, or simply

everyday persons in states of neglect who could be assisted through brokerage to the health system.

Whether or not any given police organization can adopt this broader view of their role depends on a variety of factors, including philosophy (commitment to partnership-based, community policing), resources, the structure and politics of government, and community needs and conditions. As such, we argue that the design, implementation, and testing of one of more interventions in a given locale must be driven by a thorough analysis of community needs, priorities, and resources (including what we describe as nexus arrangements between police and health organizations). From a criminological perspective, we draw from and extend upon the pillars of Problem-Oriented Policing, an approach to strategic planning that begins with analyses of problems before interventions are devised, and before initiatives are tested.

Doing both problem analysis and resource analysis is no doubt highly challenging, and in the face of this challenge, police organizations may be persuaded to doing 'model replication' (Reuland, 2010) rather than tailored innovation. We suggest that the latter approach is more fruitful, and ultimately more sustainable, as police and their health partners can focus their resources on problems and inter-agency linkages that need the most attention. Perhaps the biggest challenge with this problem-oriented approach is the data collection and mining that is required, not only within police organizations, but also across the wider service delivery system. If done well, however, this data analysis process can inform the development of clear outcomes which can be tracked over time. We further argue that this problem-oriented approach should have a spatial focus, one which examines problems, and their potential solutions in micro-level contexts. This spatial focus may be particularly valuable in comparing needs, and related possibilities for change, across urban and rural areas and even within smaller spaces of large cities.

We add that collaborative research between police, health agencies, and academics in the process of research and innovation is critical to the advancement of this problem-oriented approach and to the reduction of the theory-practice divide that has tended to plague the field of policing research. Most importantly, such collaboration provides the best opportunity to both build theory as well as advance the evidence base on what works in real-world settings.

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Endnotes

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