Understanding Best Practice: The Emergency Response to Mental Illness - An Exploratory Report

Alexander Paul Crisp
2015
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My Wife for her incredible support and understanding for this endeavour.
## Abbreviations and Glossary

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AOT</td>
<td>Assertive Outreach Team</td>
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<td>CAMP</td>
<td>Case Assessment Management Programme</td>
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<td>CIT</td>
<td>Crisis Intervention Team</td>
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<td>ER</td>
<td>Emergency Room</td>
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<td>LA</td>
<td>Los Angeles</td>
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<td>LAPD</td>
<td>Los Angeles Police Department</td>
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<td>MEU</td>
<td>Mental Evaluation Unit</td>
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<td>MHIT (LAPD)</td>
<td>Mental Health Intervention Training</td>
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<td>MHIT (NSW)</td>
<td>Mental Health Intervention Team</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>PMRT</td>
<td>Psychiatric Mobile Response Team</td>
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<td>PD</td>
<td>Police Department</td>
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<td>QPS</td>
<td>Queensland Police Service</td>
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<td>SMART</td>
<td>System Wide Mental Assessment Response Team</td>
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<td>SWAT</td>
<td>Special Weapons and Tactics</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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<td>VA</td>
<td>Veterans Administration</td>
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<td>VPD</td>
<td>Vancouver Police Department</td>
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<td>WCMT</td>
<td>Winston Churchill Memorial Trust</td>
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Executive Summary

The Police service is often the initial responding agency to emergency crisis incidents and this is an area of current national interest. The question of whether officers should respond or are the best equipped to tackle these incidents is of particular relevance in this time of financial austerity. It is unrealistic to expect officers to provide ongoing support and care. So how does the Police service interact with other emergency responders to enable emergency access to psychiatric care?

The potential role of NHS and Police partnerships to support vulnerable, mentally ill people in crisis has been historically underutilised and consequently lacks research and resources. As a serving police officer and one of the first street triage police officers in the UK I have recent specialist knowledge of the practitioner’s dilemmas when responding to a variety of mental health and crisis incidents. Providing strategic partnership solutions to the emergency response, working with commissioners and managers within health and the criminal justice system brings a very different set of challenges. This area of business has historically been underfunded and underdeveloped.

This report outlines the findings from five weeks of international site visits working with, and learning from, police services and their partner agencies who specialise in addressing the emergency response to mental illness. Several key findings became clearly apparent and run as threads throughout the report.

- There is a complex and necessary role that police have in supporting and dealing with mental ill health in the community setting.
- The need for mental health training for police professionals has importance and needs investment in order to improve outcomes.
- Partnership Co-response models can be an efficient and effective method of dealing with community and organisational demand.

I hope that within the organisations, cultural challenges and biases do not limit the potential of joint working in support of mentally ill people. The strength of all successful models, that I have witnessed, is based on the ability of all service organisations to work effectively together.

Alex Crisp, Mental Health Partnership Manager,
Office of the Police & Crime Commissioner for Leicestershire
Chapter 1: What?

Approach to research.

Introduction to the Research

This report has been submitted following the completion of a Winston Churchill Memorial Trust Travelling Fellowship. The Fellowship supported the author in examining the emergency response to mental illness with funding to visit areas of best practice internationally. The importance and relevance of this report is set against a background of business development over the last three years.

In the UK the response to mental health crisis has become a political and social priority. Landmark national responses such as the Crisis Care Concordat, have highlighted and captured the need for organisational change and improvement to the business of crisis response. This partnership document outlines standards of provision not only for health commissioners and providers, but for other agencies, in particular the Police Service. The Police Service’s response to mental illness and crisis has been scrutinised significantly over the last few years. High profile deaths in custody in London led to the publication of the Independent Commission on Mental Health and Policing Report¹ in 2013. This report set out a range of broad and far reaching recommendations for the Metropolitan Police. This could be considered a cautionary ‘shot across the bow’ for police services nationally. By far the most organisationally challenging statement made within report is that mental health is ‘Core Policing Business’².

That area of policing ‘business’ has particular significance in the current climate since financial austerity measures were introduced. The estimated business demand for mental health related work is 20-40% of total police demand³. It is worthy of note however that there is arguably a lack of reliable and robust data examining the contact that mental ill health has with policing. This data that is provided does not breakdown to the level of appropriate business intelligence which may reflect, for example, diverted demand from other agencies, crisis response and other crucial operable statistics.

In 2014 the Home Office Select Committee on Policing and Mental Health was convened and again made a series of recommendations. Discussions on diverted demand headlined in the subsequent report. However aspects such as the need to review street triage services and improve police training⁴ were also highlighted. The operational relationship of criminal justice and mental health is not a recent area of business in the UK. Not dismissing the archaic approaches to mental ill health in the past

³ House of Commons Home Affairs Committee (2015) p.8
⁴ House of Commons Home Affairs Committee (2015)
there are historical relationships between the courts and forensic mental health services. These relationships, now formalised in Liaison and Diversion models resulting from The Bradley Report\(^5\) were nationally commissioned in 2014.

At the end of 2012 leading into early 2013 a series of jointly provided response services began to emerge. Leicestershire acknowledged the need to improve their crisis service provision and developed their organisational partnerships. Leicestershire piloted a co response service placing Mental Health Professionals and Police Officers together as a response team\(^6\). This methodology, as well as other models of multi-agency crisis response, spread across the UK and became known as ‘Street Triage’. In 2013, a series of national pilots were funded by the Department of Health based on the success of models such as that in Leicestershire.

These models have been broadly dismissed as a mental health detention reduction tool, however early indications suggest a much broader implication and impact on mental health and criminal justice agendas.

It is important to acknowledge that this is not the first time that the Winston Churchill Memorial Trust (WCMT) has supported research in this area\(^7\). Both the WCMT in the UK and Australia have funded professionals to look at the criminal justice system’s relationship with mental health. The following fellows, in particular, have produced exacting reports validating the work being undertaken in areas of the USA, Canada and Australia:

- Chief Inspector Mark Bolt, Devon & Cornwall Police. The UK Criminal Justice and Mental Health Interface meets the USA: A police officer’s perspective
- Senior Sergeant Greg Giles, Queensland Police Service. Winston Churchill Memorial Trust of Australia Report
- Paula Reid, Rethink Mental Illness. Mental Health & Criminal Justice, What can we learn from Liaison and Diversion in the USA and Canada

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\(^5\) Rt Hon Lord Bradley (2009)  
\(^6\) Leicestershire Police (2015)  
\(^7\) Winston Churchill Memorial Trust (2015)
Observations made by Rhonda Moore in ‘Policing and the Mentally Ill: International perspectives’ suggest that the UK emergency response to mental health crisis lags behind those internationally. When reviewing contemporary literature on the subject she states:

‘The findings of the literature search suggest that either this a relatively neglected area of study in most of Europe to date, or traditional academic databases do not capture the relevant policing literature’

It could be argued that the last significant review of this area evolved with the legislation changes of the Mental Health Act in 1983 and then in 2007. The Mental Health Act and accompanying Code of Practice defined the roles and responsibilities of the state and all organisations that operate under the legislation. The need for the production of the Crisis Care Concordat indicates that the legislation was not being adhered to and that services were not meeting the requirements of their statutory functions. As this report will show, an important aspect of development in this area is the role that all organisations have in providing that response.

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Moore (2013)
Aims, Objectives and Purpose of the Research

The aim of this research was to learn more about some of the more established, coordinated responses to mental health emergency incidents. Where possible, to identify and review evidence of academic evaluation of service impact and the perceptions, involvement and influence of users of those service provisions.

In pursuance of the aim the research set a series of objectives, outlined as topics, for exploration:

- **The need** – establish the levels of each site’s mental health provision issues prior to their operational models being implemented
- **The motivation for change** – identify and understand why the areas developed the models
- **The partnership approach** – identify and understand the role of partnership working in the operational models
- **Roles and responsibilities** – identify and understand the roles of service users and academics on the development of models and working practices
- **Service user perspective** – identify and understand how the models deliver services to specific groups to include black, minority and ethnic, veteran and personality disordered demographic groups.

It is neither the purpose nor intention of this report to evaluate the methods being adopted in other areas. A fair and robust evaluation would be unrealistic within the scope of this work. The purpose of this report is to build a collection of best practice options on which to develop new and/or improved models of training and operation in Leicestershire and the UK.

Approach and Methodology

The approach taken to formulate this report was to gain an appreciation of the practice being undertaken at certain sites. Where suitable reviews were undertaken and available, these were to be used to support any conclusions made on the observed service. In order to select exemplars of good practice upon which this review might be based a process of research of open source materials was undertaken which highlighted six sites internationally.

Senior managers of services in these areas were approached and consequently agreed to visits. A total of six site visits were conducted in three countries over a period of five weeks. The five week research period was split into two phases with the first (USA and Canada) phase taking place in May 2015 and the second (Australia) phase taking place in July 2015. An itinerary outline can be found at Appendix A for information.

A mixed method approach was taken in order to maintain an open learning concept and take advantage of all available developmental opportunities. This approach took advantage of deployments with front line professionals within the police and mental health organisations, meetings with multi-
professional groups and individuals, impromptu informal interviews and attendance at established training courses. A series of questions were developed in order to capture reflections from each site but this was not maintained with rigidity and not undertaken with academic consent or rigor. A list of the research questions can be found at Appendix B for information.

As a means of overall context each site visit is broken down within Chapter 2 giving an overview of the service provision that was observed. Each site was very different geographically and demographically and had area specific challenges. The appreciation of the model of response that was adopted within its social and political context is important when considering possible UK adoption. Each site had key elements that added significant context to the model that was adopted. A critique is offered based on aspects that were witnessed but fuller conclusions are drawn in a broader context within Chapter 3.
Chapter 2: Now What?

Approaches taken at sites of best practice.

Memphis, Tennessee USA

Key aspects:

- Diversion from the Criminal Justice System is a prominent factor as there is a prevalence of mentally ill people within the custodial population.
- Access to mental health services in Memphis is dictated by financial means as is the case in other places in the USA.
- Access to firearms in the community is a significant impact factor for policing contact.
- Community owned model of police response

‘Memphis Model’ Crisis Intervention Team

The Crisis Intervention Team (CIT) is a prestigious, police based, method of response which has a 30 year heritage. Since its development in 1988 the CIT model has been broadly reviewed with a considerable amount of literature produced by a variety of professional and academic sources. A link to those sources can be found here: [http://www.citinternational.org/CITINT/PDF/CITResearchBibliographyofPublishedReportsAugust2015.pdf](http://www.citinternational.org/CITINT/PDF/CITResearchBibliographyofPublishedReportsAugust2015.pdf)

The model is based upon partnership and the community supporting its police service to deal with police specific mental health contacts. Specialist CIT officers receive enhanced training to deal with crisis calls but otherwise remain on their normal duties.

What has become known as the ‘Memphis Model’ of CIT has been both replicated and modified. It is estimated over 3,000 forces have adopted CIT as their response to mental health contacts. It is also noteworthy that the methodology has also been adopted outside the USA. That take up is reflected in the organisation that oversees and guides Crisis Intervention Teams namely CIT International.
The CIT concept was created by Major (retired) Sam Cochran formerly of the Memphis Police Department and Professor Randy Dupont of Memphis University. The formulation of CIT and ultimately the need for change in Memphis came from the push from advocacy groups for the police to change their approach to mental health consumers. It was ultimately the death of a mentally ill member of the Memphis community that spearheaded the development of CIT. There was an apparent lack of equity of treatment and access to care for the community which led to the promotion of a CIT concept. It is also worthy of note that although mental health is the leading aspect of CIT, race equality and diversity is also important. The programme has a strong theme of integration which each CIT area develops according to the diversity of its community.

Professor Randy Dupont & Sam Cochran founders of the Memphis Model

The CIT model\(^9\) works from 10 core elements outlined below:

\(^9\) Dupont et al (2007)

### CORE ELEMENTS

#### Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation and Networking
3. Policies and Procedures

#### Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

#### Sustaining Elements

7. Evaluation and Research
8. In-Service Training
9. Recognition and Honours
10. Outreach: Developing CIT in Other Communities

A fuller explanation of the model and its core elements can be found at: [http://www.cit.memphis.edu/information_files/CoreElements.pdf](http://www.cit.memphis.edu/information_files/CoreElements.pdf)

Apart from the employment of a mental health coordinator, who becomes the central point of contact for the programme, the model operates at relatively low cost. There is a justifiable perception that CIT is training centric. The training programme that officers receive is 5 days long and covers a broad range of training themes. Training is targeted towards patrol officers and negotiators. An understanding of mental illness and de-escalation techniques being key themes.

An example of the Memphis model CIT programme can be found at: [http://www.cit.memphis.edu/curriculuma.php?id=0](http://www.cit.memphis.edu/curriculuma.php?id=0)

According to Randy Dupont of Memphis University, the training element of CIT
promotes several aspects besides concise and relevant information around mental health. The promotion of active listening skills and de-escalation skills feature however it’s the context that adds real value. The creation of tension in role plays, to reflect street level contact, promotes confidence within officers to make decisions. Officers benefit from experiential learning with people who have lived experience of mental illness. This helps shape future responses. The training itself delivers definitive learning outcomes but in a policing environment. The context is forever changing, therefore the training empowers officers to make more informed decisions and use discretion where they feel that it is appropriate. It is noteworthy that it appears that many CIT officers go on to be supervisors.

Recommendation 1: An adapted CIT model (for UK policing style) be adopted

The CIT model is not a training programme. The observations made by the Memphis CIT suggest that in areas where CIT has succeeded, the broader aspects of CIT have been understood. Where the model has failed those areas deemed that training of police officers would resolve their broader problems. They became training rather than community centric. The aspects of established community partnerships and leadership within front line officers around mental health are essential.

CIT officers believe the training generates empathy with other important transferrable skills. This is an indicator of the strength of the model, the development of a strong relationship not only with other organisations, but with the community itself. A core element of CIT, and arguably its strongest feature, is that of community ownership. The community in effect directs the progression of the model and takes joint responsibility for the issues. Service users become empowered and reassured by having direct involvement in the programme. Non Police professionals build relationships with the police by delivering the CIT training programme.

Recommendation 2: Community ownership is built into future mental health training and response models

Independent academic evaluation of the CIT model is available but the data sets adopted are sometimes limited and inconclusive.

The benefits of CIT implementation have been reflected across the areas in which the model has been adopted.
CIT International (2015)\textsuperscript{10} states,

- ‘Less need for the use of lethal force. Since 1998, there have been two officer involved shootings involving mentally ill individuals by non-CIT trained officers of the Memphis Police Department.’
- ‘Jail Diversion. In Memphis, the census of mentally ill individuals in jail custody has dropped from 15% in 1988 to 3% today. The national average of mentally ill individuals currently incarcerated ranges from 15 to 20%.’
- ‘Arrests were reduced 90% from 20 arrests per 100 calls prior to CIT inception down to 2 arrests per 100 calls since the implementation of CIT.’
- ‘Reduction in Officer Injuries. Since CIT implementation in Memphis in 1988, officer injuries dropped 85%.’
- ‘Reduction in injuries to mental health consumers. Reported injuries to mentally ill individuals dropped 40%. (Memphis)’
- ‘Reduction in SWAT call outs. SWAT call outs dropped 55% from .042 per 100 calls to .019 per 1000 calls. (Memphis)’
- ‘Reduction in time “off patrol” Departments using the CIT model find that CIT officers are usually back on patrol within 15 minutes of bringing a mental health consumer to a designated medical centre for evaluation. Prior to CIT, officers spent an average of 4 hours with mental health consumers in Emergency Rooms.’
- ‘Reduction in civil litigation. Reductions in deaths and injuries have also significantly reduced costs associated with litigation.’
- ‘Improvements in community relations. The skills learned by CIT officers lead to successful interventions in ALL aspects of officers’ patrol responsibilities, leading to better morale and improved community relations for the department.’
- ‘Reduction in emergency room recidivism. ER recidivism rate dropped to less than 20% after implementation of CIT model. (Memphis)’
- ‘Decrease in involuntary commitments. Involuntary commitments decreased from over 40% to 25%. (Memphis)’

An observation of the Memphis CIT model is that the model is arguably ‘detention’ heavy. The reliance on police detention as an appropriate, safe method of support and assistance is one that may not be readily accepted by clinicians and community members. The benefits are significant for police services and the CIT model, as already stated presents a robustly tested method of response to mental illness.

The CIT model in Memphis gives the police service a certain amount of ownership around managing mental ill health in the community setting. The Commitment Laws, or to translate, sectioning powers have similarities to those in the UK. However it is very much Law Enforcement and Court led.

An aspect of the CIT model which was particularly significant was the fact that the model itself was readily transferable to any community. The police transfer is widely promoted as indicated by the figures that have already been quoted. However the ability for the model to translate into other

\textsuperscript{10} Link to CIT international (2015)
community environments, such as prison environments is particularly impressive.

Police officers who successfully complete the CIT training program are presented with a CIT pin badge. This pin isn’t just a token reward for course completion it represents a link with the community. The community recognises that officers wearing that pin have committed to supporting mental ill health in their community. This simple token can assist with initial engagement and trust.

CIT pin badges

Amongst the learning materials that Officers receive as part of their CIT training, there is reference to the symbolism of the rock on the front cover of the Crisis Intervention Reference Guide. The rock represents,

‘The strong foundation and commitment that CIT officers demonstrate on every crisis call they respond to’.

This could equally describe the Memphis model where all parties involved maintain that level of commitment.

Veterans Administrative (VA) Medical Centre

Military service is valued highly in the USA and the support provided to veterans in regards to physical and mental health is now well established with Veterans Administrative Medical Centres (VA) all over the country.

The mental health of veterans features on the Memphos model CIT training programme due to the particular issues faced by that community. In particular the issues of Traumatic Brain Injury (TBI) which can occur as a result of a concussive blast from explosions. The relationship between the VA and CIT in Memphos is also linked by the professionals from the VA who commit their time to support the CIT model as trainers. The knowledge of professionals who work in specialist areas validates the quality of the training being delivered and again reinforces the community ownership of the programme.

The relationship between CIT and the VA Centre raises another aspect which has been discussed recently in the UK, the establishment of Police forces that operate within the health system. This is a fairly common practice in the USA and Memphos VA Centre has its own police officers. These warranted officers meet the policing demands of the facility providing both the security and policing needs of the community based at the location. Some of the team are also trained in CIT due to the profile of the community that they have contact with. There is arguably a significant importance for a policing presence within health based settings, where the community have substantial vulnerabilities and risk being victims of crime. The placing of police officers in health based settings is perhaps ethically difficult but may well be a reality in the future for very practical reasons.

Recommendation 3: The police role within existing health care settings be reviewed and amended in order to ensure that policing in hospital settings reflects the needs of the hospital community.
Los Angeles, California
USA

LAPD Headquarters

Key Aspects:

- Large conurbation resulting in multiple health and police boundaries within geographical area. Large Urban population with significant homeless population
- Recent high profile incidents involving the shooting of individuals identified as being mentally ill
- Proactive and reactive Police Co-response models underpinned by Mental Health Intervention Training

Los Angeles (LA) is a fascinating city from a socio cultural perspective. The huge disparity of wealth is significantly apparent when considering the mansions of Beverly Hills and the Skid row in downtown LA. Mental illness although linked to aspects of poverty and other comorbidities affects both the very rich and very poor. The Officers of the Los Angeles Police Department (LAPD) often find themselves as the emergency responder to mental illness and crisis. They protect and serve the whole community not just those who have the means to pay for help.

The significant homeless population that has settled in LA has a mixture of morbidity; drug and alcohol abuse; physical illness; and mental illness. Mental illness is prevalent but often hidden or found in common with substance abuse. The ‘Skid Row’ is a community of both the very vulnerable and the dangerous who prey on them.

Interestingly it was a common perception of Police officers that attended the Mental Health Intervention Training that the homeless contacts made up the majority of the mental health related calls that they deal with. This was proven to be wrong with the majority of calls (80%) coming from those who were in a care giving environment.

Access to health care is affected by means however mental health consumers are able to obtain help via similar provision to that of the UK. Mental Health Crisis provision is provided via an Access Line supported by a Psychiatric Mobile Response Team (PMRT) which can be accessed by all members of the public.

LAPD Mental Evaluation Unit

The LAPD’s response to policing mental health demand comes in the form of the Mental Evaluation Unit (MEU). Working together with the Health Department, the LAPD invest jointly into the Unit. This partnership approach has created a unit of co-response teams working both in the office and on the street. It also worthy of note that the MEU is collocated with the missing person’s team and fixated threat unit due to the crossover in the nature of their work.

Recommendation 4: An educational programme be developed in order to educate the local community on the police role within crisis incidents.
The MEU consists of three main aspects of work namely:

- SystemWide Mental Assessment Response Team (SMART)
- Case Assessment Management Programme (CAMP)
- Mental Health Intervention Training (MHIT)

The MEU also provides a telephone triage that provides officers with support and real time intelligence around mental health related incidents. The telephone triage serves to task the SMART teams. The MEU is best described as a multi-disciplined and collocated model which addresses mental illness in the community through joint working, long term problem solving and enhanced initial response. Its focus is centred on improving both officer and public safety at mental health related incidents as well as getting people the help they need. The MEU's training team provide specialist mental health training for the department but also provide community based education on the role of police in mental health interactions. This enables the LAPD to present an open and honest approach towards policing in their community, and dispel misconceptions about the police intention and capability. This approach also serves to set the expectations of the police service and may result in increased public confidence.

Recommendation 5: Vulnerability and other specialist teams be collocated in order to enhance service provision.

The need for the LAPD to address mental health related business is linked to the demand of crisis calls from all aspects of the community. The motivation for change is as a result of the harsh reality of policing in the USA. Access to firearms in the community have resulted in Police officers being put in an unenviable position. An officer must consider if the individual that they are dealing with is carrying a gun in turn this affects their risk assessment and their tactical response. Cases of mentally ill people being shot and the horrific scenarios of 'suicide by cop' have led to the Police and the LA community wanting to change the approach to crisis.

Link to LAPD MEU website:
http://www.lapdonline.org/detective_bureau/content_basic_view/51704

SystemWide Mental Assessment Response Team (SMART)

SMART started operating in 1993. These teams are very similar to some co response models found in the UK which were first piloted in Leicestershire in 2013. The service sees a mental health professional and appropriately skilled police officer responding to mental health incidents in support of police officers. In LA these teams work from unmarked cars, in plain clothes, and act to ensure that police holds (similar to S.136MHA detentions) are both appropriate and go to the most appropriate place of care. The level of insurance that you have in the
USA has an effect on the hospitals that you can access.

The SMART mission is:

- Prevent unnecessary hospitalisations/incarcerations
- Provide for alternative care in the least restrictive environment
- Allow patrol officers to return to duty in a timely manner

(LAPD MEU, 2015)

The teams act as secondary responders to mental health incidents which include radio and 911 calls and may include SWAT incidents and barricaded suspects. The SMART officers have access to mobile data via handheld personal data assistants which assists the mobile nature of the resource allowing it to be on the road.

Recommendation 6: The use of additional mobile technology be explored in order to support the ability to task existing co response services whilst deployed.

Case Assessment Management Programme. (CAMP)

These investigation teams again see a police detective working with a mental health professional, but they focus on longer term problem solving. For example, ensuring that individuals are referred to appropriate supporting agencies, firearms are removed, criminal offences are managed, and that ongoing risk is managed. These teams manage a case load which also included frequent contacts with the Police and Fire departments. (N.B. in LA the Fire Department also performs a paramedic role)

CAMP manages individuals who are of special concern due to their frequent contacts with the emergency services and high risk behaviour. The intention to intervene and enable appropriate support to prevent further inappropriate and often risky contacts. This serves to address both LAPD and Department of Health objectives by dealing primarily with treatment resistant and sometimes violent clients.

CAMP teams also work with the court system to ensure that the courts are aware of both the criminal and mental health related issues at play. They provide informed joint recommendations to the court which can then support probation and/or treatment options post sentencing.

Recommendation 7: The mental health based relationship between the police, probation and court services is promoted to support a holistic investigation that reaches the court.
CAMP cases are triaged into three tiers:

Category 1 – Persons with a history of mental illness who have a violent criminal history or present in high risk scenarios (barricades)

Category 2 – Persons with a history of criminal activity, mental illness with numerous responses by law enforcement, or abuse of substantial police resources

Category 3 – Persons who have no criminal history but who generate repeated calls

The CAMP has similarities with Multi Agency Public Protection Arrangements (MAPPA) and Integrated Offender Management (IOM) concepts in the UK, and would arguably feature well within a PREVENT counter terrorism model.

Recommendation 8: Integrated services are developed that proactively manage individuals who present heightened risk and frequent contact.

The crossover between mental ill health and police contact is well reflected within the CAMP, which in effect manages cumulative risk of individuals from a multidisciplinary focus. CAMP will also pursue individuals who are in the possession of firearms and have become mentally unwell.

Recommendation 9: A partnership approach is established towards firearms ownership and mitigation of risk for those who become unwell and are in possession of a firearm.

CAMP has been able to reduce violent police contacts and arrests, in addition to reduce the call demand for emergency services and psychiatric hospitalisation.

Health Based provision for emergency detentions.

There are a range of health based holding options for those individuals who are detained by the police service under mental health emergency detention orders. These include those collocated with emergency departments and purpose built establishments. The level of health insurance that you possess does have an influence on the location adopted for that individual’s care. One of the benefits for the health department is the correct identification of an appropriate psychiatric facility, according to that insurance cover rather than a reliance on the county hospital.

These health based facilities offer a varying standard of care but arguably surpass the majority of the place of safety provisions available in the unit. One such unit that operates in LA offers a range of benefits:

- Rapid handover of the patient into a secure healthcare setting
- Security and health provision requiring little to no further police support in all cases
- Robust screening and full mental health assessment
- Social worker interview before release from facility
- All age/gender facility

Recommendation 10: Future development of Place of Safety provision uses international, as well as national best practice examples to improve provision.
Mental Health Intervention Training (MHIT)

The four day MHIT course is delivered by a dedicated training team within the MEU and is being ‘rolled out’ to front line patrol officers in the LAPD. The aspiration of the LAPD is to deliver 40 hours of mental health training to all of the patrol officers in the LAPD.

There is a useful comparison to be drawn between this commitment and that currently being delivered to officers in the UK. UK training provision varies between force areas but does not come close to that investment.

The MHIT has similarities with the training delivered as part of a CIT programme but is specific to the needs and issues within Los Angeles.

The MHIT programme concentrates on identifying behaviours rather than focusing on diagnoses.

Recommendation 11: Future training should concentrate on behavioural presentation rather than diagnosis.

One of the strengths of the programme is the importance of tackling the stigma of mental illness. The training makes mental illness personal, breaking down the barriers to learning by adding a human element and relating it to the lives of officers.

Recommendation 12: Training is humanised by the use of carer groups in the delivery of training programmes. Training delivered by carers can be equally powerful as training delivered by those with lived experience.

The course is thorough, real and not beyond the needs and capabilities of non-clinical police officers. The mixture of mental health awareness and police operational practice is readily accepted by Police officers as it provides context and reality. The use of a multi-disciplined training team taken from the existing SMART and CAMP resources showed a partnership approach, putting training into real scenarios and underpinning the whole course with empathy and the reality of mental illness.

*Picture courtesy of LAPD MEU taken from a LAPD training bulletin from 1948*
Recommendation 13: Training that covers the response to mental illness uses role plays as part of the learning process. They offer significant learning benefits beyond the defined learning outcomes.

A core theme maintained throughout the training is that of officer safety and it is made clear that it should not be compromised. A strong reflection of that position is that all detained persons under a mental health hold (detention) will be handcuffed. This is quite an emotive act which has arguments for and against linked to the perceived criminalisation of the mentally ill. Erratic, unpredictable and often harmful behaviour would be substantially mitigated by the use of handcuffs. There is valid argument for addressing the risk that individuals in crisis often present.

Recommendation 14: The LAPD position on the use of handcuffs for mental health detentions is fed back to the national discussion on the use of police restraint and the mentally ill.

The discussion on police contact with children who are mentally ill also presents significant emotive responses. In the USA a person is unlikely to be given an acute diagnosis prior to reaching 18 years old. A concern in the USA is that of school shootings such as Virginia Tech in 2007. The reality of school pupils becoming marginalised resulting in deteriorating mental wellbeing and responding with violent outbursts is not just a USA specific issue. The importance of mental health and social services but also the police to work with schools on supporting the mental wellbeing of children is highlighted dramatically within such scenarios. The importance of investigation at mental health related incidents involving children has been identified as key to prevent potential violent incidents from occurring. This is equally applicable to any mental health related incident where arguably the police service has sometimes failed to use its own specific skill set.

The LAPD has shown a significant commitment to addressing mental illness in their community. It has acknowledged that there is a need to deal appropriately with people in crisis. The investment into the MEU and MHIT is an indicator of this but what is most important about their approach is that they are not doing this alone. They are working with mental health partners to do this and there is investment from those partners into this method of working. The Department of Health has recognised the significant benefits to community health through partnership working. The organisation also has recognised efficiency savings that have improved by adopting a partnership approach.

The MEU is likely to expand soon as a result of its good work with even more financial commitment and investment from both partners.
Vancouver, British Columbia Canada

VPD and Vancouver MH&A Collaborative meeting

Key Aspects:

- Large homeless population
- Previous friction between the Health and Police services
- Three Health service led Co-response models to mental illness in partnership with the Police service

The Vancouver Police Department have reviewed and documented their mental health related demand clearly producing three substantial reports\(^{11}\) on the area of business. The VPD produced their first report in 2008, Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources. This was followed in 2010 by Beyond Lost in Transition with Vancouver's Mental Health Crisis: The Background published in 2013. The reports provided an open and honest approach to dealing with a community issue. A link to these reports can be found here: [http://vancouver.ca/police/about/publications/index.html](http://vancouver.ca/police/about/publications/index.html)

Each report made a case for change and provided a series of recommendations to improve the situation for both service users and the police service. The reports were analytically evidenced with a solution orientated approach highlighting areas of improvement to be undertaken within the service and identified for partner agencies.

These baseline reports, highlight the importance for understanding demand from an organisational sense. The development of the reports enabled high profile, public and political, discussion about the future of the community and police response to mental illness in Vancouver. This enabled change which informed and influenced improvements at a strategic and commissioning level.

**Recommendation 15: A public facing report on current impact of mental health related incidents on policing is produced.**

The change stimulated by those baseline reports have led to positive improvements to the response to mental illness, although the work continues.

In regards to mental health provision, Canada has similar service provisions in regards to crisis mental health. To address the emergency and more assertive aspect of mental health provision Vancouver has adopted three Co-responder models. These programmes are health led with support from the police. This health focused partnership approach is different from the other approaches seen in the USA and UK where there is a perception of a criminal justice focus. That is not to say that the other programmes are not equally as effective, and that there is balanced involvement from partners. A partnership approach has been crucial in improving service provision. In Vancouver an approach had been adopted which deals with the reality

\(^{11}\) VPD (2015)
of mental illness impacting on all services and is not just a health responsibility.

**Intelligent Response**

An aspect that underpins the police response to mental illness, and therefore the partnership models found in Vancouver, is the strength of their analytical data. Vancouver utilises analytical support to identify individuals who present as a risk, not just by current presentation, but by change in behaviour. By the application of intelligently weighted algorithms applied to police data, VPD in effect generated a mental health early warning system, which helps guide and task the co response teams. The Police Service possesses a broad range of data which if considered alongside evidence based academic research could reflect mental health deterioration and an increase in risk. The VPD have adopted a model of business intelligence to effectively use a wealth of inadequately used data to support the wellbeing of individuals within the community. This problem solving practice should be promoted.

**Recommendation 16: The use of analytical expertise should be applied to addressing mental health related demand and risk.**

Two of the three specialist services in Vancouver were reviewed, each one a partnership between VPD and Vancouver Coastal Health.

**Mental Health Emergency Service (MHES): Car 87 & Car 88**

A police officer and mental health nurse respond to community mental health calls, acting as a mental health emergency service. MHES is a long term formal partnership provision between Vancouver Police Department and Vancouver Coastal Health. The nurse and officer work as a team providing emergency mental health assessments and crisis response with this intention:

‘Our goal is to assist people to remain in the community safely and reduce the need for hospitalisation’

What is worth noting at this point is that this service has been in operation since 1984 and by all accounts is well respected within the community. The longevity of the provision is perhaps an indication of the value that both organisations have placed on the need to respond to an emergency mental health need. It is acknowledged that without this provision the demand that this service addresses would be picked up by the police service.

**VPD Car 87**

In Vancouver police, demand is often centred on mental health incidents that require a mental health assessment and incidents created to recall patients to hospital. Car 87/88 deals with the majority of this police based demand. The MHES provides a service from 0730-0330hrs daily and can be accessed directly by members of the public. This Co-response service operates in addition to existing

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12 VPD and Vancouver Coastal Health (2015)
mental health services. A link to the car 87/88 provision can be found here: http://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/community-response.html

Recommendation 17: Existing co response services operate a service that is more health led and directly accessible by the community.

Proactive responses: The Assertive Outreach Team (AOT)

An exciting concept being piloted in Vancouver is that of the Assertive Outreach Team. This should not be confused with the UK based model of Assertive Outreach although there are some similarities in regards to the challenges that these teams face.

‘AOT was introduced as a pilot project with the intent to improve the quality of life for the most marginalised and vulnerable people in Vancouver which, in turn, will also create efficiencies to the benefit of police and health services.’

The concept promotes a multi-professional approach placing police officers as part of a mental health team that addresses problematic clients. The approach arguably draws on some of the best aspects of community policing and pairs them with health based objectives. For example ensuring that clients are accessing suitable services, or that community treatment orders are revoked when applicable. The main role of AOT is to provide a bridging service from either hospital or custodial settings to primary health care. This transition of care is intended to prevent reoffending and/or readmission to hospital. It is widely acknowledged that individuals with complex needs within the community present to a variety of public services often with poor outcomes. If consideration is paid to some of the community mental health work that necessitates police involvement there are a variety of potential benefits of joint working in this area for the police service.

A proactive rather than reactive provision has been shown to prove positive outcomes in this area of business. The AOT has produced significant results in its short service life. The one year review, providing analysis from March 2014 to April 2015, reflects contact with 275 clients. A data comparison was drawn looking at a series of health and police measures taken 4 weeks prior to AOT intervention and 4 weeks after intervention. The following reductions were observed:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reduction</th>
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<tbody>
<tr>
<td>Negative Police Involvement</td>
<td>41%</td>
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<tr>
<td>Mental Health Act Apprehensions</td>
<td>51%</td>
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<tr>
<td>Violent Crimes</td>
<td>56%</td>
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<tr>
<td>Substance Offences</td>
<td>7%</td>
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<tr>
<td>Street Disorder</td>
<td>43%</td>
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<tr>
<td>Criminal Justice Involvement</td>
<td>29%</td>
</tr>
<tr>
<td>Victim of Violent Offences</td>
<td>47%</td>
</tr>
<tr>
<td>Urgent Emergency Department Visits</td>
<td>62%</td>
</tr>
<tr>
<td>Non Urgent Emergency</td>
<td>62%</td>
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</tbody>
</table>

13 VPD Mental Health Unit (2015)

14 NIHR School for Social Care Research (2012)

15 VPD Mental Health Unit (2015)
These initial results indicated and evidenced the benefits of a proactive, intelligently targeted provision. This is a sensible approach, to problem solve before crisis is reached. Crisis will inevitably present the risk for the individual, their friends and family, the public and the organisations involved with dealing with that crisis.

An even stronger argument for this approach is indicated in the current contact (March/April 2015) data for those clients. The data shown below clearly shows the long term benefit in reduction of demand to both the client and services of targeted intervention of this type.

<p>| | |</p>
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<thead>
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<tbody>
<tr>
<td>Negative Police Involvement</td>
<td>73%</td>
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<tr>
<td>Mental Health Act Apprehensions</td>
<td>87%</td>
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<tr>
<td>Violent Crimes</td>
<td>74%</td>
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<tr>
<td>Substance Offences</td>
<td>74%</td>
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<tr>
<td>Street Disorder</td>
<td>59%</td>
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<tr>
<td>Criminal Justice Involvement</td>
<td>71%</td>
</tr>
<tr>
<td>Victim of Violent Offences</td>
<td>82%</td>
</tr>
<tr>
<td>Urgent Emergency Department Visits</td>
<td>97%</td>
</tr>
<tr>
<td>Non Urgent Emergency Department Visits</td>
<td>95%</td>
</tr>
<tr>
<td>Total Mental Health bed days</td>
<td>61%</td>
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</tbody>
</table>

The AOT model could provide similarly persuasive results in a UK service environment.

**Recommendation 18:** A new proactive response service is developed to address the needs of individuals where there is identified regular demand with heightened risk and where mental illness is a contributing factor.

**Drug abuse and mental ill health**

The importance on dealing with drugs in the community was not formally considered as part of the research, however is worthy of note. Professionals raised significant concern, on several occasions, about the impact of drug abuse on the future mental wellbeing of a population. There is a push internationally to consider a more liberal, alternative stance on currently illegal drug use such as cannabis, opiates and various stimulants. Without offering a definitive opinion on the subject there are significant concerns that taking mind altering drugs will result in long term chronic mental health problems. Drug abusers, as a result, are likely to become mentally ill in both the short and long term regardless whether those individuals had a pre-existing mental health issue.
Portland, Maine USA

Key Aspects:

- Small population with small integrated police and fire service
- Crisis Intervention Team (modified)
- Police Co-response program
- Peer Support program

Portland offers perspective on a smaller community dynamic as opposed to that found in Los Angeles for example. Portland has adopted the Memphis Crisis Intervention Team model as well as co-response model. The police service in Portland have responded to the reality of their demand which includes a requirement for a response mental ill health. Arguably with an acknowledgement that the business area is inescapable and will impact on policing.

Memphis Model Crisis Intervention Team

The Portland Police Department has adopted the CIT model that originated in Memphis and has previously been explored in this report. Portland PD have trained all of their patrol officers in CIT. A commitment of 40hrs training for each officer with new officers receiving CIT training within their first year. A strict appreciation of this total workforce approach could be considered to have gone beyond the classic Memphis model. CIT is considered a specialist role in Memphis and not a generic training standard. This approach to CIT training does however reflect a movement away from the original model as other areas of the USA are recognising the core skills of CIT being attributes they feel all of their officers need to be developed. This approach also recognises the need of all officers to be equipped to deal with mental health related incidents.

Recommendation 19: A training needs analysis is conducted that considers the broader training needs of police responders and whether a CIT program will satisfy other training requirement or could be integrated.

The availability of suitable health based locations for the reception of individuals detained by the police is essential for the CIT model to work effectively. CIT is arguably a detention heavy model of response which becomes inefficient as officers are constrained to remaining with the detained person. Portland has a very effective handover process allowing officers to be released from health locations in a timely manner with detained person being safety secured.

Recommendation 20: A definitive, fit for purpose place of safety provision needs to be developed.
**Behavioural Health Specialised Co-Response Team**

Building on the CIT model Portland PD have employed a full time Mental Health Coordinator. As part of the CIT model the coordinator organises and delivers the CIT programme. The Coordinator acts as the primary point of contact for mental health and social services working towards service improvement. The Coordinator also delivers mental health training as part of the CIT program. In Portland however the Coordinator takes a more proactive role in dealing with mental health related contacts with Portland PD. The Coordinator is a qualified mental health clinician and deploys in support of officers assisting in providing the most appropriate pathway of care for members of the community. This proactive and reactive approach provides better outcomes for mental health consumers within the community as well as a more effective and efficient response for the police service.

**Recommendation 21:** The role of the mental health coordinator position should be reviewed to explore options for broader operational benefits.

The coordinator is supported by a mental health police liaison who is another clinician that operates as a support resource for the police service. The role provides a similar operational role to that of the coordinator although is funded separately.

The coordinator position also trains clinicians as part of the Co-Responder Team Internship program. This program works with a local university supporting the police response to mental illness with clinicians who are developing their experience within the community setting. Interns have been deployed in support of high demand areas and have proactively worked to reduce calls for service at those locations.

**Recommendation 22:** An internship program should be implemented as part of the existing Police mental health strategy.

The Co-Responder Team works to reduce the time spent on police incidents but has also seen benefits from reducing the amount of police mental health detentions.

**Peer Support Team**

Craig T. Steckler, Chief of Police (retired), Fremont, California Police Department observes,

‘Our collective silence only compounds the problem. By ignoring the issue we implicitly promote the unqualified expectation that cops must, without question, be brave, steadfast, and resilient. Our refusal to speak openly about the issue perpetuates the stigma many officers hold… that depression, anxiety, and thoughts of suicide are a sign of weakness and failure, not cries for help.’

Portland have intelligently addressed the need of their emergency service responders by developing a peer support network supported and sustained by

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16 Portland PD peer support program (2015)
existing community facing provision. The Peer Support Team is provided and encompasses both the Police and Fire services. Peer support acts as a gateway to receiving support enabling early identification and combating cultural stigma within the organisations.

**Recommendation 23:** Peer support services should be developed within the police service and, where possible, linked with other emergency services.

### The Concern of a Revolving Door

Portland Police Department’s commitment to mental health response is reflected in both its commitment to CIT training and its investment in the Behavioural Health Co-Responder Team. What was noticeable from the Portland experience is that training, broad detention powers and an exceptional place of safety provision is not enough.

Portland’s experience needs significant consideration especially with the national conversation taking place in the UK about the role of the police in mental health response.

An observation subsequently backed by discussion with the professionals in Portland is that the revolving door system is very apparent. Police deal with the mental health contact professionally but have no other option but to detain. They subsequently take the subject to a place of safety and efficiently handover to hospital staff and go back to their other duties. That subject is often released as they do not meet the criteria for further detention. There is no fault attached to this, the officers detained according to the behaviour that they saw and their responsibilities to act under the law, the clinicians do a proper assessment and the subject is not detainable. The individual involved however walks out of the hospital and ends up being detained by the police again and the circle continues.

In these scenarios all of the professionals involved are doing their jobs properly and yet the individual isn’t getting appropriate care, the police are deploying repeatedly to mental health related incidents and managing the risk, the hospital is repeatedly receiving police based detentions, assessing them and releasing them managing the risk. This is a silo operating system where each organisation is offering an ideal service but without integrated working.

When considering operational, strategic and commissioning responses to mental ill health in the community an integrated approach must be considered. There may be considerable risk to adopting a silo approach which may adopt models of best practice but would be hindered in achieving their outcomes due to the practices of other organisations. In real terms the development of more effective places of safety, more mental health training for police officers, may result in a poor investment without coordination. These aspects of mental health provision are of course important but will be irrelevant unless they fit into a systematic approach. What Portland has is very good professional practice and commitment but no partnership support. There is a risk that unless you can work in partnership all services end up with a less than satisfactory result.

In this situation services and service users are reliant on outstanding individuals. This is very apparent in Portland with professionals showing dedication to mental health response at strategic and operational levels ensuring the police service meets the demand of its community.
Cairns, Queensland Australia

Key aspects:

- Co response model
- Development using existing mental health coordinator positions

Senior Sergeant Greg Giles of the Queensland Police Service (QPS) was awarded a Winston Churchill fellowship in 2013. SSgt Giles observed how other police jurisdictions throughout the world have developed initiatives to best police the increasing rate of mental illness in the community. His approach to researching this work led him down a similar approach taken in this report. Of interest is that both pieces identified similar areas of best practice, in particular Memphis and LA in the USA and Vancouver, Canada.

Co-response Model

SSgt Giles developed the Cairns Co-responder model in partnership with colleagues from Queensland Mental Health Services. The model partners a police officer and mental health practitioner as a police response team. Initially utilizing existing mental health coordinator roles from both the police and health service to create the team. The Co-responder model commenced operation in 2010 with an emphasis on education resulting in promoting ‘good’ police mental health detentions i.e. safe detentions where there was an appropriate need to detain. This initial work increased the number of detentions instigated by the police which then prompted work on reducing detentions in 2012. The experience of the model has identified gaps in existing service provision. The model effectively deals with individuals that do not ‘fit’ within health and criminal justice provisions. There is very limited adult social service provision which creates an element of unmet need within the population.

The team responds to calls from both the police service and ambulance service. Mental health related demand is the 7th highest presenting business area for the QPS although there is a perception that it is in fact higher. Anecdotally mental health related demand is also significant for the ambulance service.

The service in Cairns has not been independently evaluated as other police mental health response models. Whilst a formal evaluation process has been discussed with academic institutions the lack of funding and the complexity of the task has proven too difficult to overcome. This makes it difficult to adequately support and develop this service or indeed any other. Raw data from this service is available and provides indications of positive outcomes. The data is only an indicator and arguably would struggle to stand up to scrutiny. However the qualitative examples of the service indicates the potential value in investment in a service such as this. Documented evidence in the letters of thanks from service users and families, and the feedback from front line professionals from the police and ambulance service, arguably should motivate further exploration of the model.

Recommendation 24: An independent evaluation of existing service provision (for example street triage) should be commissioned in order to sustain future development.

The relative independence of other front line professionals gives a picture of ‘reality’ away from the professionals working as part of the model. The work of
this service is well supported by operational staff in Cairns and this was reiterated by the Police officers and Ambulance staff who were interviewed. Police officers relayed accounts about co response mental health teams that I have heard internationally such as:

- Making their job easier
- Better outcomes for the client
- Reduction in detentions

A report submitted by the Cairns and Hinterland Mental Health and ATOD Service does formally evidence some of the beneficial work being delivered by the service. The report identifies ‘notable’ benefits such as:

- Integrated response
- Improved consumer outcomes
- Streamlined and coordinated response to crisis
- Improved use of police and health resources
- Improved efficiency in mental health patient transport
- Improved information sharing enabling better assessment of risk
- Improved organisational relationship

detentions also brings an additional tactical option to crisis response; the use of sedation where appropriate and clinically safe. The use of sedation in a community setting for nonphysical injury is not adopted in the UK. However it can be used in Australia with the appropriate clinical authority and necessity. There can be significant advantages to using a sedative rather than defaulting to prolonged physical restraint. This is especially relevant when considering the use of police restraint techniques and the potential risks of injury and in extreme cases death. The application of a sedative potentially reduces the risk of injury and calms the client in crisis promoting safe resolution of the incident.

Recommendation 25: The use of medical intervention in the form of sedation in mental health crisis incidents is explored as an alternative to prolonged physical restraint.

The Ambulance Service

The role of the Ambulance service is arguably more enabled than the service in the UK. The legislation in Australia has created emergency detention powers for Ambulance professionals similar to that of their police colleagues. In effect Ambulance staff can detain and convey mentally ill persons who meet the legal criteria without the need for police to enact the detention. The medical approach to

17 Cairns & Hinterland Mental Health & ATOD Service (2011)
Sydney, New South Wales Australia

Key aspects:

- Large Policing area with mixture of urban city populations and rural isolated communities
- Mental Health Intervention Team model
- Independently evaluated model
- The Gap – an international suicide hotspot

New South Wales Police have adopted an approach to mental health response that develops the skill set of their officers. The Mental Health Intervention Team (MHIT) model is inspired by the Memphis CIT model but with notable differences. The course is a four day residential course reflecting a significant financial and resource investment in the business area.

The Foreword contained within the MHIT course participant guide best describes its intention:

‘The Mental Health Invention Team Course represents the level of commitment the NSW Police Force has in ensuring that officers are provided with education pertinent to general duties policing. Front line police officers are often faced with mental health incidents that have the potential to impact on their own safety and that of the community. In order to reduce the rate of injury to police and community members and improve inter agency and consumer relations the NSW Police Force has designed the Mental Health Intervention Course in conjunction with various mental health experts. The course will provide you with the knowledge and skills to confidently interact with persons who are affected by a mental health issue. By completing this course, you are demonstrating that you are committed to the community and your colleagues by adapting best practices in your everyday policing.’

Superintendent David Donohue, NSW Police Force taken form the MHIT course participant guide.\(^{18}\)

This model of police training, which is provided by a partnership between New South Wales Police and a range of Health, Social and Academic organisations, both highlights the police commitment but also a community commitment to the police response to mental ill health.

One of the most striking parts of the model is the branding. This aspect reflects in the quality of training materials and makes a defiant statement about the professionalism of the approach. Along those lines and in a similar mould to that

\(^{18}\) MHIT (2015)
of CIT, officers who complete the MHiT course are issued with a pin badge which is one of only four pin badges that is permitted to be worn on the NSW police uniform. This permission gives it the same prestige as other police specialisms which in turn raises the profile not only of the course but of mental health within the police culture.

The content of the NSW MHiT course has commonalities with both the Memphis CIT training program and LAPD MHiT program. There are three aspects, in particular, that stand out within the NSW MHiT.

Multi-cultural and Indigenous Mental Health

Cultural aspects of mental ill health features within the NSW package. This acknowledgement of the diverse needs of different cultures in regards to mental health provision is important. Certainly the issues around CJS contact with individuals with mental health issues from Black, Minority and Ethnic groups is often negatively viewed. Mental ill health absolutely affects the whole population not just certain demographics. Concerns around the use of mental health legislation as a means of social control rightly cause cultural sensitivities. The inclusion of two sessions on cultural related topics within the training shows an informed consideration of the role of the police service in promoting safe and respectful interactions in regards to mental health contact.

Recommendation 26: Aspects of cultural difference and diversity feature within mental health training.

Personality Disorder

Personality disorders did not feature in the USA based training packages. This is arguably linked to the diagnostic prevalence of personality disorder within those populations and therefore lack of recorded contact with the police service. The inclusion of personality disorder within the NSW MHiT course highlights a need to understand the range of disorders, the potential presentation of personality disorders to police officers and the need to understand the causes of personality disorder. This topic is sensitively handled and related to police contact.

Recommendation 27: Personality disorder awareness features as part of mental health training.

Roles and Responsibilities

The roles and responsibilities of other agencies is a strong theme throughout the NSW MHiT course. One of the aspects relayed by the course delivery team is that of enabling officers to appropriately challenge other agencies to promote balanced joint working. For example the NSW Ambulance service has powers of mental health detention under the NSW Mental Health Act 2007 similar to that of police officers. However there is an arguably disproportionate demand placed on the police service to respond to mental health related calls as well as disproportionate detentions when both services are at an incident. There could be a range of reasons for this however an understanding of the appropriateness of which agency takes ownership and action can only promote efficient and effective practice. This could easily be applied to other areas such as accident and emergency departments.
Recommendation 28: The roles and responsibilities of partner agency response are identified and communicated within both training and policy.

Support for police officers and staff is, like in the other sites visited, an important part of the training. The MHIT course in partnership with the NSW Police Association have produced a range of high quality resources to support the mental health and wellbeing of officers. These resources in combination with the examples of officers with lived experience of mental illness served to provide a powerful message to delegates on the course, providing both context and personal reflection.

The NSW MHIT course has been independently evaluated by Charles Sturt University. The report, conducted in 2009, concentrated on:

‘the impact of the training on officer behaviour, and the impact of the MHIT more broadly on NSWPF’s interactions with mental health consumer’19

A highlighted benefit of the training was an indication that MHIT officers dealt with mental health related incidents more efficiently than non-trained officers. There were a selection of inconclusive outcomes especially linked to strategic level partnership working.

Academic rigour applied to this area of work varies internationally and this is recognised by Professor Duncan Chappell of the University of Sydney and editor of ‘Policing and the Mentally Ill International Perspectives’20. The NSW MHIT features within the book and discusses its relationship with models in the USA such as Memphis CIT and the LAPD SMART.

19 Herrington (2009)
20 Chappell et al (2013)
Chapter 3: So What?
Research conclusions and recommendations.

Themed Conclusions

The findings of this report have led to a series of recommendations for future development within the business of emergency response, policing and mental health provision. The experience of conducting the review of operational practice internationally has highlighted an underlying factor which has and will continue to hinder development in this area. The Independent Commission on Mental Health and Policing Report (2013) made a clear statement in regards to mental health and policing, ‘Mental health is core policing business.’

There is some evidence that the police service in the UK has accepted this supposition. There have been limited changes in regards to commitments to the Crisis Care Concordat and national review of the training in mental health awareness given to officers. In regards to organisational change, reflected in operational practice, this has been limited.

Street Triage models, in their various forms, have appeared offering a partnership response to mental illness.

However the mixed response and support nationally within both mental health services and the police could be reflective of organisational resistance to change regardless of results. This organisational resistance is not unique to the UK.

A hesitance to support this challenging area of business was identifiable within most organisations. As a result personalities rather than organisations have been, and are still, key to service development within mental health and policing. A concern is that this is not sustainable long term. There is a reality that neither the police or health services are culturally supportive of joint services. This reality was reflected in some areas by the lack of financial and logistical backing. Where truly excellent service provision existed, organisations have invested capital and realised cost to benefit potential.

**Demand**

It is noteworthy that sites for this study were chosen based on a perception that the services in that area are providing best practice in regards to emergency mental health response. The demand prior to starting their work generated a motivation for change and a need to maintain the service post initial intervention. In a convoluted way in these areas there was a need for practice to change to meet demand.

The initial response to mental health crisis in the USA does appear to involve police contact in a high proportion of cases and relies on detention to achieve support. There are several valid reasons for this, some of which we have in common in the UK. For example the police deal with behaviour in the community, some of this behaviour is criminal, some presents as concerning, some presents as anti-social. As in the UK some of that behaviour is related to the individual suffering from mental illness.

It is apparent that internationally Police contact with mental ill health is inevitable. However it is possible to focus the police response to avoid collateral contacts.

**Training**

Training emergency responders to deal with mental ill health and crisis is arguably a necessity, but one that comes with a caveat. Training will not replace adequate provision.

Training programmes such as MHIT in Los Angeles (MHIT), New South Wales (MHIT) and Memphis (CIT) is that they have broadly similar content and outcomes. What is interesting is that subtle changes to the focus for the training, and the stature of the attendees, alters the strategic and operational focus for the outcomes. For example Los Angeles MHIT has a more operational focus concentrating on a tactician’s approach to incidents reflected in a concentration on role plays and de-escalation scenarios. New South Wales MHIT, although delivering content on de-escalation techniques and role plays, has a focus more on leadership and partnership working. It works more on the issues behind the police contacts. Both MHIT courses offer a very high standard of training provision offering very credible, well evaluated packages which would arguably satisfy the training needs of police officers and staff in the UK.

Due to the financial and resource constraints of the Police Service in the UK, the prospect of releasing staff for training is unlikely to be warmly received. A business case to release front line officers for a period of up to 5 days would currently be disproportionate in balance with other training priorities. However an intelligent model of training that captures the training outcomes of the MHIT and CIT programmes with limited abstractions from operational duties would be possible. An observation of all of the training programmes is that there is a crossover with existing police training requirements. A drawback to having bespoke courses on mental health is that it often fails to integrate with operational realities and the broader scope of policing business. MHIT and CIT address this by building in training that officers already complete as part of other core areas but with a mental health context. An example of this is de-escalation and communication skills which...
feature heavily within both MHIT courses and CIT. This skill set is core to existing Officer Protection training in the UK, USA and Australia and has been previously known as Conflict Management. An option for more intelligent use of training days would be to integrate elements of a mental health training programme into existing training packages. By adding role plays, the role play elements of MHIT and CIT to existing OPC training would potentially reduce a MHIT/CIT course by up to 2 days and help to normalise mental health related work. Consideration should be taken to integrate a mental health theme throughout existing training. This will assist to break down the stigma attached to mental illness and normalise the business area within traditional training areas.

Recommendation 29: That mental health features and is integrated within existing training packages promoting both intelligent use of training resources and staff development.

Other training methods may also be useful in reducing abstractions such as online learning, webinars etc. This however should be tempered through training analysis to identify the appropriate learning style that would also promote partnership working and challenge the stigma of mental illness. The exposure of officers to clinicians and service users in a safe learning environment certainly was an incredibly positive experience.

A tiered package of training may produce a more flexible approach for the Police service in regards to mental health and crisis intervention. Training packages should be reviewed and developed to reflect actual demand of mental health and crisis on business. A proportionate approach which reflects parity of esteem with physical first aid training would perhaps be ethically and practically sound. The evaluation of the NSW MHIT programme is arguably the most robust independent literature on police mental health training.

Training can also motivate cultural change within an organisation. An increase in the mental health awareness and understanding within the Police Service would enhance the provision to the community but may also support the wellbeing and productivity of the service workforce. Provision through education does not have to be expensive and may reduce both absenteeism and presenteeism whilst building resilience. A carefully adopted programme could target both outward and inward facing mental health and wellbeing needs.

Crisis Intervention Team

CIT can provide a police response model to mental illness and crisis which could be transferred to a UK forum. Significant caution should be paid to this approach though. As has been learnt in the USA only areas that have adopted the full approach to CIT have seen it flourish. Areas which have adopted it purely as a training model for officers have seen limited benefits.

The leading aspiration to be drawn from the CIT model is that of the role of the community in the model. There are significant benefits to be taken from a service model that is ‘owned’ by the community be provided for the community. This approach empowers the mental health community making them partners in provision rather than recipients.

An honest, open approach to the police response to mental illness guided by an informed community engagement strategy would work towards an increase in public
confidence. This approach could also foster a relationship which, if applied properly, may influence change in other services to the benefit of the community but also the police service. An operational benefit could see an increased role of community advocates supported the police response to mental health related contacts.

There could be huge benefits to supporting a modified model of CIT in the UK but one that includes other emergency responders such as the Ambulance service.

CIT does have limitations however. It is arguably a detention heavy model where the threat of accountability leads to an overly risk adverse approach. Thomas von Hemert CIT coordinator in Charlottesville, Virginia commented that ultimately Police Officers have four outcomes available to them when dealing with mental health related incidents:

1. **Resolve at Location** – leave with friend and family
2. **Voluntary resolution** – subject voluntarily attends health based location
3. **Involuntary resolution** – detention under mental health legislative powers
4. **Arrest** – pursue criminal justice pathway

Tom’s statement is as true in the USA as it is in the UK. Those tactical options would produce improved outcomes if integrated with clinical options. There are discussions taking place in the UK about the role of the police service in supporting mental health in the community and dealing with police incidents in which mental health features. If the above outcomes, although limited, are satisfactory then a UK model of CIT may well be a satisfactory approach.

As was witnessed in Portland, where safe lawful detention becomes the best practice response this can be ineffective and inefficient over time. Lawful detentions do not equal the clinical approach required. Without clinical guidance at the point of contact with Police, the officer will still have to make decisions within his or her training which will be legislation based. Where officers were well trained and where short term health provision was available there is still as risk of revolving door crisis and behaviour management. This is a risk where Police Services are looking to achieve more than the CIT programme offers, which is primarily focused on officer and community safety. In the UK, where financial constraints are having a significant impact on the Police Service, there is a risk that forces will reach out to a CIT model looking for efficiency savings. CIT will not generate that outcome on its own but could in partnership with other models.

Another discussion within the CIT model is whether all police officer should receive CIT level training. The approach has been adopted in Portland as they feel that CIT training reflects the core skill requirement of a police officer for their community. However Memphis are definitive that a CIT qualified officer is a more specialised role, an incident commander or tactical advisor in some respects. The approach to this quandary will demand on a variety of factors, local demand, local provision, policing model etc. It also shows that the CIT concept could be pursued in different ways.

The role of an organisation such as CIT international highlights the need for a professional network for criminal justice and mental health. A network not only enables the sharing of best practice but could be a catalyst of new practice and learning.
Police Partnership and Co-Response Models

Four of the six sites visited adopted a Co-response or joint response model to address police and community based mental health related demand. Three of the six sites adopted a training based model of response this included the Crisis Intervention Team model which has been widely adopted across the USA and has broader international partners.

Models of joint and co response which see police officers responding with health care professionals have been operating for a substantial period. The LAPD, VPD, and QPD have all adopted differing models of co response to address the need for an emergency response to mental illness.

Co-responder models, although adopted for a substantial period of time, still suffer a lack of stringent evaluation and scrutiny. A review conducted by Shapiro\(^{22}\) in 2014 suggests,

‘...there is limited understanding of program effectiveness and the mechanisms that promote program success.’

Ultimately that there are positive results but currently the wider implications of the services are not understood. Co-response pilots and more established models need to exercise caution over how anecdotal claims are evidenced. However Co-responder models appear to provide some defined, evidenced outcomes with strong hypothetical, anecdotally supported secondary benefits.

The use of these programmes as both a reactive and proactive provision could pay dividends providing a range of benefits to both the community and that of public services. A reliance on effective crisis response carries both considerable risk and is ultimately costly in regards to resources. A proactive model of response that encapsulates an approach of prevention and early intervention could stimulate a resource efficient and cost effective provision for public sector organisations. A coordinated and integrated response not only addresses the multifaceted nature of police mental health demand but has been proven to generate more appropriate, and often more beneficial, outcomes for the mental health consumer.

Importance of Evaluation

Effective, supportive commissioning of services is reliant on adequately evidenced outcomes. An element of innovative operational experimentation should be supported as it promotes organisational change and improvement. There is a point however when hypothetical ideas and anecdotal evidence needs to be substantiated. The discussions around the validity of Police and mental health Co-responder models is a testament to the need for evaluation. There is a commissioning and provider responsibility to provide robust evaluations of service.

National governing bodies, such as the College of Policing, also have a responsibility to enable evaluations of service to support creativity in pursuance of the ‘What Works’ ideal. The criticism of a new service provision due to lack of data and evaluation is hardly balanced when the organisations involved do not adequately measure that area of business. For example you cannot expect a service to evidence improved outcomes without baseline data.

\(^{22}\) Shapiro, G.K. et al(2014)
There is no one operational model, observed as part of this report, which is universally transferrable and maintains significant benefits to service providers, and most importantly service users. Each of the models outlined in the report could be readily modified for use in the UK with beneficial results. It could be argued that theoretical modelling needs to be given some caution, based on a lack of independent evaluation. It could further be discussed on adopting an approach that is evidence led rather than evidence based.

The Re-institutionalisation of Mental Illness

A universal observation of the emergency response to mental illness in the USA, Canada, Australia and the UK is the reliance on the detention of the mentally ill in order for them to be clinically supported. This appears to be regardless of any of the approaches taken. All sites visited work under legislation and clinical guidelines that support a least restrictive method of mental health provision. It appears that when it comes to emergency provision that detention becomes a likely outcome. An improvement that could be made to all models is that of a greater push towards that least restrictive principle. It is sometimes not possible to keep an individual or the public safe without the safe detention of someone who is mentally unwell. It is sometimes the only method to ensure that the individual receives the appropriate treatment. However there should be an absolute responsibility on all public services who operate under such legislation to maintain the clinical interests of that patient/client/consumer/service user, above that of social control. Therefore when adopting any new model, or when considering further development, the views of those with lived experience and that of carers, must be considered and influence the concept.

The Final Statement

A summary of recommendations follows this conclusion. If adopted they could offer a range of short to long term benefits. In the UK the consideration of how emergency services best respond to mental illness is fraught with opinion and conjecture. In identifying whose responsibility it is to respond, there needs to be consideration of who is best placed to respond and how that response best serves the public. In a time of austerity where the public sector will inevitably feel the need to retract into ‘core business’ the gaps between public services may become broader. This defensive approach is a significant risk to our communities. There is a response to this risk. A partnership response where the community and public services work together for the benefit of their community. It may appear idealistic but where there is a will, as there is at every site evidenced in this work, this can and does happen. That approach is arguably a concept that bridges austerity and will provide the best outcomes for all concerned.
Summary of Recommendations

As noted throughout this work and supported in its conclusions a series of recommendations are outlined below. These are defined to improve existing practice and develop new practice by adopting the learning from international colleagues. These recommendations are equally valid for local considerations as they are to a national audience.

Accordingly, it is recommended that:

1. An adapted CIT model (for UK policing style) be adopted. (P.13).
   (Action: ACC Training)

2. Community ownership is built into future mental health training and response models. (P.13)
   (Action: ACC Training)

3. The police role within existing health care settings be reviewed and amended in order to ensure that policing in hospital settings reflects the needs of the hospital community. (P.15).
   (Action: Police Operations Lead).

4. An educational programme be developed in order to educate the local community on the police role within crisis incidents. (P.16)
   (Action: Police Mental Health Lead)

5. Vulnerability and other specialist teams be collocated in order to enhance service provision. (P.17)
   (Action: Blueprint 2020)

6. The use of additional mobile technology be explored in order to support the ability to task existing co response services whilst deployed (p.18)
   (Action: Police ICT lead)

7. The mental health based relationship between the police, probation and court services is promoted to support a holistic investigation that reaches the court. (p.18)
   (Action: Police Liaison and Diversion lead)

8. Integrated services are developed that proactively manage individuals who present heightened risk and frequent contact. (p.19)
   (Action: ACC Demand)

9. A partnership approach is established towards firearms ownership and mitigation of risk for those who become unwell and are in possession of a firearm. (p.19)
   (Action: Firearms Licencing Department)
10. Future development of Place of Safety provision uses international, as well as national best practice examples to improve provision (p.19)
   (Action: Crisis Care Concordat Lead)

11. Future training should concentrate on behavioural presentation rather than diagnosis. (p.20)
    (Action: ACC Training)

12. Training is humanised by the use of carer groups in the delivery of training programmes. Training delivered by carers can be equally powerful as training delivered by those with lived experience. (p.20)
    (Action: ACC Training)

13. Training that covers the response to mental illness uses role plays as part of the learning process. They offer significant learning benefits beyond the defined learning outcomes. (p.21)
    (Action: ACC Training)

14. The LAPD position on the use of handcuffs for mental health detentions is fed back to the national discussion on the use of police restraint and the mentally ill. (p.21)
    (Action: Police Mental Health Lead)

15. A public facing report on current impact of mental health related incidents on policing is produced. (p.22)
    (Action: Police Mental Health Lead)

16. The use of analytical expertise should be applied to addressing mental health related demand and risk. (p.23)
    (Action: Police Mental Health Lead)

17. Existing co response services operate a service that is more health led and directly accessible by the community. (p.24)
    (Action: Mental Health Partnership Group)

18. A new proactive response service is developed to address the needs of individuals where there is identified regular demand with heightened risk and where mental illness is a contributing factor. (p.25)
    (Action: ACC Demand)

19. A training needs analysis is conducted that considers the broader training needs of police responders and whether a CIT program will satisfy other training requirement or could be integrated. (p.26)
    (Action: ACC Training)

20. A definitive, fit for purpose place of safety provision needs to be developed. (p.26)
    (Action: Mental Health Partnership Group)
21. The role of the mental health coordinator position should be reviewed to explore options for broader operational benefits. (p.27)  
(Action: Police Mental Health Lead)

22. An internship program should be implemented as part of the existing Police mental health strategy. (p.27)  
(Action: Police Mental Health Lead)

23. Peer support services should be developed within the police service and, where possible, linked with other emergency services. (p.28)  
(Action: Police Human Resource Lead)

24. An independent evaluation of existing service provision (for example street triage) should be commissioned in order to sustain future development. (p.29)  
(Action: Office of the Police & Crime Commissioner)

25. The use of medical intervention in the form of sedation in mental health crisis incidents is explored as an alternative to prolonged physical restraint. (p.30)  
(Action: Mental Health Partnership Group)

26. Aspects of cultural difference and diversity feature within mental health training. (p.32) (Action: ACC Training)

27. Personality disorder awareness features as part of mental health training. (p.32)  
(Action: ACC Training)

28. The roles and responsibilities of partner agency response are identified and communicated within both training and policy. (p.33)  
(Action: ACC Training)

29. That mental health features and is integrated within existing training packages promoting both intelligent use of training resources and staff development. (p.36)  
(Action: ACC Training)
Next Steps

This report is to be submitted to The Police and Crime Commissioner for Leicestershire Sir Clive Loader as a strategic sponsor for pursuance of the research. In turn the recommendations will be submitted for the consideration of both the OPCC and Leicestershire Police Senior Management Teams. The support for undertaking this research comes from Leicestershire’s Police and Crime Plan in which priority 16 defines ‘Improving the Outcomes and responses for those with mental health needs’. Many of the recommendations in this research could be applied to current strategic targets within Leicestershire Police and regional forces.

A Leicestershire specific abbreviated business case has been produced from the conclusions and recommendations of this report. The objective for this work remains to translate the research into an operational reality. A concise overview of a future Leicestershire approach based on this research can be found at Appendix E.

The report will be submitted to the College of Policing who have expressed interest in the training elements of the research. The College is currently undertaking a review and revision of learning materials being delivered to the Police Service nationally. Learning and staff development features heavily within many of the models identified within this research.

Aspects of this report will feature in national conference presentations as well as in briefings to local, regional and national organisations working with mental health consumers.

References


MHIT (2015) MHIT Course Participant Guide. NSW Police, Sydney


Appendices

A. WCMT Fellowship Itinerary
B. Research question set
## Appendix A. WCMT Fellowship Itinerary

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Appendix B. Research Prompts

- **The Need.** Establish each area’s mental health provision issues prior to their operational models being implemented.

- **The Motivation for Change.** Identify and understand why the areas developed the models.

- **The Partnership Approach.** Identify and understand the role of partnership working in the operational models.

- **Roles and Responsibilities.** Identify and understand the roles of service users and academics on the development of models and working practices.

- **Service User Perspective.** Identify and understand how the models delivery services to specific groups to include black, minority and ethnic, veteran & personality disordered demographic groups.

**Questions**

1. If I was in a mental health crisis how should I get help in your area?
   a. What provision is there for me?
   b. Is it prohibitive?
   c. How does that change if the police are involved?

2. In your area what does demand look like?
   a. For the police
   b. For health services
   c. For social services

3. What model/s of operation do you have in regards to support for mental health in the community?
   a. Outline model
   b. Outline Services involved
   c. Outline particular Roles and responsibilities
   d. If a model of training
      i. How many % of staff are trained
      ii. Full time occupation
      iii. What areas of business
      iv. Why those staff?

4. How long has the model been in operation?

5. Has the model been evaluated?
   a. Independent and academic?

6. Why did you start the model?
   a. Need/demand
   b. Particular event?
7. What partners are involved in the model?
   a. Why are the police involved?

8. How are service users involved in the model?
   a. From Black, Minority or Ethnic groups
   b. Veterans
   c. Personality Disordered

9. How much does this cost? And who pays for it?

10. If you had the opportunity to start again what would you do differently?
    a. Limitations of the model
    b. Lessons learned

Overview observations:

- How do the organisations measure community satisfaction with the new process?
- How is organisational performance measured?
- What are the legal obligations for each of the organisations?
- How do organisations ensure that success isn't personality driven - how do they ensure that all organisations at both a strategic and front line level respond to changes when necessary.
- How can they ensure that resources are consistent - what is the process for down-up as well as up-down cross service feedback and for service users.
- Being mindful as to how organisations work who takes charge of these processes?