Making Early Diversion Programs Work

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Executive Summary:

Police officers can use pre-charge diversion (PCD) programs to divert individuals with a mental-health and or substance abuse issues away from the criminal justice system and towards relevant services. The Peterborough Police Service currently operates such a pre-charge diversion programs in partnership with the local Canadian Mental Health Association. The purpose of this research is to provide recommendations to improve the utilization of the program by officers as it is perceived to be underutilized.

Best practices among pre-charge diversion programs and key determinants of their success were identified through a literature review. Next, interviews with key informants were conducted to identify key areas of improvement within Peterborough's PCD program, and a comparative case study was also conducted to draw out key structural differences between Peterborough's PCD program and another PCD program operating in Durham, which is perceived to be a successful model.

The literature review revealed that there are several factors which influence the success of pre-charge diversion programs including: collaboration, on-going communication and contact between agencies, police training and awareness of the program, and guidelines regarding program eligibility criteria. Of the specialized response models reviewed, a Crisis Intervention Team model appeared to hold the greatest promise of improving program utilization.

The series of interviews following the literature review revealed critical observations. There are opportunities to improve collaboration and communication between agencies and training and promotion efforts could be improved through greater incorporation of PCD staff and material into annual training for police officers. While anecdotal evidence has suggested not all ideal candidates are being diverted, officers interviewed believed the program's applicability was limited. They most commonly attributed this to the crisis nature of most calls and the need for immediate intervention. However, evidence suggests some proportion of officers may be resistant to the program because of a perceived lack of accountability; furthermore, testimonials suggest not all officers are aware of the program or unsure of how to conduct a diversion.

Given the limited inclusion of informants from Durham, the comparative case study produced only tentative findings. It appeared that Durham has used a number of tools to promote their program such as a video and publication in police magazines. Other differences noted are the existence of the Mobile Crisis Intervention Team in Durham which can offer the assistance of a designated mental-health officer and nurse to officers requiring consultation or on-site support. This contrasts with Peterborough which offers a Mental-health Outreach Worker. The biggest caveat to note with respect to these findings is that Durham's diversion program does not appear to be more widely utilized than Peterborough's relative to population though differences between the two communities, may invalidate this comparison since different communities have differing needs and population may not be indicative

of the number of people facing mental-health issues.

Utilization is most likely to be improved through the standardization and expansion of training for officers, and the institutionalization of on-going communication and collaboration between key personnel at all levels. It is also recommended that clear responsibilities for program training and promotion be defined between and within the participating agencies. Limited resources affect all parties, but it is recommended that funding for another Mental-health Outreach Worker be secured to expand consultation and support services to officers. Focus-groups with officers should be conducted to illicit program feedback and address relevant concerns. Future research objectives should focus on police perceptions of the program, and explore in greater depth the comparative structure and performance of Durham's PCD program.

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Section 1: Introduction & Stated Research Purpose

When a police officer is dealing with an offender/suspect of a non-violent crime who is suspected of having a mental health condition and/or substance abuse issue, the responding police officer may opt to divert the offender into a mental-health support program in lieu of a formal charge. Upon agreeing to partake in the program, the offender (client) is then obliged to

complete a treatment program. The suspended charge will be withdrawn upon program completion; however, if the individual fails to engage with the program the charge will be laid. This type of program is referred to as pre-charge diversion (PCD) program. Currently, the Peterborough Police Service (PPS) operates such a program in collaboration with the Peterborough Canadian Mental Health Association (CMHA).These programs reflect the need to reduce the criminalization and incarceration of persons with mental-health and or substance abuse issues, and to ensure that such individuals are connected to relevant support and treatment services. The impetus for the current research was a perception that the program was being underutilized, and a desire to improve uptake of the program among front-line officers.

The purpose of this project is to identify key determinants of success, best practices, and areas of difference between Peterborough's program and others. Through this research the project aims to provide critical information to the host that will help to increase the utilization of the program by police officers.

Section 2: Key Research Questions and Project Goals

- What is the broad structure of PCD programs and what are the determinants of a successful and unsuccessful PCD diversion program? Success is defined here in terms of uptake amongst police officers.
- How does the program work in Peterborough? What are the experiences of this program from the point of view of the police and those who run the Program?
- What are the key structural differences between the Peterborough Police Service (PPS) pre-charge program and the Durham Regional Police Service (DRPS) program? Compared to each other how have these programs performed and what accounts for any differences in the level of uptake amongst Police officers?

- What can be done to improve uptake within the Peterborough PCD?

Section 3: Research Methodology

The over-arching aim of this research project is to identify the key elements of a successful PCD diversion program, and to identify opportunities to bolster up-take within the Peterborough PCD program. In order to achieve these aims the research will be comprised of three broad components.

A. Literature Review: Methods, Sources, & Data Collection:

The first component of the research involved a systematic review of the determinants of success of PCD programs. The following key-words were used to find relevant sources: “pre-charge diversion”, “mental-health diversion”, “pre-arrest diversion”, “pre-booking diversion”. These search criteria were used in various scholarly databases as well as google searches. Initially inclusion criteria was limited to Canadian sources; however, this was later expanded to include the US, Australia, and Europe. Academic and non-academic sources were analyzed by both researchers and all findings were synthesized in shared files.

B. Semi Structured Interviews & Focus Group: Methods, Sources, & Data Collection:

The second component of our research involved an evaluation of the operation and structure of the PPS PCD program. The core method of data collection was semi-structured interviews with key informants who were identified through purposive sampling. All informants were involved in at least one of the following activities in relation to the PCD program: implementation, training, promotion, coordination and service provision.

All interviews were conducted in person with key informants involved with the PPS PCD program. These were recorded, transcribed, and later analyzed using grounded analysis to identify emergent themes. Coding was partially informed by earlier findings from the literature

review. Findings from the literature review also informed questions asked in semi-structured interviews.

C. Comparative Case Analysis:

The third component of our research was a comparative case study of the PCD program in Durham and Peterborough. The aim of the comparative case study was to identify key differences in program structure, and any impact this may have on program performance. The DRPS PCD program was chosen because there is a perception that the DRPS program is more effective at diverting individuals. The semi-structured interviews from the second component of the research design were a key source of data; however, due to various factors only one key informant involved in the Durham PCD program was interviewed. To repeat, all interviews were recorded, transcribed, and analyzed using grounded analysis. Other sources of information included a 45-minute webinar on the region's PCD program, which was delivered by several members of Durham's Mobile Crisis Intervention Team. Websites on Durham's mental health response model and PCD program were also consulted.

Section 4: Literature Review

The literature concerning best practises and determinants of success of PCD programs is limited. Most literature does not specifically concern itself with mental-health related pre-charge diversion programs, but more broadly with "police-based diversion" or "pre-arrest diversion", which in the context of persons with mental illness, entails the diversion of an individual away from contact with the courts and towards some type of treatment provision (Hartford et al., 2004, p.ii , 2; Livingston et al., 2008, p. 11). The Peterborough & Durham PCD programs represent one specific form of diversion under this category as they involve the use of a suspended charge and on-going case management (Durham Regional Police Service & Durham Mental Health

Services, March 26th, 2015; Personal communication, February 5th, 2016). Therefore, it should be noted that many of the cited studies are not explicitly addressing PCD programs, but rather all mental-health diversions that are conducted by police prior to contact with the court and result in some type of treatment disposition. Despite the somewhat limited nature of available literature, several key determinants of success and best practices are identified below. In addition, three specialized mental-health response models are identified and evaluated.

Section 4.1: Key Determinants of Success & Best Practices

Collaboration:

One of the most commonly cited determinants of success for mental-health diversion programs operating at the police level, was collaboration between relevant agencies and parties (Livingston, Weaver, Hall, & Verdun- Jones, 2008, p.8; Centre for Addiction and Mental Health, 2005, p.4; Hartford , Mendonca & Carey, 2006, p.854; Hartford et al., 2004, p.i). In fact, Livingston et al. (2008) identify collaboration as “the single most significant factor for the success of criminal justice diversion programs” (p.7). Key elements of collaboration which are cited as essential include working collaboratively to develop and operate the program (Hartford et al., 2006, p.854), the establishment of Memoranda of Understanding to identify clear roles and responsibilities for each agency (Centre for Addiction, 2005, p.4; Livingston et al., 2008, p.13), and facilitating information sharing between mental health and criminal justice agencies and the creation of information systems that allow parties to review treatment history (Centre for Addiction, 2005, p.3). This collaboration also may entail the development of co-response models in which police and mental-health professionals respond to calls, or the creation of drop-off crisis centers with ‘no-refusal policies’ (Butler, n.d., p.47; Livingston et al., 2008, pp.13-14). In

fact, Livingston et al. (2008) report that having access to “personnel who have mental health training and/ or expertise”, for consultation and support purposes is critical for police-based diversion programs (p.12).

On-going Communication Between Key Personnel & Liaisons:

On-going communication, meetings, and participation of key personnel between and within agencies, is also cited as critical to a successful and effective diversion program (Livingston et al., 2008, p.8; Hartford et al., 2004, p.i). As Livingston et al. (2008) note “successful diversion programs begin with sustained involvement of all relevant mental health, addictions, … and criminal justice agencies”, and that this involves on-going communication and meetings regarding things such as “service coordination”, and “information sharing” (p.8).

The literature also asserts that the designation of a liaison person is a key contributing factor to the success of diversion programs (Livingston et al., 2008, p.8; Hartford et al., 2004, Centre for Addiction, 2005, p.5; Hartford et al., 2006, p.854). These individuals contribute to the operation of diversion programs by promoting and facilitating service coordination and on-going communication between all agencies involved (Livingston et al., 2008, p.8).

Training & Awareness among Officers:

Officers training and awareness of community services and relevant diversion options is cited in as a key component of successful early diversion programs (Centre for Addiction, 2005, p.4; Hartford et al., 2004, p.i; Livingston et al., 2008, pp. 8- 12). Key areas of training which have been identified as contributing to the success of police-based diversion programs include: assessment and identification skills of mental-health illnesses and addictions, education on issues related to mental health and addictions, and relevant mental-health and community services (Livingston et al., 2008, pp.12-13). In order to ensure utilization of the program, awareness-

raising and training initiatives should include all key personnel (Centre for Addiction, 2005, p.4). The designation and training "of a core group of officers as first respondents to mental health calls", has also been recommended (Livingston et al., 2008, p.8).

Clear Eligibility Criteria & Response Procedures:

The last common area of convergence in the literature was related to the specific procedures which guide a police officer's response to mental-health calls or incidents. In their review of best-practices in police-diversion programs, Livingston et al. (2008) state that "clear guidelines [are] developed to assist and support officers in making appropriate disposition decisions" (p.12). This echoes others findings that the establishment of "formal case finding procedures", are established (Center for Addiction, 2005, p.5; Hartford et al., 2004, p.iii).

4.2. Common Models of Specialized Mental- Health Response:

In order to improve police responses to incidents involving persons with mental health and or substance abuse issues police services have developed various response models often involving high levels of collaboration with mental health professionals. It is anticipated that these response models could indirectly impact pre-charge diversion programs by improving identification and assessment of individuals with mental health or addictions issues, promoting awareness of diversion opportunities to police officers either through training or on-scene assistance, and providing critical support to officers to identify what sanction is going to be most effective and most beneficial for the individual. The three dominant response models are listed below.

Crisis Intervention Team (CIT) Model:

The CIT model utilizes police as its primary agent of intervention. Under this model officers receive approximately 40 hours of crisis intervention training on mental health and addictions

issues, including training on common mental health illness and their symptomology, relevant community services, and appropriate ways to respond to various calls (Livingston et al., 2008, p. 14; Hartford et al., 2006, p.850; Personal communication, March 15th). While variations in the model exist, these officers may be designated as priority responders to calls involving persons with mental health (Livingston et al., 2008, p.14; Butler, n.d, p.47), and according to Butler(n.d.) these officers "conduct an initial mental health assessment at the scene", (p.47). Collaboration with mental-health resources in the community is an essential feature of this model (Butler, n.d., p.47). Outside of training, the most crucial form of collaboration which is often associated with this model, and said to be critical to this model's success in diverting individuals away from the justice system (Livingston et al., 2008, p.14), is the creation of a crisis center with a "single point of entry, no refusal policy and streamlined intake for police", (Butler, n.d., p.47).

Peterborough's Four County Crisis (4CC) provides a crisis intervention training to both the Peterborough Police Services and local OPP detachments (Personal Communication, March 15, 2016). This training occurs annually, but is a one-time training for officers (Personal Communication, March 15, 2016). The benefits of this type of training are noted on page 12.

Crisis Mobile Team (also known as Mobile Mental Health Crisis Unit):

This model is defined differently depending on the literature references; however, for our purposes we will adhere to the criteria outlined in a report by the British Colombia Canadian Mental Health Association, which defines a Crisis Mobile Team [CMT] as "[being] comprised of l of behavioural health experts who help police officers at the scene decide a course of action in incidents involving mentally ill offenders" (Livingston et al., 2008, p.14). This team provides consultation services to officers, and facilitates services referral (Butler, n.d., 18). As noted by Butler (n.d.) members of this team may either be directly employed by the police or by mental

health agencies in the community (pp.17-18). According to Butler (n.d.) this type of "co-response" model is far more prevalent in Canada relative to the CIT model which dominates the U.S (p.22).

Psychiatric Emergency Response Team (PERT):

In this model "mental health professionals [are paired] with police officers, both of whom respond to situations involving persons with mental disorders" (Livingston et al., 2008, p.14). It also specifies that the team members receive "80 hours of training over a four-week period" (Livingston et al., 2008, p.14). The key difference between the CMT and PERT is the training and the strict assignment of a mental health professional with an officer as opposed to a mental health professional responding to calls only with the officer already on site.

4.3: Response Models Performance & Potential Contributions to Utilization of PCD

A comparison of a CIT model in Memphis, a CMT model in Knoxville, and a 'Community-Service Officer' (CSO) model which utilizes social workers to provide assistance in crisis calls or related matters (Butler, n.d., p.18), found that the Memphis CIT model outperformed the others in a number of key areas. The evaluation produced the following findings:

"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 [person with mental illness] being taken to a treatment location (75% in Memphis, compared with 20 and 40% for the other sites)" (Steadman, Deane, Borum & Morrissey as cited in Hartford et al., 2006, p.850).

Steadman et al. (2000) found that a significant contributor to the success of the CIT model in Memphis was the existence "of a crisis drop-off center for persons with mental illness that had a no-refusal policy for police cases" (p.645). Furthermore, the CIT model provided for the greatest coverage of mental health disturbance calls, with designated CIT officers responding to 95% of mental-health related calls (Steadman et al, 2000, p.647). The CSO model, which

somewhat reflects the role of the mental health outreach worker with the PPS, suffered greatly from coverage issues as a result of its reliance on a limited number of civilian employees who were only able to reach 28% of mental-health related calls (Steadman et al,. 2000, p.647). However, it should be noted that the CMT model generated a much higher number of referrals to treatment services compared to the Memphis CIT model which exclusively relied on transportation to emergency psychiatric services (Steadman et al., 2000, p.648). It is not clear if this is due to the lack of a drop-off crisis center in Knoxville where the CMT model was studied or the presence of mental-health professionals on-site produces a larger number of diversion to mental-health treatment services.

An evaluation of crisis intervention training in Indiana indicated that crisis intervention training may improve several aspects of police responses to persons with mental health illness. Wells & Shaffer (as cited in Butler, n.d) found that the "training appeared to improve officers' ability to identify individuals with mental illness and respond appropriately; knowledge of local treatments and services; and their comfort in interactions" (p.16). The Four County Crisis (4CC) intervention training aims to achieve similar outcomes by providing education on community resources and the symptomatology of various mental health issues. Given that identifying such symptoms and knowledge of available services, particularly the PCD program, is essential to diverting an individual, it is likely crisis intervention training and an increase in the frequency of training can contribute to increased use of PCD programs.

Core Findings & Summary:

In summary, it can be concluded that while the evaluation was not concerned with the number of referrals to PCD programs, the CIT model likely represents the most conducive response model to improving uptake of the PCD program given its superior coverage of mental-health calls. Additionally, the existence of a center which can provide immediate treatment is critical to

diverting individuals away from the criminal justice system. Lastly, the limited evidence available suggested crisis intervention training could improve utilization of PCD programs in so far as it improves officer's ability to respond to and identify mental-health issues.

Section 5: Interview, Focus Group, & Primary Data Findings

Core findings from interviews have been identified below and are organized under relevant themes. It is important to note that this section deals only with the Peterborough PCD program.

Communication, & Collaboration:

The Peterborough PCD program is executed and managed by a variety of autonomous yet interconnected groups. Currently the program is operated by Peterborough Canadian Mental Health Association (CMHA) under its justice services program portfolio, and is staffed by a program manager and two Court Support Workers (Personal communication, February 5th, 2016; Personal communication, February 23rd, 2016). The program manager oversees program implementation, team meetings, and promotion and training activities. Court Support Workers provide case management services and may be involved in training and promotion activities (Personal communication, February 23rd, 2016).

Another CMHA agency which is indirectly involved is Four County Crisis who provides crisis intervention training to PPS and the OPP and houses one of its mental health outreach workers inside the police department (Personal communication, March 15. 2016). This worker provides case management services, conducts outpatient duties, and when available, provide on-site consultation to officers regarding mental-health related issues and calls (Personal communication, February 23rd, 2016). This worker does not currently attend the bi-weekly meetings of the justice programs team (Personal communication, February 5th, 2016).

Within the police department relevant parties include officers, a liaison who oversees the functioning of police partnerships with community services, and a special officer who oversees the multiple training programs officers' complete (Personal communication, February 3rd, 2016).

Evidence suggests that there are opportunities to improve communication and collaboration between key personnel at several levels. When asked about the frequency of collaboration with others at the police station, one CMHA informant replied that contact was "at a deficit" (Personal communication, February 5th, 2016). Specifically, there was an absence of regular meetings with police liaisons. There was one reported meeting with a liaison in order to facilitate further trainings of police; however, this occurred six months ago with no outcomes, and both parties cited a failure to follow up (Personal communication, February 23rd, 2016;Personal communication, February 5th, 2016; Personal communication, February 3rd, 2016).

Interviews also suggested that communication and collaboration could be improved between relevant 4CC staff and PCD staff. Interviews with key informants revealed that PCD staff do not regularly collaborate or meeting the Mental-health Outreach Worker who provides consultation services to police (Personal communication, February 5th, 2016; (Personal communication, February 23rd, 2016).). A key informant also suggested that the Mental-health Outreach Worker likely needs more training to ensure they are promoting the program and because "[they] may not be familiar with the whole [diversion] process" (Personal communication, February 5th, 2016). Another informant also identified collaboration with the mental health-outreach worker as an area of opportunity (Personal communication, February 23rd, 2016). They noted that they had "briefly" discussed the PCD program with the worker

when they first joined the PPS, but that "there has been no official meeting about it" (Personal communication, February 23rd, 2016). These are important points given that the Mental Health Outreach Worker would appear to be uniquely positioned to promote and facilitate the use of the program. It should be noted that Court Support Workers and the Mental-health Outreach Worker communicate on a frequent basis in relation to court diversion programs and shared clients (Personal communication, February 23rd, 2016), and so the basis of a collaborative relationship appears to already exist.

The last area in which communication and collaboration was identified as a potential area of opportunity, was communication between police officers and Court Support Workers. This is addressed in an ensuing section and is characterized by conflicting claims from officers and Court Support Workers.

Core Findings:

- There is a lack of regular meetings between key personnel.
- All parties express desire to see program succeed.
- Evidence suggests there is a lack of training of, and collaboration with, mental health worker and other relevant PCD staff.

Training & Promotion:

Training and promotion is critical to ensuring officers are aware of the program and able to utilize it. While such activities have been undertaken by CMHA PCD staff and 4CC, evidence suggests there are opportunities for improvement, and that a lack of clearly defined responsibilities is partly responsible for this.

There are several ways which officers were reported to have received training on the PCD program from PCD staff. One method involves PCD staff attending officers daily 15-30

minute briefings (Personal communication, February 5th, 2016), During this time, the PCD ticket and program is presented and explained to the officers who are able to ask questions (Personal communication, February 5th, 2016). It was reported that such trainings occur "periodically" (Personal communication, February 5th, 2016), but informants' responses about when the last training occurred conflicted and ranged from one year ago to a few years.(Personal communication, February 5th, 2016; Personal communication, February 23rd, 2016).

The second method of training involves the inclusion of PCD material and staff into the annual crisis intervention trainings conducted by 4CC (Personal communication, March 15. 2016). This is a one-time four day training modeled on the CIT training outlined in the literature review section (Personal communication, March 15. 2016). It covers addictions, mental health conditions and related behaviours, common stigmas, community resources and services, and guest speakers. (Personal communication, March 15. 2016). In previous years, PCD diversion staff have attended this training to educate officers on the PCD program; however, a semi-structured interview respondent reported that they are there "sometimes but not all the time", and that "the last couple of times they [PCD staff] had not been present" (Personal communication, March 15. 2016). While the structured interview respondent was unsure, they believed that the last time the staff had attended the training with the Peterborough Police Service was in 2012 (Personal communication, March 15. 2016). The structured interview respondent reported that they provide an overview of the program in the staff's absence and have facilitated dialogue during training to address police perceptions of the program (Personal communication, March 15. 2016). Speaking on this topic the informant said "I might not understand all the processes of the PCD but I understand the concept of it, the purpose of it and kind of how it flows" (Personal communication, March 15. 2016). It appeared that PCD staff were not aware the program was

being covered in these trainings in their absence (Personal communication, February 5th, 2016). The observations highlighted above indicate collaboration on training can be improved, and that there are viable opportunities to train officers.

Program promotion occurs when PCD staff attend police briefings and when PCD material is incorporated into crisis intervention training, but can also occur within the police department through the Mental-health Outreach Worker who provides consultation to officers or the community-liaison who works with the PPS (Personal communication, February 23rd, 2016). Evidence suggest that there are opportunities to improve collaboration within regards to program promotion, and that responsibilities for this activity can, at times, be unclear. When asked how police officers would go about learning more about the PCD program, one informant said "they could ask me about it, I'm supposed to play some sort of role in advocating for these programs as a CMHA representative" (Personal communication, February 23rd, 2016). As noted earlier a different informant remarked that the Mental-Health Outreach Worker may need more training to ensure they are promoting the program and because "[they] may not be familiar with the whole process" (Personal communication, February 5th, 2016). This raises doubts about the existence of clear responsibilities for program promotion among key personnel. Furthermore, when asked if there was a designated individual tasked with promoting the utilization of the PCD program, one informant stated that the "[PPS] Community liaison may be tasked with it, but I don't know for sure if he is tasked with it, although it definitely should fall under his mandate" (Personal communication, February 23rd, 2016).

One of the key informants noted that there "isn't an identified person" (Personal communication, February 5th, 2016), responsible for promoting the program but that it is a "team effort" (Personal communication, February 5th, 2016). The informant also expressed the

view that higher-ranking officers must also actively promote the program noting that "it needs to come from within, from their supervisors because they are the ones that are there for all of the shift changes" (Personal communication, February 5th, 2016). However, as discussed below, evidence suggests that not all officers are trained by their supervisors.

The focus group with three officers provided some insight into the effects of the training and promotion activities, and suggested there may be gaps in training coverage and standards, and defined responsibilities. One officer reported that training occurs "with the recruits as soon as they come in" and later elaborated that "they just give you a whole bunch of forms that you stock your briefcase with and you ask what is this what is this… and it has it on the sheet how you use it so it is pretty self-explanatory" (Personal communication, March 18, 2016). This training was not mentioned during any other interviews, and this officer appeared unfamiliar with what paperwork was required to conduct a diversion beyond the diversion ticket (Personal communication, March 18, 2016). These remarks suggest training may not be standardized and there may be gaps in what is covered. Another officer reported that they could only recall being "told about it in CIT [crisis intervention training]", and was also not familiar with what paperwork was required (Personal communication, March 18, 2016). This differs from the statement from the other officer, and suggests that training delivery is not standardized within the PPS (Personal communication, March 18, 2016). Two of the officers suggested training on the program is informal, and experiential, making remarks such as "it is just something you learn as time goes on" (Personal communication, March 18, 2016). This further highlights the importance of on-site training. The officers did effectively identify the Mental-health Outreach Worker as resource for consultation and one officer suggested that the crisis intervention training

was effective in identify and promoting relevant community services such as the CMHA (Personal communication, March 18, 2016).

Core Findings:

- Irregular attendance of PCD staff at annual 4CC training.
- There is limited incorporation of detailed PCD material in annual training.
- There is a lack of standardized training on the PCD program.
- There is a lack of clearly defined responsibilities for program training and promotion.
- Police testimonials suggest that the CIT training was successful at helping identify community services and resources.

Eligibility Criteria & Formal Case Finding Procedures:

All relevant informants could identify what general circumstances would be appropriate for a pre-charge diversion, namely first time offenders, minor and non-violent crimes, suspected mental health and or substance abuse issues (Personal communication, March 18 th, 2016;Personal communication, February 23rd, 2016;Personal communication, March 15, 2016;Personal communication, February 5th, 2016 ;Personal communication, February 23rd, 2016).

The PCD ticket does not explicitly list the offence criteria, and a key informant noted that this is because "it would be five pages long, so they cannot do this. All it says is, "does it meet the criteria for the offense?"(Personal communication, February 5th, 2016). The same key informant noted that "we [the CMHA] would not be telling the police what the direct eligibility criteria is. Their superiors and sergeants should be" (Personal communication, February 5th, 2016).

The diversion ticket does provide some assistance to officers when attempting to identify calls which would be eligible for diversion by listing commonly prescribed medications, and

setting a relatively low threshold for what constitutes suspected mental health or substance abuse by asking whether “erratic or usual behaviour is present”(Personal communication, February 5th, 2016). A mental health outreach worker with 4CC who is posted within the police department can also provide guidance to officers when available, but in all cases the decision to divert is up to the police (Personal communication, February 23rd, 2016).

The diversion ticket was created in collaboration with PPS. In fact, front-line officers were consulted extensively on what the ticket should include and how it should be designed in order to facilitate utilization of the program (Personal communication, February 5th, 2016). This demonstrates previous collaboration in program design and implementation.

Program Applicability, Usage, and Police Attitudes:

Interviews with key informants, including three officers provided critical insights into the perceptions of the program’s applicability, how it is being used, and overall understanding of the program. Given the small sample size of officers, and that only one of the three offers reported completing a PCD, these findings should be viewed as tentative.

Relevant informants reported that police are generally supportive of the program in principle (Personal communication, February 5th, 2016; Personal communication, February 23rd, 2016; Personal communication, March 15, 2016; Personal communication, February 23rd, 2016). However, all three front-line officers in the focus group maintained that the applicability of the program is limited (Personal communication, March 18th, 2016). One officer reported “usually they are in crisis [...] so it’s something that is a serious issue and we need to get them some help right away” (Personal communication, March 18th, 2016). Another officer made similar comments, while one reported “I just have never had that opportunity to even think of using that PCD program” (Personal communication, March 18th, 2016).

Interestingly, another key informant expressed a view similar to that of the police. When asked if there were many calls where a PCD could be made the informant said “Not too many that I have seen,” and reported that when he/she consulted with family members or were “helping people assess their options, the program rarely [applied] (Personal communication, February 23rd, 2016). The informant also mentioned that the voluntary aspect of the program can be problematic in cases where an individual is refusing treatment (Personal communication, February 23rd, 2016). These comments are particularly illuminating as the concerns about applicability were coming from the staff responsible for choosing or influencing the decision to divert an individual.

In general, the most frequently cited reason for the program’s limited applicability was the perceived crisis nature of most calls, and the need to provide some form of immediate intervention (Personal communication, March 18th, 2016). This sentiment is clearly visible in the first comment cited from an officer above, although it was frequently evident in many comments from the officers interviewed. One officer reported that “ we need to do something right away and we do not have the opportunity to give them the sort of soft approach because we are usually dealing with them to the point where we have to put them in cuffs, take them to the hospital or bring them to the station” (Personal communication, March 18th, 2016).

This captures the clear perception among these officers that the ‘crisis’ nature of most mental-health calls precluded the possibility of pursuing PCD because it did not offer immediate treatment (Personal communication, March 18th, 2016). These comments also reflect what appeared to be a common fear of the possibility of a dangerous incident occurring if a pre-charge diversion was utilized (Personal communication, March 18th, 2016). This fear is best reflected in the following remark: “if we divert them we are releasing them and it is not usually feasible to do

that because they are at such a crisis point that we cannot take a chance that someone is going to get hurt or killed because of it" (Personal communication, March 18th, 2016). Another interesting observation is that officers noted that a diversion would not be applied if someone was transported to the hospital for mental-health reasons (Personal communication, March 18th, 2016). It is not known whether these two measures are in fact mutually exclusive in a legal sense.

All officers also reported that the program had limited applicability because when victims are family members they are hesitant to pursue approaches which involve potentially punitive measures (Personal communication, March 18th, 2016). As one officer noted "you are caught in a bind because most families don't want us to take an arrest or divert them or send them through a court process" (Personal communication, March 18th, 2016). Another reason provided by the officers as to why they perceived the program to have limited applicability was the need or desire to provide an acceptable resolution to victims, although it should be noted only one officer cited this as a contributing factor (Personal communication, March 18th, 2016). One last cited reason for the limited applicability was that in cases where mental-health related calls were not at a crisis level alternative actions were taken such as "consultation with families" (Personal communication, March 18th, 2016).

There are several other factors which appear to be contributing to the officers' perception that the PCD program has limited applicability. One such factor is the perception that the program fails to hold the individually adequately accountable, and this appears to be related to police claims that they do not receive adequate feedback regarding what treatment plan was provided (Personal communication, March 18th, 2016). These concerns were first highlighted by another key informant during a discussion regarding crisis intervention training in Peterborough.

The informant reported that "a lot of stigma came up around pre-charge", since "some of them [police officers] would see it as a way of people getting off with crimes" or a means for an individual to "manipulate the system" (Personal communication, March 15, 2016); however, this informant later added that "it was more of a generalized statement about people who will commit crimes and then say I am crazy" (Personal communication, March 15, 2016). When asked how common those views are among officers the informant said "I would say not all but I would say maybe about 30 - 40 percent of officers" (Personal communication, March 15, 2016). It should also be noted that this same informant reported that officers would like to avoid charging individuals with mental-health issues, and noted that officers engage with and are very supportive of the crisis intervention training (Personal communication, March 15, 2016).

Concerns regarding accountability were later raised during the focus group with police officers, particular in relation to the importance of receiving feedback on an individual's treatment plan. One officer reported that "the feedback is sometimes the biggest part for anal cops who really want to know there is something punitive going on one way or another. It's not like they want their pound of flesh they just want to know something has been done" (Personal communication, March 15, 2016). Similar comments were raised by another officer (Personal communication, March 15, 2016). In fact, each of the officers believed that greater feedback on an individual's progress, treatment plan, and program resolution would improve utilization of the program (Personal communication, March 15, 2016). It should be noted that this suggestions that there was limited feedback were contested by another key informant who reported that officers are contacted upon program completion to "let them know this is what they did, this is what's been done", and that treatment plans are made available to officers although "some officers don't

care [to see it]" (Personal communication, February 23rd, 2016). Beyond this there were no other avenues of feedback identified in the interviews.

The last area which must be addressed is perceptions of whether the program is being adequately utilized. All officers interviewed reported that the program was adequately utilized given its limited applicability (Personal Communication, March 18th 2016).This point of view conflicts with the views of the of three other key informants (Personal communication, February 23rd, 2016;Personal communication, February 23rd, 2016;Personal communication, February 5th, 2016). One of these three informants cited an apparent lack of awareness among some officers to support this assertion (Personal communication, March 18th, 2016). More significantly, the Court Support Worker suggested that he/she sees ideal candidates for the PCD program going through the court system (Personal communication, February 23rd, 2016). The informant noted "that last week there was an individual [in court] who was charged with mischief, first offence, with high anxiety and no record. So he is a perfect candidate" (Personal communication, February 23rd, 2016). This individual was actually screened into the Direct Accountability Program by the court, but this program is not specifically targeted at individuals suffering from mental health (Personal communication, February 23rd, 2016). This example appears to suggest that an opportunity to divert an ideal candidate at the pre-charge phase was missed.

Assessing Demand for the Pre-charge Diversion Program:

One of the key variables which would influence the number of diversions a program is likely to generate is the number of mental-health related calls which contain a criminal component. The lack of data, however, make it difficult to assess the need for the need for the program.

In 2014 PPS received a total of 27,810 calls, and “304 individuals accounted for the 449 calls for service”(Personal Communication, March 2nd, 2016). Well this gives a very rough estimate of the number of individuals who may meet the program criteria regarding mental-health, we still do not know how many of these individuals have previously committed an offence. which would preclude them from the program. It should be noted that this data likely underestimates the number of calls where mental-health is a factor, because frequently calls are marked under different categories within the police database (Personal Communication, March 2nd, 2016).

There is however some qualitative data which generally supports the claim that there is an unmet demand for the program. This is supported by the key informant who identified that they have witnessed ideal candidates for the PCD program going through the court system.

Core Findings:

- Some police perceive that the PCD program has limited applicability, due to the perceived need for immediate intervention.
- Some police suggest some families of offenders are reluctant to pursue approaches which involve potential punitive measures.
- Some police perceive the program to fail at holding the individual adequately accountable.
- Some police claim that a lack of feedback/communication between Court Support Workers and referring officers reaffirms the perception that accountability is lacking (though suggestions of inadequate feedback are contested).
- Anecdotal evidence suggests not all eligible individuals are being diverted.
- Evidence suggests police view PCD and mental-health diversions to the hospital as mutually exclusive measures.

Police Knowledge of Program & How to Divert:

Interviews with key informants presented conflicting accounts on the percentage of Peterborough Police Service officers which were aware that the PCD program existed. All officers in the focus group estimated that roughly 90% of officers were aware of the program (Personal communication, March 18th, 2016); however, another informant said “not many”, officers from the PPS and OPP were aware of the program (Personal communication, March 15, 2016). These comments were echoed by another key informant who said “I am not convinced, though, that a lot of them are fully aware of the program. I’ll take a ticket (PCD referral) out with me when I go on call because a lot of the officers don’t even have them on them” (Personal communication, February 23rd, 2016).

While the three officers in the focus group were each aware of the PCD program, two were not entirely familiar with the required paperwork (Personal communication, March 18th, 2016). In fact, one officer noted that they had not ever used the PCD ticket and that they “would not know who to send it to, [and] would not know what to include”, although they were familiar with these procedures for other diversion programs (Personal communication, March 18th, 2016). The informant, who expressed concerns of police not being familiar with the program also said “I have seen officers not know about it. Sometimes they aren’t even sure how to apply it even when they do know about it” (Personal communication, February 23rd, 2016).

Core Findings:

- Evidence suggests some proportion of the Police Officers are unaware of the PCD program.
- Two of three officers interviewed were unfamiliar with all paperwork required to complete a PCD.

Limited Resources:

A) Mental-Health Assistance for Officers

Peterborough Police Services houses a full-time Mental-health Outreach Worker who has many responsibilities including providing consultation and support to officers during crisis calls or on matters related to mental health (Personal communication, February 23rd, 2016). However, both the employee and officers identified that this employee's ability to respond to calls or provide consultation is limited (Personal communication, March 18th, 2016). Previously there was one full-time and one part-employee; however, currently there is only the one full-time employee (Personal communication, February 23rd, 2016). Officers interviewed cited availability as a direct barrier to consultation (Personal communication, March 18th, 2016), and noted that having only one such worker provides inadequate coverage for mental health calls which "occur 24/7" (Personal communication, March 18th, 2016). The aforementioned employee did report that they do go on "ride alongs", and respond to calls "once a day on average", but that it is "quite variable" explaining that recently their outpatient caseload "basically shut down all of [their] availability for the week" (Personal communication, February 23rd, 2016).

B) Policing & Emergency Mental-Health Services:

One officer noted that police "do not have the bodies to be staffing the calls that we receive as it is," and when asked to identify any barriers to making a diversion another officer responded that they are "time-constrained" (Personal communication, February 23rd, 2016).

During the focus group officers expressed concern about mental-health resources at hospitals. Long-wait times during diversions to the hospital were cited as a frequent problem

(Personal communication, February 23rd, 2016). It was reported that it is not "unheard of" for officers to wait 3-4 hours before the individual is admitted (Personal communication, February 23rd, 2016).The police view this as a sign of inadequate staffing in the hospitals, and note that it affects their ability to respond to calls (Personal communication, February 23rd, 2016).

Core Findings:

- Overstretched Mental Health Outreach worker's ability to provide consultation to officers and correspond to calls is limited.
- Police testimonials suggest some officers perceive the diversion to take time that the police do not always have to spare.

Section 6: Comparative Case Study Findings

Program Structure: Peterborough PCD

The third component of our analysis was based on a comparative case study between the PCD programs run through the Peterborough Police and the Durham Regional Police Service. Our aim was to identify key structural differences between the programs, and how these differences effect program utilization.

Starting with an incoming call, the Peterborough Police Officer can divert a charge at their discretion if they suspect there is a contributing mental health and/or addiction issue at play (Personal communication, February 5th, 2016). The PPS do have access to an in-house Mental-health Outreach Worker, who when available can be asked to provide onsite consultation services and support (Personal communication, February 23rd, 2016). The offender/suspect who has received the PCD ticket, will then bring the ticket to the courthouse (Personal communication, February 23rd, 2016). The client has 72 hours to get in touch with the program

Court Support Worker or else the charge will be laid (Personal communication, February 23rd, 2016). The Court Support worker not only is the initial point of contact for the individual but also oversees their treatment program or in other words provides case management services. (Personal communication, February 23rd, 2016). They will help develop the program curriculum and goals with the client to facilitate a personalized approach (Personal communication, February 23rd, 2016). Bi-weekly meetings occur until the candidate is deemed to have completed the program (Personal communication, February 23rd, 2016).

In the interviews conducted with Peterborough PCD staff, no non-compliance protocol was mentioned, although testimonials suggest that no individuals have failed to complete the program to date (Personal communication, February 23rd, 2016). However, this does represent a distinct difference with the Durham Regional Police Services program, which does have a non-compliance protocol set in place.

Program Structure: Durham PCD Program

Durham Police Officers use very similar eligibility criteria when determining whether to divert an offender or not, and are also able to refer to the program at their discretion (Personal communication, March 29, 2016). Durham officers have access to a Mobile Crisis Intervention Team, comprised of two police officers (DRPS) and two mental health nurses (DMHS), that can provide onsite consultation, support, and help identify where the PCD program would be applicable (DRPS & DMHS, March 26th , 2015). The referral ticket is submitted to a designated mental health police officer who is tasked with submitting the ticket and relevant documentation to the Court Support Worker (Personal communication, March 29, 2016).

This offender then has to meet with a Court Support Worker by the next closest Tuesday (up to seven days) who will explain the program (DRPS & DMHS, March 26th, 2015). The

Court Support Worker acts as a liaison between the case manager and offending clients (Personal communication, March 29, 2016) The case manager is the one who will be overseeing the treatment component of the PCD program (Personal communication, March 29, 2016), and provides individualized user-oriented programming. The client must meet with the case manager weekly for the entirety of the program (Personal communication, March 29, 2016). If the individual fails to engage with programming early on, an officer is sent to speak with them (Personal communication, March 29, 2016). The case manager has anywhere from 3-5 months to determine if the individual appears to be on track to complete the program (Personal communication, March 29, 2016). If an offender appears to be at risk of not completing the program, the Program coordinator will assemble a "case conference" to discuss the fate of the client being served (Personal communication, March 29, 2016). The referring officer, case worker, and court-support worker would participate in this case-conference. (Personal communication, March 29, 2016). During this case conference the parties decide whether charges will be laid or to re-engage the individual.

Below is a table outlining the program structure of the two pre-charge diversion programs outlined in the paragraphs above.

Program Collaboration:

Process	**Peterborough PCD Program**	**Durham PCD Program**
Incoming Call	• Police Officer (PPS)	• Police Officer (DRPS)

Consultation	• Integrated Mental-Health Responder (4CC)
	
	*Upon Request
		• Mobile Crisis Intervention Team MCIT
		  • 2 Police Officers (DRPS)
		  • 2 Mental Health Nurses (DMHS) **acronym**

		*Upon Request
Passing Ticket & Documentation to Court	• Police Officer (PPS) • Client (Civilian)	• Ticket Passed to Mental Health Police Officer (DRPS) • Then Faxed to Court
Assessment	• Court Support Worker (CMHA)	• Court Support Worker (DMHS
Treatment	• Court Support Worker (CMHA)	• Case Worker(DMHS

Non-Compliance Procedure	• N/A	• Police Check-up
		• Case Conference
		  ◦ Police Officer (DRPS)
		  ◦ Case Worker (DMHS)
		  ◦ Court Support Worker (DMHS)

Eligibility Criteria:

In regards to eligibility criteria, the Durham and Peterborough PCD programs are quite similar. The programs are designed for those 18 years of age and older, with a mental health and/or addiction condition, who consent to the voluntary program (Personal communication, February 5th, 2016; DRPS & DMHS, March 26th, 2015). The only divergence in program eligibility requirements comes into play with the offense criteria. The Peterborough PCD offense criteria requires that it is the individual's first offense and the crime to be-diverted was a non-violent offense (Personal communication, February 5th, 2016), whereas the Durham program does not prohibit violent offences or repeat offenders (Personal communication, February 5th, 2016).

Training and promotion:

Program information is disseminated differently between the two programs. An annual training exists within the Durham program which covers the PCD program. This training, which is provided by the Mobile Crisis Team Unit and the Mental Health Support Unit, is provided to

new recruits and officers undergoing recertification (Personal communication, March 29, 2016; DRPS & DMHS,March 26th, 2015).

The Peterborough program training is managed in a different way. Historically the PCD staff have provided pre-charge related training performed at police briefings (Personal communication, February 5th, 2016). Another CMHA body, the 4CC staff provide a one-time crisis intervention training to officers, which has previously incorporated training on the PCD program and had PCD staff come to train officers, although as noted earlier there is evidence which suggests PCD staff have not been incorporated recently(Personal communication, March 15, 2016).

In regards to promotion, evidence suggests that the Peterborough PCD program has fewer promotional initiatives to encourage program utilization. The Durham Mental Health Services has produced a training video for the Durham Regional Police Service, that outlines the program, how to administer it, and specifies the benefits of using the program from the perspective of the police (Personal communication, March 29, 2016). In principle, this provides more flexibility and accessibility to the training. Durham Mental Health Services also appears to have commissioned promotional material in police publications (Personal Communication: March 29th, 2016).

Comparison of Program Utilization:

The Durham Regional Police Service (DRPS) services a much larger population than the PPS, with a serviced population of 645,000 (DRPS, n.d., para.1) versus nearly 86,000 (Peterborough Police Service, 2014, p.4). Consequently, DRPS has a larger staff with approximately 1,1000 employees (DRPS, n.d., para.1) compared to PPS which has 145 employees (PPS, 2014, p.4). The Durham Regional Police Service PCD program diverted 52 charges between January 2009

and April 2015 (DRPS & DMHS, March 26th, 2015) versus the Peterborough Police Service PCD program which diverted 5 charges between October 2014 and February 2016 (Personal communication, February 23rd, 2016).

While Durham Regional Police Service averages roughly double the number of diversions per month when compared to Peterborough, it services around eight times the population. While it is difficult to make comparisons across jurisdictions which may be different in many respects, this data raises questions about the assertion that the DRPS outperforms the PPS in terms of PCD uptake.

Section 7: Recommendations

In the section below we have identified key areas for improvement for the Peterborough PCD program. During the course of the research it was clear all parties shared a concern for the well-being and quality of life of those with mental-health issues. Additionally, instances of positive collaboration and communication were identified. However, for the purposes of improving program utilization, only key areas of improvement are identified.

The first key area of improvement is collaboration and communication between key personnel of the agencies involved with the program. The second key area is training and promotion, which includes issues such as the limited incorporated of PCD staff and material into key trainings and what appears to be a lack of standardized training and defined responsibilities for these activities. This area is closely connected to that of police perceptions and knowledge of the program. Ensuring all officers are aware of and comfortable with the program will be critical, as will addressing and exploring their perceptions that the program has limited applicability and does not adequately hold individuals accountable. Another key area for improvement is staff and

organizational resources. A lack of staff and resources impacts program operations, particularly on-site consultation services as officers noted having only one Mental-health Outreach Worker means they do not always have access to such supports.

In light of the core findings identified throughout this report we propose a series of measures be taken to address each of the identified areas of improvement and the utilization of the program. Many of these recommendations such as regular meetings, gathering police feedback, and expanding training were made by PCD staff and 4CC staff involved in the PCD program.

1. Improve incorporation of PCD staff into annual Crisis Intervention training.

2. Establish clear responsibilities between and within agencies for program training and promotion.

3. Establish recurring communication through annual status updates with: PPS, PCD staff and relevant 4CC personnel.

4. Hold focus groups with Police Officers to identify key concerns and service gaps. Can be used to recalibrate program structure.

5. Ensure all officers receive training on the program. This includes identifying key police briefings and 4CC training's to deliver PCD training. Exploring the feasibility of providing a standardized training and refreshers to all officers and new recruits is recommended as crisis intervention training is a one-time training.

6. Increase the number of Mental-health Support Staff to assist with consultation in order to facilitate program utilization.

7. Explore the feasibility of creating a 24 crisis center with a no-refusal policy for police referrals or expand collaboration with pre-existing services at the Peterborough Regional Health Centre.

8. Create detailed materials or video outlining program structure, process, and benefits to be provided to police and CIT training

Summary Table: Core Findings & Recommendations

Communication
a) Lack of regular meeting (Key Personnel)
b) Lack of Collaboration
Training & Promotion
c) Lack of clearly defined roles
d) Lack of standardized training
e) Intermittent presence of PCD staff at 4CC training
f) Limited incorporation of PCD material into training
Police Perception: Limited Applicability
g) Does not provide immediate intervention at time of crisis
h) Family reluctant
i) Lack of accountability
Program Usage:
j) Tentative evidence not all eligible candidates are diverted
Police Knowledge:
k) Unaware of program
l) Unaware of required documentation
Limited Resources
m) Under staffing: Mental Outreach worker unavailable for consultation

1. Improve incorporation of PCD staff into annual Crisis Intervention training.

Addresses: D, E, F, K, L, J

2. Establish clear responsibilities between and within agencies for program training and promotion.

Addresses: B, C, D, K, L

3. Establish recurring communication through annual status updates with: PPS, PCD staff and relevant 4CC personnel.

Addresses: A, B, C, D, E, F, K, L

4. Hold focus groups with Police Officers to identify key concerns and service gaps. Can be used recalibrate program structure.

Addresses: G, H, I, J

5. Ensure all officers receive training on the program, identify key police briefings or training to achieve this.

Addresses: B, J, K, L

6. Increase the number of mental health support staff to assist with consultation in order to facilitate program utilization.

Addresses: A, B, G, H, I, J, K, L, M

7. Explore the feasibility of creating a 24 crisis center for police referrals or expand collaboration with pre-existing services at PRHC

Addresses: G

		8. Create detailed materials or video outlining program structure, process, and benefits to be provided to police and CIT training **Addresses:** D,F,K,L

Section 8: Conclusion

The research presented throughout this project has highlighted key areas of improvement within regards to training and promotion and, more broadly, communication and collaboration both within and between agencies. All agencies appeared to share a similar vision for ensuring that those suffering from mental-health issues received the most appropriate intervention. Evidence suggested, however, that officers do not always feel that the pre-charge diversion program is applicable in this regard for a variety of reasons, most notably the perception that most calls require immediate intervention. Perhaps more significantly, certain evidence suggests that a significant proportion of officers may be unware of the program or unsure how to implement it. While limited resources appear to affect the availability and ability of key parties to fulfill some roles, improved collaboration and coordination and clearly defined roles and responsibilities for activities such as program training and promotion could improve awareness and utilization of the program among officers.

A critical opportunity from the point of view of program promotion and training is the annual crisis intervention training. Provision of standardized PCD training material and regular attendance of PCD staff would be beneficial not only for training purposes, but to establish a rapport with officers, and address the concerns they may have regarding program applicability and accountability. Since this is an annual one-time training which is not provided to all officers,

other mechanisms for program promotion and training will need to be identified in collaboration with police counterparts. This may involve periodic attendance at police briefings. Given competing claims regarding the level of feedback officers receive and various concerns raised by officers, opportunities for future focus groups should be identified and the program should utilize this feedback to guide the program's implementation.

While there were competing views on whether the program was being under-utilized, some testimonials from Court Support Worker suggested that not all ideal candidates were being diverted. All parties appeared committed to ensuring such individuals were directed towards the most appropriate system, and many of the recommendations provided to achieve this end were put forward by informants themselves. This commitment and energy will no doubt remain an asset of the program and be vital to ensuring future program goals are met.

Glossary:

PPS: Peterborough Police Service
DRPS: Durham Regional Police Service
CMHA: Canadian Mental Health Association
DMHS: Durham Mental Health Service
4CC: Four County Crisis

Systematic Review: As defined by the Campbell Collaboration a systematic review "uses transparent procedures to find, evaluate and synthesize the results of relevant research" (para.2). These reviews include the following elements: "clear inclusion [or] exclusion criteria, an explicit search strategy, and systematic coding and analysis of included studies" (Campell Collaboration, para.5)

Grounded Theory Analysis: According to Bernard (2002) is "a set of techniques for (1) identifying categories and concepts that emerge from text, and (2) linking the concepts into substantive and formal theories" (pp.462-463). This involves using interview transcripts to identify themes, identifying connections between these themes, constructing a theory from these connections, and using illustrative quotes to present your results. (Bernard, 2002, p,463).

References

Butler, A (n.d.). Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices. Retrieved from http://icclr.law.ubc.ca/sites/icclr.law.ubc.ca/files/publications/pdfs/Mental%20Illness%20and%20the%20Criminal%20Justice%20System_Butler_ICCLR_0.pdf

Centre for Addiction & Mental Health. (2005).*A Needs Assesment Regarding Pre-Charge Diversion for Persons with Mental Illness in Toronto*.Retrieved from http://www.hsjcc.on.ca/Resource%20Library/Court%20Diversion-Support%20Programs/A%20Needs%20Assessment%20Regarding%20Pre-charge%20Diversion%20for%20Persons%20with%20a%20Mental%20Illness%20in%20Toronto%20-%202005.pdf

Durham Regional Police Service. (n.d.) *Community Profile*.Retrieved from http://www.drps.ca/internet_explorer/career/display.asp?Category=Community%20Profile&Under=Uniformed%20Recruiting%20=%3E%20Advantages%20to%20Working%20in%20Durham%20Region

Durham Regional Police Service & Durham Mental Health Services [Webinar]. (2015, March 23). Mental health adult pre-charge diversion program webinar. Retrieved from http://www.hsjcc.on.ca/Resource%20Library/Policing/Mental%20Health%20Adult%20Pre-Charge%20Diversion%20Program%20Webinar%20-%202015-03-26.htm

Durham Regional Police Service. (2016). *Mental Health Unit*. Retrieved from **http://www.drps.ca/internet_explorer/our_organization/unit.asp?Scope=Unit&ID=78**

Hartford, K., Carey, R., & Mendonca, J. (2006). Pre-arrest diversion of people with mental illness: Literature review and international survey. *Behavioural Sciences & the Law, 24 (6),* 845-856. Retrieved from http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Pre-arrest%20Diversion%20of%20People%20with%20Mental%20Illness%20-%20Literature%20Review%20and%20International%20Survey%20-%202006.pdf

Hartford, K., Davies, S., Dobson, C., Dykeman, C., Furhman, B., et al. (2004). *Evidence-based practices in diversion programs for persons with serious mental illness who are in conflict with the law: Literature review and synthesis*. Retrieved from http://bcm.connexontario.ca/Resource%20Library/Court%20Diversion-Support%20Programs/Evidence-Based%20Practices%20in%20Diversion%20Programs%20for%20Persons%20with%20Serious%20Mental%20Illness%20Who%20are%20in%20Conflict%20w%20the%20Law%202004.pdf

Livingston, D.J., Weaver, C., Hall, N., & Verdun-Jones, S. (2008). Criminal justice diversion for persons with mental disorders: A review of best practices. Retrieved from http://www.cmha.bc.ca/files/DiversionBestPractices.pdf

Peterborough Police Services. (2014). *Peterborough Lakefield Community Police Service Annual Report 2014. Retrieved from* http://www.peterboroughpolice.com/wp-content/uploads/2014/06/2014-Annual-Report-PDF1.pdf

Steadman, J.H., Deane, W.M., Borum, R., & Morrissey, J.P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services, 51,*

(5), 645-649. Retrieved from

http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.5.645