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The UK Criminal Justice and Mental Health Interface meets the USA: A police officer's perspective

Chief Inspector Mark Bolt

Devon & Cornwall Police
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INTERNATIONAL CIT CRISIS INTERVENTION TEAM

POLICE BALTIMORE COUNTY MARYLAND

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Executive Summery

This report relates to my Winston Churchill Travelling Fellowship. I was given the opportunity and grabbed it with both hands, to travel to the USA and study their criminal justice -mental health interface. It is difficult to put into words much of what I have seen and experienced. I know that we have a lot to learn and also a lot to give. The connections I have made will continue to benefit me and my drive to improve the way the UK criminal justice system take care of those individuals with mental illness that intercept with it. At this time there is a huge drive within the UK to improve our services. It has been building since Lord Bradly reported in 2009. However, much of his recommendations have yet to be implemented across the UK. There are areas of good practice and I hope that Devon and Cornwall is seen as one of those. However, we still have a way to go. Chicago and Baltimore have issues similar to each other but have developed different approaches, both of which have their merits. I have tried throughout to view my findings from a practicing police officer's point of view looking to beg, steal and borrow ideas where I can. What I did find was that those working within the system to improve it were doing so with tireless effort and utmost care for those individuals with mental health needs.

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Background

I have been a serving police officer in the Devon and Cornwall Police since 1990. I am currently a Chief Inspector and over the last few years have become increasingly involved with the interface between mental health and criminal justice. This started in 2006 where as a Sector Inspector I became involved in the commissioning of Cornwall's healthcare place of safety (at that time known as the Alternative Place of Safety (APOS)).

The police are given powers from either Acts of Parliament or Common Law. It is the officer's job to decide which power to use under which circumstances. The application of a proportion these powers is clear, i.e. most issues to do with driving vehicles come under the Road Traffic Acts. However, some, including those related to mental health are less clear and rely on the officer's interpretation of circumstances and previous experience.

The Mental Health Act 1983 provides officers the power to detain a person for their own safety if that officer perceives that the person has a mental illness. The part of the Act that provides this power is Section 136:

> 136.—(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.
>
> (2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an [approved mental health professional][1] and of making any necessary arrangements for his treatment or care.
>
> [(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.
>
> (4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.][2]

This section of the Act has many elements and in general the officer who is considering its use is only seeing the behaviour of an individual and not the causes of that behaviour. Therefore the officer has to act only with the information provided by the presenting situation and without the benefit of an in depth knowledge of the person standing before them. The use of this power has been subject to research, argument and abuse has been at the centre of my project well before I even realised I had a project.

Other than using the power myself as a Constable and a Sergeant my deeper involvement in this area of work started in relation to developing an understanding as to what was a "place of safety". Up until 2006 the only place of safety available to officers in Cornwall was a police station with a

police cell. For those that have never experienced such a place it is not somewhere where you would want to go if you were suffering a mental health crisis. As a consequence Health Authorities across the country started to commission APOS within healthcare environments. As Cornwall'sAPOS happened to be located in the area for which I had responsibility for day to day policing it fell to me to write the police side of the operational policy relating to its use. From the inception of the APOS I then became embroiled in the interface between mental health and criminal justice. Over the last eight years have expanded my knowledge and understanding of the tensions, interpretation of laws and frustration of all those involved in the care of those with mental illness whether it be a Constable at 2 O'Clock in the morning speaking to someone obviously distressed and in need of immediate care and control or the matron of the place of safety wondering why the police have brought the same person back three times in a week when they have been told numerous times that the person is playing the system just to get a warm bed for the night.

In Cornwall, a county with a population of 550,000, on average one person a day is detained under Section 136 MHA but less than 10% are then further detained in a hospital following formal Mental Health Act Assessment (MHAA). This begs the question: do the police overuse this power?

A further issue relates to the use of custody for detention under this power. Limitations of the health provided place of safety mean that approximately 60-70% of those detained under Section 136still end up in a police cell. The issues are around those that are drunk and or violent which impact on the ability of the place of safety to manage those risks, and also resource at the place of safety itself.

Due to my role in the development of the place of safety I was asked to sit on the County wide multi-agency Mentally Disordered Offenders Group. The clue is in the title: this group has representatives from any agency that has an interest in offenders with mental health issues. This lead to me becoming involved in many conversations and initiatives aimed at making things better for those with mental health issues that also happened to be offenders. Early on in my involvement I raised the question and continue to do so is how do you tell the difference between "mad" and "bad"? I have been involved in two recent major projects that fuelled my application for a fellowship. First, I have been working on a National Health Institute for Health Research funded project (the Interface Project). This used innovative case-linkage methods to examine the criminal justice-mental health interface in Cornwall with a view to understanding inter-agency decision making and the impacts on the management of individuals with enduring moderate to severe mental health needs. This has involved mapping 80 individuals' journeys over a 12 month period looking at the intersects between the mental health world and the criminal justice system. It has included offenders, victims and those detained under the Section 136 MHA provisions (and often those who have experienced a range of such police contacts). It was the lead researcher Dr Lynne Callaghan that suggested we could learn from an "advanced system" and suggested the two sites of my study being Chicago, Illinois and Baltimore in Maryland, USA.

My other latest achievement and perhaps the greatest so far has been the introduction of Community PsychiatricNurses (CPNs) into the policing arena to offer early advice and guidance to police officers dealing with offenders who may (or may not!) have mental health problems. This is in response to Lord Bradley's (2009) recommendations. However the implementationin Cornwall was a due to a series of fortunate events revolving around the relationships I had built with those in the mental health world working with offenders. The reason I say it was my greatest was due to the collaborative working alongside the forensic mental health team that enabled this initiative to be

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realised. This has led to a much greater understanding of each other's roles and responsibilities and will enable us to tackle any further challenges in the coming years. Our custody CPNs come under the badge of the Liaison and Diversion service. There is a national blueprint for such schemes and as of January 2014 there are enhanced pilot areas in the country finalising that blueprint. The national scheme deals only with those individuals suspected of committing a criminal offence. The Cornwall model differs in that due to the excellent collaborative partnerships established in Cornwall, the CPNs also work alongside our Neighbourhood Policing Teams. This innovative work offers support to those within the community whose behaviour has not yet reached the offending stage and, with the support of the CPNs in conjunction with the police, may never do so. Prevention is far better than cure. Elements to this scheme include CPNs working in the three police stations in Cornwall which have police custody units, CPNs working in the Courts county-wide and a researcher examining the impact of the service on the individuals and on the public services affected. The scheme is managed by Cornwall Partnership NHS Foundation Trust Centre for Mental Health and Justice and is funded by Offender Health, Department of Health.

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My Project Aims

My project was developed to answer the following questions:

1. How can we reduce the number of detentions under section 136 of the Mental Health Act?
2. How can we increase the percentage of those detained going to the Place of Safety rather than a police cell?
3. How can we enhance the opportunity to divert offenders with mental illness out of the criminal justice system while still maintaining the safety of the community?
4. How can we ensure that individuals with health needs are fairly dealt with in the court system?

Four apparently simple questions but all with very complex, varied answers.

It has been said many a times, mainly by me, that law enforcement is the same the world over. It has also been said by persons much cleverer than I am, 'why reinvent the wheel, just steal with pride'. If that is so then the Winston Churchill Memorial Trust has given me the opportunity to see for myself and do just that.

In order to try and glean some answers my initial project outline had me going to Chicago, Illinois for three weeks and then onto Baltimore, Maryland for the remaining three weeks. On consulting Dr Callaghan, reviewing the research literature and forward planning to where would we like to be in 5 years time with mental health-criminal justice services in Cornwall, it was apparent that the USA had well developed, tried and tested approaches to the questions presented above. I wanted a plan to enable me to get embedded in the processes I was studying, looking at the issue from a practitioner's point of view. Having been there on an over bridge at 2 O'clock in the morning trying to talk a depressed person away from the edge, I wanted to know how the practitioners saw and used the solutions available to them and understand the experience of individuals in receipt of their services.

In the USA there have been two different approaches to enhancing practice: one is to specially train officers in the area of dealing with those in mental health crises (Crisis Intervention Teams) and the second is to develop working partnerships where a special unit is developed putting a clinical practitioner in a car with a police officer and having them respond to calls relating to individuals in mental health crisis (mobile crisis teams).

Crisis Intervention Teams (CIT) were developed in Memphis Tennessee in 1988 following a tragedy where an individual in mental health crisis was shot and killed by a police officer sent to deal with the call. Chicago has a well-developed CIT programme alongside a well-developedMental Health Court system. Chicago Police Department's CIT programme is underpinned by ongoing research led by Professor Amy Watson of the University of Illinois, Chicago.

The second approach, mobile crisis teams, that I have come to know as 'cop in a car with a clinician', was developed in San Diego, California again following a tragic fatal shooting. Baltimore County has

been running such a scheme since 2001. Baltimore County is a large geographical area and can be considered semirural. Although its resident population is around 30% greater than Cornwall's and has a slightly smaller geographical area than Cornwall, it has very similar issues in relation to its rural, coastal and urban mix. It also surrounds Baltimore City which hosts John Hopkins Hospital, home of Mellissa Reuland from the Justice CenterThe Council of State Governments. She is the author of many a report studying differences between the above models and how the type of Law Enforcement body influences which model is most suited to that jurisdiction. Spending time in Baltimore would enable me to spend time with her to learn more about this comparison of these two very different models of practice.

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My Itinerary

My plan, as stated, was to spend equal time in Chicago. I intended to send time out on the streets with the practitioners, meeting the managers and the leaders in those organisations and speaking to users (or consumers as they are known in the USA) of those services. I also planned to observe the support that existed outside of the police to make either programme a success. However as a 23 year veteran of the police service I have learned to be flexible and change plans as opportunities arise or disappear. My itinerary eventually became:

1. Fly into Chicago and then fly out the next day to Connecticut. Spend three days in Hartford Connecticut at the CIT international conference meeting practitioners, commissioners, partner agencies and service users.

2. Fly back to Chicago and spend 18 days in Chicago working with Chicago Police Department, Illinois states attorney, Cook County Court, Cook County Jail, University Of Illinois Chicago, Thresholds Project, Serenity House, Du Page County Courts.

3. Fly to Baltimore spend 7 days and nights working with the Baltimore County Police Mobile Crisis Team.

4. Drive to Arlington Virginia and spend 3 Days in Arlington working with Arlington County Police Department, Arlington University, Arlington Department of Human Services Behavioural Healthcare Division and the National Alliance on Mental Illness (NAMI)

5. Drive back to Baltimore (hand back my Ford Mustang!) spend 11 Days with Baltimore County Police Mobile Crisis Team, Maryland State Police Baltimore County Jail, Center for States Government, Springfield Hospital, Baltimore County Jail, Maryland States Attorney, Spring Grove Hospital Center

What I learned.

Hindsight is a wonderful thing! I attended the Crisis Intervention Team International Conference and left there wishing that I had attended the conference and then spent two to three months planning my schedule. However, on arrival in Chicago when the hard work started I realised no matter how much I had planned and crammed in there would always be more to see and experience.

I was aware that the USA's law enforcement system was different to that in the UK but here I learned that my understanding was so far removed from the reality of the situation. In the UK there are 43 Police Forces who provide all aspects of Law Enforcement across the Country. Although we do have the National Crime Agency it is still in its infancy and relies heavily on local police forces for much of its enforcement action. Consequently in the UK there is one law enforcement body per geographic area, thereby simplifying planning and partnership working.

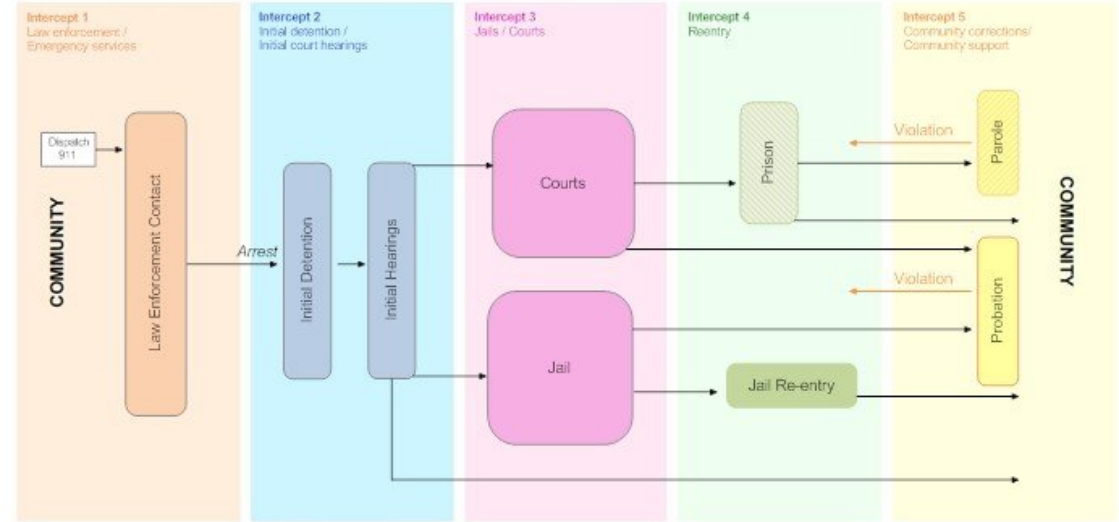
In general the States are divided into Counties and within those Counties there are areas of urban populations. Each State has its own law enforcement body, for example the Illinois or Maryland State Police. Each County will have its own Sherriff's departments and larger cities or towns may have their own police forces, provided by and answerable to the local council, whether it be Town or City. The jurisdictions overlay and sometimes it is difficult to work out which agency has primacy. Further, it is the responsibility of the County Sherriff to provide and oversee the County Jail and usually the State to provide the state prison facilities. The result of this system is that the USA has 18000 law enforcement agencies the average size of which is 15 "officers". Given that Chicago Police Department has around 13000 officers and New York City has about 36000, there are some small police forces in the USA. This fact becomes very relevant when local law enforcement has to work with local government and locally provided health provision (the latter of which is comparably fragmented).

In Chicago I worked primarily with the Chicago Police Department the primary Law Enforcement body in the City itself and with the Cook County Sherriff, SherriffDart, responsible for running the Jail and the Courts. In Baltimore I worked with the Baltimore County Police Department who were the primary lawenforcement body throughout the County with Maryland State Police having a primacy over the State Highways. The Jail and the Courts are run by the County Sherriff, Sherriff Fisher.

What I learned at this point was, as I suspected, the British policing model is the best in the world!

Sequential Intercept Model

Whilst at the Conference in Hartford I first came across the "sequential intercept model". This is a map of interactions between the criminal justice system and the mental health world and a simple version is shown below.



Most of the work I have carried out in the UK relates to "intercepts" 1 and 2 and was hoping to develop my work to intercept 3. The Sequential intercept model is used to map the pathways of individuals through the criminal justice process for a particular area. It enables all those involved in law enforcement, criminal justice and mental health to better understand the processes from point of first access. In the USA this will be a 911 call and police officers attending that call all the way through to being released from jail to be integrated back into the community. It is also used to identify gaps or duplication of effort and make the whole process more understandable. Whilst in Hartford I attended many workshops where the Intercept model was discussed and used as a diagnostic tool. It was here that I formed my first action for my return.

<u>Action: Introduce and develop a Sequential Intercept Model for Cornwall.</u>

There are some caveats to the implementation of this model. First, Cornwall does not have any prisons and second our first point of contact may be a neighbourhood level, or Intercept minus one as I came to describe it. It is clear that the model would need some adaptation to the context of Cornwall, but that the County would benefit from the translation of its principles.

It is also worth mentioning that whilst at the Conference I was also able to share with the team from Philadelphia who were just starting a Liaison and Diversion custody based scheme the findings form our scheme in Cornwall. The contact is ongoing

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Models for Police Dealing With Those in Mental Health Crisis

Crisis Intervention Teams

During the Conference I was Introduced and almost but not quite indoctrinated into the ways of the CIT model. The model requires that 40% of the frontline police officers receive training through what is described as an academy. This training better equips the officer to deal with someone in mental health crisis which will often result in an emergency call and the attendance of the police.

<table>
<tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>0745 - 0800</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td><td>Roll Call</td></tr>
<tr><td>0800 - 0850</td><td>Introduction, History & Overview</td><td rowspan="3">Risk Assessment & Crisis Intervention Skills</td><td>Child & Adolescent Disorders</td><td rowspan="3">Community Resource Panel/ Mental Health Court Project</td><td rowspan="3">Crisis Intervention Role Play & Virtual Hallucinations Machine</td></tr>
<tr><td>0900 – 0950</td><td rowspan="3">Mental Illness: Signs & Symptoms</td></tr>
<tr><td>1000 – 1050</td><td>Geriatric Issues</td></tr>
<tr><td>1100 – 1150</td><td>Department Procedures</td><td>Luncheon</td></tr>
<tr><td>1200 – 1300</td><td>Lunch</td><td>Lunch</td><td>Lunch</td><td rowspan="4">Crisis Intervention Role Play & Hearing Voices Simulation Exercise</td><td>Lunch</td></tr>
<tr><td>1300 – 1350</td><td>Developmental Disabilities</td><td rowspan="3">Family Perspectives & Consumer Panel</td><td>Psychotropic Medications</td><td>Summary & Evaluation</td></tr>
<tr><td>1400 – 1450</td><td rowspan="2">Substance Abuse & Co-Occurring Disorders</td><td rowspan="2">Legal Issues</td><td>Written Examination</td></tr>
<tr><td>1500 - 1550</td><td>Superintendent's Ceremony</td></tr>
</table>

The above is an example of the content of the training, taken here from the Chicago Police Department. The founder of CIT,a Memphis Police Department Major Sam, is passionate about the need to keep to the training schedule.However I did meet other smaller forces or combinations of departments across a large rural area that could not entertain officers being absent from core duties for a week at a time. Therefore they have adapted the schedule and train every Monday for five weeks either face to face or due to huge distances involved, some of the training is carried out via video link. I saw examples of how to enhance the training and how to make it relevant to the agencies or departments involved. This, linked to the mapping undertaken in each area using the intercept model led to an enhanced service driven to keep police officers safe and ensuring the needs of those in crisis are met. I also learned that USA law enforcement has a considerably different approach, it has to be said out of necessity, to emergency calls than we do currently in the UK. That is due without doubt to the availability and proliferation of firearms in the USA.

At every encounter at the forefront of every police officer's mind in the USA must be "has that person got a firearm?" The consequence of that simple fact is that police officers in the USA police with what I would describe as 'shock and awe'. Take control, take command is at the heart of every encounter. Add to that a mental health crisis and it is a recipe for trouble. Consequently a large

proportion of the training programme is around identification of those in mental health crisis and de-escalation which often goes against what the officers have been taught in their initial training academies. This certainlyresonated with me, albeit not to the same extremes. I still feel we police the majority of the time with consent, asking for compliance rather than demanding it. However when confronted with an individual in crisis our approach becomes closer to that of our USA counterparts. Therefore what is lacking in the training and approach of the officers back home is the process of de-escalation to a point where the officer can have a sensible discussion with the individual about the alternatives to protective custody. Included in this training was a huge amount of consumer input from original design to assistance with role play exercises. Who better to play an individual in mental health crisis than an individual that has experience their own mental health crisis?

I was able to see CIT trained officers first hand whilst onpatrol with the Chicago Police Department as they responded to on average 63 mental health crisis calls a day. Officers that have received the training are designated as CIT officers and the despatcher will endeavour to call them first if a call can be identified as a mental health call. In fact one of the calls that came in whilst I was on patrol was from a lady who was feeling depressed to the extent of threatening self-harm whospecifically requested a CIT officer attend.

One of the issues I discussed with the CIT programme manager Sgt Lori Cooper was the identification of mental health calls and how data were collected. Chicago PD is working closely with Professor Amy Watson of the University of Illinois in evaluating the CIT programme and has been in direct contact with Dr Callaghan to discuss data collection and similarities with the studies in the UK.

Mobile Crisis Teams

The next stage of my project took me to Baltimore County Police Department to experience their Mobile Crisis Team. This is the second model of police response to those in mental health crisis that I examined. However it is not just as simple as “cop in a car with a clinician”. I spent a total of 7 days with the unit working on both day and late shifts alongside their teams. I wanted to experience the workings of the team from within with a view to replicating it, if appropriate, on my return to Cornwall. The response team was only one aspect of the solution that Baltimore County Police Department has put in place to manage the demands placed upon it by those individuals within the community that find themselves in crisis. Whilst there I also met with the Chief of Police who spoke very highly of the unit but only in terms of keeping patrol officers on the street rather than sitting at a hospital waiting with a patient. I felt there was much more to it than that.

The State Laws in Maryland are similar to those in Illinois and reflect the need of the police to be able to take someone against their will to a hospital for emergency mental health assessment and treatment. This is known here as an Emergency Petition (EP). The mobile crisis unit is a collaboration between a health provider Sante and the Baltimore County Police Department. Sante provide the clinicians and also a 24 hour 365 day a year crisis hotline and emergency, free at point of use, counselling session. The performance indicator used by the team to denote success is the number of calls attended that did not result in an Emergency Petition. This had synergy with my initial project outline of finding ways to reduce the number of times we use the Section 136 MHA power of detention in Cornwall.

The police officers that formed part of the team had received additional training in dealing with those with mental illness, although not to the degree of those attending a CIT academy. Their primary role, as I was reminded on numerous occasions was to keep the clinicians safe. In one instance I did see the cop physically place himself between the client and the clinician. I did get the feeling that they would "take a bullet" for their charge. I hope it never has to come to that.

The thrust of the diversionary practice was to look for alternatives and place upon the client the feeling that they had a part to playand had choices in their care. A tactic often used was to form an agreement, a pact between the clinician and the client which stated that they would not do anything untoward after the team had left and that they should take up counselling if this was offered. However, it was the alternative arrangements that seem to have the greatest impact on the decision to EP or not. In Cornwall that service does not exist and officers have only two choices: Section 136 or walk away.

The team was either despatched direct to an incident by the 911 call handler or by the hotline. However it seemed that the majority of calls I attended were where an officer had already attended and wanted the assistance of the specialist unit. The Mobile Crisis Team provided two units, a cop and a clinician in each from 1000hrs through to 0100hrs seven days week. The County was split into two halves with a unit covering each half. Each unit therefore had roughly 340 square miles to cover. Fortunately the population centres surround Baltimore City and calls to the outlying rural areas are rare.

Having been called to a couple of incidents by officers already in attendance I started to get the impression that the team was being used as a safety blanket by those officers and as such I started to question those officers as to what they would do if the team were not available. In every case the answer was to use the EP powers. However where it was obvious that there was not going to be an alternative to the use of the power, the mobile crisis team was still despatched. In discussions with the team they were frustrated that front line officers would call the team when it was clear that they knew the action they should be taking. This then reduced the availability of the team from responding to further calls.

The Best of Both Models

In Arlington I saw what can only be described as the gold standard collaboration between law enforcement and health in the shape of the Arlington County Community Services Board. Arlington is a small but very affluent County in Virginia, just across the river from Washington DC. It has an area of around 26 Square miles and plays host to the largest office block in the world, the Pentagon(which, incidentally, has its own Police Department). The Arlington County Police Departmentis responsible for Law Enforcement and the Arlington County Sherriff's Department is responsible for the running of the jail both work closely with the Community Services Board. They used the sequential intercept model to map services, fill gaps and plan for the future. They have a well-developed CIT programme as well as offering alternative approaches such as free at point of use emergency counselling services. They have developed a Crisis Intervention Centre which functions as a "one stop shop" offering office based and outreach services. The jail also operates to a very high standard, in fact it's the only jail I know that has received a five star rating on YELP!

I would like to think that this should be the model we aspire to. I was able to link Arlington with Chicago who were keen to develop such a community based system.

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In Baltimore I visited Melissa Reuland from the Justice Center from The Council of States Government. Melissa has been working in the area of mental health and lawenforcement for many years and is the author of many a report including "Improving Responses to People with Mental Illnesses- Tailoring Law Enforcement Initiatives to Individual Jurisdictions." This provides a tool for assessing the specific factors that drive an area's problems associated with law enforcement interactions with people with mental illness. Again hindsight is a wonderful thing and I wish I had met with Melissa at the start of my travels rather than towards the end. However I learned a lot from her in the short time I spent in her company.

Having experienced both models first hand I believe both have their merits and aspects that are transferrable into UK policing. Well before I left the USA I had planned the following actions:

Action: Use the toolkit from "Improving Responses to People with Mental Illnesses- Tailoring Law Enforcement Initiatives to Individual Jurisdictions" to assess the landscape of Devon and Cornwall with regards to the implementation of a crisis intervention model.

This will form the framework to answer the three questions raised in developing my project. I sit on the Force's mental health forum and have introduced the findings of my project. I hope to use this to steer the Force to adopting a model that is workable and sustainable.

Action: Develop and introduce a mental health training programme for front line officers

This will be based on the CIT model with emphasis on recognition of mental illness and vulnerability, de-escalation and safety planning.

Action: Explore a process to support frontline officers with immediate access to clinical help and advice.

This is a challenge in a rural area. Urban models already exist in the UK but the rurality and lack of mental health resources in Cornwall make this a challenge.

Action: Develop alternative immediate care options such as telephone support or counselling services

This will link closely with the previous action. Currently there are limited options for front line staff dealing with mental health crisis. In order to reduce the number of individuals being taken to a police cell, viable alternatives that manage the risk and allow officers to return to frontline duties need to be found.

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Police Drop Offs

On arrival in Chicago I was able to see how CIT training fitted in with Health provision and learn more about how the Laws in the USA compare with ours.

Firstly each State has its own law making mechanism and Laws can vary from State to State. However, in each state I visited there were laws surrounding the ability for Law Enforcement Officers to take someone into protective custody in order that they can be treated involuntarily at a hospital for a mental illness. This is very much like the Powers under Section 136 except it appears in the USA these powers can also be exercised in a private place. The replication of this in the UK would make a huge difference in very specific but quite regularly experienced instances.

The first and most major difference I witnessed was that the health care system in the USA works in a very different way to that in the UK. Both have their merits. Put in very simple terms in the UK the money lies within a service. The NHS commission and fund a service and that service is paid for whether or not it is used. In the USA it is payment by results, or more accurately the money lies with the individual and the services receive funding for each patient they treat. Funding is located, in the main, with the health insurance of the individual or the individual is State funded if they have no or limited insurance. This, in my opinion has led to some unforeseen consequences. It is easier to access funding if there is a diagnosis. As a consequence I met many individuals or heard of children that had been diagnosed with mental illness that may not have received the same diagnosis in the UK (despite parity in diagnostic criteria used). Also, the system in the USA seems to be geared towards treating a crisis, stabilising and releasing without necessarily thinking about the future. There is money in treating a crisis. There are 38 Accident and Emergency departments in Chicago City, catering for a population of 2.7million and on the whole each is run as a profit making business. Compare that against the one Accident and Emergency Department in Cornwall Catering for a population of 0.53 Million, as they say in the USA "you do the math".

In Chicago no one recognised in mental health crisis goes to a police cell. In fact some hospitals will actively encourage officers to take those in crisis to their emergency rooms as they will then receive funding. This encouragement comes in the form of assistance on arrival and a quick turn round. In fact many hospitals had their own police doors and reception areas known as "Police Drop Offs. Although I think in addition to the ease of drop off, a coffee and donut machine may help in future. It isn't all about getting people through the doors for the funding: this enhanced service has the benefit of those that are ill going to the right place first time and keeping police officers on the streets.I visited numerous Emergency rooms including those equipped to deal with children. (I am told the youngest that particular unit had brought in by the police was aged 7 years). The benefits are obvious but it will take a lot of work to translate the good practice I observed to our health system.

<u>Action: Explore incentivisation with Health Commissioners responsible for commissioning the health provided place of safety</u>

One of the greatest frustrations of UK officers is that having detained an individual in mental health crisis, the Place of Safety refuse to admit them. I can understand their viewpoint, sometimes, when assessing and managing the risks to the individual and staff. They have no incentive to accept. Often,

it is perceived that the decision is not based on what would be best for the individual or the true risk, just an excuse. The USA model works because the driver is monetary reward The trick will be developing a model that allows such reward within the UK healthcare syste

Mental Health Courts

Chicago is also well known for its forward thinking Court Systems. I visited both the Courts and the County Jail. It was at this point that I discovered that the word diversion has two meanings. For me when I talk about our custody Liaison and Diversion scheme the goal is to divert people out of the criminal justice system altogether at the earliest stage. The word diversion in the USA relates to diverting away from the jails. Cook County jail has a population of 10,000 and is spread over 96 acres. Just to bring that into perspective the entire prison population of the UK is around 85000. The process in the USA seems to be that everyone that gets arrested will spend some time in jail, even if it is awaiting appearance before a judge to set bail. It is said that thelargest mental health centre in America is a huge compound in Chicago, with thousands of people suffering from manias, psychoses and other disorders, all surrounded by high fences and barbed wire.

Chicago Sheriff Tom Dart: "It really is one of those things so rich with irony: The same society that abhorred the idea that we lock people up in mental hospitals, now we lock people up in jails."

I can see why it is so important to divert people away from jail, having spent a day visiting it was one of the most desolate places I have ever visited on earth.

I was hoping that the Mental Health Court system that has been running for some 20 years in Chicago could have been replicated in the UK, specifically Cornwall. The model I envisaged would have all those offenders with a mental health problem appearing in one court where services could concentrate their efforts around diversion. In fact that this is what happens in Chicago, but the defendants are still kept within the criminal justice system and have to sign up to a programme monitored by the court that has them mandated to attend therapy, be drug tested, get and hold down a job and attend court every month to three months to appear before a judge. Any breach will mean jail time. This programme can last from 18-24 months depending on the offence. It has done a great deal to reduce the jail population and does help those suffering from mental health issues get on the straight and narrow.

It was duringmy last few days that I had an experience that has fundamentally changed the way in which I view offenders with mental illness and the way in which we deal with them. I visited Baltimore County Jail, not as overwhelming as Cook County Jail but not quite up to the standards of Arlington County Jail. I would however give it 4 stars on YELP. I spent the morning with the resident mental health team. Their role is to look after the mental health of the inmates. Whilst there I met a young man who had murdered his grandparents with a baseball bat whilst suffering from a psychotic episode. He held a rational conversation with me. The role of the jail and its mental health team in these circumstances was to treat this young man until he was fit enough to stand trial. He was almost ready. He was aware of what he had done and was actively asking never to be released as he could not face being in a position where he hurt another person. I have spent my career catching criminals and punishing them for what they have done. This man committed a crime when he was very unwell. He has been made better and now the system will punish the man he is now for what the man he was has done. That has made me think.

Action: Explore the potential to develop mental health courts in Cornwall

The specialist courts in Chicago were centred on mandating individuals into treatment/rehabilitation with the aim of preventing re-entry into the criminal justice process. Dedicated court sessions deal with each type of problem solving court together with judges and other professionals with specialist knowledge. Assigned case workers develop plans on an individual basis and mobilise resources to ensure a holistic approach involving criminal justice, health and social care agencies to support the individual to meet the agreed goals of the programme. Currently in Cornwall, individuals with mental health needs are supported, where possible, by specialist court liaison nurses. However, when an individual enters court, no other professionals involved in the court session have specialist knowledge of mental health, the impact that this can have on criminal justice involvement, and also the experience of attending court. Further, criminal justice outcomes are, in general, not conditional on accessing treatment but more with the standard sentencing guidelines available to magistrates to deal with every offender.

This action can be realised through a feasibility study to identify how a specialist mental health court could be delivered in Cornwall, based on the fundamental principles of the USA problem solving model. It is intended that this will initially mirror the domestic violence courts already actioned in Cornwall with dedicated sessions and specialist staff.

I experienced some of the health and social care providers offering services to those offenders on problem solving court programmes to support them to stay out of jail.. The Threshold project in Chicago provides support to offenders post discharge. A series of key workers manage a case load, ensuring that their clients have medication if required, assist with managing their finances, find accommodation and ensure they meet their probation appointments. Having spent a day with a key worker, Laura and interviewed a client, Sammy, I can see the benefits of such a scheme. The necessity for a large proportion of Threshold's services were driven by the closure of numerous state run mental health hospitals in recent years, which explains the above comment from Sherriff Dart. Thus there is now a greater requirement for the provision of care in the community in Chicago. Another such provider is Serenity House. This is an organisation that runs a halfway house for rehabilitating offenders. The clientsmainly have a history of substance abuse, whether it be drugs or alcohol, but often there is an underlying mental health issue that is either the cause or the result of such abuse. The situation reminds me of a saying about chickens and eggs. Serenity works with the courts to accept individuals on diversion schemes. They have strict rules including curfews, employment regulations and random drug testing. I interviewed two clients that told me similar stories of their offending history that had resulted in long jail sentences deferred to be managed in a different way. Both were thankful for the programme stating that they feel they would have just served their sentence in jail and left straight back into a lifestyle that would have had them back in jail in a very short period of time. Serenity had them back on a pathway to becoming fully functioning members of society.

What had me thinking whilst I was visiting both Thresholds and Serenity was that I was unaware if any such programmes existed in Cornwall and if they did, that we needed to find ways to get them involved in the Cornwall Intercept model. This takes me back to my first action, finding out exactly what is out there.

In addition to working directly with the Mobile Crisis Team in Baltimore I also spent time with an officer whose primary role was to manage risks in relation to workplace violence. Incidents of extreme violence at the workplace, whether it be an office building or educational establishment are unfortunately not so rare as one would hope. I witnessed an incident involving a threat to cause serious damage to a municipal building. However, it highlighted to me the need for all agencies to freely share information.It was only because the Mobile Crisis Team keep records of their calls in duplicate, Health providers and Police that, a serious escalation of what at first was thought to be a credible threat and as such had caused the mobilisation of both the FBI and Secret Service was prevented because Law Enforcement then had access to data previously only accessible to Health. Although not as extreme in the UK it is imperative that we continue to build appropriate data sharing protocols.

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National Alliance on Metal Illness (NAMI)

Arlington also plays host to the main offices of the National Alliance on Mental Illness or NAMI. Born in 1979 when a group of parents from across the country became aware that they were fighting for the same goal to make things better for their children who had mental illness. Although spread out over the whole Country they managed to form a powerful lobby, without the aid of the internet and social media. NAMI has grown and now provides support in each State and works closely with Law Enforcement to develop whatever model of crisis intervention works best. I met with the current hierarchy of NAMI and tried sow the seed that they need to expand into the UK, however at this time they have no plans to do so. They provide training in the community to families coping with mental illness, to public sector workers such a Police, Fire, Health. Each successful CIT programme include NAMI. In the UK the "Interface" research project has an element of service user involvement to advise on issues from their perspective. In the States NAMI provides that perspective. Role players assist in the training of Police Officers, family members lobby for change in legislation and all from this not for profit organisation.

Action: Use the service user group to form the seed of a NAMI type organisation for Cornwall

The Interface project has a vibrant and enthusiastic service user consultative group who informed the research. The consultants are keen to continue to work towards the enhancement of criminal justice-mental health focussed services through consultation regarding research, practice and training. It is intended to work with and expand this group to develop further funding bids in order to work towards the setting up of a solid criminal justice-mental health focussed service user led organisation mirroring the aims and principles of NAMI in Cornwall.

WINSTON CHURCHILL MEMORIAL TRUST

Conclusions

I have learned a great deal from my project not only about the interface between law enforcement and the criminal justice system but also about myself and my views and values. I have returned to my place of work. I was an Inspector when I left for the States and was promoted as soon as I returned. I have already taken some of what I have learned and started to implement. At this time there is a great drive throughout the Country to improve pathways for those with mental illness within the criminal Justice system. Funding has been found to provide pilots for a street triage process. The Liaison and Diversion schemes are being developed along a blueprint with a view to national roll out in 2016/17.

There is so much we can learn from other areas such as the USA. They have had to adapt as priorities have changed. In certain areas they were driven to change by horrific circumstances and we should do so before we experience similar tragedy.

With the contracting public sector we will need to work better together and to do so we need to understand the landscape. The sequential intercept model is not rocket science and can easily be used to map services in a geographic area. Once done it is easy to see service gaps and try to plug them.

The police service is also contracting and we are continually having to do more with less. The research projects I have been involved in in Cornwall have shown that 40% of our business relates to vulnerable people with mental health issues. We detain 365 people a year in crisis, the majority of whom will spend time in a police cell. Speaking to officers they ask the question “what else could I do?”. We need to provide them with appropriate training and alternatives to detaining people in mental health crisis in police cells.

The CIT training programme will provide insight into mental illness and how to communicate appropriately with some in crisis. Detention will still be an option but should not be the first option or the only option. We need to be able to change a person’s care plan without the need to incarcerate them. After assessment it is found that 50% of detainees do not have a diagnosable mental illness, but a crisis. Emergency Counselling services and Mobile Crisis Teams are the gold standard and I can see how they would work in an urban environment. In sleepy rural Cornwall covering 1336 Square miles the mobile team would be forever travelling. Providing telephone support to those in crisis as well as to officers facing crisis would be a more workable solution. We may have to look to our ever increasing volunteer sector to provide the emergency support to those that need it that do not need detention.

The mental health courts work well and again are driven by necessity in Chicago. You can get free mental health services in Chicago you just have to get arrested first! The drive is to keep those with mental illness out of jail. I want to adapt the process to keep those with a mental Illness that has caused their behaviour to degenerate into criminal activity out of the criminal justice system unless the only way we are going to keep them and the community safe is by using the criminal justice system as a driver for treatment. This is the most tricky of my actions to implement and will take a lot of collaboration and effort to achieve.

Service users, consumers or whatever the terminology is for members of our communities that have interacted with the criminal justice system because they are ill should be at the heart of whatever processes we put in place. NAMI provides them with a voice in the USA. In the UK we have MIND, Rethink, the Revolving Doors Agency and others. I want to engage with a body of people that will help me develop at a local level a service to the community. It needs to involve families, carers and service users. I am hoping that the Service User Group that Dr Callaghan initiated for the Interface Project can be morphed into such a body

Actions Since My Return

Since my return I have implemented a training programme loosely based on the Crisis Intervention Team programme. What is missing though is the service user input.

I am working with Dr Callaghan to sow the seed for a service user group involving family members to guide and offer support in the development of the training.

I have started to look for support mechanisms to offer alternatives for officers. There is a possibility of widen the scope of our Street Pastors initiative to provide the counselling services I saw in Baltimore and Arlington.

I have started the conversations with the Health Commissioner responsible for the place of safety around incentivisation.

I have presented my findings and thought to my Chief Officer Group and have been asked to provide an options paper on how we can reduce the use of section 136,offering alternatives and how we can reduce the number of mentally ill people in our cells.

I am presenting my project to a national mental health/ law enforcement forum towards the end of April 2014

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