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

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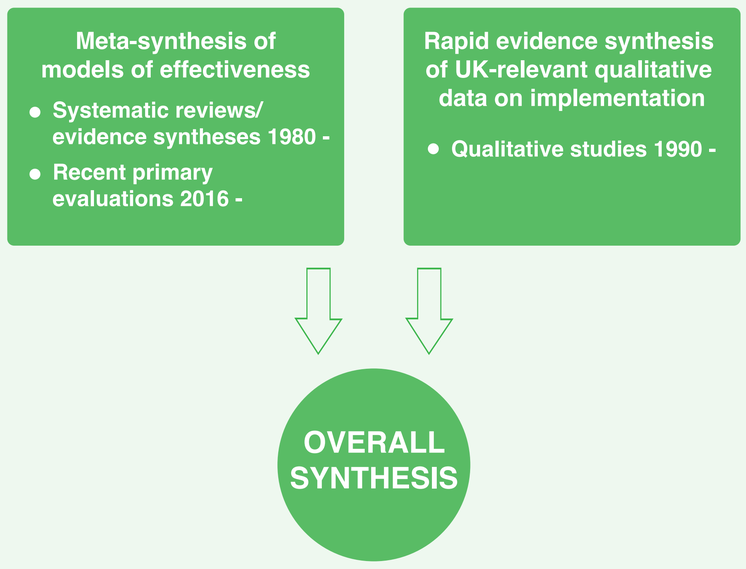
WHY IS EVIDENCE NEEDED NOW?

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.

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.

SOURCES OF EVIDENCE



Five systematic reviews (6 articles), eight primary studies reporting quantitative data, and eight primary studies (9 articles) reporting qualitative data were included in the rapid evidence synthesis.

The majority of qualitative evidence came from a Department of Health funded evaluation of nine street triage pilots, supplemented by five other small scale pilot evaluations.

Most systematic reviews and primary studies were at risk of multiple biases due to their designs and/or lack of reporting of methods. The volume of qualitative evidence presented in PRMHT studies was relatively limited. Even within the Department of Health-funded evaluation of pilots, some of the sub-themes were based on statements from just one or two individuals.

SUMMARY OF EVIDENCE

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.

Acceptability & 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

Success may relate to making the 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).

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.

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 be overcome by providing MHPs with improved mobile information technology.

MHPs and control room staff did not always have knowledge of the constraints on police powers, resulting in misunderstandings or inappropriate recommendations for action.

In some instances, repeated service users created disproportionately high demand for services.

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 defined clearly 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.

FUTURE RESEARCH PRIORITIES

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
- 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 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
- Qualitative data may help better understand which approaches work best and why, but 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

The research reported here is the product of the **York HS&DR Evidence Synthesis Centre**, contracted to provide rapid evidence syntheses on issues of relevance to the health service, and to inform future HS&DR calls for new research (Project ref: 16/47/11 (13/182/14))

Details are available at **Health Services and Delivery Research 2019; 7(20)** (https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/164711/#/)

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