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RESEARCH REPORT

Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey†

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Mental health diversion is a process where alternatives to criminal sanctions are made available to persons with mental illness (PMI) who have come into contact with the law. One form of mental health diversion is pre-arrest, in which the police use their discretion in laying charges. Concomitant with the growth of pre-arrest diversion programs is a growing body of research devoted to the phenomenon. The purpose of this paper is to review the existing literature of pre-arrest diversion, and to report the results of an international survey of pre-arrest diversion programs we conducted to identify evidence-based practices. On the basis of our review and survey, we note that successful pre-trial programs appear to integrate relevant mental health, substance abuse and criminal justice agencies by having regular meetings between key personnel from the various agencies. Often, a liaison person with a mandate to effect strong leadership plays a key role

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in the coordination of various agencies. Streamlining services through the creation of an emergency drop-off center with a no-refusal policy for police cases is seen as crucial. While there is some indication that mentally ill offenders benefit from their participation in this form of diversion, the evaluative literature has not yet achieved the ''critical mass'' necessary to create generalizable, evidence-based knowledge. The absence of generally agreed-upon outcomes could lead to the inequitable application of basic principles of diversion. We suggest that indicators, benchmarks, and outcomes must be agreed upon if a comprehensive understanding of pre-arrest programs is to emerge.

INTRODUCTION

Mental health diversion is a process where alternatives to criminal sanctions are made available to persons with mental illness (PMI) who have come into contact with the law. The objective is to secure appropriate mental health services without invoking the usual criminal justice control of trial and/or incarceration. Treating the mental disorder, it is hoped, reduces the likelihood of further offending, and the focus is on helping individuals to access community support and treatment. In one form of diversion, pre-arrest or pre-charge, the police use their discretion in laying charges (Steadman, Morris, & Dennis, 1995).

Three factors are thought to contribute to subjecting PMI to criminal prosecution, even for minor crimes: (a) increased numbers of persons with PMI residing in the community, (b) police handling of crises, and (c) poor access to treatment.

Interviews with police officers in London, Ontario, illustrate these concerns:

> I don't believe that when they [government] looked at closing down the hospitals the intended treatment was ever that the police would arrest and charge people who are suffering a mental illness. But that's what's happening out on the street.
> They're [PMI] not receiving adequate supervision in the community. They're not receiving adequate help to deal with their illness and as a result they end up dealing with the police. We're sort of the last line after they've dealt with everybody else.
> We are not stopping the problem. We're just putting a very quick Band-Aid solution on it. By arresting that person, criminalizing them, just to remedy the situation on the street. Yes they're committing the offence, the arrests are lawful, but they are not the correct course of action (Hartford, Heslop, Stitt, & Hoch, 2004).

As Teplin and Pruett (1992) note, involvement of the police with the mentally ill is based on two principles: (a) the protection of the public and (b) parens patriae, which involves the protection of the disabled citizen. Increasingly, the police are seen as the first entry point into the mental health system for PMI (Lurigio and Swartz, 2000).

> They have a mentally ill family member, who is not able to get treated, and their last course of action is to initiate a call to police, and request that a charge be laid in hopes that that person could be committed for some type of assessment. It's just unbelievable that a family member would be forced to do that (Hartford et al., 2004).

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Pre-arrest diversion, however, is a complex process that frequently involves informal assessments by the officer on the scene; in a study of 1,396 police–citizen encounters, for example, researchers found that police tend not to rely on conventional mental health resources or arrest, but prefer informal disposition because it requires ''neither paperwork not unwanted downtime (time off the streets)'' (Teplin & Pruett, 1992, p. 152).

Police responses to PMI are becoming more formalized. Many police services are organizing so that community mental health agencies can be contacted to help with calls involving mentally ill persons and, rather than charge the individuals, assist them to obtain treatment. For example, in a study intended to identify best practices between the criminal justice system and the mental health system in four cities in Southwestern Ontario (Hartford, 2003), systemic police programs for facilitating interactions with PMI were found to consist of the following options: (a) modest in-service education on mental health issues; (b) 40 hours of additional training in mental health issues for officers who would then be first responders to calls involving PMI; (c) a service agreement with a mobile mental health crisis service to attend calls from the police; and (d) a mobile crisis team consisting of mental health professionals and police officers specially trained in mental health issues. Only one study had documented a method for identifying the numbers of PMI in contact with police: an important outcome measure for assessing the effectiveness of pre-arrest diversion over time (Hartford, Heslop, Stitt, & Hoch, 2005). There is a need to identify the characteristics of 'successful' pre-arrest diversion programs. The purpose of this paper is to identify evidence-based practices in pre-arrest diversion programs for PMI through a literature review focusing solely on mental health. (co-occurring disorders were excluded from this review by our mandate from our funding agency, the Ontario Ministry of Health and Long-Term Care). We also wish to offer, by means of an international Internet survey, illustrative information about how these practices are implemented.

METHOD

To recover peer-reviewed articles from the scholarly literature, we conducted free-text searches of databases such as *Web of Science*, *Medline*, *PubMed*, and *PsychInfo*, among others. We also conducted extensive searches of the Internet for electronically published documents and for references to unpublished items. Relevant documents were retrieved from Web sites associated with universities, advocacy groups, information clearinghouses and all levels of government, as well as existing pre-arrest programs throughout North America, Great Britain and Australasia. Ultimately, we identified 92 articles concerned specifically with some form of pre-arrest diversion. The preponderance of these—53—arise from the U.S.

The retrieved articles were assigned to the project's 13 investigators for review. The investigators were researchers and practitioners in the fields of police services, criminal justice and mental health; articles were assigned for review on the basis of each investigator's particular expertise. The investigators assessed the literature for strengths and weaknesses using a standardized literature appraisal tool emphasizing

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research methods, the number and measures of data, the author's findings, and any conceptual or methodological problems.

The international Internet survey of pre-arrest programs was part of a larger survey, which was intended to collect information about mental health courts and court diversion programs. The results have been reported elsewhere (Hartford et al., 2005b). The pre-arrest portion of our survey was sent to police departments and consisted of 60 questions, which were designed to elicit descriptive data about the following: (a) program structure and annual volume, (b) administrative policy—planning, evaluation, personnel, funding, and monitoring criteria, (c) networking—referral to community agencies and interagency memoranda of agreements, and (d) current training and future needs for training in mental health or legal issues. The survey instrument was reviewed by the research team and by the Ontario Ministry of Health and Long-Term Care, who commissioned an examination of major findings in the diversion literature. Ethical approval was granted from the University of Western Ontario's Health Sciences Research Ethics Board.

To determine how diversion practices were implemented, a survey of English-speaking countries was conducted. Identifying the sample was a multi-stage effort. The first step was identifying published e-mail addresses. Documents published by the Substance Abuse and Mental Health Services Administration (SAMHSA) and The National GAINS Center for People with Co-Occurring Disorders in the Justice System (U.S. Department of Health and Human Services, n.d.) and the Council of State Governments (2001) provided e-mail listings of police pre-arrest programs. After consideration of the new federal privacy legislation, the Canadian Association of Chiefs of Police released their membership directory to us, which contained 129 e-mail addresses. The second step involved Internet searches. Police e-mail addresses or fax numbers in Australia and New Zealand were located. The third step involved using literature and personal contacts. Thus, e-mail addresses of individuals from Canadian, U.K., Australian and New Zealand police agencies were identified. E-mails inviting prospective respondents to participate in the survey, and directing them to the survey Web site, were sent in four waves between May 24 and July 7, 2004. From our perspective, the rank of the person completing the questionnaire was not important; e-mail recipients were asked to forward the survey to the person in the department best qualified to complete it. After each wave, the research team discarded unusable addresses and added new addresses. The unusable addresses were identified through "bouncebacks" or from individuals who responded that they were not the correct person to complete the survey; we identified new addresses by attempting to have them identify the correct individual. We also identified new addresses by continuing to search the Internet and other resources. Thus, each wave of e-mails represents a distinct iteration of the sample (as Table 1 illustrates). Ultimately, 54 police departments from the U.S., Canada, the U.K., and Australia responded.

However, because the agencies to which we distributed the survey were compiled from numerous secondary sources—some of which proved to be obsolete or inaccurate—we are unable to assert that the respondents represent the actual statistical population of all pre-arrest diversion programs. Similarly, the iterative development of the sample means that it is impossible to identify a stable denominator by which to calculate the return rate.

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Table 1. Successive mailings to police departments and their geographic distribution

	T1	T2	T3	T4	Total
Australia					
E-mails	35	0	27	34	96
Responses	1	1	0	0	2
Canada					
E-mails	134	113	109	124	480
Responses	6	14	4	6	32
New Zealand					
E-mails	13	9	9	7	38
Responses	0	0	0	0	0
U.K.					
E-mails	68	53	56	61	238
Responses	1	2	2	1	6
U.S.					
E-mails	61	52	56	57	226
Responses	4	5	3	4	16
Totals					
E-mails	311	227	257	283	1078
Responses	12	22	9	11	54

RESULTS

Literature Review Results

The literature was found to not yet convey a clear and consistent picture of best practices in pre-arrest diversion. Since diversion programs have only developed recently, it is unsurprising that the literature is mainly descriptive and not evaluative. In a multi-method project, police discretion regarding disposition after encounters with persons thought by police to be mentally ill ranged through (a) informal (52%), (b) no action (20.3%), and (c) arrest (14.9%) (Green, 1997). Research also tended to focus on various aspects of police training that led to a lowering of arrest rates of mentally ill offenders. Such research suggested that law enforcement personnel maintained negative attitudes toward PMI and that this bias was due to lack of knowledge about symptoms of mental illness (Cotton, 2004). Thus, it was proposed that police should be trained in issues related to mental illness and crisis intervention so they could better serve this population. In a survey of major U.S. police departments, 88% of the responding agencies reported that they offered some form of training for their officers in how to deal with PMI (Deane, Steadman, Borum, Veysey, & Morrissey, 1999). Early evaluations of such training employed three primary outcome measures: knowledge of mental illness, attitudes toward PMI, and changes in job-related behavior and performance (Godschalx, 1984). These early studies provide some limited support for the ability of educational intervention to improve officers' knowledge of mental health issues. Similarly, Mulvey and Reppucci (1981) examined the effectiveness of crisis intervention training for police, but found no significant differences between trained officers and a control group in terms of officers' attitudes, knowledge or performance. Despite the inconclusiveness of this early research, several models of pre-booking diversion programs have since emerged.

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1. *The Crisis Intervention Team* (CIT) model was first implemented in Memphis, TN (population of 650,000), in 1988. This is a police-based, pre-booking diversion program. CIT officers receive 40 hours of training in psychiatric disorders and substance abuse issues, as well as relevant legal issues. Officers can make referrals or transport an individual to an emergency service, which has a no-refusal policy for police cases (Bazelon Center for Mental Health Law, n.d.). According to the National Alliance for the Mentally Ill (NAMI), the CIT program has been adopted in hundreds of communities across the U.S. (NAMI, n.d.).
2. *The Psychiatric Emergency Response Team* (PERT) model has been operating in San Diego, CA (population of 1,223,400), since 1996. PERT teams consist of police officers with training in mental illness and mental health professionals, who both respond to calls involving PMI. Police officers receive 80 hours of initial training on assessing PMI and on identifying appropriate resources for referral (Bazelon Center for Mental Health Law, n.d.).
3. The *Mobile Crisis Team* (MCT) model has been operating in Santa Fe, NM (population of 62,203). It is comprised of behavioral health experts who help police officers at the scene decide a course of action in incidents involving mentally ill offenders. Case managers may refer the person to an appropriate outpatient facility.
4. *The Community Service Officer* (CSO) model has been in place in Birmingham, AL (population of 1,079,089), for more than 20 years. The civilian community service officers (CSOs), who have six weeks of classroom and field training, assist police officers by providing crisis intervention and some other assistance. CSOs are civilian police employees with prior professional training in social work or related fields (Bazelon Center for Mental Health Law, n.d.).

Steadman, Deane, Borum, and Morrissey (2000) compared the three models involving the following cities: (a) the CIT model in Memphis, (b) the CSO model in Birmingham, AL, and (c) the MCT model in Knoxville, TN (population of 475,000). The Memphis CIT model resulted in lower arrest rates (2%, compared with 5 and 13% for the other study sites), and more incidences of a PMI being taken to a treatment location (75% in Memphis, compared with 20 and 40% for the other sites). The authors attribute the difference in part to the existence in Memphis of a mental health emergency facility with a ''no refusal'' policy for police cases.

Since no strict randomized controlled trials have been conducted among pre-arrest divertees, our knowledge of the short- or long-term outcomes of pre-arrest diversion programs rests on less rigorous forms of evidence. There is virtually no information on optimal staffing or funding levels, nor does the literature offer generalizable evidence on which to base decisions surrounding policy, planning, or training. Nevertheless, a number of studies have usefully described or evaluated elements common to many pre-arrest diversion programs. We summarize findings from the most relevant studies in Table 2. In selecting articles for inclusion in this table, we concentrated on studies that (a) dealt exclusively with pre-arrest diversion, (b) had clearly defined process or outcome measures, and (c), while not necessarily generalizable, nevertheless offered findings likely to be helpful to pre-arrest diversion programs in other communities. After excluding purely descriptive accounts and non-empirical policy-oriented papers, seven studies met these criteria.

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Table 2. Key pre-trial diversion studies

Study	Method	Measures	Conclusion
Strauss et al. (2005)	Quasi-experiment	Process measure: characteristics of PMI brought to emergency psychiatric service (EPS) by CIT officers.	Demographics, diagnosis, and disposition of CIT-referred PMI did not differ from non-CIT-referred PMI.
Watson, Corrigan, & Ottati (2004)	Controlled experiment	Process measure: does information that a subject has a mental illness influence the way police officers respond in several types of situation?	Officers are less likely to take action based on information provided by victims and witnesses with mental illness. No differences were found in police response to suspects with or without a mental illness.
Hails & Borum (2003)	Survey	Process measures: amount of mental health training provided to police; use of specialized responses for calls involving PMI.	Training varied. Median of 6.5 hours for basic recruits and 1 hour for in-service training. 32% had some specialized response for dealing with calls involving PMI. 21% had a special unit or bureau within the department to assist in responding to these calls; 8% had access to a mental health mobile crisis team.
Steadman et al. (2001)	Descriptive study	Process measure: description of important principles in three pre-arrest programs.	Key principles include single point of entry, having a no-refusal policy and streamlined intake for police cases, establishing legal foundations to detain certain individuals, ensuring innovative, intensive cross-training, and linking clients to community services.
Steadman et al. (2000)	Field study	Outcome measure: study compared three models of police responses to PMI: how often specialized professionals responded and how often cases were resolved without arrest.	Proportion of calls resulting in specialized response varied through 28, 40, and 95%. All programs had relatively low arrest rates.
Deane et al. (1999)	Survey	Process measure: strategies police use to obtain information from the mental health system about dealing with mentally ill persons.	174 departments responded (90%). 96 departments had no specialized response for dealing with PMI while 78 did.
Borum, Williams, Deane, Steadman & Morrissey (1998)	Survey	Outcome measure: police perceptions of program effectiveness.	Officers rated their own programs as being highly effective in meeting the needs of PMI in crisis, keeping PMI out of jail, minimizing amount of time officers spend on these calls, and maintaining community safety.

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Survey Results

Of the 54 police departments to respond, 30 were from Canada, 16 from the U.S., six from the U.K. and two from Australia. Because of the difficulties involved in compiling a comprehensive sampling frame of all pre-arrest diversion programs in Canada, the U.S., the U.K., Australia and New Zealand, this survey was intended from the outset to yield a 'snapshot' of mental health diversion as it is commonly practiced, rather than a statistically generalizable dataset. Nevertheless, the survey provides a glimpse of common practices and concerns among the respondents.

Program Characteristics

Formal Versus Informal Diversion. Fifteen respondents (27%) stated that they had a formal diversion program in place.

Numbers of PMI Diverted Away From Arrest. Nine respondents (16%) indicated a wide range of diverted PMI, from a high of 1,700 to a low of 6.

Crisis Intervention and Mobile Response Teams. Twenty-one (38.8%) respondents noted that their department's program involved a CIT team, while an equal number noted that their department's program was associated with a mobile mental health response agency.

Training

Training in Mental Health Issues. The majority ($n = 38$, 70.4%) of officers receive special training in mental health issues. Thirty-two (59.2%) respondents noted that more training is needed in the area of diagnosis and approaches to de-escalating potentially volatile situations.

Outcomes and Monitoring

Criteria for Monitoring Success. Twenty-four respondents (44%) indicated that they had specific criteria to monitor the diversion program's success. Outcomes revolved around the following factors:

- increasing the number of officers trained to deal with mental health issues;
- increasing the percentage of PMI diverted from jail to treatment;
- decreasing the percentage of use-of-force incidents when dealing with the mentally ill;
- reduced recidivism in identified PMI;
- for programs with CIT teams in place, comparing percentage of diversions from jail to treatment with previous year, and by CIT and non-CIT members;
- number of arrests of the mentally ill compared with the previous year.

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Table 3. Agencies and services provided to pre-arrest diverted PMI

Crisis intervention (42%)[a]	Individual therapy (13%)[a]
Case management (35%)[b]	Group therapy (10%)[a]
Risk assessment (29%)[a]	Money management (8%)[c]
Assistance obtaining medical care (25%)[c]	Substance abuse (31%)[a]
Medication management (21%)[a]	Acute care hospitalization (25%)[b]
Housing assistance (19%)[c]	Family therapy (17%)[a]
Assistance obtaining financial aid (15%)[c]	Safe beds (17%)[b]
Assistance with other benefits (15%)[c]	Long-term care hospitalization (13%)[b]
Day treatment (15%)[b]	

[a]Treatment modality.
[b]Treatment delivery.
[c]Social support.

Services and Referral Options

Common Services and Referrals. Thirty respondents (55%) identified services or agencies to which their departments divert PMI. The most common services or agencies providing services are identified in Table 3.

As we have mentioned, this survey is not generalizable to a larger population of police departments with pre-arrest programs; accordingly, we present this information as a general indication of the type and range of services to which our respondents divert PMI, rather than a detailed cross-tabulation of individual respondents by number of services. Nevertheless, it is instructive to note that the preponderance of services to which PMI are diverted by respondents are crisis intervention, case management, and substance abuse treatment programs. Less common are programs or services we define as social support, including help obtaining financial aid, housing or other forms of assistance. When asked whether other services should be available, 17 respondents (31%) noted that the availability of, and access to, treatment facilities, housing assistance, and other supports were seriously lacking. Further research might explore more thoroughly what configuration of services is optimal for pre-arrest diversion. Additionally, a review of diversion for co-occurring disorders is warranted.

No Refusal Policies. Despite the clear convergence in the literature on the importance of local mental health facilities with a 'no refusal' police for police cases, only 10 respondents (18%) reported the existence of such a program in their jurisdictions.

Memoranda of Understanding. Seventeen respondents (31%) had established formal memoranda of understanding with other community agencies.

Program Costs

Only 11 respondents (20%) were able to provide an estimate of their program's annual budget. Responses ranged from a low of $3,000 to a high of $3,000,000 (U.S.). Since existing institutions (i.e. police departments) tend to encompass pre-booking diversion within program budgets, it is likely that respondents were unable to easily distinguish the direct and indirect costs of their diversion programs.

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Funds tend to be provided predominantly by state or county governments and/or agencies.

DISCUSSION

Several researchers have attempted to redress the conceptual confusion surrounding mental health diversion (Goldkamp & Irons-Guyn, 2000; Steadman et al., 2001; Slate, 2003). From this work the following four key elements are associated with programs that were perceived to be successful and that are certainly applicable to pre-arrest diversion. They are

- first, all relevant mental health and criminal justice agencies were involved in program development;
- second, representatives of the various agencies held regular meetings;
- third, a drop-off center with a no-refusal policy for police cases was created;
- fourth, a liaison person or ''boundary spanner'' was appointed. This person had a mandate to coordinate efforts among the various agencies.

Despite relative unanimity on these points, a consensus on the identification and definition of pre-arrest outcomes has yet to be achieved. In the literature, a wide variety of positive and negative outcomes were found. Positive outcomes identified were (a) treatment compliance, (b) treatment effectiveness, (c) independent living skills, (d) community integration, (e) quality of life, and (f) housing/reduced homelessness. Negative outcomes included (a) recidivism, (b) re-hospitalization, (c) co-occurring disorders, such as alcohol and drug addition, (d) incarceration rates, and (e) symptomatology. The absence of generally agreed-upon outcomes could lead to the inequitable application of basic principles of diversion. The foregoing highlights a fundamental gap in the current research. As yet, there is no clear indication how effective pre-arrest programs actually are, or what the long-term outcomes are for PMI who have experienced diversion. If a comprehensive understanding of pre-arrest programs is to emerge, their implementation needs to be tied to a replicable method of evaluation involving commonly agreed-upon indicators, benchmarks, and outcomes. Only with such data can randomized controlled trials assess whether the financial resources spent on pre-arrest programs are justifiable in terms of their effect on PMI. As we have suggested, standardized outcomes for pre-arrest diversion programs might be helpful for researchers. Some of the outcomes identified for other types of diversion (Broner, Lattimore, Cowell, & Schlenger, 2004) include service utilization, housing, recidivism, symptom change, functioning and quality of life, employment, and satisfaction with life in general. Additionally, it may be useful for researchers to develop a conceptual model of police pre-arrest diversion that reflects the complex interactions between police, PMI, the courts, and mental health agencies, as well as other local and contextual factors that may affect the program's operation. One such model is the Sequential Intercept Model (Munetz & Griffin, 2006), which identifies five points in the criminal justice system at which PMI might be diverted (or ''intercepted''). While not developed specifically for pre-arrest diversion, the model is predicated on an assumption that, ideally, PMI should be diverted at an early stage in their contact with the criminal justice system (namely, by police or emergency services).

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CONCLUSIONS

Existing studies on pre-arrest diversion lack (a) control groups (even studies with focus groups need to use a 'control' condition), (b) longitudinal designs to assess long-term outcomes, and (c) objective data on key variables to allow comparisons across studies/countries. The survey's low response rate and its concomitant sampling bias is a limitation and thus survey results are not generalizable. Response rates could be enhanced by if a Web site dedicated to pre-arrest diversion were established. The pre-booking jail diversion program survey currently being conducted in 2006 by the U.S. National Gains Center is intended to develop a U.S. registry to identify and catalogue existing programs (http://www.gainscenter.samhsa.gov/programs/default.asp). Based on our experience, it would be important that such a database include contact names to facilitate interaction with researchers. Established programs in English-speaking countries could use such a Web site as a clearinghouse of information. However, in spite of our self-selected convenience sample, the themes that emerged from the respondents can provide expanded criteria for process and outcome evaluations.

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