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WHAT WORKS? COLLABORATIVE POLICE AND HEALTH INTERVENTIONS FOR MENTAL HEALTH DISTRESS

CRIME AND JUSTICE

social research

What Works? Collaborative Police and Health Interventions for Mental Health Distress

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Executive Summary

The police coming into contact with those in mental health distress has been identified as a key issue in the Mental Health Strategy 2017-2027, Policing 2026, and Justice in Scotland: Vision and Priorities 2017. It is also a main theme for the newly established Health and Justice Collaboration Improvement Board.

Research Aims and Overview

This evidence review looks at collaborative interventions which help support people in mental health distress. It aims to outline 'what works' when individuals present in mental health distress to the police. The key objective is to examine interventions that have been utilised internationally and, where evaluations are available, identify what aspects of the approach work well/not so well.

Types of Intervention and What Works

Many collaborative interventions have been developed and piloted across the world. Interventions tend to fall into one of three categories:

- Increased training on mental health and distress for police officers
- Mental health staff working with the police service to triage, give advice or support over the phone or face-to-face if necessary
- 'Ride along' models where police and health practitioners work together in the response of mental health emergencies.

Increased police training and liaison

This type of intervention provides dedicated training to police on mental health. Evaluations found that:

- Evidence suggested that training is best delivered by mental health staff
- Role-playing is beneficial for real life experience
- Important to dedicate enough hours to training
- Interventions were more effective when the training was combined with some form of increased liaison with mental health practitioners.

Mental Health practitioner Embedded as a Contact for Police

A mental health nurse is embedded in control room, custody suite or provides a direct line of contact for officers. Evaluations found that this approach:

- Improved communication and information sharing
- Reached more service users than face-to-face interventions
- Was best for rural areas
- Was more costly overall but less expensive by case.

Co-Response Team

Team of one mental health nurse and one police officer. Evaluations found that:

- The teams were less likely to detain, hospitalise or charge individuals unnecessarily
- Some evidence of improved service-user experience
- Co-response teams did not provide as much geographical coverage or respond to as many incidents as other models
- Teams must be truly mobile to be efficient
- The teams were reliant on the nurses knowledge of the local area and health services.

Scottish Evaluations

There are two Scottish interventions currently being piloted or rolled out, with some evaluative evidence available. The Community Triage model piloted in a number of areas by Police Scotland provided a mental health nurse to conduct telephone assessments. This has been found to greatly reduce the length of time police spend on calls.

Distress Brief Interventions (DBI) are more in line with the first model. DBIs provide training to front line staff to improve compassionate response and referrals for onward care. The pilot is still in its infancy but a complete evaluation is being carried out.

Other types of promising interventions

There are a range of other promising interventions that can improve outcomes for mentally distresed individuals. These include those that are focused on prevention and early intervention - in other words, those aimed at preventing a crisis from occuring in the first place. These preventative or ‘upstream’ interventions can be used alongside the other types of interventions that will be discussed here. There are also interventions which involve assessing individuals remotely via a ‘telehealth’ assessment.

Conclusions

There are many examples of innovative and succesful collaborations for improving processes and outcomes for those in mental health distress presenting to the police. There are three main types of intervention approach and each can lead to different outcomes for the services or the individual. Therefore, it is clearly important to consider what the desired outcome of a planned intervention is. For example, reduced time spent by the police dealing with incidents, provide support to more individuals, smoother process and resolutions for the individuals, cost savings, better use of place of safety etc.

Overall, the evidence points to the most successful approaches being those which are well co-ordinated between policing and health, involve a high degree of information sharing and clear communications and consider the needs of local areas. There is also scope for innovation. One area that appears particularly

untapped through our examination of the evidence is technological innovation. For example, remote assessments. It may also be valuable to look into more preventative interventions, intevening before a crisis point is reached.

The recent establishment of the Health and Justice Collaboration Improvement Board could be a real facilitator in overcoming some of the structural and cultural barriers. The Board is ideally placed to direct a strong co-ordinated approach, which could lead to improved outcomes for both sectors and for individuals.

Introduction

Background

It is becoming well recognised that the police are dealing with increasing numbers of people in mental health distress and that this is placing significant demand on their services and that of health services. In Scotland:

- 1 in 6 adults struggle with their mental health each year (Scottish Government, 2016)
- Only 1 in 3 people who would benefit from mental health treatment are receiving it (Scottish Government, 2017)
- Police Scotland estimate that they responded to around 57,000 incidents in 2015 which had a mental health aspect (Police Scotland, 2016)
- 1,133 people were detained in a Place of Safety as a result of mental health concerns (Mental Welfare Commission, 2017)

There are no definitive data on the nature and scale of individuals in mental health distress coming into contact with the police, but we can get some insight through looking at data on the use of Section 297 (s297) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act). This provides police with the power to detain people from a public place for reasons related to mental health and hold them in a place of safety for a mental health assessment (However, it must be noted that these findings only provide a general indication of the issue and do not provide a complete picture – there are a number of reasons why these statistics are not entirely representative[1] including that they only account for those people assessed in A&E, and do not account for those assessed by e.g. out of hours, GPs etc.):

- 41% of all referrals were between 2100 hours and 0100 hours identifying a peak time in which support is needed.
- Over half of the referrals were as a result of concerns of suicide or self-harm which identifies a key distress presentation that police are encountering.
- 96% were seen within 2 hours which is well within waiting time requirements to be seen by a doctor or in accident and emergency (A&E) departments but is a long time for police to be away from patrol duties.
- 62% of referrals were allowed to go home (Macaskill et al., 2011).

[1] Across the country, Police Scotland (PS) have identified disparity in the reporting to the Mental Welfare Commission (MWC) . PS have engaged with MWC and conducted an initial review of practices. Measures taken following this were not as effective as anticipated, therefore further work in this area resulted in revised reporting processes being put in place in April 2018. PS are actively monitoring these processes in conjunction with the MWC.

Policy context

There has been extensive interest in this area throughout 2017 and on-going into 2018. Key national strategies have been published and a formal, cross sector leadership network created:

- Scottish Government strategy, Justice in Scotland: Vision and Priorities: identifies the relatively poor physical and mental health and wellbeing of those in contact with the criminal justice system. Includes as a priority the need for collaborative working and a particular focus on addressing mental health and addictions.
- Scottish Government, Mental Health Strategy: includes an action to support the criminal justice system to work effectively with local partners to improve outcomes for those with mental health problems.
- Police Scotland, Policing 2026: highlights that supporting vulnerable people or people in crisis is a major demand on police resources: mental health issues are identified as the most common vulnerability.
- Scottish Government led, Health and Justice Collaboration Improvement Board: comprising leaders of a range of key organisations, and established to provide strategic leadership to accelerate progress on issues where the health and criminal justice system intersect. One of the themes of this group is specifically policing and distress.

In recognition and support of the need for more and better collaboration between policing and health, we need a robust evidence base upon which to base decisions and action. This review is an initial step to developing the evidence.

Research Aims and Overview

This evidence review looks at collaborative interventions which help to support people in distress. It aims to outline ‘what works’ when individuals present in distress to the police. The key objective is to examine interventions that have been utilised internationally and, where evaluations are available, identify what aspects of the approach work well/not so well.

Methods and Limitations

The Scottish Government Library Service conducted a literature search in October 2017. Snowball techniques were then used to identify further relevant articles. We also asked academic and practitioner contacts to share any relevant references with us. Parameters placed on the search were based on time (past 10 years) and geography (Western jurisdictions as likely to be similar in policing and culture).

This review does not purport to provide a comprehensive and definitive account of the evidence on collaborative police and mental health interventions across the world. Rather, it is an examination of material which could be identified and accessed within a relatively short space of time.

Terms and Definitions

The key focus of this report is Mental health distress. Distress is defined as “an emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response” (DBI, 2017a: 1). It therefore requires no further police, ambulance or fire assistance yet the individual will require some treatment, assessment or care for their distress which has fallen on police to navigate this.

Types of Interventions and What Works

Many collaborative interventions have been developed and piloted across the world (Macaskill et al., 2011; Martínez, 2010; Shapiro et al., 2015). Each of the inter-agency approaches tend to fall into one of three categories (Kane et al., 2017; Shapiro et al., 2015; Wood and Watson, 2017):

- Increased training on mental health distress for police officers alongside improved interaction with mental health staff
- Mental health staff working with police services to triage and offer advice and support over the phone, or face-to-face
- A co-responding police and mental health team response or mobile unit

This section goes through each of these types of intervention in turn. It discusses some examples of where these have been used, considers evaluations and provides a summary of 'what works' for each type of approach.

Increased Police Training and Liaison

Increased police training to deal with mental health distress is a key aspect of most interventions. The use of increased training is often coupled with increased and more appropriate liaison with mental health services and is apparent in interventions such as:

- Crisis Intervention Teams (CIT)
- Mental Health Intervention Teams in Australia
- Connect Project in North Yorkshire

Studies suggest that police training tends to reduce the time police spend at the scene for a mental health incident and increases the numbers of police transportation to hospital while reducing arrests (Paton et al., 2016). However, there has been a lack of rigorous evaluation and understanding of its exact effectiveness to inform wider policy or practice (Forchuk et al., 2010; Paton et al., 2016).

In a study assessing what is needed for police in Scotland with regards to mental health, McKinnon (2014) highlighted that improving police training on mental health in line with physical health is a minimum requirement. Training should help officers identify mental illness or distress and divert the individual appropriately (Wood and Beierschmitt, 2014), thus preventing unnecessary arrests.

Although police training is encouraged in most interventions, the amount of training and a high level of understanding of its purpose is important (Martínez, 2010). A study of training interventions across Ontario found that 27 out of the 31 approaches surveyed provided five hours of training or less when the recommended amount of training was 40 hours (Durbin et al., 2010). Moreover, Ogloff et al. (2013) administered three different mental health screening tests to determine the number of people in custody who required specific mental health

care. The results varied depending on the test administered which indicates that there can be an inconsistency in identifying mental health issues even if a standardised test is used. Therefore, it is important to note that police training is not proposed as a replacement for professional mental health assessments but rather should ensure police can identify and divert people in distress appropriately.

Despite this, however, the Ontario study also found that training helped police to identify mental health issues but they encounter a problem when trying to get support from mental health services. Therefore an intervention which falls into this category of increased training would work most effectively when it also provided increased liaison with mental health staff. Otherwise, police officers use of training and their ability to adopt it to tackle mental health issues is highly reliant on their local knowledge of health services and the individual needs of the person in distress (Wood and Watson, 2017).

Crisis Intervention Teams

Crisis Intervention Team (CIT) models provide increased training and are particularly popular in America. Police officers are specially trained by mental health professionals to improve the identification of mental health issues and knowledge of care pathways available (Blevins et al, 2014). Some models also have non-refusal drop off points where police can take a person in distress and their care is guaranteed to be taken over by health services. The key aim is to improve the ability for officers to resolve the incident at the scene through the use of their training or with appropriate referrals (ibid).

Wood and Beierschmitt (2014) analysed mental health calls in one area of Philadelphia over eight years and identified that repeat callers to the CIT service created mental health hotspots. These repeat incidents highlight that CIT is helping police identify mental health issues more appropriately but the lack of long-term support for those who are in distress mean that the number of incidents is not reducing.

Existing studies, particularly outcome evaluations, on CIT are limited (Blevins et al., 2014). Evidence reviews are not available in this area because official data are not consistently recorded; the questions of interest are not covered in standard concern forms; and a lack of data sharing procedures means that a call from a person in distress cannot be followed through the system to gather information on the concern and the outcome (ibid).

Mental Health Intervention Teams in Australia

Another example of an increased training intervention are the Mental Health Intervention Teams (MHIT) in Australia. The evaluation of MHIT measures the intervention's success against its initial aims (Herrington and Pope, 2013). It found:

- The length of time spent by police at mental health incidents reduced overall. This reduction was put down to a smoother hand-over to health staff due to increased knowledge of symptoms and health terminology.

- The roles and responsibilities of each service were reinforced during the pilot which reduced unnecessary police attendance at incidents.
- There was improved collaboration between the services, however, there were still tensions around the reduction of police burden causing an increased health burden. This was recommended to be addressed by use of a centrally funded, holistic approach towards mental health to reduce competition between the services for resources.
- There was no significant impact in terms of reducing incidents or injury on mental health cases. Still, it was noted that previous cases of injury were small and often in these cases injury had been self-inflicted as a result of self-harm. Training is unlikely to reduce the cases of self-harm as they tend to occur before an officer has attended,

This evaluation indicates that the training has improved collaboration and confidence while reducing the burden on police time however, a more rigorous evaluation with comparators would help to support the conclusions.

Connect Project

A systematic review on police training programmes, conducted as part of a wider study by the University of York and North Yorkshire Police, provided some valuable insights into the use of police training interventions in the UK. It has to be noted that some of the conclusions were difficult to draw based on the wide variation of study designs and low quality of studies identified in the systematic review. This is partly due to the lack of studies which focused on training programmes specific to police and so the scope of articles included in the systematic review had to be widened to include other non-mental health trained professionals (Booth et al., 2017). Nevertheless, of the studies that were available with a specific mental health focus, a statistically significant improvement was found on the confidence and attitudes of trainees during mental health interactions. However, when looking at training that was provided only to police officers, there was no statistically significant impact on either skills or arrest rates. However, the study did find that there were positive effects on training when it included a dramatization or role-play element and when it was delivered by mental health staff.

On the back of this systematic review, the Connect Project developed a training package delivered to police by mental health practitioners. To determine the effectiveness of this package, a randomised control trial (RCT) was conducted of 12 police stations, half of which received the training and half had not (Scantlebury et al., 2017). After six months the study found that the training did not have a significant impact on the reduction of incidents reported to the control team, however, it did improve how police record the incidents. This supports the premise that increased training leads to change in attitudes and confidence of officers.

Moreover, the systematic review and RCT supports literature which promotes joint training delivered by mental health staff (Fenge et al., 2014; Kesic et al., 2013; Wood and Watson, 2017). This provides insights into the roles and responsibilities of the health service for police officers and vice versa which could challenge

professional cultural barriers in place between the two services with regards to this area.

Alongside opening up a dialogue between the services on the front line, the Connect Project identified the need for there to be a high level of co-ordination between the services for interventions to be successful (Solar and Smith, 2016). Currently, front line decisions are made by services independently and locally by regional boards, quasi-governmental agencies, and policy programmes (ibid). Having one police force in Scotland centralises this more so than in England but co-ordinating with health boards and local authorities has the potential to be relatively complex. In the face of budget cuts and austerity this is likely to create an even greater degree of complexity as neither service has the resources to take on the co-ordinating responsibility (ibid).

Summary

The evaluations of interventions that adopted an increased training model have found that:

- Police training on mental health is essential for any collaborative intervention to ensure police are able to firstly identify people in distress
- Training reduces unnecessary arrests and hospitalisation, provides smoother hand-overs and, ultimately, reduces the time police spent on incidents
- Training improves police confidence when responding to mental health calls
- Joint training with elements of role playing is an effective approach
- There must be adequate resources to deliver the required level of training
- An element of liaison must run parallel with increased training to ensure care pathways for service users are improved alongside improved identification
- Inconsistent recording has reduced the quality and comparability of evaluations.

Embedded Mental Health Staff in the Police

Another category of intervention is the embedding of a mental health professional within an area of the police, usually in a contact control room (CCR) or custody suites.

One of the key benefits on having a nurse within police settings is that they have access to both health and police records and information. Moreover, closer working and communication should improve information sharing and collaborative working. Wherever a member of mental health staff member is employed, the aim is to provide police officers with a direct contact to gain advice, support or on occasion provide a mental health assessment.

Interventions include:

- Some models of Street Triage
- Liaison and diversion

- Embedded staff in CCR

Street Triage

The traditional design of Street Triage aligns better with the co-response team category – to be discussed in more depth in the next section. However, two Street Triage pilots fall under the 'embedded mental health staff member' category. Firstly, the London Street Triage pilot was conducted across four London boroughs and provided 24 hour mental health telephone assistance to police (Hobson et al., 2015).

The evaluation of the London pilot (Hobson et al., 2015) found that:

- There was an increase of mental health incidents across the pilot areas
- The use of police custody as a place of safety declined
- While uptake of the service was initially low, police who did use the service tended to use it for place of safety recommendations

The findings, however, were not significant as similar trends occurred across London where no pilot was implemented. Also, the pilot was not fully staffed which was attributed to the low uptake as knowledge of the service and its availability was not as high as anticipated. Moreover, although police custody reduced as a place of safety this could be because officer who were utilising the service were calling for place of safety recommendations. Although this is a positive outcome it is not utilising the service to its full potential and further police training would be necessary to ensure police fully understand the purpose and remit of the scheme.

The second relevant pilot was conducted across nine areas in England and, although some of the pilot areas adopted a co-response model, most embedded a mental health nurse within a police setting or provided a dedicated phone-line for police to contact a nurse directly.The evaluation (Reveruzzi and Pilling, 2016) found that effective outcomes of the pilot included:

- the joint training programmes including clarity about the population to be served and agreed referral pathways
- joint ownership at a senior management level
- co-location of police and health staff such as in a control room or the provision of a dedicated phone line
- development of agreed protocols
- regular review process

A key finding is that much of the success was attributed to increased communication between the services and having a dedicated mental health nurse to provide support and information. Although it is difficult to differentiate between the pilot areas which adopted a co-response model, much of the data collected, regardless of the model, referred specifically to the above outcomes which are associated with having a nurse embedded in police settings.

Liaison and Diversion

Liaison and Diversion is another intervention which falls under this category. Maskrey et al. (2016) define diversion as the removal of a person suffering from mental ill health who is in contact with the criminal justice system to a more appropriate part of the criminal justice system or to community care in order to provide better outcomes. Liaison and Diversion (L&D) approaches aim to provide an assessment at the earliest point of contact with the criminal justice system so the individual can be diverted where possible or appropriately supported throughout their journey in the criminal justice system (Kane et al., 2017). They were first recommended in 1992 but have not always been consistently applied because of poor implementation, under funding and a lack of cross-stakeholder understanding (Fenge et al., 2014). The approach has since been endorsed for a national roll out in the 2009 Bradley review however its implementation at a national level is still inconsistent.

A refreshed L&D model was trialled across ten areas in England in 2014 and evaluated in 2016 (Disley et al., 2016). The evaluation found that:

- support workers who provide care after an individual has been referred through L&D are a key strength to ensure future engagement
- information sharing was recognised as a strength of the scheme
- valued partnerships are essential to ensure that referrals are appropriate
- across the ten test sites, relationships varied but consistently police were found to respond to the intervention well in all areas
- embedding a nurse in a custody suite was more expensive than prior approaches but it addressed more mental health cases and, as a result, the cost per case was less

Embedded Staff Member in Contact Control Room (CCR)

The approach of embedding a mental health nurse in a control role was piloted and evaluated in Norfolk Constabulary, England (Maskrey et al., 2016). The method seeks to reduce demand on police officers, reduce risk to harm to all parties and ensure appropriate care is provided by providing early intervention before a crisis point is reached (Gwent Police, 2016).

The evaluation of the Norfolk pilot found that the intervention reduced the use of s136 apprehensions, however, as an observational study no control group was used to measure the extent (Maskrey et al., 2016). The lack of a control group also meant that time and cost savings could only be inferred. From the estimates it is likely that the intervention reduced the cost to police and health services by reducing s136 detentions, however, even the estimated savings would not cover the cost of implementing the intervention. Still, further quantitative and qualitative data collected in the evaluation found that the intervention successfully supported mental health and police staff while providing better outcomes for service users. These benefits must also be considered alongside cost effectiveness. The

evaluation also found that there is scope within the intervention's current approach to expand its involvement in cases of self-harm, vulnerable adults and detentions under the Act.

The Norfolk model had four mental health nurses in the control room during peak hours to support control room staff and provide information and advice to police on scene or a person in distress. This was deemed more suitable than a street triage approach due to the rural structure of Norfolk and could be considered suitable for the rural areas of Scotland.

Information sharing was a key aspect to the success of these approaches (Fenge et al., 2014). The Norfolk pilot had written an information sharing agreement to be signed by relevant partners to ensure this. However, at the time of the evaluation the NHS trusts involved had yet to sign which, therefore, could have inhibited the accuracy of the evaluation or the success of the pilot (Maskrey et al., 2016).

Summary

In summary, evaluations of embedding a mental health member of staff in the police show that:

- Training is needed to ensure that police are utilising the service at the right times and for the right reasons.
- Information sharing between both services improves with this model which improves communication overall.
- Offering a telephone consultation works well as it provides support to more people than if the same nurse had to travel to conduct a face-to-face assessment. This has obvious benefits in rural areas and can reduce further distress caused by police or ambulance transportation.
- The cost of the service appears to exceed the potential cost savings however as it reaches more people the cost per case is less.
- A lack of comparative studies means that findings, particularly cost savings, can only be inferred.

Co-Response Teams

Co-response teams are made up of a mental health professional, often a nurse, and a specially trained police officer. The design of the co-response models vary depending on the intervention and the geographical location in which it is based. The differences are exemplified in the Street Triage pilots in England in which one had a mental health nurse on patrol with a police officer while another had a recovery programme integrated into the police response (Horspool et al., 2016). Co-response models that have been adopted and evaluated internationally include:

- Some Street Triage models
- Mobile Crisis Response Units

- PACER

Co-response models in general have been studied with more use of comparison or control groups than other models. A study conducted in Canada compared an area with a co-response team in place to a control area with no intervention before implementation, after one year, and after two years. The study found that, although the use of the co-response model increased and was in high demand, the call time reduced significantly (Kisely et al., 2010). The study assessed quantitative data of out-patient attendance after the intervention and qualitative data of service user experience and concluded that the intervention provided increased engagement and positive service user experience. However, the study did have limitations, particularly with recording bias and difficulty in generalising the qualitative findings, but it is one of the few studies with a control group and mixed methods evaluation.

A further study of service users experiences of a co-response model compared to police only responses found that co-response teams were more likely to provide voluntary and mandated escorts while police only models provided more involuntary escorts (Lamanna et al., 2017). Focusing on the service user experience, Lamanna et al. (2017) also found that the users commented on the knowledge, empathy and communication skills of nurses in the co-responding teams which improved de-escalation of the crisis. Similarly, a review of joint response models found that they referred many more people to mental health services, however, this provided a less traumatic and more engaging outcome for the service user (Shapiro et al., 2015).

Co-response models demonstrate an improved co-operation between services however a lack of resources is hindering this co-operation as the services, particularly health, are ill equipped to deal with this new demand (Morgan and Paterson, 2017). A study conducted by Ogloff et al. (2013) demonstrated the impact of this by surveying police officers in Australia. They found that 55% of officers surveyed would ideally seek the help of a Mental Health Crisis Assessment Team but, due to a lack of availability of the service, would actually detain the distressed individual under their equivalent of the Mental Health Act. Similarly, in a study comparing three different types of interventions in Canada, Durbin et al. (2010) found that, even when co-response models were in place, their use was low with the majority of officers opting to use it in less than 25% of cases.

Street Triage

In terms of specific co-response interventions and their success, much of the research is focused on Street Triage. The Nottingham Street Triage scheme provided two cars with a police officer and a mental health nurse available during the peak times of 16:00- 01:00 (NHS England, online). The one year pilot saw a 53% reduction on s136 detentions and, although there was a liaison service already in place, its success is contributed to the collaborative approach so much so that the funding for the scheme has continued beyond the pilot.

A Street Triage pilot in nine areas across England, identified that all areas had to adopt a different design as a result of varying geography, population and level of

mental health detentions (Reveruzzi and Pilling, 2016). An evaluation of the pilot found that it reduced s136 detentions, increased the use of health based places of safety, and reduced time spent in police custody (ibid). However, as there were a number of different approaches and models adopted across the pilot areas, it is difficult to infer which model contributed to the positive outcomes. Furthermore, although the pilots were all implemented locally and were run individually by selected police forces, they often ran across two or more NHS Trusts (Horspool et al., 2016). Mental health staff involved in Street Triage pilots, therefore, found it difficult to collaborate between the different health trusts and between institutional and community services. The success of the interventions was largely based on their own knowledge of the operating location and the services available (ibid). Therefore, increased knowledge of the services is necessary on both sides for the co-response model to be successful or it may be more appropriate to implement interventions more locally.

PACER

The Police Ambulance Crisis Emergency Response (PACER) model in Australia, and subsequent adaptations such as A-PACER and N-PACER, were developed from CIT and other approaches that have been successful across America (Huppert and Griffiths, 2015). PACER was implemented alongside increased police training and saw mental health professionals travel with police officers and respond to mental health calls or provide telephone consultations when a face to face response was not possible. This would ensure an appropriate and timely assessment by a mental health professional and more accurate and quicker hand-overs. The police officer can then manage the safety of the situation and will only provide transportation to an emergency department or a mental health hospital if the service user presents as violent.

A study of the A-PACER model compared to other Australian approaches found that police were less forceful, mental health staff were quicker to respond and assessed crises more accurately in person than over the phone (Evangelista et al., 2016). This resulted in less people being inappropriately imprisoned or hospitalised. An assessment of N-PACER model in Australia found that this approach provided service users with a greater perception of procedural justice, however, it was still found to be coercive and reduce service user autonomy (Furness et al., 2016). Moreover, although service users tended to be more satisfied with the co-response model some felt it would be more appropriate for health staff to respond alone (Evangelista et al., 2016).

A thorough assessment of the PACER pilot was evaluated against three outcomes: length of stay in emergency departments; time spent at crisis by the first responder; and cost effectiveness. Based on these outcomes it was found (Allen Consulting Group, 2012) that:

- Time in emergency departments was reduced due to improved handovers
- Police as first responders spent less time on mental health incidents due to less time spent in emergency departments and reduced need for police transport

- PACER appears to be less expensive than time and resources spent on alternative approaches. This costing, however, is based on many assumptions.

Moreover, the PACER approach receives strong ownership from both health and police sides but police refer to the success of the intervention being down to the locally devolved structure of the police force which contrasts with the centralised decision making structure of the Department of Health in Victoria (Allen Consulting Group, 2012).

Summary

Co-response models, particularly Street Triage and PACER pilots, have generally received positive evaluations. Findings include:

- Individuals who are in distress and are seen by a co-response team are less likely to be hospitalised, detained or charged unnecessarily.
- Co-response models did not provide as much geographical coverage or respond to as many cases as increased training models but they provided a better resolution on the scene on the incident.
- Service users generally had an improved experience and better onwards engagement with a co-response model to the extent that police contribution is deemed unnecessary.
- The local implementation has been identified as a key to the interventions success as it improves knowledge of staff and co-ordination. Such interventions may therefore be more strategically placed in local areas but must also balance the standardisation of a national approach.
- Although the interventions are recognised to be financially and resource intensive this is deemed as a short term impact. This investment is seen to provide further long term benefits as the skills learned during the co-response team hours can be applied by police on general policing duties. Moreover, working together would improve understanding from both health and police sides of the other sides' responsibilities and pressures which would further challenge cultural barriers.

Scottish Interventions

Community Triage

There are two collaborative interventions currently being piloted in Scotland which seek to address mental health distress. Firstly, Community Triage (CT) is a Police Scotland led intervention which was initially piloted in the Greater Glasgow and Clyde area in 2015 and has since been piloted in Edinburgh and Dundee. CT has been advocated by the Justice Vision and Priorities (Scottish Government, 2017) and by SAMH (2017). Police Scotland and health services continue to work together to develop these local partnerships.

CT provides a direct line for police to contact for a mental health assessment with the option for a mental health nurse to respond with a face to face assessment in the community (Wright, 2017). Generally, the CT pilots have found that:

- The majority of incidents were resolved over the phone
- Most assessments were conducted in a private place with the outcome allowing the person to remain at home
- Only a fraction were admitted to hospital or sent to A&E
- Police time spent on mental health calls has reduced in all areas.

Distress Brief Interventions

Distress Brief Interventions (DBI) were developed in response to the Scottish Government's Suicide Prevention (2013) and Mental Health (2012) strategies. The programme is set up as a two tiered, collaborative service working towards a common goal of providing a compassionate and effective response to those in distress. The first tier is delivered by front-line staff (primary care, police, ambulance and A&E) to ensure they provide a compassionate response with accurate referrals onto tier two. Tier two is provided by third sector organisations who are appointed at the local level as appropriate to provide community based support within 24 hours and for up to 14 days (DBI, 2017a). This intervention is difficult to categorise within the three identified categories. Generally, it aligns with an increased training model but it focuses more on the increased liaison, particularly onward referrals and care. The DBI pilot covers four areas in Scotland: Aberdeen, Inverness, Scottish Borders and North and South Lanarkshire and is co-ordinated by a programme board that reports into the Scottish Government. The pilot is set to last 53 months and a full evaluation is being carried out.

Other types of promising interventions

There are a range of other promising interventions that can improve outcomes for mentally distresed individuals. These include those that are focused on prevention and early intervention- in other words, those aimed at preventing a crisis from occuring in the first place. These preventative or 'upstream' interventions can be used alongside the other types of interventions that have been discussed here. There are also interventions which involve assessing individuals remotely via a 'telehealth' assessment.

Early intervention/prevention approaches

As was noted earlier, the Norfolk pilot aims to intervene at an early stage in order to prevent a crisis point. However, there are interventions and approaches which intervene at an even earlier stage and aim to prevent an individual from reaching a crisis point. These are referred to as 'upstream' interventions, and they aim to be proactive rather than reactive to individuals experiencing mental health distress. To put this into context, these interventions are part of a 'second generation' approach to support those experiencing mental distress; the 'first generation' of reform focused on improving the capabilities of police and law enforcement to respond to crises (Wood and Beierschmitt, 2014).

It is important to bear in mind that preventative interventions in this context sit in a broader area of early intervention and prevention work that spans a range of areas, including health and justice. 'Hot spot policing' has developed as an approach to help prevent individuals experiencing mental health distress from presenting to the police in crisis (Wood and Beirschmitt, 2014). A growing body of evidence suggests that mental health related calls and transportations are not evenly distributed across geographic areas; rather, there are clusters or hotspots (termed also as 'hotspots of vulnerability') where calls and transportations are disproportionately high. Other research evidence suggests that these hot spots are also those streets and areas where crime and disorder are also concentrated (White and Weisburd, 2017). Broadly, hot spot policing involves applying the same interventions and approaches explored- for example, the co-response model and CIT- but applying them in a more targeted way to these particular geographic locations. This is supported by criminological evidence- police knowledge and resources are best utilised when they are focused (as opposed to being applied in a uniform way) (White and Weisburd, 2017).

A recent study in the US applied a co-response model to a crime hot spot, and findings from this pilot suggest that a more targeted application of this model would maximise its effectiveness. Firstly, the process evalaution of this pilot intervention found that a pro-active (rather than reactive) approach was feasible. Secondly, despite some initial scepticism that local citizens would be guarded when interacting with police and mental health workers, there was in actual fact considerable openess. The evaluation also found that professionals were able to help citizens with other problems, in addition to mental health issues. This would potentially be of significant value when considering the co-morbidity of mental

health issues with other issues, including those that commonly co-occur, such as problem substance use. Furthermore, the evaluation found that community relationships with the police had improved as a result of this longer term engagement. Lastly, there was a sense that the more frequent police presence had contributed to reductions in the level of crime and disorder, although this was not quantifiable (all White and Weisburd, 2017). These findings are echoed by a study from Wood and Beierschmitt (2014) who call for a move from 'case management' to 'place management'; that is, shifting from looking at individuals, to looking at communities where mental health calls and transportations (and related issues) are experienced disproportionately.

Further research and evaluation is required, as well as careful consideration of how hot spot policing could apply to Scotland with its distinct geographic and structural context (as outlined earlier). However, available evidence suggests this is a promising approach.

Tele-health assessments

Tele-health "involves the remote exchange of electronic information between patients and health care professionals" (Steventon and Bardsley, 2012). Tele-health is used throughout the world and applied to a range of health issues, including those which are related to mental health (Saurman et al., 2011). It has the overall aim of improving the quality of health-care while reducing budgetary pressures (Steventon and Bardsley, 2012). In the context of mental health, telecommunication technologies (such as video link) can be used to assess an individual from a geographical distance. In this particular context, tele-health is often referred to as 'telemental health', 'tele psychiatry or 'tele psychological services'.

As with other interventions and approaches in this field, a greater number and/or more in depth evaluations of tele-health interventions would be welcome. However, a comprehensive review of telemental health interventions concluded that they were effective in diagnosing and assessing across the general population, as well as across different population sub groups (such as adults, children, and the elderly); in terms of the effectiveness of these, they were comparable to face to face consultations (Hilty et al., 2013). As has been raised already, satisfaction with a service, from the perspective of both patients and health-care providers, is of course very important. Another comprehensive review found both groups to be satisfied with the service offered by telepsychiatry (Khalifa et al., 2008).

Key benefits to telemental health include savings in time, money and travel (Khalifa et al., 2008). These benefits may be particularly felt in rural or remote locations where the time and financial costs associated with patient transportation to facilities are typically higher than in urban areas; this was borne out in an Australian study which piloted an effective service to provide 24 hour access to mental health specialists via video-link (Saurman et al., 2011).

There are a number of drawbacks and concerns associated with telemental health assessments. For example upfront costs will be incurred when the technology is

installed, though the evidence suggests that this may be offset by reducing costs overall (Hilty et al., 2013). There are concerns around the availability and reliability (e.g. technical issues) of technology (Khalifa et al., 2008). There are potential diagnostic issues in the sense that some symptoms are more likely to be obscured in a video encounter than in a face to face interaction- for example, restless legs beneath a desk (Khalifa et al., 2008). However, for such cases, a video assessment could be used as a initial assessment, before a follow up face to face assessment; an approach that developed in an the Australian study (Saurman et al., 2011). Another concern relates to patient privacy- for example, a private discussion could be overheard by a non clinical member of staff; local arrangements would have to be made to minimise the risk of this.

Further research is needed into the use of tele-health for mental health, and the practical and ethical considerations that tele-health raises must be fully addressed. However, the available evidence suggests that tele-health assessments in the context of mental health distress are a valuable tool, either as stand-alone or initial assessments. Moreover, while mental health issues are unique and raise particular patient needs, it is important to reiterate that tele-health is widely (and increasingly) used internationally, and successfully responds to and treats a range of health issues.

Conclusions

Policing and mental health distress has become a prominent issue in Scotland and there is recognition that there is opportunity to work together in this area for better outcomes. This review is an initial look at the evidence on policing and mental health, focusing on interventions and what works. This forms the basis to start to inform decisions around whether and how policing and health should work together and what this should look like.

There are many examples of innovative and succesful collaborations across the world for improving processes and outcomes for those in mental health distress presenting to the police. This demonstrates, firstly, that Scotland is not alone in facing this challenge and secondly, that there is a wealth of information that can inform the next steps taken in Scotland.

There are three main types of intervention approach and each can lead to different outcomes for the services or the individual. Therefore, it is clearly important to consider what the desired outcome of a planned intervention is. For example, reduced time spent by the police dealing with incidents, provide support to more individuals, smoother process and resolutions for the individuals, cost savings, better use of place of safety etc.

Overall, the evidence points to the most successful approaches being those which are well co-ordinated between policing and health, involve a high degree of information sharing and clear communications and consider the needs of local areas. There is also scope for innovation. One area that appears particularly untapped through our examination of the evidence is technological innovation. There may be potential to learn from other areas of health here. For example, remote assessments may be used as an important initial assessment before following up with a face to face assessment.

While this review has largely explored colloborative approaches that respond to individuals presenting in crisis, it has also touched on a more ‘upstream’ approach which employs these same interventions but in a more targeted way (e.g. to areas where mental health calls or required transportations are particularly high). This approach has the aim of preventing individuals from eventually reaching a crisis point. While additional research and evaluation is needed, findings from existing evidence (including evidence from other areas) reinforces the wisdom of exploring these further.

The recent establishment of the Health and Justice Collaboration Improvement Board could be a real facilitator in overcoming some of the structural and cultural barriers. The Board is ideally placed to direct a strong coordinated approach, which could lead to improved outcomes for both sectors and for individuals.

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