WA Police Force Mental Health Co-Response Evaluation Report

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Any opinions outlined in this report are the views of the authors and should not be taken as the view of the Western Australia Police Force. The authors would also like to acknowledge that the findings of this study were relevant to the Western Australia Police Force at the time of the research, and that employee attitudes and/or agency policies may have changed since the data were collected.
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Executive Summary

Current context

On January 18 2016, the Western Australia (WA) Police Force implemented the WA Police Force Mental Health Co-Response (MHCR) Commissioning Trial. The trial was introduced in response to increased demand on police to attend to and manage incidents that involved a mental health element. Available agency data indicates a 296% increase in demand over an eight year period, from 4,766 incidents in 2007 to 18,902 incidents in 2015. This steady increase in demand was combined with national concerns about the ability of police officers to respond appropriately to mental health incidents. Media reports from all Australian policing jurisdictions provide numerous examples of the poor management of mental health crises by police (e.g., the fatal shooting of Ian Fackender in 2017 in NSW and the fatal shooting of Danukul Mokmool also in 2017 in NSW; ABC News, 2018 March 5), and statistics consistently demonstrate that many police shootings involve individuals with a mental illness (Australian Institute of Criminology, 2013). In the week of finalising this report, a case in Victoria provided a salient reminder of the need for change in the way police manage mental health incidents. According to media reports, the situation commenced with a routine welfare check of a known mental health consumer; a check that was instigated by mental health services. CCTV footage from the consumer’s security system captured police management of the welfare check. Police arrived at the consumer’s residence and requested the individual accompany them to hospital. The consumer refused, indicating that he was fine and that he did not need to attend hospital. Police officers, six of them in total, discharged OC spray, and used a baton as well as empty hand tactics to wrestle the consumer to the ground. Police proceeded to blast the consumer with a garden hose as he sat handcuffed on his front lawn. One officer took out his mobile telephone and filmed the incident with media reports emphasising the smirk clearly present on the officer’s face. The media described the situation as “horrific” and indicated that the Victorian Opposition Leader, Matthew Guy, had labelled the case "abhorrent" (9News, 2018 April 3).

The need to change police operational deployment models has long been recognised, and so jurisdictions have trialled various police-based models (e.g., MHIT in New South Wales) and/or health-based models (e.g., CAT in Victoria) for responding to mental health

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1 Changes were made to the criteria used to report mental health incidents in 2016 which prohibits any longitudinal comparisons with more recent data.

2 It is acknowledged that this act may have been to eliminate the OC spray from the consumer’s eyes. However, this was not communicated to the consumer. Therefore, it was the manner in which this action was delivered that was being criticised.
crises. However, Lee et al. (2015) argues that single agency responses (e.g., police or health) to mental health crises are unlikely to provide an effective solution because the response is too simplistic and does not account for the complicated and multifaceted nature of mental health incidents. Further, many of these initiatives focus on improving police response at the point of crisis; either by up-skilling police or limiting their involvement in the crisis response. Wood et al. (2011) argue that initiatives can, and should be implemented throughout ‘all stages’ of the police process to assist individuals experiencing a crisis and alleviate the burden of mental health crises on policing. Those stages are identified as prevention, pre-arrest and point of arrest (including transportation and custody; Wood et al., 2011).

**WA Police Force response**

This report provides an overview of findings from the evaluation of the WA Police Force Mental Health Co-Response (MHCR) Commissioning Trial. The trial involved a holistic approach to police response to and management of individuals experiencing a mental health crisis. The trial, which incorporated mental health expertise at each stage of police response to crisis situations; at the point of dispatch, at the point of physical contact at the scene and post arrest within the custody setting, was the first of its kind implemented in Australia.

MHCR involved mental health practitioners co-located with police at the Police Operations Centre (POC), two mobile teams operating in North West Metropolitan and South East Metropolitan Districts and the Perth Watch House (PWH). The trial operated 6 days a week Monday to Saturday, 2.00pm – 10.00pm. Consistent with a pluralistic persuasion and the pragmatic paradigm, the evaluation undertaken by the Sellenger Centre for Research in Law, Justice and Social Change (ECU) applied a concurrent triangulation mixed methods approach, to ensure rigour and to achieve depth of data (Creswell, 2009). The specific research questions addressed within the evaluation framework were:

1. Does the MHCR influence perceptions of role adequacy, confidence and decision making of frontline police, police operations and police watch house staff?
2. Does the MHCR influence demand on agency resources in responding to situations involving people with mental illness?

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3 During the trial, WA Police Force had four districts covering metropolitan Perth (North West Metro, Central Metro, South East Metro and South Metro).
3. Does the MHCR influence police arrests of people with mental illness and referral of people with mental illness to emergency departments and increase referral to other community based services (non-emergency services or psychiatric facilities)?

4. Does the MHCR influence adverse events for community members and police that arise from the management of people with mental illness?

5. Does the MHCR influence stakeholder satisfaction with police management of situations involving people with mental illness?

Consistent with a mixed-methods approach, both quantitative and qualitative methods were incorporated to address each research question. Quantitative data was derived from incident surveys completed by police officers responding to mental health related tasks and a survey administered to police officers. Qualitative data was derived from the conduct of semi-structured, face to face or telephone interviews with associated participants. Given the volume of both quantitative and qualitative data that informs each research question, this report provides a separate chapter describing quantitative and qualitative findings as they relate to the Police Operations Centre (POC) (Chapter 3), policing districts (Chapter 4), the Perth Watch House (Chapter 5), and mental health consumers (Chapter 6). In the concluding chapter, collective findings are itemised under each specific research question (Chapter 7).

**Overall findings**

Overall, the evaluation demonstrated the value of the Mental Health Co-Response model implemented by the WA Police Force. Findings showed benefits in terms of resource allocation, the safety and wellbeing of officers and consumers, and integrated inter-agency collaboration at each stage of the model. Findings also showed that although police are being called to a growing number of mental health incidents, the majority are not criminal incidents. Given a lack of access to what are perceived as appropriate mental health services, community members call police as a last resort for assistance. These are welfare checks, and because police are not and should not be expected to be trained mental health practitioners, there is a clear need to incorporate a mental health practitioner in crisis responses. Although this research has focused on the benefits associated with a shared (police and health) co-response model, the need for a shared model is implicitly stated within findings. The term need is purposely used to differentiate between a want, or a nice thing to have, as there is an absolute need to address

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4 The term ‘welfare check’ in the context of this report refers to any incident in which there is a reasonable belief that the person’s health or wellbeing is at risk. It is acknowledged that this definition of ‘welfare check’ may differ to that used in the health context.
current community demand. This demand for non-criminal welfare checks may not constitute policing business. However, until community members perceive themselves as able to access relevant mental health services, they will continue to contact police, who are compelled to respond to crisis incidents. Therefore, there will be a need for a co-response model until the gaps in the mental health system are identified and subsequently filled.

At the first stage of the model, the mental health practitioner in the POC ensured that response officers were better prepared to respond to a given mental health task, provided significant assistance in working across agencies to streamline police response (e.g., transports) and provided invaluable assistance in locating persons at risk (e.g., providing contact details, other known addresses). The need to incorporate a mental health practitioner in police response to incidents at the district level is somewhat different. The effective resolution of the incident is significantly aided by the ability of mental health practitioners to engage with the consumer and de-escalate the situation. Of equal importance is the presence of a mental health practitioner at the Perth Watch House. The early identification of mental illness ensures the appropriate custodial care of the detainee experiencing mental health concerns, other detainees, and policing staff. Furthermore, it ensures that appropriate diversionary options are exercised.

Overall findings suggest the need to continue and expand the WA Police Force MHCR model, with careful consideration as to how this is achieved. Within each stage of the model (e.g., POC, districts, Perth Watch House) there was demand for more coverage (e.g., more hours of the day, more days of the week to include Sunday), and service to the entire metropolitan area. The implications of addressing demand with a finite resource must be a key consideration, with every effort being made to ensure that the work of the Mental Health Co-Response Mobile Teams (MHCMTs) is not diluted by extending the resource beyond capability. The critical importance of co-location must be acknowledged given the integrated and collaborative relationships that formed over the course of the trial and the clear benefits associated with these relationships. The need for a clear communication strategy to ensure all operational police officers are not only aware of the availability of the resource but also the capabilities of the resource is evident. There is also a need for this expertise to be formally acknowledged.

The work of the Mental Health Co-Response Unit (MHCRU) must also be acknowledged. Over the 2-year trial period the research team observed their dedication, determination and absolute commitment to ‘best practice’. Although the needs of the agency were clearly at the forefront of decision making, the clear commitment to addressing the needs of mental health consumers in a respectful way to preserve dignity requires significant mention.
The MHCRU exhibited strong leadership, open and transparent relationships with Health, and a positive proactive approach to roadblocks encountered during the process of refining the model that is in place today. The MHCRU provided a strong foundation for the trial, as well as responsive, on-going support for each stage in the model. Two very different agencies have been working collaboratively to address a very complex issue. The policies and procedures they have implemented and refined over the trial period should be documented and preserved to ensure the founding principles of the model are not lost.

An overview of findings relating to each stage in the WA Police MHCR Trial are presented below.

**Findings specific to the Police Operations Centre (POC) – Chapter 3**

During the MHCR, a mental health practitioner was located within the POC. The role of the mental health practitioner was to obtain relevant information from health databases, and either add this information to the Computer Aided Dispatch (CAD) system, or provide this information direct to operational police staff within the POC (e.g., dispatchers and radio supervisors). It was expected that this strategy would aid efficiencies in WA Police resource allocation and decision-making when responding to mental health related tasks. It was also expected that the presence of the mental health practitioner in the POC would enhance staff knowledge and confidence in responding to incidents involving an individual experiencing a mental health crisis. To isolate the effect of the MHCR trial, the POC mental health practitioner was tasked to perform this role only for mental health related tasks that occurred in the test districts; North West Metro (NWM) and South East Metro (SEM), unless the incident was high priority and a request was made by the Duty Inspector or Senior Supervisor. In this circumstance, POC staff were able to draw on the expertise of the mental health practitioner, irrespective of the location of the task.

Data provided by the MHCRU (Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial, 22,376 Mental Health CAD tasks that occurred within trail districts, were sent to the mental health practitioners’ console. Of these tasks, 19,365 tasks were reviewed/actioned by the mental health practitioner. A further 784 CAD tasks from outside trial districts were reviewed/actioned by the practitioner at the request of POC Inspectors/Supervisors. Data further indicates that, of the jobs reviewed since July 2016,

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5 WA Police definition of Mental Health CAD task includes: Welfare Checks (Code 48); Missing Persons (Code 49); Mental Health Incident (Code 68)
9% of persons were identified as currently active with Mental Health (n= 1607), 32% of persons were identified as having a past history with Mental Health Services, but were not active clients at the time of the incident (n= 5806), 38% of persons were not known to mental health services (n= 6852) and 21% of persons in the CAD tasks were not able to be identified (n= 3675).

Chapter Three of this report details research findings that examined the impact of having a mental health practitioner located within the POC. Semi-structured interviews with dispatchers, POC supervisors, POC management, and mental health practitioners assigned to the POC were conducted. The ultimate outcome attributed to the presence of a mental health practitioner at the POC was a reduction in risk for both individuals experiencing a mental health crisis, and police officers as police were better prepared to respond to the incident. Improved police response was enabled as radio POC staff had the requisite information to inform police of risks and make valid and informed decisions about the allocation of resources to counter those risks (i.e., send more response units, increase the priority level of the task). This had a direct and positive impact on efficient resource allocation as the resources allocated to the task were appropriate to the nature of the task.

Co-location was discussed as providing critical benefit. Due to co-location (health working alongside police in the POC) a genuine, integrated collaboration developed between the two agencies. Each gained an understanding of the demands and restrictions placed upon the other which resulted in collegial and productive working relationships. An issue discussed in many interviews was the need to expand the role, to cover more hours in the day, more days of the week (i.e., include Sunday) and to service all police districts.

Interviews with non-MHCR officers identified the need to reconsider the role of the POC practitioner. Specifically, frontline police officers were of the view that the mental health practitioner should be providing mental health information to response teams in ‘real time’, whilst also participating in the process of developing an approach strategy. Therefore, the mental health practitioner should also be providing advice in terms of how to manage the incident effectively on the basis of the information that they hold, and their expertise. This type of model is applied at the district level via MHCRMTs and significantly aids decision making.

**Findings specific to police districts- Chapter 4**

During the MHCR a mental health practitioner was also placed in trial districts (NWM and SEM) as part of a Mental Health Co-Response Mobile Team (MHCRMT). This team comprised of two uniform Co-Response officers and an Authorised Mental Health Practitioner
(AMHP) in an unmarked vehicle, as a first responder to incidents involving an individual experiencing a mental health crisis. It was expected that this strategy would aid efficiencies in WA Police Force resource allocation, decision-making, actions and outcomes when responding to mental health related tasks. It was also expected that the presence of the mental health practitioner in test districts would improve officer knowledge and confidence in responding to individuals experiencing mental health crises.

Data provided by the MHCRU (Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial, SEM and NWM MHCRMTs attended:

- 2907 mental health tasks in which the consumer was engaged.
- 1014 mental health tasks in which the consumer was not engaged (e.g., unable to locate, resolved without attendance).
- 737 non-mental health welfare checks.
- 1226 non-mental health police tasks.

Furthermore, MHCRMTs received 1019 requests for advice/assistance from other WA Police units (recorded since May 2016).

Chapter Four of this report details research findings that examined the impact of having a mental health practitioner co-responding with police to incidents involving an individual experiencing a mental health crisis. Semi-structured interviews with MHCRMT practitioners and police officers and their managers, and non-MHCR police officers in test districts indicated that MHCRMTs ensured the respectful resolution of incidents, thereby meeting the real needs of those experiencing a mental health crisis. Positive impacts on resource allocation were also observed as incidents were resolved in a timely manner, transportation was less frequent and less time was spent in ED.

Improvements to MHCRMT officer knowledge, skill and teamwork were reported by police officers, mental health practitioners and management. Police officers discussed the skills they had obtained in training and the knowledge they gained whilst working alongside the practitioners. This knowledge reduced stigma which facilitated more genuine, responsive communication with the mental health consumer. Furthermore, many MHCRMT officers displayed a genuine interest in working to improve police responses to mental health; an attitude that was critical to effective incident resolution. The skills gained enabled officers to work collaboratively with the mental health practitioner. Members of MHCRMTs were aware that their position was perceived by some non-MCHRT officers and managers to be providing “security” for the mental health practitioner. However, both MHCRMT officers and practitioners vehemently opposed this view. Although it was acknowledged that the role of the
A police officer was to ensure that the environment was safe for the mental health practitioner to conduct an assessment, officers and mental health practitioners worked as a team when engaging with the individual in crisis. It was this team work that was described as the main success of MHCRTTs. Roles and boundaries remained clearly delineated, each applying their own unique skill set to assist in the respectful resolution of the incident. However, findings did reveal a number of tensions and frustrations emerging from (a) the inconsistency between business as usual and the MHCR model, (b) the positioning of MHCRTTs, (c) understandings of the role and value of MHCRTTs and (d) disparate organisational policies and procedures (police and health). This indicates the need for better awareness of, and exposure to, the work of MHCRTTs and the need to centralise the teams, so that they are managed by the MHCRU.

A survey administered to police officers in test and control districts aimed to determine perceptions of role adequacy in responding to an individual experiencing a mental health crisis. Findings revealed increased confidence of MHCRT officers only, again, highlighting the need for exposure to the work of MHCRT. Survey participants also indicated the need for the role to be expanded.

Incident data, which compared the processes and outcomes of all incidents involving a person experiencing a mental health crisis in test and control districts revealed that when police assistance was requested, MHCRTTs impact significantly. The expertise of the mental health practitioner increases the likelihood of a speedy resolution of the incident and reduces the likelihood of transportation. As the mental health practitioner is familiar with health processes and procedures and has contacts within the hospital system, time taken at ED’s is reduced and time taken to hand over to health is also reduced. These benefits are realised because the representatives of both agencies are co-located (e.g., health and police). A police outcome was also significantly less likely in the true/test districts. This implies that MHCRTTs were better able to resolve mental health related incidents without the need for formal police intervention. Evidently then, the MHCR model lends itself to the decriminalisation of individuals experiencing mental health crises. Police use of force was also lower in the true/test districts which implies that MHCRTTs are better able to de-escalate and resolve situations that involve individuals experiencing a mental health crisis peacefully, without having to use force to gain control of the situation.

**Findings specific to Perth Watch House- Chapter 5**

During the MHCR trial, a mental health practitioner was also located within the Perth Watch House. The role of the mental health practitioner was to observe and screen detainees
as they were processed into the Watch House. The mental health practitioner was able to access the health database and provide Watch House staff with any relevant information pertaining to the detainees’ mental health. If deemed necessary the mental health practitioner was able to further assess detainee mental health in a one on one, non-contact interview room. It was expected that this strategy would aid the detection and appropriate management of detainees experiencing mental health concerns whilst in custody, improve staff knowledge and confidence in responding to detainees who may be experiencing mental health concerns and improve efficiencies in WA Police resource allocation.

Data provided by the MHCRU (Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial:

- 13068 detainees were registered in custody during trial times.
- 8671 detainees were screened by the practitioner.
- 6% of detainees were currently active with Mental Health Services (n= 372).
- 33% of detainees were identified as having past history with Mental Health Services but were not active at the time they were held in custody (n= 2147).
- 61% of detainees were not known to mental health services (n=3918).

Further performance indicators reported by the MHCRU are outlined in Chapter 5 and provided in Appendix A.

Chapter Five of this report details research findings that examined the impact of having a mental health practitioner located within the Perth Watch House. Interview data with police auxiliary officers, supervisors, members of the management team and mental health practitioners working at the Perth Watch House revealed that the presence of the Mental Health Practitioner improves the standard of custodial care afforded to detainees, increases accountability, reduces pressure, ensures the effective allocation of resources and enables the formation of appropriate management plans for detainees. Interviews however identified gaps in service provision, with participants indicating the need for a twenty-four hour a day, seven day a week service (as it is for the medical nurse). A focus group conducted with the Forensic Mental Health Court Liaison Service (FMHCLS) revealed the presence of the Mental Health Practitioner in the Watch House enabled more effective allocation of health resources and better informed decision-making within the court setting.

Findings specific to Mental health consumers and their carers- Chapter 6

The MHCR was designed to ensure the respectful treatment of mental consumers, to reduce risk to mental health consumers, and to increase the likelihood of diversion from the
criminal justice system to health. Therefore, it was considered fundamentally important to examine the experience of mental health consumers and their carers with MHCR. Chapter Six of this report describes those experiences. Interviews with mental health consumers and their carers revealed that consumers and carers engaged positively with MHCRMTs and saw the MHCR model as a significant improvement on the traditional crisis response model applied by police. Consumers felt empowered and for the first time, described having a voice in terms of what the outcome of the incident would be.

Findings specific to evaluation research questions- Chapter 7

Chapter 7 summarises collective findings as they relate to each research question. These findings are summarised below:

Research Question 1

Does the MHCR influence perceptions of role adequacy, confidence and decision making of frontline police, police operations and police watch house staff?

The MHCR trial appeared to have had little impact in terms of the perceived role adequacy of frontline police, police operations and police watch house staff. However, it is important to consider the role of police within the MHCR model. Despite the perception of regularly performing the role of ‘street corner psychiatrist’, the role of police is actually to bring an end to a crisis incident and this objective is typically achieved. Whether the police adequately responded to the mental health element of an incident however, is unlikely. In the context of the MHCR model, it was the mental health practitioner, not police officers, who addressed the mental health aspect of the task; providing expert advice on how to approach and de-escalate the situation. Therefore, the impact of the MHCR model on police officer perceptions of role adequacy in responding to tasks involving an individual with mental health concern might be expected to be minimal.

In terms of officer confidence in managing situations in which an individual is experiencing a mental health crisis (e.g., de-escalating, communicating), survey data revealed benefits only for officers within MHCRMTs. Qualitative interviews with staff in the Watch House however indicated that participants felt more confident with the standard of custodial care provided to detainees due to the knowledge and expertise of the mental health practitioner. In terms of decision-making, collective findings show that information provided under MHCR via the POC influences the decision making of POC participants, but does not influence the decision
making of frontline police officers. Furthermore, information provided under MHCR via mobile MHCRMRTs and the Watch House mental health practitioner does influence decision making of frontline police and Watch House participants. Important to consider in relation to this research question are the findings relating to the perceived adequacy of training in mental health. A significant majority of participants felt that training was deficient in this area which would likely impact on judgements of role adequacy, confidence and decision-making.

**Research Question 2**

*Does the MHCR influence demand on agency resources in responding to situations involving people with mental illness?*

For the purposes of this research question, agency resources were defined as:

a. Calls for service involving people with mental illness.

b. Repeat calls for service involving people with mental illness.

c. Time taken attending incidents involving people with mental illness.

d. Transportations of people with mental illness.

e. Time taken for police handover of people with mental illness into health care.

With respect to (a) calls for service and (b) repeat calls for service involving people with mental illness, interview data suggested that the MHCRMRTs had a positive impact. Officers discussed ‘repeat consumer management plans’ in which police worked with health services to ensure the individual was able to access health supports which resulted in a reduction of calls for police assistance. However, interviews with consumers, albeit it a limited number, revealed that although referrals were made, they were not able to access services.\(^6\) Therefore, the potential for MHCRMRTs to impact on calls for service is limited by the availability of relevant services and access to the same. Despite this, whilst the WA Police Force cannot control who a Person At Risk (PAR) calls when in a state of crisis, it can control the management of these calls- MHCR ensures that these calls are managed in a way that reduces impact on agency resources.

With respect to (c) time taken attending incidents involving people with mental illness, (d) transportations of people with mental illness and (e) time taken for police handover of people with mental illness into health care, the impact of MHCR was positive. Incident data

\(^6\) WA Police data has been provided indicating that over the trial period, 1283 referrals were made to mental health and other community services (excluding Court Liaison; please see Appendix A). As stated, data tracking to determine the uptake of these referrals was outside the scope of this evaluation and was to be undertaken by the Mental Health Commission.
revealed that police time taken attending incidents involving people with mental illness was significantly lower in true/test districts, the PAR was significantly less likely to be transported in true/test districts and when transported to a health facility, the time spent at the health facility was significantly lower in true/test districts. Evidently, the expertise of the mental health practitioner increases the likelihood of a speedy resolution of the incident and reduces the likelihood of transportation. As the mental health practitioner is familiar with health processes and procedures and has contacts within the hospital system, time taken at ED’s is reduced and time taken to hand over to health is also reduced. These benefits are realised because the representatives of both agencies are co-located (e.g., health and police).

Research Question 3

*Does the MHCR influence police arrests of people with mental illness and referral of people with mental illness to emergency departments and increase referral to other community based services (non-emergency services or psychiatric facilities)?*

The findings of this research show that advice, and referral to relevant services was significantly more likely to be provided in true/test districts. A police outcome was also significantly less likely in the true/test districts, as was police apprehension under the Mental Health Act. Qualitative data showed that the expertise of the mental health practitioner enabled the determination of “real risk,” and when this was low, enabled mental health consumers to be supported in their homes rather than being transported to hospital. In the absence of MHCR, the default response of police officers who felt ill equipped to accurately gauge risk, was to transport the PAR to hospital. On this basis, demand placed on EDs would have likely reduced.

Research Question 4

*Does the MHCR influence adverse events for community members and police that arise from the management of people with mental illness? Adverse events are defined as:*

a. Use of force to manage people with mental illness.
b. Injuries to people with mental illness during encounters with police.
c. Injuries to police caused by people with mental illness.

The findings of this research show that use of force by police during incidents involving a person experiencing mental illness was lower in true/test districts. The pattern of findings was
equivalent in terms of use of force by the PAR. The frequency of injury was too low to enable statistical analysis.

Research Question 5

Does the MHCR influence stakeholder satisfaction with police management of situations involving people with mental illness?

The findings of this research showed that mental health consumers and carers engaged positively with MHCR and saw the MHCR model as a significant improvement on the traditional crisis response model applied by police. Consumers felt empowered and for the first time, described having a voice in terms of what the outcome of the incident would be. All mental health consumers and carers who participated in this research had contact with the MHCRMT for non-criminal matter/s (i.e., a welfare check) and had frequent engagement with police. The most significant frustration for mental health consumers and their carers related to the struggle to survive emotionally, practically and financially in a mental health system described as “broken.”

Examples of tasks undertaken by all components of MHCR are contained in Appendix B. These examples were provided by the Mental Health Co-Response Unit.

Recommendations

It is acknowledged that MHCR is an interim solution to a broader community problem that multiple agencies are tasked to address. As a crisis response model, MHCR works effectively and meets the needs of mental health consumers. In the absence of a centralised mechanism and process for addressing this broader community issue, there is a need for the WA Police Force to continue applying this interim solution, described by many participants as a “Band-Aid response.” Recommendations based on the findings of this research are that:

1. The WA Police Force consider transitioning from a MHCR trial, to a business as usual model, with MHCRMTs being embedded in all districts. However, the risks in executing this recommendation without adequate resourcing and an adequate communication strategy must be considered. With regard to resourcing, there is a substantial risk that the positive impact of MHCRMTs will be diluted if the teams (as they are currently resourced) are required to service the entire metropolitan area. This
is already evident from non MHCR officers in test districts who have indicated that although the MHCRMTs are beneficial and necessary, they are not often called due to the perceived inability of the team to meet their needs (e.g., because they are already responding to another task and/or are too far away to respond to the task in a timely manner). The timeliness of response from co-response teams is critical to their perceived benefit, as evident in the A-PACER evaluation (Evangelisata et al., 2016). As such, if additional resources are not available at this time, serious consideration is needed to ensure the best outcomes are achieved with a limited resource. With regard to an adequate communication strategy, if the model is to be implemented across the metropolitan area there is a need to ensure that all officers and staff are informed of each element of the model. Officers must be told who they can contact, when and for what purpose. A key issue in research findings was the lack of information provided to police staff upon implementation of the model which impacted negatively on roles, relationships and use of the service.

2. Management awareness: Ensure that District management and supervisors who are not directly involved in MHCR but are involved in the allocation of the District resource (e.g., Officer In Charge (OIC) of Response Teams, OICs of DCCs etc.) are exposed to the work of MHCTs. As evidenced in Chapter 4, when management are not aware of the capabilities of the MHCRMTs they are unlikely to use them to their full potential. Managers and officers in charge of district resource allocation and operational decision-making must understand the capabilities of all district resources at their disposal to better utilise the most appropriate resource at the most appropriate time.

3. Alternatively, the WA Police Force could consider centralising the MHCRMTs which are attached to the already centralised MHCRU. This will establish only one line of command and will ensure that the specialist knowledge held within the team is appropriately utilised at all times (i.e., eliminates the likelihood that MHCRMTs will be required to back-fill administrative tasks that are unrelated to MHCR work). This would also enable MHCRU management to ensure the wellbeing of officers (e.g., rotate from the road to other relevant tasks such as education).

4. The WA Police Force reconsider the role of the mental health practitioner in the POC. Although the mental health practitioner is a valuable source of information for those working within the POC, the value to frontline police is limited with the model as it is currently applied. If the POC mental health practitioner was able to provide ‘real time’ advice via radio to first responder units in transit, an effective strategy could be
developed that minimizes risk for all parties. Given the volume of welfare checks, the ability of the POC mental health practitioner to talk to those in crisis whilst units are in transit would also be beneficial.

5. The WA Police Force consider strategies to ensure that non-MHCR officers are exposed to the knowledge and expertise of the MHCRMT. Findings indicated that only MHCR officers benefitted from exposure to the mental health practitioner in terms of confidence in dealing with mental health tasks. This effect could be extended if a system of rotation through, or secondment to MHCRMTs was considered. This recommendation requires careful consideration as the positive impact of MHCRMT is derived from the nature of the officers that work in the teams (e.g., personality) and the solid working relationships that have developed between MHCR officers and practitioners. Despite this, the benefit to be derived from exposing a greater number of general response officers to the work of the MHCRMTs would be substantial. If rotation through, or secondment to teams is considered too disruptive, MHCR officers could be encouraged to work alongside general response officers on a more frequent basis. Drawing on the MHIT model in NSW, their knowledge and expertise as a MHCR officer should be formally acknowledged and operational policy should require that they assume the role of ‘incident controller’ of any task where mental health is deemed relevant (e.g., as is done with MHIT in NSW). This would reduce tension between business as usual practice and MHCR practice (described in Chapter 4), as MHCR practice will formally take precedence.

6. The WA Police Force continue to apply a colocation model. The benefits derived from MHCR were largely due to the fact that police and mental health practitioners were collocated. This fostered an understanding of the respective policy and operational frameworks impacting significantly on decision making and the management of incidents. The effective team oriented approach to the management of the problem (e.g., un-treated/diagnosed mental health consumers) would be unlikely to eventuate if health and police were not collocated.

7. With regard to the tensions described in Chapter 4 resulting from the disparate organisational policies and procedures of police and health, there is a need for consultation between the agencies to overcome any logistical impediments that present a threat to the efficient operation of the MHCR model (e.g., issues such as rostering, the nature of jobs that should be attended, time to complete paperwork, etc.).
8. The WA Police Force consider increasing the amount of time a mental health practitioner is rostered to ensure peak business times are well covered. A consistent message, particularly in the POC and Watch House was that the mental health practitioner was not available when needed. This was evident to a greater extent in these locations as there was no substitute service when the mental health practitioner was not on shift (whereas in the Districts, general response officers were able to respond to tasks). Addressing this recommendation may require the analysis of internal data to determine peak times.

9. The WA Police Force reconsider the current approach to training in mental health. Currently, emphasis is placed on the acquisition of knowledge about mental illness, with less emphasis placed on how to manage incidents involving a person experiencing a mental health crisis. It would be useful to develop a ‘scaffolded’ approach to training across a variety of current training programs. For example:

   a. **Tier 1: Recruit training.** Introduction to mental health and the management of those experiencing mental illness.

   b. **Tier 2: Recruit training.** OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance.

   c. **Tier 3: Annual in-service training.** OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance. The critical differentiation between annual in-service training and recruit training is that in-service training must further develop skills and knowledge. A greater level of proficiency/expertise should be expected and officers should be provided the opportunity to debrief with the mental health practitioner about scenarios they have encountered in the field. This would also aid in the identification of officers deemed suitable for a role in the MHCRMTs.

   d. **Tier 4: MHCR training.** Officers apply to complete an intensive course, a component of which must include a certain number of hours to be completed on the road with the MHCRMTs. This approach will provide understanding and exposure to the work of MHCRMTs, build further skill and enable the application of these skills whilst working alongside MHCR specialists. Debriefing at the completion of the course should be required. Those who successful complete Tier 4 will enable knowledge transfer from the MHCTs
back into response work and will also form a pool of potential officers to recruit from when positions become available in MHCRMTs. Completion of this level of training should be formally recognized (e.g., by way of a badge).

**e. Tier 5: MHCR specialist.** Once an officer has worked within a MHCRMT for a period of time and is deemed proficient in that role (KPIs will be required), their level of expertise as a MHCR officer should be formally recognized. This final tier of training recognizes the expertise that is developed with experience.

10. The WA Police Force, along with their partners in the Department of Health and Mental Health Commission consider establishing a multi-agency task force, or together advocate that Parliament establish a Select Committee to establish and provide advice on:

a. The current state of mental health services in Western Australia (e.g., number, range, type, access requirements).

b. The capacity of mental health services to meet demand for service provision.

c. Plural policing models to address the issue of managing mental illness within the community.

d. How plural policing models should be funded given the requirement for a multi-agency response.

e. Appropriate key performance indicators.

There is no doubt that the increased demand placed on policing agencies to manage criminal and non-criminal incidents involving a person experiencing a drug induced, and/or (un)diagnosed mental health concern cannot be addressed by police alone. A multi-agency, multi-level approach is required to address the issue of mental health in the community.
1. Introduction and methodology

This report provides an overview of findings from the evaluation of the Western Australia (WA) Police Force Mental Health Co-Response Commissioning Trial (MHCR). The trial was introduced in response to increased demand on police to attend to and manage incidents which involved an individual experiencing a mental health crisis. Traditionally, WA Police officers acquire knowledge of legislative responsibilities under the Mental Health Act (2014) during recruit foundational training at the WA Police Academy. Additional non-compulsory training is available through the Mental Health First Aid Training. The MHCR built on training to provide an operational deployment model consisting of the following elements:

1. Mental Health Co-Response Unit
   a. Training, policy, process, liaison and advisory.
2. Police Operations Centre
   a. Mental health triage and advice to attending officers, information sharing and risk assessment.
3. Mental Health Co-Response Mobile Teams (MHCRMTs)
   a. Police and mental health practitioner response to crisis, management of persons in crisis, linkage to support networks, family and service providers.
   b. Mental health Co-Response officers involved in the trial received an additional 3-day training package based on the NSW Police MHIT training package.
4. Perth Watch House
   a. Mental health triage, diversion and linkage with service providers and support networks.

The broad objectives of the MHCR were to:

1. Reduce the risk of injury for police and the individual experiencing a mental health crisis.
2. Improve collaboration between government and non-government agencies.
3. Increase opportunity for diversion from the criminal justice system to the health system and/or other support networks.
4. Reduce time taken for police handover of mental health consumers into health care.

The Sellenger Centre was appointed to evaluate the MHCR to determine if the MHCR increases the effectiveness of police management of encounters with individuals experiencing a mental health crisis. The cost effectiveness of the MHCR was beyond the scope of this evaluation and
was considered independently by the WA Police Force. The impact for mental health services and the uptake of referrals to mental health services was also beyond the scope of this evaluation and was considered by the Department of Health and the Mental Health Commission respectively.

Consistent with a pluralistic persuasion and the pragmatic paradigm, the evaluation framework applied a concurrent triangulation mixed methods approach (Creswell, 2009). This framework is illustrated in Figure 1 below.

![Concurrent triangulation mixed method approach](http://www.emeraldinsight.com/fig/1730_10_1016_S1474-8231_08_07009-2.png)

**Figure 1. Concurrent triangulation mixed method approach**

The specific research questions addressed within the evaluation framework were:

1. Does the MHCR influence perceptions of role adequacy, confidence and decision making of frontline police, Police Operations and Perth Watch House staff?
2. Does the MHCR influence demand on agency resources in responding to situations involving people experiencing a mental health crisis?
3. Does the MHCR influence police arrests of individuals experiencing a mental health crisis and referral of individuals experiencing a mental health crisis to emergency departments and increase referral to other community based services (non-emergency services or psychiatric facilities)?
4. Does the MHCR influence adverse events for community members and police that arise from the management of people experiencing a mental health crisis?

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7 Image copied from [http://www.emeraldinsight.com/fig/1730_10_1016_S1474-8231_08_07009-2.png](http://www.emeraldinsight.com/fig/1730_10_1016_S1474-8231_08_07009-2.png)
5. Does the MHCR influence stakeholder satisfaction with police management of situations involving people experiencing a mental health crisis?

As demonstrated within the evaluation framework, both quantitative and qualitative methods were incorporated to address each research question. Although the specific approach and methods applied are described throughout the body of this report, the overall research design incorporated is illustrated in Figure 2 below.

**Figure 2: Research design**

As shown in Figure 2, the true treatment group consisted of mental health incidents attended to by Mental Health Co-Response Mobile Teams (MHCRMT) and associated participants in the districts where MHCRMTs were located during the period of the trial; the North West Metropolitan (NWM) district and the South East Metropolitan (SEM) district. The test control group consisted of mental health incidents attended to by police officers (non-MHCRMT) and associated participants in the districts where MHCRMTs were located during the period of the trial (NWM and SEM). The true control group consisted of mental health incidents attended to by police officers and associated participants in districts where no MCHRT were situated during the period of the trial; the Central Metropolitan (CM) district and the South Metropolitan (SM) district.

Both quantitative and qualitative methods were incorporated to address each research question. Quantitative data was derived from incident details and a survey administered to police officers. Qualitative data was derived from the conduct of semi-structured (face to face or telephone) interviews with associated participants. The term ‘associated participant’ is broad and includes police officers, supervisors, managers, mental health practitioners, consumers and other relevant stakeholders. Given the volume of both quantitative and qualitative data that informs each research question, to aid clarity this report will provide a separate chapter.
describing quantitative and qualitative findings as they relate to the Perth Watch House, the Police Operations Centre, policing districts, and mental health consumers. In the concluding chapter, collective findings will be itemised under each specific research question. Therefore, data relevant to each stage in the process will be presented as a separate study within each chapter to ensure adequate depth is conveyed. The final chapter will link each form of data to specific research questions and will therefore summarise outcomes.
2. Overview of literature

In recent times, the prevalence of mental illness has increased to such a degree that it has become a major issue for health services and law enforcement agencies worldwide (Hollander, Lee, Tahtalian, Young, & Kulharn, 2012; Laing, Halsey, Donohue & Cashin, 2009; Wood, Swanson, Burris & Gilbert, 2011). There is now a significant body of research to show that a significant proportion of individuals who come into contact with police and the broader criminal justice system have a history of mental illness (Hollander et al., 2012; Shapiro, Cusi, Kirst, O’Campo, Nakhast & Stergiopoulos, 2015; Senior, Noga, & Shaw, 2014; Steadman, Deane, Borum, & Morissey, 2000; Teplin & Pruett, 1992). One widely cited explanation for this trend is the shift, in most Western countries, away from institutionalised care of those experiencing mental health issues towards community based care (Hollander et al., 2012; Office of Police Integrity [OPI], 2012; Shapiro et al., 2015). Although this shift was implemented under the banner of social progression, it has resulted in a number of unforeseen circumstances, such as homelessness, poverty and drug and alcohol use, which has ultimately led to the criminalisation of those experiencing mental health concerns (Lamb & Bachrach, 2001; OPI, 2012).

Research examining police interactions with individuals experiencing mental health concerns suggests that a significant amount of police time is spent responding to these types of incidents (Godfretson, Thomas, Ogloff, & Luebbers, 2011; Hollander et al., 2012; OPI, 2012). For example, Godfretson et al., (2011) found that just under half (48.2%) of the Victorian police officers who participated in the research (N=3534), indicated that, on average, they would respond to at least one or two incidents involving an individual experiencing a mental health crisis per week, whilst 39.0% of the officers indicated that, on average, they would respond to between three and ten incidents per week. Hollander et al., (2012) yielded similar findings with a sample of police officers from three police stations in Victoria (N=44). Just under half of police respondents (41%) indicated that they attended at least one mental health crisis per week, and roughly a quarter (21%) indicated that they conveyed an individual experiencing a mental health crisis to the emergency department (ED) at least once a week. Such findings highlight the frequency with which police are involved in managing individuals experiencing a mental health crisis (Godfretson et al., 2011; Hollander et al., 2012; OPI, 2012). In discussing the frequency with which police are involved in the management of those experiencing mental health issues, Teplin and Pruett (1992) went so far as to suggest that it is an expectation that modern police can and will act as a “street corner psychiatrist” (p. 154) to persons experiencing a mental health crisis.
Despite the prevalence of contact with, and the expectation that police should be able to assist those experiencing a mental health crisis, research consistently demonstrates that police officers are ill equipped to fulfil this function as they lack the requisite knowledge, skills and abilities required (Borum, 2000; Godfretson et al., 2011; Ogloff et al., 2013; OPI, 2012; Teplin & Pruett, 1992). Ogloff et al., (2013) identified that most police officers lack formal training with regard to responding to mental health crises. This is supported by the findings of Godfretson et al., (2011) who discovered most officers received no formal training in responding to a mental health crisis within the community. The most commonly reported methods utilised by police officers in responding to a crisis were informal and learnt through observations of more senior, but equally unqualified officers (Godfeston et al, 2011; Ogloff et al., 2013). Reported challenges experienced by police in responding to individuals experiencing a mental health crisis include effectively communicating with the individual and uncertainty with regards to how best to respond in crisis situations (Borum, 2000; Godfretson et al., 2011). These challenges may go some way to explaining why incidents involving mental health crises can often escalate and result in police use of force and arrests for minor transgressions (OPI, 2012).

Given the degree of contact between police and persons experiencing a mental health crisis, along with concern regarding police management of such incidents (OPI, 2012), policy makers recommended the development of appropriate police operational deployment models to address identified deficiencies in police response (e.g., lack of mental health training) (OPI, 2012). In Australian jurisdictions, a number of initiatives have been developed and trialled; the Mental Health Intervention Team (MHIT) in New South Wales, the Crisis Assessment Treatment Teams (CATT) in Victoria and the Police Ambulance and Clinical Early Response (PACER) model in Victoria (OPI, 2012; Wood et al., 2011). All three models had the primary purpose of reducing resource and time constraints experienced by front line police officers dealing with mental health consumers, whilst improving consumer experiences through referral to appropriate treatment services (OPI, 2012).

MHIT is an initiative that attempts to directly address some of the major challenges associated with traditional police responses, most notably the lack of training provided to response officers (Wood et al., 2011). The model was developed by and implemented within New South Wales (NSW) Police in 2008 (NSW Police, n.d.). The program is led by a unit of specially trained police officers who respond to mental health-related tasks and provide secondary mental health training to others in the agency (OPI, 2012). MHIT officers are operational police officers and wear a police uniform. This is a purposeful approach designed
to combat the common, frontline mentality of such positions being out of touch with ‘the realities of policing’ and to highlight the fact that mental health and operational police response cannot be extricated (OPI, 2012). Police officers who complete the 4-day training course, run by the MHIT, are recognised and assume the role of lead officers upon arrival at any incident where mental health issues are considered relevant to the task; promoting an appropriate response to mental health crises (OPI, 2012). The training covers a number of relevant areas including identification of mental health behaviours; de-escalation, communication and crisis intervention; a better understanding of the legislation relating to the management of individuals experiencing a mental health crisis; and a lived experience component in which mental health consumers share their lived experiences with officers (NSW Police, n.d.). Evaluations of the MHIT have shown that it can be effective for increasing the ability of police officers to respond to mental health crises, particularly with regard to de-escalation (OPI, 2012). Further to this, research which focused on officer perceptions of MHIT have been mostly positive, with a commonly cited benefit being enhanced understanding of the experiences of those living with mental illness (Wood et al., 2011).

Despite attempting to address one of the major limitations of police responses to mental health crises (education and training), the MHIT has not escaped criticism (Borum, 2000). Borum (2000) argues that it is unrealistic to expect police officers to obtain the appropriate level of knowledge and skill that is required to proficiently respond to mental health crises. This critique was not levelled specifically at the MHIT initiative, but rather was a general statement relating to role and time constraints within the police profession (Borum, 2000). Borum (2000) argues that it takes mental health clinicians years of education and training to develop an understanding of mental illness and how it affects people, and so, police officers, whose role and profession is fundamentally different to that of a mental health practitioner, cannot expect to become proficient in this area due to limited time and resources.

In response to the recognised limitations of police training and police response to mental health incidents, alternate models have developed. One such model is the Crisis Assessment Team (CAT; OPI, 2012). CAT is a mental health response model that aims to limit police participation in mental health crises by having mental health professionals respond instead (Wood et al., 2011). Therefore, when police encounter an individual experiencing a mental health crisis they can request the attendance of a CAT (Hollander et al., 2012; OPI, 2012). Although clinicians are undoubtedly better able to screen and assist individuals experiencing a mental health crisis compared to police officers, CAT has also been subject to a number of criticisms (Boscarito et al., 2014; Hollander et al., 2012; OPI, 2012). Two major
limitations of CAT that have consistently been cited in the literature relate to the timeliness of service and the lack of collaboration and communication between the representatives of different agencies (Boscarto et al., 2014; Hollander et al., 2012). With regard to the timeliness of service, research has found that there are often major delays associated when the CAT team is required (Boscarto et al., 2014; Hollander et al., 2012; OPI, 2012). Boscarto et al. (2014) also found dissatisfaction with the CAT initiative amongst a sample of 11 mental health consumers. Participants in the study explained that the major time lags between police initially responding and CAT arriving on site contributed to heightened levels of distress (Boscarto et al., 2014). This is consistent with the findings of Evangelista et al. (2016) who demonstrated that mental health consumers became increasingly distressed at the level of public attention directed at them when police officers remained at the scene for prolonged periods of time.

There are evident limitations associated with the aforementioned efforts to improve police response to mental health crisis. Lee et al. (2015) argues that single agency responses to mental health crises, such as MHIT (police response) and CAT (health response), are unlikely to provide an effective solution because the response is too simplistic and does not account for the complicated and multifaceted nature of mental health incidents. This suggests the need to draw upon the skills of a variety of agencies in developing an appropriate response model. Consensus with this view is evident from the more recent implementation of co-response models, which involve health and police personnel, co-responding to mental health incidents (Boscarto et al., 2014; Lee et al., 2015; Shapiro et al., 2015). The first example of a co-response model, implemented in Australia in 2007, was the Victorian Police, Ambulance and Clinical Early Response (PACER) model (Huppert & Griffiths, 2015; OPI, 2012). The PACER model consists of a police officer and a mental health clinician who attend mental health-related, police tasks as secondary responders (OPI, 2012). This interagency pilot aimed to improve both police process and the experience of those experiencing a mental health crisis (OPI, 2012). For example, the opportunity to provide a mental health assessment at the scene (e.g., in the individuals home) not only enables police to avoid spending excessive amounts of time waiting in an emergency department, it also reduces the amount of time a mental health consumer is required to wait before receiving appropriate assistance, and enables assistance to be provided in the comfort of their home (OPI, 2012). As the team comprised a mental health professional and a police officer, access to both police and health information systems enabled more informed decision making during an incident.

Initial research evaluating the impact of PACER indicated that the strategy was effective in establishing a number of positive outcomes (Huppert & Griffiths, 2015).
Specifically, PACER decreased the proportion of mental health consumers requiring transportation to ED and significantly reduced average response times (Huppert & Griffiths, 2015). Variants of the PACER model (e.g., A-PACER and N-PACER; operating in different locations in Victoria) have also been found to represent a more efficient use of police resources (Lee et al., 2015; Shapiro et al., 2015). PACER programs have also been positively received by stakeholders, with research indicating that police officers and mental health clinicians are supportive of the initiative (Lee et al., 2015; McKenna, Furness, Oakes & Brown 2015). Police officers and clinicians who had worked as part of PACER teams acknowledged that communication, collaboration and information sharing were all vastly improved when compared to other strategies such as CAT (McKenna et al., 2015). Furthermore, personnel from both agencies suggested the program offered a great opportunity to develop new skills and acquire knowledge (McKenna et al., 2015).

An important stakeholder group to consider in evaluations of co-response models are the consumers at the centre of mental health related police incidents. Evangelista et al. (2016) conducted a qualitative examination of the experience of consumers who came into contact with the A-PACER program. This program was a variant of the PACER program where clinicians were not located at the police station, but at a psychiatric facility within 2km of the station. Findings showed that consumers were mostly positive about the A-PACER experience as response was timely, which according to Boscato et al. (2014) is crucial to the effective management of crisis situations. Another positive aspect of the A-PACER program was that personnel (both clinicians and police) were perceived, by consumers, to be more sensitive than those who respond under a traditional police or health model (e.g., CAT; Evangelista et al., 2016). Other perceived benefits of the A-PACER program included; effective communication and skill in de-escalating the situation, the persistence of the team in providing assistance, effective communication between the clinician and ED staff (when transport was required) which enabled a streamlined admission process and, a greater likelihood that he consumer would experience a desired, as opposed to an enforced, outcome (Evangelista et al., 2016).

Although the PACER initiative (and its variants), have been positively received and research indicates positive outcomes, the Department of Health in Victoria has raised serious concerns about the programs’ efficiency (OPI, 2012). In particular, concern is raised about the mental health resource which is attached to the model given the lack of mental health services and qualified clinicians throughout Australia (OPI, 2012). It is suggested that while PACER is a worthwhile initiative, it does not make good use of mental health clinicians’ time (OPI, 2012). This concern is likely based on the findings of research showing that almost half (48%) of the
consumers of the PACER program were not in need of mental health assistance (OPI, 2012). Criticisms have also been levelled at researchers who have claimed initiatives like PACER are cost effective. With regard to the PACER initiative specifically, it was argued that analyses of the cost were calculated using incomplete data (OPI, 2012). While these limitations are important to consider it is also important to acknowledge that programs such as PACER are limited in that they only seek to alleviate the issues associated with responding to an individual experiencing a mental health crisis within the community that is, at the pre-arrest stage. Hence, there is a limit to the positive impact that co-response teams can achieve in addressing the underlying issues associated with mental health crises, and the impact of the teams once an individual formally enters the criminal justice system. Indeed, Wood et al. (2011) have argued that initiatives can, and should, be implemented throughout ‘all stages’ of the police process to assist individuals experiencing a crisis and alleviate the burden of mental health crises on policing. Those stages are identified as prevention, pre-arrest and point of arrest (including transportation and custody; Wood et al., 2011).

Police detainees are an important group to consider as research indicates that the prevalence of mental illness in this population is high (Bashkeev et al., 2010; Bashkeev et al., 2012; Forsythe & Gaffney, 2012; Heffernan, Finn, Saunders, & Bryne. 2003). For example, Bashkeev et al. (2010) found amongst a sample of 150 police detainees that 25.4% had prior admission to a psychiatric hospital. Further to this, almost three quarters of the sample met the criteria for a diagnosable mental illness (Bashkeev et al., 2010). This is consistent with the findings of Forsythe and Gaffney (2012) who found, in a study involving 778 detainees, that between 43-55% reported being previously diagnosed with a mental illness.

Given the prevalence of mental illness within police detainee populations (Bashkeev et al., 2010; Ogloff et al., 2013), a number of researchers have argued that police custody may represent an important opportunity to direct those in need of mental health assistance to appropriate services in the community (Forsythe & Gaffney, 2012; Sirdfield & Brooker, 2012; Senior et al., 2014). Much of the research published in this area indicates that policy makers and researchers may need to revise or improve current practices in dealing with those experiencing a mental health crisis whilst detained by police. It appears that in most jurisdictions screening and treatment directives are undertaken by police officers with assistance from medical health staff (who are primarily trained in physical not psychological medicine; Ogloff, Davis, Rivers, & Ross, 2007). One potential strategy is to apply a co-response model equivalent to PACER within Police Watch Houses. If this were to occur, a
mental health practitioner would be on hand within Police Watch Houses to assist police officers in identifying and managing mental illness amongst police detainees.

Unlike police officers, mental health practitioners are formally trained and able to provide valid and reliable assessments of detainee mental health and associated risk. Unlike police, mental health practitioners are able to access health data pertaining to a persons’ mental health history which would not only assist in the assessment of the individual whilst in custody but may also enable contact with existing support services and access to existing treatment plans. Finally, the presence of a mental health practitioner within a Police Watch House would enable referral to community services. A number of detainees are released and returned immediately to the community, despite being in need of psychological assistance. A mental health practitioner’s knowledge of the services available, as well as their ability to refer an individual with a mental illness to an appropriate service, are likely greater than that of police.

Research exploring the utility of multidisciplinary responses to mental health crisis at all stages of the policing process aligns with the “all-stages” approach proposed by Wood et al. (2011). The WA Police Force is the first policing agency in Australia to implement a multiple stage co-response model which involves the placement of mental health practitioners;

- in the Police Operation Centre- to inform the deployment of police resources and assist police in their preparation for attendance at mental health related incidents,
- in District based co-response teams- to facilitate positive outcomes for consumers and police in the pre-arrest stage of the policing process, and;
- in the Perth Watch House- to ensure the appropriate assessment, management and referral of detainees experiencing mental health concerns post arrest, whilst in police custody.

The remainder of this report discusses the findings of the evaluation of the commissioning trial.
3. Police Operations Centre: The impact of a mental health practitioner

3.1 Introduction and overview

Police Operations Centres (POC) are communication facilities that manage calls for police assistance from the public and other parties. Therefore, a POC will receive calls, generate information reports, dispatch first responders and monitor officer attendance at the scene. The quality and depth of the information obtained by call takers and provided to dispatchers impacts significantly on the approach and response tactics that officers will employ to resolve the incident. Although call takers extract as much information from callers as possible, they will also search police information systems for additional information to inform officers of potential risks that will likely impact on the operational tactics employed. Therefore, police responses are limited by the nature of the information obtained by call-takers and held within information management systems. As the nature of information held by police is dependent on an individual, or an address having come to the attention of police in the past, the likelihood of prior warning that an incident involves an individual experiencing a mental health crisis is limited.

For this reason, there are obvious benefits to be derived from inter-agency collaboration (e.g., police and health) within the POC setting. Drawing on the experience of Queensland Police who implemented a Police Communications Centre Mental Health Liaison Service in January 2015 (Queensland Forensic Mental Health Service, 2016), the WA Police MHCR co-located a Department of Health, mental health practitioner within the WA Police Force POC as part of their MHCR model. This type of co-location was designed to facilitate immediate access to mental health advice, consultation, risk assessment information and crisis management for officers attending mental health incidents. The mental health practitioner operated from 2.00pm to 10.00pm and had access to the Department of Health Psychiatric Services On-Line Information System (PSOLIS), and other health databases. Therefore, the mental health practitioner was able to determine if an individual who was the focus of a police task, was known to mental health or health services, and if so, was able to provide risk assessment information to enhance police response to the incident. To isolate the effect of the MHCR trial, the POC mental health practitioner was tasked to perform this role only for mental health related tasks that occurred in test districts (NWM and SEM), unless the incident was high priority and a request was made by the Duty Inspector or Senior Supervisor. In this circumstance, POC staff were able to draw on the expertise of the mental health practitioner, irrespective of the location of the task.
Data provided by WA Police Mental Health Co-Response Unit (MHCRU; Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial, 22,376 Mental Health CAD tasks\(^8\) which occurred within trial districts were sent to the practitioners’ console. Of these tasks, 19,365 tasks were reviewed/actioned by the practitioner. A further 784 CAD tasks from outside trial districts were reviewed/actioned by the practitioner at the request of POC Inspectors/Supervisors. Data further indicates that, of the jobs reviewed since July 2016, 9% of persons were identified as currently active with Mental Health (n= 1607), 32% of persons were identified as having past history with Mental Health Services, but were not active clients at the time of the incident (n= 5806), 38% of persons were not known to mental health services (n= 6852), and 21% of persons in the CAD task were not able to be identified (n= 3675).

Despite the potential benefits associated with information sharing and co-location, it is important to acknowledge the possible challenges associated with an arrangement that requires employees who operate within very different organisational cultures to collaborate. Therefore, it is important to determine the impact of having a mental health practitioner placed at the POC.

3.2 Research design

A mixed methods approach was incorporated for the purposes of this research. During phase one of this research, semi-structured interviews were conducted by telephone or face to face with dispatchers, POC supervisors, POC management, and mental health practitioners assigned to the POC. Questions guiding the interview focused on perceptions of the impact of having a mental health practitioner based at the POC.

During phase two of this research, a survey was administered to staff within the POC to determine perceptions of role adequacy in responding to an individual experiencing a mental health crisis. The measure incorporated was derived from a subscale within the Work Practice Questionnaire, created by The National Centre for Education and Training on Addiction (NCETA), for use in the field of alcohol and other drugs (AOD). Within this context, role adequacy refers to workers’ confidence in their capacity to effectively respond to AOD issues (Clement, 1986; Shaw, Cartwright, Spratley & Harwin 1978). Judgements of role adequacy reflect perceived knowledge of, and level of skill in responding to AOD issues (Clement, 1986;

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[\(^8\) WA Police definition of Mental Health CAD task includes: Welfare Checks (Code 48); Missing Persons (Code 49); Mental Health Incident (Code 68).]
Shaw et al., 1978). Permission was obtained to adapt scale items to suit the mental health context. The NCETA report the reliability of the original scale as having an internal consistency of .91 and a test-retest reliability of .86 when retested after a 2 to 3-week interval. In addition to role adequacy, the Sellenger Centre Mental Health Survey assessed officer confidence, perceptions of training, knowledge, and perceptions of the value of a mental health practitioner to the work that they undertake.

Response officers in test districts were also surveyed, and interviewed, to ascertain their perceptions of the value of having a mental health practitioner located within POC to the work that they undertake. The mental health practitioner was tasked with adding relevant mental health related information to CAD entries for the purpose of better preparing response officers for their attendance at, and response to the task. This data, although collected within the district-based officer survey and interviews, is reported within this chapter as it relates to perceptions of the mental health practitioner within the POC.

### 3.3 Participants

**Phase 1: Semi structured interviews**

Four dispatchers, nine radio supervisors, seven team leaders/managers and two mental health practitioners consented to participate in this research. To ensure participant anonymity, demographic detail was limited to years of service (range; 9-40 years). Gender and rank was excluded due to the small number of managers overall, and the fact that senior female officers would clearly be identifiable.

**Phase 2: Survey participants**

Participants comprised 37 individuals located within the POC: 33 (89.0%) male and 4 (11.0%) female. The average age of participants was 48.81 years (SD= 9.50), ranging from 27 to 66 years. All participants were employed on a full time basis, 62.2% were sworn police officers whilst the remaining 37.8% were unsworn police staff. The substantive levels of sworn police officers were: Constable (2.7%), Senior Constable (32.4%), Sergeant (18.9%), Senior Sergeant (8.1%), Inspector (2.7%). The average length of service was 22.78 years.

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9 Percentages do not equal 100 due to missing data.
3.4 Procedure

*Phase 1: Semi structured interviews*

The ECU Human Research Ethics Committee approved the conduct of this research. To facilitate data collection in the first instance, the research team visited the POC on two separate occasions. The Officer in Charge of the POC facilitated participant recruitment by assigning a supervisor to approach staff and seek their consent to participate in an interview. On consenting to the interview, staff were directed to an empty office on POC premises where a member of the research team was waiting to conduct face to face interviews. As a supervisor had sought initial consent it was considered unlikely that participants would feel comfortable declining to participate, if in fact, they did not wish to take part in the research. For this reason, prior to the interview commencing, participants were informed by the member of the research team that they were not required to participate, and that if they preferred not to participate, they could return to work and their supervisor would not be informed. No participant declined to be interviewed.

When staff were not available on shift at the POC to participate in a face to face interview, the research team sent an email inviting staff to participate via a telephone interview. Any staff who were willing to participate were asked to indicate a suitable day and time for the interview to take place. The research team then called the participant at this pre-determined time to conduct the interview.

Interviews were recorded and transcribed verbatim. Interview length ranged from 10 to 41 minutes in duration. All identifying information was omitted from transcriptions. Thematic analysis was applied to facilitate the development of a rich description of perceptions. Analysis was iterative and data driven (Braun & Clarke, 2006) whereby themes and related sub-themes were identified inductively (Patton, 2002).

*Phase 2: Survey*

The WA Police Force circulated an email invitation to participate in this aspect of the research. A link to an on-line survey hosted by Qualtrics was provided within the body of the email invitation. An information letter appeared on the first page of the survey and outlined the purpose of the research. Those consenting to participate entered the survey, which took approximately 10 minutes to complete.
3.5 Findings and interpretations

3.5.1 Phase 1: Semi structured interviews

Perceptions of the impact of having a mental health practitioner located at the POC could be characterised by four distinct themes; co-location and organisational cultures, validity of decision making, resource efficiencies, and reduced risk. A call to the POC was characterised as the first stage of the police response process. Therefore, any activity or decision making occurring at this stage impacts significantly on outcomes for both the person experiencing a mental health crisis and first responders. These themes are illustrated in Figure 3 below.

Figure 3: Impact of a mental health practitioner in the POC - Core themes

Co-location and organisational cultures

Valid/informed decision making

Resource efficiencies

Reduced risk for all parties

Co-location and organisational cultures

Participants perceived Mental Health Co-Response (MHCR) as a genuine collaboration between health and police- two entities that operate within a necessarily rigid and strict policy framework with distinctly different organisational cultures. Police and health were described historically as being at odds with one another, each feeling that the other was obstructing the process and being deliberately difficult. However, since MHCR was implemented, participants had come to realise that reactions originally characterised as obstructive, were simply individuals following the directives imposed by organisational processes. For example, a mental health practitioner indicated;

In the past, when police followed a process, we would assume they were blocking or being obstructive...but they are not...they are following the process they have been told to follow. Now I have a much better understanding of the other agencies perspective...and the same goes for police about health...in the past,
police called health and expected them to fix the situation but they couldn’t…Police often got frustrated, but now they understand that health doesn’t have powers under the Mental Health Act

As a result of this understanding, participants described the slow, but steady development of collegial and productive working relationships. The development of productive working relationships was described as slow due to a lack of communication upon roll out of the MHCR model and the initial placement of the mental health practitioner within the POC. In terms of communication, participants consistently articulated, “typical WAPOL, let’s just drop it on ya, give you no information about it…you hear all the rumours and everything else and eventually you’ll figure out why that strange person is sitting there.” In terms of placement, the mental health practitioner was initially placed in a separate office within the POC. Participants perceived this as creating a divide and provided little opportunity for engagement. During this period, the mental health practitioner was described as operating within an “oppressive and isolating environment.”

Managers described observing this lack of engagement and responded by bringing the mental health practitioner on the floor as part of the POC team. Managers were of the view that “people are far more likely to engage in conversation if they can walk past you without having to come into an office to do so. The move was about work environment and encouraging engagement.” This initiative was described as having an immediate and positive impact. More importantly, knowledge transfer started to occur because of general conversations amongst staff about particular incidents and scenarios. For example, one participant indicated, “Yeah because you’ll have a general conversation. I may have a question…won’t walk into the office to ask but I will ask whilst walking past- here’s a scenario, what do you think?” In describing the benefits of co-location and the collegial working environment another participant stated:

I think they add a different perspective to conversations, they are very willing and open to share their professional knowledge, about and personality disorders um so they’re almost, though osmosis, they’re helping to upskill us because they are sharing what they know and we are just picking that up through informal conversations because we’re working alongside them. So we’re learning indirectly and directly from them.

Participants were clear in their view that a blended organisational culture had developed under MHCR, as stated by one participant; “It’s a real harmonious thing- all working together… [it’s] creating harmony across interagency - rather than working in silos”. The shared understanding of different operational frameworks and collegial “team” approach
facilitated significant and positive outcomes in relation to process and for the community. Processes were described as more streamlined due to the assistance of the mental health practitioner. As an example, participants described regularly receiving referrals for the escort of a mental health consumer without the paper work required by police. In the past, this would require police to explain what was required from their perspective, which resulted in push back from health, leading to the fracturing of relationships. Under MHCR, POC staff discussed the issue with the mental health practitioner who liaised with health to ensure that the correct paper work was submitted. The practitioners understanding of health policies and systems meant that any issues were resolved in a timely fashion. As stated by one participant, Health would then;

...fax the correct paperwork through, I put a job on for them. It helps them because it is completed in a timely manner and they get the escort that they desire. I get the paper work that I need, put that on the database and file it. Everyone’s happy. Job completed- makes it easy.

The implementation of streamlined processes was described as benefiting consumers as their needs were being met in a timely and efficient manner. Interagency collaboration was also described as better servicing the community in general. As stated by one participant:

My personal view is that one of the biggest barriers that have we have to really servicing the community is the fact that all of our agencies work in competition with funding, with all sorts of things, I’ve seen a lot of people high up in different agencies that are very power hungry and it’s all about them, and their agency and their career path and all those sorts of things and I think having MHPs in the office, is actually working at the ground level to dissipate that to actually create a whole of government team approach to things.

Valid/informed decision making

Participants described the greatest benefit of the mental health practitioner within the POC was the value of the information provided and the subsequent impact on decision making. When call takers received calls and had a suspicion, but limited evidence of the need for a higher priority, they described asking the mental health practitioner for information and advice. For example;

When we see a job come in and it looks like it’s a regular... [we] ... see if there’s something they can find out so we can prioritise it higher or differently. We can start chasing the JH600 car with the mental health practitioner in it to see when
they are on duty, or get someone out there now or work out if we can hold off for 45 minutes until they come on afternoon shift.

Despite the value of the additional information provided by the mental health practitioner, participants were clear in their view that more mental health practitioners were required for longer durations (e.g., 24 hours, 7 days per week). Participants described being frustrated when informed decisions could only be made at certain times during the day, or in districts where Mental Health Co-Response Mobile Teams (MHCRMTs) were available. As described by one participant, “it’s frustrating as all buggery when you’re on a district where there isn’t that availability and you’re going wow, this would be gold if we had the mental health car in this district and they’re not.” Although participants indicated that they could still contact crisis care phone lines to source relevant information when the POC mental health practitioner was not on duty, this was perceived as “just a waste of time,” due of the sheer volume of jobs on the system, and the fact that the help line was perceived to be under staffed. Participants described feeling comforted in the knowledge that when the mental health practitioner was on duty and a request for a welfare check raised red flags, “we’ve got those guys and can ask them to run the name as a priority and then get a car out there.” As articulated succinctly by one participant:

We try to connect the dots, and now we have a really big dot! Oh, he was only released from Graylands two weeks ago? Started binging on medications? Then we should prioritise over Mary Brown, whose neighbour is concerned because two newspapers are on the doorstep.

Resource efficiencies

Participants also described the presence of a mental health practitioner at the POC had a direct and positive impact on efficient resource allocation. Although this theme was similar in context to that of decision-making regarding risk, it could be distinguished by an added emphasis on perceptions of the appropriateness of resource allocation. For example, welfare checks were described as impacting significantly on police resources. As one participant articulated, “We’re not doing crime, we’re the welfare police. Believe me. You have no concept

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10 In order to isolate the effect of the MHCR trial, the POC mental health practitioner only reviewed/actioned tasks that occurred in test districts (NWM and SEM), unless the incident was high priority and a request was made by the Duty Inspector or Senior Supervisor.
of the amount of time we are spending backstopping other agencies on work that really isn’t our core business.” Participants described that prior to MHCR, response officers were routinely dispatched to incidents where individuals were behaving in an abnormal manner. Officers were then required to make a judgement call, based on limited knowledge of mental health, as to whether they were able to leave the individual in their home or transport them to an ED. This was described as a significant risk to the police officer who would not likely have the knowledge, or the life experience to make the judgement call that was required of them, and the individual experiencing a mental health crisis. As such, this scenario would likely lead to the misallocation of limited resources as officers were most likely to transport the individual to hospital to enable a trained medical practitioner to make a determination about the individual’s wellbeing. As such, those officers would have likely been held up in an emergency department for hours, after transporting an individual who may well have been able to remain at home.

Participants described the situation with MHCR in place very differently. Although it is unlikely that a decision as to whether an individual should be transported or not, could be made solely on the basis of information on the mental health database, this information is of great benefit in assessing the situation. Under MHCR, the mental health practitioner reviews CAD, then interrogates health systems to add relevant information for officers attending;

No known mental health. Bingo! Officers now know when they go there that there is no known history to be aware of. That helps a lot.” Or, “Let’s get a MHCRMT there, rather than trying to cart people or wait for St. Johns.

Information provided by the mental health practitioner was also able to inform resource allocation in terms of the priority of jobs, and the number of response units that would likely be required at a particular task. In this way, resource allocation was better informed and appropriate to the level of risk associated with the task.

Reduced risk for officers and mental health consumers

The ultimate outcome attributed to the presence of a mental health practitioner at the POC was described as a reduction in risk for both individuals experiencing a mental health crisis, and police officers. For example, the mental health practitioner was described as consistently reviewing CAD and adding succinct and relevant information that had saved lives. One participant described a circumstance where on the initial job, the attending vehicle left the scene as it appeared that no-one was home. Information was added by the mental health
practitioner, prompting a MHCRMT to be dispatched. On arrival, the MHCRMT “forced entry and found the person subject of an overdose in the house.” As the MHCR model has evolved, reviewing CAD was described as occurring in live time, so “we’re getting relevant information even before we attend the scene.” The timeliness of information was described by participants as the critical component.

The reduction of risk for police officers was described as multidimensional. Participants described one form of risk to be officer mental health and well-being. More specifically, because police officers were attending incidents with the knowledge that they had all relevant information from the mental health practitioner, the trauma they experienced was lessened when the outcome of an incident was negative. As one participant articulated, “It is traumatic for officers. Second guessing themselves- you can imagine. They have gone there, made a decision, and someone has taken their life.” The information provided by the mental health practitioner located at the POC was also described by participants as reducing physical risk for police officers. For example, “having knowledge before the job- this person is prone to hiding weapons so be careful to ensure the safety of bystanders and ourselves. It helps with decision making. The plan will be to take the person down really quickly.” This also eased the pressure experienced by dispatchers who felt a sense of responsibility for responding officers. For example, as described by one dispatcher:

Anything that improves the safety of my guys on the street is a bonus. So if there is a history of mental health issues, history of violence with that mental health issue, particularly if there are weapons involved, the more information that I can make sure the guys have has gotta be a benefit... My primary role is not just to press the button and send the information to the tasking units, it’s to do my level best to get the information that will help them and the clinician has proved great value in that because obviously they have access to information that we don’t.

3.5.2 Phase 2: Survey

The survey of POC staff sought to determine perceptions of role adequacy, confidence and decision making of staff within POC. Perceptions of training and the presence of a mental health practitioner within the POC were also examined.
Role Adequacy

Survey findings for participant perceptions of role adequacy are shown in Table 1 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 1: POC staff perceptions of role adequacy

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree to which participants perceive they have the necessary experience to respond to mental health related tasks</td>
<td>3.68</td>
<td>1.23</td>
</tr>
<tr>
<td>Degree to which participants have responded to a wide range of mental health tasks</td>
<td>4.14</td>
<td>1.21</td>
</tr>
<tr>
<td>Degree of confidence participants have in their ability to respond to mental health related tasks</td>
<td>3.86</td>
<td>1.25</td>
</tr>
<tr>
<td>Degree to which participants perceive they have the necessary knowledge to help people with mental health related tasks</td>
<td>3.54</td>
<td>1.26</td>
</tr>
<tr>
<td>Degree to which participants perceive they do not have the skills necessary to respond to mental health related tasks</td>
<td>2.38</td>
<td>1.19</td>
</tr>
<tr>
<td>Degree to which participants perceive they are able to respond as competently to those with mental health related issues</td>
<td>3.38</td>
<td>1.32</td>
</tr>
<tr>
<td>Combined Total Role Adequacy</td>
<td>3.70</td>
<td>1.00</td>
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</table>

As shown in Table 1, participants somewhat disagreed that they do not have the skills necessary to respond to mental health related tasks (M=2.38), suggesting a level of perceived skill in this area. Furthermore, participants neither agreed, nor disagreed that they had the necessary experience to respond to mental health related tasks (M=3.68), that they were confident in their ability to respond to mental health related tasks (M=3.86), that they have the necessary knowledge to help people with mental health related tasks (M=3.54), or that they were able to respond as competently to those with mental health related issues as those without (M=3.38). However, participants somewhat agreed that they had responded to a wide range of mental health tasks (M=4.14).
Confidence

Survey findings for participant confidence in addressing mental health incidents are shown in Table 2 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 2: POC staff confidence

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence in ability to identify a person suffering a mental health issue</td>
<td>3.97</td>
<td>0.99</td>
</tr>
<tr>
<td>Confidence in ability to identify a person suffering a drug induced mental health issue</td>
<td>3.89</td>
<td>0.90</td>
</tr>
<tr>
<td>Confidence in ability to manage an incident involving a person with a mental health issue</td>
<td>3.89</td>
<td>1.05</td>
</tr>
<tr>
<td>Confidence in ability to communicate during an incident involving a person with a mental health issue</td>
<td>4.00</td>
<td>1.09</td>
</tr>
<tr>
<td>Confidence in ability to negotiate during an incident involving a person with a mental health issue</td>
<td>3.63</td>
<td>1.19</td>
</tr>
<tr>
<td>Confidence in ability to de-escalate an incident involving a person with a mental health issue</td>
<td>3.66</td>
<td>1.03</td>
</tr>
<tr>
<td>Confidence in decision making during an incident involving a person with a mental health issue</td>
<td>3.97</td>
<td>1.01</td>
</tr>
<tr>
<td>Combined Total Perceived Confidence</td>
<td>3.86</td>
<td>0.99</td>
</tr>
</tbody>
</table>

As shown in Table 2, POC staff indicated ambivalent views as to their ability to manage mental health related tasks. On average, participants neither agreed nor disagreed that they felt confident in their ability to identify a person suffering a mental health issue (M=3.97), neither agreed nor disagreed that they were confident in their ability to identify a person suffering a drug induced mental health issue (M=3.89) and neither agreed nor disagreed that they were able manage an incident involving a person with a mental health issue (M=3.89). Participants also neither agreed nor disagreed that they were able to negotiate during an incident involving a person with a mental health issue (M=3.63), de-escalate an incident involving a person with a mental health issue (M=3.66) and neither agreed nor disagreed that they had confidence in their decision making during an incident involving a person with a mental health issue (M=3.97). However, POC staff somewhat agreed that they felt confident in their ability to communicate during an incident involving a person with a mental health issue (M=4.00). This sense of ambivalence might reflect the fact that POC staff are somewhat detached from (i.e., not physical engaged in) the incident.
Training

Survey findings for participant perceptions of training are shown in Table 3 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 3: POC staff perceptions of training

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA Police training on how to respond to people experiencing a mental health issue is perceived as adequate</td>
<td>2.51</td>
<td>1.22</td>
</tr>
<tr>
<td>Participant perceptions of the adequacy of training for responses to mental health incidents</td>
<td>2.20</td>
<td>1.18</td>
</tr>
<tr>
<td>Combined Total Training</td>
<td>2.36</td>
<td>1.15</td>
</tr>
</tbody>
</table>

As shown in Table 3, POC staff on average somewhat disagreed that WA Police training on how to respond to people experiencing a mental health issue was adequate (M=2.51) and that training for responses to mental health incidents was adequate (M=2.20).

Perceptions of a mental health practitioner within POC

POC staff perceptions

All participants in the POC had noticed the addition of mental health related information on CAD entries as jobs were dispatched. However, participants neither agreed, nor disagreed that the addition of mental health information had influenced their decision making in dispatching the task (M=3.82). Despite this, participants somewhat agreed that the mental health related information was valuable to their decision making in dispatching the task (M=4.21).

Of all participants, 81% had specifically requested information from the mental health practitioner in the POC and participants somewhat agreed that this information influenced their decision making (M=4.12) and was valuable to their decision making on the task (M=4.18). The difference in findings between questions relating to information initiated by the practitioner (presented in the paragraph above) versus information requested by the police (presented in the preceding sentence) suggests there is greater value in police-initiated requests for information, as opposed to practitioner-initiated offers of information. Overall, participants somewhat agreed that there was value in having a mental health practitioner in the POC adding information to CAD entries (M=4.70).
Participants were also asked to provide feedback in relation to the presence of the mental health practitioner in the POC via an open ended, free narrative question. Twenty-six participants provided a response to the question. Qualitative responses were reduced to key words and phrases and frequencies and coded by two members of the research team. Inter-rater reliability, calculated via Cohen’s kappa, demonstrated an ‘almost perfect’ level of agreement in the codes assigned to qualitative responses (κ = 0.91; Landis & Koch, 1977). The nature and frequency of key responses are shown in Table 4 below. The most frequent feedback provided by participants related to the value of information provided by the POC mental health practitioner.

Table 4: Nature and frequency of qualitative feedback responses – POC staff

<table>
<thead>
<tr>
<th>Nature of response</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP in POC is valuable in terms of providing information</td>
<td>14</td>
<td>45.2</td>
</tr>
<tr>
<td>MHP in POC is valuable (value specified, e.g., ‘saves a great deal of time’, ‘assists the safety of officers’, ‘influences priority of dispatch’)</td>
<td>3</td>
<td>9.7</td>
</tr>
<tr>
<td>MHP in POC is valuable (value unspecified, e.g., ‘it’s great’ or ‘it’s necessary’, ‘it’s invaluable’)</td>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>Role needs to be expanded (e.g., need 24/7 coverage)</td>
<td>5</td>
<td>16.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>31</strong></td>
<td></td>
</tr>
</tbody>
</table>

Test District police officer perceptions of the mental health practitioner within POC

Response officers within the test districts were also asked about the information provided by the POC mental health practitioner on CAD entries. The majority of participants (70.2%) had noticed the addition of mental health related information on CAD entries as jobs were dispatched. However, participants neither agreed, nor disagreed that the addition of mental health information had influenced their decision making on the task (M=3.30), or was valuable to decision making on the task (M=3.46). Of all participants, 45.0% were aware that there was a mental health practitioner located in the POC adding information to CAD entries, and participants somewhat agreed that there was value in having a mental health practitioner in the POC adding mental health information to CAD entries (M=4.23).

Response officers within the test districts were also asked to provide feedback in relation to the presence of the mental health practitioner in the POC via an open ended, free narrative question. Seventy-three participants provided a response to the question. Qualitative responses were reduced to key words and phrases and frequencies and coded by two members

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11 Total (31) > N (26) as multiple codes were assigned to individual responses as required
of the research team. Inter-rater reliability, calculated via Cohen’s kappa, demonstrated an ‘almost perfect’ level of agreement in the codes assigned to qualitative responses (κ = 0.88; Landis & Koch, 1977). The nature and frequency of key responses are shown in Table 5 below. The most frequent feedback provided by participants was that the mental health practitioner in the POC was not of value because the information loaded onto CAD was not relevant/useful/current/correct.

Table 5: Nature and frequency of qualitative feedback responses- District staff regarding POC

<table>
<thead>
<tr>
<th>Nature of response</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP in POC is valuable (value specified- e.g., ‘invaluable to police safety and decision-making’, ‘frontline assistance’ ‘assists inter-agency work’)</td>
<td>11</td>
<td>13.7</td>
</tr>
<tr>
<td>MHP in POC is valuable (value unspecified- e.g., ‘it’s good’)</td>
<td>12</td>
<td>15.0</td>
</tr>
<tr>
<td>MHP in POC is valuable/nice to have but does not impact decision-making in the moment (e.g., useful for history but need to deal with crisis at hand).</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>MHP in POC is not useful/helpful as the information loaded onto CAD is not relevant/useful/current/correct</td>
<td>13</td>
<td>16.2</td>
</tr>
<tr>
<td>Not aware there was a MHP in the POC</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Perceived benefit; e.g., ‘appears to be essential’, ‘seems like a great idea’ (in these cases the respondent did not appear to have any experience with the MHP but perceived it to be a good idea)</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Role needs to be expanded (e.g., need 24/7 coverage)</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>Suggested change to/expansion of duties (e.g., look at other job codes/ add info prior to dispatch/take calls from the field)</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Suggested expansion to frontline (e.g., need more MHCR cars in the district)</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>80</strong></td>
<td></td>
</tr>
</tbody>
</table>

3.6 Conclusion

The qualitative findings of this research support the notion of a relationship between the nature of information held in police information management systems and the effectiveness of police responses to calls for assistance. The form of inter-agency collaboration that has eventuated under MHCR has led to the development of a hybrid organisational culture whereby a health/police team works independently (e.g., each has their own expertise), yet collaboratively (e.g., effective team approach) to increase the likelihood of valid decision making, and the appropriate allocation of limited police and health resources. The ultimate outcome, is reduced risk to individuals experiencing a mental health crisis and reduced risk to

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12 Total (80) > N (73) as multiple codes were assigned to individual responses as required
police officers. Given these outcomes, participants felt it was important to consider the nature of current shift rotations (e.g., 2.00pm to 10.00pm) as “unfortunately people threaten suicide 24 hours of the day, not between the hours of 2 to 10.”

The quantitative findings of this research showed that POC participants’ perceptions of role adequacy were ambivalent, in the sense that they neither perceived themselves to be adequate or not adequate. POC participants also neither agreed nor disagreed that they were confident in their ability to manage mental health related tasks. This may be because POC staff are somewhat detached from the management of incidents that occur on the ground. Furthermore, POC participants neither agreed, nor disagreed that mental health information on CAD entries had influenced their decision making in dispatching a task. However, when POC participants sought information from the mental health practitioner, the information provided somewhat influenced decision making and was considered valuable to decision making. Qualitative responses from the survey administered to POC participants emphasised the value of the information provided by the mental health practitioner to decision making. However, it is important to note that frontline police officers neither agreed nor disagreed that the additional information available on CAD entries influenced decision making on the task, or was valuable to decision making on the task. Qualitative feedback indicated that this was because the information that was added to CAD was not relevant, or useful for the task, was not current and/or was not correct. It is understood that information sharing protocols between police and health have been a key issue throughout the trial. Information sharing is limited due to legislative requirements and so any change to the nature of information exchanged would require legislative change. This indicates the need for clear communication strategies, outlining to frontline police, the nature of information that can be provided and why. Despite this, frontline police officers still saw value in having a mental health practitioner located within the POC.
4. Mental Health Co-Response: A district level view

4.1 Introduction and overview

Deinstitutionalization has been characterized as the most significant development in the history of mental health care (Moffet, 1988). The change to service provision acknowledged the right of those with mental illness to live in the community by shifting the setting of mental health service delivery from institutions to the general community (Maude, 1996; OPI, 2012). Whilst the implementation of this approach to mental health care recognised the rights of those with a mental illness, there were a number of negative, unforeseen outcomes (Lamb & Bachrach, 2011). The nature of these outcomes; high rates of homelessness, drug and alcohol use, poverty, victimization and criminalization (Lamb & Bachrach, 2001), has resulted in increasing police contact and management of individuals experiencing mental illness in the community (Godfredson, Ogloff, Thomas, & Luebbers, 2010; Godfredson, Thomas, Ogloff, & Luebbers, 2011). Early research from New South Wales indicated that approximately 10% of work volume was attributed to the management of individuals experiencing mental illness, (Fry et al., 2002) and research from New Zealand found that 8.6 per cent work volume was attributed to the management of this cohort (Drew & Badger, 1999). More recent research conducted in Victoria showed that of all contacts/encounters with community members each week (who may be offenders, victims, witnesses or vulnerable people), 20 per cent were perceived by officers to be mentally ill (Godfredson et al., 2011).

Although a significant proportion of police work now seems to involve the management of those experiencing mental health crises, research suggests that police feel ill-equipped to deal with such encounters. For example, research conducted with Victoria Police has shown that officers experience difficulty, “(1) gaining support from mental health services; (2) communicating with the mentally ill; (3) avoiding violence/aggression; and (4) cooperation and compliance” (Godfredson et al., 2011, p188). A suggested consequence of failing to equip officers with the skills required to effectively manage those experiencing a mental health crisis is the excessive or unnecessary use of force. This was evident in Victoria where an increase in fatal police shootings was attributed to increased encounters with aggressive, individuals experiencing a mental health crisis (Prenzler, Porter, & Alpert, 2013).

Given the negative outcomes associated with police management of individuals experiencing a mental health crisis, a variety of strategies have been trialled, both internationally and nationally, to enable better police response to mental health consumers. One common approach is the provision of specialist training for officers in managing situations which involve an individual who is experiencing a mental health crisis. One such model, the
Memphis Model (or Crisis Intervention Team Model) was implemented in 1988 in Memphis, Tennessee following a police shooting of an individual with a mental illness (Compton, Bahora, Watson & Oliva, 2008). The program involves 40 hours of training in de-escalation and the effective handling of situations involving an individual who is experiencing a mental health crisis (Compton, et al., 2008). Upon completion of training, officers form part of a Crisis Intervention Team (CIT). The CIT responds to all incidents involving individuals experiencing a mental health crisis with the purpose of assessing the situation, de-escalating and referring and transporting to appropriate mental health services (Steadman, Deane, Borum & Morrissey, 2000). The model has been demonstrated to eventuate in low arrest rates and high rates of referral to mental health services (Steadman et al., 2000).

In New South Wales, a similar model, the Mental Health Intervention Team (MHIT) was implemented in 2008 (NSW Police Force, n.d.). The model involves a four day, intensive training course aimed at improving police response to individuals experiencing a mental health crisis. Training focusses on communication, de-escalation skills, and risk assessment, as well as providing officers with insight in to the lived experience of mental health consumers and their carers (NSW Police Force, n.d.). Evaluation of the model demonstrated improved officer confidence in dealing with mental-health consumers which was associated with a willingness to engage with and work towards improved outcomes for the individual (e.g., de-escalation of the situation; (Herrington & Pope, 2011).

More recent developments in police response to those experiencing a mental health crisis has involved collaborative, inter-agency initiatives between police and health agencies. Given the recognized importance of developing evidence based frameworks that facilitate the development of models of best practice, many of these initiatives have also been subject to extensive evaluation. Relevant models are summarised below:

**The Birmingham Model**

This model was developed in Birmingham, Alabama and involved the development of a team of community service officers (i.e., mental health clinicians) who assisted police with the management of incidents involving persons experiencing mental illness. The community service officers were not sworn police officers and merely provided assistance in terms of crisis intervention, follow up and referral (Steadman et al., 2000). This model has been demonstrated to eventuate in low arrest rates, with the majority of matters being resolved at the scene of the incident (Steadman et al., 2000).
The Knoxville Model
This model was developed in Knoxville, Tennessee and formed part of a statewide response and sat alongside the Memphis Model. In this particular jurisdiction, a mobile crisis unit was formed for the purpose of responding to incidents involving individuals experiencing a mental health crisis. Within this jurisdiction, the unit also responded to incidents involving mental illness within the Prison setting (Steadman et al., 2000). This model has been demonstrated to eventuate in low arrest rates and high rates of referral to specialist mental health services (Steadman et al., 2000).

Police, Ambulance and Clinical Early Response Model (PACER)
This model was developed and implemented in Victoria, Australia, in 2007. A co-responder unit was formed, which consisted of a police officer and mental health clinician. The co-responder units were secondary responders to incidents involving individuals experiencing mental health crises and provided mental health assessments at the site of incident. Both health and police data were incorporated on site to determine how the incident should be managed and resolved (OPI, 2012). This model has been shown to improve the speed at which mental health assessments are conducted, to increase the range of mental health services made available to the individual experiencing a mental health crisis and to reduce the need to draw upon the services of already overloaded emergency departments (OPI, 2012).

The WA Police Force Mental Health Co-Response (MHCR) Model
The WA Police Force MHCR model constitutes a modified version of the PACER model. This hybrid model consists of the placement of a mental health practitioner in the Police Operations Centre (discussed in Chapter 3 of this report), in the Districts as part of a Mental Health Co-Response Mobile Team (MHCRMT), and in the Perth Watch House (discussed in Chapter 5 of this report). This chapter discusses the impact of having a mental health practitioner in the Districts co-responding alongside police to incidents involving an individual experiencing a mental health crisis.

The role of the mental health practitioner within the MHCRMTs was to (a) perform initial clinical and risk assessments on consumers using the mandated State-Wide Standardised Clinical Documentation (SSCD), (b) conduct checks on the mental health database (PSOLIS) and hospital medical records, (c) determine the consumers mental health needs and level of
urgency, and to (d) complete appropriate documentation. Where urgent mental health intervention was required, necessitating transportation to a medical facility for assessment, the mental health practitioner was responsible for enacting Mental Health Act Forms (Transport Order) and arranging the most appropriate form of transportation. The mental health practitioner was also responsible for (a) interventions at the scene, (b) referrals to mental health services and other treatment and support services, (c) liaising with medical staff/ triage at Emergency Departments to advise of pending presentations, and for (d) liaising with Mental Health Inpatient Units for direct admission as required. The mental health practitioner provided assistance to co-response police officers, as well as non-MHCR officers who contacted the team for advice/assistance.

Data provided by WA Police Mental Health Co-Response Unit (Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial, SEM and NWM MHCRMTs attended:

- 2907 mental health tasks\(^{13}\) in which the consumer was engaged,
- 1014 mental health tasks where consumer was not engaged (e.g., unable to locate, resolved without attendance),
- 737 non-mental health welfare checks, and;
- 1226 non-mental health police tasks.

Furthermore, MHCRMTs received 1019 requests for advice/assistance from other WA Police response units (recorded since May 2016).

The purpose of this element of the research was to consider the impact of mental health practitioners, co-responding to mental health tasks, alongside police.

### 4.2 Research design

A mixed methods approach was incorporated for the purposes of this research. During phase one of this research, semi-structured interviews were conducted by telephone or face to face with MHCRMT practitioners and police officers and their managers, and non-MHCR police officers in test districts.

During phase two of this research, a survey was administered to police officers in test and control districts to determine perceptions of role adequacy in responding to an individual experiencing a mental health crisis. The measure incorporated was equivalent to that described

\(^{13}\) WA Police definition of Mental Health CAD task includes: Welfare Checks (code 48); Missing Persons (code 49); Mental Health Incident (code 68).
in Chapter 3. In addition to role adequacy, confidence, perceptions of training and perceptions of the value of a mental health practitioner to the work undertaken (for test districts) were assessed.

During phase three of this research, incident data was collected for all jobs involving an individual experiencing a mental health crisis. Data was collected quarterly using an incident survey, for a two-week duration, across a 12-month period in both the test and control districts. A pilot run of incident data collection occurred in 2016. Those data did not form part of data analysis. The schedule of data collection is shown in Table 6 below.

Table 6: Schedule of incident data collection

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Test Districts</th>
<th>Control Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Pilot December</td>
<td>Incident data collected for 3 weeks</td>
<td>Incident data collected for 3 weeks</td>
</tr>
<tr>
<td>2017</td>
<td>20/03/2017-02/04/2017</td>
<td>Incident data collected for 2 weeks</td>
<td>Incident data collected for 2 weeks</td>
</tr>
<tr>
<td>2017</td>
<td>05/6/2017-18/06/2017</td>
<td>Incident data collected for 2 weeks</td>
<td>Incident data collected for 2 weeks</td>
</tr>
<tr>
<td>2017</td>
<td>28/08/2017-10/09/2017</td>
<td>Incident data collected for 2 weeks</td>
<td>Incident data collected for 2 weeks</td>
</tr>
<tr>
<td>2017</td>
<td>27/11/2017-10/12/2017</td>
<td>Incident data collected for 2 weeks</td>
<td>Incident data collected for 2 weeks</td>
</tr>
</tbody>
</table>

As MHCRMTs operated on a 2.00pm to 10.00pm shift 6 days per week Monday to Saturday, data collected by non-MHCR during the hours of 2.00pm to 10.00 pm only were included in statistical analyses. Data collection was scheduled quarterly to control for potential seasonal and shift variations and to ensure the sample size for the MHCRMTs was adequate to enable statistical analysis.

Relevant categories of incident details collected are shown in Table 7 below.
Table 7. Categories of incident data collected

<table>
<thead>
<tr>
<th>Categories</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td>Response unit</td>
</tr>
<tr>
<td></td>
<td>PD number</td>
</tr>
<tr>
<td></td>
<td>Task type (provide advice/scene attendance)</td>
</tr>
<tr>
<td>Job details</td>
<td>CAD number</td>
</tr>
<tr>
<td></td>
<td>Job initiated by</td>
</tr>
<tr>
<td></td>
<td>Job type</td>
</tr>
<tr>
<td></td>
<td>Attend address</td>
</tr>
<tr>
<td></td>
<td>First responders?</td>
</tr>
<tr>
<td>Time analysis</td>
<td>First response call sign</td>
</tr>
<tr>
<td></td>
<td>Time arrive</td>
</tr>
<tr>
<td></td>
<td>Time clear task</td>
</tr>
<tr>
<td></td>
<td>Total time task</td>
</tr>
<tr>
<td></td>
<td>MHCR Mobile Team time dispatched</td>
</tr>
<tr>
<td></td>
<td>Time arrive</td>
</tr>
<tr>
<td></td>
<td>Time clear task</td>
</tr>
<tr>
<td></td>
<td>Total time task</td>
</tr>
<tr>
<td></td>
<td>Other police units required?</td>
</tr>
<tr>
<td></td>
<td>MHCR mobile team actions</td>
</tr>
<tr>
<td></td>
<td>MHCR mobile team outcomes</td>
</tr>
<tr>
<td>Transportation</td>
<td>Transported?</td>
</tr>
<tr>
<td></td>
<td>Reason for transportation</td>
</tr>
<tr>
<td></td>
<td>Where transported</td>
</tr>
<tr>
<td></td>
<td>Who transported</td>
</tr>
<tr>
<td>Hospital attendance</td>
<td>Conveyed to</td>
</tr>
<tr>
<td></td>
<td>Time arrived at location</td>
</tr>
<tr>
<td></td>
<td>Time departed location</td>
</tr>
<tr>
<td></td>
<td>Total time MHCR team at location</td>
</tr>
<tr>
<td>Police outcome</td>
<td>Outcome type</td>
</tr>
<tr>
<td>Consumer information</td>
<td>SID number</td>
</tr>
<tr>
<td></td>
<td>Date of birth</td>
</tr>
<tr>
<td></td>
<td>Age</td>
</tr>
<tr>
<td></td>
<td>Adult/juvenile</td>
</tr>
<tr>
<td></td>
<td>Mental health history disclosed by</td>
</tr>
<tr>
<td></td>
<td>Suspected drug/alcohol use</td>
</tr>
<tr>
<td>Use of force</td>
<td>Force applied</td>
</tr>
<tr>
<td></td>
<td>Type of force</td>
</tr>
<tr>
<td></td>
<td>Injury to consumer</td>
</tr>
<tr>
<td></td>
<td>Injury to officer</td>
</tr>
<tr>
<td></td>
<td>Injury to another person</td>
</tr>
<tr>
<td></td>
<td>Additional information?</td>
</tr>
</tbody>
</table>

4.3 Participants

Phase 1: Semi structured interviews

Interviews were conducted in 2016 and 2017. In 2016 interviews were conducted with nine police officers working as part of a MHCRMT and five mental health practitioners. In
2017 interviews were conducted with 11 MHCR officers and eight mental health practitioners. Eight managers were also interviewed (from police and health) as were 12 non MHCR police officers from test districts. To ensure participant anonymity, demographic detail was limited to years of service (range; 0.5-42 years). Gender and rank was excluded due to the small number of managers overall, and the fact that senior female officers would be clearly identifiable.

**Phase 2: Survey**

Participants comprised 402 police officers from control (N=206) and test districts (N=196): 302 (75.0%) male and 100 (25.0%) female. The average age of participants was 39.85 years ($SD= 10.459$), ranging from 20 to 64 years. The proportion of full time police officers was 96.0% and part time was 4.0%. The substantive level of participants was: Constable (26.9%), First Class Constable (16.2%), Senior Constable (34.8%), Sergeant (18.7%), Senior Sergeant (3.2%) and Inspector (0.2%). The average years of service was 11.8. The work location of participants was: Response Teams (31.6%), Local Policing Teams (41.0%), District Control Centre (7.0%), Mental Health Co-Response (3.2%) and other (17.1%; e.g., Detectives).

**Phase 3: Incident data**

Over the period of data collection shown in Table 6, 3491 jobs were identified as ‘MH-related’ on CAD. To be identified as ‘MH-related’ and relevant to the MHCR trial, incidents needed to occur in the metropolitan area and meet the following inclusion criteria:

- All 68 Mental Health incidents.
- Any 49 Missing Person, 48 Welfare Checks and 44 Escort incidents that referenced one or more key terms such as ‘mental’, ‘psych’, ‘referral’, ‘Form 1’, ‘Form 3’, ‘Form 4’, ‘suicide’, ‘self-harm’.
- Any incident with disposition ‘MH’.

An additional 257 incidents were identified as ‘Additional CAD incidents’, which were not identified through the CAD. Instead, these jobs were identified by officers attending an incident who subsequently identified that mental health was a relevant factor and so completed an incident survey. This equates to a total of 3748 potential incidents. The MHCR Unit (MHCRU) identified that of these incidents 1844 were suitable for inclusion in the research and required a MHCR incident survey to be completed. A total of 1425 of these forms were received by

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14 Inclusion criteria were determined by the Mental Health Co-Response Unit.
15 A member of the Co-Response Unit personally interrogates all the tasks. Then using the criteria on the survey sheets:
the MHCRU from control locations and a total of 328 incident surveys were received at the MHCRU from MHCTs. Incident surveys received by ECU were entered into SPSS and cleaned (e.g., duplicate incidents were deleted from the data set, as were incidents with substantial data missing). Following this process, 1319 incident surveys remained in the final data set. Of the total incident surveys, 925 were collected during the trial time of 2.00pm to 10.00pm and were therefore included in statistical analyses.

4.4 Procedure

Phase 1: Semi structured interviews

The ECU Human Research Ethics Committee approved the conduct of this research. Recruitment of participants for face to face interviews was facilitated by the Inspector of the Mental Health Co-Response Unit, Officers in Charge of district offices and Program Managers of mental health services who emailed and/or approached staff and invited them to participate in an interview. To facilitate data collection, the research team visited the site offices of police and mental health to meet with willing participants. Interviews were conducted in an empty interview room within the site office. Given that a supervisor had invited staff to participate it was considered likely that participants would not feel comfortable declining to participate to their supervisor. For this reason, prior to the interview commencing, participants were informed that they were not required to participate, and that if they preferred not to participate their supervisor would not be informed. No participant declined to be interviewed.

When staff were not available in the office for a face to face interview, the research team sent an email inviting staff to participate via a telephone interview. Any staff who were willing to participate were asked to indicate a suitable day and time for the interview to take place. The research team then called the participant at this pre-determined time to conduct the interview.

All interviews were recorded and transcribed verbatim. Interview length ranged from 13 to 71 minutes in duration. All identifying information was omitted from transcriptions.

- Any task which requires escort of a Person at Risk (PAR) using police powers under MHA Section 156 or 157.
- Any task at which attending officers contact a mental health service for advice.
- Any task where community mental health services are in attendance at any time.
- Any task where community mental health services request assistance.
- Any task that contains in CAD narrative that PAR or person of focus is suspected of suffering mental illness
- Any task where it is suspected that PAR/person of attention is suffering a mental illness. Determination is made that a survey sheet is appropriate based on the above and overall narrative of the job.
Thematic analysis was applied to facilitate the development of a rich description of perceptions. Analysis was iterative and data driven (Braun & Clarke, 2006) whereby themes and related sub-themes were identified inductively (Patton, 2002).

**Phase 2: Survey**

The Phase 2 procedure was equivalent to that described in Chapter 3.

**Phase 3: Incident data**

An incident survey was developed to capture the details (listed in Table 7) of mental health tasks attended by police officers in test and control districts. Officers were instructed to complete the incident survey at the conclusion of each incident involving an individual experiencing a mental health crisis, during each quarterly two-week period. These incident surveys were owned by the WA Police Force and were provided to the research team to enter data in a re-identifiable format. Incident surveys were returned to the WA Police Force at the conclusion of data entry. Therefore, the research team held and analysed de-identified data in a re-identifiable format (i.e., a unique identifier was linked to a coding sheet to enable cross validation should it be required). Data was then analysed using SPSS for Windows.

Parametric analyses are reported throughout the results despite several normal distribution and homogeneity of variance assumption violations because the analyses are considered robust when the sample size is large (Tabachnik & Fidell, 2013). Furthermore, non-parametric analyses were performed to check for any Type 1 errors. When the pattern of non-parametric significance was consistent with the parametric analyses, parametric analyses are reported. When the pattern of parametric significance was inconsistent with the parametric analyses, both parametric and non-parametric results are reported.

**4.5 Findings and interpretations**

**4.5.1 Phase 1: Semi structured interviews**

Perceptions of the impact of having a mental health practitioner work alongside police in a MHCRMT could be characterised by five distinct themes- benefits for the individual experiencing a mental health crisis, officer knowledge, skills and teamwork, roles and boundaries within the team, positive resourcing impacts and tensions. Each theme is described in detail below.
**Individual: Respectful resolution of incidents**

Participants were clear in their view that the newly formed MHCRMTs provided individuals who were experiencing a mental health crisis with a service that met their real needs in a respectful way. Prior to MHCR, and in districts where MHCR was not available, response officers were described as attending mental health incidents and dealing with the problem in a hurried manner, often with an abrupt and distant approach, which escalated tensions amongst those involved in the situation. Response officers were described as being focused on a speedy resolution of the incident so that the next job could be attended. Therefore, not enough attention was devoted to ensuring the safety of the individual in crisis. This description was not intended as a criticism of response officers— it was described as a response driven by the requirement to meet District Key Performance Indicators (KPIs) and the expectations of line managers. The different style of response was well articulated by one member of a MHCRMT:

> When you rock up to a job, unless you’re specifically trained like us, you’re not going to a job thinking- ok this person has a mental illness, let’s try and help them, you’re going into a job as a response officer which means that you’re thinking things could go wrong, I have to protect myself, I need to go home at the end of the night. So it’s almost a different kind of mind set you walk into the job with. If you’re a response officer and someone walks out the door going all crazy, you know, you grab them, you throw them to the ground, you handcuff them. With MHCR, we know that we’re dealing with people with mental health, we’ve had more training. If that same person comes out the door, we know whether they’re a threat, we’ve got the Department of Health records to show whether they’re violent or not, and all those type of things will help us actually make a better decision on how we handle that person when we get there.

Furthermore, prior to MHCR, and in districts where MHCR was not available, response officers reported a reliance on transporting an individual experiencing a mental health crisis to an emergency department (ED) for medical intervention, for example, one officer described: “before [MHCR], just to cover myself, it would be nah- you’re going to hospital”. Officer reliance on transportation is understandable as they do not possess the required knowledge to assess the situation from a health perspective and so take them to a professional who does possess this knowledge, to ensure the wellbeing of the person at risk (PAR). Whilst transportation addressed the issue of risk from the officer’s perspective, this resolution impacted negatively on resources, with officers “invariably ending up at ED for hours and hours,”. Furthermore, transportation was often not the best outcome for the individual
experiencing a mental health crisis. For example, one participant described an incident attended by the MHCRMT where a young girl who lived alone was threatening to suicide. Although the mental health practitioner was considering sectioning the young girl, every time hospital was mentioned she became very distressed.

That was the one thing she didn’t want, was to be forced to go to hospital. If the clinician hadn’t been there she would have been in hospital. We told her she needs to be more aware of the other options available to her and that the clinician was bending over backwards to help. An agreement was formed where her Mum would stay overnight so she could stay at home with her cat who she loved. A 9.00am appointment was made with the psychiatrist in Bentley. She agreed to go and for mum to stay with her so she could avoid an overnight stay in hospital which is what terrified her.

This was the best outcome for the young girl, and facilitated the development of trust with both police and health. Furthermore, the individual experiencing the mental health crisis was able to contribute to the process of decision making which was empowering.

In terms of positive outcomes for the individual there was some discussion as to whether MHCRMTs assisted “real mental health clients” or whether their time was spent primarily dealing with the behaviours of people in social crisis (relationships, drug and alcohol use etc.). Some mental health practitioners felt that the teams should only be dealing with “legitimate” mental health clients whilst others felt there was an important role that could be played in dealing with crises in the community more generally, enabling the detection of undiagnosed mental health issues and/or mental health clients who are not engaged with services. These mental health practitioners had an appreciation of the skills they have in de-escalating a situation no matter what the cause/nature, and felt they played an important role in improving outcomes for all involved.

Officer knowledge, skill and teamwork

Participants were clear in the view that mental health has now become a standard policing role. Given a lack of community based services to address mental health needs, and roadblocks when trying to access available services, as a last resort, the public call police when in crisis. For this reason, it was described as vital that police acquire the skills required to respond to the growing number of mental health incidents. Participants within MHCRMTs felt that respectful and appropriate resolution of incidents involving an individual experiencing a mental health crisis was more likely due to the skills they had obtained within training, the
knowledge they had gained whilst working alongside the mental health practitioner and particular attributes which they felt were inherent to them (e.g., empathy, a desire to improve police response to mental health). Participants described being able to put “active listening skills into practice,” being able to communicate “normally and genuinely” with an individual experiencing a mental health crisis. For example, one participant described in the past speaking “slowly and loudly, not realising that you could talk normally.” In essence, participants described training, and working alongside the practitioner as eliminating the stigma associated with mental illness and the subsequent negative interpersonal responses that are facilitated by stigma. These skills enabled the police officers to collaborate with the mental health practitioner and contribute meaningfully to the respectful resolution of incidents for those experiencing a mental health crisis. Participants also described feeling more confident in their decision making during mental health incidents because a mental health practitioner with the relevant expertise was available to guide and inform decision making.

Members of MHCRMTs were aware that their position was perceived by some non-MCHR officers and managers to be simply providing “security” for the mental health practitioner. However, both MHCR officers and practitioners vehemently opposed this view. Although it was acknowledged that the role of the police officer was to ensure that the environment was safe for the mental health practitioner to conduct an assessment, officers and mental health practitioners worked as a team when engaging with the individual in crisis. It was this team work that was described as the main success of MHCRMTs. Officers described that over time, after watching the practitioners work, they were aware of the types of questions that the mental health practitioner would ask and how to ask these questions to obtain the necessary information to assess the individual’s mental wellbeing. At times, when the PAR preferred to engage with a police officer rather than the clinician, officers asked the questions, that the clinician would usually ask, to enable the clinician’s assessment of the individual. Officers were adamant that they were not fulfilling the role of practitioner, but were instrumental in facilitating communication to obtain the information that was required by the practitioner to assess the situation from a mental health perspective. Officers also described obtaining additional information that would assist the clinician make a clinical determination about the individual’s mental wellbeing. For example, whether there was food in the house, whether medications were visible in the house and so on. Officers and practitioners felt that their close working relationship and team approach to the management of situations greatly increased the likelihood that individuals experiencing a mental health crisis would engage with the mental health practitioner and agree to the need for treatment, or some form of intervention.
Roles and boundaries within the team

As discussed above, participants within MHCRMTs described learning valuable skills from clinicians in terms of how to respond to incidents. Specifically, the skills introduced during mental health training were put into practice and refined on observing and conversing with the mental health practitioner. Although it might be assumed that roles would inevitably become blurred (e.g., police performing duties that should be performed by the mental health practitioner and mental health practitioners performing policing duties), participant narratives indicated that this had, in the very large majority of circumstances, not occurred. A culture had developed with health and police working collaboratively, applying their own unique skill sets to resolve an incident respectfully. As one participant indicated, “We go to a job and on the way we discuss what information we have on the police system. They look up their systems and we discuss a plan. They go ‘this’ and we go ‘that’ and we are sorted.”

Although participants indicated that no one overstepped their role consistently, they did describe occasions where the nature of the incident necessitated each party perform part of the role of the other. For example, one participant described attending an incident with a medicated schizophrenic man who was cared for by his wife. On attending, the man became agitated and because he was medicated and therefore ‘safe’, his wife became angry with the mental health practitioner. The incident quickly escalated and his wife insisted on speaking to police alone. The mental health practitioner returned to the car and police officers entered the house. On entering the house, the power to the house immediately went out and police torches were subsequently turned on. At the same time, an unknown individual had driven towards the rear of the property and entered the back of the house. The mental health practitioner was concerned for the safety of officers and adopted the role of ensuring safety and pressed the emergency button in the police vehicle to alert other police officers of the incident. A number “of cars came with lights and sirens buzzing. It was awesome that the clinician had enough foresight to do it.” The police officers had turned their torches on because there was a power outage and the man entering the premises was an extended family member.

On very rare occasions, situations were described in which boundaries were overstepped. When this occurred the strength of the collaborative working relationship between health and police in responding to these situations was apparent. Open and honest communication between parties enabled the resolution of issues and staff from each agency reported learning valuable lessons from the way the other agency responded to and managed the situation. As a result, situations that may have damaged relationships were handled in such a way that interagency relations were strengthened. Such situations also highlighted the critical
importance of role sharing and role rotation between co-response work and non-co-response work.

**Positive resource impacts**

The impact of the MHCRMTs on police resources was discussed. MHCR and non-MHCR police officers indicated that MHCR had significantly reduced the frequency with which they were required to convey individuals experiencing a mental health crisis to ED. Furthermore, in the event that transportation was essential, the time spent in EDs was also described as having reduced significantly. This enabled officers to “get back on the road” and respond to incidents where other community members required their assistance.

In addition to transportation and time at hospital EDs the impact on repeat callers or “frequent flyers” was also discussed. MHCRMTs were described as facilitating the effective management of these individuals, leading in the longer term to a positive impact on police resources. One such intervention was described, by a member of the management team in one of the test districts.

*We had a lady at [suburb], I think it was, was one of these types of people that whenever she was faced with an issue she would ring 000 to report a wide range of issues. She’d make stories up of herself being raped, or being bashed or being robbed or whatever, simply to solicit a police response and I think over about a 3-month period, just as the co-response team were being established I think we had about 113 separate calls to her house. The problem with those is that, because the response team within that District, I think there’s about 180 officers that work 7 days, 24 hours, were going to her address it would never be a consistent number of officers. So, that trend wasn’t becoming apparent. And so they would then go, they would introduce themselves, quickly identify that she was suffering from mental health issues, make arrangements for her family to come and take her off our hands, they’d try to plug her into some kind of support, and I think on the average it would probably take an hour to an hour and a half on each occasion. When the mental health team took over and we established this issue, they simply went out with the mental health practitioner over one or two visits, properly plugged her in to support, properly wrapped around her some good processes for managing her and I don’t think we’ve had a call to her house since. So you’ve gone from a regime of 113 hours [averaging one hour per call] that involved 2 officers per attendance involving an hour and a half each occasion, you work the*
maths out on that it’s probably 300 hours of lost police time, to someone that is now plugged in to proper support and health management and no longer a drain on police resources.

This example indicates positive impacts for the individual with mental health concerns and for responding officers, as well as at an agency level in terms of the amount of police resources consumed by that individual. This highlights the value of MHCR in effectively managing individuals with mental health issues, diverting general response teams (resources) away from that individual and mobilising the MHCRMT to manage the task. In this way, there was a recognition that to address the impact of mental health tasks on police resources, there is a need to work in collaboration with other stakeholders to address the underlying problem, which is not the role of a response team. In essence, the MHCRMTs encapsulate, and put into action, problem-orientated policing. As described by one participant:

Whatever the task is, they [response teams] go there, complete the task and move on to the next task, so it becomes quite repetitive. So things like mental health, that really present a significant challenge... because of the nature of those tasks, they can be quite long winded. And if you try to cut them off short, by trying to put some sort of Band-Aid solution on them, and then leave, it’s inevitable that somewhere else down the shift or the next day, because of the nature of mental health, that job will resurrect itself in another form. You know the person will go off again or they’ll go to another address and have another- for want of a better word- brain snap, and that necessitates another task or a whole bunch of tasks. Whereas now the response teams can focus on their policing issues, and allow the mental health team, who have the capacity and capability of spending a lot more time, and have a lot more expertise because they have the practitioner with them, to actually deal with the jobs effectively and make a difference.

**Tensions and frustrations**

Although the benefits associated with MHCR were acknowledged by all participants (police officers, police management, mental health practitioners and health management), many points of tension and frustration were described as emerging from (a) the inconsistency between business as usual and the MHCR model, the (b) positioning of MHCRMTs, (c) understandings of the role and value of MHCRMTs and (d) disparate organisational policies and procedures (police and health). Within the context of business as usual as opposed to MHCR, the skills developed by MHCR police officers during training, and on the job whilst
working as part of a MHCRMT, were also applied when allocated to a non-MHCR response team. However, this was described as causing some tension. Those participants rotating from MHCR to non-MHCR within a test district described how the style of policing incorporated by non-MHCR officers was vastly different to that of their own. For example, one participant described attending an incident that was quickly resolved. However, as the police officers were about to leave, the occupant disclosed that he was schizophrenic and not on medication. The participant indicated that:

*The other police officer said ‘can we go to the next job now’- he was just about response. But I kept talking to the person and told him I was co response. He indicated he was okay, but then decided to tell me about crazy ways of killing yourself. I couldn’t just let that go and leave. I spoke to him- to see if he had a plan. I questioned him just like a clinician would have. I have learnt a new way of engaging with people and talking with them. I asked if he was safe at the moment and he said yes. But I felt the presence of the other police officer and felt he would have left 15 minutes before I did, but I couldn’t disregard what I now know because of my involvement in MHCR.*

Therefore, although the operational deployment model had changed under MHCR, district priorities and KPIs had not.

This tension between business as usual and MHCR was most evident when speaking with non-MHCR police officers in test district police stations where MHCR was operating and MHCRMTs were located. Non-MHCR police officers did not see the benefit in MHCR, describing the model as having the effect of “handballing” mental health consumers from one unit to the next. One participant indicated that he would never engage MHCR because it “feels like you are just handballing to someone else because they have a mental illness. If we are going to have to arrest them anyway, then I can speak to them.” A number of participants were of the view that MHCR was a waste of scarce resources. More specifically, they described situations where MHCR attended and resolved the incident leaving the mental health consumer at home. However, a later shift on the same day, described as “the clean-up team” was typically called to the same address, subsequently apprehending the individual experiencing a mental health crisis. This group of participants felt that if the mental health consumer had been apprehended and transported during the first incident, his or her needs would have been met sooner. Although a number of participants described these tensions, others articulated different views, describing any form of police response to incidents involving mental illness as a “temporary, Band-Aid fix”. Therefore, from the perspective of this group of participants, the
problem (e.g., the mental illness) will never go away, so the likelihood of being called out to a second incident involving the same person is high. These individuals saw the effective management of that individual, (e.g., from a police, health and PAR’s perspective), as the ultimate goal, and were of the view that so long as it is deemed safe, the longer the individual experiencing a mental health crisis can remain in comforting surroundings, the better.

Tensions between MHCRMTs and non- MHCR officers also arose due to an apparent lack of understanding of the role and value of MHCRMTs. This was perhaps most evident in a scenario described by one participant in which police were required to attend to a job involving a PAR with a personality disorder. General response teams attended and the situation escalated with Tactical Response Group (TRG) and dog squad also assigned to the task. The MHCRMT was on shift and present at the scene and the PAR was a known client of the mental health practitioner. A MHCR officer was also attached to the management of the PAR in the community (via the MHCRMTs case management approach to managing ‘frequent flyers’; PARs who exhibit a high level of risk and/or frequent contact with police). Rather than accessing the knowledge and expertise of the mental health practitioner and MHCR officers, the MHCRMT was instructed to direct traffic further down the road. This indicates a lack of understanding of the skills and expertise of mental health practitioners and the MHCR officers who are required to deal with volatile situations on a frequent basis. Whilst understandably, the risk may have been deemed too high for the practitioner to engage directly with the PAR, officers would have been able to utilise the mental health practitioner’s knowledge of the client to assist in the resolution of the situation (i.e., working with the negotiator). However, this was seemingly not considered or deemed valuable by officers in charge of the situation. This incident resulted in significant frustration for the MHCRMT and highlights the need for WA Police supervisors and management to be informed of and exposed to the role and capabilities of the mental health practitioners, and the ways in which they can be utilised to assist in jobs involving known mental health clients.

Tensions were described by MHCR participants who essentially answered to “two bosses” because of the way in which MHCRMTs were positioned in the agency. Although MHCRMTs were managed by the Custodial Services and Mental Health Division, they were positioned at the district level within Engagement and Support and therefore also reported to the Officer in Charge (OIC) of that unit. Although all MHCR officers described the need for down time because of the pressures associated with, and the general intensity of MHCR work, their placement during down times was dependent on the preference of the OIC of Community Engagement. In one district, MHCR police officers were given, what were perceived to be
menial administrative tasks during down times, which brought little reward and were seen by MHCR officers as a waste of a specialised, district resource. In other districts, MHCR officers were able to join general response teams. This was often described as rewarding as these police officers were keen to be out on the road making a difference in situations that were not as intense as MHCR work but in which their skills were of benefit. Participants questioned the logic associated with dual line management, suggesting that MHCRMTs should be centralised and travel to districts as required.

Although the notion of centralisation was considered appealing, potentially increasing the distance required to attend incidents was also considered problematic. MHCR police officers described already experiencing frustration in their attempt to attend as many incidents as possible. When one incident is in Mirrabooka and the second is in Two Rocks, participants indicated that it was challenging to attend in a timely fashion. Non-MHCR officers in police stations positioned some distance away from the MHCRMT’s station, described MHCR as “the best thing since sliced bread”. However, response officers at that station rarely requested MHCR attendance because of the time it would likely take for them to reach the incident. Although comfort was derived from being able to telephone the mental health practitioner for advice, the added benefits that could be derived from MHCRMT attendance were not realised. Frustration regarding the lack of availability of MHCRMTs has the potential to impact negatively on the reputation of MHCRMTs, and response officers’ subsequent engagement with the team. Members of the MHCRMTs experienced added frustration about their inability to get to all jobs where their presence would likely prove useful as they were aware of the negative implications that could follow from their inability to attend.

Additional tensions were described as emerging because of disparate organisational policies and procedures (e.g., police and health). All participants indicated that the two to ten shift time for mental health practitioners made little sense as the practitioner was required “24/7”. Furthermore, incongruent rosters created ‘dead-time’ for officers who, upon starting their shift at 1pm, were required to wait until 2pm for the mental health practitioner to start their shift. This meant that the team was often not able to start their response work until after 2pm. Mental health practitioners then finished at 10pm whilst officers finished at 11pm. MHPs worked an 8 hour shift to maintain consistency with their shifts on non-MHCR days.

Tensions were also described regarding the types of jobs that the team should attend. Some mental health practitioners reported a reluctance to engage with youth, older adults, individuals with intellectual disability and drug and alcohol affected individuals as “all these conditions are specialities in their own right” and these were not cohorts that mental health
practitioners were required to deal with in their usual work at an adult mental health service. From their perspective, they lacked the specific knowledge and expertise to deal with these cohorts in a meaningful way. Others disagreed, for example one practitioner stated; “I don’t care. I treat the symptom. The cause of it’s irrelevant to me. So if I go around and someone’s high on meth and they’re exceptionally paranoid I’m treating the paranoia. The fact that meth gave it to them is not my problem. My problem is someone’s unwell, they need an intervention”.

From the police perspective also, attendance was required and so they were required to go.

Participants also described challenges associated with the parameters of information sharing and a lack of clear policy in relation to confidentiality. Although mental health practitioners applied a common sense approach, a lack of agency directive created anxiety. Participants described how simple it would be to unintentionally misuse an information management system. In the absence of clear dual policy frameworks, mental health practitioners and police described feeling very apprehensive.

**4.5.2 Phase 2: Survey data**

Survey data sought to determine if MHCR influenced perceptions of role adequacy, confidence and decision making of frontline police. This was based on the assumption that in test districts, the presence of a mental health clinician within MHCRMTs would facilitate a transfer of knowledge to police officers and increase confidence in decision making, regardless of being part of a MHCRMT or not. For this assumption to be correct, the pattern of findings should show higher perceptions of role adequacy and confidence in test districts (non-MHCR police officers) compared to control districts.
Role Adequacy

Survey findings for police officer perceptions of role adequacy for test and control districts are shown in Table 8 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 8: Police officer perceptions of role adequacy

<table>
<thead>
<tr>
<th>Element</th>
<th>Test Districts</th>
<th>Control Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree to which police officers perceive they have the necessary experience to respond to mental health related tasks</td>
<td>3.72 1.07</td>
<td>4.08 1.03</td>
</tr>
<tr>
<td>Degree to which police officers have responded to a wide range of mental health tasks</td>
<td>4.54 0.94</td>
<td>4.40 0.84</td>
</tr>
<tr>
<td>Degree of confidence police officers have in their ability to respond to mental health related tasks</td>
<td>3.93 0.96</td>
<td>3.67 0.96</td>
</tr>
<tr>
<td>Degree to which police officers perceive they have the necessary knowledge to help people with mental health related tasks</td>
<td>3.47 1.17</td>
<td>2.91 1.13</td>
</tr>
<tr>
<td>Degree to which police officers perceive they do not have the skills necessary to respond to mental health related tasks</td>
<td>2.52 1.20</td>
<td>2.93 1.20</td>
</tr>
<tr>
<td>Degree to which police officers perceive they are able to respond as competently to those with mental health related issues</td>
<td>2.56 1.15</td>
<td>3.75 1.02</td>
</tr>
<tr>
<td>Combined Total Role Adequacy</td>
<td>3.78 0.85</td>
<td>3.64 0.58</td>
</tr>
</tbody>
</table>

As shown in Table 8, on average, participants within the test districts somewhat agreed that they had responded to a wide range of mental health related tasks (M=4.54). Participants somewhat disagreed with the statement that they did not have the skills necessary to respond to mental health related tasks (M=2.52), suggesting that officers perceived some level of skill in responding to mental health related tasks. However, officers somewhat disagreed that they had the ability to respond as competently to those with mental health related issues as those without (M=2.56). Participants in test districts neither agreed, nor disagreed that they had; the necessary experience to respond to mental health related tasks (M=3.72), confidence in their ability to respond to mental health related tasks (M=3.93), and the necessary knowledge to help people with mental health related tasks (M=3.47).

For control districts, participants somewhat agreed that they had the necessary experience to respond to mental health related tasks (M=4.08), and that they had responded to a wide range of mental health related tasks (M=4.40). Participants somewhat disagreed with the statement that they did not have the skills necessary to respond to mental health related...
tasks (M=2.93), suggesting that officers perceived some level of skill in responding to mental health related tasks. However, participants somewhat disagreed that they had the necessary knowledge to help people with mental health related tasks (M=2.91). Furthermore, participants neither agreed, nor disagreed that they had confidence in their ability to respond to mental health related tasks (M=3.67), and the ability to respond as competently to those with mental health related issues as those without (M=3.75).

Comparisons of means across test and control districts suggests that officers in both test and control districts perceive that they have responded to a wide range of mental health tasks. Officers in the control district perceived greater experience in dealing with MH tasks compared to officers in the test district and more strongly agreed that they deal with MH tasks just as competently as non-MH tasks in comparison to officers in the test districts. Officers in test districts indicated a slightly greater level of confidence, a higher level of knowledge necessary to deal with mental heal tasks and were slightly less likely to agree that they lacked the necessary skills to respond to mental health related tasks compared to officers in the control districts. An independent samples t-test was conducted on police officer perceptions of overall role adequacy (incorporating the averaged total of all scale items). Assumptions of normality and homogeneity of variance were met. Findings demonstrated there was not a significant difference between test and control districts in terms of their perceptions of role adequacy, \( t(399) = -1.89, p > 0.05 \). The mean role adequacy for test districts was 3.78 and the mean role adequacy for control districts was 3.64. When excluding Mental Health Co-Response officers from the sample (N=13), findings still demonstrated no significant difference between test (M=3.72) and control districts (M=3.65) in terms of their perceptions of role adequacy, \( t(386) = -0.96, p > 0.05 \).
Confidence

Survey findings for police officer confidence in addressing mental health incidents for test and control districts is shown in Table 9 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

**Table 9: Police officer confidence**

<table>
<thead>
<tr>
<th>Element</th>
<th>Test Districts</th>
<th>Control Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence in ability to identify a person suffering a mental health issue</td>
<td>4.13, 0.80</td>
<td>4.11, 0.78</td>
</tr>
<tr>
<td>Confidence in ability to identify a person suffering a drug induced mental health issue</td>
<td>4.12, 0.91</td>
<td>4.04, 0.77</td>
</tr>
<tr>
<td>Confidence in ability to manage an incident involving a person with a mental health issue</td>
<td>4.04, 0.90</td>
<td>3.89, 0.86</td>
</tr>
<tr>
<td>Confidence in ability to communicate during an incident involving a person with a mental health issue</td>
<td>4.03, 0.89</td>
<td>3.84, 0.88</td>
</tr>
<tr>
<td>Confidence in ability to negotiate during an incident involving a person with a mental health issue</td>
<td>3.91, 0.98</td>
<td>3.76, 0.91</td>
</tr>
<tr>
<td>Confidence in ability to de-escalate an incident involving a person with a mental health issue</td>
<td>3.88, 0.96</td>
<td>3.86, 0.79</td>
</tr>
<tr>
<td>Confidence in decision making during an incident involving a person with a mental health issue</td>
<td>4.10, 0.91</td>
<td>3.44, 1.13</td>
</tr>
<tr>
<td><strong>Combined Total Perceived Confidence</strong></td>
<td><strong>4.02, 0.75</strong></td>
<td><strong>3.85, 0.64</strong></td>
</tr>
</tbody>
</table>

As shown in Table 9, on average, participants in the test districts somewhat agreed that they had confidence in their ability to identify a person suffering a mental health issue (M=4.13), a drug induced mental health issue (M=4.12), and to manage an incident involving a person with a mental health issue (M=4.04). Participants in the test districts also somewhat agreed that they had confidence in their ability to communicate during an incident involving a person with a mental health issue (M=4.03), and in their decision making during an incident involving a person with a mental health issue (M=4.10). However, participants neither agreed, nor disagreed that they had confidence in their ability to negotiate during an incident involving a person with a mental health issue (M=3.91) or de-escalate an incident involving a person with a mental health issue (M=3.88).

For control districts, participants somewhat agreed that they had confidence in their ability to identify a person suffering a mental health issue (M=4.11) and a drug induced mental health issue (M=4.04). However, participants neither agreed nor disagreed that they had confidence in their ability to manage an incident involving a person with a mental health issue (M=3.89), communicate during an incident involving a person with a mental health issue (M=3.85), or...
(M=3.84), negotiate during an incident involving a person with a mental health issue (M=3.76),
de-escalate an incident involving a person with a mental health issue (M=3.86) and their
decision making during an incident involving a person with a mental health issue (M=3.44).

Comparisons of means for each scale item, across test and control districts suggests
slightly higher levels of officer confidence within the test districts compared to the control
districts. An independent samples t-test was conducted on police officer’s perceived confidence
(including the averaged total of all scale items). Assumptions of normality and
homogeneity of variance were met. Findings demonstrated there was a significant difference
between test and control districts in terms of perceived confidence, \( t(391) = -2.455, p = 0.01 \).
The mean confidence for test districts was 4.02 and the mean confidence for control districts
was 3.85. When excluding Mental Health Co-Response officers from the sample (N=13), there
was no significant difference between test (M=3.97) and control districts (M=3.85) in terms of
confidence, \( t(378) = -1.690, p > 0.05 \). This indicates that increased confidence in the test
districts can be accounted for by MHCR officers.

*Training*

Survey findings for police officer perceptions of training in the management of mental
health incidents for test and control districts are shown in Table 10 below. Responses were
provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

**Table 10: Police officer perceptions of training**

<table>
<thead>
<tr>
<th>Element</th>
<th>Test Districts</th>
<th>Control Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>WA Police training on how to respond to people experiencing a mental health issue is perceived as adequate</td>
<td>2.65</td>
<td>1.16</td>
</tr>
<tr>
<td>Police officer perceptions of the adequacy of training for responses to mental health incidents</td>
<td>2.59</td>
<td>1.18</td>
</tr>
<tr>
<td>Combined Total Training</td>
<td>2.62</td>
<td>1.14</td>
</tr>
</tbody>
</table>

As shown in Table 10, on average, participants within the control and test districts somewhat
disagreed that WA Police training on how to respond to people experiencing a mental health
issue was adequate (Control M=2.45; Test M=2.65), and that training for responses to mental
health incidences was adequate (Control M=2.43; Test M=2.59).

An independent samples t test was conducted on police officer perceptions of training
(including the averaged total of all scale items). Assumptions of normality and
homogeneity of variance were met. Findings demonstrated there was not a significant difference between test and control districts in terms of their perceptions of training, $t(390) = -1.626, p > 0.05$. The mean response for perceptions of training in test districts was 2.62 and the mean response for perceptions of training in control districts was 2.43. When excluding Mental Health Co-Response officers from the sample (N=13), findings still demonstrated no significant difference between test (M=2.57) and control districts (M=2.43) in terms of their perceptions of training, $t(377) = -1.196, p > 0.05$.

**Test districts perceptions of the Mental Health Co-Response Mobile Team**

All participants in the test districts were aware that a Mental Health Co-Response Mobile Team (MHCRMT) operated within the districts and 82.5% of participants had involvement with the MHCRMT. Of those who reported involvement with MHCRMTs, 59.3% had requested information from the team and attendance at an incident; 22.7% had requested attendance at an incident only and 4.1% had simply requested information (numbers do not equal 100 due to missing data). Participants somewhat agreed that the information provided by the MHCRMT was valuable to decision making on the task (M=4.07), and was valuable to the resolution of the task (M=4.10). Participants also somewhat agreed that there is value having a MHCRMT assist frontline police officers (M=4.53).

Participants were also able to provide comment or feedback regarding the MHCRMTs in their district via an open ended, free narrative question. Eighty-five participants provided a response to the question. Qualitative responses were reduced to key words and phrases and frequencies and coded by two members of the research team. Inter-rater reliability, calculated via Cohen’s kappa, demonstrated an ‘almost perfect’ level of agreement in the codes assigned to qualitative responses ($\kappa = 0.83$; Landis & Koch, 1977). The nature and frequency of key responses are shown in Table 11 below.
Table 11: Nature and frequency of qualitative feedback responses- District officers

<table>
<thead>
<tr>
<th>Nature of response</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHCR is valuable in terms of saving time</td>
<td>7</td>
<td>6.3</td>
</tr>
<tr>
<td>MHCR is valuable in terms of their expert knowledge/skills</td>
<td>10</td>
<td>9.1</td>
</tr>
<tr>
<td>MHCR is valuable in improving consumer outcomes</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>MHCR is valuable (specified other, e.g., reduces demand on response officers, able to provide appropriate response)</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>MHCR is valuable (specified other, e.g., ‘an excellent asset’, ‘an excellent idea that has well and truly shown it’s worth’, ‘excellent’)</td>
<td>19</td>
<td>17.3</td>
</tr>
<tr>
<td>Have not used MHCR</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>Needs to be expanded (number of cars, days, times, locations)</td>
<td>53</td>
<td>48.2</td>
</tr>
<tr>
<td>Suggested change to role (e.g., team to provide feedback, team to avoid follow-up work)</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>110</strong></td>
<td></td>
</tr>
</tbody>
</table>

4.5.3 Phase 3: Incident data

Incident survey data collected within the trial time (Monday to Saturday, 2.00pm to 10.00pm) is presented according to the following experimental conditions:

- ‘True Control’ refers to data from response officers in districts where no MHCRMTs operate (Central Metropolitan (CM) and South Metropolitan (SM) districts).
- ‘Test/Control’ refers to data from response officers, not working as a part of a MHCRMT but in districts where MHCRMTs operates (South East Metropolitan (SEM) and North West Metropolitan (NWM) Districts).
- ‘True Test’ refers to data from the MHCRMTs (both SEM and NWM).

Table 12 below shows the number of incident surveys collected across districts falling within each experimental condition.

Table 12: Frequency of incident surveys as a function of experimental condition

<table>
<thead>
<tr>
<th>Experimental condition</th>
<th>District</th>
<th>No of incidents</th>
<th>% of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=339)</td>
<td>CM</td>
<td>123</td>
<td>36.3</td>
</tr>
<tr>
<td></td>
<td>SM</td>
<td>216</td>
<td>63.7</td>
</tr>
<tr>
<td>Test/Control (N=258)</td>
<td>NWM</td>
<td>136</td>
<td>52.7</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>122</td>
<td>47.3</td>
</tr>
<tr>
<td>True Test (N=328)</td>
<td>NWM</td>
<td>169</td>
<td>51.5</td>
</tr>
<tr>
<td></td>
<td>SEM</td>
<td>159</td>
<td>48.5</td>
</tr>
</tbody>
</table>

16 Total (110) > N (85) as multiple codes were assigned to individual responses as required
Table 13 below shows the number of incident surveys collected across district business units in each experimental condition.

Table 13: Frequency of incident surveys as a function of district business unit

<table>
<thead>
<tr>
<th>Condition</th>
<th>Business unit</th>
<th>No of incidents</th>
<th>% of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=324)</td>
<td>Response team</td>
<td>291</td>
<td>89.8</td>
</tr>
<tr>
<td></td>
<td>LPT</td>
<td>33</td>
<td>10.2</td>
</tr>
<tr>
<td>Test/Control (N=239)</td>
<td>Response team</td>
<td>204</td>
<td>85.4</td>
</tr>
<tr>
<td></td>
<td>LPT</td>
<td>35</td>
<td>14.6</td>
</tr>
<tr>
<td>True Test (N=328)</td>
<td>MHCR</td>
<td>328</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.5.3.1 Nature of incident

Table 14 below shows the entity that requested assistance from the WA Police Force, and the frequency of requests from each entity across experimental conditions.

Table 14: Entity that initiated WA Police Force involvement

<table>
<thead>
<tr>
<th>Entity</th>
<th>True Control (N=336)</th>
<th>Test/Control (N= 254)</th>
<th>True Test (N= 327)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>PAR</td>
<td>66</td>
<td>19.6</td>
<td>37</td>
</tr>
<tr>
<td>Police</td>
<td>16</td>
<td>4.8</td>
<td>11</td>
</tr>
<tr>
<td>Third Party</td>
<td>180</td>
<td>53.6</td>
<td>160</td>
</tr>
<tr>
<td>Health Service</td>
<td>83</td>
<td>24.7</td>
<td>58</td>
</tr>
</tbody>
</table>

*Percentages do not equal 100 as multiple response options were provided.

As shown in Table 14, across all experimental conditions, a third party was most likely to have contacted police to request assistance. Police were more likely to have initiated police involvement in the true test condition (15.0%) which likely reflects MHCR tasks that have been initiated by other police response units (i.e., requesting the assistance/attendance of MHCR). Many health initiated jobs consist of tasks in which health have requested police attendance to undertake a health-related activity when risk is deemed to be high (e.g., transportation of a mental health client). MHCRMTs would not usually attend these jobs which explains the lower rate of health-initiated tasks in the true test condition.

Table 15 below shows the type of incident attended by police, and the frequency of attendance at each type of incident across experimental conditions.
Table 15: Type of incident

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>True Control</th>
<th>Test/Control</th>
<th>True Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Welfare check</td>
<td>216</td>
<td>63.7</td>
<td>164</td>
</tr>
<tr>
<td>Mental health task</td>
<td>44</td>
<td>13.0</td>
<td>25</td>
</tr>
<tr>
<td>Missing person/Absconder</td>
<td>19</td>
<td>5.6</td>
<td>15</td>
</tr>
<tr>
<td>Escort</td>
<td>9</td>
<td>2.7</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>15.0</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>339</td>
<td>100</td>
<td>256</td>
</tr>
</tbody>
</table>

As shown in Table 15, the type of incidents attended by police and the frequency of attendance at each was relatively consistent across experimental conditions. The frequency of attendance was highest for welfare checks and lowest for escorts.

4.5.3.2 Time

Table 16 below shows the total time spent when responding to mental health related tasks across experimental conditions. Tables 17 and 18 below present time at task according to whether the individual was transported or not. Table 17 shows the time that was taken attending mental health related tasks when the individual was not transported, and Table 18 shows the time that was taken attending tasks when the individual was transported. Time is recorded in terms of hours and minutes. Time at task is calculated from the time of arrival at the task to the time that the task was cleared (i.e., travel time to the task is not included in time at task analysis).

Table 16: Time at task

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=334)</td>
<td>1:46</td>
<td>1:36</td>
<td>0:04</td>
<td>8:22</td>
</tr>
<tr>
<td>Test/Control (N=254)</td>
<td>1:38</td>
<td>1:33</td>
<td>0:02</td>
<td>10:10</td>
</tr>
<tr>
<td>True Test (N=314)</td>
<td>0:51</td>
<td>0:41</td>
<td>0:03</td>
<td>3:56</td>
</tr>
</tbody>
</table>

Table 17: Time at task when individual WAS NOT transported

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=85)</td>
<td>0:45</td>
<td>0:37</td>
<td>0:05</td>
<td>4:03</td>
</tr>
<tr>
<td>Test/Control (N=66)</td>
<td>0:58</td>
<td>0:55</td>
<td>0:06</td>
<td>4:37</td>
</tr>
<tr>
<td>True Test (N=197)</td>
<td>0:41</td>
<td>0:26</td>
<td>0:05</td>
<td>2:42</td>
</tr>
<tr>
<td>Condition</td>
<td>Mean</td>
<td>SD</td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------</td>
<td>-----</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>True Control (N=206)</td>
<td>2:18</td>
<td>1:41</td>
<td>0:06</td>
<td>8:22</td>
</tr>
<tr>
<td>Test/Control (N=157)</td>
<td>2:02</td>
<td>1:40</td>
<td>0:03</td>
<td>10:10</td>
</tr>
<tr>
<td>True Test (N=73)</td>
<td>1:31</td>
<td>0:55</td>
<td>0:12</td>
<td>3:56</td>
</tr>
</tbody>
</table>

As shown in Table 16, the time that was taken attending incidents was significantly lower in the true test condition (M=0:51), compared to the true control (M=1:46) and the test/control (M=1:38) condition; $F(2, 899)= 41.807$, $p<.01$. Although Table 17 shows that the time taken attending an incident when the individual was not transported was lower in the true test condition (M=0:41), compared to the true control (M=0:45) and the test/control (M=0:58) condition, this difference was not statistically significant; $F(2, 345)= 5.293$, $p=.05$ (non-parametric analysis indicated no significant difference). However, when an individual was transported, the time taken at the incident was significantly lower in the true test condition (M=1:31) compared to the true control (M=2:18) and the test/control (M=2:02) conditions $F(2, 433)= 6.720$, $p<0.1$. This pattern of findings implies that MHCRMTs spend less time at incidents, particularly when transport is required. This may be explained by ‘handovers’ from MHCRMTs to non-MHCR units to undertake a conveyance when transport was required. Reasons as to why another police unit would be given the task of transporting the PAR to hospital would include that the person was violent, made verbal threats and/or presented a risk of violence to themselves and/or police. Also, if the mobile team assisted at a task that was deemed not MH-related (e.g., a family violence task), the non MHCRMT response car would likely continue with any subsequent transportation. This hand over enabled the MHCRMT to remain on the road, responding to mental health tasks in the community. Alternatively, in circumstances where the MHCRMT does undertake the transport, data indicates that they experience a faster handover to health services (see Tables 16 and 18).
4.5.3.3 Additional unit attendance at incidents

Table 19 below shows the number of times additional units were required to attend mental health incidents, and the number of additional units that attended.

Table 19: Involvement of additional units

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidents where other units required</th>
<th>How many units?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>True Control (N=339)</td>
<td>89</td>
<td>26.3</td>
</tr>
<tr>
<td>Test/Control (N=258)</td>
<td>85</td>
<td>32.9</td>
</tr>
<tr>
<td>True Test (N=328)</td>
<td>84</td>
<td>25.6</td>
</tr>
</tbody>
</table>

As shown in Table 19, the number of times additional units were required to attend mental health incidents was equivalent across experimental conditions and on average, one additional unit attended.

In 65.4% of incidents in the true test condition, MHCRMTs were the first responders to attend the incident (N=214). In the remaining incidents where MHCRMTs were secondary responders (N=113, 34.5%), the average total time that first responders were at the incident was 1:10 hours (SD= 1:09; min= 0:01 max= 6.55 hours).

4.5.3.4 Incident actions

Table 20 below shows the number of incidents attended where the unit was unable to locate the person at risk (PAR) and therefore took no action, for each experimental condition.

Table 20: Number of incidents where unit took no action (unable to locate PAR)

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=334)</td>
<td>41</td>
<td>12.3</td>
</tr>
<tr>
<td>Test/Control (N=255)</td>
<td>31</td>
<td>12.2</td>
</tr>
<tr>
<td>True Test (N=328)</td>
<td>50</td>
<td>15.2</td>
</tr>
</tbody>
</table>

As shown in Table 20, the PAR was unable to be located more often in the true test condition (15.2%), than in the true control (12.3%) or the test/control (12.2%) condition. Of those incidents where the person at risk was located, Mental Health Emergency Response Line (MHERL)\(^{17}\) was significantly more likely to be contacted for advice in the true control condition; \(\chi^2(2, N=796)= 57.058, p= .000\). These data are shown in Table 21 below.

\(^{17}\) MHERL is a 24/7 public contact service, operated by the Department of Health, for persons or their carers/families experiencing a mental health crisis. MHERL is the first point of contact for police officers dealing with people experiencing a mental health crisis.
Table 21: Number of incidents where unit contacted MHERL for advice

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=286)</td>
<td>24</td>
<td>8.4</td>
</tr>
<tr>
<td>Test/Control (N=223)</td>
<td>7</td>
<td>3.1</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>1</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Tables 22 and 23 below show the number of incidents where the attending unit contacted other mental health services for information or advice, or to request their attendance.

Table 22: Number of incidents the unit contacted MHS for information/advice

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=286)</td>
<td>21</td>
<td>7.3</td>
</tr>
<tr>
<td>Test/Control (N=223)</td>
<td>17</td>
<td>7.6</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>23</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Table 23: Number of incidents the unit contacted MHS to request attendance

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=286)</td>
<td>15</td>
<td>5.2</td>
</tr>
<tr>
<td>Test/Control (N=223)</td>
<td>18</td>
<td>8.1</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>12</td>
<td>4.3</td>
</tr>
</tbody>
</table>

As shown in Tables 22 and 23, the proportion of incidents where the attending unit contacted other mental health services for information was equivalent across experimental conditions; ($\chi^2(2, N=786) = .190, p>.05$). The proportion of incidents where the attending unit contacted other mental health services to request attendance was also equivalent across experimental conditions; ($\chi^2(2, N=786) = .183, p>.05$). Other mental health services (i.e., other than the MHCR mental health practitioner) were more likely to attend incidents in the true control condition (MHS attended 9.9%, N=29 of all incidents) and the test/control condition (MHS attended 11.0%, N=25 of all incidents), compared to the true test condition (MHS attended 4.7%, N=13 of all incidents; ($\chi^2(2, N=797) = 7.810, p<.05$).

The MHCRMTs were contacted for advice by non-MHCR units in the test/control condition in 11.7% of incidents. MHCRMTs attendance was requested in 10.8% of incidents. The MHCRMTs attended 7.5% (N=17) of jobs in the test/control condition and attended 70.8% of jobs they were called to. For all incidents attended (N=277), the mental health practitioner formally engaged\(^{18}\) with the PAR in 80.1% of incidents.

---

\(^{18}\) The term ‘formally engaged’ refers to any form of triage/assessment that was undertaken by the MHP.
4.5.3.5 Incident outcomes

For incidents where the PAR was located, advice was significantly more likely to be provided to the PAR in the true test condition; ($\chi^2(2, N=796) = 57.058, p= .000$) compared to true control and test/control conditions. Furthermore, a referral to relevant support services was significantly more likely to be made in the true test condition ($\chi^2(2, N=796) = 92.520, p= .000$), and a police outcome was significantly less likely in the true test condition ($\chi^2(2, N=796) = 7.067, p<.05$). These findings are shown in Tables 24, 25, and 26 respectively.

Table 24: Number of incidents in which advice was provided to PAR

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=293)</td>
<td>42</td>
<td>14.3</td>
</tr>
<tr>
<td>Test/Control (N=226)</td>
<td>37</td>
<td>16.4</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>108</td>
<td>39.0</td>
</tr>
</tbody>
</table>

Table 25: Number of incidents in which a referral was provided to PAR

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=293)</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Test/Control (N=226)</td>
<td>4</td>
<td>1.8</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>58</td>
<td>20.9</td>
</tr>
</tbody>
</table>

Table 26: Number of incidents where a police outcome was involved

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=293)</td>
<td>33</td>
<td>11.3</td>
</tr>
<tr>
<td>Test/Control (N=226)</td>
<td>27</td>
<td>11.9</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>16</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Table 27 below provides an overview of the types of police outcomes across experimental conditions.
There was no significant difference in the likelihood of arrest across the three conditions ($\chi^2(2, N=75)=1.699, p>.05$).

### 4.5.3.6 Transport

The findings of this research show that the PAR was significantly less likely to be transported (to any location) in the true test condition; ($\chi^2(2, N=796)=140.581, p=.000$). These data are shown in Table 28 below.

#### Table 28: Number of jobs in which the PAR was transported [to any location]

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=293)</td>
<td>208</td>
<td>71.0</td>
</tr>
<tr>
<td>Test/Control (N=226)</td>
<td>160</td>
<td>70.8</td>
</tr>
<tr>
<td>True Test (N=277)</td>
<td>75</td>
<td>27.1</td>
</tr>
</tbody>
</table>

Furthermore, the PAR was significantly less likely to be transported under the Mental Health Act ($\chi^2(2, N=438)=27.047, p=.000$). Overall reasons for transportation for each experimental condition can be seen in Table 29 below, and the venue the PAR was transported too can be seen in Table 30 below.
Table 29: Reason for Transport

<table>
<thead>
<tr>
<th>Reason for transport</th>
<th>Experimental condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>True Control</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>MH Act 156/157</td>
<td>120</td>
</tr>
<tr>
<td>Transport Order</td>
<td>22</td>
</tr>
<tr>
<td>Voluntary conveyance</td>
<td>24</td>
</tr>
<tr>
<td>Medical emergency</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
</tr>
</tbody>
</table>

Table 30: Where PAR transported

<table>
<thead>
<tr>
<th>Reason for transport</th>
<th>Experimental condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>True Control</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Hospital ED</td>
<td>187</td>
</tr>
<tr>
<td>MH facility</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
</tr>
</tbody>
</table>

Table 31 below shows who transported the PAR when required. The pattern of findings demonstrates that transportation by the responding unit was lower, and transportation by another WA Police Force unit was higher in the true test condition. There are a number of explanations for this lower rate of ‘own unit transport’ in the true test condition. Firstly, if the person was violent, made verbal threats and/or presented a risk of violence to themselves and/or police, a non MHCR response unit would be given the task of transporting the PAR to hospital. Also, if the mobile team assisted at a task that was deemed not MH-related (e.g., a family violence task), a non MHCR response unit would likely continue with any subsequent transportation. A hand over to non-MHCR units enabled MHCRMTs to remain on the road, responding to mental health tasks in the community.
Table 31: Who transported PAR

<table>
<thead>
<tr>
<th>Who transported</th>
<th>Experimental condition</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>True Control</td>
<td>Test/Control</td>
<td>True Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>WAPOL own unit</td>
<td>106</td>
<td>51.0</td>
<td>78</td>
<td>48.8</td>
<td>2</td>
</tr>
<tr>
<td>WAPOL with SJA</td>
<td>46</td>
<td>22.1</td>
<td>38</td>
<td>23.8</td>
<td>25</td>
</tr>
<tr>
<td>SJA only</td>
<td>30</td>
<td>14.4</td>
<td>25</td>
<td>15.5</td>
<td>21</td>
</tr>
<tr>
<td>WAPOL other unit</td>
<td>9</td>
<td>4.3</td>
<td>9</td>
<td>5.6</td>
<td>16</td>
</tr>
<tr>
<td>MHS</td>
<td>9</td>
<td>4.3</td>
<td>6</td>
<td>3.8</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>3.9</td>
<td>4</td>
<td>2.5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>100</strong></td>
<td><strong>160</strong></td>
<td><strong>100</strong></td>
<td><strong>75</strong></td>
</tr>
</tbody>
</table>

Table 32 below shows that the time spent waiting for external transport when requested was equivalent across experimental conditions.

Table 32: When transport was requested from external agency, time waiting for external transport

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=38)</td>
<td>0:23</td>
<td>0:30</td>
<td>0:02</td>
<td>2:50</td>
</tr>
<tr>
<td>Test/Control (N=34)</td>
<td>0:17</td>
<td>0:17</td>
<td>0:02</td>
<td>1:10</td>
</tr>
<tr>
<td>True Test (N=24)</td>
<td>0:24</td>
<td>0:19</td>
<td>0:09</td>
<td>1:20</td>
</tr>
</tbody>
</table>

Table 33 below shows the actual health facility the PAR was transported to, when transportation was required to a health facility.

Table 33: Health facility PAR transported to

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=188)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fiona Stanley Hospital</td>
<td>34</td>
<td>18.1</td>
</tr>
<tr>
<td>St John of God Hospital Midland</td>
<td>28</td>
<td>14.9</td>
</tr>
<tr>
<td>Royal Perth Hospital</td>
<td>29</td>
<td>15.4</td>
</tr>
<tr>
<td>Rockingham</td>
<td>49</td>
<td>26.1</td>
</tr>
<tr>
<td>Peel</td>
<td>29</td>
<td>15.4</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>10.1</td>
</tr>
<tr>
<td>Test/Control (N=139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joondalup Health Campus</td>
<td>30</td>
<td>21.6</td>
</tr>
<tr>
<td>Armadale Health Service</td>
<td>31</td>
<td>22.3</td>
</tr>
<tr>
<td>Royal Perth Hospital</td>
<td>18</td>
<td>12.9</td>
</tr>
<tr>
<td>SCGH</td>
<td>21</td>
<td>15.1</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>28.1</td>
</tr>
<tr>
<td>True Test (N=56)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sir Charles Gardiner Hospital</td>
<td>17</td>
<td>30.4</td>
</tr>
<tr>
<td>Graylands Hospital</td>
<td>9</td>
<td>16.1</td>
</tr>
<tr>
<td>Armadale Health Service</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>Royal Perth</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>25.1</td>
</tr>
</tbody>
</table>
The findings of this research also showed that time spent at a health facility (all types combined) was significantly lower in the true test condition; F(2, 313)= 9.144, p= .000. Parametric analysis indicated that time spent at an emergency department was significantly lower in the true test condition; F(2, 270)= 4.942, p < .01. However, non-parametric analysis indicated no significant difference in the medians of the three groups (medians were as follows; true control=1:05, test/control= 1:10 ad true test= 0:40). Although the pattern of findings shows that time spent at a mental health facility was lower in the true test condition, this finding was not statistically significant; F(2, 36)= .122, p>.05. The pattern of findings in relation to each variable can been seen in Tables 34, 35, and 36 below.

**Table 34: Time spent at health facility (all health facilities combined)**

<table>
<thead>
<tr>
<th>District</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=167)</td>
<td>1:27</td>
<td>1:19</td>
<td>0:01</td>
<td>6:47</td>
</tr>
<tr>
<td>Test/Control (N=105)</td>
<td>1:12</td>
<td>1:01</td>
<td>0:01</td>
<td>5:33</td>
</tr>
<tr>
<td>True Test (N=44)</td>
<td>0:37</td>
<td>0:36</td>
<td>0:00</td>
<td>2:33</td>
</tr>
</tbody>
</table>

**Table 35: Time spent at emergency department**

<table>
<thead>
<tr>
<th>District</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=153)</td>
<td>1:32</td>
<td>1:19</td>
<td>0:01</td>
<td>6:47</td>
</tr>
<tr>
<td>Test/Control (N=90)</td>
<td>1:21</td>
<td>1:01</td>
<td>0:01</td>
<td>5:33</td>
</tr>
<tr>
<td>True Test (N=30)</td>
<td>0:49</td>
<td>0:38</td>
<td>0:01</td>
<td>2:33</td>
</tr>
</tbody>
</table>

**Table 36: Time spent at mental health facility**

<table>
<thead>
<tr>
<th>District</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=11)</td>
<td>0:18</td>
<td>0:37</td>
<td>0:02</td>
<td>2:10</td>
</tr>
<tr>
<td>Test/Control (N=14)</td>
<td>0:18</td>
<td>0:28</td>
<td>0:04</td>
<td>1:56</td>
</tr>
<tr>
<td>True Test (N=14)</td>
<td>0:13</td>
<td>0:18</td>
<td>0:00</td>
<td>0:58</td>
</tr>
</tbody>
</table>

**4.5.3.7 Mental health consumer details**

For all incidents attended, the average age, gender, and status (adult as opposed to juvenile) of the PAR was equivalent across experimental conditions. A PAR was typically an adult (as opposed to juvenile) between the ages of 33 to 37, with a slightly higher proportion of males compared to females. The proportion of incidents where attending officers recorded having prior interaction with the PAR due to mental health concerns was also equivalent across experimental conditions, and was reasonably low overall. These findings are shown in Tables 37, 38, 39, and 40 respectively.
Table 37: Age of PAR

<table>
<thead>
<tr>
<th>District</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=327)</td>
<td>35.19</td>
<td>14.25</td>
<td>3</td>
<td>87</td>
</tr>
<tr>
<td>Test/Control (N=250)</td>
<td>33.40</td>
<td>14.09</td>
<td>7</td>
<td>83</td>
</tr>
<tr>
<td>True Test (N=323)</td>
<td>37.54</td>
<td>15.26</td>
<td>6</td>
<td>85</td>
</tr>
</tbody>
</table>

Table 38: Gender of PAR

<table>
<thead>
<tr>
<th>District</th>
<th>Male %</th>
<th>Female %</th>
<th>Transgender %</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=322)</td>
<td>53.3</td>
<td>46.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Test/Control (N=254)</td>
<td>54.7</td>
<td>44.5</td>
<td>0.8</td>
</tr>
<tr>
<td>True Test (N=324)</td>
<td>60.2</td>
<td>38.9</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Table 39: Status of PAR: Adult or juvenile

<table>
<thead>
<tr>
<th>District</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=327)</td>
<td>Adult</td>
<td>291</td>
</tr>
<tr>
<td></td>
<td>Juvenile</td>
<td>36</td>
</tr>
<tr>
<td>Test/Control (N=250)</td>
<td>Adult</td>
<td>213</td>
</tr>
<tr>
<td></td>
<td>Juvenile</td>
<td>37</td>
</tr>
<tr>
<td>True Test (N=323)</td>
<td>Adult</td>
<td>293</td>
</tr>
<tr>
<td></td>
<td>Juvenile</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 40: Number of incidents where attending officers had had previous interaction with PAR due to mental health concerns

<table>
<thead>
<tr>
<th>District</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=274)</td>
<td>62</td>
<td>22.6</td>
</tr>
<tr>
<td>Test/Control (N=212)</td>
<td>52</td>
<td>24.5</td>
</tr>
<tr>
<td>True Test (N=289)</td>
<td>75</td>
<td>26.0</td>
</tr>
</tbody>
</table>

4.5.3.8 Use of force

The findings of this research show that use of force by police during incidents involving a person experiencing mental illness were significantly lower in the true test condition than the test/control and the true control condition; ($\chi^2$ (2, N=834)= 10.918, p<.01). Although the incidence of use of force by the PAR was too low to enable statistical analyses, the pattern of findings suggests that use of force by the PAR was also lower in the true test condition than the test/control and the true control condition. These data can be seen in Tables 41 and 42 below.

Table 41: Use of force by police

<table>
<thead>
<tr>
<th>Condition</th>
<th>Numbers of jobs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=299)</td>
<td>42</td>
<td>14.0</td>
</tr>
<tr>
<td>Test/Control (N=235)</td>
<td>28</td>
<td>11.9</td>
</tr>
<tr>
<td>True Test (N=300)</td>
<td>18</td>
<td>6.0</td>
</tr>
</tbody>
</table>
### Table 42: Use of force by PAR

<table>
<thead>
<tr>
<th>Condition</th>
<th>Numbers of jobs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>True Control (N=299)</td>
<td>7</td>
<td>2.3</td>
</tr>
<tr>
<td>Test/Control (N=235)</td>
<td>7</td>
<td>3.0</td>
</tr>
<tr>
<td>True Test (N=300)</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

When force was used, 2 PARs in the True Control condition sustained an injury and 1 PAR in the True Test condition sustained an injury. When force was used, 4 police officers in the True Control condition sustained injuries and 2 police officer in the Test/Control condition sustained an injury.

#### 4.6 Conclusion

The qualitative findings of this research emphasised that MHCR provided significant benefits for the individual experiencing a mental health crisis. In particular, MHCR enabled the respectful resolution of incidents whereby the mental health consumer was provided a voice, enabling them to have some control over the outcome of the incident. Positive resource impacts for the agency were also described as incidents were resolved in a timely manner, transportation was less frequent and less time was spent in ED. However, tensions were described as emerging from the inconsistency between business as usual and the MHCR model, the positioning of MHCRMTs, understandings of the role and value of MHCRMTs and disparate organisational policies and procedures (police and health).

Qualitative data from MHCR officers and mental health practitioners also showed that the expertise of the mental health practitioner enabled the determination of “real risk,” and when this was low, enabled mental health consumers to be supported in their homes rather than being transported to hospital. In the absence of MHCR, the default response of police officers who felt ill equipped to accurately gauge risk, was to transport the PAR to hospital. This situation highlighted tensions between business as usual and the MHCR model. Non-MHCR officers described frustration as they were, at times, required to attend an address which had previously been attended by the MHCT. On this second attendance, response officers resorted to transporting the individual to an ED. Officers indicated that if the individual had been apprehended in the first instance they would not need to play “clean-up” and the individual would have had their needs met sooner. This view indicates a lack of understanding regarding the needs of individuals experiencing mental health crises. As described by MHCR and mental health practitioner participants, and as demonstrated by the incident data, more often than not, the needs of the PAR are to have their welfare checked, their medication checked, and for referrals to be made to health services. When the MHCR team is available, apprehension and
transportation to a hospital emergency department is often not required as this does not meet the needs of the PAR. Instead, apprehension and transportation to a hospital meets the needs of response officers in moving responsibility for the PAR from police to health, at least for a period of time. This is a short-sighted view as hospitals inevitably release the PAR and again, the PAR comes to the attention of police. This tension between business as usual and the MHCR model could be dissipated if response officers and MHCR officers were able to work together on a more frequent basis. This would enable exposure to the MHCR approach, knowledge transfer and may facilitate the development of the same collaborative working relationship between police units, as was evident between MHCR officers and mental health practitioners.

The quantitative findings of this research showed frontline police officer perceptions of role adequacy were ambivalent, in the sense that they neither perceived themselves to be adequate or not adequate. However, frontline police officers from true/test districts were more confident in their ability to manage mental health related tasks. Despite this, when excluding mental health co-response officers from analyses, findings showed no differences in perceptions of confidence across test and control districts. Frontline police officers in both test and control districts neither agreed nor disagreed that they were confident in their ability to manage mental health related tasks. Finally, frontline police officers who had requested information from the MHCRMTs indicated that the information provided somewhat influenced decision making and was considered valuable to decision making.

The findings from incident data showed that the proportion of incidents deemed to be mental health related was equivalent across all policing districts. By far the greatest frequency of police attendance in all policing districts was for a welfare check. Furthermore, the proportion of incidents where attending officers recorded having prior contact with a PAR because of mental health concerns was equivalent across all policing districts. Based on the role of the MHCRMTs, it was expected that the MHCRMTs would report a greater degree of prior contact with mental health consumers, as this would indicate the efficient allocation of the district resource. The MHCRMT should be (and reportedly are) dealing with known MH consumers and establishing management plans to 1) reduce recidivist calls to police but also 2) when recidivist calls occur, ensure that the MHCRMT is dispatched to the task. The MHCRMT has access to the individual’s mental health history and are in a position to establish a relationship with the PAR to enable the efficient resolution of incidents. In terms of recidivist calls for police response, whilst it is impossible to control who the PAR calls in a time of crisis,
police are able to control the *management* of these calls once received by police. Whilst this was reported in qualitative interviews, the same was not reflected in incident data.

Incident data also showed that police time taken attending incidents involving individuals experiencing a mental health crisis was significantly lower in true/test districts. The time taken attending incidents where the individual was not transported was also lower in the true/test districts (although this difference was not statistically significant). Furthermore, when the individual was transported, the time taken attending incidents was significantly lower in the true/test districts. This pattern of findings implies that MHCRMTrs spend less time at incidents, particularly when transport is required. This may be explained by ‘handovers’, from the MHCRMTrs to a non MHCR unit when an individual required transportation. This handover enabled the MHCRMTr to remain on the road, responding to mental health tasks in the community. Alternatively, in circumstances where the MHCRMTr does undertake the transport, data indicates that they experience a faster handover to health services.

Findings also showed the PAR was significantly less likely to be transported in true/test districts. Hence, when MHCR attends a mental health related task they are more likely to leave the PAR in their home, reducing resource-related impacts associated with transportation (for both police and health services) and enabling a less disruptive/intrusive outcome for the PAR. When transported to a health facility (all facilities combined), time spent at the health facility was significantly lower in true/test districts. When this transport was to an ED, time spent at ED was also lower in true/test districts and when transport was to a mental health facility, time spent at the facility was, again, lower in true/test districts.

The findings of this research also show that advice, and referral to relevant services was significantly more likely to be provided in true/test districts. This implies that the MHCR has a positive impact on the likelihood of PAR engagement with mental health services in the community. The desired outcome associated with this is a reduction in the need for future police attendance. However, this is dependent on the availability of services and PAR uptake of these referrals, analysis of which was outside the scope of this evaluation. A police outcome was also significantly less likely in the true/test districts. This implies that MHCRMTrs were better able to resolve mental health related incidents without the need for formal police intervention. Evidently then, the MHCR approach lends itself to the decriminalisation of individuals experiencing mental health crises.

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19 The impact of the MHCR model on health services and the uptake of referrals made by MHCRMTrs were to be evaluated by the Department of Health and the Mental Health Commission respectively.
Finally, the findings of this research show that use of force by police during incidents involving a person experiencing mental illness was lower in true/test districts. The pattern of findings was equivalent in terms of use of force by the PAR. This implies that MHCRMTs are better able to de-escalate and resolve situations that involve individuals experiencing a mental health crisis peacefully, without having to use force to gain control of the situation.
5. Perth Watch House: The impact of a mental health practitioner

5.1 Introduction and overview

Police Watch Houses are a unique custodial setting whereby individuals are charged and held without having yet been convicted of an offence or held in protective custody (e.g. intoxicated person). Given the prevalence of mental health concerns evidenced in prison settings (Australian Institute of Health and Welfare, 2015), and the fact that Watch Houses are a gateway into formal custody settings, it is likely that many individuals detained in a Watch House will have underlying mental health concerns that require attention. As such, Watch Houses provide a unique opportunity for early intervention, ensuring that those with mental health needs have those needs both recognised, and addressed. However, there is a need to consider whose role it should be to identify and address detainee mental health concerns. Police are not trained mental health practitioners and to develop the depth of knowledge required to reliably detect and address mental health concerns would require extensive training.

Given these issues, the Mental Health Co-Response Commissioning Trial (MHCR) included the placement of a mental health practitioner within the Perth Watch House. The role of the mental health practitioner was to screen detained persons subsequently lodged at the Watch House. The assessments were implemented to facilitate the effective management of detainees identified as demonstrating signs, symptoms or a history of mental illness. It was anticipated that this capability would provide an opportunity for early intervention and diversion, and streamlined access for detainees to treatment, support and diversionary options where appropriate. The mental health practitioner had direct access to Department of Health databases, and used this information to contribute to the screening and risk assessment process involving the detainee’s mental health status.

Data provided by WA Police Mental Health Co-Response Unit (MHCRU; Progress Report # 27, Final Trial Results, see Appendix A) indicates that over the course of the trial;

- 13068 detainees were registered in custody during trial times
- 8671 detainees were screened by the practitioner
- 6% of detainees were currently active with Mental Health Services (n= 372)
- 33% of detainees were identified as having past history with Mental Health Services but were not active at the time they were held in custody (n= 2147)
- 61% of detainees were not known to mental health services (n=3918)\(^\text{20}\)

\(^\text{20}\) Further performance indicators are provided in Appendix A (Progress Report # 27, Final Trial Results).
Data provided by the WA Police Force MHCRU also indicates that over the course of the trial, 31 detainees required immediate assessment under the Mental Health Act (involuntary transports to medical facility), 468 detainees were assessed in a non-contact room 468 (data reported since September 2016), 139 referrals were made to the Forensic Mental Health Court Liaison Service, 383 referrals were made to external mental health services, and 183 referrals were made to other community services.

The purpose of this element of the research was to determine the impact of having a mental health practitioner placed at the Perth Watch House.

5.2 Research design

A mixed methods approach was incorporated for the purposes of this research. During phase one of the research, semi-structured interviews were conducted by telephone or face to face with supervisors, police auxiliary officers, members of the management team and mental health practitioners working at the Perth Watch House. A focus group was also conducted, face to face, with the Forensic Mental Health Court Liaison team. The team were interviewed as interested parties to the MHCR trial, given their role in providing assistance to detainees at the next stage of the process, when they presented at court. Questions guiding the interview and focus group focused on perceptions of the impact of having a mental health practitioner based at the Watch House.

During phase two of this research, a survey was administered to Perth Watch House staff to determine perceptions of role adequacy in responding to detainees experiencing mental health crises. The measure incorporated was equivalent to that described in Chapter 3. In addition to role adequacy, confidence, perceptions of training, knowledge and perceptions of the value of a mental health practitioner to the work undertaken were assessed.

5.3 Participants

*Phase 1: Semi structured interviews*

Eighteen police auxiliary officers (PAOs), eight supervisors, two managers and three mental health practitioners consented to participate in this research. To ensure participant anonymity, demographic detail was limited to years of service (range; 0.5-20 years). Gender and rank was excluded due to the small number of managers overall, and the fact that senior female officers would be clearly identifiable. The focus group, conducted with members of the Forensic Mental Health Court Liaison team, consisted of five practitioners.
**Phase 2: Survey**

A total of 45 participants from the Perth Watch House completed the survey; seven police officers and 38 police auxiliary officers. The majority of participants were male (N=31, 70.0%; female, N=14, 30.0%) and the average age of participants was 36.69 years (SD= 11.19), ranging from 20 to 63 years. The proportion of full time participants was 98.0% and part time was 2.0%. The average length of service was 5.72 years (SD= 6.01).

**5.4 Procedure**

**Phase 1: Semi structured interviews**

The ECU Human Research Ethics Committee approved the conduct of this research. To facilitate data collection in the first instance, the research team visited the Perth Watch House. The Officer in Charge (OIC) of the Watch House facilitated recruitment of PAOs, police officers and the mental health practitioner on shift by assigning a supervisor to approach staff and seek their consent to participate in an interview. On consenting to the interview, staff were directed to an empty office on Watch House premises where a member of the research team was waiting. As a supervisor had sought initial consent it was considered unlikely that participants would feel comfortable declining to participate, if in fact, they did not wish to take part in the research. For this reason, prior to the interview commencing, participants were informed by the member of the research team that they were not required to participate, and that if they preferred not to participate, they could return to work and their supervisor would not be informed. No participant declined to be interviewed.

When staff were not available on shift at the Watch House to participate in a face to face interview, the research team sent an email inviting staff to participate via a telephone interview. Any staff who were willing to participate were asked to indicate a suitable day and time for the interview to take place. The research team then called the participant at this predetermined time to conduct the interview.

Interviews were recorded and transcribed verbatim. Interview length ranged from 10 to 52 minutes in duration. All identifying information was omitted from transcriptions. The focus group with the Forensic Mental Health Court Liaison team was conducted in an office at Graylands Hospital. The focus group ran for 47 minutes, was recorded and also transcribed verbatim. Thematic analysis was applied to facilitate the development of a rich description of perceptions. Analysis was iterative and data driven (Braun & Clarke, 2006) whereby themes and related sub-themes were identified inductively (Patton, 2002).
**Phase 2: Survey**

The Phase 2 procedure was equivalent to that described in Chapter 3.

### 5.5 Findings and interpretations

#### 5.5.1 Phase 1: Semi structured interviews

The reported impact of having a mental health practitioner located at the Watch House is represented in Figure 4 below. The figure illustrates participant reports that the MHCR model within the Watch House setting enabled police and health services to ‘wrap around’ the individual detainee experiencing mental health concerns, in terms of ensuring appropriate custodial and mental health care. Whilst all stakeholders reported benefits from the strategy, participants were clear in their view that benefits were greatest for the individual at the centre of the process.

![Figure 4: Impact of mental health practitioner in the Watch House: Core themes](image)

Themed relating to the impact of the strategy for each stakeholder included: for the individual, improvements to detainee state of mind, timely and appropriate response to mental health concerns, and connection to services. Themes relating to the impact of the strategy for police included; additional resources which resulted in a reduction in pressure, greater accountability in custodial care, effective allocation of resources and improvements to officer knowledge and awareness. Themes relating to the impact for health services included: reduced demand on health services, more effective resource allocation at court, better informed decision making at court and gaps in service provision. These themes are discussed in further detail below.
The individual: Detainee state of mind

As illustrated in Figure 4, the most significant impact of the presence of a mental health practitioner in the Watch House was reported to be experienced by detainees who were experiencing mental health concerns. As one participant articulated:

...there are spin-offs, the pressure goes off us a lot, it makes our job a lot easier but some of the tortured souls that come in here ... to see them go to sleep with a little bit more peace of mind; it benefits the person in custody for sure.

The provision of mental health services within the Watch House was described as calming detainees with mental health concerns. The Watch House was described by all participants as an intimidating place, particularly for those with mental health concerns who may not necessarily be cognisant of where they are and what is happening to them. Participants described hysterical and/or suicidal detainees, unwilling to engage with police due to either fear and intimidation, or the perception that police will not understand their mental health concerns. Participants indicated that the presence of a mental health practitioner in the Watch House served to reduce fear, apprehension and/or aggression, providing detainees with someone to talk to, who has the necessary expertise to calm and reduce the risks associated with their mental state. As one participant articulated:

I’ve just been fighting with them [the detainee] in the sally port. I see them go into that room [with the mental health practitioner] and I see them come out of that room a much more controlled person, going off to sleep. It’s amazing- 100% put their head down and go to sleep.

The individual: Timely and appropriate responses

Participants described a sense of comfort from the fact that historical processes for dealing with detainee mental health concerns had ceased. Previous process required officers to call external service providers when a mental health practitioner was required at the Watch House. Although participants understood that service providers were under-resourced, they described being frustrated because calls for assistance to the Watch House were considered a low priority relative to calls for assistance to mental health consumers who remained within the community. Although a detainee, with a mental health concern, who is located within the Watch House would perhaps be better placed in a health facility rather than detention, officers and mental health practitioners reported that external service providers were typically of the view that the detainee was at least safe (secure and under observation). On the other hand, mental health consumers who were located in the community, remained a danger to themselves.
and others. Participants were clear in their view that the presence of the mental health practitioner in the Watch House ensured that detainees received a timely and appropriate response to mental health concerns. As one participant articulated; “In the past, we would have been able to get them help, but not quickly and maybe not the help that they required straight away. Here we can do that”.

Participants provided a number of examples to illustrate timely and appropriate response to detainees’ mental health concerns. For example, participants described forming a detainee and sending them directly to a mental health facility, rather than to an emergency department (ED), with a bed arranged at the facility prior to their arrival. An ED was not considered an appropriate place for many detainees who experience mental health concerns. Conveying individuals with mental health concerns to an ED was described as placing unnecessary and increased demands on both police and health services, and creating unnecessary angst for the individual in need of mental health care. A different example provided by participants was making contact with the detainee’s community-based service when the health database indicated that the detainee was overdue on their medication. In these instances, the mental health practitioner would organise for the medication to be provided, to the detainee, in the Watch House. In this way, the practitioner in the Watch House served as a safety net for service provision and ensured health databases were up to date in circumstances when the individual had been out of contact with their service providers in the community.

The individual: Connection to services

Mental health practitioners in the Watch House were also described as connecting detainees to services in the community, for example, by placing a pamphlet in their property and asking the detainee to commit to calling a service the next day. The provision of mental health services in the Watch House was also described as leading to improved service provision for detainees should they be required to appear at court following their detainment at the Watch House. Specifically, the mental health practitioner in the Watch House was able to update health databases and indicate to the Forensic Mental Health Court Liaison Service, who provide assistance to those with mental health concerns in the Central Law Courts, which individuals needed to be seen. This information not only assisted the individual but also informed the decision making and resource allocation of the Forensic Mental Health Court Liaison service (discussed below).
Police: Additional resources

The presence of a mental health practitioner in the Watch House was described as having a positive impact for police. This impact was distinctly evident amongst Watch House supervisors as opposed to police auxiliary officers. This can be understood in the sense that it is supervisors who are responsible for operational decision-making (e.g., resource allocation) and decisions regarding the custodial care of individuals whilst they are detained in the Watch House. Participants described the provision of a mental health practitioner as “a much needed resource.” This resource provided information, made relevant inquiries and ensured that the mental health aspects of detainee wellbeing were addressed, enabling participants to focus on the duties/ responsibilities they were adequately trained to perform. Having an appropriately trained resource was described as comforting, providing participants with peace of mind that mental health needs would not be overlooked or missed. As articulated by one participant:

Peace of mind, peace of mind is absolutely huge. When you’re really under the hammer, going 100 miles an hour, trying to get everything processed and everything correct juggling all balls up in the air, you’ve got a professional whose identifying these mental health issues and addressing them.

Although participants described significant and obvious differences between the roles undertaken by custodial staff, the medical nurse and the mental health practitioner, they emphasised that each worked together with precision to ensure appropriate custodial care of the detainee. This precision had developed over the course of the trial, once roles and responsibilities were distinguished and individuals developed a sense of clarity in their role relative to the role of others in the Watch House.

Police: Reduced pressure

Participants were clear in their view that the added resource of a mental health practitioner in the Watch House, and the ability to draw on their knowledge and expertise, relieved the pressure felt by participants who had very little understanding of mental health. Having to make decisions about the custodial care of individuals experiencing mental health concerns with limited knowledge and understanding was described as “a big burden and risk to carry.” Participants referred to deaths in custody, coronial inquiries and investigations by oversight bodies and the relief they experienced that critical decisions about the wellbeing of detainees were now informed by those who had the required expertise. On discussing the potential of a coronial inquiry one participant stated “I could hear the question coming at me you know “well what qualifications do you have to make these choices?” Participants described
now being able to ask the opinion of a trained professional who can check the mental health history of the detainee and provide their clinical assessment of the situation to ensure that appropriate care is provided, thereby reducing risk, and providing peace of mind. Once again, this benefit was most relevant to supervisors. As articulated by one participant:

*I feel so much more comfortable when these people come in and for once I don’t have to make some sort of a judgement call, is the person faking, is the person just tripping out on drugs or is there massive underlying mental issues. I’m not educated in that, why should it be upon me to make a call about that.*

**Police: Greater accountability in custodial care**

In terms of custodial care, one participant explained that the presence of a mental health practitioner had “raised the bar” in terms of accountability in custodial care. It was acknowledged that individuals were held in custody to protect the wider community. However, it was also considered fundamentally important to provide custodial care for those individuals, “and if they are in need of mental health assistance that we have that readily available with someone who is qualified.” The presence of a mental health practitioner ensures appropriate custodial care because risks are identified and appropriately managed. Processes of past had required participants to rely on untrained judgement to identify mental health issues and to develop a management plan. A particularly compelling view was expressed by one participant in recalling how WA Police managed the mental health of detainees in the Watch House prior to the introduction of the mental health practitioner:

*I didn’t realise how wrong we’d been doing it until these people [MHP] came along. It was so bad. If there had of been a death in custody my god…I was making choices for people that I shouldn’t have, probably, just for expediency sakes, to get the job done… how lucky are we that we got through that unscathed. Bloody hell. I can’t believe it’s not 24/7.*

**Police: Effective allocation of resources**

Participants were of the view that informed decision-making, facilitated by the mental health practitioner, enabled the more effective allocation of resources. Historically, detainees exhibiting strange behaviour were simply sent to hospital because of the risks associated with doing nothing; “if I had any doubt whatsoever we’d just send them to the hospital- losing officers and vehicles.” With MHCR, participants indicated they were now able to draw on professional knowledge to distinguish between mental health and behavioural issues.
Participants were able to consult with the mental health practitioner to determine if the detainee had a mental health history, or have the detainee assessed by the practitioner to determine the underlying causes of their behaviour. On this basis Watch House supervisors were better able to determine whether the individual required further assessment at a hospital or whether they were able to remain in the Watch House, under the observation of the mental health practitioner and the medical nurse. This not only ensured appropriate custodial care for the individual detainee, but to all detainees in the Watch House, as staff were able to remain in the Watch House where they are needed, rather than engaging in unnecessary transports to an ED department.

**Police: Officer knowledge and awareness**

Participants were of the view that their knowledge of mental health had grown considerably due to the presence of a mental health practitioner. Supervisors noted that they, and other officers were more tuned in to mental health and were more aware of relevant legislation. Mental health practitioners also reported a change in the knowledge and responses of officers and supervisors in relation to the mental welling of detainees. An example included an officer asking the mental health practitioner to assess a detainee because they were exhibiting behaviour that raised some concern about their wellbeing, when previously, the officer was not attuned to identifying behaviour that was not overtly unusual. Another example, provided by both officers and mental health practitioners, officers were better able to distinguish behaviour that was drug induced as opposed to an organic mental health concern. This learning and increased confidence in assessing behaviour was facilitated by conversations with the mental health practitioner and observing the mental health practitioner at work. For some participants, this increased awareness and confidence highlighted gaps in current knowledge and training. Although participants did not expect to have full knowledge of mental health, they were of the view that certain matters of direct relevance to their work would be useful to know (e.g., how to talk to someone with mental health concerns to calm them; medications; behavioural patterns and triggers). As articulated by one participant, “*It would be interesting to know what they’re saying to calm them down- that would be helpful- as they are not here 24 hours a day.*” This highlights a need for further training so that, as stated by one officer, “*we could work better in unison with the MH nurse*”.  

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Health services: Reduced demand on health services

The presence of a mental health practitioner in the Watch House was also perceived as impacting on health services. Participants were clear in their view that informed decision making within the Watch House reduced the need to convey a detainee to ED and increased the likelihood that detainees with legitimate mental health concerns were in fact conveyed. However, participants were also of the view that the presence of a mental health practitioner in the Watch House reduced demand on community health services who would otherwise be called to the Watch House to assess the detainee (e.g., Inner City Health)

Health services: Effective resource allocation

The presence of a mental health practitioner in the Watch House was also described as enhancing service provision in the next stage of the process, when the individual was required to attend court. This was particularly evident in relation to decision-making and the allocation of resources attached to the Forensic Mental Health Court Liaison Service (FMHCLS). The FMHCLS was described as a limited resource. One clinician is allocated to the Central Law Courts each day to attend to the needs of those appearing before court who have a mental health history in order to assess their mental health needs. As the process is fast, the clinician is working against the time pressures of court process. Therefore, there is not a lot of time to gather information, assess the client and inform legal professionals of any mental health issues. The presence of the mental health practitioner in the Watch House was described as enabling the court clinician to focus and to prioritise efforts appropriately. Specifically, the clinician was able to check the database, determine which detainees had been seen by the mental health practitioner in the Watch House, and from that, determine who they needed to follow up as a matter of priority. Therefore, there was a more targeted delivery of a limited service which has obvious benefits for those presenting at court with mental health concerns. As one clinician articulated:

*I’m noticing with Co-Response there, I’ve been able to be a bit more pointy in my selection of who I see. For example, yesterday I probably had 5 people who I needed to see. I was able to put one aside because Co-Response had already met with him in custody. He told them he was treated, he was ok, he was settled. From that entry I thought, you know what, I don’t need to touch base with this bloke... so it just felt like I was able to be a bit more focussed.*
**Health services: Informed decision making**

Effective resource allocation (described above) resulted from better informed decision-making which was enabled by the presence of the mental health practitioner in the Watch House. In addition to identifying priority individuals, court clinicians also indicated that information provided by the mental health practitioner in the Watch House was used to inform clinical assessments of those individuals. For example, based on information provided by the mental health practitioner (via the health database), court clinicians were able to assess the improvement or deterioration of mental state from the time of detainment to the time of court attendance, and from that, determine the most appropriate response. For example, one court clinician indicated that the mental health practitioner reported that the detainee had been on a drug binge and was not overdue for medication. In this case, the court clinician was able to determine that the detainee’s behaviour was likely due to intoxication and therefore did not recommend a hospital order, thereby avoiding the most restrictive option for the detainee. Although the court clinician would likely have come to the same conclusion after fully assessing the detainee, the process was described as expediting an appropriate response, whilst ensuring the effective use of resources (e.g., the clinician’s time, hospital beds and appropriate care).

**Health services: Gaps in service provision**

In relation to health services in general (not related to the FMHCLS), all participants described significant gaps in service provision for detainees. Some gaps were identified in relation to the nature of the MHCR model, and other gaps related directly to the availability of appropriate community based services beyond the period of detainment. In terms of the MHCR model, participants emphasized that the mental health practitioner was not available at the busiest times in the Watch House. Participants were strongly of the view that the service should be twenty-four hours a day, seven days a week, as it is for the medical health nurse. The remaining participants were of the view that at a minimum, the service should be provided throughout the night and on Sundays. Participants described experiencing significant difficulties when a detainee comes in before a mental health practitioner commences a shift. Participants were required to decide whether to wait for the mental health practitioner or call an external service. If an external service is called, the delay is often significant which means decision-making falls back on the medical health nurse. The impact was described as significant. As one participant indicated; “It can be limiting by the fact of when they are
available because you become reliant on their input and when they’re not there obviously you don’t have it.”

In terms of health services, the availability of the mental health practitioner in the Watch House highlighted a lack of follow-up therapeutic services once the custodial process was complete. Clinicians in particular, and all remaining participants expressed concern that whilst valuable resources had been added enabling the identification of detainees experiencing a mental health issue, no changes had been made to the already stretched services in the community that are required to respond to that newly identified need.

5.5.2 Phase 2: Survey findings

Survey data sought to determine perceptions of role adequacy, confidence and decision making of Perth Watch House staff. Perceptions of training and the presence of a mental health practitioner within the Perth Watch House were also examined.

Role Adequacy

Survey findings for Watch House participants’ perceptions of role adequacy are shown in Table 43 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 43: Perth Watch House staff perceptions of role adequacy

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree to which participants perceive they have the necessary experience to respond to mental health related tasks</td>
<td>3.31</td>
<td>1.15</td>
</tr>
<tr>
<td>Degree to which participants have responded to a wide range of mental health tasks</td>
<td>4.13</td>
<td>1.01</td>
</tr>
<tr>
<td>Degree of confidence participants have in their ability to respond to mental health related tasks</td>
<td>3.53</td>
<td>1.12</td>
</tr>
<tr>
<td>Degree to which participants perceive they have the necessary knowledge to help people with mental health related tasks</td>
<td>3.16</td>
<td>1.19</td>
</tr>
<tr>
<td>Degree to which participants perceive they do not have the skills necessary to respond to mental health related tasks</td>
<td>3.00</td>
<td>1.09</td>
</tr>
<tr>
<td>Degree to which participants perceive they are able to respond as competently to those with mental health related issues</td>
<td>3.42</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Combined Total Role Adequacy</strong></td>
<td><strong>3.42</strong></td>
<td><strong>0.86</strong></td>
</tr>
</tbody>
</table>

As shown in Table 43, participants somewhat agreed that they had responded to a wide range of mental health tasks (M=4.13). However, participants neither agreed, nor disagreed that they had the necessary experience to respond to mental health related tasks (M=3.31), neither
agreed, nor disagreed that they were confident in their ability to respond to mental health
related tasks (M=3.53), neither agreed, nor disagreed that they have the necessary knowledge
to help people with mental health related tasks (M=3.16), neither agreed, nor disagreed that
they do not have the skills necessary to respond to mental health related tasks (M=3.00), and
neither agreed, nor disagreed that they were able to respond as competently to those with mental
health related issues as those without (M=3.42). This pattern of findings suggests an ambivalent
sense of capability amongst Watch House staff in relation to their role in responding to mental
health tasks.

Confidence

Survey findings for participant confidence in addressing mental health incidents are shown in Table 44 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

Table 44: Perth Watch House staff confidence

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence in ability to identify a person suffering a mental health issue</td>
<td>3.98</td>
<td>0.93</td>
</tr>
<tr>
<td>Confidence in ability to identify a person suffering a drug induced mental health issue</td>
<td>3.93</td>
<td>0.86</td>
</tr>
<tr>
<td>Confidence in ability to manage an incident involving a person with a mental health issue</td>
<td>3.64</td>
<td>1.01</td>
</tr>
<tr>
<td>Confidence in ability to communicate during an incident involving a person with a mental health issue</td>
<td>3.86</td>
<td>0.80</td>
</tr>
<tr>
<td>Confidence in ability to negotiate during an incident involving a person with a mental health issue</td>
<td>3.64</td>
<td>0.94</td>
</tr>
<tr>
<td>Confidence in ability to de-escalate an incident involving a person with a mental health issue</td>
<td>3.80</td>
<td>0.90</td>
</tr>
<tr>
<td>Confidence in decision making during an incident involving a person with a mental health issue</td>
<td>4.02</td>
<td>0.76</td>
</tr>
<tr>
<td>Combined Total Perceived Confidence</td>
<td>3.84</td>
<td>0.76</td>
</tr>
</tbody>
</table>

As shown in Table 44, participants on average, neither agreed nor disagreed that they felt
confident in their ability to identify a person suffering a mental health issue (M=3.98), that they
were confident in their ability to identify a person suffering a drug induced mental health issue
(M=3.93), that they were confident in their ability to communicate during an incident involving
a person with a mental health issue (M=3.86), and that they were confident in their ability to
de-escalate an incident involving a person with a mental health issue (M=3.80). Participants
were slightly less confident in their ability to negotiate during an incident involving a person
with a mental health issue (M=3.64) and manage an incident involving a person with a mental health issue (M=3.64). However, participants somewhat agreed that they were confident in their decision making during an incident involving a person with a mental health issue (M=4.02).

**Training**

Survey findings for participant perceptions of training are shown in Table 45 below. Responses were provided on a 5 point Likert scale ranging from 1= strongly disagree to 5= strongly agree.

<table>
<thead>
<tr>
<th>Element</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA Police training on how to respond to people experiencing a mental health issue is perceived as adequate</td>
<td>3.30</td>
<td>1.13</td>
</tr>
<tr>
<td>Participant perceptions of the adequacy of training for responses to mental health incidents</td>
<td>2.95</td>
<td>1.16</td>
</tr>
<tr>
<td>Combined Total Training</td>
<td>3.13</td>
<td>1.04</td>
</tr>
</tbody>
</table>

As shown in Table 45, participants on average neither agreed nor disagreed that WA Police training on how to respond to people experiencing a mental health issue was adequate (M=3.30) and somewhat disagreed that training for responses to mental health incidents was adequate (M=2.95).

**Perceptions of a mental health practitioner within the Perth Watch House**

In relation to staff engagement with the mental health practitioner, 80.0% of participants had been provided with information from the mental health practitioner and 62.0% had specifically requested that information. Participants who had been provided information somewhat agreed that the information influenced decision making when dealing with detainees (M=4.09), that the information provided was valuable (M=4.20), and that there is value having a mental health practitioner in the Perth Watch House (M=4.59).

Participants were also asked to provide feedback in relation to the MHCR trial in an open ended, free narrative question. Twenty-five participants provided a response to the question. Qualitative responses were reduced to key words and phrases and frequencies and coded by two members of the research team. Inter-rater reliability, calculated via Cohen’s kappa, demonstrated an ‘almost perfect’ level of agreement in the codes assigned to qualitative
responses ($\kappa = 0.85$; Landis & Koch, 1977). The nature and frequency of key responses are shown in Table 46 below. The most frequent response in relation to the presence of the mental health practitioner was that the role needed to be expanded in terms of hours on shift.

Table 46: Nature and frequency of qualitative feedback responses- Watch House

<table>
<thead>
<tr>
<th>Nature of response</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP in WH is valuable in terms of expert knowledge/opinion/information</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td>MHP in WH is valuable in terms of ensuring detainee wellbeing</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td>MHP in WH is valuable in terms of ensuring the safety of others (e.g., staff)</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td>MHP in WH is valuable (value unspecified, e.g., ‘they do a great job and are very helpful’, ‘glad we have MH available at the WH’)</td>
<td>6</td>
<td>20.0</td>
</tr>
<tr>
<td>Role needs to be expanded (e.g., more hours, 24/7 coverage)</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>MHP in WH has a negative impact on process/procedures (e.g., takes longer to process detainees)</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td>Other (e.g., MHPs are inconsistent in their practice, need for officer training, MHP needs better access to community MH resources)</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td>TOTAL$^{21}$</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

5.6 Conclusion

The qualitative findings of this research suggest that the presence of a mental health practitioner in Police Watch Houses provides opportunity for the early identification of mental health issues and also for early intervention. Including a mental health practitioner in the Perth Watch House as a component of the MHCR model mostly benefits detainees by ensuring they are calm and at ease, in a positive state of mind and connected to appropriate services. However, there are also benefits for both police and health. From the perspective of police, access to a mental health practitioner increases accountability, reduces pressure, ensures the effective allocation of resources and the formation of an appropriate management plan for detainees. Benefits for health include a reduced demand for health services (e.g., EDs) and the improvement of service provision at the court stage. Despite these identified benefits, gaps were identified in terms of when a mental health practitioner is rostered on. Findings also emphasised a significant lack of therapeutic services in the community to address the newly identified demand for services.

The quantitative findings of this research show that Watch House participant perceptions of role adequacy were ambivalent, in the sense that they neither perceived themselves to be adequate or not adequate. Furthermore, Watch House participants neither agreed nor disagreed that they were confident in their ability to manage mental health related

$^{21}$ Total (30) > N (25) as multiple codes were assigned to individual responses as required
tasks. Finally, participants in the Watch House somewhat agreed that the information provided by the mental health practitioner influenced decision making when dealing with detainees, and that the information was valuable.
6. Consumer perceptions of Mental Health Co-Response

6.1 Introduction and overview

In the last decade, a significant body of work has emerged emphasising the benefits to be derived from including mental health consumers in the process of identifying what services are needed by consumers and how services should be structured and delivered (Lammers & Happell, 2004; Borg, Karlsson, Lothrus & Davidson, 2011). The involvement of consumers and their carers is also recommended in research that examines aspects of mental health and well-being, and service development and delivery (Rose, Thornicroft & Slade, 2006). Both State and Federal government in Australia have gone so far as to suggest that the exclusion of consumer voices in mental health research is unethical (Peterson, 1999). In terms of the research process, it has been suggested that mental health consumers be involved in both research design (e.g., the development of research questions and data collection instruments) and the collection of data (e.g., by providing training in relation to the appropriate implementation of research methods when working with consumers). What has yet to occur in the literature is the broader discussion as to the circumstances which render it appropriate for consumers to be involved (e.g., what constitutes a service and what does not), and how this can be implemented in a manner that is consistent with the principles embedded within the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (National Statement).

The evaluation of the Mental Health Co-Response Trial (MHCR) is consistent with the definition of research provided in the National Statement: “Human research is conducted with or about people, or their data or tissue” (National Statement, 2015, p7). Although the initiative is classified as research, the research was not focused on the mental health and well-being of individuals, or mental health service development and delivery. It might be argued that MHCR constitutes a service provided by police to address the needs of mental health consumers. However, the MHCR is in fact a police operational deployment model, borne out of the growing number of incidents that police are required to attend that involve an individual experiencing a mental health crisis. It was some eight years ago that Clifford (2010, p. 356) described “inadequate deinstitutionalisation reforms” in Australia that strained the National Mental Health System to the degree that it was unable to meet the demand for mental health services. Many mental health consumers were described as “falling through the cracks”, unable to access services (Clifford, 2010, p. 358). The consequence of no treatment, in combination with limited social supports, was an increased likelihood of coming to the attention of police.

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Some eight years later, the situation appears to remain unchanged with police reporting a high number of calls for assistance to address mental crises.

Although MHCR is not a mental health service, necessitating the input of mental health consumers in its development and implementation, there is no doubt that it has been designed to better meet the situational needs of consumers at the point of crisis. Therefore, the model has been designed to ensure the respectful treatment of mental consumers, to reduce risk to mental health consumers, and to increase the likelihood of diversion from the criminal justice system to health services. On this basis, it is fundamentally important that the experience of mental health consumers and their carers be considered in the research examining the effect of the MHCR. What is challenging to determine is how this should occur in a safe and ethical manner. For example, to reduce risk, what research method should be incorporated? Who should conduct interviews with mental health consumers, and at what point after contact with police, and what questions should be asked? During the MHCR evaluation, these questions were initially explored in a meeting with a Mental Health Consumer Reference Group. During that meeting, it was determined that semi-structured interviews rather than a survey, would constitute the most appropriate means of exploring consumer experiences. It was also suggested that mental health consumers conduct those interviews. The nature of the information to be sought was also canvassed.

Although it was recommended that a mental health consumer collect this data (i.e., conduct the semi-structured interviews), the risk to the mental health consumer was considered too high. After all, face to face semi-structured interviews were to be conducted with offenders and non-offenders who had experienced a mental health crisis, who may, or may not have resolved their crisis at the point of interview. On reflection, as the decision was for researchers to conduct those same interviews (deemed of too great a risk for an untrained mental health consumer), some might attribute that decision to the perpetuation of stigma associated with mental illness. However, at the time of decision making, the logic applied was that the trained researchers, also psychologists, with years of experience working in a research capacity with offenders and non-offenders, would be best placed to identify and manage the obvious risks for mental health consumers that were associated with the research. On this basis, an application for the conduct of this element of the research was submitted to the ECU Human Research Ethics Committee (HREC) and was subsequently approved as being consistent with the National Statement; in particular, Chapter 4.5 People with a cognitive impairment, an intellectual disability, or a mental illness, and Chapter 4.6 People who may be involved in illegal activities.
The approved process for the recruitment of participants required the WA Police Force to compile a list of potential participants from test districts. An invitation from ECU was then mailed by the WA Police Force to potential participants. On contacting the research team, a suitable time for a telephone interview was to be negotiated on the basis that an appropriate support person was present on the premises at the time of the interview. Although the benefits to be derived from this element of the research were considered by the ECU HREC to outweigh the potential risk (as the research was granted ethics approval), when data collection commenced, an adverse event occurred that challenged the appropriateness of this decision.

Although the aforementioned process was followed, the research team received a telephone call from a social worker who indicated her client had received a letter and wished to participate in a telephone interview. The social worker left her client in the room and consent to participate was obtained in the normal manner. As the interview commenced, it became clear from the individual’s responses that she was heavily medicated and was subsequently unable to provide consent. The interview was gently terminated and the social worker was asked to return to the room to ensure the wellbeing of the individual. At that time, the social worker informed the researcher that the individual was currently hospitalised and in a rehabilitation facility. She was asked if her client was okay and she indicated that she was. Some half an hour later, the social worker called back and indicated that her patient had received the letter via WA Police in a police envelope and that this caused her patient stress and concern, which is the only reason why her patient agreed to participate. There are two reasons why this necessitated an immediate review of the process to participant recruitment: (a) consumers’ prior contact with the WA Police Force, which was subsequently used as a means of facilitating the research, impacted the voluntary nature of participation, and (b) some participants were experiencing acute mental illness at the time of recruitment and so could not consent to participate in the research.

Given this experience, a variation to the method of participant recruitment was submitted to, and approved by the ECU HREC. The new process required the WA Police Force to contact potential participants by telephone, and to gauge participants’ level of wellness, and interest in participating in the research. If participants were interested, researcher contact details were provided. The onus was then on the participant to make contact if they genuinely wished to participate. Although this revised process was followed, new problems associated with risk were identified during the first interview. The participant interviewed by telephone was a mental health consumer (e.g., recipient of a police welfare check) and was clearly unwell, but coherent. He insisted on participating in the interview and assured the researcher that he was safe and had no current thoughts of self-harm. Rather than address the semi-structured
interview questions, during the interview he spoke of his mental health status, and the poor quality of mental health services available. He took frequent breaks as he found it challenging to discuss these issues. He was asked many times if he would like to stop, and if he was okay. He indicated that participating in the interview was really important to him and that he wanted to continue. Despite his insistence on continuing, the researcher was not comfortable doing so and tried a number of times to terminate the interview subtly and gently. However, the participant continued to return to the issues. As his main concerns with mental health services related to his perception of being disregarded, it was important to carefully navigate the termination of the interview to ensure that he did not feel that he was being dismissed, or had not been heard. Although this participant insisted that he was safe at the end of the interview, and grateful for the opportunity to have a voice, significant risk was identified in conducting interviews by telephone, despite the voluntary nature of the telephone call and the presence of a support person on the premises. Specifically, there was no way to assess non-verbal behaviour of the participant, no way to assess that a support person was in fact present, and no means to assist the participant if they became distressed, and/or if a telephone call was terminated. For this reason, a variation to the method of data collection was submitted to, and approved by the ECU HREC. The new process saw a qualified mental health clinician added to the research team to conduct semi-structured interviews face to face with consumers and their carers, either at the time or soon after police contact. Again, risk to the participant was considered too great to justify the use of a mental health consumer as an interviewer.

The above detail is provided to demonstrate the efforts made by the research team to capture the voice of consumers, and their carers, with respect to the MHCR initiative. The research teams acknowledges and agrees that it is critical to capture the perspectives of those who are the focus of the response model. However, the above discussion also seeks to demonstrate the hazards that were encountered and negotiated in attempts to elicit and capture this valid and valuable perspective in a safe and ethical way. In particular, the discussion serves to highlight the critical need for greater discussion about, and attention to, these matters at a policy level.

6.2 Research design

This aspect of the research adopted a qualitative design. Semi-structured interviews were conducted by telephone or face to face with mental health consumers and their carers. Questions guiding the interview focused on experiences with MHCR. Thematic analysis was applied to facilitate the development of a rich description of experiences. Analysis was iterative.
and data driven (Braun & Clarke, 2006) whereby themes and related sub-themes were identified inductively (Patton, 2002).

6.3 Participants

Four non-criminal mental health consumers and three carers participated in this research. Three of the mental health consumers were male and one was female. The age of consumers ranged from 28 to 54 years. One of the carers was male and two were female. The age of carers ranged from 53-54 years. One was the carer of a sibling, and two were carers of adult children.

6.4 Findings and interpretations

Carer and consumer perspectives were characterised by four themes; daily struggles, having a voice, reducing the trauma and inability to access non-medical services (e.g., counselling). Each theme is discussed below:

**Daily struggles**

Carers described multiple family members with mental health issues who struggled to survive in a community that stigmatises the mentally ill and ascribes parents the ultimate responsibility for the mental illness experienced by their children. Struggles were described at both practical and emotional levels. At the practical level, parents struggled to cater for the day to day needs of dependent adult children who “lack the personal skills that are essential to function in the community.” One participant described a 22-year-old son who after years of illicit drug use during adolescence “can’t look after himself and forgets things.” This mother described taking her son with her each time she leaves the house so that she can monitor his wellbeing. On a daily basis, she reminded him to shower, shave, wear clean clothes and to take his medication. She ensured that his room was habitable, regularly filling garbage bags full of mouldy food, “hundreds of smoke butts, half-butts and fast food boxes.” This mothers’ ultimate goal was to help her child “feel validated as a human being.” Carers also described struggling financially with dependent adult children who were mentally unfit for work, but were required by government agencies to seek work. When off medication, dependent adult children neglected to attend required meetings and submit paper work to attain financial support. The financial burdens associated with this lack of income fell upon parents who then experienced difficulties meeting basic needs.
Daily struggles were amplified by the fact that often, the delineation between carer and mental health consumer was not clear cut. For example, in an interview with one carer, a mother described her perception of her son’s experiences with police before MHCR and subsequently with MHCR. During the interview the carer described the approach of the mental health practitioner as compassionate and caring, and described the outcome of the incident as empowering. Towards the end of this interview, the carer indicated that two weeks prior, MHCR had attended her home as her husband had called for assistance because she had been off her medication for a week and was starting to escalate. The same mental health practitioner had exercised the same compassionate and practical approach with her and for that reason, she was truly grateful. Although this carer vehemently indicated that MHCR has to stay, she was actually both a mental health consumer and a carer. Other carers described their own mental health needs in detail. One carer described having experienced multiple suicide attempts. She described a long history of self-harm and psychosis. This carer was currently medicated, and cared for three children who all had mental health issues. The experience of mental illness by multiple family members, (i.e., ‘consumers’ as well as ‘carers’), added complexity to the struggles reported by participants, as well as complexity to the interview process (i.e., delineating between experiences as a carer and as a consumer). Consequently, within this sample, the distinction between carer and consumer could be regarded as somewhat arbitrary.

**Having a voice**

The key benefit of MHCR, as reported by participants, was the voice that Mental Health Co-Response Mobile Teams (MHCRMTs) provided to carers and consumers. Under this response model, carers felt empowered, but more importantly, felt that their loved one had a voice in the process. If their loved one feared hospital, then every effort was made to keep the consumer in the home. This sentiment was echoed by mental health consumers who described a sense of procedural justice. They felt comfortable in being themselves, saying what they thought without fear of judgement from the MHCRMTs. Common carer narratives were:

“They were gentle, spoke to X with respect, reassured X. He was terrified.”

*Nothing could have been done better. They did a marvellous job. I got a bit upset when I saw him, and I wasn’t asking the right questions. I was so glad they were around when I needed them. You have to make sure you tell the bosses- they are marvellous.*

In fact, carers and consumers described their interactions with MHCRMTs with reference to each of the elements of procedural justice. The teams were neutral in their approach,
indicated trustworthy motives, enabled consumer and carer participation in the process and treated carers and consumer’s with dignity and respect. A consequence of this procedurally just approach was a reduction in the trauma experienced by families.

**Reducing the trauma**

Episodes of mental health crisis were described by carers as extremely traumatic; “you just want to cry your eyes off, your heart is breaking.” MHCRMTs were described as “beautiful, well trained people” who saved lives and for that reason, carers were of the view that more MHCRMTs were “desperately needed.” Both carer and mental health consumer narratives were powerful, emotional, and desperate. These individuals described feeling disempowered in a system that failed to recognise or meet the real needs of those living with mental illness. Carers in particular described a significant need for more community mental health support services. However, they felt powerless in terms of being able to do anything to address the problem. As one carer articulated, “the mentally ill are not a powerful lobby group as mental illness is seen as shameful, that is the common attitude.” Carers suggested that because the mental health system would likely remain in the same deficient form, police will always be required to attend mental health crises. The MHCR model was regarded as a necessary approach to ensure the best possible outcomes resulting from police response to such incidents.

**Inability to access non-medical services**

Although carers and mental health consumers described MHCRMTs as providing information and/or referral to relevant support services, their past experiences with mental health services impacted on the likelihood that they would pursue those services. Mental health consumers described having contact with psychiatric services and therefore had access to appropriate medical interventions. However, other forms of treatment (e.g., psychological, drug and alcohol) had long waiting periods, or were too expensive to access. On this basis, the range of support services and access to services because of the demand for services was described as problematic.

**6.6 Conclusion**

The findings of this research showed that mental health consumers and carers engaged positively with MHCR and saw the MHCR model as a significant improvement on the traditional crisis response model applied by police. Consumers felt empowered and for the first
time, described having a voice in terms of what the outcome of the incident would be. All mental health consumers and carers who participated in this research were non-criminal and had frequent engagement with police. The most significant frustration for mental health consumers and their carers related to the struggle to survive emotionally, practically and financially in a mental health system that described as “broken.”
7. Research questions and recommendations

This report has provided an overview of findings from the evaluation of the Western Australia (WA) Police Force Mental Health Co-Response Commissioning Trial (MHCR) implemented in the Western Australian metropolitan area. The specific research questions addressed by the evaluation were:

1. Does the MHCR model influence perceptions of role adequacy, confidence and decision making of frontline police, Police Operations and Police Watch House staff?
2. Does the MHCR model influence demand on agency resources in responding to situations involving people with mental illness?
3. Does the MHCR model influence police arrests of people with mental illness and referral of people with mental illness to emergency departments and increase referral to other community based services (non-emergency services or psychiatric facilities)?
4. Does the MHCR model influence adverse events for community members and police that arise from the management of people with mental illness?
5. Does the MHCR model influence stakeholder satisfaction with police management of situations involving people with mental illness?

Both quantitative and qualitative methods were incorporated to address each research question. However, as the volume of data was extensive, to aid clarity this report has provided a separate chapter describing quantitative and qualitative findings as they relate to (a) the Police Operations Centre (Chapter 3), (b) policing districts (Chapter 4), (c) the Perth Watch House (Chapter 5) and (d) mental health consumers (Chapter 6). In this final chapter, collective findings are grouped according to each research question, and recommendations are presented for consideration by the WA Police Force.

7.1 Research Question 1

Does the MHCR influence perceptions of role adequacy, confidence and decision making of frontline police, Police Operations and Police Watch House staff?

Role adequacy and confidence

Judgements of role adequacy reflect perceived knowledge of, and level of skill in responding to mental health incidents. Perceptions of role adequacy amongst POC participants were ambivalent, in the sense that they perceived themselves to be neither adequate or not adequate. The pattern of findings for frontline police officers was equivalent. Furthermore,
there was no significant difference in perceptions of role adequacy across test and control districts. For Watch House participants, perceptions of role adequacy were also ambivalent. Given the presence of a MHP in the POC and Watch House it would be expected that perceptions of role adequacy would be higher and/or officers would be more certain of their ability in their role. Likewise, given the presence of a MHP within test districts, it would be expected that perceptions of role adequacy would be higher in these districts compared to control districts, in which no MHP was present. Given that data did not support these expectations, the findings of this research suggest that MHCR does not influence perceptions of role adequacy.

POC participants neither agreed nor disagreed that they were confident in their ability to manage mental health related tasks. The pattern of findings for frontline police officers was different, with frontline police officers from true/test districts being more confident in their ability to manage mental health related tasks. However, when excluding mental health co-response officers from analyses, findings showed no differences in perceptions of confidence across test and control districts. Frontline police officers in both test and control districts neither agreed nor disagreed that they were confident in their ability to manage mental health related tasks. Therefore, the higher levels of confidence observed in true/test districts were driven by higher levels of confidence reported by mental health co-response officers. Like POC participants, Watch House participants neither agreed nor disagreed that they were confident in their ability to manage mental health related tasks. Again, given the presence of a MHP in the POC and Watch House it would be expected that perceived confidence would be higher and/or officers would be more confident in their role. On this basis, the findings of this research show that MHCR does not influence the perceived confidence of POC or Watch House participants, but does increase the perceived confidence of frontline police officers who are directly involved in MHCRMTs. Qualitative data supported these quantitative findings, revealing that non-MHCR officers felt ill equipped to manage mental health incidents because they did not have the specialist knowledge required to make informed decisions.

In interpreting these findings, it is important to acknowledge the role of police in the context of responding to mental health related incidents. The finding of officer ambivalence with regard to their role and their confidence may reflect ambivalence as to whether officers perceived it to be their role to respond to an individual experiencing a mental health crisis, and/or due to a lack of clarity as to the meaning of ‘response’ in this context. Despite the perception of regularly performing the role of ‘street corner psychiatrist’, the role of police is actually to bring an end to a crisis incident and this objective is typically achieved. In this way,
officers are likely to perceive that they are able to respond to the situation, but are perhaps unsure whether they have the ability to respond to the mental health element of the task. When an incident involves a person experiencing a mental health crisis, additional trauma may be encountered as a consequence of the tactics incorporated by police which could be minimised if tactics were informed by an understanding of the behavioural manifestations of mental illnesses. Therefore, whilst the policing role is performed adequately and with confidence, the outcome of the incident is unlikely to be optimal because of a lack of expertise in mental health. This also accounts for ambivalent perceptions in true/test districts, and the POC and Watch House. The role of the mental health practitioner was to provide advice to inform decision making. Therefore, police performed their typical role (resolving the incident), and the mental health practitioner performed their typical role (providing expert advice on how to approach and de-escalate). It is also important to consider the findings relating to the perceived adequacy of training in mental health. A significant majority of participants felt that training was deficient in this area which would likely impact on judgements of role adequacy and confidence.

**Decision making**

POC participants neither agreed, nor disagreed that mental health information on CAD entries had influenced their decision making in dispatching a task. However, when POC participants sought information from the mental health practitioner, the information provided somewhat influenced decision making and was considered valuable to decision making. An overwhelming majority of qualitative responses from POC participants emphasised the value of the information provided by the mental health practitioner to decision making.

Frontline police officers neither agreed nor disagreed that the additional information available on CAD entries influenced decision making on the task, or was valuable to decision making on the task. Frontline officers also indicated that on many occasions the information provided on CAD was not of use/not relevant/incorrect or not current. Yet frontline police officers still saw value in having a mental health practitioner located within the POC. Frontline police officers who had requested information from the MHCRMTs indicated that the information provided somewhat influenced decision making and was considered valuable to decision making. These findings indicate that information requested of the MHP by police officers was of more benefit than general information loaded onto CAD by the MHP.

Participants in the Watch House somewhat agreed that the information provided by the mental health practitioner influenced decision making when dealing with detainees, and that the information was valuable. Collectively, the findings of this research show that information
provided under MHCR via the POC influences the decision making of POC participants, but does not influence the decision making of frontline police officers. Furthermore, information provided under MHCR via MHCRMTs and the Watch House mental health practitioner does influence decision making of frontline police and Watch House participants.

Qualitative data from non-MHCR frontline police officers showed that the perceived value of the mental health practitioner in the POC was driven by what that role ‘could’ provide if structured in a different way. As a fast incident response time was the priority, CAD entries and in particular updates were rarely scrutinised as a matter of priority. Instead, whilst in transit, frontline police officers developed a strategy to be applied when arriving at the incident. For this reason, frontline police officers were of the view that the mental health practitioner should be providing mental health information to response teams in ‘real time’, whilst also participating in the process of developing a strategy. Therefore, the mental health practitioner should also be providing advice in terms of how to manage the incident effectively on the basis of the information that they hold, and their expertise. This type of model is applied at the district level via MHCRMTs and significantly aids decision making.

Although this research has focused on the benefits associated with a shared (police and health) co-response model, the need for a shared model is implicitly stated within the findings of this research. Findings showed that police are being called to a growing number of mental health incidents, but the majority of these are not criminal incidents. Given a lack of access to what are perceived as appropriate mental health services, community members call police as a last resort for assistance. These are welfare checks and because police are not, and should not be expected to be trained mental health practitioners, there is a clear need to incorporate a mental health practitioner in crisis responses. The need is somewhat different for criminal incidents at the district level involving an offender experiencing mental illness. The effective resolution of the incident is significantly aided by the ability of mental health practitioners to effectively communicate with the individual and de-escalate the situation. Of equal importance is the presence of a mental health practitioner at the Watch House. The early identification of mental illness ensures the safety of the detainee. However, it also ensures that appropriate diversionary options are exercised (e.g., recommended for referral to the Start Court).

On the basis of the findings of research question 1, it is recommended that:

- The WA Police Force reconsider the role of the mental health practitioner in the POC. Although the mental health practitioner is a valuable source of information for those working within the POC, the value to frontline police is limited with the model as it is...
currently applied. If the POC mental health practitioner was able to provide ‘real time’ advice via radio to first responder units in transit, an effective strategy could be developed that minimizes risk for all parties. Given the volume of welfare checks, the ability of the POC mental health practitioner to talk to those in crisis whilst units are in transit would also be beneficial.

- The WA Police Force consider strategies to ensure that non-MHCR officers are exposed to the knowledge and expertise of the MHCRMT. Findings indicated that only MHCR officers benefitted from exposure to the mental health practitioner in terms of confidence in dealing with mental health tasks. This effect could be extended if a system of rotation through, or secondment to a MHCRMT was considered. This recommendation requires careful consideration as the positive impact of MHCRMT is derived from the nature of the officers that work in the teams (e.g., personality) and the solid working relationships that have developed between MHCR officers and mental health practitioners. Despite this, the benefit to be derived from exposing a greater number of general response officers to the work of the MHCRMTs would be substantial. If rotation through, or secondment to teams is considered too disruptive, MHCR officers could be encouraged to work alongside general response officers on a more frequent basis. Drawing on the MHIT model in NSW, their knowledge and expertise as a MHCR officer should be formally acknowledged and operational policy should require that they assume the role of ‘incident controller’ of any task where mental health is deemed relevant (e.g., as is done with MHIT in NSW). This would reduce tension between business as usual practice and MHCR practice (described in Chapter 4), as MHCR practice will formally take precedence.

- The WA Police Force reconsider the current approach to training in mental health. Currently, emphasis is placed on the acquisition of knowledge about mental illness, with less emphasis placed on how to manage incidents involving a person experiencing a mental health crisis. It would be useful to develop a ‘scaffolded’ approach to training across a variety of current training programs. For example:
  a. **Tier 1: Recruit training.** Introduction to mental health and the management of those experiencing mental illness.
  b. **Tier 2: Recruit training.** OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance.
c. **Tier 3: Annual in-service training.** OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance. The critical differentiation between annual in-service training and recruit training is that in-service training must *further develop* skills and knowledge. A greater level of proficiency/expertise should be expected and officers should be provided the opportunity to debrief with the mental health practitioner about scenarios they have encountered in the field. This would also aid in the identification of officers deemed suitable for a role in the MHCRMTs.

d. **Tier 4: MHCR training.** Officers apply to complete an intensive course, a component of which must include a certain number of hours to be completed on the road with the MHCRMTs. This approach will provide understanding and exposure to the work of MHCRMTs, build further skill and enable the application of these skills whilst working alongside MHCR specialists. Debriefing at the completion of the course should be required. Those who successful complete Tier 4 will enable knowledge transfer from the MHCTs back into response work and will also form a pool of potential officers to recruit from when positions become available in MHCRMTs. Completion of this level of training should be formally recognized (e.g., by way of a badge).

e. **Tier 5: MHCR specialist.** Once an officer has worked within a MHCRMT for a period of time and is deemed proficient in that role (KPIs will be required), their level of expertise as a MHCR officer should be formally recognized. This final tier of training recognizes the expertise that is developed with experience.

### 7.2 Research Question 2

*Does the MHCR influence demand on agency resources in responding to situations involving people with mental illness?*

For the purposes of this research question, agency resources were defined as:

- **a.** Calls for service involving people with mental illness.
- **b.** Repeat calls for service involving people with mental illness.
- **c.** Time taken attending incidents involving people with mental illness.
- **d.** Transportations of people with mental illness.
- **e.** Time taken for police handover of people with mental illness into health care.
The findings of this research showed that the proportion of incidents deemed to be mental health related was equivalent across all policing districts. By far the greatest frequency of police attendance in all policing districts was for a welfare check. Furthermore, the proportion of incidents where attending officers recorded having prior contact with a PAR because of mental health concerns was equivalent across all policing districts.

The findings of this research showed that police time taken attending incidents involving people with mental illness was significantly lower in true/test districts. The time taken attending incidents where the individual was not transported was also lower in the true/test districts (although this difference was not statistically significant). Furthermore, when the individual was transported, the time taken attending incidents was significantly lower in the true/test districts.

The findings of this research showed that the person at risk (PAR) was significantly less likely to be transported in true/test districts, and significantly less likely to be transported under the Mental Health Act. When transported to a health facility, time spent at the health facility was significantly lower in true/test districts, and time spent at emergency departments (ED) was also significantly lower in true/test districts. The pattern of findings for time spent at a mental health facility was also lower in true/test districts. Collectively, these findings show that MHCR has not reduced the demand for police services, but has reduced demand placed on agency resources when service is required.

Qualitative data provided insight into the nature of these findings and reinforce the need for a shared co-response model. The term need is purposely used to differentiate between a want, or a nice thing to have, and an absolute need to address current community demand and need. Reduced calls for police assistance were listed as key performance indicator (KPI) for MHCR as it was assumed that mental health consumers would be referred to services, and would also engage with those services. Findings did show that advice, and referral to relevant services was significantly more likely to be provided in test districts. However, interviews with consumers described challenges associated with accessing relevant services. Therefore, it is perhaps unrealistic to expect MHCR to impact on calls for police assistance when the underlying problem (e.g., untreated mental illness), has not gone away. MHCR will unlikely impact on demand for police services until further research explores the issue of the availability of relevant services and access to the same.

Despite this issue, when police assistance is requested, MHCR impacts significantly. The expertise of the mental health practitioner increases the likelihood of a speedy resolution.
of the incident and reduces the likelihood of transportation. As the mental health practitioner is familiar with health processes and procedures and has contacts within the hospital system, time taken at ED’s is reduced and time taken to hand over to health is also reduced. These benefits are realised because the representatives of both agencies are co-located (e.g., health and police).

On the basis of the findings of research question 2, it is recommended that:

- The WA Police Force consider transitioning from a MHCR trial, to a business as usual model, with MHCRMTs being embedded in all districts. However, the risks in executing this recommendation without adequate resourcing and an adequate communication strategy must be considered. With regard to resourcing, there is a substantial risk that the positive impact of MHCRMTs will be diluted if the teams (as they are currently resourced) are required to service the entire metropolitan area. This is already evident from non MHCR officers in test districts who have indicated that although the MHCRMTs are beneficial and necessary, they are not often called due to the perceived inability of the team to meet their needs (e.g., because they are already responding to another task and/or are too far away to respond to the task in a timely manner). The timeliness of response from co-response teams is critical to their perceived benefit, as evident in the A-PACER evaluation (Evangelisata et al., 2016). As such, if additional resources are not available at this time, serious consideration is needed to ensure the best outcomes are achieved with a limited resource.

With regard to an adequate communication strategy, if the model is to be implemented across the metropolitan area there is a need to ensure that all officers and staff are informed of each element of the model. Officers must be told who they can contact, when and for what purpose. A key issue in research findings was the lack of information provided to police staff upon implementation of the model which impacted negatively on roles, relationships and use of the service.

- The WA Police Force consider increasing the amount of time a mental health practitioner is rostered to ensure peak business times are well covered. A consistent message, particularly in the POC and Watch House was that the mental health practitioner was not available when needed. This was evident, to a greater extent, in these locations as there was no substitute service when the mental health practitioner was not on shift (whereas in the Districts, general response officers were able to respond
to tasks). Addressing this recommendation may require the analysis of internal data to determine peak times.

- The WA Police Force continue to apply a colocation model. The benefits derived from MHCR were largely due to the fact that police and mental health practitioners were co-located. This fostered an understanding of the respective policy and operational frameworks impacting significantly on decision making and the management of incidents. The effective team oriented approach to the management of the problem (e.g., un-treated/diagnosed mental health consumers) would be unlikely to eventuate if health and police were not collocated.

- The WA Police Force, along with their partners in the Department of Health and Mental Health Commission consider establishing a multi-agency task force, or together advocate that Parliament establish a Select Committee to establish and provide advice on:
  
a. The current state of mental health services in Western Australia (e.g., number, range, type, access requirements).
  b. The capacity of mental health services to meet demand for service provision.
  c. Plural policing models to address the issue of managing mental illness within the community.
  d. How plural policing models should be funded given the requirement for a multi-agency response.
  e. Appropriate key performance indicators.

There is no doubt that the increased demand placed on policing agencies to manage criminal and non-criminal incidents involving a person experiencing a drug induced, and/or (un)diagnosed mental health concern cannot be addressed by police alone. A multi-agency, multi-level approach is required to address the issue of mental health in the community.

### 7.3 Research Question 3

**Does the MHCR influence police arrests of people with mental illness and referral of people with mental illness to emergency departments and increase referral to other community based services (non-emergency services or psychiatric facilities)?**

The findings of this research show that advice, and referral to relevant services was significantly more likely to be provided in true/test districts. A police outcome was also
significantly less likely in the true/test districts, as was police apprehension under the Mental Health Act. Qualitative data showed that the expertise of the mental health practitioner enabled the determination of “real risk,” and when this was low, enabled mental health consumers to be supported in their homes rather than being transported to hospital. In the absence of MHCR, the default response of police officers who felt ill equipped to accurately gauge risk, was to transport the PAR to hospital. On this basis, demand placed on EDs would have likely reduced. Findings in relation to this research question add further weight of the recommended continuation and expansion of the model.

7.4 Research Question 4

Does the MHCR influence adverse events for community members and police that arise from the management of people with mental illness? Adverse events are defined as:

a. Use of force to manage people with mental illness.
b. Injuries to people with mental illness during encounters with police.
c. Injuries to police caused by people with mental illness.

The findings of this research show that use of force by police during incidents involving a person experiencing mental illness was lower in true/test districts. The pattern of findings was equivalent in terms of use of force by the PAR. The frequency of injury was too low to enable statistical analysis. Again, findings in relation to this research question add further weight of the recommended continuation and expansion of the model.

7.5 Research Question 5

Does the MHCR influence stakeholder satisfaction with police management of situations involving people with mental illness?

The findings of this research showed that mental health consumers and carers engaged positively with MHCR and saw the MHCR model as a significant improvement on the traditional crisis response model applied by police. Consumers felt empowered and for the first time, described having a voice in terms of what the outcome of the incident would be. All mental health consumers and carers who participated in this research were non-criminal and had had frequent engagement with police. The most significant frustration for mental health consumers and their carers related to the struggle to survive emotionally, practically and
financially in a mental health system that described as “broken.” Findings in relation to this research question add further weight for the need for the MHCR model.

7.6 Overall recommendations

It is acknowledged that MHCR is an interim solution to a broader community problem that multiple agencies are tasked to address. As a crisis response model, MHCR works effectively and meets the needs of mental health consumers. In the absence of a centralised mechanism and process for addressing this broader community issue, there is a need for WA Police Force to continue applying this interim solution, described by many participants as a “band-aid response.” Recommendations based on the findings of this research are that:

1. The WA Police Force consider transitioning from a MHCR trial, to a business as usual model, with MHCRMTs being embedded in all districts. However, the risks in executing this recommendation without adequate resourcing and an adequate communication strategy must be considered. With regard to resourcing, there is a substantial risk that the positive impact of MHCRMTs will be diluted if the teams (as they are currently resourced) are required to service the entire metropolitan area. This is already evident from non MHCR officers in test districts who have indicated that although the MHCRMTs are beneficial and necessary, they are not often called due to the perceived inability of the team to meet their needs (e.g., because they are already responding to another task and/or are too far away to respond to the task in a timely manner). The timeliness of response from co-response teams is critical to their perceived benefit, as evident in the A-PACER evaluation (Evangelisata et al., 2016). As such, if additional resources are not available at this time, serious consideration is needed to ensure the best outcomes are achieved with a limited resource.

   With regard to an adequate communication strategy, if the model is to be implemented across the metropolitan area there is a need to ensure that all officers and staff are informed of each element of the model. Officers must be told who they can contact, when and for what purpose. A key issue in research findings was the lack of information provided to police staff upon implementation of the model which impacted negatively on roles, relationships and use of the service.

2. Management awareness: Ensure that District management and supervisors who are not directly involved in MHCR but are involved in the allocation of the District resource
(e.g., OICs of Response Teams, OICs of DCCs etc.) are exposed to the work of MHCTs. As evidenced in Chapter 4, when management are not aware of the capabilities of the MHCRMTs they are unlikely to use them to their full potential. Managers and officers in charge of district resource allocation and operational decision-making must understand the capabilities of all district resources at their disposal to better utilise the most appropriate resource at the most appropriate time.

3. Alternatively, WA Police Force could consider centralising the MHCRMTs which are attached to the already centralised MHCRU. This will establish only one line of command and will ensure that the specialist knowledge held within the team is appropriately utilised at all times (i.e., eliminates the likelihood that MHCRMTs will be required to back-fill administrative tasks that are unrelated to MHCR work). This would enable MHCRU management to ensure the wellbeing of officers (e.g., rotate from the road to other relevant tasks such as education).

4. The WA Police Force reconsider the role of the mental health practitioner in the POC. Although the mental health practitioner is a valuable source of information for those working within the POC, the value to frontline police is limited with the model as it is currently applied. If the POC mental health practitioner was able to provide ‘real time’ advice via radio to first responder units in transit, an effective strategy could be developed that minimizes risk for all parties. Given the volume of welfare checks, the ability of the POC mental health practitioner to talk to those in crisis whilst units are in transit would also be beneficial.

5. The WA Police Force consider strategies to ensure that non-MHCR officers are exposed to the knowledge and expertise of the MHCRMT. Findings indicated that only MHCR officers benefitted from exposure to the mental health practitioner in terms of confidence in dealing with mental health tasks. This effect could be extended if a system of rotation through, or secondment to MHCRMTs was considered. This recommendation requires careful consideration as the positive impact of MHCRMT is derived from the nature of the officers that work in the teams (e.g. personality) and the solid working relationships that have developed between MHCR officers and practitioners. Despite this, the benefit to be derived from exposing a greater number of general response officers to the work of the MHCRMTs would be substantial. If rotation through, or secondment to teams is considered too disruptive, MHCR officers could be encouraged to work alongside general response officers on a more frequent basis. Drawing on the MHIT model in NSW, their knowledge and expertise as a
MHCR officer should be formally acknowledged and operational policy should require that they assume the role of ‘incident controller’ of any task where mental health is deemed relevant (e.g., as is done with MHIT in NSW). This would reduce tension between business as usual practice and MHCR practice (described in Chapter 4), as MHCR practice will formally take precedence.

6. The WA Police Force continue to apply a colocation model. The benefits derived from MHCR were largely due to the fact that police and mental health practitioners were co-located. This fostered an understanding of the respective policy and operational frameworks impacting significantly on decision making and the management of incidents. The effective team oriented approach to the management of the problem (e.g., un-treated/diagnosed mental health consumers) would be unlikely to eventuate if health and police were not collocated.

7. With regard to the tensions described in Chapter 4 resulting from the disparate organisational policies and procedures of police and health, there is a need for consultation between the agencies to overcome any logistical impediments that present a threat to the efficient operation of the MHCR model (e.g., issues such as rostering, the nature of jobs that should be attended, time to complete paperwork, etc.).

8. The WA Police Force consider increasing the amount of time a mental health practitioner is rostered to ensure peak business times are well covered. A consistent message, particularly in the POC and Watch House was that the mental health practitioner was not available when needed. This was evident, to a greater extent, in these locations as there was no substitute service when the mental health practitioner was not on shift (whereas in the Districts, general response officers were able to respond to tasks). Addressing this recommendation may require the analysis of internal data to determine peak times.

9. The WA Police Force reconsider the current approach to training in mental health. Currently, emphasis is placed on the acquisition of knowledge about mental illness, with less emphasis placed on how to manage incidents involving a person experiencing a mental health crisis. It would be useful to develop a ‘scaffolded’ approach to training across a variety of current training programs. For example:

   **Tier 1: Recruit training.** Introduction to mental health and the management of those experiencing mental illness.
Tier 2: Recruit training. OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance.

Tier 3: Annual in-service training. OSTTU training to include live dynamic mental health scenarios where a mental health practitioner provides advice about how to approach and then critiques performance. The critical differentiation between annual in-service training and recruit training is that in-service training must further develop skills and knowledge. A greater level of proficiency/expertise should be expected and officers should be provided the opportunity to debrief with the mental health practitioner about scenarios they have encountered in the field. This would also aid in the identification of officers deemed suitable for a role in the MHCRMTs.

Tier 4: MHCR training. Officers apply to complete an intensive course, a component of which must include a certain number of hours to be completed on the road with the MHCRMTs. This approach will provide understanding and exposure to the work of MHCRMTs, build further skill and enable the application of these skills whilst working alongside MHCR specialists. Debriefing at the completion of the course should be required. Those who successful complete Tier 4 will enable knowledge transfer from the MHCTs back into response work and will also form a pool of potential officers to recruit from when positions become available in MHCRMTs. Completion of this level of training should be formally recognized (e.g., by way of a badge).

Tier 5: MHCR specialist. Once an officer has worked within a MHCRMT for a period of time and is deemed proficient in that role (KPIs will be required), their level of expertise as a MHCR officer should be formally recognized. This final tier of training recognizes the expertise that is developed with experience.

10. The WA Police Force, along with their partners in the Department of Health and Mental Health Commission consider establishing a multi-agency task force, or together advocate that Parliament establish a Select Committee to establish and provide advice on:
- The current state of mental health services in Western Australia (e.g., number, range, type, access requirements).
- The capacity of mental health services to meet demand for service provision.
- Plural policing models to address the issue of managing mental illness within the community.
- How plural policing models should be funded given the requirement for a multi-agency response.
- Appropriate key performance indicators.

There is no doubt that the increased demand placed on policing agencies to manage criminal and non-criminal incidents involving a person experiencing a drug induced, and/or (un)diagnosed mental health concern cannot be addressed by police alone. A multi-agency, multi-level approach is required to address the issue of mental health in the community.
References


Landis, J. R. & Koch, G. G. The measurement of observer agreement for categorical data. *Biometrics, 33*(1), 159-74.


Appendix A

PROGRESS REPORT # 27
January 15 to 17, 2018

FINAL TRIAL RESULTS
QUANTITATIVE ONLY

January 18, 2016 to January 17, 2018

MENTAL HEALTH CO-RESPONSE TRIAL
SUMMARY

The Mental Health Co-Response Trial officially commenced 18 January 2016 and finished on 17 January 2018. Due to reporting periods covering increments of 4 weeks, the previous progress report (number 26) ended 14 January 2018 and this report (number 27) incorporating the final three days of data capture has been combined. Included in this report is statistical data only (quantitative). No qualitative data has been included due to the reporting timeframes. The final progress totals for each of the operational sites; Police Operations Centre (POC), SEM and NWM Mobile Teams and Perth Watch House (PWH) have been updated.
## QUANTITATIVE RESULTS

### POLICE OPERATIONS CENTRE (POC)

<table>
<thead>
<tr>
<th>Mental Health Task Profile</th>
<th>This Report</th>
<th>Trial Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health CAD tasks sent to Practitioners console*</td>
<td>110</td>
<td>22376</td>
</tr>
<tr>
<td>CAD tasks within trial districts review/action by Practitioner</td>
<td>107</td>
<td>19365</td>
</tr>
<tr>
<td>CAD tasks outside trial districts review/action by Practitioner at request of POC Inspector/Supervisor.</td>
<td>5</td>
<td>784</td>
</tr>
</tbody>
</table>

*WA Police definition of Mental Health CAD task includes: Welfare Checks (code 48); Missing Persons (code 49); Mental Health Incident (code 68).

### Reviewed mental health consumer status information - reported since July 2016

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons identified as currently active with Mental Health services.</td>
<td>19</td>
<td>1607 (9%)</td>
</tr>
<tr>
<td>Persons identified as having past history with Mental Health services (currently not active).</td>
<td>31</td>
<td>5806 (32%)</td>
</tr>
<tr>
<td>Person not known to mental health services in CAD task.</td>
<td>28</td>
<td>6852 (38%)</td>
</tr>
<tr>
<td>Persons not able to be identified in CAD task.</td>
<td>29</td>
<td>3675 (21%)</td>
</tr>
</tbody>
</table>

NB: Consumer status information is obtained through the referencing of DoH held records (mental health history) of one or more named persons on a single CAD task. Does not include demographical information on CAD jobs allocated outside of trial districts.
CAD Tasks assessed by practitioner at Police Operations Centre 2016

04/07/16 Expansion of the trial districts to include entire NWM and SEM districts. As a result unable to recapture tasks provided for assessment in June period.

Mental Health CAD tasks sent to Practitioners console.
CAD tasks within trial districts reviewed/actioned by Practitioners.
CAD tasks outside trial districts reviewed/actioned by Practitioners.
CAD Tasks assessed by practitioner at Police Operations Centre 2017/2018

- Mental Health CAD tasks sent to Practitioners console.
- CAD tasks within trial districts reviewed/actioned by Practitioners.
- CAD tasks outside trial districts reviewed/actioned by Practitioners.
### SOUTH EAST METROPOLITAN DISTRICT MOBILE TEAM

<table>
<thead>
<tr>
<th>Tasks attended</th>
<th>This Report</th>
<th>Trial Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental Health task - Consumer directly engaged/assessed</td>
<td>7</td>
<td>1318</td>
</tr>
<tr>
<td>• Mental Health task - Consumer not engaged/assessed</td>
<td>8</td>
<td>548</td>
</tr>
<tr>
<td>(e.g. person at risk not located, task resolved without attendance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Welfare check (non mental health)</td>
<td>4</td>
<td>436</td>
</tr>
<tr>
<td>• Police task (non mental health)</td>
<td>7</td>
<td>688</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Additional frontline support - recorded since May 2016

- Requests for advice/assistance by other police to Co-Response Mobile Team
  - 7 requests
  - Total 333 requests

### Engaged consumer demographic information

- Male Adult
  - 3 engagements
  - 696 encounters (53%)
- Male Juvenile (under 18)
  - 0 engagements
  - 26 encounters (2%)
- Female Adult
  - 4 engagements
  - 552 encounters (42%)
- Female Juvenile (under 18)
  - 0 engagements
  - 44 encounters (3%)
- Total Aboriginal/TI
  - 0 engagements
  - 146 encounters (11%)
- Persons with known MH History
  - 7 engagements
  - 1067 encounters (81%)

(More than one consumer can be engaged at a task).

### Performance indicators - consumers engaged

- Average time taken to complete task by mobile team (minutes)
  - 36
  - 71
- Mental Health Transports undertaken
  - 0
  - 340
- Average time spent at Health Facility/ED (minutes)
  - 0
  - 52
- Referrals to mental health and other community services
  - 1
  - 328

NB Tasks are classified into four categories. Mental health tasks attended where consumer is engaged, mental health tasks where consumer is not engaged (e.g. unable to locate, resolved without attendance), other welfare checks and other general policing tasks not related to mental health.
NORTH WEST METROPOLITAN DISTRICT MOBILE TEAM

### Tasks attended

<table>
<thead>
<tr>
<th>Task Description</th>
<th>This Report</th>
<th>Trial Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health task - Consumer directly engaged/assessed</td>
<td>7</td>
<td>1589</td>
</tr>
<tr>
<td>Mental Health task - Consumer not engaged/assessed</td>
<td>2</td>
<td>466</td>
</tr>
<tr>
<td>(e.g. person at risk not located, task resolved without attendance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare check (non mental health)</td>
<td>4</td>
<td>301</td>
</tr>
<tr>
<td>Other police task (non mental health)</td>
<td>2</td>
<td>538</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Additional frontline support - recorded since May 2016

- Requests for advice/assistance by other police to Co-Response Mobile Team. 10 686

### Engaged consumer demographic information

- Male Adult 3 784 (49%)
- Male Juvenile (under 18) 0 41 (3%)
- Female Adult 4 703 (44%)
- Female Juvenile (under 18) 0 61 (4%)
- Total Aboriginal/TI 1 112 (7%)
- Persons with known MH History 7 1257 (79%)

(More than one consumer can be engaged at a task).

### Performance indicators - consumers engaged

- Average time taken to complete task by Co-Response (minutes) 51 56
- Mental Health Transports undertaken 2 397
- Average time spent at Health Facility/ED (minutes) 38 36
- Referrals to mental health and other community services 3 389

NB Tasks are classified into four categories. Mental health tasks attended where consumer is engaged, mental health tasks where consumer is not engaged (e.g. unable to locate, resolved without attendance), other welfare checks and other general policing tasks not related to mental health.
CAD tasks attended by mobile teams 2016

18/07/16 Expansion of the trial suburbs for the mobile teams in the NWM and SEM districts.

26/09/16 Mobile teams undertaking all types of welfare checks.
# PERTH WATCH HOUSE

## Assessed detainee demographic information - reported since August 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>This Report</th>
<th>Trial Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detainee currently active with Mental Health services.</td>
<td>3</td>
<td>372 (6%)</td>
</tr>
<tr>
<td>Detainee identified as having past history with Mental Health services (currently not active).</td>
<td>7</td>
<td>2147 (33%)</td>
</tr>
<tr>
<td>Detainee not known to mental health services.</td>
<td>27</td>
<td>3918 (61%)</td>
</tr>
</tbody>
</table>

## Performance indicators

<table>
<thead>
<tr>
<th>Description</th>
<th>This Report</th>
<th>Trial Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detainee requiring immediate assessment under the Mental Health Act (involuntary transports to medical facility)</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>Detainees assessed in non-contact room</td>
<td>3</td>
<td>468*</td>
</tr>
<tr>
<td>Referrals to MH Court Liaison Services</td>
<td>1</td>
<td>139</td>
</tr>
<tr>
<td>Referrals to External MH Services</td>
<td>3</td>
<td>383</td>
</tr>
<tr>
<td>Referrals to other community services</td>
<td>0</td>
<td>183</td>
</tr>
<tr>
<td>Added value to PWH staff (i.e. information, advice)</td>
<td>7</td>
<td>648**</td>
</tr>
</tbody>
</table>

* Reported since September 2016.
** Reported since July 2017
Detainees assessed by practitioner at Perth Watch House 2016

<table>
<thead>
<tr>
<th>PR1</th>
<th>PR2</th>
<th>PR3</th>
<th>PR4</th>
<th>PR5</th>
<th>PR6</th>
<th>PR7</th>
<th>PR8</th>
<th>PR9</th>
<th>PR10</th>
<th>PR11</th>
<th>PR12</th>
</tr>
</thead>
<tbody>
<tr>
<td>472</td>
<td>502</td>
<td>512</td>
<td>517</td>
<td>517</td>
<td>519</td>
<td>415</td>
<td>495</td>
<td>504</td>
<td>525</td>
<td>528</td>
<td>603</td>
</tr>
</tbody>
</table>

- Number registered during trial times
- Number assessed by Mental Health Practitioner
- Linear (Number assessed by Mental Health Practitioner)
Detainees assessed by practitioner at Perth Watch House 2017 - 2018

Number registered during trial times

Number assessed by Mental Health Practitioner

Linear (Number assessed by Mental Health Practitioner)
Appendix B- Trial Case Studies

Police Operations Centre

1. Caller contacted police and raised concern for her neighbour (consumer) who the caller had not seen for almost a week. The consumer had no known family in Perth, her mail box was overflowing and a strange smell was in the vicinity of the consumers unit. The caller also stated that she believed the consumer was a heavy drug user and suffered from depression. The POC mental health practitioner checked the mental health data base and identified that the consumer was currently an inpatient at the Sir Charles Gairdner Hospital (SCGH) Mental Health Inpatient unit. Consumer’s location was confirmed by police call to SCGH. Caller advised that consumer’s whereabouts were known and police attendance and resources not required.

2. Consumer contacted police threatening self-harm and disclosing mental health illness. POC mental health practitioner checked the person’s details on the mental health database and confirmed the consumer was active with mental health services, experiencing suicidal and homicidal thoughts. POC mental health practitioner also advised WAPOL this task was suitable for attendance by the Mental Health Co-Response mobile team. Attending police were aware of this additional ‘risk’ information (no risks identified on WAPOL database), which assisted in their decision making, resulting in them contacting the Co-Response mobile team to attend the scene and assist. Mobile team conducted assessment and deemed consumer was not at risk to herself or to others and was currently seeing a psychologist for support. POC mental health practitioner value adding to task assisted attending police and attendance by mobile team. This ensured that appropriate assistance was provided to consumer and transport to a hospital emergency department for assessment was not required.

3. Caller contacted police concerned for her 75-year-old male neighbour (consumer), who she has not seen for a few days. The consumer is wheelchair bound and does not have any known family or friends in Perth. Consumer goes out daily, but always returns by 4.00pm. The caller has taken some food to consumer’s house and he is not there, despite the fact that the lights are on inside the house. His wheelchair also appears to be missing. Caller has tried to contact him on the phone and it rings out. She states that this is very out of character and she is concerned for his welfare. The mental health practitioner checked on the health database and identified that the consumer was currently an inpatient at Royal Perth Hospital. Caller was advised of consumer’s whereabouts and police resources not required to attend scene, possible force entry to house or to search for consumer.

4. Lifeline contacted police concerned for the welfare of an unidentified male consumer who was threatening self-harm. Using the consumer’s mobile phone number, attempts were made to identify the phone number and locate an address on the WAPOL data base. The POC mental health practitioner searched the mental health data base and identified a recent address for the consumer not known to WAPOL in O’Connor. Police were dispatched to this address and upon arrival noted the smell of gas and observed a gas bottle inside the flat. Police evacuated occupants from the surrounding flats as a precaution. The consumer was located by police and had superficial cut marks to the inside of his forearms. He was later conveyed to Fiona Stanley Hospital by St. Johns Ambulance for further assessment. POC mental health practitioner providing a possible location for the consumer ensured police attendance was in a timely manner and were able to provide appropriate medical intervention to the consumer.
South East Metro MHCRMT

1. Consumer called police on triple ‘0’ reporting she was feeling suicidal. Consumer had been at the races all day and was affected by alcohol. A police vehicle was dispatched Priority ‘2’ and located the consumer sitting on the front veranda of her premises crying and visibly distressed. The mobile team attended and the mental health practitioner conducted an assessment on the consumer deeming she was experiencing a situational crisis and not at immediate risk to herself. The mental health practitioner ascertained the consumer is currently linked in with a private psychiatrist and has a mental health management plan in place. Consumer was allowed to remain at home that evening in the care of her sister and no further police action was required. Traditional police response to this incident may have resulted in the consumer being transported to a hospital emergency department for a mental health assessment.

2. NSW Police received a “000” from a person residing in New South Wales reporting they had received a text message from the consumer claiming self-harm. Mobile phone was registered to the female consumer in Western Australia. The mobile team attended at the consumer’s residence and she initially denied sending the text message, however after engagement by the mobile team, the consumer advised that she was dealing with numerous issues including the suicide of her sister in-law and her partner and was facing homelessness with her three children with no financial means to support her family. The mental health practitioner conducted an assessment of the consumer and deemed she was not at immediate risk to herself or to others and was referred to Armadale Assessment and Treatment Team (ATT) for a follow up appointment the next day and was allowed to remain home with her children that evening. As a result, this alleviated requirement for further police involvement and possible transport to an emergency department for an assessment.

3. Consumer’s mother called triple ‘0’ stating her 12-year-old daughter (consumer) was experiencing a psychotic episode. She had taken possession of a knife and threatened self-harm. The consumer’s mother managed to take the knife from her and the consumer was told to go to her bedroom. The consumer became angry, damaging property in her bedroom before leaving the house on foot. The mobile team conducted patrols for the consumer and located her nearby walking along the road. She was conveyed home, where the mother met the mobile team. It transpired that the consumer and her brother were victims to complaints of physical and sexual abuse by a relative. The court case involving the consumer’s brother was listed for the following day causing tension in the household. Mental health practitioner conducted a mental health triage on the consumer and as a result, she was allowed to remain at home with her mother and a trusted family friend. The mental health practitioner followed up with the consumer’s social worker and the Child and Adolescent Mental Health Service (CAMHS) the following day. This ensured the consumer and her mother received the appropriate mental health intervention and support. Traditional police response to this incident may have resulted in the consumer being transported to a hospital emergency department for a mental health assessment.

North West Metro MHCRMT

1. Police were contacted by a neighbour of the consumer who held concerns for her welfare. The consumer’s children were then currently in the custody of Department of Child Protection
and Family Support and the consumer had attempted self-harm in the past by overdosing. The consumer had been released from Joondalup Health Campus the previous day for mild concussion. The neighbour was unable to locate the consumer when she went to her house. The mobile team advised attending police that they would monitor the task and were available if required. The neighbour reported to police that she managed to make contact with the consumer and police were no longer required to attend. As a result of this information, the task was closed by police without attendance at the consumer’s residence. The mobile team mental health practitioner was aware of the consumer from his work with community mental health services and had concerns regarding the consumer’s welfare. POC mental health practitioner confirmed the consumer had a history of dependence on prescribed medication and was active with mental health services.

As a result, the mobile team requested the task to be re-opened for their attendance. Upon arrival, the mobile team could smell gas vapour and were unable to gain access to the house as the doors were locked. Entry was forced to the residence due to serious concerns for the consumer. The consumer was located in her bed in an unconscious state. St. John ambulance were contacted for immediate and urgent response. The consumer regained consciousness and admitted to ingesting 21 zanax tablets so she could overdose. The consumer’s sister attended scene and revealed to the mobile team the text messages from the consumer indicating her intent of self-harm. While waiting for the ambulance to arrive, the mental health practitioner maintained clinical observations on the consumer. The consumer was transported to Joondalup Health Campus as a voluntary patient for treatment of her overdose and mental health issues. Without intervention by the mobile team, the consumer faced a potential serious medical emergency.

2. Consumer is known to mental health services and is deemed as a high risk of self-harm and suicide. The mobile team attended her address to conduct a welfare check but the consumer was not located at the address.

A short time later another caller contacted Police reporting a female standing on the outside railing of a Mitchell Freeway overpass bridge. It appeared the female was preparing to jump from the bridge. The mobile team was dispatched and arrived two minutes later along with other police vehicles a short time later. On arrival it was ascertained that the female standing on the bridge was the consumer from the original welfare check. The mobile team mental health practitioner engaged with the consumer from the other side of the railing. Additional services including Department of Fire and Emergency Services (DFES), Main Roads and SJA were requested to attend by the mobile team. The police negotiator was contacted and enroute to the scene.

The mental health practitioner spoke to the consumer for 40 minutes and persuaded her to climb back over the railing safely and without incident. Consumer was placed on Mental Health Act forms and conveyed to Sir Charles Gairdner Hospital (SCGH) by SJA where she was admitted as an involuntary patient.

3. Caller contacted police concerned for the welfare of a male person (consumer) who approached him and asked him to call the police. The consumer spoke limited English and was difficult to understand. The mobile team attended and located the consumer waiting on the road outside of the callers address. A request was made for a language interpreter to assist as it was ascertained from the consumer he was Vietnamese. An interpreter was not available at that time and the consumer provided his name. The mental health practitioner checked the mental
health data base and discovered the consumer was overdue for his depot injection. The consumer was unpredictable, hearing voices and believed that police wanted to kill him. The mental health practitioner enacted Mental Health Act forms and the consumer was conveyed directly to Graylands hospital. The mobile team spent a total of only 7 minutes at the hospital.

**Perth Watch House**

1. 34 year old male detainee was arrested for disorderly behaviour and taken to the PWH. Detainee had a long standing diagnosis of paranoid schizophrenia since age 18 which is complicated by significant poly substance misuse, non-compliance and disengagement from services and has had numerous admissions to inpatient mental health units over the years. In addition the detainee had multiple Department of Health alerts for assaults on staff both in the community and while an inpatient. PWH Custodial staff requested he be assessed by the mental health practitioner as they had concerns regarding his mental state and the risk he posed to both himself and the general community, as he was due to be bailed.

   The detainee was assessed by the mental health practitioner in a non-contact interview room. He presented as a significant risk to himself and others, due to mental state, potential methamphetamine intoxication and level of aggression. He was placed on Mental Health Act forms and escorted to Royal Perth Hospital Emergency Department. On arrival at the Emergency Department, the detainee was given intravenous sedation and placed on four point restraints, then later transferred to a secure mental health ward. Following a 16 day admission and a noticeable improvement in his mental state he was discharged to his local Community Mental Health Service for ongoing follow up and treatment. Intervention by the PWH mental health practitioner ensured the detainee received the appropriate mental health intervention.

2. 57 year old male detainee was brought into the PWH for disorderly conduct. He had a past history of a major mental illness, but had not been in contact with mental health services for two years. The detainee presented as loud and aggressive. He was uncooperative during the assessment with the mental health practitioner declining to answer questions. He was bailed granted bail, before being placed on mental health and transported to Graylands Hospital by ambulance. Detainee received the mental health treatment intervention he required upon released from PWH.

3. 27 year old male detainee was arrested by Australian Federal Police (AFP) at Perth Airport and charged with attempting to bring multiple weapons (14 knives) into Australia when returning from Bali. The detainee normally resided in Victoria. He refused to answer the Health and Welfare questions when requested and presented as highly agitated and verbally aggressive. After conducting inquiries the PWH mental health practitioner identified that the detainee had a history of treatment in a forensic hospital in Victoria. The practitioner contacted the institution and was advised that the detainee had a diagnosis of Paranoid Schizophrenia and had multiple alerts for violence, threats, assaults and self-harm and was considered highly dangerous.

   The detainee continued to be highly aggressive while in his cell, spitting, throwing food and defecating in the cell. When PWH staff attempted to communicate with the detainee he made threats against staff. Due to the presenting behavior the practitioner was unable to undertake a formal mental health assessment of the detainee but suspected that the detainee was suffering a relapse of Paranoid Schizophrenia. As there were no Community Forensic Mental Health staff due to attend the Magistrates Court the next day the practitioner drafted a report for the
Magistrate recommending that the detainee be placed on a Hospital Order to the Frankland Centre for further assessment. The following day the Magistrate placed the detainee on a Hospital Order and he continues to receive treatment at the Frankland Centre.