
# Police Management of Mental Health Crises in the Community

## Law Enforcement and Mental Health Special Interest Group (LEMH SIG) Guideline

# Global Law Enforcement & Public Health Association Inc. (GLEPHA)

## Law Enforcement and Mental Health Special Interest Group (LEMH SIG) Consultation:

# Police Management of Mental Health Crises in the Community

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## Glossary of terms

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| CIT | Crisis Intervention Team |
| CJS | Criminal Justice System |
| MCIT | Mobile Crisis Team |
| MHFA | Mental Health First Aid |
| MHS | Mental Health System |
| MoU | Memorandum of Understanding |
| NGO | Non-Government Organisation |

# Overview

This guideline aims to improve the outcomes of situations where police respond to people who are experiencing mental health crises in the community. This guideline focuses on: i) enhancing police responses to managing mental health crises, and ii) improving partnerships with people with lived and living experience of mental health issues and community mental health services. Although this guideline's focus is on the police management of mental health crises, it is imperative to emphasise the need for the public MHS to: i) improve mental health promotion and early intervention to prevent and decrease the occurrence of mental health crises, ii) develop alternatives to police involvement when mental health crises do occur, and iii) enable appropriate and timely follow-up care and treatment for people who experience mental health crises in the community.

## Who is this guideline for?

- Police organisations and police officers.
- People experiencing mental health issues, their advocacy organisations, and their significant others.
- Community mental health organisations, social and welfare organisations, and their employees.
- Academics and NGOs interested in the intersection between policing and mental health.
- Local, state and federal (where relevant) government departments tasked with health promotion, prevention, early intervention, community support and treatment policy and practice.

# Recommendations

### Overarching recommendations

- *Police involvement in mental health crises in the community, albeit necessary in some circumstances, should be recognised as a restrictive and inappropriate intervention that reduces people's autonomy and may lead to worsening of their mental health in some cases. There needs to be a greater emphasis on reducing the demand on police services to manage mental health crises in the community.*

- *There ought to be greater emphasis on increasing availability and effectiveness of community mental health services that aim for prevention of mental health crises, early and non-police intervention in mental health crises, follow-up care, and restoring individuals to their optimum mental health following a mental health crisis.*

- *Police roles and responsibilities in the management of community mental health crises need to be clearly specified and adhered to by all stakeholders. The resulting training for all police officers needs to be based on the parameters of this prescribed role, which ought to be grounded on best available evidence, considerations of local needs and resources, and the preferences of people who experience mental health issues in our community.*

- *The important work at the intersection of police and mental health needs to be based on the values of trust, respect, honesty, equality, and transparency between people with lived and living experiences, police organisations, and mental health services. It is of utmost importance that, from the outset, these partnerships meaningfully involve experts-by-experience as partners.*

- *Policy and practice related to the intersection of police and mental health needs to be firmly underpinned by good quality research. In addition to researching and further advancement of current initiatives, additional progress can be made through the use of large-scale reliable linked data sets between policing and health partners, including emergency departments, to understand service demand, care pathways, and clinical outcomes for people. The creation and implementation of preventative policies should be based on these, in both the MHS and the CJS.*

**Specific recommendations**

I. *There must be adequate and corresponding development and sustainability of social determinants of health and early prevention and treatment options within communities that meet the self-identified needs of people with, or at risk of developing, mental health issues.*

II. *Police training and responses to managing mental health crises in the community ought to be: based on relevant laws and regulations as well as on the available best-practice evidence, specifically tailored to the local needs and available resources, and with ongoing involvement of both experts-by-experience and other experts in mental health.*

III. *Police training should follow a tiered approach, whereby all police officers receive some mental health training, and where police performing in special duties receive further specialised training specific to their duties.*

IV. *The exact training curricula will be locally determined, however, the following ingredients are essential: 1) identification of signs suggestive that a person is experiencing mental distress; 2) verbal and non-verbal communication skills, 3) verbal and environmental de-escalation strategies, 4) the training ought to be experiential and scenario-based, and 5) there must be ongoing guidance from experts-by-experience and other experts in mental health in developing, delivering, and evaluating training.*

V. *Strategies ensuring sustainability of training initiatives ought to be prioritised, such as: 1) development of good quality evaluations which inform future improvements; 2) appropriate and timely re-training programmes, and 3) availability of accessible repositories of relevant mental health information.*

VI. *Training evaluation needs to be inclusive of how training is manifested in the performance of duties.*

VII. *Reductions in discriminatory attitudes toward people experiencing mental health issues and fostering of professional and respectful attitudes and relationships, underpinned*

*by strong organisational values, ought to be a part of any police education strategy/response to the police-mental health interface.*

VIII. *To further reduce the incidence of use of force on people who are experiencing mental health issues, any training police receive on managing mental health crises in the community needs to be aligned with the use of force training and tactical options training.*

*IX. Given the upholding of the necessary protections of information retention, dissemination, and destruction, the voluntary Vulnerable Persons Registry may be a useful tool to further assist in the successful police management of mental health crises.*

*X. Good partnerships are those formed and sustained between experts-by-experience (their significant others), the police, and the MHS. For equity in partnerships, it is vital to include representatives of local peer-run organisations to ensure a representative voice from those communities.*

*XI. Good partnerships are those based on the values of trust, respect, honesty, equality, and transparency.*

*XII. Effective partnerships between people experiencing mental health crises and police extend beyond experts-by-experience involvement in program development, delivery and evaluation and, crucially, to their treatment during these encounters with police. Therefore, there ought to be a focus on procedural justice and, wherever possible under the given situation and within the legal context, people experiencing mental health crises in the community are to be assisted through the least coercive means and ought to be supported in actively contributing to their care at the time.*

*XIII. Effective partnerships between the police and the mental health services are those where: 1) police involvement in mental health crises is minimised, 2) there are timely and effective community crisis services available, 3) local MoUs that guarantee timely transfer or introduction to accepting hospitals and other community facilities are adhered to, and 4) there is appropriate follow-up mental health care and treatment in the community.*

*XIV. To ensure the sustainability of these partnerships, ongoing regular meetings with all representatives, appropriate information gathering and sharing, and ongoing evaluations, are essential.*

*XV. To advance and inform future policy and practice, it is crucial to design rigorous research studies to explore important questions regarding best practice when police manage mental health crises in the community. This includes collecting comprehensive and reliable data on situational, person-based, and police variables.*

*XVI. Practitioners and experts-by-experience need to be involved in providing meaningful interpretations of the implications of research findings.*

*XVII. Research findings need to be accessible to the relevant stakeholders through ensuring considered publication outputs and the development of a comprehensive knowledge*

*translation strategy. An initiative such as an accessible knowledge hub is important to the advancement of research, policy and practice.*

XVIII. *Where possible, anonymised routine data should be exploited to summarise outcomes for people in contact with police and MHS within existing pathways of care, and/or of the effectiveness of new interventions as they are implemented. Data on an individual level is particularly powerful where direct linkages can be made between health and police databases and should be pursued, permitting estimates of service use, and clinical outcomes of people.*

XIX. *Prior to implementing relevant policies and practices police forces ought to consider: 1) their own organisational policies, resources, and needs, 2) the needs and recommendations of people with lived experiences of mental health issues, 3) the rights, responsibilities and accessibility of the key stakeholders, and 4) evidence regarding best-practice responses.*

# Introduction

In the recent decades, the contact between the police (law enforcement) and people who experience mental health issues and mental illness [ii] has increased. As a result of the deinstitutionalisation of the public mental health system that occurred in the late 1980s and early 1990s, the treatment and support for those experiencing mental health issues, some of whom had been given diagnoses of a mental illness, mainly occurs within the community. It is estimated that anywhere between 10% and 40% of police time is dedicated to resolving calls involving a person who appears to police to be experiencing a mental health issue or crisis, or is known to have been given a diagnosis of mental illness (e.g., Godfredson, Thomas, Luebbers, & Ogloff, 2011; Morabito, Savage, Sneider, & Wallace, 2018). Although most of these contacts can be described as routine and non-eventful, in a minority of cases police officers use force, and even less commonly fatal force. Police forces have made (and continue to make) significant changes and improvements to the way in which they interact with people experiencing mental health crises and mental illness in the society. Nevertheless, there is a considerable variety in the type of training and models that police departments across the Western world provide. While some of these approaches have been evaluated, to a degree, others have not, and the generalizability and applicability of these models remains unknown. As such, the evidence base for what works, for whom, and under what circumstances remains limited and altogether poorly understood. Properly understanding the mechanisms associated with positive outcomes in this area is essential to being able to assist those at this intersection to reach more positive outcomes from these encounters. Documenting these in one readily accessible guideline is one way of providing the means and opportunity for widespread impact and sustainable improvements.

To properly understand what works, for whom and under what circumstances, it is crucial to listen to and document the expert views and experiences of a wide range of people who are either immediately involved, or in some way impacted by incidents that occur at this interface. Clearly, operational police officers and mental health clinicians are faced with these kinds of challenges on a routine basis and are often required to make decisions in time pressured, often resource-limited circumstances. Also, centrally important is the meaningful incorporation of the expert views and experiences of people with lived and living experience of mental health issues [iii] and of their significant others. This is particularly important to ensure that the guideline is relevant to people affected by the recommendations and that it acknowledges general or specific preferences and choice. A group of 50 individuals with expertise in one or more of these

[ii] *Mental illness* will be used instead of *mental disorders, where required,* throughout this document as a preferred less stigmatising terminology. At present, the formal diagnostic terminology maintains the term *mental disorders* to refer to various mental health conditions diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM V; American Psychiatric Association, 2013) or the International Classification of Diseases 11 (ICD 11; World Health Organization, 2018). A mental disorder therein is roughly defined as disturbance of one's cognitions, perceptions, affects, and behaviour that is significantly affecting their everyday living, such as their relationships, employment, and/or education. A person may experience mental health issues, however, they may not have a formal diagnosis of a mental disorder according to these two classificatory systems and/or the police may not be aware of a formal diagnostic history. Therefore, to be inclusive, unless referring to a known history of mental illness, we will use the term *mental health issues*, which may include a formal diagnosis of a mental illness.

[iii] Over the years, there have been many challenges and revisions to the nomenclature used in this area (e.g. consumers, patients, clients, service users, etc; see McDonald, 2006). In line with the most recent developments, we will use terms *experts-by-experience* and *people with lived experience* of mental health issues throughout this document.

areas were invited to a two-day consultation in Toronto, Canada, to discuss the issues of importance when police manage mental health crisis[iv] incidents in the community.

Over the course of two days in October of 2018, a consultation group of 31 people met and sought to combine a synthesis of the available evidence base with practical expertise and lived experience. People who attended the consultation included representatives from the following groups: operational police, mental health clinicians, people with lived experience of mental health issues, and their significant others. A select group of academics, who had established expertise in policing and mental health also attended. The consultation group included representatives from Australia, the USA, Canada, the United Kingdom, and the Netherlands.

The ultimate goal of this consultation was to develop a Best Practice Guideline regarding policing models of responding to mental health crises, the focus being on training and partnerships. In order to achieve this goal, the group followed the general format and processes recommended by the United Kingdom's National Institute for Health and Care Excellence (NICE) for the development of Practice Guidelines.

## Literature summary

Broadly speaking, current police responses to dealing with incidents involving people who experience mental health issues have been categorised as: i) specialised police responses, ii) co-responder model/street triage responses, or iii) bespoke responses based on local needs and considerations[v].

### Specialised Police Responses

Perhaps the best-known model of police-based programming is the *Crisis Intervention Team* (CIT), commonly used in the United States and in the state of New South Wales, Australia. The CIT model, also known as the Memphis Model in its original form, began in Memphis in 1988 following a police fatal shooting of a man who was experiencing a severe mental illness (Dupont & Cochran, 2000). The CIT model is composed of patrol-based police officers who self-select and receive 40 hours of extensive training in crisis intervention and psychiatric issues (such as mental illness, substance abuse, effective communication methods, legal frameworks, etc.). CIT trained officers respond to calls that are identified as those where mental illness is a presenting factor. Its proponents posit that CIT is *more than just training* because it involves the development of strong partnerships with stakeholders and the community, and active changes to police and mental health services organisational policies and practices (Donohue & Andrews, 2013; Watson & Fulambarker, 2012; Watson, Ottati, Draine, & Morabito, 2011). For example, a central element of CIT that is also claimed to be one of its

[iv] *Mental health crises* are here defined as those incidents where a person is experiencing difficulties with their cognitions, perceptions and emotions, and which are impacting on their behaviour in such a way that police believe they are in a crisis that may lead to an increased risk of harm to self or to others.

[v] Traditionally, as per Steadman et al., (2000), responses at this intersection had been divided into: a) *police-based specialised police response* (e.g. Memphis CIT, CSO), b) *police-based specialised mental health response* (e.g. co-responder models like the MCIT and street triage), and c) *mental health-based mental health response* (i.e. community mental health teams, such as the Victorian Acute Community Intervention Service). Co-responder models and street triage models are essentially the same type of response.

main success points is a drop-off mental health centre (Martinez, 2010), developed through the partnerships formed with community organisations. In many communities, the CIT model has been adapted to the practicalities of the local context. However, in some cases, the CIT program has been seen only as a police training program or modified in ways that have produced unanticipated and problematic results[vi]. To aid communities interested in implementing a successful CIT-based response, CIT International recently published a detailed and comprehensive guide that at the very outset emphasises the importance of establishing and maintaining effective community partnerships to the success of any CIT program (Usher, Watson, Bruno, Andriukaitis, Kamin, Speed, & Taylor, 2019).

Following their review of the literature on CIT effectiveness, Compton and colleagues (Compton, Bahora, Watson, & Olivia, 2008) suggested that depending on the exact adaptation of the CIT model and its stipulated goals, the program can be viewed through many different prisms: officer safety program, officer training program, community safety program, or prison diversion program among others. This also means that there is some variability to what CIT looks like in practice, which is likely to have implications for its evaluation.

The literature on CIT suggests that this model has positive effects on officer cognitive and attitudinal outcomes and leads to: i) significant and sustained increases with respect to officer knowledge about mental illnesses and confidence in handling these calls (Compton, Bakeman, Broussard, et a., 2014a; Bonfine, Ritter, & Munetz, 2014, Wells & Scafer, 2006); and ii) significant changes in attitudes about, and reduced levels of stigma towards, people with a mental illness (Compton, Bakeman, Broussard, et al., 2014a). However, these studies do not consider what attitudes people with lived experience consider less discriminatory. There is also relatively strong evidence that the training leads to changes in officer behaviour related to use of force and call resolution, with CIT training consistently associated with increased linkages to care and in some studies reduced rates of arrest (Compton, Bakeman, Broussard, et al., 2014b; Kubiak, et al 2018; Watson, Ottati, Draine & Morabito, 2011). Collectively, the published research findings have led some proponents to propose that CIT can be argued to be *best practice* with respect to improving individual (i.e., officer-level) attitudinal outcomes and linkages to care (Watson, Compton, & Draine, 2017).

At this time, there remains a lack of research that has examined cost effectiveness of CIT. Additionally, there is significant variation in CIT implementation and without a fidelity measure, it is difficult to compare across studies or determine the active ingredients beyond the training of officers. The research on CIT to date has also been criticised for the lack of inclusion of experts-by-experience and family members with respect to how they experience these encounters and what are their dispositional preferences in these situations.

### Co-responder model/street triage responses

Whereas most research has been conducted on the effectiveness and impact of the CIT model, comparatively less research has been conducted and reported on the embedded co-responder-type responses. While the specifics vary somewhat between services, the essential component of the embedded *co-responder* models is that a police officer and a mental health worker (e.g., most often a mental health nurse, but may also be a social worker) are a team that respond together to calls involving people experiencing mental health issues (Cotton & Coleman, 2010). The distinction is made here between an *embedded* co-responder model and

[vi] See the CIT International's website regarding research at www.CITInternational.com/research.

services co-responding to an incident, with the latter being a situation where a police service and an outreach mental health service respond together to a mental health crisis incident in the community, following either service being the initial recipient of the mental health crisis call and requesting the attendance of the other service.

It is important to mention that a number of places have official responses to mental health crises that are best described as both a co-response and embedded co-responder models. For instance, in each state of Australia, the Crisis Assessment and Treatment Teams (CATTs) have existed for more than two decades; a Mental Health System based service, they aim to respond to mental health crises in the community, and originally were to be accompanied by police only where violence was a risk factor (Caroll, Pickworth, & Protheroe, 2001). Although initially introduced following mental health system deinstitutionalisation to provide a mobile community mental health crisis service operating 24 hours/7 days, their role over time has moved away from this aim and into what can be described as short-term treatment/case management service (Bonighton, 2012). This development, claimed police, mental health workers, and people with lived experiences, resulted in a significant gap in responding to community mental health crises; a gap that was then by default left to the police service to attempt to address (Bonighton, 2012). Since the introduction of the new Victorian *Mental Health Act* in 2014, this service has been both somewhat modified and renamed – now called the *Acute Community Intervention Service*, it provides for outreach, hospital, and telephone assessment in acute situations, at times together with police officers (Department of Health, 2014). In addition to this independent co-response, Victoria also has an embedded co-response model that operated across the state, called PACER (Police, Ambulance, and Clinical Early Response; Department of Health, 2014; Pearson, 2009). Perhaps the most widely-known working example of embedded co-response model is the original Mobile Crisis Intervention Team (MCIT)[vii] which is the most common police response used in Canada. A further response based on a similar model, the *street triage* model, is the most common approach used by 42 of 43 Police Forces in England and Wales (HMICFRS, 2018).

A recent systemic review of the co-responder model by Puntis and colleagues (2018) noted that due to the significant variability in the responses that can be and are subsumed under this umbrella term (e.g. first vs. second response team, hours of operation, on-the-scene vs. telephone mental health support, etc.) as well as the lack of experimental studies, it is difficult to make significant conclusions about the effectiveness or efficacy of this type of model as a police response to mental health related situations. Indeed, although both the PACER and MCIT models are considered co-responder responses, they not only differ in the aforementioned considerations, but also in the training that the officers performing these duties receive: whereas PACER officers receive no extra mental health training specific to their PACER duties, the MCIT officers receive in excess of 40 hours specific mental health training, as well as additional training that addresses emerging needs (Bonomo, *personal communication, 19* October 2018).

Despite the differences in the practical application of these different co-responder models, the limited published research that is available shows some promising results. For example, co-responder evaluations conducted across the pilot sites in England and Wales have generally found the street triage model to be associated with reductions in involuntary hospitalisations, or Section 136s (e.g., Heslin, Callaghan, Packwood, Badau, & Bayford, 2016;

[vii] The current MCIT model based out of Toronto has evolved to involve police members receiving specialised mental health training similar to that received by the CIT members.

Jenkins et al., 2017; Keown et al., 2016). Whereas some studies have found the model to be more cost effective (Heslin et al., 2016), others have found that it increased the costs slightly (Heslin, Callaghan, Barrett, et. al., 2017). In Victoria, Australia, co-responder model evaluation results indicate that it is associated with faster access to mental health services, faster release of first responders, reduced use of police transport to psychiatric facilities, reduced Emergency Department trajectories, and reduced costs (Allen Consulting Group 2012; McKenna, Furness, Oakes, & Brown, 2015). Whilst those who are experiencing mental health issues would understandably prefer a community based response at times of mental health crises (e.g. Boscarato et al., 2014), where police attendance may be necessary, the PACER model is generally seen as more beneficial, as well as being more preferred, by a range of stakeholders and people with lived experiences (Boscarato et al, 2014; Evangelista et al., 2016, Lee et al., 2015).

More recently, police forces that have adopted a co-responder approach to mental health crises have additionally incorporated other elements into their response model leading to an augmented model. Arguably one of the most prominent examples of this hybrid type of model has been the introduction of CIT-style training for MCIT officers we noted above. While Toronto's co-responder team officers receiving 40 hours of specialist mental health training, under the Hamilton Model, a team similar to Toronto's MCIT is dispatched alongside a primary police unit to mental health crises, and its members receive specialist mental health training (Fahim, Semovsky, & Younger, 2016).

Although limited in number, the existing evaluations of both of these responses show some promising results. The Hamilton Model has been found to be associated with reduced Emergency Department visits and a reduction in time officers report spending on these calls (Fahim et al., 2016). Evaluations of Toronto's MCIT model show somewhat different results: Almost a third of the mental health crises were repeat incidents and police spent longer time on these calls, however, wait times in Emergency Departments for voluntary admissions, which were more common under this response, were shorter than for non-MCIT responses (Lamanna et al., 2018). Further, people with lived experience who used the MCIT service generally had a favourable view of the response, in that they found it more compassionate and empowering, and MCIT staff more knowledgeable, than those who had a non-MCIT response (Lamanna et al., 2018). To improve generalisability of these findings, more studies that also include random sampling of participants are required.

### Bespoke/other responses

Other jurisdictions have opted for a range of bespoke police-mental health responses, based on their local needs. By way of example, in some small rural places all officers may receive a degree of mental health training, and their responses to incidents where people are experiencing mental health crises occur on the basis of the received training in line with rules and regulations from locally developed MoUs with mental health services about the management of these incidents (Cotton & Coleman, 2010). There have also been more recent innovations in remote video assessments - "tele psychiatry" or "tele psychological services"- it has been argued that this type of approach can be particularly important in rural and remote areas where there are limited services spanning significant geographical distances (Saurman et al., 2011).

In some police jurisdictions in the UK, police have devised bespoke training packages based on local needs and available resources, such as the one-day bespoke training package for officers in the County of Yorkshire that have led to improvements to the police recording of mental health-related incidents (Scantlebury et al., 2017). Another tailored mental health training package developed for professionals working in managing psychiatric crises across the Northern England Strategic Clinical Network is simulation training called RESPOND. This training is delivered in two modes to a range of professionals working in this area, including police officers. It has been evaluated twice to date (Machray, 2017). These two evaluations indicate promising results, with RESPOND training appearing to improve understanding and collaboration between stakeholders in successfully managing mental health crises. Furthermore, some two thirds of the trained participants reported applying this new knowledge and skills on the job. Although promising, RESPOND initiative needs a more comprehensive evaluation with greater numbers of participants, and importantly greater inclusion of people with lived experiences.

In Scotland, a police street triage model operates in a number of areas (McGeough & Foster, 2018). While mental health training is mandatory for all frontline police officers there are a lack of details about the type of training received and its evaluations (Scottish Government, 2017). Distress Brief Interventions is an innovative approach piloted in a number of jurisdictions in Scotland, and it involves: i) providing targeted training to first responders including police on how to respond to individuals in mental health crises, and ii) improving their referrals to and responses of the select partner community mental health organisations in both treatment and future crisis prevention (McGeough & Foster, 2018). In excess of 500 police officers have received the special mental health training (DBI, 2018), however, although a formal evaluation is underway, any evidence of effectiveness has yet to be formally reported.

In addition to the previously-described embedded co-responder model operating in Hamilton, Canada, a service called Social Navigator Program (SNP) also operates out of that locality. SNP is a mobile unit staffed by police and paramedic staff that aims to connect people who experience social and mental health issues and who are in frequent contact with police with a range of social and health agencies (Kurdziel, 2016). The most recent evaluation reported a number of positive results for those people who accessed this model, including a decrease in mental health related calls to police (37% decrease over 12 months, Kurdziel, 2016). Further and more rigorous examinations would provide greater information about their functioning, effects, and dissemination possibilities.

In Queensland, Australia, a joint initiative between Police, Ambulance and Health departments based on local needs analysis began in 2004, called the Mental Health Intervention Project (Carr, 2007). In addition to forming effective partnerships and communication between these departments, including regular case conference meetings and information sharing protocols, this model also implemented *First Response Officer Training* for police (Queensland Police, 2017). This training is a one-day scenario-based training package, teaching strategies such as using advanced tactical communication and de-escalation skills with people who may be experiencing a range of mental illnesses (Carr, 2007). There are no published examinations of the effects of this training on resolving encounters with people experiencing mental health crises in the community. Further to this training, an embedded co-responder model operates out of one mental health area in that state (Queensland Government, 2019); however, again there are no published evaluations of this embedded co-responder model alone or in comparison with the standard response.

Another more recent development in many police forces in the Western world has been their provision of Mental Health First Aid (MHFA) training to police officers. MHFA was developed in Australia approximately 20 years ago. Its aim was to provide a mental health awareness program to train people in identifying common signs and symptoms of mental illness, provide some initial mental health help, and to guide or help refer the person to other appropriate supports (Kitchener & Jorm, 2002). The training is up to 12 hours long and, while it can be delivered in either a face-to-face format or online, it is predominantly delivered via a face-to-face modality. It is a popular training course. Indeed, a recent publication suggests that MHFA has been delivered in 25 different countries, with in excess of 2 million people completing the training (MHFA Australia, 2019). The training orientates people to how common mental illnesses are in the community, then considers the five steps of the MHFA approach: 1) assess risk of suicide or harm; 2) listen non-judgmentally; 3) provide reassurance and information; 4) encourage the person to get appropriate professional help; and 5) encourage self-help strategies for a range of mental health issues, including a series of scenarios, covering both emerging and crisis-types of situations (Kitchener & Jorm, 2006). A recent meta analytic review, published by Morgan and colleagues in 2018, suggested small to moderate effects associated with MHFA training for up to six months after completing the training, such as: improved knowledge about mental health problems, reduced stigmatising attitudes, improved accurate identification of people with mental health issues, and improved intentions to offer MHFA to someone experiencing a mental health issue. The findings about its effects post six months follow up were less clear, as were those regarding its effects on actual behaviour change, representing significant research gaps. Additionally, the original MHFA training, which has been provided to many public safety personnel, was not specifically devised for emergency responders and police officers. An 8-hour version has been adapted for police officers and other first responders and named Mental Health First Aid for Public Safety. Caution should be taken by those services looking to apply it based on some of its espoused advantages, such as shorter duration (Thomas & Watson, 2017). In addition, this version has not received the same amount of scrutiny as the original as no known studies have been conducted on its effectiveness.

Sweden has trialled an approach that seemingly builds on the model of services co-responding to mental health crises, however, there is a move away from police responses and towards prioritising community mental health responses. This initiative begun in 2011 in Stockholm County, Sweden, with pilot implementation of Psychiatric Emergency Response Team (PAM) (Bouveng et al., 2017). PAM is a prehospital emergency psychiatric assessment and care team of two mental health nurses and a paramedic responding to mental health crises from a specially designed vehicle (Bouveng et al., 2017). Bouveng and colleagues' descriptive evaluation of the program in 2015 indicated that most of the calls were medium to high priority that were responded to within 20 minutes (2017). About 40% of calls resulted in hospitalisations, with the remainder either assisted on the scene or through a mental health follow up organised in the community. Although a very promising intervention, further research is required before considering disseminating this response to other areas and contexts.

Overall, although very different in their approach and mode of operation, these models have in common the fact that they are based on, and reliant upon, forming effective working partnerships with local mental health and community organisations and most involve officers with some degree of knowledge of mental health issues (Martinez, 2010). However, some peer run organisations for people living with mental health issues assert that they are seldom meaningfully included in planning of these new models of operation (Jennifer Chambers,

*personal communication*, 08 September 2019), a situation that ought to be rectified for greater success and future progress in this area.

It is also important to note that whereas most of these responses are *first generation responses* to improving outcomes of police mental-health related calls, there has been a recent trend towards developing *second generation responses* (McGeough & Foster, 2018; Wood & Bierschmitt, 2014). These *upstream interventions* are examples of *hotspots policing*, where following police being able to identify *hotspots of vulnerability*, they then target those places with preventative interventions that improve health and safety (Enang, Dougall, Woof, Heyman, & Aston, 2019). As such, these responses replace *case management* approach to policing with *place management* in an effort to improve the general wellbeing of peoples living in a specific area identified as having a higher incidence of mental health issues (Wood & Bierschmitt, 2014). Wood and colleagues are among the voices who argue that the more effective health promotion would involve targeted partnerships among many different public and private organisations to promote public health and safety (Wood, Taylor, Groff, & Ratcliffe, 2015). An example of an initiative with prevention as one of its aims was trialled in one area of the state of Victoria, Australia, in 2012, called Police and Community Triage (PACT). It looked at proactively linking in people with social, welfare and mental health issues with partner community organisations. Its evaluation showed that there was a significant reduction of contact with the police subsequent to receiving relevant community interventions (Kesic & Thomas, 2012). Wood and Watson (2017) assert that to improve this guardianship role of the police, the following need to be prioritised in the near future: i) focus on improving procedural justice during mental health related calls; ii) improving current evidence of what works through integrated data-sets, and iii) balancing case-based focus with place-based focus.

## Summary of narrative themes emerging from group discussions

The two days of consultations began by considering the literature review summarised above. Some of the main points related to the premise that the police have made and continue to make significant changes and improvements to the way in which they interact with people who are experiencing mental health crises in the community. Despite this, there remain significant gaps in the evidence base related to which models/approaches, by what mechanisms, and under what circumstances are the most successful. Moreover, despite the continuous attempts at improvement the police have made, the MHS, on the other hand, is viewed as continuously reducing community mental health services and resources, thus, resulting in greater need for the police to manage mental health crises in the community (Bonighton, 2012). Instead of making improvements in the prevention, early detection and treatment of mental health conditions in the community, the MHS was seen by the consultation group to be displacing mental health care to the CJS, including to the police as the gatekeepers of the CJS. These views are not new in this area; based on the numerous research findings of the overrepresentation of mental illness in police cells (e.g. Baksheev, Thomas, & Ogloff, 2010) and in the CJS (e.g. Fazel, Hayes, Bartellas, Clarici, & Trestman, 2016), it has been argued for many decades now that our prisons have become the new mental health institutions and that police are operating as what has been termed “street corner psychiatrists” (Lamb et al., 2002, p.1266). It is asserted that as a result of the shortage of appropriate community care, the police, as the only 24-hour emergency service, are taking on the additional responsibility of providing regular assistance to persons experiencing mental health crises and mental illness

(Carroll, 2005; Wylie & Wilson, 1990). Lack of resources to enable access to social determinants of health (e.g. housing, for details see Mikkonen & Raphael, 2010) and options to recover from trauma (e.g. appropriate therapy) are other factors that can lead to people experiencing mental health crises that may result in increased interactions with the police.

Following is the summary of some of the main narrative themes stemming from the two-days of the consultation group discussions on how the police can best assist people who are experiencing mental health crises in the community, with particular emphasis on effective models of training and partnerships. These are documented under four main group discussion topics.

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## 1. Training - *Everyone needs some training*.

Perhaps the most important principle is that the development of any initiative cannot start until there is greater clarity about what is the police role and responsibility when it comes to responding to mental health crises in the community. Thus far, police operating in this sphere have been reactionary in filling the gaps of existing mental health services. Therefore, it was argued that there needs to be a cultural shift from what has become somewhat of a norm with regard to community mental health prevention and treatment where the management of psychiatric crises, and at times care and treatment, have been displaced to the police and the CJS. Consequently, in addition to the anti-stigma campaigns that are commonplace in most Western countries, there must be adequate and corresponding development and sustainability of early prevention and treatment options within the community MHS. A good example of the existence of robust community-based crisis services that include community safe beds is Toronto's Gerstein Crisis Centre that offers community-based phone support, mobile crisis team support and short term stay in a staffed residence (www.gersteincentre.org). The resulting component of police training and responses to a community's management of mental health crises ought to be specifically tailored to the local needs and available resources, as well as the laws and regulations that govern these, and importantly, based on the available best-practice evidence. Experts-by-experience must be integral and meaningful contributors to the development, delivery and evaluation of any training package that is about police managing mental health crises in the community. CIT is an example of bringing together police services, mental health services, and community members which is most often represented by experts-by-experience and advocates, to look at existing crisis services of the community, identify gaps, and work in partnership with equal voice for further enhancements. These partners co-deliver the training, and work together on a continuing basis to support effective crisis responses.

It is also possible for training to be entirely developed and delivered by experts-by-experience, also applying best evidence. In 2000, the Toronto Police Service hired the Queen Street Patients Council (now the Empowerment Council), a service user advocacy organisation, to develop and deliver a course by people with personal experience of mental health crisis for the Toronto Police Service. In less than two years, every uniformed officer had attended this training, which included receiving a handout on de-escalation techniques developed through consultation with the community of people with lived experience. Anecdotal evidence suggests

that there was a reduction in incidents of police use of fatal force involving people in crisis following this training (Jennifer Chambers, *personal communication*, April 23, 2019).

Police training on mental health should be bespoke and follow a tiered approach, similar to the TEMPO model proposed by Cotton and Coleman (2014). Using this approach means that *all* police would receive general mental health training, and that exact training ingredients, mode, intensity and duration need to be tailored to the specific duties different police perform. The first step, however, would be a needs analysis and identification of the police service's role to be able to then identify what the police force training needs and resources are. Although the specific training curriculum should be based on the local needs and resources and appropriately linked in with other training topics (e.g. use of force), the following ingredients need to be prioritised and form a standard part of any training: 1) signs that a person is experiencing mental health crisis; 2) verbal and non-verbal communication skills, 3) verbal and environmental de-escalation strategies, and 4) be experiential and scenario-based, with ongoing input from experts-by-experience in development, delivery and evaluation of training.

The sustainability of any training initiative requires specific and detailed attention. In addition to devising appropriate short- to long-term evaluations of training outcomes, refresher (booster) training also needs to be provided to officers. It is crucial that any training be appropriately evaluated, using a framework such as the Kirkpatrick Model (Machray, 2017) to guide multilevel evaluations, and importantly, to ensure that the training has an effect on officer behaviour. Although considered a viable option by some group participants, the use of body cameras to evaluate behavioural change as an outcome of training comes with a caution because they only tend to show a part of the scene, thus may give a skewed perception of the encounter. The exact timing and the curriculum of refresher training would depend on many factors, including who the recipients are (general vs. specific duties), adult-learning recommendations, and be adapted to organisational priorities. Additionally, the group discussed another factor very important to sustainability of training knowledge and responses, that is the existence of accessible repositories of easily consumable information on the management of mental health crises incidents (e.g. the details of context specific and local resources, such as laws, MoUs, protocols or practice guidelines, receiving hospitals, partnering social services, police mental health champions, and other pertinent information that police on the ground can readily access). Additionally important for sustainability is the ongoing availability of mental health professionals[viii] to provide telephone assistance to police on the scene, especially important initiative in remote and rural communities, and one which has been shown to be helpful and used across different models, including co-response models and CIT-based responses (McGeough & Foster, 2018).

**The following recommendations resulted from this part of the discussion:**

*I. There must be adequate and corresponding development and sustainability of social determinants of health and early prevention and treatment options within communities, that meet the self-identified needs of people with, or at risk of developing, mental health issues.*

[viii] Mental health professional includes those people with lived experience of mental health issues working within peer/mental health advocacy and community mental health organisations.

II. *Police training and responses to managing mental health crises in the community ought to be: based on relevant laws and regulations as well as on the available best-practice evidence, specifically tailored to the local needs and available resources, and with ongoing involvement of both experts-by-experience and other experts in mental health.*

III. *Police training should follow a tiered approach, whereby all police officers receive some mental health training, and where police performing in special duties receive further specialised training specific to their duties.*

IV. *The exact training curricula will be locally determined, however, the following ingredients are essential: 1) identification of signs suggestive that a person is experiencing mental distress; 2) verbal and non-verbal communication skills, 3) verbal and environmental de-escalation strategies, 4) the training ought to be experiential and scenario-based, and 5) there must be ongoing guidance from experts-by-experience and other experts in mental health in developing, delivering, and evaluating training.*

V. *Strategies ensuring **sustainability** of training initiatives ought to be prioritised, such as: 1) development of good quality evaluations which inform future improvements; 2) appropriate and timely re-training programmes, and 3) availability of accessible repositories of relevant mental health information.*

VI. *Training evaluation needs to be inclusive of how training is manifested in the performance of duties.*

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**2. Fitting the training with current options** - *How can we use training to minimise use of force, and reduce injuries to police and community members? Is there other learning required in addition to the mental health approach adopted locally?*

Although police use of force is rare in countries like Australia, New Zealand, the UK, and Canada, contemporary research internationally has consistently demonstrated that police are more likely to use force on people whom they know to have, or suspect of having, a mental illness (Kesic, Thomas, & Ogloff, 2013; 2014). Perhaps the most important discussion theme here related to the need to consider the impact that stigma and discrimination towards people who have a mental health issue, and specifically the inappropriate linking of mental illness to violent behaviour, have had on the level of trust and outcomes between the police and people who experience mental health issues. Concerted efforts need to be made at all levels, starting with the grassroots education of community, to reduce the prejudice and discrimination towards people with mental health issues. Importantly, however, efforts need to be rooted in consultation with expert-by-experience peer advocacy organisations and best evidence regarding reduction of stigma and prejudicial attitudes (e.g. how erroneous likening of mental illness and violence, and emphasis on biomedical causes of mental illness, may increase prejudice; see Angermeyer & Matschinger, 2003; Sief, 2003; Walker & Read, 2002). Specific to police organisations, there needs to be a sustained impetus for the culture change with regard to interacting with people experiencing mental health issues. This would include correcting attitudes that promote prejudiced and discriminatory behaviour and fostering of professional and respectful attitudes as a priority of any education strategy. Some existing training models

(e.g. the CIT, MHFA) aim to reduce stigmatising attitudes, however, unless some content is delivered to the whole of the organisation and embedded within organisational values, these important anti-stigma components are likely to have limited impact. Importantly, ridding police services of prejudice toward people who experience mental health issues may also improve the mental wellbeing of police members and increase their help-seeking behaviours when mental health issues occur.

To further reduce the use of force on people who are experiencing mental health issues, any training police receive on managing mental health crises in the community needs to be aligned with use of force training. Importantly, where possible, use of force training and mental health training should emphasise trauma informed approaches to interacting with people whom the police know, or suspect, to have mental health issues. Creation of voluntary *Vulnerable Persons Registries* similar to the ones in Toronto, (Canada), and Melbourne (Australia), where people with lived experience and their family volunteer important information to the police, such as signs that they are unwell, best approaches in crises, and supports, may be another means of avoiding the use of force. Police-populated registers such as the national Vulnerable Persons Database (VPD) in Scotland are also in existence, although guidance on the assessment of vulnerability has been prioritised by Police Scotland (Murray, Heyman, Wooff et al., 2017; Enang, et al., 2019). However, where these registries are created, it is crucial to consider issues of information sharing, privacy, and information retention to ensure that the rights of people are citizen-centred. It is important to note that countries and jurisdictions have their own mechanisms of information sharing between the police and mental health services. These information sharing protocols need to be standardised to ensure the privacy of people who experience mental health issues and mental illnesses are upheld. Importantly, mental health calls should not be included in criminal data bases unless a crime is involved.

**The following recommendations resulted from this part of the discussions:**

*VII.* *Reduction in discriminatory attitudes toward people experiencing mental health problems and fostering of professional and respectful attitudes and relationships, underpinned by strong organisational values, ought to be a part of any police education strategy/response to the police-mental health interface.*

VIII. *To further reduce the incidence of use of force on people who are experiencing mental health issues, any training police receive on managing mental health crises in the community needs to be aligned with the use of force training and tactical options training.*

*IX.* *Given the upholding of the necessary protections of information retention, dissemination, and destruction, the voluntary Vulnerable Persons Registry may be a useful tool to further assist in the successful police management of mental health crises.*

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**3. Good Partnerships** - *What do good partnerships look like? How do we improve mental health trajectories and reduce criminal justice contact? Improve police functionality and streamline their involvement in MH related incidents?*

The main point from these discussions was the consensus that good partnerships are those formed and sustained between people with lived and living experiences of mental health issues, their significant others (e.g. family, partners, etc.) and advocacy organisations, the police, and the MHS. Good partnerships are those based on the values of ***trust, respect, honesty, equality, and transparency***. Participants perceived that each stage of foundation, implementation and sustainability of a partnership require careful consideration to ensure its success. As such, in addition to upholding of their core values and inclusion of considered partners, each community must consider who else needs to be included to address their local needs, such as organisations representing other marginalised groups, NGOs, Universities, social services, or others. It is equally important to ensure that experts-by-experience and their advocacy organisations are appropriately chosen by and responsive to the needs of people with lived experience of mental health issues. There were numerous examples across the represented countries of police partnerships with many community organisations.

This group discussed other important considerations of a successful partnership, such as that common values and goal(s) need to be identified at the outset. The participants agreed that the most suitable common goal is the increase of available and appropriate community mental health resources, including access to crisis services, to assist people who experience mental health crises in the community, thereby reducing the demand on the less appropriate services, such as the police, to manage these situations. Therefore, future focus ought to be on preventative interventions, both by the MHS and other social services that meet basic human needs, as well as through focus on improving police guardianship role and *second generation responses*. Effective partnerships between the police and the mental health services are those where: i) police involvement in mental health crises is minimised, ii) there are timely and effective community crisis services available, iii) local MoUs that guarantee timely transfer or introduction to accepting hospitals and other community facilities are adhered to, and iv) there is appropriate follow up mental health care and treatment in the community. Crucially, at the time of the systems responding to a mental health crisis event, it is of utmost importance that the values of trust, respect, honesty, equality, privacy and transparency are upheld, where procedural justice is prioritised. Wherever possible under the given situation and within the legal context, people experiencing mental health crises in the community are to be assisted through the least coercive means and ought to be supported in actively contributing to their care at the time (such as selecting preferred transport, preferred community treatment setting, etc.).

To ensure sustainability of these partnerships, the consultation group proposed convening regular meetings with all representatives, with appropriate information gathering and sharing, and ongoing evaluations. A few participants outlined such successful initiatives in their own locations (e.g. Toronto, Amsterdam). The frequency of these convened meetings is likely to depend on the aims of the committees, whereby those committees that may be formed with the aim of streamlining the care and management of individual cases may meet more often (e.g. weekly, as is the case in Amsterdam, or fortnightly as per Toronto), whereas those tasked with policy related decision-making may meet less often.

**The following recommendations resulted from this part of the discussions:**

*X. Good partnerships are those formed and sustained between experts-by-experience (their significant others), the police, and the MHS. For equity in partnerships, it is vital*

*to include representatives of local peer-run organisations to ensure a representative voice from those communities.*

XI. *Good partnerships are those based on the values of **trust, respect, honesty, equality**, and **transparency**.*

XII. *Effective partnerships between people experiencing mental health crises and police extend beyond experts-by-experience involvement in program development, delivery and evaluation and, crucially, to their treatment during these encounters with police. Therefore, there ought to be a focus on procedural justice and, wherever possible under the given situation and within the legal context, people experiencing mental health crises in the community are to be assisted through the least coercive means and ought to be supported in actively contributing to their care at the time.*

XIII. *Effective partnerships between the police and the mental health services are those where: 1) police involvement in mental health crises is minimised, 2) there are timely and effective community crisis services available, 3) local MoUs that guarantee timely transfer or introduction to accepting hospitals and other community facilities are adhered to, and 4) there is appropriate follow-up mental health care and treatment in the community.*

XIV. *To ensure the sustainability of these partnerships, ongoing regular meetings with all representatives, appropriate information gathering and sharing, and ongoing evaluations, are essential.*

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**4. Advancing evidence and policy** - *How do we continue to improve evidence to advance and inform policy and practice?*

There was overwhelming consensus among the group members regarding the importance of continued advancement of good evidence to inform and improve policy and practice in this area. Group members underscored the importance of designing research studies of high fidelity to explore important questions regarding best practice when police manage mental health crises in community. At the local level, it was suggested that prior to implementing policies and practices from other jurisdictions or those not expressly designed for police work (e.g. the widespread application of MHFA), police forces ought to consider: i) their own organisational policies, resources and needs, ii) the needs and recommendations of people with lived and living experiences of mental health issues, iii) the rights, responsibilities and accessibility of the key stakeholders, and iv) evidence regarding best-practice.

Additionally, securing significant and ongoing funding was considered highly important to ensure that good quality independent research that helps build best practice responses can be conducted. The quality and fidelity of research in this area should not be compromised to ensure fast delivery of results of limited applicability, an observed recent trend. The use of new large datasets of linked prospective and retrospective data were highlighted as options to summarise, at a population level, service outcomes and clinical outcomes for people who come to police attention, and to use this data to model future needs

following a Population Data Science approach (McGrail, Jones, Akbari, et al., 2018). Subsequently, that data may be used as epidemiological evidence to underpin studies and evaluations of interventions for early prevention, treatment of, and response models to mental health problems in the community as has been demonstrated with other emergency services (Duncan, Best, Dougall, et al., 2019).

The group felt that it was vitally important that when good data are obtained and analysed, practitioners and experts-by-experience are involved in providing meaningful interpretations of the range of possible implications of such findings. Ideally people with lived experience should be consulted, if possible from the earliest opportunity, to guide meaningful research questions, design and evaluation. To further ensure that the research is applicable and translated into improvements to policy and practice, the findings should be appropriately reported for a range of specific audiences; this needs to be underpinned by a suitably informed knowledge translation strategy. Setting up a knowledge hub is very important for the stakeholders and partners to have access to updated research and resources, to continue important conversations, and to share information to advance and inform policy and practice. The CIT International website is an example of a similar initiative, however, it is limited to CIT responses only. Setting up a broader knowledge hub through the Global Law Enforcement and Public Health Association (GLEPHA, https://gleapha.wildapricot.org) was discussed as an important priority for this group to ensure the current work and discussions continue and that key information can be made more readily available to interested parties.

**The following recommendations resulted from this part of the discussions:**

*XV.* *To advance and inform future policy and practice, it is crucial to design rigorous research studies to explore important questions regarding best practice when police manage mental health crises in the community. This includes collecting comprehensive and reliable data on situational, person-based, and police variables.*

*XVI.* *Practitioners and experts-by-experience need to be involved in providing meaningful interpretations of the implications of research findings.*

*XVII.* *Research findings need to be accessible to the relevant stakeholders through ensuring considered publication outputs and the development of a comprehensive knowledge translation strategy. An initiative such as an accessible knowledge hub is important to the advancement of research, policy and practice.*

*XVIII.* *Where possible, anonymised routine data should be exploited to summarise outcomes for people in contact with police and MHS within existing pathways of care, and/or of the effectiveness of new interventions as they are implemented. Data on an individual level is particularly powerful where direct linkages can be made between health and police databases and should be pursued, permitting estimates of service use, and clinical outcomes of people.*

*XIX.* *Prior to implementing relevant policies and practices police forces ought to consider: 1) their own organisational policies, resources and needs, 2) the needs and recommendations of people with lived experiences of mental health issues, 3) the rights, responsibilities and accessibility of the key stakeholders, and 4) evidence regarding best-practice responses.*

## Overarching Recommendations

- *Police involvement in mental health crises in the community, albeit necessary in some circumstances, should be recognised as a restrictive and inappropriate intervention that reduces people's autonomy and may lead to worsening of their mental health in some cases. There needs to be a greater emphasis on reducing the demand on police services to manage mental health crises in the community.*

- *There ought to be greater emphasis on increasing availability and effectiveness of community mental health services that aim for prevention of mental health crises, early and non-police intervention in mental health crises, follow-up care and restoring individuals to their optimum mental health following a mental health crisis.*

- *Police roles and responsibilities in the management of community mental health crises need to be clearly specified and adhered to by all stakeholders. The resulting training for all police officers needs to be based on the parameters of this prescribed role, which ought to be grounded on best available evidence, considerations of local needs and resources, and the preferences of people who experience mental health issues in our community.*

- *The important work at the intersection of police and mental health needs to be based on the values of* ***trust, respect, honesty, equality, and transparency*** *between people with lived and living experiences, police organisations, and mental health services. It is of utmost importance that, from the outset, these partnerships meaningfully involve experts-by-experience as partners.*

- *Policy and practice related to the intersection of police and mental health needs to be firmly underpinned by good quality research. In addition to researching and further advancement of current initiatives, additional progress can be made through the use of large-scale reliable linked data sets between policing and health partners, including emergency departments, to understand service demand, care pathways, and clinical outcomes for people. The creation of and implementation of preventative policies should be based on these, in both the MHS and the CJS.*

## Concluding remarks

Police services have made and continue to make significant improvements in the way in which they respond to people experiencing mental health crises and mental health issues in the community. The different models of training and practice in this area, from those more well-known and researched like the CIT-based responses, to bespoke models that show promise but to date lack rigorous research examinations, have in common their reliance on effective and sustainable partnerships with community mental health services. Successful collaborations also include meaningful and continuous involvement of experts-by-experience, from

consideration of what is best practice response in a location based on available research evidence, location needs and available resources, through to its implementation and evaluation. In addition to continued improvement of outcomes of mental health crises police respond to, future research, policy and practice responses ought to prioritise development of multiple interagency collaborations that aim for prevention and reduction of these events from occurring. It is crucial that these future developments are driven by robust data in their conceptualisation, implementation, and sustainability.

## Future directions

This guideline is a product of collaboration between experts-by-experience, law enforcement, mental health practitioners and researchers who attended the LEPH conference in Toronto in 2018. A core group of original members involved in this initial discussion and in drafting this document also form GLEPHA's *Law Enforcement and Mental Health Special Interest Group (LEMH SIG)*. The LEMH SIG aims to bring together the combined expertise and practical wisdom of people with lived and living experience of mental health issues and their significant others, police officers, mental health practitioners, academics and policy experts, to advise upon and develop a Best Practice Guideline regarding policing models of responding to mental health-related incidents.

The LEMH SIG will progress the themes and recommendations from the 2018 consultation at the 2019 consultation, which will take place in Edinburgh, Scotland, prior to the beginning of the LEPH 2019 main conference event (18th and 19th October 2019). In addition to progressing the current themes, the meeting in Edinburgh will also focus on the issues that have been especially relevant to the Scotland context. This guideline will be extended following those consultation outcomes.

# References


The Allen Consulting Group (2012). Police, Ambulance, and Clinical Early Response (PACER) Evaluation: Final Report. Retrieved from https://www2.health.vic.gov.au/about/publications/researchandreports/Police-Ambulance-and-Clinical-Early-Response-PACER-Evaluation-Report on 5 May 2019.

Angermeyer, M. & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia: trend analysis based on data from two population surveys in Germany. British Journal of Psychiatry, 186(3), 331–334.

Appelbaum, K.L. (2000). Police encounters with persons with mental illness: Introduction. *The Journal of the American Academy of Psychiatry and the Law*, 28; 325.

Baksheev, G.N., Thomas, S.D.M., & Ogloff, J.R.P. (2010). Psychiatric disorders and unmet needs in Australian police cells. *Australian and New Zealand Journal of Psychiatry, 44*, 1043-1051

Bonfine, N., Ritter, C., & Munetz, M.R. (2014). Police officer perceptions of the impact of crisis assessment team (CIT) programs. *International Journal of Law and Psychiatry, 37*; 341-350.

Bonighton, R. (November 2012). *Policing People who Appear to be Mentally Ill*. Office of Police Integrity Report to the Victorian Legislative Council. Retrieved from https://www.parliament.vic.gov.au/file_uploads/Policing_people_who_appear_to_be_mentally_pyt8YbmN.pdf on 20 March 2019.

Boscarato, K., Lee, S., Kroschel, J., Hollander, Y., Brenan, A., & Warren, N. (2014). Consumer experience of formal crisis-response services and preferred models of crisis intervention. *International Journal of Mental Health Nursing, 23*; 287-295. doi:10.1111/inm.12059

Bouveng, O., Bengtsson, F.A., & Carlborg, A. (2017). First year follow up of the Psychiatric Emergency Response team (PAM) in Stockholm County, Sweden: A Descriptive Study. International Journal of Mental Health, 46:2, 65-73, doi: 10.1080/00207411.2016.1264040

Carroll, M. (2005). Mental health system overburdening police. *Police Journal, 86*, 18-22.

Caroll, A., Pickworth, J., & Protheroe, D., (2001). Service innovations: An Australian approach to community care: The Northern Crisis Assessment and Treatment Team. *Psychiatric Bulletin, 25*, 439-441.

Coleman, T., & Cotton, D. (2014). *TEMPO: Police Interactions. A report towards improving interactions between police and people living with mental health problems.* Mental Health Commission of Canada.

Compton, M.T., Bahora, M., Watson, A.C., & Oliva, J.R. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. *Journal of the American Academy of Psychiatry and Law, 36*; 47-55.

Compton, M.T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D'Orio, B.M., Oliva, J., Thompson, N.J. and Watson, A.C. (2014a). The police-based Crisis Intervention Team (CIT) model: I. Effects on officers' knowledge, attitudes, and skills. *Psychiatric Services, 65*; 517-22. https://doi.org/10.1176/appi.ps.201300107

Compton M.T., Bakeman, R., Broussard, B., Hankerson-Dyson, D., Husbands, L., Krishan, S., Stewart-Hutto, T., D-Orio, B., Oliva, J.R., Thompson, N.J., & Watson, A.C. (2014b). The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. *Psychiatric Services, 65*; 523-529. https://doi.org/10.1176/appi.ps.201300108

Cotton, D., & Coleman, T.G. (2010). Canadian police agencies and their interactions with the mentally ill: Police perceptions and characteristics. *Police Practice and Research: An International Journal, 11*; 301-314.

Department of Health (2014). Acute Community Intervention Service Guidelines. Retrieved from https://www2.health.vic.gov.au/mental-health/mental-health-services/support-and-intervention/acute-community-intervention-service on 10 June 2019.

Distress Brief Interventions (October, 2018). Minister for Mental health visits Police Scotland training base. Retrieved from https://www.dbi.scot/general/minister-for-mental-health-visits-police-scotland-training-base/ on 10 June 2019.

Donohue, D., & Andrews, G. (2013). NSW Police Force Mental Health Intervention Team. Forging a New Path Forward in Mental Health and Policing in the Community. *In* D Chappell [Ed.]. *Policing and the Mentally Ill. International Perspectives.* Boca Raton, FL: CRC Press. pp. 105-120.

Duncan, E., Best, C., Dougall, N., Skar, S., Evans, J., Corfield, A., …Wojcik, W. (2019). Epidemiology of emergency ambulance service calls related to mental health problems and self-harm: a national record linkage study. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, 27(34), https://doi.org/10.1186/s13049-019-0611-9

Dupont, R., & Cochran, S. (2000). Police response to mental health emergencies – Barriers to change. *Journal of the American Academy of Psychiatry and Law*, 28; 338-344.

Enang, I., Murray, J., Dougall, N., Wooff, A., Heyman, I., & Aston, E. (2019). Defining and Assessing vulnerability within law enforcement and public health organisations: A scoping review. Health and Justice, 7(2), doi: 10.1186/s40352-019-0083-z.

Evangelista, E., Lee, S., Gallagher, A., Peterson, V., James, J., Warren, N., Henderson, K., Keppich-Arnold, S., Cornelius, L., & Deveny, E. (2016). Crisis averted: How consumers experienced a police and clinical early response (PACER) unit responding

to a mental health crisis. *International Journal of Mental Health Nursing*, 25; 367-376. doi:10.1111/inm.12218

Fahim, C., Semovski, V., & Younger, J. (2016). The Hamilton Mobile Crisis Rapid Response Team: A first-responder mental health service. *Psychiatric Services, 67*; 929. doi:10.1176/appi.ps.670802

Fazel, S., Hayes, A., Bartellas, K., Clerici, M., & Trestman, R. (2016). The mental health of prisoners: A review of prevalence, adverse outcomes and interventions. Lancet Psychiatry. 3: 871–881. doi:10.1016/S2215-0366(16)30142-0.

Godfredson, J.W., Thomas, S.D., Ogloff, J.R. and Luebbers, S. (2011). Police perceptions of their encounters with individuals experiencing mental illness: a Victorian survey. *Australian and New Zealand Journal of Criminology, 44*; 180-95. doi: 10.1177/0004865811405138

Heslin, M., Callaghan, L., Barrett, B., Lea, S., Eick, S., Morgan, J., Bolt, M. Thornicroft, G., Rose, D., Healey, A., & Patel, A. (2017). Costs of the police service and mental healthcare pathways experienced by individuals with enduring mental health needs. *British Journal of Psychiatry, 210*; 157-164. https://doi.org/10.1192/bjp.bp.114.159129

Heslin, M., Callaghan L., Packwood, M., Badau, V., & Bayford, S. (2016). Decision analytic model exploring the cost and cost-offset implications of street triage. *BMJ Open*, 6, e009670. doi:10.1136/bmjopen-2015-009670

HMICFRS (2018). Policing and Mental Health: Picking up the Pieces. Retrieved from https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/policing-and-mental-health-picking-up-the-pieces.pdf on 6 September 2019.

Horspool, K., Drabble, S.J. and O'Cathain, A. (2016). Implementing street triage: A qualitative study of collaboration between police and mental health services. *BMC Psychiatry, 16*; 313. doi: 10.1186/s12888-016-1026-z.

Jenkins, O., Dye, S., Obeng-Asare, F., Nguyen, N., & Wright, N. (2017). Police liaison and section 136: Comparison of two different approaches. *Psychiatric Bulletin, 41*; 76-82. doi:10.1192/pb.bp.115.052977

Keown, P., French, J., Gibson, G., Newton, E., Cull, S., Brown, P., Parry, J., Lyons, D., & McKinnon, I. (2016). Too much detention? Street triage and detentions under Section 136 Mental Health Act in the North-East of England: A descriptive study of the effects of a street triage intervention. *BMJ Open, 6*; http://dx/doi.org/10.1136/bmjopen-2016-011837

Kesic, D. & Thomas, S. (July, 2012). *Evaluation of Police and Community Triage (PACT) Pilot: Final Report*. Monash University: Centre for Forensic Behavioural Science.

Kesic, D., Thomas, S.D., & Ogloff, J.R. (2012). Estimated rates of mental disorders in, and situational characteristics of, incidents of nonfatal use of force by police. *Social*

*Psychiatry and Psychiatric Epidemiology, 48*; 225-232. http://doi.org/10.1007/s00127-012-0543-4

Kesic, D., Thomas, S.D.M., & Ogloff, J.R.P. (2013). Use of nonfatal force on and by persons with apparent mental disorder in encounters with police. *Criminal Justice and Behavior, 40*; 321-327. http://doi.org/10.1177/0093854812474425

Kitchener, B.A., & Jorm, A.F. (2002). Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behaviour. *BMC Psychiatry,* 2:10. https://doi.org/10.1186/1471-244X-2-10

Kitchener, B.A., & Jorm, A.F. (2006). Mental health first aid training: Review of evaluation studies. *Australian and New Zealand Journal of Psychiatry, 40*; 6-8.

Kurdziel, S. (2016). Social Navigation Program (SNP) Comprehensive Evaluation of 2014 and 2015 clients. Hamilton Police Service, Hamilton, ON.

Lamanna, D., Shapiro, G.K., Kirst, M., Matheson, F.I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police-mental health programmes: Service user experiences and outcomes in a large urban centre. *International Journal of Mental Health Nursing, 27*; 891-900. https://doi.org/10.1111/inm.12384

Lamb, H.R., Weinberger, L.E., & De Cuir Jr, W.J. (2002). The police and mental health. *Psychiatric Services, 53;* 1266-1271. https://doi.org/10.1176/appi.ps.53.10.1266

Lee, S., Thomas, P., Doulis, C., Bowles, D., Henderson, K., Keppich-Arnold, S., Perez, E., & Stafrace, S. (2015). Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. *International Journal of Mental Health Nursing, 24*; 538-546. doi:10.1111.inm.12153

Machray, C. (2017). Post impact and summary of findings following the evaluation of RESPOND multiagency mental health simulation training November 2016 – March 2017: Executive Summary. Quintessent Ltd.

Martinez, L.E. (2010). Police departments' response in dealing with persons with mental illness. *Journal of Police Crisis Negotiations*, 10; 166-174.

McDonald, C. (2006). *Challenging Social Work: The Context of Practice*. Basingstoke: Palgrave.

McGrail, K., Jones, K., Akbari, A., Bennett, T., Boyd, A., Carinci, F., …Kotelchuck, M. (2018). A Position Statement on Population Data Science. *International Journal of Population Data Science,* 3(1), https://doi.org/10.23889/ijpds.v3i1.415

McGeough, E., & Foster, R. (2018, August). What works? Collaborative Police and Health Interventions for Mental Health Distress. Scottish Government. Retrieved from https://www.gov.scot/publications/works-collaborative-police-health-interventions-mental-health-distress/pages/2/ on 5 June 2019.

McKenna, B., Furness, T., Oakes, J., & Brown, S. (2015). Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *International Journal of Mental Health Nursing, 24;* 386-393. https://doi.org/10.1111/inm.12140

Mental Health First Aid Australia (2019). Our Impact. Retrieved from https://mhfa.com.au/our-impact/our-global-impact on 20 March 2019.

Mikkonen, J., & Raphael, D. (2010). Social Determinants of Health: The Canadian Facts. Toronto: York University School of Health Policy and Management. Report retrieved from http://www.thecanadianfacts.org/ on 06 September 2019.

Moore, R. (2010). Current trends in policing and the mentally ill in Europe: A review of the literature. *Police Practice and Research; An International Journal*, *11*; 330-341.

Morabito, M.S., Savage, J., Sneider, L., & Wallace, K. (2018). Police Response to People with Mental Illnesses in a Major U.S. City: The Boston Experience with the Co-Responder Model, *Victims & Offenders, 13*, 1093-1105, doi: 10.1080/15564886.2018.1514340

Morgan, A., Ross, A., & Reavley, N.J. (2018). Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behaviour. *PLoS ONE*, *13*(5), e0197102. http://doi.org/10.1371/journal.pone.0197102

Murray, J., Heyman, I., Wooff, A., Dougall, N., Aston, L., & Enang, I. (2017). Law enforcement and public health: setting the research agenda for Scotland. Scottish Institute for Policing Research. Retrieved from https://www.napier.ac.uk/research-and-innovation/research-search/outputs/law-enforcement-and-public-health-setting-the-research-agenda-for-scotland on 29 August 2019.

Pearson, D. D. R. (2009). *Victorian Auditor General's report: Responding to mental health crises in the community*. Melbourne: Victorian government Printer.

Puntis, S., Perfect, D., Kirubatajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E., & Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry*, 18:256. http://doi.org/10.1186/s12888-018-1836-2

Queensland Police. (2017). Mental Health Intervention Project. Retrieved from https://www.police.qld.gov.au/programs/mhip.htm on 10 June 2019.

Queensland Government (2019). How people in crisis are receiving timely mental health intervention. Retrieved from https://clinicalexcellence.qld.gov.au/improvement-exchange/how-people-crisis-are-receiving-timely-mental-health-intervention on 10 June 2019.

Saurman, E., Perkins, D., Roberts, R., Roberts, A., Patfield, M., & Lyle, D. (2011). Responding to Mental Health Emergencies: Implementation of an innovative Telehealth Service in rural and remote New South Wales. *Australia Journal of Emergency Nursing* 37; 453-459.

Scottish Government, (April 19, 2017). Police mental health training. Retrieved from https://blogs.gov.scot/justice-safety/2017/04/19/police-mental-health-training/ on 10 June 2019.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health Services Research, 42;* 606–620. https://doi.org/10.1007/s10488-014-0594-9

Sieff, E. M. (2003). Media frames of mental illness: The potential impact of negative frames. *Journal of Mental Health*, *12*(3), 259–269.

Steadman, H.J., Deane, M.W., Borum, R., & Morrissey, J.P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services, 51*; 645-649.

Thomas, S.D.M., & Watson, A.C. (2017). A focus for mental health training for police. *Journal of Criminological Research, Policy and Practice, 3;* 93-104.

Usher, L., Watson, A., Bruno, R., Andriukaitis, S., Kamin, D., Speed, C., & Taylor, S. (2019, August). Crisis Intervention Team (CIT) Programs: A Best Practice Guide to Transforming Community Responses to Mental Health Crises. Memphis: CIT International. Retrieved from http://www.citinternational.org/bestpracticeguide on 5 September 2019.

Watson, A.C., Compton, M.T., & Draine, J.N. (2017). The crsis intervention team (CIT) model: An evidence-based policing practice. *Behavioral Science and the Law, 35*; 431-441.

Wells, W., & Schafer, J.A. (2006). Officer perceptions of police responses to persons with a mental illness. *Policing: An International Journal of Police Strategies & Management, 29*; 578-601. https://doi.org/10.1108/13639510610711556

Wood, J.D. & Beierschmitt, L. (2014). Beyond police crisis intervention: Moving "upstream" to manage cases and places of behavioural health vulnerability. *International Journal of Law and Psychiatry*, *37*, 439-447

Wood J.D., Taylor, C.J., Groff, E.R., & Ratcliffe, J.H. (2015). Aligning policing and public health promotions: Insights from the world of foot patrol. *Police Practice and Research, 16*, 211–223. doi:10.1080/15614263.2013.846982.

Wood, J.D. & Watson, A.C. (2017). Improving police interventions during mental health-related encounters: Past, present and future. *Policing and Society. 27*, 289-299.

Wylie, J. R., & Wilson, C. (1990). *Deinstitutionalisation of the mentally disabled and its impact on police services*. Payneham, SA: National Police Research Unit.