UNIVERSITY of York

Evidence *summaries*

Police-related mental health triage interventions: a rapid evidence synthesis

- The volume of crisis calls related to people with serious mental illness is an increasing challenge for police services

- Police officers are often the first responders to mental health-related incidents and consequently become a common gateway to care

- There is little robust evidence on the effectiveness of models of police-related mental health triage (PRMHT)

- Limited evidence suggests reductions in formal detentions, higher hospital admission rates, increased likelihood of follow-up by secondary mental health services if patients are not admitted, and an increase in the use of a health-based place of safety. However, the results were not entirely consistent and not all important outcomes were measured

- Data from a relatively small number of individuals provided evidence of the feasibility of PRMHT interventions, and their acceptability to police and mental health staff. Various barriers and facilitators to the implementation of PRMHT models were also identified

Why is this evidence needed now?

The volume of crisis calls related to people with serious mental illness is an increasing challenge for police services. Police officers are often the first responders to mental health-related incidents and consequently become a common gateway to care. This has raised concerns about inappropriate use of police resources and police officers' relative lack of knowledge, skills and support when handling the mental health needs of individuals in crisis.

Mental health street triage schemes were established in a Department of Health pilot in 2013. Police-related mental health triage (PRMHT) or "Street triage" – as piloted in England – typically takes the form of mental health professionals supporting police officers when responding to emergency calls involving a person who may be suffering from a mental illness.

Summary of evidence

This summary comes from a recent rapid evidence synthesis on police-related mental health triage interventions.[1]

Models of interagency collaboration for people with apparent mental ill health

There is no universally accepted classification of interventions in this area. A recent scoping review of interagency collaboration models between the police and other agencies for people with apparent mental ill health identified a range of possible models.[2] These models included:

- Co-response: A shared protocol pairing specially trained police officers with mental health professionals to attend police call-outs involving people with mental ill health – often how UK street triage pilot schemes have been conceptualised.

- Information sharing agreements: Information about people with mental ill health being shared between police and other agencies or between the individual with mental ill health and the police and other agencies.

- Co-location: Mental health professionals being employed by police departments to provide on-site and telephone consultations to officers in the field.

- Consultation: Police agencies accessing advice from mental health professionals when working with people with mental ill health, often via telephone.

- Pre-arrest diversion: Providing police officers with specialist mental health training to better manage situations involving people with mental ill health and offer treatment as an alternative to arrest.

Schemes that have described themselves as "street triage" can incorporate a number of approaches and may be one form of intervention that belongs to a larger cluster of interventions with similar aims. We therefore used the term police-related mental health triage interventions (PRMHTs) rather than "street triage".

Evidence on their effectiveness

There is little robust evidence on the effectiveness of PRMHT models. The limited evidence available from the quantitative studies suggests fewer formal detentions, higher hospital admission rates, increased likelihood of follow-up by secondary mental health services if patients are not admitted, and an increase in the use of health based places of safety. However, the results were not entirely consistent.

There is minimally reported, inconsistent and conflicting evidence on the effects of PRMHT interventions on quality/timeliness of assessment, referral and treatment, access to services, demand for police resources and number of repeated

contacts with individuals. There is an absence of reliable quantitative evidence for other relevant outcomes.

Evidence on their acceptability and feasibility

Qualitative evidence on PRMHT models in the UK primarily consists of the views of a relatively small number of police and mental health staff directly involved in delivering pilot interventions.

Acceptability

In general, police staff appeared to value PRMHTs and both police and health staff noted an improvement in quality of care.

Service user feedback was rare, though some qualitative evidence suggested that service users preferred to interact with mental health professionals (MHPs) than police officers. This was attributed to MHP communication skills and the association of police uniforms with authority and criminalization.

Feasibility

Strategic response to mental health related incidents may need to consider which pathways prove most effective for service users and make most appropriate and efficient use of both police and NHS resources. Some barriers to successful outcome lay outside the control of police or even PRMHT staff (e.g. lack of coordination between neighbouring NHS Trusts). Similarly, the availability and resources of local services need to be taken into account.

Retaining consistent staff on PRMHT duties may enhance relationships and understanding, increase efficiency and result in fewer issues around police vetting procedures. However, this could restrict mental health knowledge to fewer police staff and result in poorer integration with the wider force. Reallocating police and MHP staff to PRMHT from other active roles may also have important consequences.

Evidence on the barriers and facilitators relating to their implementation

Barriers

There appears to be uncertainty about how and when best to deploy MHPs to the scene of an incident. There may be a trade-off between MHPs having better access to records in a hospital/control room versus using their hands-on skills to aid in incident resolution. In conjunction with other information-sharing measures, this kind of barrier might potentially be overcome by providing MHPs with improved mobile information technology.

Improved knowledge about the constraints on police powers among MHPs and control room staff may prevent misunderstandings or inappropriate recommendations for action.

Measures to address the disproportionately high demand created by repeated service users may be worth further evaluation.

Facilitators

Qualitative evidence emphasised the value of strong partnerships between police and health services, co-location of services and the value of shared information. PRMHT interventions would likely benefit from immediate access to shared information across the police/health interface, facilitated by agreed protocols and underpinned by appropriate technology that permits compatibility of data across police and health systems.

In all cases, lines of accountability and responsibility need to be clear among all PRMHT staff. Similarly, roles, responsibilities and reciprocal arrangements need to be clearly defined between PRMHT services, crisis teams and other related health services.

Immediate and consistent availability of MHP support was very important to police officers responding to mental health related incidents, with immediacy sometimes seen as a key difference between PRMHT and crisis teams. 24-hour availability appears crucial, and appropriate communication technology may improve accessibility.

Many resource savings attributed to PRMHT interventions stemmed from their value in accelerating the assessment of user needs. We did not find any evidence comparing different models in terms of needs assessment, despite their potential to have quite different costs and benefits.

What is most important for future research

Several systematic reviews and recent studies have called for prospective, comprehensive and streamlined collection of a wider variety of data to evaluate the impact of PRMHT interventions.

On the basis of the evidence included in this rapid evidence synthesis, future evaluations would be more informative if they addressed the following:

- Clearly articulate the objectives of the PRMHT intervention.

- Involve all stakeholders (including people with mental health issues) in the design and evaluation of interventions to help identify these objectives.

- Collect and analyse outcomes that relate directly to the stated objectives. Quantitative data should extend beyond section 136 rates, places of safety, and process data, to measuring the outcomes that are most important to the police, mental health and social care services, and individual service users.
- Evaluations should take into consideration the short-, medium- and longer-term effects of PRMHT interventions.
- Commissioners and funders of research need to provide adequate funding to allow collection of suitable data.
- It is likely that better data collection processes will be needed. However, these processes should not be overly burdensome to front-line police or health staff.
- Where possible, study designs should have an appropriate concurrent comparator.
- The collection of qualitative data may help better understand which approaches work best and why, though such research should capture dissenting views as well as those of advocates.

Any future cost-effectiveness analysis of PRMHT should take a multi-agency perspective to understand the relative impact of introducing a particular model on the resource use across police, health and social services.

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