# WHAT WORKS: CRIME REDUCTION SYSTEMATIC REVIEW SERIES

# NO. 6: POLICE RESPONSES TO PEOPLE WITH MENTAL HEALTH NEEDS: A SYSTEMATIC MAP OF THE LITERATURE

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# 1   1. BACKGROUND

## 1.1   People with mental health problems and the criminal justice system

People with mental health problems are overrepresented in the criminal justice system and feature disproportionately at all levels of the criminal justice pathway (Singleton 1998): They are more likely to be arrested than people without a mental health problem for offences of similar severity (Charette et al 2014) and are more likely to be victims of crime than the perpetrator (Schnittker 2013). They are also over represented in the prison population and are at risk of poorer outcomes (Fazel et al 2016).

In the UK and other countries, there has been a move towards the 'de-institutionalisation' of people with mental illness from the 1980s. This has meant that their treatment and support increasingly takes place within the community. This, however, is reliant on the availability of such mental health community and acute services, and in times of a mental health crisis it is the police who are often the first point of professional contact and who function as 'gatekeepers' to services more suited to these clients' needs.  It has been estimated that between 20-40% of police time in the UK involves a mental health concern and demand appears to be increasing (College of Policing 2015).

In the prison population, it has been estimated that in excess of 70% of UK prisoners, including both sentenced prisoners and those on remand, have at least one mental health disorder (Birmingham 2003). In addition, around 75% of all UK prisoners have a dual diagnosis of a mental health problem with alcohol or drug misuse (Department of Health 2009), which may further increase the likelihood of coming into contact with the criminal justice system in the first place, but also increases the likelihood of relapse soon after discharge and subsequent re-entry to the criminal justice system (Chang et al 2015).

### 1.1.1   Economic impacts of mental health problems on the criminal justice system

Mental ill-health has been estimated to cost more than £105 billion per annum in England alone in 2009-10 (>£113 billion in 2015 prices), including costs to the NHS and those associated with corollary adverse impacts on educational and employment outcomes, productivity, and increased crime (Department of Health 2014). A 2007 report estimated that £1.6 billion is spent annually arresting, convicting, imprisoning and supervising people with identified mental health problems (Revolving Doors Agency 2007). Processing adult offenders with mental health problems through the criminal justice systems has been found to absorb, on average, more resources (including police, court, prison and probation services), with corollary higher costs, than processing those without mental health problems who have committed an equivalent offence (Corner et al 2007). Similarly, treating the physical health issues of patients with a mental health problem has been estimated to impose up to 45% higher costs on the health system than treating those without, even after the cost of treating the mental health issue has been excluded (Welch et al 2009, Naylor et al 2012).

### 1.1.2   Use of police custody

For the majority of contacts, police can resolve a situation without the need for arrest, but there are two ways in which a person with mental health problems may come into contact with police officers and be taken into custody.  An officer may arrest the individual where an offence has been committed or suspected, and take them into police custody for formal charging or if the person is assessed to be in urgent and immediate need of care or control,

the police officer may detain the person under section 136 of the Mental Health Care act 2007 and take them to a place of safety.

Both the *Code of Practice for England* and the *Code of Practice for Wales* state that police custody should be used as a place of safety only in "exceptional" circumstances. However, police stations are in practice often used as a 'place of safety' rather than, for example, an accident and emergency department, due to their capacity to securely detain such individuals (Docking et al., 2008). In addition, designated NHS Mental Health Section 136 'suites' are often unavailable, either due to overcrowding or insufficient staff (HMIC 2013). It is estimated that each year in the UK, as many as 11,000 people with mental health needs are detained in a police station as a 'place of safety' (HMIC 2013) under the Mental Health act 2007, Section 136.

Such an approach may, however, be inappropriate for a number of reasons: for example, police stations and holding suites are often crowded and chaotic places, which can be frightening and disorienting for vulnerable individuals and the required psychiatric care is often not readily available.

In response to this, there is increasing interest among criminal justice and mental health agencies, developing initiatives designed to improve relationships between police and people with mental health problems, reduce unnecessary arrests, reduce the use of inappropriate detentions under the mental health act section 136, and ultimately reduce the criminalisation of those with mental health problems (Lamb and Weinberger 2002).

## 1.2   Research and policy background

### 1.2.1   Models of police response

In the UK these initiatives have been based on two main models of specialised police responses for people with mental health problems that originated in the US: crisis intervention teams (CIT) and co-responder teams. The CIT programme came into being in Memphis, Tennessee in 1988 through partnership between the National Alliance on Mental Illness (NAMI) and the Memphis police, in the wake of a tragic incident in which police had killed an individual presenting with a mental disorder. This 'Memphis Model' approach is based on training officers to recognise persons with symptoms of mental illness, providing them with tools to diffuse potentially inflammatory situations and facilitate links to appropriate support or treatment.

The co-responder approach was developed in Los Angeles in the 1980s, and was designed to increase the chance of individuals in crisis who came into contact with police being connected with appropriate treatment. This was achieved by forging links with community mental health services and partnering police officers with mental health professionals.

UK based examples of co-responding models of specialized police response include Street triage which primarily aims to reduce the inappropriate use of section 136, by co-locating mental health professionals in police stations or police cars or police officers in mental health settings.

### 1.2.2   Link schemes and Liaison and Diversion schemes.

Similar to the co-responder approach, police can work with community outreach teams to alert them to people with mental health and other needs in the community. These agencies

work closely with neighbourhood police officers and also aim to link people with mental health problems to the services they need in order to break harmful cycles of disengagement from mental health care, mental health crisis care services, and involvement in the criminal justice system. (Accendo 2013).

Liaison and Diversion services involve close working with health professionals, towards the joint commission of services between police and health. The Offender Health Collaborative (OHC) has been set up as a working collaboration between six specialist organisations: NACRO, the crime reduction charity, Revolving Doors Agency, Centre for Mental Health, Institute for Mental Health, NHS Confederation and Cass Business School. It has been commissioned by NHS England to develop an operating model for liaison and diversion. In consultation with the Department of Health and other stakeholders, the OHC defined the service as:

"…a process whereby people of all ages in contact with the youth and criminal justice systems are screened and where appropriate assessed or referred for assessment, so that those with mental health problems, learning disabilities, cognitive disorders, substance misuse problems and other vulnerabilities are identified *as soon as possible in the justice pathway"* (Riggs, 2014)

These approaches, or variations thereon, have since been adopted in many other jurisdictions in the US (Reuland 2004) and also throughout Europe and Australia.

### 1.2.3 Diversion into mental health services

Police officers have long had discretionary powers to divert individuals, including those with mental health problems, away from the criminal justice system. Police cautions can be issued instead of arrest, usually to people who are first-time offenders. Individuals receiving cautions are also required to accept responsibility for their actions to avoid arrest and a criminal record, and may be conditional, such as requiring restoration be made to the victim in the form of a written apology, or that the offender attends a treatment programme.

In parallel with attempts to improve interactions between police and people with mental health problems by changing attitudes, increasing knowledge and skills, and inter-agency working with mental health professionals, there has also been an increasing interest in police using their existing powers to divert people with mental health problems into more appropriate community-based care and away from the criminal justice system altogether (Bradley 2009, Sainsbury Centre for Mental Health 2009, Scott et al 2013). This reflects more widespread recognition in recent years that many contacts with police among this client group can be directly attributable to the mental health problems. For example, minor disorder offences and nonviolent offences may result from atypical behaviour, a mental health crisis, or mental health problems with concurrent drug and/ or alcohol addictions. (NHS England 2016).

In the UK, the Lord Bradley Review (Bradley 2009) has prompted renewed interest in the effectiveness of diversion into community-based alternatives (The Scottish Association for Mental Health Scotland 2014; Revolving Door Agency 2013). Informed by recommendations from this review, successive UK coalition and conservative governments have responded by committing £25 million to locating mental health nurses in police stations and courts (liaison and diversion schemes, RAND evaluation forthcoming), with the dual aims of getting the

right treatment to people with mental health problems (and thereby limiting unnecessary contact with the criminal justice system), and reducing reoffending.

### 1.2.4   Police responses to people with mental health problems

A UK Independent Commission on Mental Health and Policing (2013) led by Lord Adebowele set forth a number of recommendations to guide police practice in response to people with mental health problems.  First, that mental health needs to be recognised as a "core businesses of the police, and should be reflected accordingly in policy and operations" (pp. X6. Second, that improvements in staff training are needed, along with development of safer methods of restraint, so that staff can develop the skills and confidence necessary to manage mental health issues in the community. Record keeping and information systems were also highlighted as requiring improvement, alongside the need for more effective interagency working.

Whilst these recommendations clearly highlight scope for improvement, a recent UK Care Quality Commission (Care Quality Commission 2014) survey of people in the UK who had experienced a mental health crisis found that the majority of respondents reported positive experiences of contacts with police, in terms of being listened to, being taken seriously and being provided with advice and support to facilitate access to relevant services. Indeed, some respondents reported their experiences of contacts with police had been more positive than interactions with some specialist mental health services.  This finding suggests that when officers have sufficient skills and confidence, their actions in dealing with people with mental health problems can be perceived as effective in facilitating access to relevant services and are valued.

### 1.2.5   Views of police

A study carried out in 2010 by McLean and Marshall explored police officers' views on their roles in dealings with people with mental health problems and with mental health services in Scotland.  Interviews with police officers revealed that many have experienced significant emotional impact arising from dealings with mentally vulnerable individuals and had concerns about both the impact of their role as frontline mental health staff on police resources and their primary role in public safety, as well as on the wellbeing of the people they were trying to help.  Officers cited successful collaborative working as a substantial positive influence on outcomes, while reporting that failures in communication and co-operation with partners in mental health services had significant negative impacts.

### 1.2.6   The need for a systematic map and review

Numerous individual primary impact evaluation studies have been published in the US and UK on different responses and models of police working with people who have mental health problems.  To date there has been no attempt to systematically describe the research evidence base for all the different police responses and models of police response to people with mental health problems.

To address this gap, this project aims to construct a systematic map of the research literature. Maps systematically and transparently describe the current state of the literature in a way that identifies where the research is stronger or weaker, and provides access to a body of knowledge in particular areas of the research. (Dickson et al 2013). It provides a way for

policy makers, practitioners and academics to locate relevant research and identify areas for future research and evidence synthesis. The study described in this report is a component of a series of systematic maps and reviews undertaken as part of the commissioned What Works programme to support the What Works in Crime Reduction at the College of Policing and undertaken at the EPPI-Centre at University College London.

This current systematic map of the literature informs the first stage of a two stage review and meta-analysis of crime and mental health outcomes of police pre arrest diversion of people with mental health issues (Schucan-Bird et al 2017).

# 2  METHODOLOGY

## 2.1  Systematic map questions and approach

The questions that the map will address are:

1. What is the nature and extent of the empirical research evidence on police responses to people with mental health problems?
2. What types of police responses are described in the studies?
3. What different types of models of police responses are described in the studies?
4. What outcomes are described in the studies?
5. What methods are employed in assessing the impact of police responses on people with mental health problems?

To answer these questions, the map identifies and describes the extent and nature of empirical research in terms of in terms of:

- The geographical location
- The date of publication
- The characteristics of people with mental health problems
- The characteristics of professionals working with police
- The aim of the study
- The study design
- The type of police response
- The model of response
- The outcomes measured

It is not the purpose of the map to assess the quality of the studies or synthesise the results but to describe the characteristics of the research literature.

### 2.1.1  Scope and definitional issues

This section describes the key concepts that are used in this map. Systematic maps require clear definitions of concepts to develop the search strategy and inclusion criteria used to select studies.  These concepts and definitions were developed from the wider literature and input from stakeholders.

### 2.1.1.1 Dual diagnosis

An individual presenting with both mental health issues and substance misuse is said to have a 'dual diagnosis'. A commonly accepted definition put forward by Davis (2003) defines 'dual diagnoses as "any mental health problem/diagnosis co-existing with ongoing substance misuse or abuse".

Someone with a dual diagnosis is more likely to come into contact with the criminal justice system, and such individuals commonly have more complex needs and poorer management of diagnoses (NACRO, 2007). People with dual diagnosis tend to fare worse than mentally disordered individuals without comorbid substance misuse. They are at particular risk of self-harm and suicide.

The relationship between mental health disorders and substance misuse may be bidirectional: substance misuse can be both a cause and a consequence of poor mental health.

### 2.1.1.2 Learning disability

There is no single definition of learning disability and terms used have also changed over time: learning difficulties may be a term preferred by self-advocates, but others who may care for people with more complex needs disagree that this term captures the significant varying degrees of disability and support needs a person may have (Foundation for People with Learning Disabilities, not dated).

Terms used can differ in different countries, for instance the term intellectual disability is more widely used in the US while in the UK this is more commonly described as learning disability.

The UK definition of learning disability is

- significantly reduced ability to understand new or complex information, to learn new skills
- reduced ability to cope independently which starts before adulthood with lasting effects on development.

(Department of Health 2001)

The US definition is similar but takes a more quantitative approach to learning disability:

- significantly sub average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test
- concurrent deficits or impairments in present adaptive functioning
- onset is before age 18 years.

(American Psychiatric Association 1994).

In the UK, police are required to request an appropriate adult (a parent, social worker or other nominated appropriate adult) for children or vulnerable adults who are taken into custody to ensure the person understands their rights and to represent their best interests.

### 2.1.1.3    Police officers
Police officers involved in delivering first response interventions to people with mental health problems are:

- Police officers who have had training in recognising mental health problems, crisis resolution and de-escalation techniques, such as officers in a crisis intervention team, or officers who have had other mental health awareness training.

- Police officers who may not have had any additional training in dealing with people with mental health problems.

### 2.1.1.4    People with mental health problems
The term mental health problems is used in this review to show that police officers and people working with them may not know the specific nature of the mental health problem they may come into contact (i.e. have a diagnosis of mental ill health) with, and the person experiencing mental health problems may not be currently known to mental health services and professionals.

### 2.1.1.5    Mentally vulnerable people
People who are deemed as mentally vulnerable includes those persons who may not fully understand the significance of what is said to them (in a criminal justice setting) and would require the support and advocacy of an appropriate adult.

### 2.1.1.6    Mentally disordered individuals
A term usually used in a legal context to describe the small proportion of people with mental health problems that are detained subject to Part 3 of the Mental Health Act 1983.

### 2.1.1.7    Models of police response
The configuration of police staff, police training skills and knowledge, location and ways of working with other mental health agencies in response to people with mental health problems in the community.

### 2.1.1.8    Mental Capacity Act 2005
People who are assessed to be lacking mental capacity are defined as being unable (at that time) to make decisions for themselves in their interests.  An example may be when a person with a dual diagnosis of mental illness and alcohol addiction was intoxicated. Police officers would not have any powers under the act to compel a person who lacked capacity into treatment.   Refusal to accept diversion into treatment instead of arrest would not in itself indicate the person lacked mental capacity, even if the officer believed the diversion into treatment would be in their best interests.

### 2.1.1.9    Section 136. Mental Health Act 2007
One way in which persons with a mental disorder may come into contact with the police is through the use of Section 136 of the Mental Health Act 2007 - mentally disordered persons in public places (Docking et al 2008).  Section 1 of the Act defines mental disorder as "*any disorder or disability of the mind*".  This definition excludes learning disabilities "*unless that disability is associated with abnormally aggressive or seriously irresponsible conduct*" and dependence on alcohol or drugs.  Under this directive:

> "*If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that*

*person or for the protection of other persons, remove that person to a **place of safety** […] A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care (emphasis added)"*

## 2.2 Methods

### 2.2.1 Type of map.

This map of the literature uses systematic review methods to search for published and unpublished literature about police responses to people with mental health problems from a range of sources. The systematic map can be used to identify research gaps for future research, and areas potentially relevant for systematic reviews.

### 2.2.2 User involvement

To ensure the relevance and usefulness of this project, a range of users/ stakeholders have been consulted in the process of scoping the review and developing the protocol. The user group represents policy, practice and academic perspectives with an interest in the area of policing and mental health review (see Appendix 1.2 for details):

1. Policy and decision makers that are funding and/or implementing police responses to people with mental health needs

2. Individuals and organizations implementing and/or designing interventions to improve police responses to people with mental health needs

3. Academic researchers

The stakeholder consultation group provided verbal and email input at the initial stages of the project. Consultation with these members was principally undertaken on a one-to-one basis, via telephone, to identify and discuss key issues in the field (in terms of policy, practice and research). These discussions served to inform the development of the scope and direction of the map and review.

## 2.3 Defining relevant studies: Inclusion and exclusion criteria

As the search terms were kept broad to capture as many potentially relevant studies as possible, a further stage was applied to identify relevant studies. Results from the searches were uploaded into the EPPI-Centre's dedicated software EPPI-Reviewer 4 (Thomas et al 2010)) and any duplicates were removed.

To be included for further coding, the study had to meet the following inclusion criteria:

Published after 1995

- Studies published before 1995 will be excluded as being less relevant to current policy and practice.

Population

- People experiencing mental health problems who come into contact with the police or mental health care professionals working with police (including community mental health nurses, psychiatric staff, ambulance crew);
- Police officers; or
- Mental health care professionals working with police.

Intervention

- Any form of police first response intervention delivered to people with mental health problems. Interventions may be delivered either by police services alone or by multiple agencies including (but not limited to) police services.

Study type

a) Systematic review that includes assessment of the outcomes, economic impacts OR
b) Primary study (reports empirical data, either numerical or textual, on the outcomes, economic impacts and/ or a process evaluation of an eligible intervention).

Comparator

- All comparators are included in the map. These are likely to be police compared to other sectors, usual responses or no response.

Outcomes

- All outcomes as described in the study are included in the map.

Geographical location

- Systematic review includes studies conducted in, OR primary study collected from, the UK or other OECD countries (i.e. those with similar economic, welfare and criminal justice systems to the UK): Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxemburg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United States.

## 2.4 Identification of potential studies: Search strategy

The search strategy has several components: the main effort is invested in the search of bibliographic databases and this is supplemented by a search of relevant websites, grey literature and hand searches of relevant journals. The map is based on a literature search built around the terms for "police" and "people with mental health problems".

### 2.4.1 Bibliographic databases

The search strategy for bibliographic databases combined search terms that describe mental illness (population) with terms that describe police responses (intervention). Key terms identified from existing systematic reviews of police responses to people with mental illness were used to develop a search string that was piloted and tested.

The bibliographic databases relevant to criminal justice field that were searched are listed in appendix 5.1.6. p79

### 2.4.2 Searching relevant journals

As bibliographic databases do not always have more recent journals indexed, key journals were searched for relevant articles.

- Mental Health and Criminal Justice
- Policing: A journal of Policy and Practice
- Police Practice and Research: An International Journal

Websites of organisations involved in police responses to people with mental health problems were also searched systematically for potentially relevant publications and reports. The websites searched are listed in Appendix 6.1.8.

### 2.4.3 Screening studies: selecting studies for inclusion

Eligibility for inclusion in the systematic map was determined based on screening the title and abstract for primary studies and the full texts for systematic reviews. A standard coding tool was developed and applied to each of included studies to describe, or map the research evidence base against the studies' key characteristics.

Key characteristics of the included studies were:

- geographical location,
- date of publication,
- type of study
- aim of the study
- people delivering the interventions,
- characteristics of people receiving the intervention,
- name of intervention
- model of police response
- types of outcomes measured by the intervention

### 2.4.4 Identifying and describing studies: quality assurance process

For quality assurance, a sample of 10% of the titles and abstracts was screened by two reviewers against the inclusion and exclusion criteria and compared. Discrepancies were discussed and resolved by a third reviewer until a high level of consistency was reached.

Figure 1.  Overview of number of studies as they flow through the review process.



'Grey' literature,

531

Bibliographic database

10,084

Results 10,615

Included studies

Mapped for key characteristics

475

Duplicate 2,744

EXCLUDE- not enough information in ti, ab 148

EXCLUDE- pre 1995 645

EXCLUDE-Not in English 11

EXCLUDE- Not in OECD country 362

EXCLUDE-population, no police 4,557

EXCLUDE-population, no person with mental health problems 943

EXCLUDE-not an empirical study 543

EXCLUDE- setting- not in the community 187

# 3 Results

## 3.1 Extent and nature of the empirical literature on police and responses to people with mental health problems

The following section reports on the different aspects and characteristics and trends in the empirical literature on police responses to people with mental health problems.

It gives an overview of the topics of interest in the literature over time, the purpose and aims of the studies, countries which publish the most studies and the populations, participants and characteristics described in the studies.

### 3.1.1 Year of publication

There has been steady, increasing interest in research on addressing police responses to people with mental health problems in the literature published in English in OECD countries. There was a 50% increase in studies being published from 2013 – 2014 and a decline to lower than average rates of publication by 2015. The

Figure: 3.1 Rate of study publication
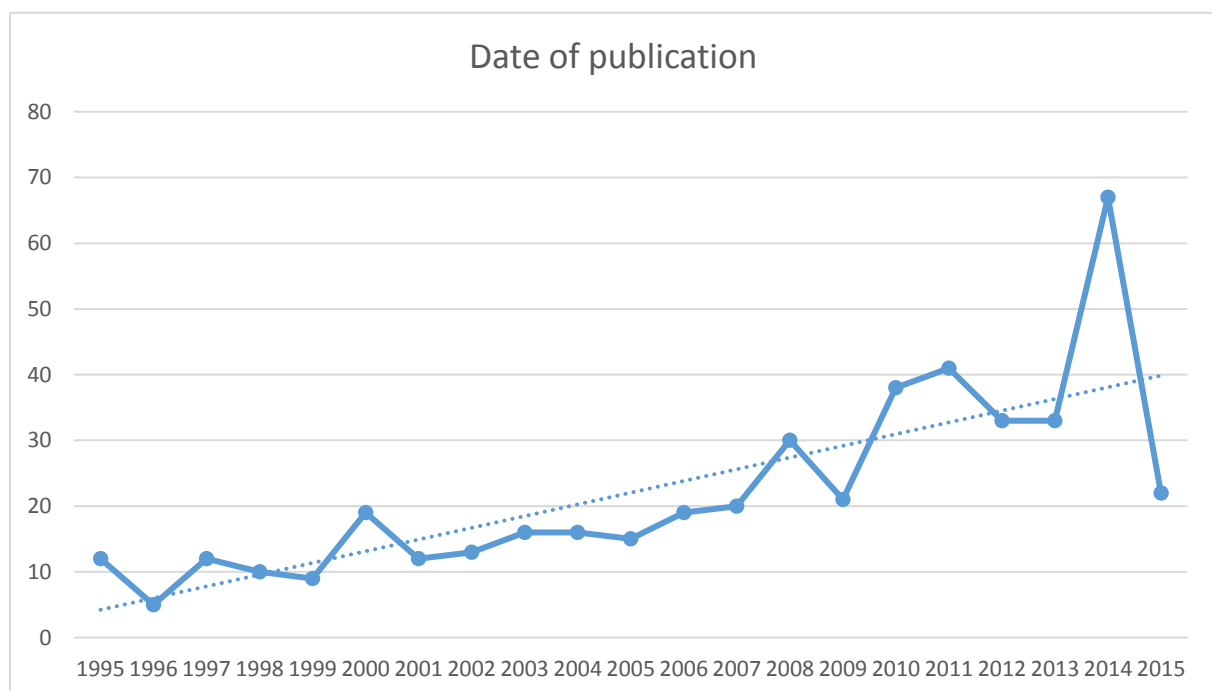


### 3.1.2 Geographical location

A high proportion of studies were published with a focus of the study in the UK (23%) but the proportion of studies with a focus on the US (43%) was nearly double this. The higher representation of the studies in the UK and US will also be a reflection in part of the choice of bibliographic databases that reference majority of US and UK journals and the inclusion of studies published in English in higher income countries

Figure: 3.2 Geographical location of studies



Geographical location of studies
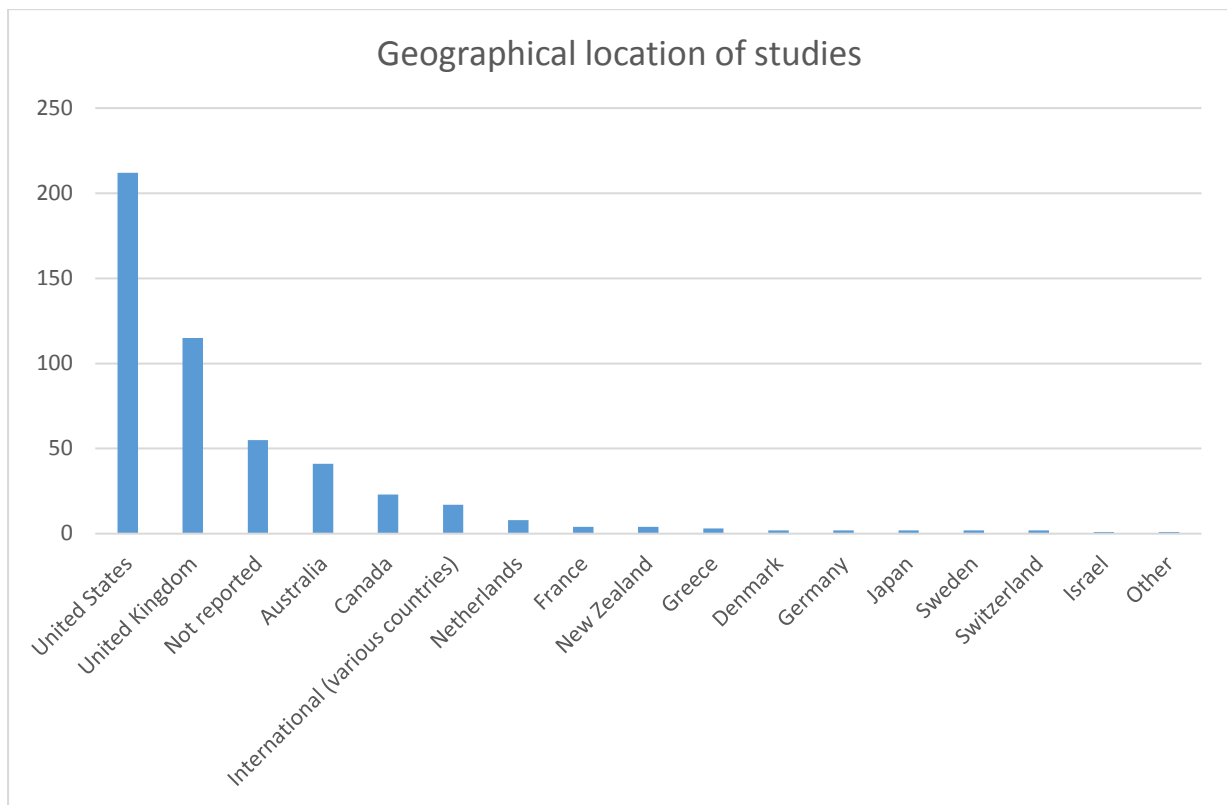
*(Numbers not mutually exclusive)*

### 3.1.3   Types of studies

Over a quarter (27%) of the study types found were observational in design and looked at the rates, prevalence, incidents and patterns of characteristics. There was a notable lack of high quality experimental study designs that tested different police responses to people with mental illness to usual or alternative approaches. There was only one study that was described as a randomised controlled trial and only 4 studies that were systematic reviews of polices responses to people with mental health problems (<1%).

Figure: 3.3 Study types



## Study types

| Study type | Value |
|---|---|
| Linked study | ~1 |
| Randomised controlled trial | ~1 |
| Protocol for review | ~2 |
| Systematic Review | ~5 |
| Not clear | ~8 |
| Cohort | ~19 |
| Case study | ~22 |
| Non-randomised controlled trial | ~24 |
| Policy and guidance | ~26 |
| Cross sectional survey | ~38 |
| Observational | ~53 |
| Process evaluative study | ~54 |
| Views study | ~66 |
| Non systematic Review | ~82 |
| Prevalence. rates, characteristics | ~144 |
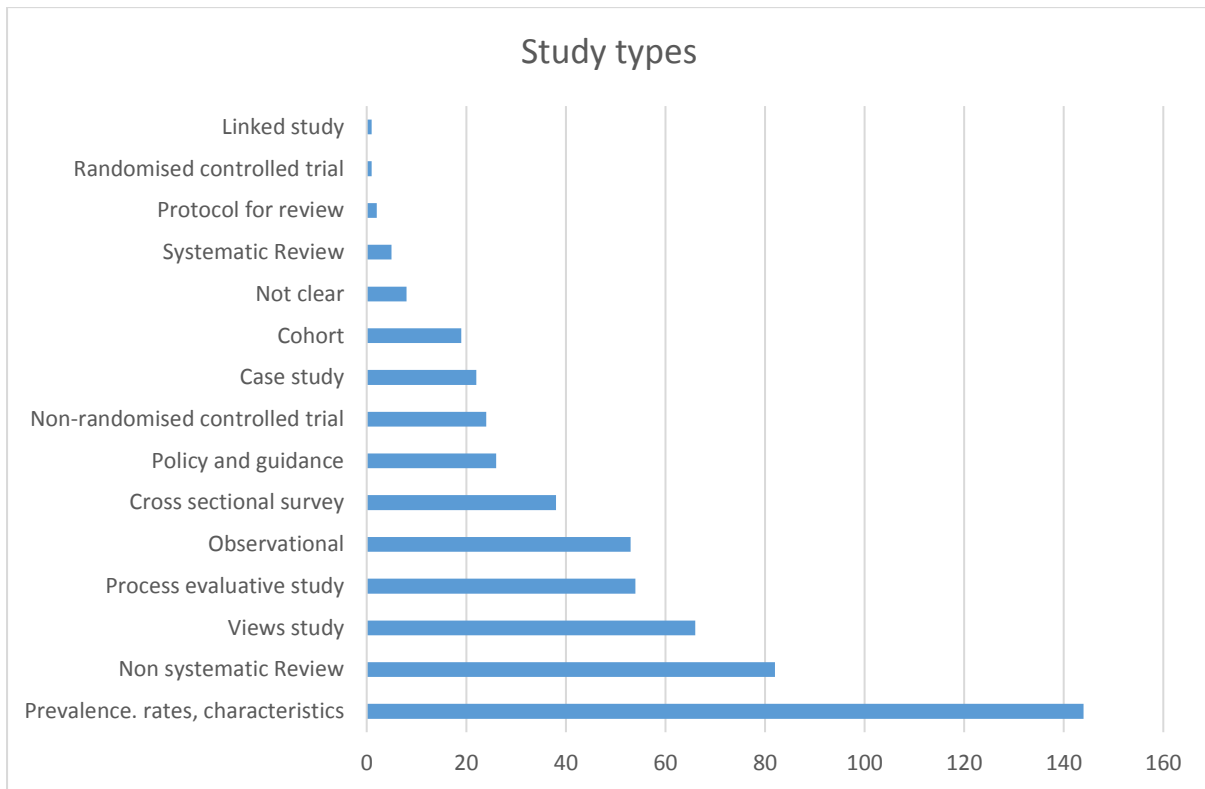
*(Numbers not mutually exclusive)*

### 3.1.4   Aims of the studies

By far the majority of the studies aimed to evaluate the impact of a policy, programme or intervention (38%). Although there was a lack of high quality and reliable study designs for evaluating effectiveness, it is clear that the studies of police responses to people with mental health problems in the literature had this as their aim. In addition to evaluating impact, 9% of the studies aimed to describe how a programme was implemented.   The second highest number of studies after evaluation of an intervention, policy or programme were by studies that identified or looked at relationships between factors (19%) these included moderator analyses, looking at how different factors and characteristics can effect an outcome, such as gender or minority ethnic status.

There were few studies that included the views and experiences of people with mental health problems who come into contact with police themselves (3%) compared to 11% of police officer views and experiences.

Figure 3.4 Aims of the studies
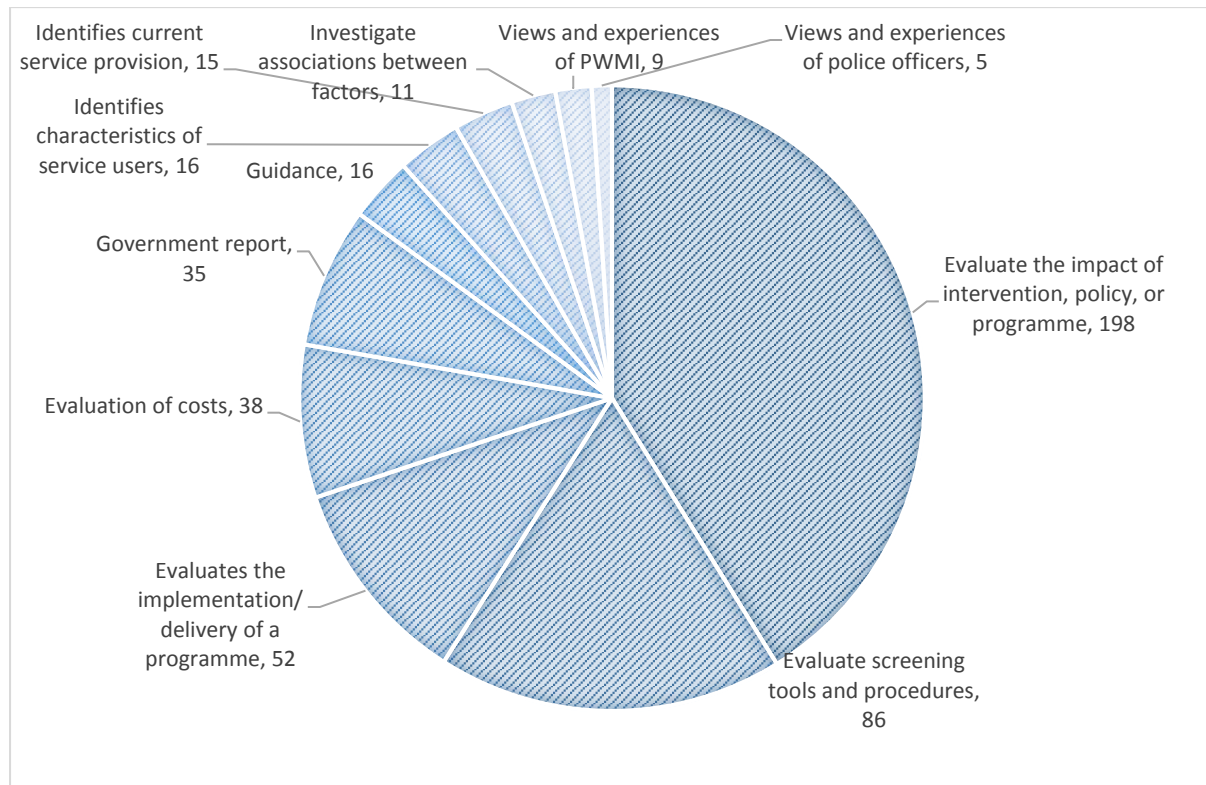


*(Numbers not mutually exclusive)*

## 3.2 Who was being studied: Participant characteristics

### 3.2.1 People with mental health problems described in the studies.

Just over a third of the included studies (37%) provided some additional information on the characteristics of the people with mental health problems that the police had contact with.

The wide range of different descriptions of mental health problems suggest the diversity of mental health problems both diagnosed and not diagnosed. Some of the categories are about specific conditions and assume a formal medical diagnosis, and having a formal diagnosis does not necessarily mean that the person is receiving mental health care at the time of contact with police. The descriptions of mental health problems in the studies tend to be more general.

There were thirty-four different additional characteristics that were described in the included studies, and over half of the studies were found in only six categories which are described in more detail below.

The most common characteristics of people with mental health problems described in the studies were people detailed under section 136 or 135 of the mental health act 1983, Dual diagnosis (a mental health problem and use of alcohol and/or drugs), people with mental health problems who are victims of crime, people with mental health illness/problems, people with a learning disability and mental health problems and children and young people with mental health problems.

### 3.2.2   Section 135/136

16% of studies described additional characteristics of people with mental health problems were UK studies that featured people who were removed under powers of the mental health act 1983, section 136 (from a public place) or 135 (from a private setting).  People with mental health problems who are removed from a private or public place under this act are believed to be experiencing a mental health crisis of such intensity that they are in need of immediate help, for their own safety or others. Police have powers to take people to a place of safety for assessment of their mental health needs.

The publication dates ranged from 1995 – 2015 but more than half of these studies were published in the past five years (55%).  This increased interest in the use of alternatives to police custody as a place of safety in the literature may be in response to a Home Office circular (Home office 2008) that recommended that police stations should be used as a place of safety only in exceptional circumstances and that alternative places should be found.

### 3.2.3   Dual Diagnosis

The second highest number of studies that described characteristics of people with mental health problems was for "dual diagnosis", (16%) and were published between 1991 – 2013. Some of the studies describe people with a diagnosis of mental illness, who also misuse drugs or alcohol.  Another way the studies describe people with mental health problems can come into contact with police is because of alcohol or drug use offences initially but who may also have mental health problems which may or may not be diagnosed at that time.

In addition to the studies that describe people with mental health problems as having dual diagnosis were a smaller number of studies (7 studies or 4%) that were about people with mental health problems and the use of alcohol or drugs but who may not have a formal diagnosis of either.

### 3.2.4   People with mental health problems as victims of crime

There were nineteen studies that looked at police response to people when they were a victim of crime these were published between 1999 and 2015 and published in the US (9), UK (6) and Australia (1)  the remainder did not report the country of study. The types of police responses that were in these studies are listed overleaf.

Figures 3.5 Studies about people with mental health problems as victims of crime



Studies about people with mental health problems as victims of crime
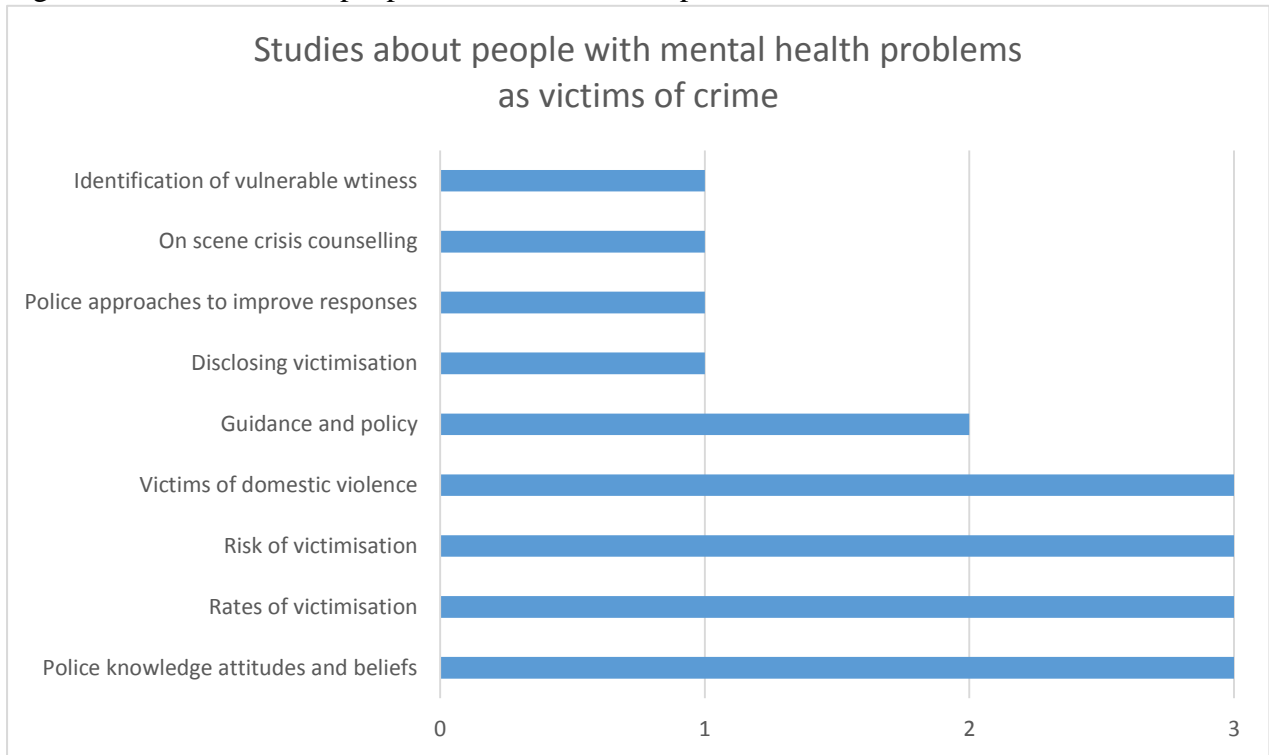
*(Numbers not mutually exclusive)*

Fourteen studies did not provide further description of the participants over and above having mental illness or mental health problems.

### 3.2.5  People with learning disabilities

There were the same number of studies (14) that were about people with mental health problems and learning disabilities. These studies were published between 1995 and 2015 and were published in the UK (9), US (2) and the remainder were not reported.

The within-category topics of the studies are shown in the chart below.

Figures 3.6. Studies of people with mental health problems with and learning disabilities and the police response



Studies of people with mental health problems with and learning disabilities by police response

| Category | Value |
|---|---|
| Liaison and diversion | 1 |
| ASBOS | 1 |
| Pathways into CJS | 1 |
| Intermediaries | 1 |
| Guidance | 1 |
| UK Government report | 1 |
| Appropriate adults | 1 |
| Police responses | 2 |
| Training officers about learning disabilities | 2 |
| Identifying people with mental health needs | 3 |
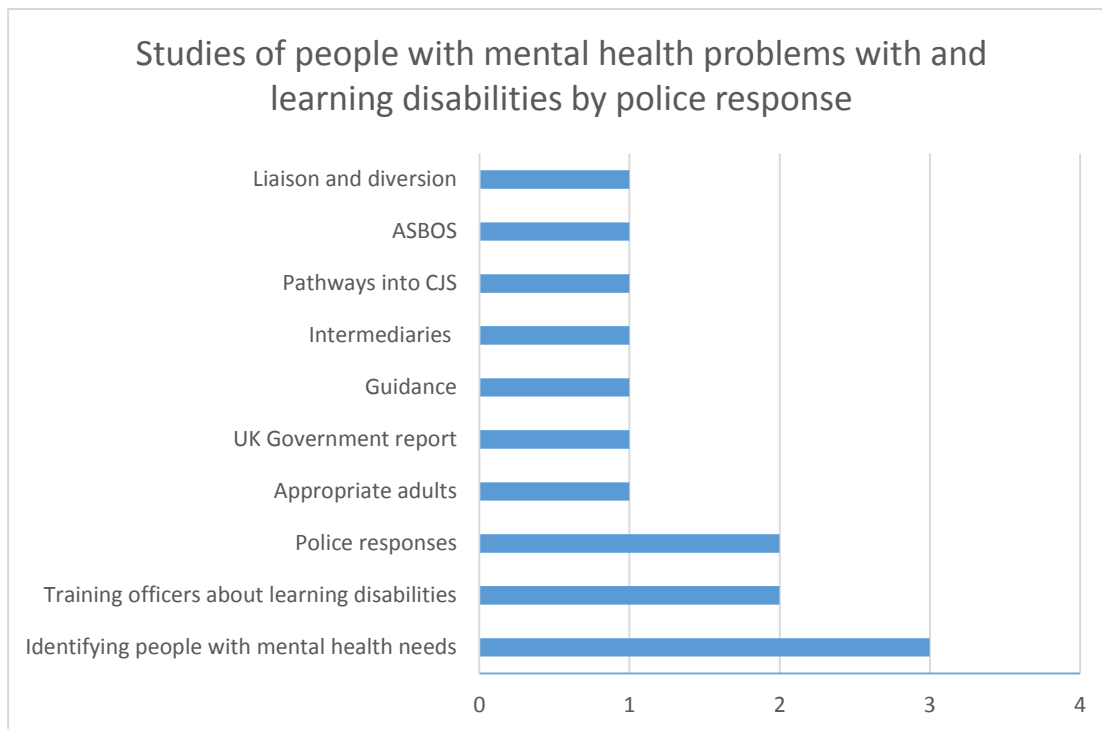
*(Numbers not mutually exclusive)*

### 3.2.6   Children and young people

There were twelve studies that looked at children and young people with mental health problems. These were published between 2000 and 2015 and were published in US (6) and the UK (5).

Two studies looked at the mental health needs of young offenders, the remainder of the studies had one study each look at early intervention, the use of an appropriate adult, hostage negotiations case study of a juvenile, the use of anti-social behaviour orders, crisis intervention teams for juveniles, homeless youth, youth diversion, and the needs of violence exposed and traumatised children.

The remainder of the studies and the characteristics of people with mental health problems are shown in the chart overleaf.

Figure: 3.7 Characteristics of people with mental health problems in studies



PWMI as victims of crime

Mental health problems

Children and young people

Use of drugs or alcohol

Homeless

Rural-Urban

Veterans

Domestically violent

Severe and persistent mental illness (SPMI)

Psychosis

Male

Excited delerium

vulnerable adults

Older people

Police officers

High risk

Enduring moderate to severe mental health needs (EMHN)
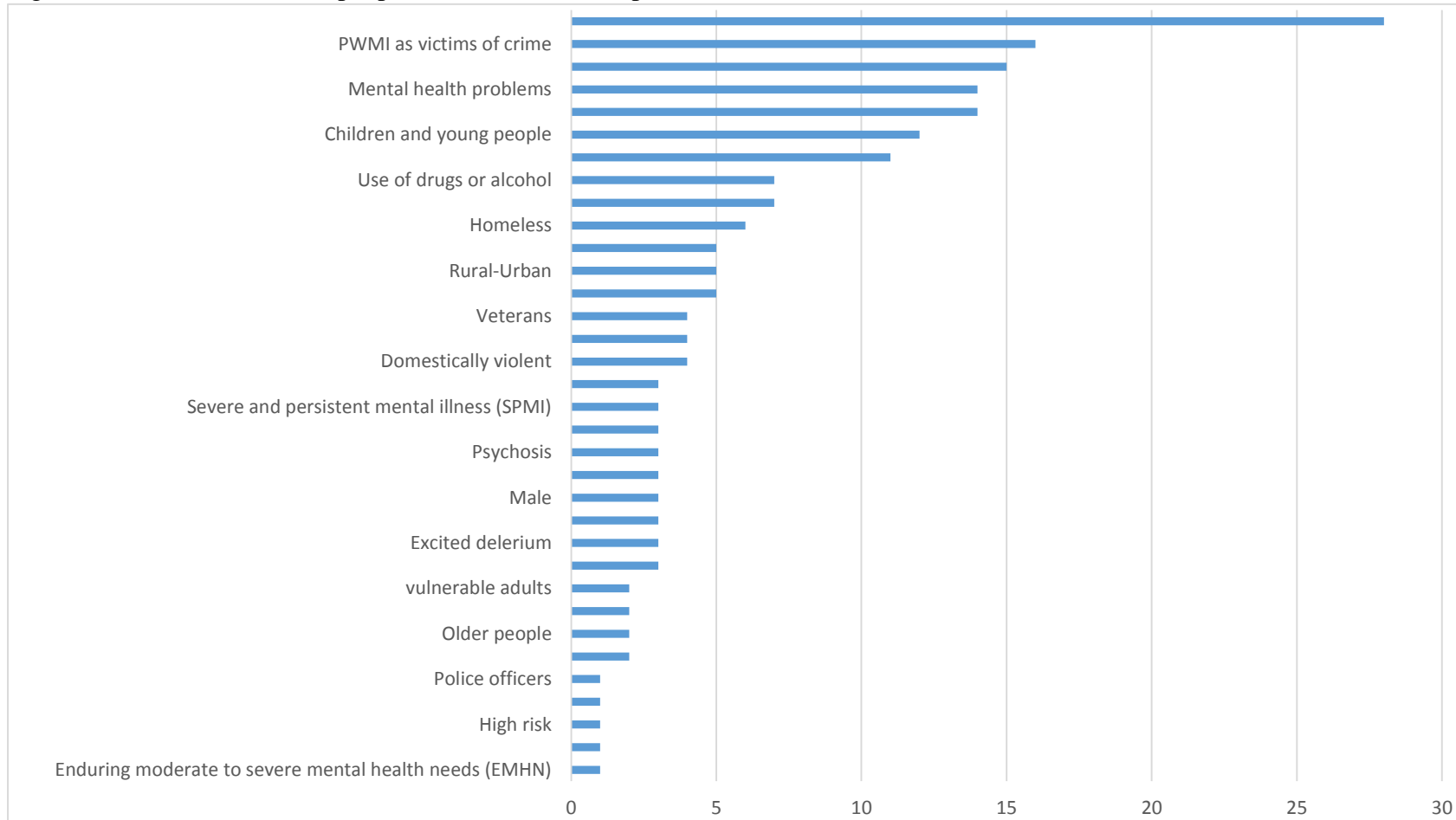
*(Numbers not mutually exclusive)*

### 3.2.7   Mental health professionals working with police described in the studies

There were twenty-nine studies that described characteristics of health and mental health care professionals who worked with police. The studies that describe characteristics of mental health professionals working with police are from a more recent date range that the other characteristics in the studies, 2003 - 2015 and were published in the UK (28%), US (24%), various countries (10%) and 3% in Australia, Canada and Denmark.

Figure: 3.8.  Health and Mental health professionals in studies



Health and mental health professionals in studies
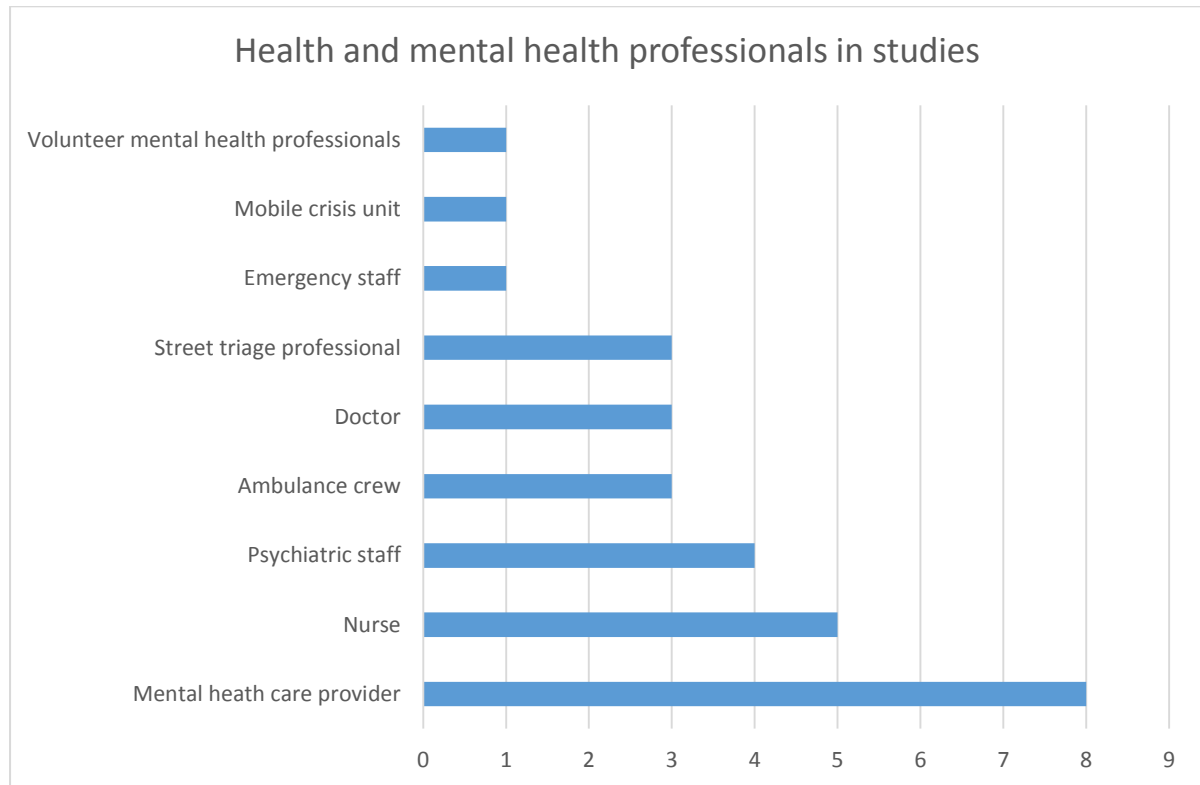
*(Numbers not mutually exclusive)*

Over half of the studies focused on mental health care staff working with police officers in response to people with mental health problems in the community (33%) or providing mental health care assessments (19%). The remainder of the topics are shown in the chart overleaf.

Figure 3.9 Topic of mental health care professionals in studies



**topic of studies with mental health professionals**

| Topic | Value |
|---|---|
| On scene counselling | 1 |
| phone triage | 1 |
| Use of named person | 1 |
| Street triage | 2 |
| MH workers providing training for police | 2 |
| Mental health professionals working in diversion programmes | 3 |
| Mental health workers involved in assessment | 4 |
| Police and mental health services working together | 7 |
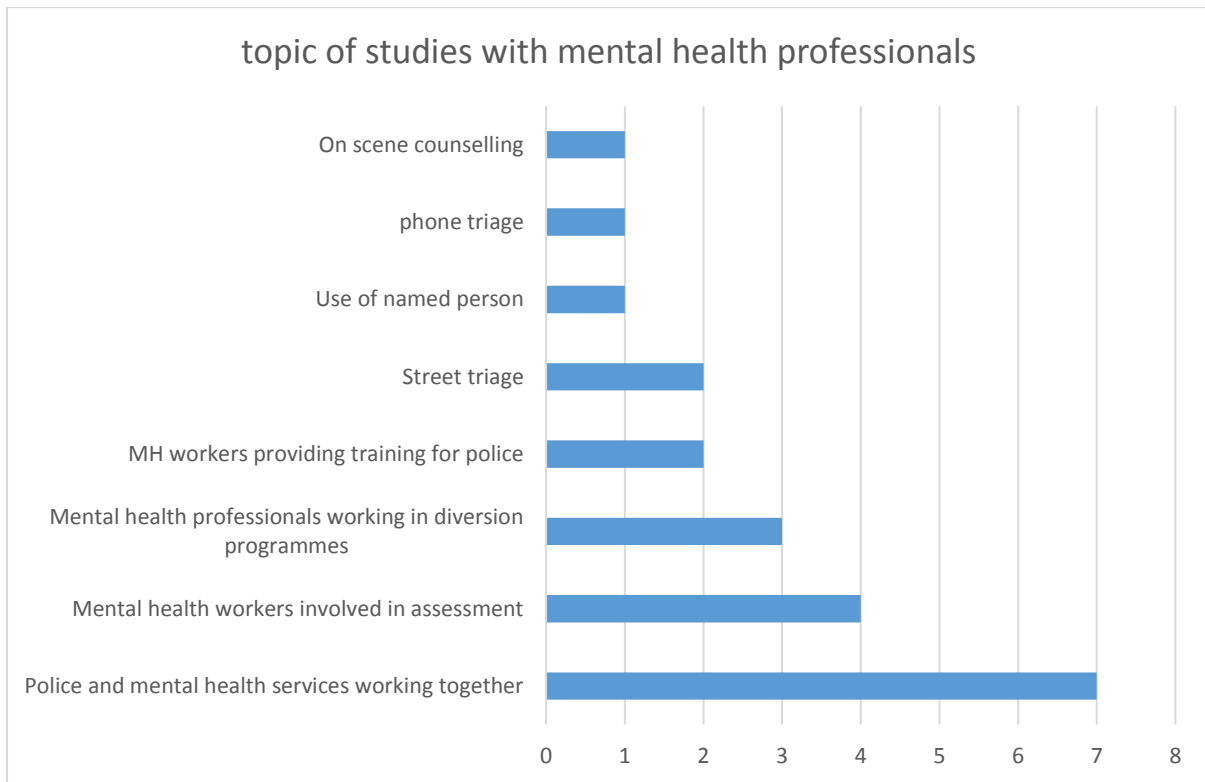
*(Numbers not mutually exclusive)*

### 3.2.8 Characteristics of Criminal justice personnel described in the studies

There were eighty studies that described additional characteristics of police and other criminal justice personnel. These studies were published between 1997 – 2016 and the majority of these studies were published in the US (73%) other countries of publication included UK (10%), various countries (4%), Netherlands (4%), Australia (3%), Canada (1%) and Israel (1%) Almost all of the studies that described additional characteristics of police and criminal justice personnel were about crisis intervention team officers (CIT). See chart overleaf.

Figure 3.10. Characteristics of Criminal justice personnel in studies



Characteristics of criminal justice personnel
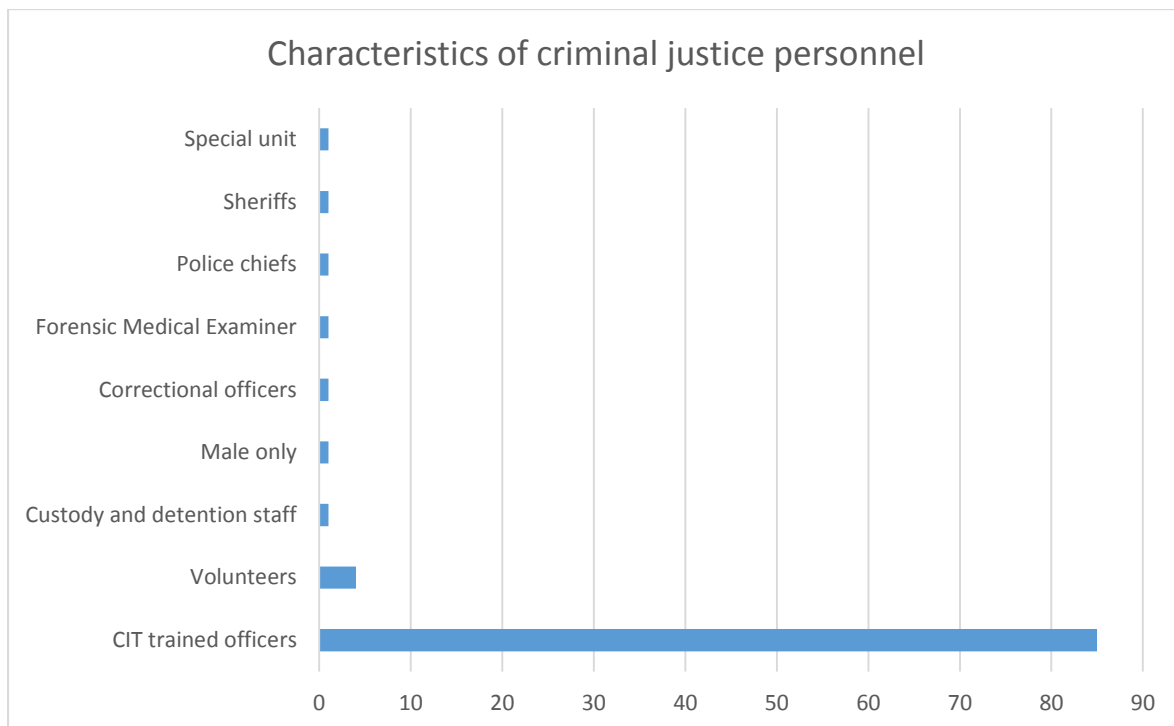
*(Numbers not mutually exclusive)*

### 3.2.9 Other professionals working with police described in the studies

There were twenty-seven studies that described characteristics of other professionals working with police and were published between 2000 – 2015.  Of the 11 studies that reported the country of publication, the majority of these were in the UK (82%) and the US (18%). The characteristics of the other professionals that work with police are shown in the chart overleaf.

Figure 3.11 Characteristics of other professionals in studies



Characteristics of other professionals
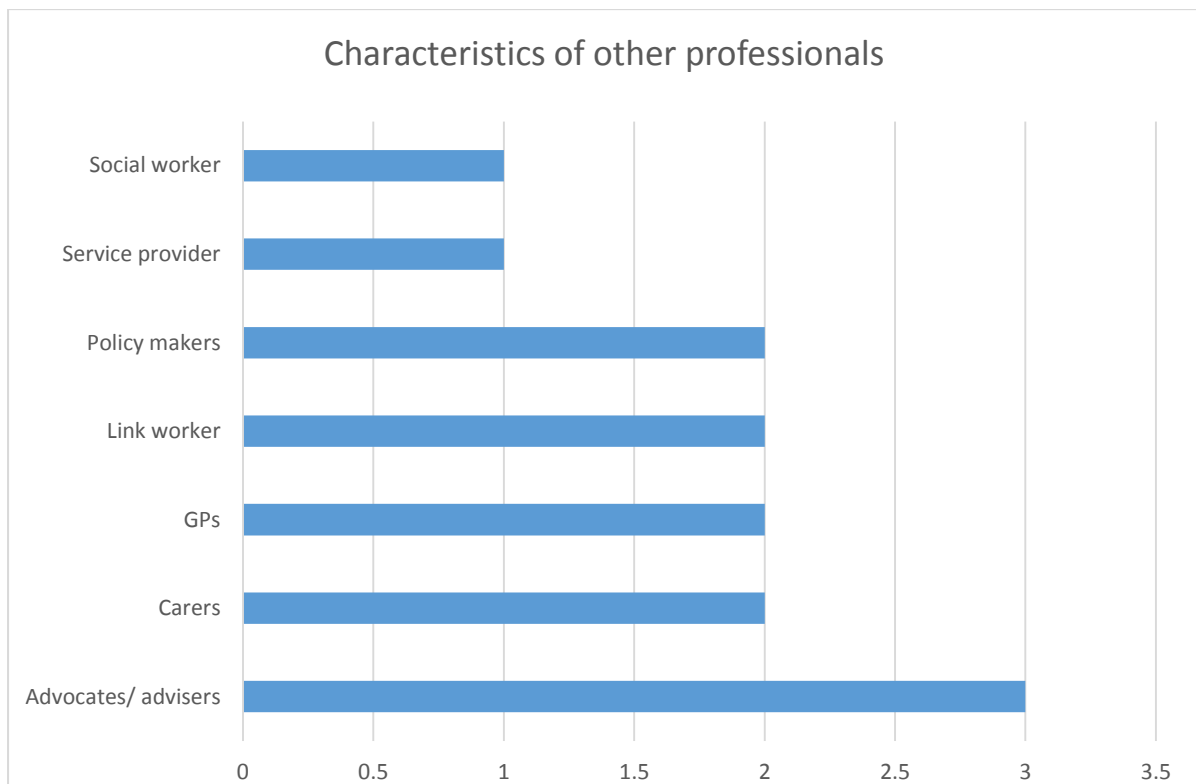
*(Numbers not mutually exclusive)*

The topics of the studies that described other professionals working with police were: involving stakeholders, including service users, and social workers. Three studies included link workers who worked with police, one study each featured staff from the educational sector working with police, other studies involved professionals providing training to police, or providing assessment and police working alongside a "named person" (a previously nominated advocate for a child or vulnerable person. Scotland).

Figures 3.12. Characteristics of other professionals working with police studies



Characteristics of other professionals working with police
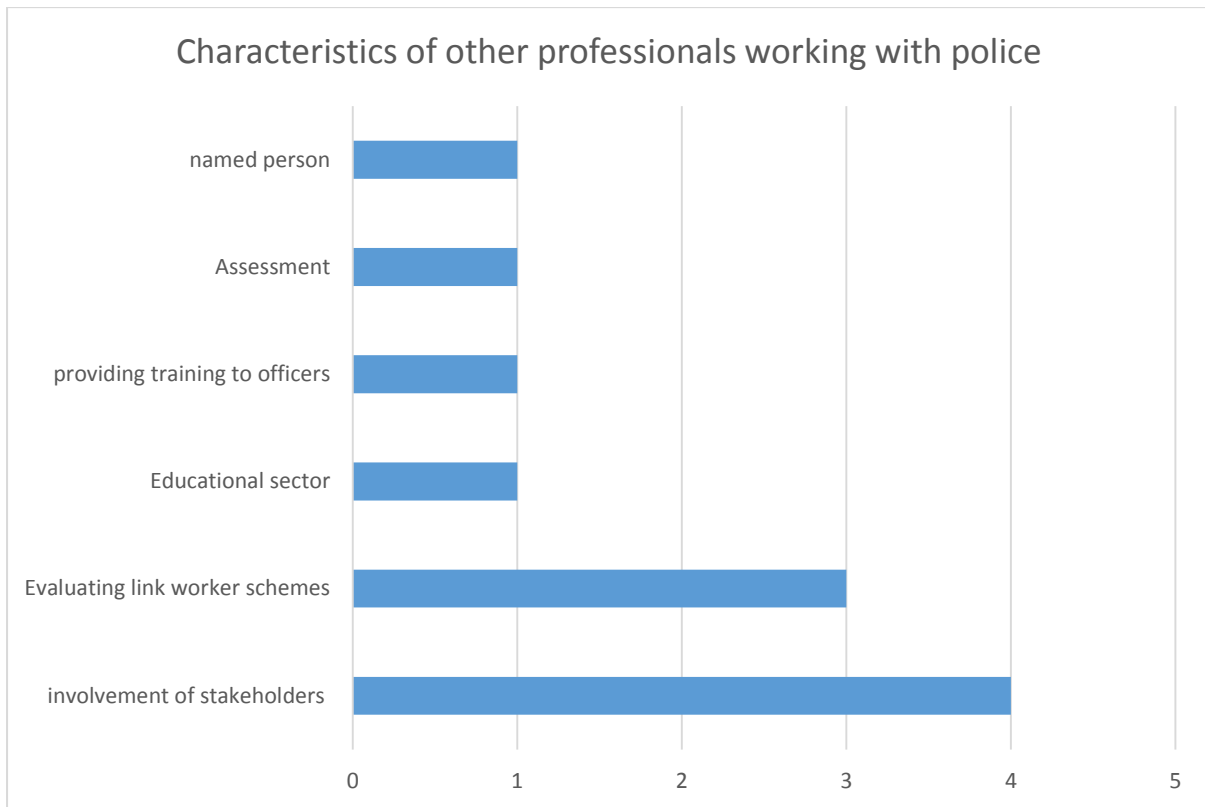
3.3 What police responses did they study?

The studies looked at police responses and interventions delivered by police and the health and mental health professionals who were working with them. The majority of the studies were about police responses generally and did not describe a specific type of intervention, but described the responses, activates or actions available to police officers who come into contact with people with mental health problems.. More specific detail about the type of police responses are listed under each heading.

Table 1. Types of police responses
*(Numbers not mutually exclusive)*

| Police response (general) | 139 |
|---|---|
| Responding to absconders | 2 |
| Responding to PWMI as victims of crime | 12 |
| Responding to domestically violent mentally ill | 1 |
| | |
| Section 135 | 4 |
| Section 136 | 28 |
| | |
| Police response (not specified) | 101 |
| Police knowledge and skills | 97 |
| Training | 61 |

| | |
|---|---|
| Identification of mental health needs | 10 |
| Assessment and referral | 22 |
| Transport and transfer | 5 |
| **Crisis services and responses** | **81** |
| Psychiatric emergency response | 1 |
| Post-Crisis Assistance Programme | 1 |
| Community based crisis resolution | 1 |
| Crisis counselling unit | 1 |
| Crisis Negotiation Team | 3 |
| Mobile mental health crisis team | 10 |
| Crisis Intervention Team (CIT) | 65 |
| Critical Incident team (CIT) | 4 |
| **Sanction** | **75** |
| Detention | 14 |
| ASBOs | 1 |
| Arrest | 61 |
| **Pre-arrest diversion** | **70** |
| Pre-arrest diversion | 58 |
| Involuntary outpatient commitment | 1 |
| involuntary psychiatric admissions | 3 |
| Involuntary mental health order | 1 |
| Outreach | 5 |
| **Multi-agency working** | **71** |
| Coordination of services | 3 |
| In house mental health worker | 3 |
| Multi-Agency working | 30 |
| Partnership with Mental Health Professionals | 26 |
| Phone/Street triage | 6 |
| Referral | 10 |
| **Use of force** | **32** |
| Use of Tasers | 8 |
| Use of CS gas | 1 |
| Armed response | 17 |
| Use of force (not specified) | 7 |
| **Police interview** | **10** |
| Miranda warning (US right to silence) | 2 |
| Negotiation strategies | 4 |
| Interview | 4 |

| Advocacy | 8 |
|---|---|
| Named person provision | 1 |
| Appropriate adults | 6 |
| Use of a registered Intermediary | 1 |

### 3.3.1 What named interventions, programme and specialised models of police responses did they study?

The three models of specialised police response can be distinguished by the location of professional judgement about whether a person has a mental health problem and if so what the appropriate response should be., In the co-responding model, the location of professional judgement of mental health status and appropriate response is with the mental health professional that attends with the police officer.

In the police judgement model, it is for the officer to exercise their professional judgement on determining the mental health status and response of the person they are attending.   At times this is enhanced with additional training, such as with the Crisis intervention team, at other times it is left to the officer's standard training and discretion.

Related to police professional judgement is the Link scheme, which is a referred professional judgement model, this relies on police officer judgement to an extent, but the determination of mental health needs and appropriate response is by the link workers who assesses the person's needs and link to mental health and other services.

The following section will describe the programmes and studies that fall under each of these models.

### 3.3.2 Co-responding model of police response

There were thirty-three studies that looked at programmes that were a co-responding model of police response and were published 1995 – 2015.   The studies were mainly published in the US (61%) and the UK (14%). The remainder of the studies were published in Australia (14%), and Canada (4%).  A further 7% of the studies had an international focus and included programmes from various countries.

In some co-responding models described in the studies, the police and mental health professional form a dedicated unit. They are comprised a number of police officers on shift rotation and on duty mental health care staff. (Mobile mental health care unit or teams 34%, Child development community policing programme (10%), Integrated Mobile Crisis Response Team (IMCRT) (3%), Police, Ambulance and clinical early response (PACER) 3%, Police–based mental health response (3%) and mental health based mental health response (3%).

Other types of co-responding police responses aimed specifically to prevent the inappropriate use of police powers to remove people from the community under a compulsory mental health order and instead access appropriate care by providing advice and expertise on mental health to officers on the scene or by telephone (Street triage (10%).

Finally, other types of co-responding programmes develop closer partnerships with mental health care services such as a police-mental health partnership (13%).

Figure 3.13 studies about the co-responding police model
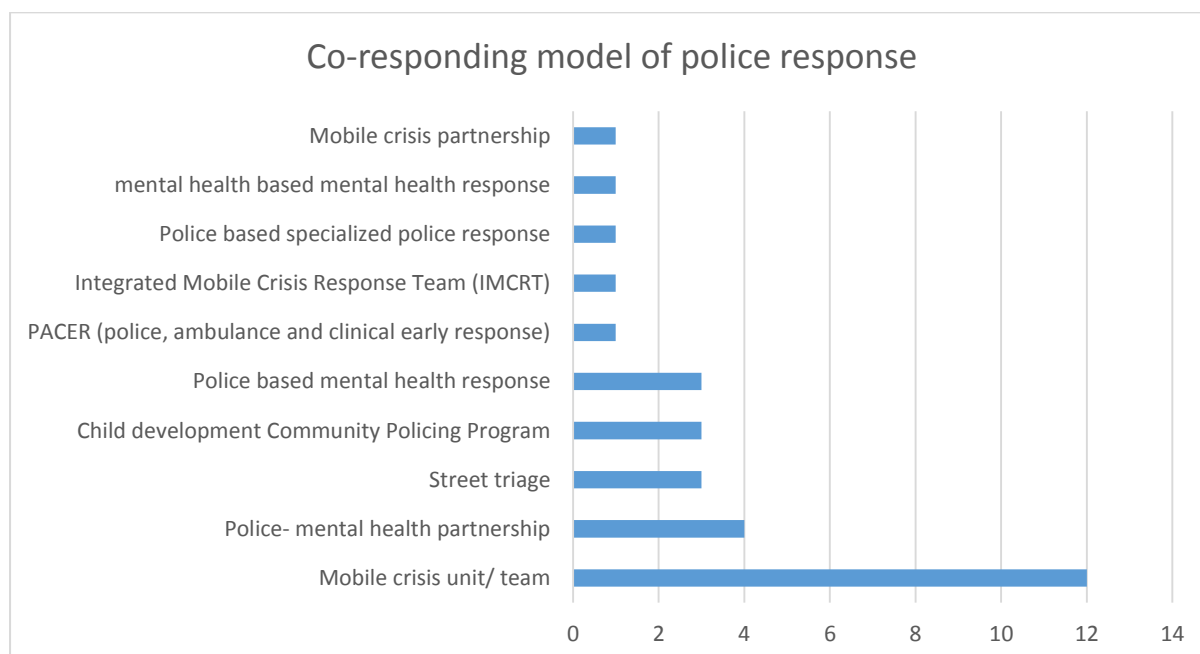


*(Numbers not mutually exclusive)*

### 3.3.3  Police judgement model of police response

There were eighty-five studies that featured a police judgement model of response. These were published between 1995 and 2016. The majority of the studies were published in the US (52%) followed by the UK (32%), Australia (4%), Canada (2%), Germany (1%), Netherlands (1%), New Zealand (1%). A further 7% of studies had an international focus.

Over half of the police judgement model studies featured officers in Crisis intervention teams and the majority of these studies were published in the US (57%).

### 3.3.4  Crisis Intervention teams

CIT international, is the non-profit organisation whose purpose is the promotion and dissemination of information, evaluation and standards of CIT to police jurisdictions in the US and in other countries looking to implement the model (CIT International 2016). The organisation describes CIT as a collaboration between officers as first -responders, community mental health and advocates. The goals of CIT are to:

- Improve Officer and Consumer Safety
- Redirect Individuals with Mental Illness from the Judicial System to the Health Care System

 (Dupont 2007)

### 3.3.5   The use of section 135 or 136, mental health Act 1983

The other most common types of police response models are about the use of UK section 135 or 136 of the UK mental health act 1983.  The use of these emergency powers of 135 or 136 require a police officer to recognise the symptoms of mental illness and decide whether to remove the person from a public place (section 136) or a private place (135)  if they believe the person is in immediate need of care and take them to a place of safety.

Fifteen studies focused on the act and the use of these emergency powers, nearly half of these were about the use of section 136 (47%), which is the section of the act that deals with removal of persons from a public place.  Only one study looked at the use of section 135, which is the emergency power to remove a person from a private place.  Two studies looked at police officer perspectives on the use of section 135 or 136, and one study each looked at difficulties in their use, quality of care,  pathways into care,  people with mental health problems and their carers' perspectives, and one government review of the use of section 135 and 136.

### 3.3.6   Place of safety

Fifteen studies looked at section 136 and 135 and the appropriate place of safety. Five studies looked at the use of police custody as a place of safety and were published after 2008, following government guidance that recommended that police stations be used as a place of safety only as a last resort (Home Office circular 2008).  Five UK studies that looked at the use of section 135/136 looked at alternative settings to police custody available to police officers. Four UK studies looked at the use of Accident and emergency room in general hospitals as the place of safety.

### 3.3.7   Police diversion

Six studies looked at the police use of discretion in diverting individuals away from the criminal justice system and into mental health care these were all US studies. Four of these studies referred to the Sequential Intercept Model (Munetz & Griffin 2006) as a framework to understand points long the criminal justice pathway where agencies can intercept and divert individuals with mental health problems away from the criminal justice system and into more appropriate care. The aim is to reduce the criminalisation of people with mental illness and reduce criminal justice contact by dealing with the underlying problems and causes of CJS contact.

The first opportunity to intercept and divert away from the criminal justice pathway is at police contact, and this can also include co-responding police and mental health workers and crisis intervention teams (CIT) and referrals to professionals who can link to services. This diversion takes place before an arrest takes place and the person is charged and taken into custody (or pre-booking).

Figure 3.14. Studies about the Police judgement model



**Police judgement model**

| Category | Value |
|---|---|
| Mental health intervention team | 1 |
| Crisis Intervention Team (CIT), (Ohio model) | 1 |
| BASTA- the alliance for mentally ill people | 1 |
| TEMPO | 1 |
| HELP-PC | 1 |
| A&E as a place of safety (135/136) | 4 |
| Diversion at the point of arrest | 6 |
| Place of safety section 135/136 | 5 |
| Police custody as a place of safety (135/136) | 5 |
| Detention under section 135/ 136 | 15 |
| Crisis Intervention teams CIT (Memphis model) | 52 |

*(Numbers not mutually exclusive)*

### 3.3.8   Link to services model

There were far fewer studies that looked at Link to services models compared to the co-responding and police responses models (5) these were published between 2000 – 2014 and were from UK (50%), US (38%) and Australia (13%).

Three of the four studies that looked at Link worker scheme were from the UK and were implemented by the not for profit organisation Revolving doors.  The service aimed to prevent people with unmet mental health needs becoming caught in a spiralling cycle of crisis, crime and mental health problems (Accendo  2012).

One US study described jail diversion that also made links to other services, such as housing and welfare assistance.

Another US study looked at police diversion that included a Liaison person to coordinate various agencies.

The US study that looked at Post crisis assistance also looked police diversion that used a link scheme to connect people with mental health problems with various agencies.

Figure 3.15 studies about the link to services model
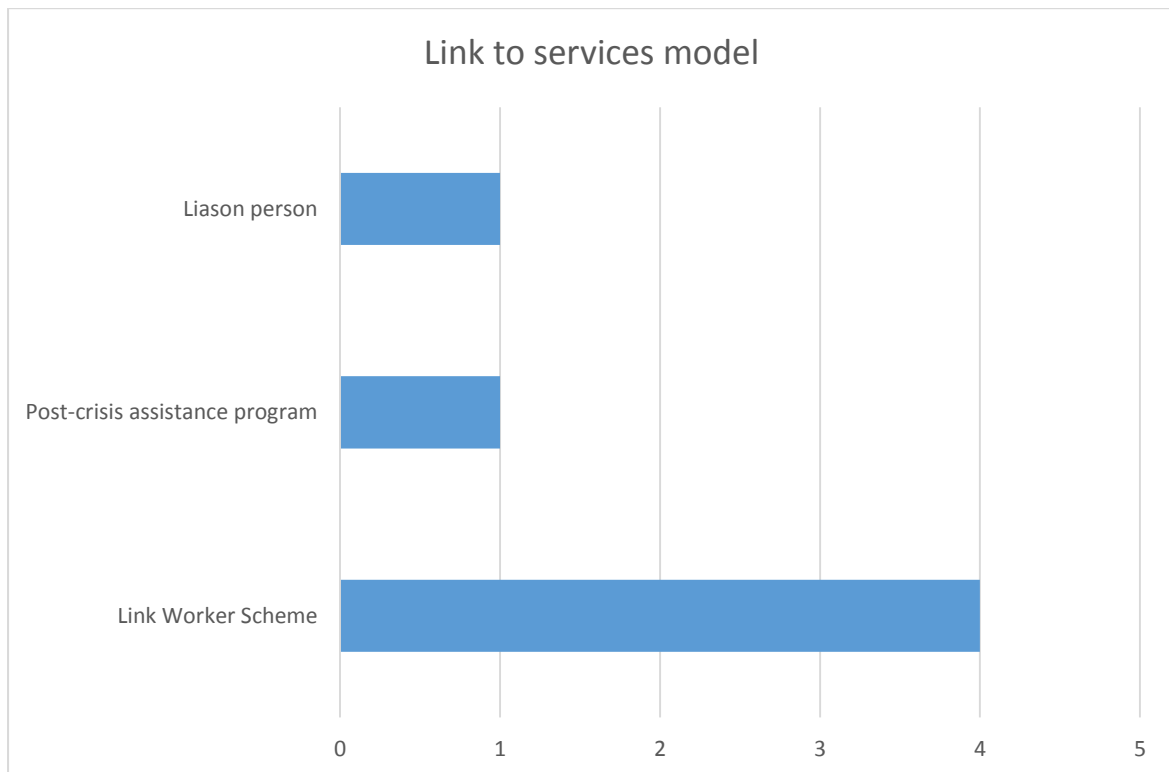


*(Numbers not mutually exclusive)*

## 3.4   Aim of the studies

The majority of the studies aimed to evaluate the impact of an intervention, policy or programme.  There has been a steady increase in these kinds of studies over time and a sharp increase in these types of studies in 2014.  However, as mentioned previously, only one study was described as a randomized controlled trial, the "gold standard" of experimental study design for evaluating effectiveness of interventions.  Therefore the majority of the studies that aimed to evaluate effectiveness are of study designs that are of less robust study design.

Figure 3.16 Aims of the studies



Aim of study

| Category | Value |
|---|---|
| Views and experiences of police officers | 5 |
| Views and experiences of PWMI | 9 |
| Investigate associations between factors | 11 |
| Identifies current service provision | 15 |
| Identifies characteristics of service users | 16 |
| Guidance | 16 |
| Government report | 35 |
| Evaluation of costs | 38 |
| Evaluates the implementation/ delivery of a programme | 52 |
| Evaluate screening tools and procedures | 86 |
| Evaluate the impact of intervention, policy, or programme | 198 |

## 3.5    Outcomes measured police responses

### 3.5.1    Qualitative themes

By far majority of the qualitative studies were concerned with the changes in officer's skills, attitudes and beliefs about mental health or people with mental health problems (70%).

Figure 3.17. Qualitative themes
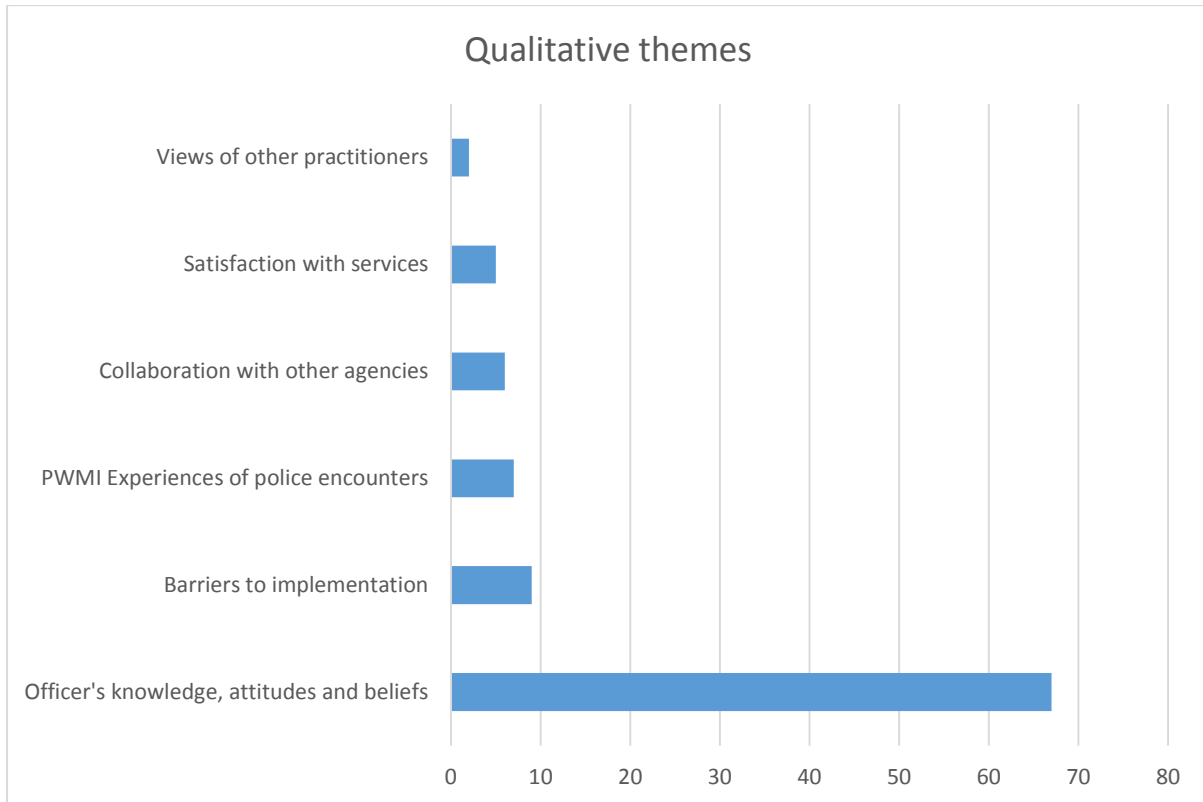


### 3.5.2    Quantitative outcomes

The most commonly reported outcomes in the different quantitative study design of police responses were concerned with the use of resources (84).  Over half (52%) of the police response studies that reported on resource use were concerned with costs (21%) access to mental health and other services ( 21%) and police time use (12%).

Figure 3.18. Resource use outcomes



Resource use outcomes
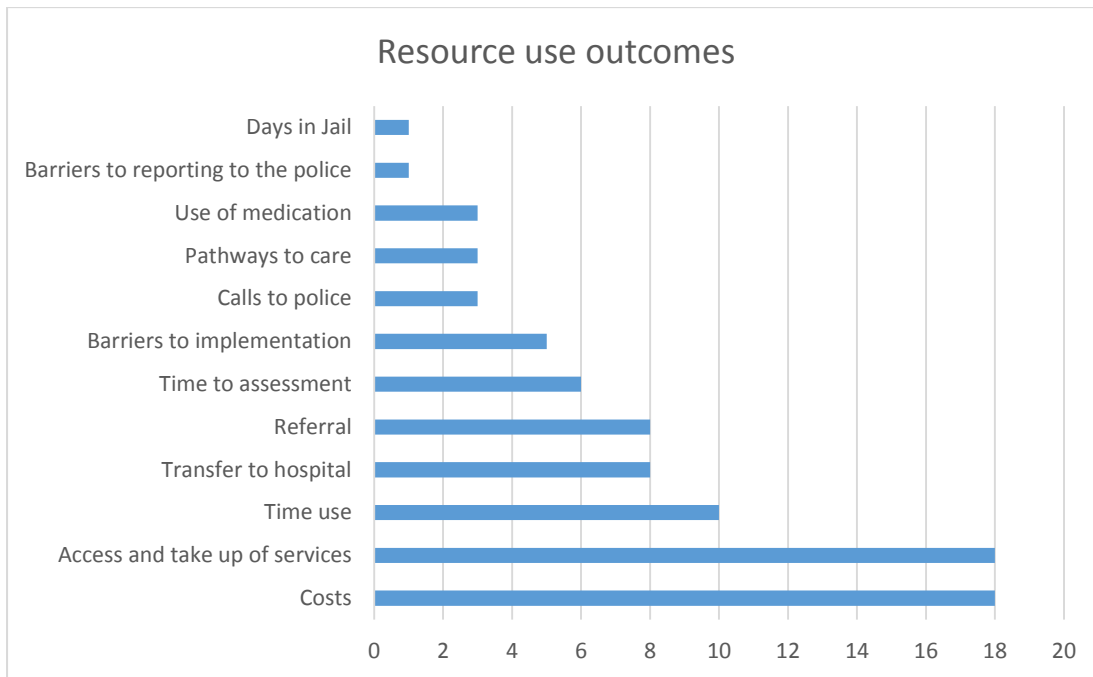
*(numbers not mutually exclusive)*

The use of sanction was reported as an outcome of interest 70 times. Almost all of these were to do with arrest as an outcome (96%)

Figure 3.19. Use of sanction outcomes



Sanction outcomes
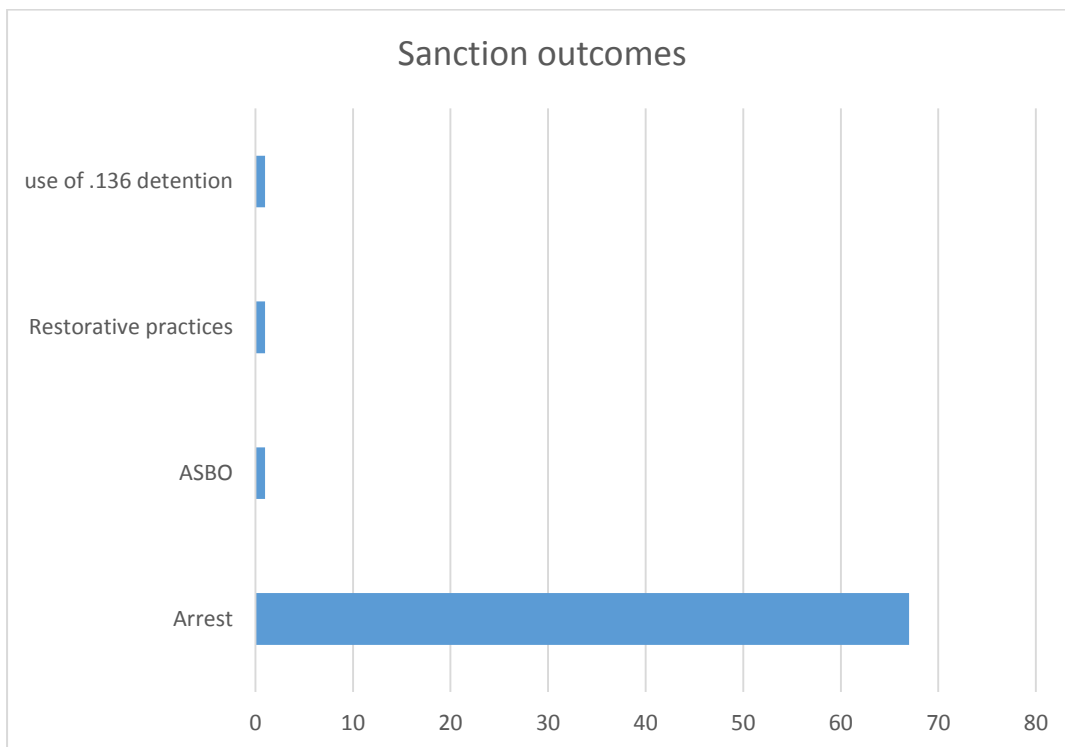
*(Numbers not mutually exclusive)*

Negative outcomes were reported as an outcome in 50 studies. Most of these were concerned with the Suicide of people with mental health problems (40%) followed by police use of force (30%).

Figure 3.20. . Negative outcomes
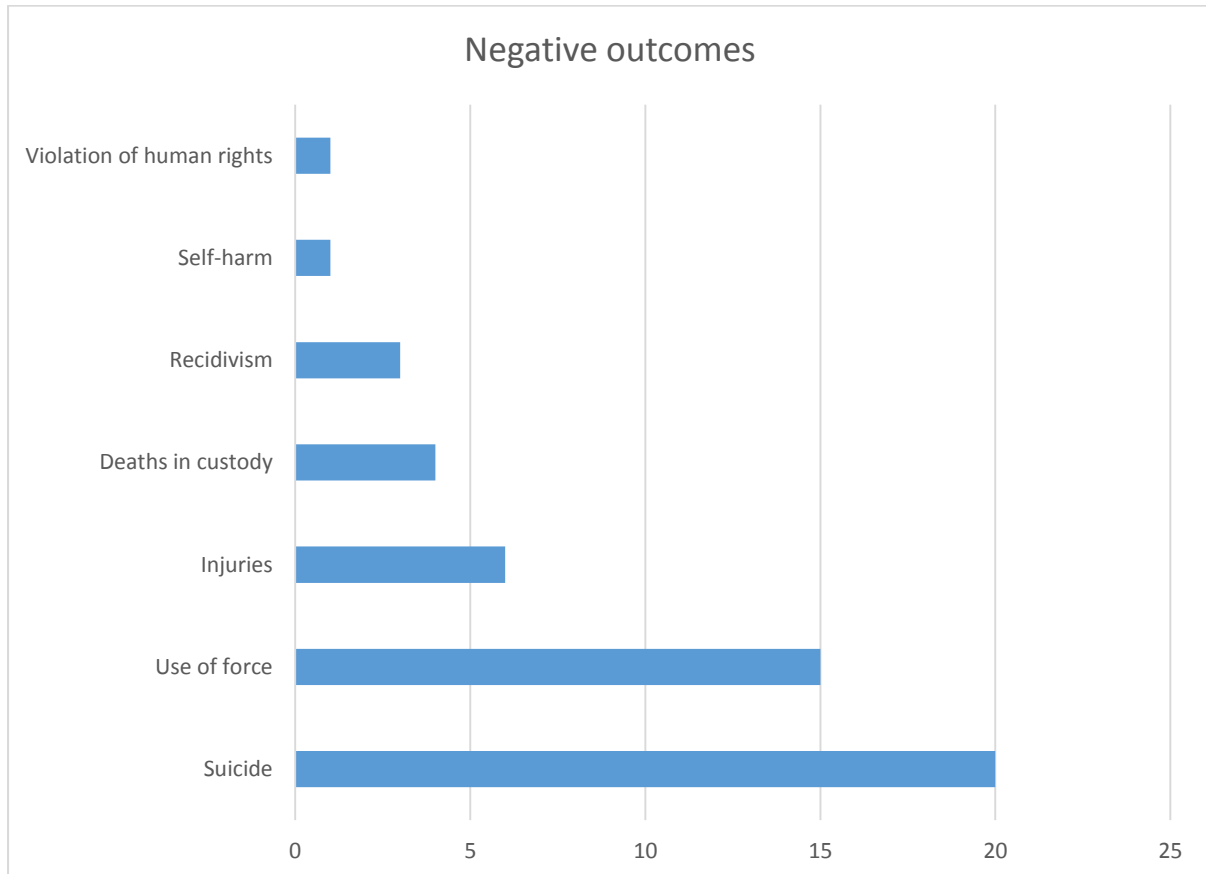


*(Numbers not mutually exclusive)*

The studies that reported on diversion from criminal justice as an outcome (24), mainly had keeping people with mental health problems out of jail as the outcome (45%).

Figure 3.21. Diversion as an outcome



**Diversion outcomes**

(y-axis categories, top to bottom: Descalation, Resolving crisis, keeping PWMI out of jail)

| Category | Value |
|---|---|
| Descalation | 4 |
| Resolving crisis | 8 |
| keeping PWMI out of jail | 10 |

x-axis: 0, 2, 4, 6, 8, 10, 12
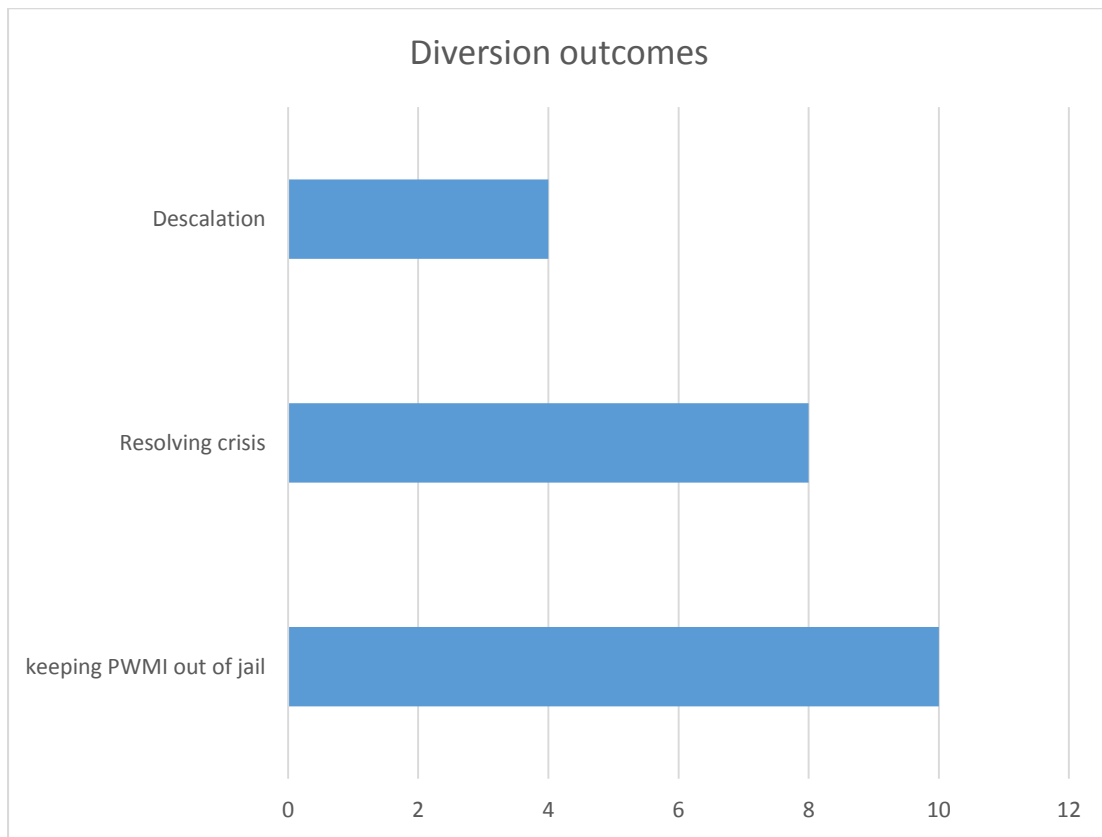
*(Numbers not mutually exclusive)*

The studies that reported on Officers skills and competencies as an outcome (17) the majority of these (76%) reported outcome on police decision making (41%) and being able to identify mental illness (35%).

Figures 3.22. Officer knowledge and skills outcomes



Officer knowledge and skills outcomes
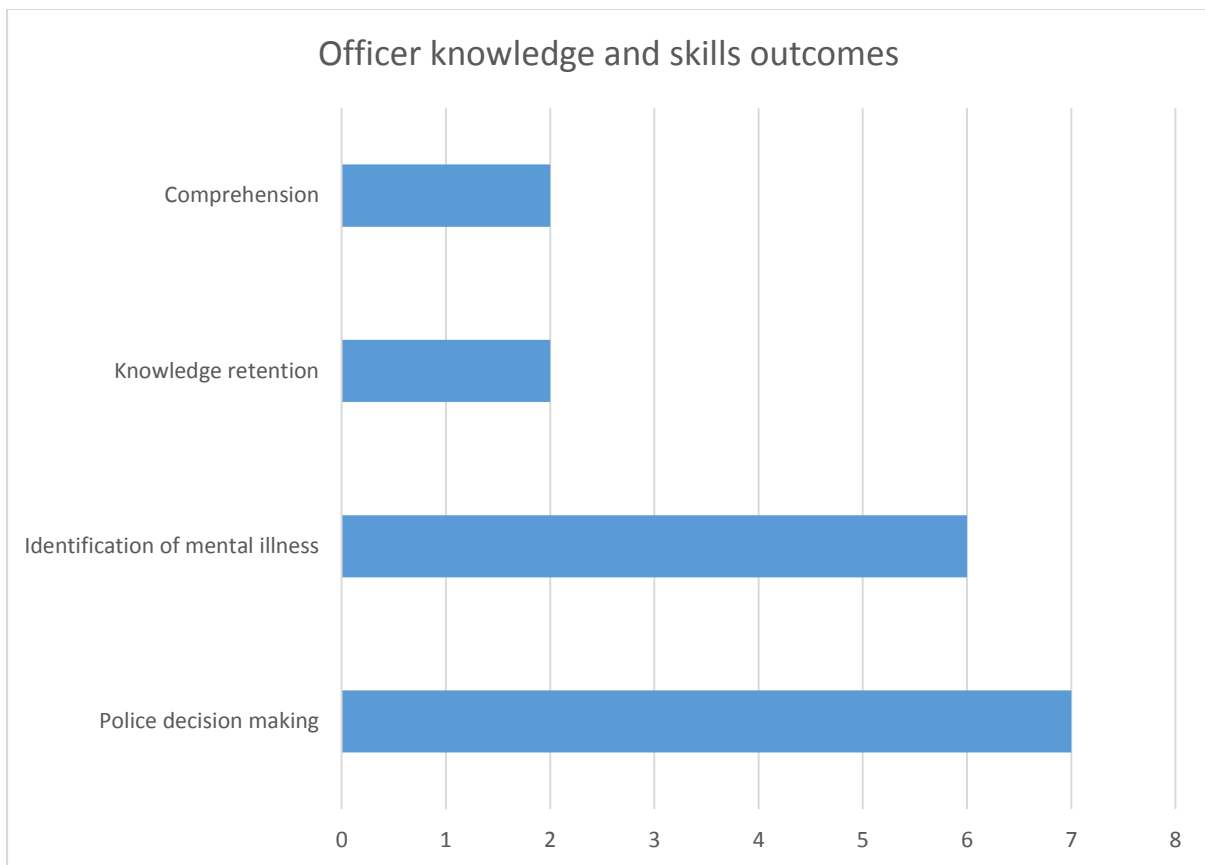
*(Numbers not mutually exclusive)*

Safety was reported as an outcome only 8 times. once each for community safety, staff safety, or wellbeing as an outcome., followed by twice for patient safety and three times for officer safety as an outcome.

Resolving crisis as an outcome of police response was reported as an outcome only five times. Three times for emergency admission as an outcome, and one each emergency protective custody and Emergency examination orders (EEOs).

## 3.6 Systematic reviews

There were 4 systematic reviews identified and these are listed in the table below.

**Table 3: List of included systematic reviews**

| SR1 | Anderson KK, Flora N, Archie S, Morgan C, McKenzie K | A meta-analysis of ethnic differences in pathways to care at the first episode of psychosis. (2013) |
|-----|-----|-----|
| SR2 | Compton MT, Bahora M, Watson AC, Oliva JR | A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. (2008) |
| SR3 | Shapiro GK, Cusi A, Kirst M, O'Campo P, Nakhost A, Stergiopoulos V | Co-responding Police-Mental Health Programs: A Review. (2014) |
| SR4 | Taheri S A | Do Crisis intervention teams reduce arrests and improve officer safety? A systematic review and meta-analysis. (2014) |

A further 78 reviews were identified in the searching and screening process but did not meet the inclusion criteria for systematic methods of review. The individual primary research studies included in these excluded literature reviews were identified and checked against included primary studies. Any primary studies not already identified were added to EPPI – Reviewer, screened, and if meeting the inclusion criteria, included for the map as an individual primary study.

The majority of the systematic reviews included studies from the US, followed by reviews that included studies from various countries (not specified) and were published from between 2008 up until 2014.

Figures 3.23. Systematic review by geographical location



Systematic reviews by geographical location
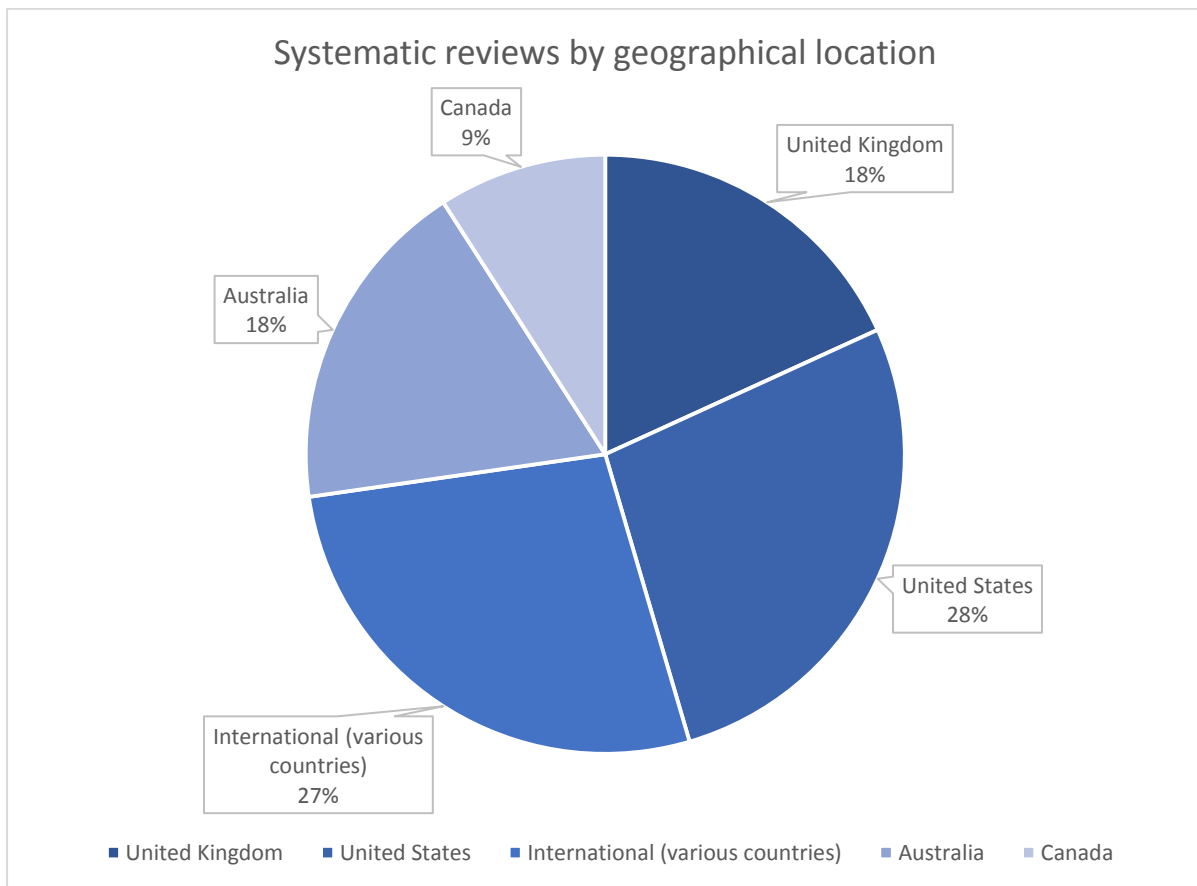
*(Numbers not mutually exclusive)*

*3.6.1.1    Included studies in systematic reviews*

In total the reviews included 35 unique primary studies. There as a wide range of study designs included in the reviews: the review that specified the study design as a criteria for inclusion were SR2, SR4 Experimental and Quasi-experimental studies or controlled trials, SR2, SR4,  descriptive studies were included in SR2 and SR3,  surveys in SR2, SR3,  Mixed methods and ethnographic studies in SR3. One review (SR1) did not specify a study design for inclusion but instead looked at any type of study that may answer their review question.

There was little overlap of studies, with only one study appearing in more than one review.

Table. 4.  **Individual studies appearing systematic reviews**

| Borum R, Deane MW, Steadman HJ, et al : Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. Behav. Sci Law 16:393–405, 1999 | SR2 | SR3 |
|---|---|---|

SR1 Anderson et al 2013.

The Anderson et al systematic review looked at the ethnic differences in pathways into care at the first episode of psychosis and the and the likelihood this came from general practitioner, police involvement, and involuntary admission to care and included 7 studies from Canada and England.. Studies were coded by two reviewers independently and discussed until consensus reached and each study critically appraised and a quality rating score applied. While they found that ethnic differences were often not disaggregated, or that the individual studies were underpowered to detect differences between ethnic groups, once the studies' findings were combined they were able to detect difference by ethnic groups.

There were three reviews that synthesised the evidence of effectiveness of two models of specialised police response, Crisis intervention teams in SR2 Compton et al (2008) and SR4 Taheri (2014) and the Co-responding model in SR3 Shapiro et al (2014).

The Compton study reviewed the evidence on the "Memphis model" Crisis intervention team. The aim of the review was to review the literature on CIT at a time when the model of police responses was increasingly adopted in states across the US. The review employed systematic searching methods but did not critically appraise the individual studies for internal and external validity and all studies' findings were given equal weight. The review included "evaluations, surveys or outcomes studies to examine research questions or test hypothesis related to CIT" (Compton et al 2008) and found 12 studies relevant to their review., Outcomes measured were combined into themes of Officer-Level Outcomes: Enhanced Preparedness, Confidence/Self-Efficacy and Knowledge, and Reduced Social Distance, Dispositions of Calls Eliciting a CIT Response, CIT as Prebooking Jail Diversion. The authors also discuss other related findings such as implementation issues.

The Taheri systematic review and meta-analysis also included studies that measured the effectiveness of the "Memphis model" of crisis intervention (CIT), as a mechanism of diversion of people with mental health problems from the criminal justice system. The review found 8 studies that met the inclusion criteria of experimental or quasi experimental study designs with outcomes of official or officer-reported arrests of a person with mental illness, police officer use of force, or of police officer injury.

The Shapiro review (SR3) looks at the effectiveness of co-responding models, and points out that there is a lack evidence of effectiveness on co-responding as a model of police response compared to the CIT programme, but the authors state there is a need for such a review as this this model is in fact the preferred model in other countries, such as Canada. The review included all study designs that included the co-responding model that is both police and mental health care workers responding. The review employed systematic searching methods but did not critically appraise the individual studies for internal and external validity and all studies' findings were given equal weight. The review identified eleven peer-reviewed papers, seven reports, and three dissertations. The outcomes measured were averting crisis escalation and injury, linking emotionally disturbed persons (EDPs) with community services, reducing pressure on the justice system (i.e. through reducing the number of arrests and police officers' handling time), improving officers' perception of individuals who have a mental illness, reducing the number of hospital admissions, cost effectiveness, and program perception (Shapiro et al 2014) given the likely heterogeneity of the studies included, a narrative synthesis was used to combined the findings from the individual studies.

# 4 Discussion

From over 10, 000 records identified from bibliographic databases and hand searching 4 systematic reviews and 471 primary studies met the inclusion criteria and were coded on title and abstract for this systematic map. A wide range of police responses were covered by the systematic reviews and primary studies, and a limited number of models of policing specifically for people with mental health problems, however the level of detail in each may be limited by the information available in the title and abstract.

It is worth noting that a relatively high proportion of studies were identified from hand searching. These typically were reports of impact evaluations that were conducted by independent or consultant organisations, rather than journal articles written by academic researchers. As a result these studies would not be found in the usual bibliographic databases, and highlights the need for systematic reviewers to include thorough hand searching in their overall search strategy.

## 4.1.1 Study designs

The majority of the studies in the map aimed to evaluate the effectiveness of a police response intervention, yet very few of the studies were of a design commonly believed to be the able to isolate the effect of the intervention compared to usual practice, i.e. the gold standard Randomised controlled trial. This lack of high quality experimental research may point to the fact that police practices based on research evidence of "what works" is relatively new. It may also reflect the difficulties inherent in designing "gold standard" experimental trials in this area. There are a number of ethical and practical conditions that the randomised controlled trial would have to meet including identifying the population, one that can give informed consent, that have an equal chance of being in the experimental group as the control group, while controlling for all confounding factors in a potentially volatile and changing environment.

There was a notable lack of systematic reviews of police responses, interventions and models of specialised police response to people with mental health problems, which may in part be related to the lack of robust study designs for evaluation in the primary studies.

In sum, there was a lack of primary and synthesised research evidence on the impact of police responses to people with mental health needs.

## 4.1.2 Criminal justice liaison and diversion.

There were no studies that evaluated the UK criminal justice and liaison and diversion (CJLD) programme at the point of police contact. Currently, diversion takes place once a person has been arrested and persons eligible for diversion are identified by specialist diversion staff while a person is in custody and not included in this map of police first responses. However as mentioned previously guidance from reviews of the CJLD strongly suggested that the most effective time to divert an individual from the criminal justice system would be at the earliest opportunity, i.e. before an arrest takes place (Department of Health 2009, Centre for Mental Health 2009, Scott 2013,)

The theory of criminalization, which is more prominent in the US and Canada, suggests that people with mental health problems are more likely to be arrested for the same offence than a person without mental health problems, or that the minor offences committed are for anti-social behaviour or so called "survival crimes", therefore to avoid criminalizing mental

illness diversion into treatment would be the appropriate response. There is broad agreement in the UK and the US (Sainsbury Centre for Mental Health, 2009, Munetz 2006, Pinals 2010,) that diversion should occur at the earliest opportunity to avoid the cycle of arrest, relapse and rearrest, due to unmet mental health needs.

There is a need to synthesis the evidence on whether diversion at the earliest opportunity, i.e. before an arrest takes place has an impact on criminal justice outcomes, and whether diversion into mental health treatment is more effective in decriminalizing mental illness.

A systematic review of police pre-arrest diversion of people with mental health issues: a systematic review of the impacts on crime and mental health examines this issue and forms the second stage of the 2 stage review of police responses to people with mental health problems, part of the What Works Centre for Crime Reduction Review Series. (Schucan-Bird and Vigurs, 2017)

However, diversion from the criminal justice system at the earliest opportunity, i.e. before an arrest takes place, necessarily relies on the ability, skills and knowledge of the police officer to identify mental health problems. In the US police officers who volunteer, are trained in crisis intervention and have their skills and knowledge enhanced with additional training about mental health. In the UK, the most common specialised police response has been the co-responding model, which places the skills and knowledge for identification of mental illness with the mental health care worker who attends the incident with the police officer. Similarly, the UK Criminal Liaison and Diversion schemes takes place after an arrest has already taken place and eligibility for diversion is determined by a specialist criminal justice and liaison officer.

There have been no primary studies to date that have compared the effectiveness of criminal justice diversion schemes in the UK diverting at the point of police contact. The emphasis of the research literature in the UK is diversion after arrest, or to reduce the inappropriate use of police powers to detain a person in need of immediate care and control under the mental health act Section 136.


### 4.1.3   Link schemes

Given the diversity of characteristics of people with mental health described in the literature it would seem that having skills and knowledge about mental health problems that police officers are likely to encounter is an important part of the professional knowledge and skills set of police officers in their community and that police officers would also need access to specialised mental health expertise and support.

There was very little research on how police can link a person to a wider range of services to meet their immediate and long term needs including mental health services. It would seem likely that an evaluation of multiagency working for effectiveness and cost effectiveness would be a useful area for further research.

### 4.1.4   Skills and knowledge of police officers

The studies that reported on the characteristics of people with mental illness were very diverse and often intersected with other areas of police involvement, such as drug and alcohol abuse and homelessness. The range of mental health issues described in the literature reflect the interests and concerns of academics and practitioners over time, and this diversity of

participant characteristics may reflect the complexities of identifying and responding appropriately with people with mental ill health, all being "core business" of policing. (Independent Commission on Mental Health and Policing 2013).

The largest proportion of study outcomes were about changes in officer skills and knowledge. A review of research of interventions that aim to increase the skills and knowledge of police officers in mental health would be useful to know if this too has an impact on criminal justice community safety, and mental health wellbeing outcomes.

## 4.2    Strengths and limitations of the systematic map

### 4.2.1    Coding of primary studies

The primary research studies were coded for the key characteristics only on the title and abstract of the large number of studies identified for pragmatic reasons given the high number of studies found, there is a risk that important information that was not stated in the title and abstract would be missed. However, the majority of the studies abstracts contained enough information to describe the key characteristics of the study to systematically map the research literature on police responses to people with mental health.

### 4.2.2    Relevance to the UK context

The majority of the studies of police diversion have been from the US.  The obvious contextual difference is the fact that police officers in the US are routinely armed and officers in the UK are not. The most common specialised police response in the studies was the US crisis intervention team (CIT), which originated in response to a shooting of an unarmed person with mental illness by an armed officer in 1988.   This raises questions on how transferrable the crisis intervention team model, would be to the UK context in terms of the definition of "crisis" and the content of training required.  This suggests a need for high quality research in the area of policing and people with mental health problems in a UK context.

## 4.3    Conclusion

The purpose of this report is to systematically identify and describe this empirical evidence in order to:

- Systematically describe the research evidence base for all the different police responses and models of police response to people with mental health problems.
- Systematically and transparently describe the current state of the literature in a way that identifies where the research is stronger or weaker, and provides access to a body of knowledge in particular areas of the research. (Dickson et al 2013). It provides a way for policy makers, practitioners and academics to locate relevant research and identify areas for future research and evidence synthesis.

- To identify research gaps for future research, and areas potentially relevant for systematic reviews.

The majority of the literature related to United States and Canada criminal justice agencies and focused on addressing the criminalization of people with mental health problems and increasing officer-client safety, this was typically in the form of crisis intervention teams. There may be issues in terms of generalizability to the UK context in terms of availability and access to free at the point of entry mental health care services.  There is a need for high

quality research evidence of effectiveness of models of specialised police response that are relevant to the UK context.

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# 6 Appendices

### 6.1.1 Appendix 1.1: Authorship of this report
The authors of the review are Carol Vigurs and Katie Quy.

### 6.1.2 Details of user involvement

Details of the membership of the Advisory Group

| Name | Title | Organisation |
| --- | --- | --- |
| Professor Ian Cummins | Senior Lecturer in Social Work | University of Salford |
| Dr Victoria Herrington | Director Research and Learning | Australian Institute of Police Management |
| Dr Yasmeen Krameddine | Postdoctoral fellow Department of Psychiatry | University of Alberta |

Details of the membership of the stakeholder consultation group

| Name | Title | Organisation |
| --- | --- | --- |
| Sarah Brennan | Chief Executive | YoungMinds |
| Ian Cummings | Senior Lecturer in Social Work | University of Salford |
| Dr Wendy Dyer | Senior Lecturer in Criminology | University of Northumbria |
| Dr Victoria Herrington | Director Research and Learning | Australian Institute of Police Management |
| Dr Yasmeen Krameddine | Research Fellow | University of Alberta |
| Simon Thorneycroft | Mental health coordinator | Office of the Police and Crime Commissioner for Dorset |

### 6.1.3 Inclusion and exclusion criteria for the map

| Criteria | Inclusion | Exclusion |
|---|---|---|
| **1. Language** | Published in English | Published in any language other than English |
| **2. Focus of report/ population of study** | Adults (aged 16 or over) have come into contact with the police<br><br>OR<br><br>Police officers who have come into contact with people with mental health difficulties, or crisis | Populations that are not adults with mental health difficulties<br><br>NOR<br><br>Police officers experiencing mental health difficulties.<br><br>Population groups who are under 16. |
| **3. Intervention** | Victims or perpetrators with mental illness , crisis or disorder that have come in contact with the police<br><br>Includes multi-agency interventions include an element of involvement from the criminal justice system.<br><br>Include specific following interventions:<br><br>-use of section 136. Mental Health Act<br><br>-Triage<br><br>-Crisis teams<br><br>- Multi-agency working | Victims or perpetrators with mental illness , crisis or disorder that have NOT come in contact with the police<br><br>Exclude interventions delivered by other criminal justice agencies, e,g, the prison service, the probation service Exclude interventions<br><br>Exclude interventions delivered by other public sectors (e.g. NHS), or the voluntary or third sector (e.g. Women's Aid) that have NOT been funded by the criminal justice system. |

- Co-responder programmes

- Appropriate adult

- Diversion schemes

| 4. Study type | Systematic review (i.e. describes search strategies and inclusion criteria used) that includes outcome, economics and/ or process evaluation | Literature review or narrative review without explicit methods detailing search strategy and inclusion criteria |
| --- | --- | --- |
| | | Systematic review of primary studies that do not include empirical data |
| | OR | |
| | Primary study that examine the impact of police approaches to interactions with people with mental health difficulties | Exclude primary studies without empirical data, either numerical or textual |
| | | Commentaries, position papers, policy documents (i.e. reports without empirical data), methodological papers (e.g. validation of measurement tools), historical analyses (before WW II), student textbooks without |

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| | | explicit reference to empirical research. |
| | | Exclude studies that do not tell us about the impact of police interventions with people with mental health difficulties |
| **5. Geography** | Systematic review includes studies OR primary study where data has been collected from OECD countries (Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxemburg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States) | Systematic review includes studies from non-OECD countries. Primary studies collect data from non-OECD countries. |
| **6. No Abstract** | | If no abstract is provided, please undertake a quick Google search for the abstract. |
| | | Exclude studies where it is not possible to easily locate an abstract or summary of the report. |

## 6.1.4 Search strategy for bibliographic databases

**ASSIA**

ti(Police OR policing OR "law enforcement" OR officer* OR YOT OR YOTS OR constable*) OR ab(Police OR policing OR "law enforcement" OR officer* OR YOT OR YOTS OR constable*) OR

su(police OR "police officers" OR "community management" OR arrests OR "police-citizen interactions" OR "crisis intervention")

AND

ti(crisis OR crises OR mentally OR Mental* OR psychiatr* OR vulnerab* OR homeless* OR suicid* OR mind OR "at risk") OR ab(crisis OR crises OR mentally OR Mental* OR psychiatr* OR vulnerab* OR homeless* OR suicid* OR mind OR "at risk") OR

su("mental health" OR "psychiatric disorders" OR "mental health services" OR "mental illness" OR suicide OR "mentally ill people" OR vulnerability OR "mental states" OR "emotional disturbance" OR "therapeutic communication" OR sectioning OR "at risk")


**Proquest – Criminal justice abstracts, Psychology Journals**

ti(Police OR policing OR "law enforcement" OR officer* OR YOT OR YOTS OR constable*) OR ab(Police OR policing OR "law enforcement" OR officer* OR YOT OR YOTS OR constable*)

OR

SU.EXACT("Police") OR SU.EXACT("Law enforcement") OR SU.EXACT("Community policing")

And

ti(crisis OR crises OR mentally OR Mental* OR psychiatr* OR vulnerab* OR homeless* OR suicid* OR mind) OR mentally OR Mental* OR psychiatr* OR vulnerab* OR homeless* OR suicid* OR mind)

OR

SU.exact("mental health care") OR SU.exact("mental disorders") OR SU.EXACT("Suicides & suicide attempts") OR OR SU.EXACT("Behavior disorders") OR SU.EXACT("Psychiatry") OR SU.EXACT("Personality disorders") OR SU.EXACT("Crisis intervention")

## 6.1.5  Coding tool for the map

| 1. Study type<br>What is the study design? | <ul><li>Systematic Review</li><li>Non systematic Review</li><li>Randomised controlled trial</li><li>Non-randomised controlled trial</li><li>Cohort</li><li>Prevalence. rates, characteristics</li><li>Process evaluative study<br>A study that assesses the operation, implementation and delivery of an intervention, policy or practice.</li><li>Case study</li><li>Cross sectional survey</li><li>Observational</li><li>Views study</li><li>Protocol for review</li><li>Policy and guidance</li><li>Linked study</li><li>Not clear</li></ul> |
|---|---|
| 2. Aim of the study | <ul><li>Evaluate the impact of intervention, policy, or programme</li><li>Evaluate screening tools and procedures</li><li>Evaluates the implementation/ delivery of a programme</li><li>Evaluation of costs</li><li>Government report</li><li>Guidance</li></ul> |

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|---|---|
| | • Identifies characteristics of service users<br><br>• Identifies current service provision Local, regional and national surveys to establish current level of service provision, e.g. areas that have implemented CIT, a survey of the amount of training provided<br><br>• Investigate associations between factors<br><br>• Views and experiences of PWMI<br><br>• Views and experiences of police officers |
| 3.For systematic reviews only | • Study types included<br><br>• Included studies<br><br>• Number of included studies |
| 4. Geographical location<br>Where was the primary study conducted?<br>OR For systematic reviews, where were the included studies conducted? | Select all that apply.<br><br>• United Kingdom<br><br>• United States<br><br>• Not reported<br>The abstract does not explicitly report the country in which the study has been conducted.<br><br>• International (various countries)<br><br>• Australia<br><br>• Austria<br><br>• Belgium<br><br>• Canada |

| | |
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| | - Cyprus |
| | - Czech Republic |
| | - Denmark |
| | - Estonia |
| | - Finland |
| | - France |
| | - Germany |
| | - Greece |
| | - Holland |
| | - Hungary |
| | - Iceland |
| | - Ireland |
| | - Israel |
| | - Italy |
| | - Japan |
| | - Korea |
| | - Luxemburg |
| | - Mexico |
| | - Netherlands |
| | - New Zealand |
| | - Norway |
| | - Poland |
| | - Portugal |
| | - Slovak Republic |
| | - Slovenia |

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|---|---|
| | <ul><li>Spain</li><li>Sweden</li><li>Switzerland</li><li>Turkey</li><li>Other<br>Select if the abstract does not specify the country but only describes a region, e.g. 'europe' or 'north america'. Please specify.</li></ul> |
| 5. Date of publication | <ul><li>1995</li><li>1996</li><li>1997</li><li>1998</li><li>1999</li><li>2000</li><li>2001</li><li>2002</li><li>2003</li><li>2004</li><li>2005</li><li>2006</li><li>2007</li><li>2008</li><li>2009</li><li>2010</li><li>2011</li></ul> |

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|---|---|
| | - 2012<br><br>- 2013<br><br>- 2014<br><br>- 2015<br><br>- 2016 |
| 6. Criminal Justice Intervention<br>What intervention is being evaluated?<br>(add) | Sanction<br><br>- Detention in police cells<br><br>- ASBOs<br><br>- Arrest<br><br>Pre-arrest diversion<br><br>- Pre-arrest diversion<br><br>- Involuntary outpatient commitment<br><br>- involuntary psychiatric admissions<br><br>- Involuntary mental health order<br><br>- Outreach<br><br>Advocacy<br><br>- Named person provision<br><br>- Appropriate adults<br>also known in Australia as the<br>independent third person<br><br>- Registered Intermediary<br><br>Multi-agency working<br><br>- Coordination of services<br><br>- In house mental health worker<br><br>- In house social workers |

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| | • Multi-Agency working |
| | • Partnership with Mental Health Professionals |
| | • Phone/Street triage |
| | • Referral |
| | Police interview |
| | • Miranda warning (US right to silence) |
| | • Negotiation strategies |
| | • Interview |
| | Police response (general) |
| | • Responding to absconders |
| | • Responding to PWMI as victims of crime |
| | • Responding to domestically violent mentally ill |
| | • Section 135 |
| | • Section 136 |
| | • Police response (not specified) |
| | Crisis services and responses |
| | • Psychiatric emergency response |
| | • Post-Crisis Assistance Programme |
| | • community based crisis resolution |
| | • Crisis counselling unit |
| | • Crisis Negotiation Team |
| | • mobile mental health crisis team |
| | • Crisis Intervention Team (CIT) |

| | |
|---|---|
| | • Critical Incident team (CIT)<br><br>Police knowledge and skills<br><br>• Training<br><br>• Identification of mental health needs<br><br>• Assessment and referral<br><br>• Transport and transfer<br><br>Use of force<br><br>• Use of Tasers<br><br>• Use of CS gas<br><br>• Armed response<br><br>• List of force (not specified) |
| 7. Characteristics of study participants (add)<br><br>For impact evaluation studies, code according to the sample that received the intervention.<br><br>For process or view studies, code for the sample who provided views, perceptions or experiences about the intervention. | Mental / health professional working with police<br><br>• Ambulance crew<br>• Doctor<br>• Emergency staff<br>• Mental health care provider<br>• Mobile crisis unit<br>• Nurse<br>• Psychiatric staff<br>• Street triage professional<br>• Volunteer mental health professional<br><br>Other professionals working with police<br><br>• Advocates/ advisers<br>• Carers<br>• Family<br>• GPs<br>• Link worker<br>• Policy makers<br>• Service provider<br>• Social worker<br><br>Criminal Justice System Personnel<br><br>• Both Male and Female |

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| | <ul><li>Custody and detention staff</li><li>Male only</li><li>Female only</li><li>Correctional officers</li><li>CIT trained officers</li><li>Forensic Medical Examiner</li><li>Level of education</li><li>Level of knowledge</li><li>rank of personnel</li><li>Police</li><li>Police chiefs</li><li>Sheriffs</li><li>Volunteers</li><li>Special unit</li></ul><br>Characteristics of PWMI<br><ul><li>BME (write in)</li><li>Children and young people</li><li>Domestically violent</li><li>Dual diagnosis</li><li>Enduring moderate to severe mental health needs (EMHN)</li><li>Excited delerium</li><li>Female</li><li>Fetal Alcohol Spectrum Disorder</li><li>High risk</li><li>Homeless</li><li>inpatients in mental health units</li><li>Language</li><li>Learning disability</li><li>Male</li><li>Mental health problems</li><li>Mentally ill offenders</li></ul> |

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|---|---|
| | • Mentally disordered persons |
| | • Older people |
| | • Personality disorder |
| | • Police officers |
| | • PWMI/ Service user |
| | • PWMI as victims of crime |
| | • PWMI detained under section 135/136 |
| | • Psychosis |
| | • Rural-Urban |
| | • SES |
| | • Schizophrenia |
| | • Study Participants not clear |
| | • Serious mental illness |
| | • Severe mental illness/ problems |
| | • Severe and persistent mental illness (SPMI) |
| | • Suicidal/ self harm |
| | • Use of drugs or alcohol |
| | • Veterans |
| | • vulnerable adults |
| | • Victims of domestic violence |
| 8. Type of intervention/ programme/ model name (add) | • A&E as a place of safety (135/136)<br>• BASTA- the alliance for mentally ill people<br>• Child development Community Policing Program<br>• Crisis mobile team (CMT) Santa Fe, Mexico |

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| | <ul><li>Criminal justice Liaison and Diversion services (CJLDS)</li><li>Co-Responding police-mental health teams<br>calls that are assessed as involving a mental health issue are attended to by both a police officer and a mental health professional.<br>They may be based in either a mental health care facility or a police station.<br>They usually operate within set hours.</li><li>Crisis Intervention teams CIT (Memphis model)<br>police officers typically have 40 hours training in de-escalation techniques.<br>Are serving officers who volunteer for additional CIT duties</li><li>Detention under section 135/ 136</li><li>Integrated Mobile Crisis Response Team (IMCRT)</li><li>Diversion at the point of arrest scheme (DAPA)</li><li>Place of safety section 135/136</li><li>HELP-PC<br>risk assessment screening in police custody</li><li>Link Worker Scheme<br>Link schemes are available to officers with concerns about individuals, aims to connect the individual to a range of services, including mental health services, but also housing, and benefits advice</li><li>Mental health intervention team</li><li>Mobile crisis unit (MCU)</li><li>Crisis Intervention Team (CIT), (Ohio model)</li><li>PACER (police, ambulance and clinical early response)</li><li>Police custody as a place of safety (135/136)</li><li>Post-crisis assistance program</li><li>TEMPO</li><li>Street triage<br>Police are assisted in making mental health assessments by mental health care professionals.</li></ul> |

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| | Street triage can involve co-responding, ride-along, or assessments by a mental health professional on police premises (NOT under section .136)<br>• Youth justice diversion<br>• Mobile co-responding team<br>• Link scheme<br>• Crisis intervention team (CIT)<br>• Street triage<br>• Telephone triage<br>• training officers<br>Not CIT |
| 9. Outcomes of impact evaluation studies/ For all impact evaluation primary studies and systematic reviews, select all the outcome measures that are used in the study. (add) | • Not Clear/ NA<br><br>Quantitative outcomes<br><br>Sanction<br><br>• Arrest<br>• ASBO<br>• Restorative practices<br>• Prosecution<br>• use of .136 detention<br><br>Resource use<br><br>• Costs<br>• Time use<br>• Calls to police<br>• Access and take up of services<br>• Barriers to implementation<br>• Barriers to reporting to the police<br>• Days in Jail<br>• Pathways to care<br>• Time to assessment<br>• Transfer to hospital<br>• Referral<br>• Use of medication<br><br>Diversion |

| | |
|---|---|
| | - keeping PWMI out of jail |
| | - De-Escalation |
| | - Resolving crisis |
| | Resolving crisis |
| | - Involuntary admission |
| | - Emergency protective custody |
| | - Emergency examination orders (EEOs) <br> Australia |
| | Officers' skills |
| | - Identification of mental illness |
| | - Knowledge retention |
| | - Police decision making |
| | - Comprehension |
| | Safety |
| | - Wellbeing |
| | - patient safety |
| | - Staff safety |
| | - community safety |
| | - Officer safety |
| | Negative outcomes |
| | - |
| | - Use of force |
| | - Suicide |
| | - Self-harm |

| | |
|---|---|
| | • Injuries |
| | • Deaths in custody |
| | • Recidivism |
| | • Violation of human rights |
| | • |
| | Qualitative outcomes |
| | • PWMI Experiences of police encounters |
| | • Views of other practitioners |
| | • Officer's knowledge, attitudes and beliefs |
| | • Satisfaction with services |
| | • Collaboration with other agencies |
| | • Barriers to implementation |
| 10. Reference to theory of change or programme approach<br>Does the report explicitly mention a theory of change/ logic model or programme theory for the intervention? | • Yes (ADD BELOW)<br><br>• Attribution theory<br>-"Attribution theory deals with how the social perceiver uses information to arrive at causal explanations for events. It examines what information is gathered and how it is combined to form a causal judgment" (Fiske, & Taylor, 1991)<br><br>Attribution theory is concerned with how and why ordinary people explain events as they do.<br><br>• Procedural justice<br><br>• Racial bias<br><br>• Stereotypic views of violence against women |

| | |
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| | <ul><li>enhanced self efficacy and social distance</li><li>Criminalization hypothesis<br>-Police officers inappropriately use arrest to resolve encounters with mentally disordered suspects</li><li>Overcoming stigma</li><li>Suicide by cop</li><li>Social Distance</li><li>Unmet mental health</li><li>Supporting desistance</li><li>social constructivism</li></ul> |
| 11. Setting (add) | <ul><li>All settings</li><li>Airport</li><li>Community</li><li>Community mental health centre</li><li>Court</li><li>Compulsory transfer centre</li><li>Crisis response site<br>a pre-booking diversion centre</li><li>general hospital</li><li>Police custody</li><li>Medical emergency room</li><li>Psychiatric hospital/ Unit</li><li>not clear</li><li>Place of safety</li><li>police academy</li></ul> |

| | <ul><li>Police station</li><li>School</li><li>Setting not clear</li></ul> |
| --- | --- |

### 6.1.6   Bibliographic database searches

<u>Criminology</u>
>Criminal Justice Abstracts (CJA)
>National Criminal Justice Reference Service Abstracts Database (NCJRS)
>Campbell Library C2 SPECTR
>National Police Library


<u>Psychology</u>
>PsycArticles
>PsycINFO
>MEDLINE

<u>Social Science</u>
>ASSIA
>EconLit
>Social Policy and Practice
>Social Science Citation Index

<u>Systematic reviews</u>

>Cochrane Central Register of Controlled Trials
>Cochrane Database of Systematic Reviews
>DARE (Database of Abstracts of Reviews of Effectiveness)
>WP1 database


### 6.1.7   Grey literature searches

Our comprehensive search strategy included "grey" literature to capture data that may not be available in peer reviewed periodicals.


<u>Grey literature databases</u>
1) CrimDoc Criminology Library Grey Literature
2) Google and Google Scholar
3) SCOPUS
4) Social Programs That Work

### 6.1.8 Websites searched

The following websites were searched for relevant research literature:

The Australian Institute of Police Management  http://www.aipm.gov.au/

The Barrow Cadbury Trust http://www.barrowcadbury.org.uk/

The Centre for Problem Oriented Policing http://www.popcenter.org/

The Center for Evidence Based Crime Policy http://cebcp.org/

The Department of Health https://www.gov.uk/government/organisations/department-of-health

Her Majesty's Inspectorate of Constabulary (HMIC) http://www.hmic.gov.uk/

Home Office  https://www.gov.uk/government/organisations/home-office

MIND www.mind.org.uk

The National Alliance on Mental Illness http://www.nami.org/

 Ministry of Justice https://www.justice.gov.uk/

National Police Chief's Council http://www.npcc.police.uk/

National Offender Management Service http://www.justice.gov.uk/about/noms

NICE National Institute for Health and Care Excellence  http://www.nice.org.uk/

National Institute of Justice, http://www.nij.gov/Pages/welcome.aspx

The Police Executive Forum http://www.policeforum.org/

Rethink mental Illness http://www.rethink.org/

Revolving Doors Agency http://www.revolving-doors.org.uk/about-us/

The United States Department of Justice http://www.justice.gov/cjs/

Young Minds http://www.youngminds.org.uk/