



QUEENSLAND POLICE SERVICE

ABN: 29 409 225 509

OFFICE OF THE ASSISTANT COMMISSIONER DOMESTIC AND FAMILY VIOLENCE COMMAND

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28 April 2022

Dr Amanda Beem
Acting Committee Secretary
Mental Health Select Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: mhsc@parliament.qld.gov.au

Dear Dr Beem

Thank you for the opportunity to appear before the Mental Health Select Committee in its public hearing of Tuesday, 12 April 2022 for the *Inquiry into the opportunities to improve mental health outcomes for Queenslanders* on behalf of the Queensland Police Service (QPS).

Please find enclosed answers to questions taken on notice during the public hearing.

Should you require further information, please contact Acting Superintendent Leonie Fordyce, Vulnerable Persons Group, Domestic, Family Violence and Vulnerable Persons Command on [REDACTED] or [REDACTED].

I thank you again for your correspondence.

Yours sincerely

Peter Brewer
A/ASSISTANT COMMISSIONER
DOMESTIC, FAMILY VIOLENCE & VULNERABLE PERSONS COMMAND

Enc.

Question on Notice
Mental Health Select Committee
Public Hearing – 12 April 2022

QUESTION

Do you have any data on how many emergency examination authorities have been issued by police officers when responding to mental health calls for service?

ANSWER

The tables below detail the number of emergency examination orders (EEOs) and emergency examination authorities (EEAs) issued by police officers between the years 2016 to 2021 inclusive.

Before the *Mental Health Act 2000* was repealed by the *Mental Health Act 2016*, police officers made EEOs under division 3 of the former Act. The *Mental Health Act 2016* replaced EEOs with EEAs. The new scheme commenced on 5 March 2017.

Year	Number of EEOs
2016	10,517
2017	2,023

Notes:

1. This data is preliminary and may be subject to change.
2. Data is based on occurrences with a Mental Health Act 2000 (EEO) incident [1581].
3. Data for code [1581] was replaced with code [1586] from March 2017.

Year	Number of EEAs
2017	9,823
2018	10,151
2019	10,015
2020	9,699
2021	11,223

Notes:

1. This data is preliminary and may be subject to change.
2. Data is based on occurrences with an EEA incident [1586].
3. Data for code [1581] was replaced with code [1586] from March 2017.

**Question on Notice
Mental Health Select Committee
Public Hearing – 12 April 2022**

QUESTION

Could the committee be provided with copies of the co-responder model evaluation reports from 2016 and 2017?

ANSWER

Two evaluations of the co-responder model have been conducted.

The West Moreton Hospital and Health Service, Queensland Health conducted a review of the Ipswich co-responder model in 2017, titled *West Moreton Hospital and Health Service Mental Health Co-Responder (MH CORE) Service Review*. The Queensland Mental Health Commission provided the Mental Health Select Committee with a copy of the report in its answers to question on notice dated 28 January 2022.

Centacare Cairns and Far North Queensland Partners in Recovery conducted a joint review of the Cairns co-responder model in 2017, titled *Review of the Cairns Mental Health Co-Responder Project*. This report covers the period of 2011 through 2016 inclusive and has become informally known as the “2016 Cairns evaluation” despite being published in 2017. A copy of the report is provided.

Key findings from the review identified that the Cairns Co-responder improved experiences and outcomes for consumers resulting in reduced trauma, less use of force, and reduced stigmatisation. Additionally, the model has been shown to improve interagency collaboration, improve the safety of first responders and a more efficient and effective use of first responders and mental health practitioners.

Question on Notice
Mental Health Select Committee
Public Hearing – 12 April 2022

QUESTION

Is there any data that breaks down mental health calls for service by day of the week?

ANSWER

The table below details the number of calls for service relating to mental health between the years 2016 and 2021 inclusive broken down by day of week.

Day of week	Number					
	2016	2017	2018	2019	2020	2021
Sunday	2,627	6,431	6,300	8,576	8,686	4,239
Monday	5,271	2,771	7,238	7,359	3,583	12,961
Tuesday	5,606	2,996	3,109	8,159	8,758	3,895
Wednesday	2,325	8,786	3,419	3,646	11,545	8,541
Thursday	5,627	2,556	10,337	4,085	4,191	7,964
Friday	7,583	6,571	3,143	11,980	3,444	8,770
Saturday	3,001	5,555	7,195	3,604	8,288	4,385
Total	32,040	35,666	40,741	47,409	48,495	50,755

Notes:

- Incident types include the following initial incident types:
502 - Suicide
503 - Attempting/Threatening Suicide
504 - Mental Health
716 - Authority to Return
- Data was sourced from QCAD. QCAD rollout was gradual and therefore figures might not be directly comparable between years.
- Day of week is based on the create date of the incident.

Question on Notice
Mental Health Select Committee
Public Hearing – 12 April 2022

QUESTION (as amended by the Member for Southport in writing on 13 April 2022)

My question is in respect of lost time hours as a result of mental health calls for service. Pages 3 to 5 of the Queensland Police Service submission refers to mental health calls for service, the annual number of which has risen between 2016 and 2022 based on the provided data. In relation to these calls for service, can you advise:

- a) Total police hours spent supporting and conducting mental health calls for service for the 2016 – 2022 period, reported separately by year;
- b) The average time spent and number of officers required for mental health calls for service for the 2016 – 2022 period, reported separately by year;
- c) Number of hours, officers and time spent waiting at hospitals, emergency departments, mental health departments and other support services as a result of mental health calls for service for the 2016 – 2022 period, reported separately by year.

ANSWER

Part (a) and (b)

The table below details the number of hours spent conducting mental health calls for service (MHCFS) and the average time spent at, and number of officers who responded to, these calls for service.

Year	Total time spent responding to MHCFS (hours)	Number of incidents ¹⁰	Average time spent responding to MHCFS (hours)	Average number of officers per MHCFS
2016	21,316	8,584	2.48	3.14
2017	20,901	8,731	2.39	3.12
2018	24,106	9,519	2.53	3.25
2019	36,579	14,208	2.57	3.26
2020	41,886	16,085	2.60	3.41
2021	50,884	16,246	3.13	3.37
2022	14,566	4,735	3.08	3.37

Notes:

1. Incident types include the following revised incident types:
 - 502 - Suicide
 - 503 - Attempting/Threatening Suicide
 - 504 - Mental Health
 - 716 - Authority to Return
2. Revised incident type that are 'Merge', 'Repeat' and 'ICEMS' have been excluded.
3. 2022 data is to 14 April 2022.
4. Data was sourced from QCAD. QCAD rollout was gradual and therefore figures might not be directly comparable between years.

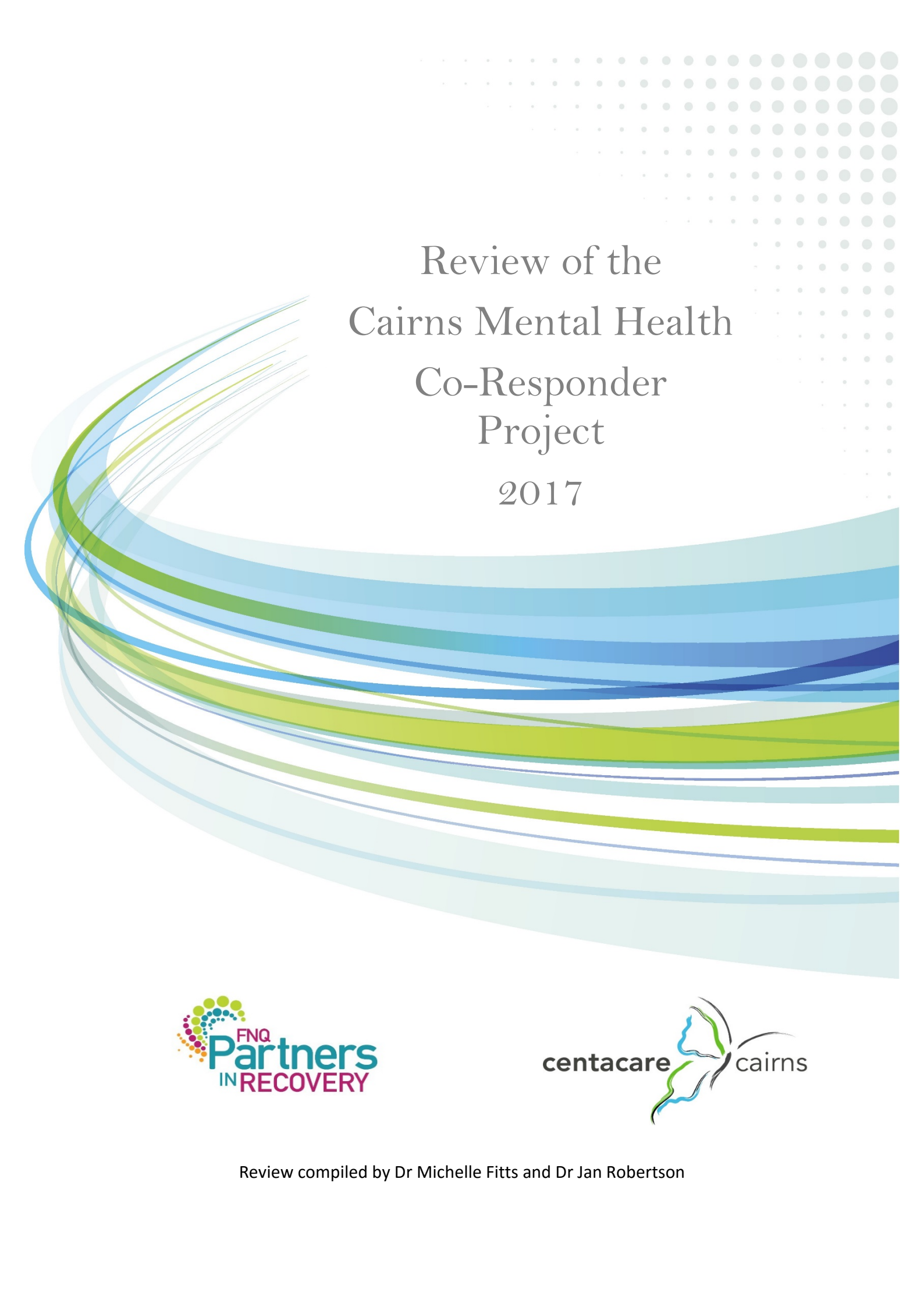
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5. Total time is calculated as the number of hours between dispatch time and return time. Times where the dispatch and return times were the same were excluded.
6. Total time is calculated as the number of hours per job, not the cumulative time per police officer attending the same job.
7. Average officers is calculated as the total number of officers for all incidents divided by the number of incidents.
8. If there were more than one dispatch time recorded, the earliest time has been used for the calculations.
9. If there were more than one return time recorded, the latest time has been used for the calculations.
10. The number of incidents reported shows the revised incident type. This varies from the initial incident type, which is based on the call for service received, as shown in Table 1 to the written submission.

There are additional tasks undertaken by the QPS to support the immediate response to a mental health related call for service. For example, police officers may also review addresses subject to repeat calls for service and engage in case management and follow-up in collaboration with partner agencies to improve future responses and interventions. Time spent on these tasks is not recorded.

Part (c)

The time it takes a police crew to respond to a mental health call for service is recorded across the whole job and is not broken down based on the place of that response. Accordingly, the QPS is unable to provide the number of hours, officers and time spent waiting at hospitals, emergency departments, mental health departments and other support services as a result of mental health calls for service.



Review of the Cairns Mental Health Co-Responder Project 2017



Review compiled by Dr Michelle Fitts and Dr Jan Robertson

Foreword

Centacare Cairns, as lead agency for Far North Queensland Partners in Recovery, was privileged to be able to fund and participate in the review of the Cairns Mental Health Co-Responder project. The Co-Responder model is widely viewed as being a successful collaborative venture between Queensland Police Service and Queensland Health (later joined by Queensland Ambulance Service). We wanted to research why the model works so well and to determine the benefits to our community, particularly those members of our community living with a severe mental illness and their families.

Important to Centacare Cairns was the success of the Co-Responder model in protecting and enhancing the human rights of people with a mental illness. We see the Co-Responder model providing important options for people experiencing a mental health crisis to lessen the possibility of people entering either health or justice 'custodial' settings. These options relate to the fundamental freedoms and basic rights outlined in the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)*. These options were limited prior to the introduction of the Co-Responder model therefore our intention was to highlight the human rights and other benefits of the model and to establish how mental health and wellbeing could be further enhanced in this region and beyond.

Thank you to each member of the project team for your commitment to the review and the model. Thanks also to the Co-Responder personnel who, on a daily basis, work hard to make sure people with a mental illness are afforded the most appropriate care and attention in a time of great need.

Gary Hubble
Manager
Partners in Recovery
Far North Queensland
Centacare Cairns
April 2017

Partners in Recovery is an initiative of the Federal Government: Department of Health



Acknowledgements

We wish to acknowledge the time committed to the review by interview and survey participants.

A special acknowledgement is made of Senior Sergeant Matthew Moloney's efforts in creating the opportunity for this review to be undertaken, funded by Partners in Recovery.

Invaluable guidance, contribution and review of the report has been provided by the following members of the Cairns Mental Health Co-Responder Stakeholder Group and the Review Reference Group:

- Gary Hubble, Peta O'Neill, Hannah Downing (Centacare Cairns - Partners In Recovery)
- Joe Petrucci, Shelley Wallace, Ailsa Rayner (Queensland Health)
- Inspector Don McKay; Detective Senior Sergeant Marty Ots, Sergeant Matthew Moloney, Senior Sergeant Gregory Giles, Senior Constable Angela Evans (Queensland Police Service)
- James Andrews (Queensland Ambulance)
- Travis Shorey (Mission Australia – Partners in Recovery)
- Associate Professor Alan Clough (James Cook University)
- Adjunct Professor Ernest Hunter

Abbreviations

AMHS	Authorised Mental Health Service
AMHP	Authorised Mental Health Practitioner
ATR	Authority to Return
QCAD/CAD	Queensland/Computer Aided Dispatches
CAMP	Case Assessment Management Program
CIT	Crisis Intervention Team
CMHCP	Cairns Mental Health Co-Responder Project
CIMHA	Consumer Integrated Mental Health Application
CIP	Crisis Intervention Plan
EEO	Emergency Examination Order
ITO	Involuntary Treatment Order
LARU	Low Acuity Response Unit
MH	Mental Health
MHIC	Mental Health Intervention Coordinator
MHIP	Mental Health Intervention Project
MOU	Memorandum of Understanding
NCRA	Non-clinical Related Activities
OLC	Operational Liaison Committees
PACER	Police and Clinical Early Response (Unit)
PIR	Partners in Recovery
POS	Provisions of Service
QAS	Queensland Ambulance Service
QCAD	Queensland Computer Aided Dispatches
QH	Queensland Health
QHRS	Queensland Health Enterprise Reporting System
QH-MHS	Queensland Health – Mental Health Service
QPRIME	Queensland Police Records and Information Management Exchange
QPS	Queensland Police Service
SMART	System-wide Mental Assessment Response Team
SS-HS	Social Service – Homelessness Service
SS-MHSS	Social Service – Mental Health Support Service
SS-YS	Social Service – Youth Service

EXECUTIVE SUMMARY

This review examines an innovative model of practice that seeks to improve the resolution of mental health crises in an outer regional city. The Cairns Mental Health Co-Responder Project commenced in 2011. This is an inter-sectoral collaboration between Queensland Health and Queensland Police Service, strongly supported by Queensland Ambulance, and based upon internationally recognised models of best practice. The project team is comprised of an Authorised Mental Health Practitioner and a Police Officer who are co-located within an acute care mental health team. They are equipped to make joint rapid responses to mental health crises in the community utilising existing first responder communication systems. Through a Memorandum of Understanding between Queensland Health and the Queensland Police Service, this team is able to access and share consumer information in a timely manner, which informs risk assessment and appropriate interventions.

The review process was guided by a group of key stakeholders who agreed that objectives of the review should inform: best practice by first responders and efforts to better resource the current model and a formal evaluation study design.

The results of this review indicate the project has resulted in at least the following:

- Improved experiences and outcomes for consumers including reduced trauma, less use of force and reduced stigmatisation
- De-escalation and prevention of crisis situations
- Improved inter-agency collaboration
- Improved safety for first responders and mental health practitioners
- Reduction in use of involuntary assessment procedures
- Saving of staff-hours by first responders and mental health practitioners
- Provision of further mental health training opportunities for first responders
- Improved awareness and utilisation of the project by Queensland Police Service, Queensland Ambulance Service and Queensland Health mental health service providers.

The main recommendation for improvement of the project was an extension of hours of operation to cover all peak hours of need.

Key stakeholders identified essential components contributing to the success of the model including: the appointment of co-located staff who are highly motivated to work in the area of mental health with a combination of strong clinical skills and demonstrated experience of working effectively in crisis situations; senior and executive level support and governance from the participating agencies, and; regular inter-sectoral forum providing the opportunity to not only guide and monitor project implementation but also address any operational issues.

The lack of many comparators, in part due to systems changes, has limited the opportunity to fully reflect on changes in the impacts of the Cairns Mental Health Co-Responder Project between 2011 and 2016. However, the review indicates that through effective inter-agency collaboration, the project has achieved its stated aims, i.e. to improve the resolution of mental health crises in the particular context of an outer regional city. As reported by key stakeholders, there are identifiable instances in which mental health crises were prevented from escalating into extreme situations, including siege events requiring high level police responses. However, a more formal evaluation approach is required to accurately capture the full range of project outputs and impacts.

Based on the findings of this review the following recommendations are made:

- An adequately resourced and comprehensive evaluation should be undertaken in order to assess project outputs and impacts including a cost-effectiveness analysis
- Existing data systems should be comprehensively reviewed to identify gaps in the relevance and sufficiency of data collected, including both shared and service-specific indicators. This would entail a collaborative effort between participating services in order to accurately reflect all aspects of Cairns Mental Health Co-Responder Project activity
- Further exploration should be undertaken to determine the experiences of the model with consumers and carers and refine recommendations for improvement
- Consideration should be given to ensuring the sustainability of the project through resourcing a core Queensland Police Service position at a designated rank which

recognizes the associated high level of risk and responsibility. This position could be enhanced by access to accredited mental health training

- A pool of specially trained Queensland Police Service staff should be available to provide leave cover in order to ensure project continuity. Contingent upon resources further QPS staff could be available to extend the hours of project operation to cover all peak times of demand.

While acknowledging mental health training for first responders is not core business of the Cairns Mental Health Co-Responder Project, there were strong calls from stakeholders for systematic and ongoing workforce mental health capacity building for police and ambulance officers regarding mental health issues including crisis management. Consistent with recognised best practice this should involve the participation of members of the consumer advocacy community; including individuals with lived experienced of being mentally unwell and groups of carers. The increased proportion of Emergency Examination Orders generated by first-responders over the review period which did not result in assessment documents being made indicate additional training in the use of Emergency Examination Orders may be of benefit.

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Preface

Over thirty years working as a clinician in remote northern Australia I have come to appreciate the critical importance of working closely with police in settings where mental health services are limited or absent. That was possible because of personal relationships developed through experience and over years. With high staff turnover in both services working relationships are now significantly more difficult, emphasizing the importance of formalized protocols and practices, which is even more important in metropolitan settings where police officers and mental health practitioners are likely to be called on to respond to crises involving unfamiliar individuals and families. Inter-service collaboration (including QAS) to those ends has been the purpose of the Cairns Mental Health Co-Responder Project (CORP) and this report documents findings from a review of that project's operation since 2011.

The materials drawn on are primarily service activity data and practitioner commentary. The sensitive nature of the issues considered and the innovative approaches undertaken present significant challenge in terms of analysis and evaluation – this report is a preliminary review which will provide a firm foundation for an expanded and comprehensive evaluation. In parallel to the work undertaken for this report, a small number of consumers and carers were interviewed by Centacare Cairns, independently of the project report team, to provide insight into the lived experience of those going through crises and, for some, their experiences in relation to the CORP model.

It is not possible to extrapolate from this purposively-selected group, but their voices make some important points that resonate with the report, providing direction to a more formalized qualitative evaluation. This can be exemplified with just a few quotes. Thus, a consumer with experience of CORP reported that: *“it's not fun becoming unwell and the QPS getting involved, but is such a relief to know a program like this is there to assist ... for all people”*. This informant going on to raise the important point of ensuring Indigenous representation among the police and mental health staff responding to crises and addressing the needs of mental health clients brought into the police watch-house.

A carer who had been through crises but without the involvement of CORP wrote that: *“[It] wouldn't be so scary & be affected by just the police;[it provides] ease of mind of carers; they are trained to deal with those situations; if police turn up can make matters worse”*. A carer who did have experience with CORP recorded that: *“The Co-Responder unit attended*

when my son was living alone. It was comforting to know that they had experience of mental health and had the authority of the police". This carer had previously lived in a rural town and was able to comment both to the importance of sensitive police involvement and the potential additional benefits of a CORP model: "I have also lived in [rural town] which did not have this service. I was forced to ring the police on several occasions. I was initially unwilling to call them but found them on the whole to be kind & understanding. However, a Co-Responder model would have been my 1st choice of intervention if available as they have a deeper understanding of mental health symptoms".

Nothing about us without us. The importance of these few voices is in acknowledgement that not only must the best interest of those disadvantaged by mental illness and those who care for them be in the forefront of service planning, but that they should be involved in that process and its evaluation. To that end this report provides valuable directions. Getting there still requires a lot of work and solid relationships between service providers and with those for whom they work.

Adjunct Professor Ernest Hunter 2017

SECTION ONE: INTRODUCTION and BACKGROUND

This report provides a review of the development, implementation, impacts and perceived benefits of the Cairns Mental Health Co-Responder Project (CMHCP). This project commenced in 2011 and arose from the state-wide, tri-agency Mental Health Intervention Project described more fully below. The project involves the co-location of an Authorised Mental Health Practitioner (AMHP) and a police officer in a Queensland Health Mental Health Acute Care Team (ACT) setting. The team works collaboratively to prevent and resolve mental health crisis situations in the community.

Police and mental health crisis

Police officers are frequently the first responders to incidents where individuals display signs of poor mental health and are in crisis. Police are involved where there are safety concerns for the individual and the public. There is a growing body of evidence in Australia and internationally that the level of contact between the criminal justice system and individuals with poor mental health is increasing (1). The trend has been attributed to a range of reasons including insufficiently resourced community mental health services and deinstitutionalisation (2). Interactions between police and people in mental health crisis are recognised as involving risk of harm for all parties. In order to minimise these risks and improve outcomes, specialised responses have been developed (3). These include first line responses by specially trained police who act as liaisons with mental health services (4) and Co-Responder models where police and mental health professionals work collaboratively to provide a joint response to a mental health crisis situation.

Consumers and mental health crisis

Consumers participating in two Australian studies have described their experiences of formal responses to mental health crises by police when responding alone, i.e. without involvement of personnel with mental health skills. Consumers reported unsympathetic attitudes, feelings of intimidation, and the disproportionate use of force – feelings which were described as being immensely distressing. The use of force was perceived to escalate crisis situations (5, 6). However, recent research indicates collaborative police and mental health responses in Victoria, Australia, have contributed to improved consumer experiences

and outcomes. The Co-Responder team achieved these through: improved communication and de-escalation; engaging quickly, building trust and understanding; providing a rapid response; ensuring information hand-over to Emergency Department (ED) and psychiatry staff, and; defining Crisis Intervention Plans with further opportunity to develop care plans that incorporate consumers' wishes (6).

The Queensland Mental Health Intervention Project

Commenced in 2006, the Mental Health Intervention Project (MHIP) is a state-wide tri-agency partnership between Queensland Police Service (QPS), Queensland Health (QH) and the Queensland Ambulance Service (QAS) (7). The project aimed to provide a more coordinated, interagency response to mental health crisis situations (8), to prevent and/or safely resolve mental health crisis situations and reduce the risk of injury to members of the community and agency staff (9).

The partner agencies work together at the district level, meeting regularly to identify local solutions, including developing and using collaborative protocols, to respond to mental health issues (7). Through targeted mental health training for first responders and the enhancement of existing collaborative protocols, particularly assessment of risk through information sharing arrangements, the specific objectives of MHIP were to:

- Increase the number of mental health incidents resolved safely
- Increase the number of individuals referred to and subsequently transported by QAS
- Increase the number of Emergency Examination Orders (EEOs) completed by QAS
- Reduce the number of repeat calls to mental health incidents by QPS and QAS
- Reduce the amount of police time spent resolving mental health incidents
- Increase the efficiency of inter-agency protocols and,
- Review completed EEO's and provide feedback to QPS and QAS.

Inter-agency collaboration was also intended to enhance skill and knowledge levels of mental health clinicians and police, and improve relationships and cooperation between QH, QPS and QAS. These combined efforts were also intended to increase and improve community support networks and crisis prevention capacity.

QH implemented 14 Full Time Equivalent (FTE) specialist clinical MHIC positions across 16 QH districts. These positions remain attached to ACTs within regions across the state. QPS MHIC positions are filled by existing divisional staff who submitted an Expression of Interest in the role. As part of their role, MHICs supported all agencies through maintenance of formal contact with key police, health (mental health) and ambulance stakeholders and became proactive members of local Operational Liaison Committees (OLCs) (10). These local interagency committees, also developed under the MHIP, are attended by senior management and provide a forum to review incidents or individuals in crisis where MH and emergency service were involved and for discussing complex cases with the intention of improving processes e.g., develop Crisis Intervention Plans or recommend further assessments such as Forensic Assessments (11). The MHICs were also to provide information and advice to other health services and professionals along with assistance in development of early intervention models and short-term clinical referral services. The OLC in Cairns meets every six weeks to focus on a key question – ‘What can be done to improve the outcome for Mental Health Consumers?’ From this fundamental aim, the OLC explores opportunities across the scope of all three agencies being QPS, QAS and QH. The Cairns Mental Health Co-Responder project was an initiative of the Cairns MHIP OLC.

Cairns Mental Health Co-Responder Model

MHIP utilised the Mental Health Collaboration Memorandums of Understanding (MOUs) between QH and QPS (2011) and between QAS and QPS (2007) which guide interagency coordination when responding to people with a mental illness who are in crisis. However, the initial role of the MHICs was consultation and liaison. In order to improve responses to mental health crisis, particularly outcomes for consumers, recommendations were made to trial other models of joint response at the scene by QPS and QH.

Based on a collective decision by senior Police aware of other internationally accepted models, where a mental health worker accompanied police in responding to mental health calls (12), a six month trial of a Co-Responder team located in Cairns commenced in April 2011. The initial aims of the Cairns Mental Health Co-Responder Project (CMHCP) project were to:

- Demonstrate that a partnership between Police and Mental Health is an effective model for responding to people with a mental health condition experiencing a crisis;
- Provide a rapid intervention to enable a more timely, informed and accurate assessment of a consumer experiencing poor mental health which will effectively prevent harm to the individual or to others, and to resolve situations safely and satisfactorily;
- Reduce EEO's obtained by QPS and QAS officers during the times when the Co-Responder Team is available;
- Reduce the workload on the Emergency Department at the Cairns Base Hospital by transporting only individuals who require treatment to the department;
- Provide interventions within the community that reduce the risk of behavioural escalation and remove the need for hospitalisation; promoting care/treatment within the community where possible;
- Enhance communications between Mental Health and Police. This could include the provision of more rapid access to mental health database information and Police database information, to better serve consumers in need;
- Enhance mutual understanding of Police and Mental Health service systems, and;
- Provide onsite mental health training to QPS and QAS staff.

The model was affiliated with the National Standards for Mental Health Services 2010, incorporating a collaborative approach, which ensures services are accessible and meet the needs of the community in a timely manner. Policing staff serving in the Cairns region have since engaged with other policing jurisdictions internationally to document best practice when responding to individuals in the community with poor mental health in crisis (13, 14).

The Co-Responder team is comprised of a uniformed QPS Police Officer, and a plain clothed QH Mental Health clinician. The team is co-located with the Cairns QH Acute Care Team for the Adult Mental Health Cluster, Cairns & Hinterland Mental Health & ATOD Service. The team works together to provide an immediate joint response to people who are in mental health crisis. The team shares a QPS radio, private QH office space and an unmarked vehicle. A QAS radio and dedicated phone was added to the project in 2014. Operating within the provisions of a Memorandum Of Understanding (MOU) between QH

and QPS (15), as delegated staff members, the team work collaboratively to prevent and resolve mental health crisis situations. Under this MOU, the individual QH and QPS databases are directly accessed by the respective staff members and only information relating to risk is verbally shared. This sharing of consumer information, where possible, assists with rapid risk assessment based on the consumer's history and informs appropriate interventions.

Quality audit of the Cairns Co-Responder Trial

At the end of the trial period, an initial quality audit (QA), comprised of both quantitative and qualitative components, was undertaken by QH (16). The following provides an overview of its findings.

An examination of police calls for service found the number of mental health related calls increased by 43% in the period the project was operating in 2011 (n=530) compared to the comparative period prior to the trial of the model (n=370). In relation to EEOs, police responded to a higher number of EEOs during the 2011 period of operation of the model compared to comparative periods in 2009 and 2010. Figures reported in the 2011 QA indicated the team may have contributed to cost reductions through saved person-hours for QPS staff, with the team attending many ATRs and EEOs.

Surveys were completed by QPS staff, QH mental health service staff and carers of mental health consumers. Half of the participants had utilised the services of the Co-Responder team. Overall, there was a positive response to the Co-Responder model. For survey participants who had used the project, two thirds of Mental Health Service Staff and more than two thirds of QPS participants reported that the service had saved them time in their day to day work, often between 1 to 4 hours per week.

Three quarters of service requests for the project were for consultation and liaison but assistance was also involved: determining risk, ATR assistance, transport of consumers and direct client liaison. The main responses for service providers not using the project were either not having any mental health-related tasks that required Co-Responder assistance or lack of knowledge about the service. The majority of participants in all three groups considered the project to have benefits for QPS and QH as well as for consumers and their families.

Nearly three quarters of carers participating were aware of the model and a quarter of them had used the assistance of the Co-Responder team. All carers surveyed thought the model would be beneficial to both consumers and carers and should continue into the future.

The CMHCP was extended beyond its initial trial period and continues to operate. Currently the model only operates during regular daytime business hours. The model has been formally recognised, having received several awards (17) listed below:

- 2010 - Queensland Mental Health Achievement Award – Queensland Government
- 2011 - Assistant Commissioner Certificate QPS (Highly Commended)
- 2012 - Lantarn Award for Excellence in Policing Operations QPS Far North Region
- 2012 - National Crime Prevention Award - Australian Institute of Criminology
- 2013 - Health and Community Services Workforce Innovation Award – Innovation Awards Workplace Council

**Figure 1: Cairns Mental Health Co-Responder Project Pilot team member
Senior Sergeant Greg Giles**



Figure 2: Current Cairns Mental Health Co-Responder Project team member
Shelley Wallace (Authorised Mental Health Practitioner)

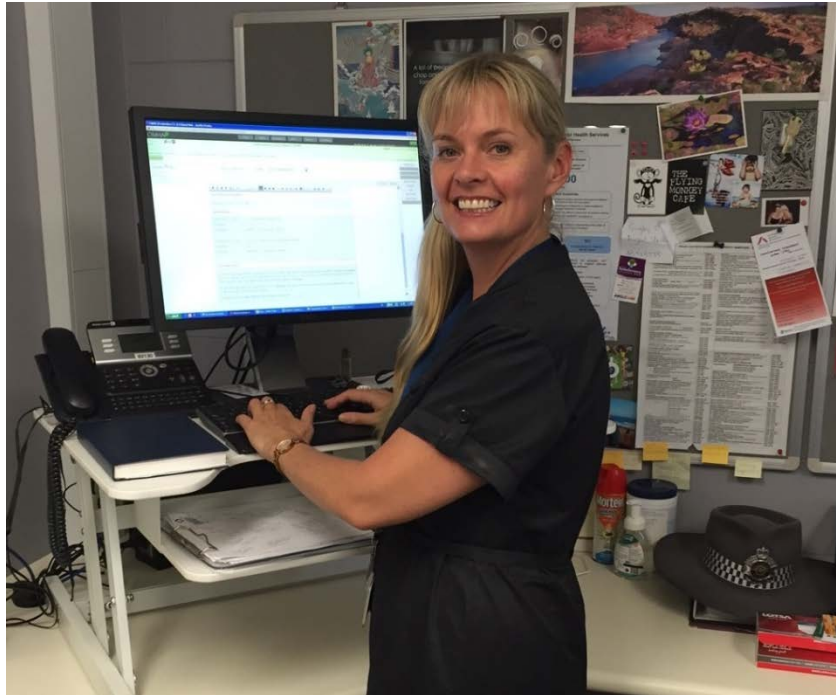


Figure 3: Current Cairns Mental Health Co-Responder Project team member
Senior Sergeant Angela Evans

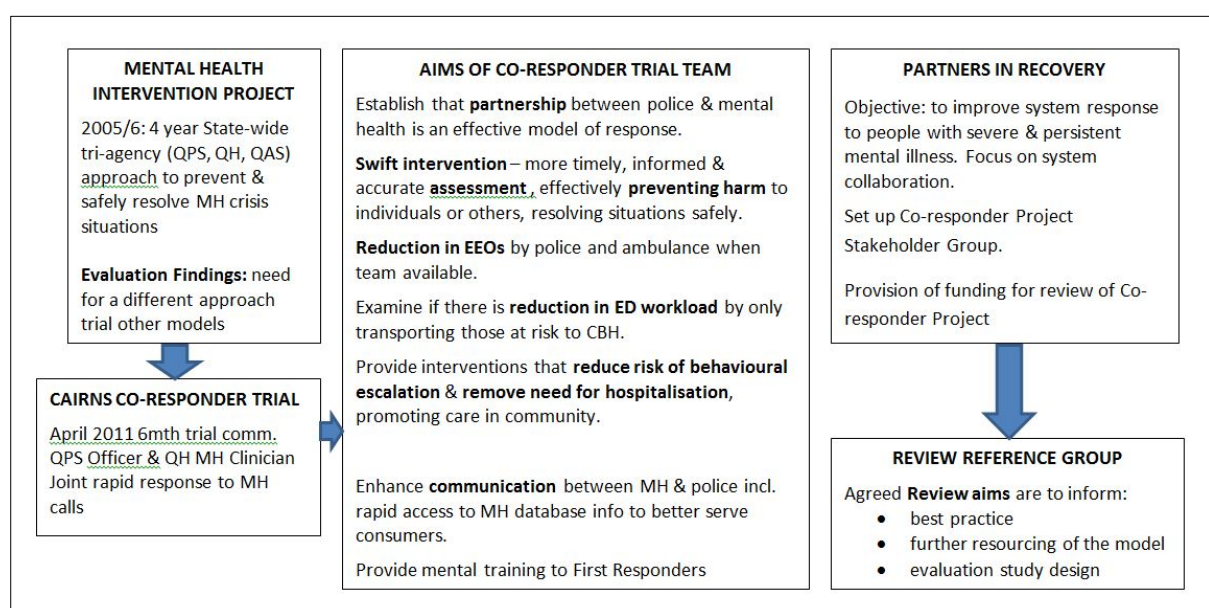


SECTION TWO: REVIEW APPROACHES

Review Reference Group

The current model, in place since 2011, has not yet undergone a comprehensive formal evaluation. In early 2016, Partners in Recovery (PIR) set up a Stakeholder Group to support the CMHCP and provided sufficient funding to undertake a review, not a full evaluation of the Cairns model. PIR is a Commonwealth initiative to support people with severe and persistent mental illness with complex needs and to support their carers and families. Drawing on key stakeholders involved in the development, implementation and use of the CMHCP model, a reference group was established in May 2016 to guide the review process. The Review Reference Group included those representing: QH Mental Health, QPS, and PIR, with James Cook University providing methodological input. The group was further expanded to include representatives from QAS, consumer services and Indigenous services. These individuals provided guidance and feedback regarding all aspects of the research through regular meetings of the whole group or independently when required. The process of development of the review and its aims are depicted in Figure 4.

Figure 4: Map of the development of aims of the review of the Cairns Mental Health Co-Responder Project



Objectives of this review

The objectives of this review, agreed on by the Reference Group, are outlined below:

- To understand the project's impact on frontline services (government, non-government) and on consumers of mental health services in Cairns and their families;
- To describe best practice by QPS and QH to prevent and/or safely resolve mental health crisis events;
- To inform efforts to secure further resources required to improve the current model, and;
- To inform the design of a more comprehensive evaluation of the model in full, including a cost-benefit analysis and using appropriate comparative methods.

Elements of this review are based on the original 2011 quality audit approach (16) to enable the review and activities captured in the first review to be used as a comparator for the information reported here. The 2011 Quality Audit included the following information sources:

- Police calls for service related to mental health calls (initial job codes of: 503 and 504);
- Emergency examination order data using QPRIME data;
- Authority To Return data, and;
- Online surveys with QPS staff, MH service staff and carers of MH consumers.

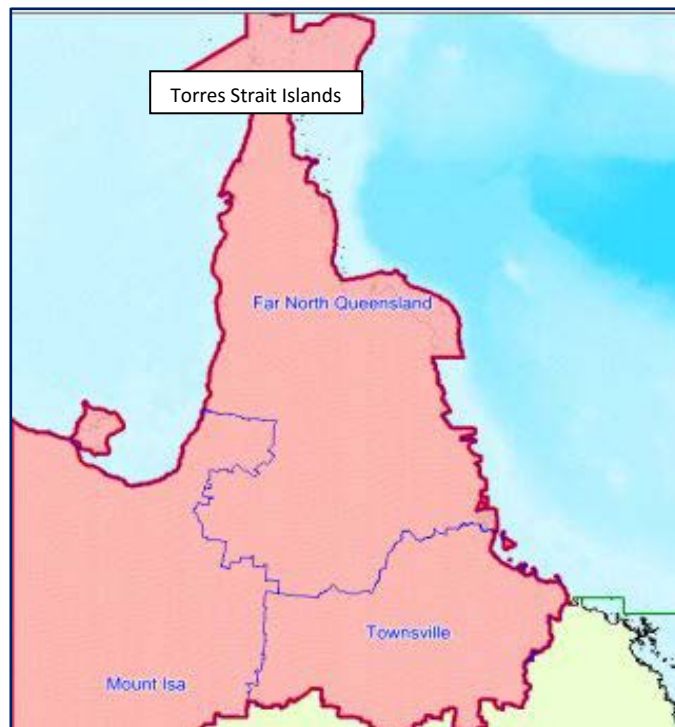
Setting

Cairns is a provincial coastal city approximately 1800 kilometres by road from the state capital, Brisbane, situated in the far north of Queensland. The city has a permanent population of 156,000 people, with approximately 10% of the population identifying as Aboriginal and/or Torres Strait Islander.

The city is an international and domestic tourist destination, with a substantial component of backpackers. The rate of homelessness is significantly higher than the overall rate for Queensland (18) with disproportionately high numbers of Indigenous peoples in the homeless group, including transient people from remote communities in Cape York (19).

The Northern Police Region is comprised of three police districts: Far North Queensland; Mount Isa and Townsville (Figure 5). Cairns is within the Far North District. The Far North District covers 362,818 square kilometres and, in 2015, personnel included 657 Police Officers (20).

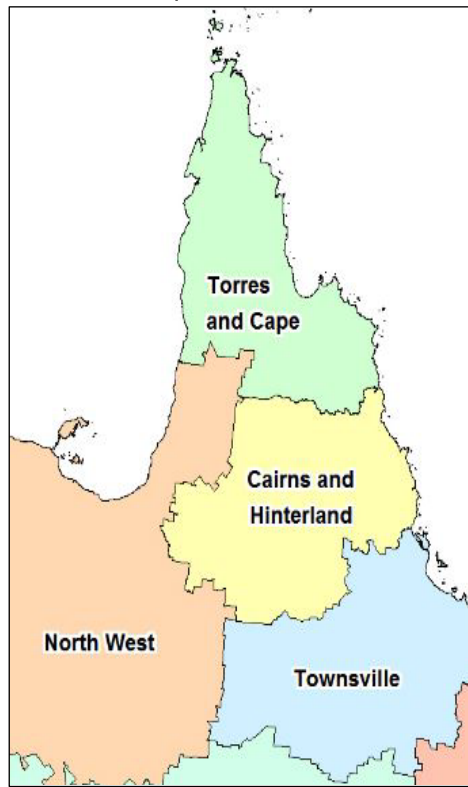
Figure 5: Map of Northern Police Region and districts, Queensland



Obtained from *POLSI Profiles: Resident Profile, Far North Queensland Police District*; Queensland Government 2016

Authorised Mental Health Services in Cairns and Hinterland Hospital and Health Services District (Figure 6) include inpatient and specialist health units at Cairns Base Hospital. District community-based components are located in Edmonton, Smithfield, Innisfail, Tully, Mareeba, Atherton and two sites in Cairns. The Cairns-based service area of the CMHCP extends from Palm Cove in the north to the community of Gordonvale in the south and includes QPS divisions of Smithfield, Cairns, Edmonton and Gordonvale (Figure 7).

Figure 6: Northern Queensland Ambulance and Queensland Health Hospital and Health Services Districts



Obtained from *Maps: Queensland Health*;
Queensland Government, 2015

Figure 7: Geographical reach of the
Cairns Mental Health Co-Responder Project



Legislative Framework

The Mental Health Act (2000) provides the legislative framework for the involuntary assessment, treatment and protection of people with mental illness, at the same time protecting their rights and freedoms (21). At times, persons with mental illness may require involuntary assessment and treatment. The processes for these are separate in order to provide safeguards for the consumers (22). Provisions of the Act relating most frequently to the activities of the Co-Responder team are described below.

Request and Recommendation

A *Request for Assessment* can be made by any person over the age of 18 years, excluding a relative or employee, who believes the person has a mental illness where an assessment may be necessary without their consent. A *Recommendation for Assessment* can be made by doctors and AMHPs, with the recommendation effective for 7 days. These documents, also known as R&Rs, must be made by different people (22). There are occasions where involuntary assessment provisions cannot be applied because the person cannot be examined by a doctor or an AMHP. In these cases the Justice Examination order (JEO) or EEO provisions may be used to enable this examination (23).

Emergency Examination Orders

An EEO authorises the temporary detention and examination of a person who is experiencing mental illness where their actions may result in immediate harm to themselves or someone else. If the EEO criteria apply, then a person can be forced to go to an Authorised Mental Health Service for examination by an AMHP. Following examination, it may be decided that the person should undergo Involuntary Assessment, which in turn can lead to the making of an Involuntary Treatment Order (ITO) (8). EEOs can be made by a police officer, ambulance officer or psychiatrist (24). The person may be detained for up to 6 hours for examination by a doctor or AMHP (22).

Justices Examination Orders

Any adult community member who believes a person requires involuntary assessment may apply for a *Justices Examination Order* (JEO) which must be sworn under oath. A Magistrate or Justice of the Peace (JP) may also make this order. The JEO, which

covers a seven day period, is sent to the administrator of an AMHS who must arrange for an AMHP, in consultation with a doctor or psychiatrist, to examine the person to determine if involuntary assessment is required. People who do not meet the assessment criteria are those found not to appear to have a mental illness, those who do not require immediate treatment or those who agree to engage voluntarily with the mental health service (25).

Authority to Return

An *Authority to Return* (ATR) is a process QH undertakes when a mental health consumer:

- Leaves an inpatient or community AMHS while being detained for involuntary assessment, also known as Absent Without Permission (AWOP)
- Is authorised to be in the community on Limited Community Treatment (LCT) or on a community category of an ITO but is required to return to an inpatient facility because of mental health needs, or,
- Is authorised to be in the community on LCT but fails to return to the inpatient facility at the end of the authorised leave period.

The authorised doctor may issue an ATR to police with a 'Request for Police Assistance' which enables them to act alone, i.e., without a health practitioner present. This allows the police to return a patient to an inpatient facility of the authorised mental health service for assessment, treatment or care. The appropriate use of an ATR is when the patient's whereabouts are unknown or it is unsafe for the patient to be returned by health practitioners without assistance from police (24).

Data sources

The review framework includes a combination of qualitative and quantitative methods to examine both the processes in the development and implementation of the model and its impacts. Data sources included:

- Observation notes from visits to CMHCP site;
- QPS and QH operational documents relating to the role of the Co-Responder team;
- Semi-structured interviews with key stakeholders to document stakeholders knowledge of the model's function, operations and impacts;
- An on-line survey with QPS staff and QH mental health service staff;

- QPS Queensland Police Records and Information Management Exchange (QPRIME) and Queensland Police Computer Aided Dispatch (QCAD) databases;
- QAS Computer Aided Dispatch and patient information databases, and;
- Queensland Health Consumer Integrated Mental Health Application and Queensland Health Enterprise Reporting Service (QHERS).

Interviews

A semi-structured interview schedule was used. Selected QH and QAS staff, QPS members and representatives from social support services, including consumer advocacy groups and specialist services for youth, homeless and Indigenous consumers, were approached and invited to participate in a confidential interview either face-to-face or by phone. Participants were asked about:

- Options for emergency mental health responses by health and police prior to the Co-Responder project;
- Benefits of the project to service providers and consumers;
- Essential components of the project model;
- Challenges and enablers in project implementation, and;
- Suggestions for improvements to the model.

Depending on their role and/or involvement with the project, some more targeted questions were asked regarding the model's development and implementation, including identification of key stakeholders, essential components and suggested improvements. Participants were asked for permission to record the interviews so that de-identified transcriptions could be compiled for analysis.

Surveys

Senior management representatives of QH, QAS and QPS (also Review Reference Group members) distributed invitations by e-mail to frontline workers inviting them to participate in a confidential web-based survey. Consenting participants were asked to click the consent box after reading the Information Sheet describing the Review before continuing with the survey.

The survey questions included questions used to compile the information in the 2011 report so that direct comparisons could be made. A supplementary set of questions were added to the survey. These additional questions were informed by the literature review as well as interviews with QPS members, QH personnel and with consumer advocacy group representatives. Survey participants were asked to provide information about the following:

- Length of experience in the Cairns region and current position;
- Mental health or related training and education completed;
- Understanding of the model's processes and activities;
- Experiences related to the use of the model, and;
- Benefits and improvements to the model.

For all questions, participants were encouraged to add qualitative comments to further explain their responses.

Ethical and consent considerations

Approvals to conduct this low-risk Quality Audit were received from Far North Queensland Human Ethics Committee and QPS Research Committee on the 17th of July 2016 and 20th of September 2016 respectively. QAS permissions were granted from the Office of the Commissioner on the 1st of November 2016.

Limitations of the study

There are several main limitations of the study:

- This review compares the operations, functions and perceptions of effectiveness of the model between two six-month periods (2011 and 2016). This kind of before-and-after review would ideally be done with involvement from the same participants and data sources. Specifically, the interview and survey data reported here for 2016 often comes from participants who may not have contributed to the information used in the 2011 review. The results and conclusions must be interpreted with this limitation in mind.
- The quantitative information used comes from data systems that were not specifically designed for the purposes of documenting the activities of the Co-Responder model across police, ambulance and health services. These systems all face the challenge of

having standardized, coded descriptors of incidents entered into their systems in standard ways across large services dealing with many other complex matters. A main effect of this limitation is to make it difficult to reconcile all the numbers and proportions in the quantitative information reported.

- A full economic impact assessment is lacking from this review, as it was from the 2011 review. This kind of study component was not possible given the resources required to extract and analyse the necessary data from the administrative systems of the key service providers. The cost savings estimated in this audit are therefore to be regarded as preliminary only.

SECTION THREE: REVIEW OF THE LITERATURE

This review provides a basis from which to identify essential components and elements of best practice of the CMHCP. The review research team took a strategic approach to review the literature pertaining only to specialised response approaches to mental health crises in the community. A systematic scoping review of peer-reviewed and grey literature would probably have missed several important sources of information and review. A strategic review also allowed more of a critical assessment of the available literature and permitted the inclusion of policy and practice documents which informed the definition of elements of best practice. Systematic searches were conducted on Psychinfo, MEDLINE and Informit databases. A hand search for grey literature was also undertaken.

Generally, there are two main types of specialised response approaches described in the literature: Crisis Intervention Team and Co-Responder approaches. A summary of the Crisis Intervention Team and Co-Responder approaches are discussed below.

Table 1. Summary of specialised teams to respond to community mental health crisis

	Crisis Intervention Team	Co-Responder
Aim	Initial aim to improve safety during encounters between police and consumers (26)	To improve access for people with mental illness have to adequate treatment
Approach	Specifically trained police officers provide first line response to mental health related calls. Police bring individuals in crisis to an around-the-clock, no-refusal treatment centre.	A specially-trained officer and mental health clinician form teams to attend and investigate the scene of a crisis involving mental illness.
Staffing	A selected group of officers, holding certain qualities and who nominate to take the role (27). These police remain on patrol duties.	In some locations the model runs several days per week from 3pm through to 11pm (28). In others, the triage desk is operational 24 hours a day. Officers allocated are usually equipped and uniformed.
Training	Forty hours of specialist, intensive training is completed. Police officers are trained to identify signs and symptoms of mental illness and develop de-escalation skills.	Specialist mental health training for the department Also provide community based education on the role of police in mental health interactions. In some localities, CIT training is offered

Crisis Intervention Team Model

Perhaps the best known model is the Crisis Intervention Team (CIT) model, also referred to as the Memphis model, having originated in that Tennessee city (29). Essentially, the model is a program based on police-based intervention, with the cornerstone of the model

being the specialised training delivered to a select group of officers who continue to carry out patrol duties.

According to the model, CIT trained officers are deployed to provide a first-response to the majority of incidents involving people with mental illness. Emergency call dispatchers are trained to identify mental health crisis calls and assign these calls to CIT-trained officers. Upon deployment, the CIT-officer is given the authority of officer in charge, regardless of rank. These officers are responsible for:

- assessing a situation;
- de-escalating situations and reducing the need for use of force;
- transporting individuals to emergency psychiatric services, and;
- providing provision of treatment referrals as an opportunity for re-direction from the criminal justice system or arrest where appropriate.

To enable the model to run efficiently, a critical element is streamlining the referral process for CIT officers through the identification of an emergency drop-off location with psychiatric facilities and a no-refusal policy at nominated facilities. Also supporting the model's implementation and effective operation are these elements: i) modifications to existing police department procedures; ii) collaboration between police with MH providers and other stakeholders, and; iii) support for the police from the community to address mental health concerns? (29).

Training is only offered to a select squad of officers, namely those who are interested and who volunteer to become CIT officers and those who are successful in the selection process (27). The selection process includes a review of the officers' personal files, recommendations and an interview. There must be enough team members that one CIT-trained officer can respond to every call involving a person in crisis. This has resulted in 25% of the total number of officers in a department trained (26).

Over the last three decades, the model has been replicated and modified within law enforcement agencies across the US including New Mexico, Oregon (Portland), Ohio and Washington State (Seattle) as well as in Australia (New South Wales) and the UK (30, 31). In New South Wales, a dedicated unit of operational police complete intensive training involving specialist practitioners, MH service consumers and intensive role playing (31).

Crisis Intervention Training for selected police officers responding to mental health crisis includes:

- Understanding the signs and symptoms of mental health disability, including co-occurring disorders;
- Medication issues;
- Civil commitment laws;
- Site visits to psychiatric facilities;
- Panel presentations with people with mental illness and their family members;
- Learning de-escalation techniques, and;
- Engaging in role-play scenarios.

The intensive training package consists of 40 hours (five days) of didactic presentations combined with scenario-based activities to enable participants to acquire realistic and practical skills (32). The training provides an opportunity for officers to familiarise themselves with the MH Services in their community. Participation of members of the consumer advocacy community, including individuals with lived experience of being mentally unwell and groups of carers, are also considered to be critical to the success of training CIT officers (26).

The Memphis model, developed in 1988, was designed in response to an incident between police and an individual with a known history of mental illness with the individual fatally shot (33). In response, representatives from the Memphis Police Department, the National Alliance on Mental Illness, the University of Memphis, the University of Tennessee, behavioural health providers, and consumer representatives pioneered the CIT model of law enforcement training.

Co-Responder Model

The model is a collaborative approach between law enforcement and mental health whereby trained police officers team up with mental health professionals to provide specialised responses. These teams are used, as secondary response option when responding police officers and/or specialised police emergency response teams are unable to de-escalate the situation where the person is known or presumed to have a mental illness.

Los Angeles (LAPD) was one of the first police departments to advance this type of response with the development of the System-wide Mental Assessment Response Team (SMART) (34). SMART developed in response to policing gaps in service, namely

i) difficulties in linking people with mental illness to appropriate services (35) and, ii) police officers' limited awareness about community MH resources (36). SMART activities are operated by a triage desk, whose role is to triage all the department's contacts with persons where knowledge of poor mental health has been established. The triage desk, staffed for 24 hours a day, seven days week, provides advice and guidance to responding officers in the field and completes a Mental Evaluation Incident Report (34). For confidentiality purposes, Mental Evaluation Incident Reports and information related to the incident are kept separate from the Crime Analysis Databases. A triage mental health nurse sits alongside the officer and queries the LA County Department of Mental Health database to identify case managers, psychiatrists, or treatment centres. Collectively, the triage staff determines whether to dispatch a SMART unit or to direct the patrol officers to transport the person directly to a mental health facility.

In addition to the Co-Responder model team, the LAPD developed the Case Assessment Management Programme (CAMP) in 2005 which pairs police with a variety of health professionals from the LA County Department of Mental Health, including psychologists, nurses and social workers, to develop long-term support and treatment strategies for individuals who have repeated calls for emergency services. CAMP has a mandate to identify, monitor and engage this cohort and construct a case management-style approach to link individuals with appropriate services. Individuals' cases remain open and ongoing. If the Triage Unit determines a person has had repeated contact with police or has demonstrated high risk behaviours, the case will be referred to the CAMP for more intensive case management.

It is worth noting that the LAPD piloted a CIT program in 2001. While it was disbanded, CIT training continued and is now offered to officers who are most likely to come into contact with people experiencing mental health crisis.

Other Co-Responder model locations

The Police Ambulance and Clinic Early Response (PACER) unit (28, 37), initiated in 2007 as joint venture between the then Department of Human Services and Victoria Police, comprises of one dedicated police and mental health officer to attend crisis situations. Similar to the LA-based model, PACER attendance is a secondary response. It can be

activated by the operational police unit or requested by ambulance services through existing police communications. PACER assistance is requested for: onsite clinical assessment of an individuals' mental health status; onsite telephone advice on mental health referral options, advice on appropriate transport options; advice on de-escalation tactics and options; and design of intervention strategies for high users of emergency services. The types of incidents the unit may attend to include suicide/self-harm, threaten/harm others, welfare concerns, family violence, assist ambulance and other activities such as education.

An evaluation of the model's impact for individuals experiencing crisis, as well as resource and system demands was conducted (37). The evaluation, comparing the PACER's delivery over a 16-month period to a comparative location that provided the usual service provision, utilised the following to inform the assessment:

- Policy and program documentation, including protocols and legislation;
- Data sources from agencies involved in the unit including Victoria Police activity sheets, mental disorder transfer and use of force information; Victorian Emergency Minimum Database (Department of Health) transfer information and Victorian Ambulance Clinical Information System;
- Focus groups, telephone interviews and meeting with key stakeholders about policy, practices, existing challenges in dealing with MH crisis, benefits of the PACER unit and directions, and;
- Literature review of published and grey literature to inform consumer and carer perspectives and experiences with integrated models of police and mental health crisis response.

Summary of the benefits related to the Victorian Police Ambulance and Clinic Early Response (PACER) model

In comparison to the usual form of service, the PACER model (31):

- Provided more timely access to mental health assessment for the individual in crisis and reduction in time from three hours to one hour;
- Enabled 'real time' police and mental health background information, meaning more accurate completion of risk assessments of consumers;
- Reduced length of hospital stay for PACER-referred individuals compared to counterparts at comparator site. At emergency departments more information is

provided by PACER unit about individuals' circumstances (compared to police referrals), that may assist in the more timely treatment and outcome for individuals;

- Increased transport of individuals with poor mental health by ambulance (PACER: 48.8%; comparator: 36.8%) compared to police (PACER: 39.9%; comparator: 60.8%);
- Enabled greater relief of first-response police resources to attend other duties (in approximately one third of the usual time taken);
- Lowered the number of referrals to emergency department (PACER: 52%; comparator: 82%). Rather, a greater number of individuals were directly referred to psychiatric facilities (PACER: 27%; comparator: 17%), and;
- Provided better streamlined mental health information by improving inter-agency sharing of information related to the individual in crisis. In turn, this enabled more effective response related to assessment and referrals.

Considerations identified for other regions contemplating implementing a similar unit include:

- Funding and source constraints – particularly rostering availability and differing role descriptions between mental health clinical roles generally and the PACER clinician role;
- Cultural and organisational differences between agencies – different service boundaries can effect co-ordination and delivery of services, and;
- Geographical implications – transferring similar unit to a non-urban locality comes with challenges related to resources and larger catchment areas.

A consistent definition of mental health crisis across the three agencies (police, mental health and ambulance) and improvements to information collection in databases by all three agencies were among the recommendations for improvement.

Benefits of specialised policing models

Reviews conducted with the police officers who received CIT training in Memphis and other localities where CIT is operational have discussed several positive changes and outcomes. Studies have identified a number of benefits related to the CIT model among individuals experiencing poor mental health including changes in attitudes towards people

with poor mental health, reduced criminalisation and reduced transportation by law enforcement to mental health facilitates (33). Benefits for police officers related to the CIT model include time saved on work hours by being able to attend to other duties (33).

Similar to the CIT model, a range of benefits have been described in reviews of the Co-Responder. Unlike the CIT model, the Co-Responder model team benefits from shared access to mental health and criminal justice information (38). Essentially this enables police officers and mental health professionals equally to have access to criminal justice data on individuals' arrest records, warrants, prior police contacts for psychiatric problems, and weapon ownership. Both kinds of information are useful for understanding the emergency situation and provide the opportunity for officers to make an informed decision about the situation. It was identified that the model improved timeliness of mental health assessment in a safe manner and offered appropriate referral pathways for individuals experiencing crisis (37). Other reported benefits include greater mental health practitioner safety at the scene with inclusion of a police officer and improved treatment of aggressive patients.

Opportunities to deliver these models more effectively were noted. Although the no-refusal policy is essential to the CIT model, a survey of CIT programs found that only one-third had formal agreements with receiving health or psychiatric facilities (39). The majority of CIT models are operating in major cities and there are several challenges for any replication of the model in a rural or remote context. For example, health facilities in small centres are often not operational out of hours and do not have the same security measures. On this basis, facilities are unlikely to accept an individual in crisis if staff safety cannot be assured.

The implementation of relevant data collection to enable ongoing monitoring of the program as well as finding longer-term, tangible measures of success were also noted as essential to evaluate specialised policing models.

Table 2: Summary of selected studies reporting on outcomes of Police response models

	Study	Location	Method	Outcomes
Crisis Intervention Training	(40)	Georgia, US	Survey of 159 officers immediately before and after 40-hour CIT training program.	- Self-reported improved attitudes regarding aggressiveness among individuals with schizophrenia - Greater knowledge MH-related knowledge and more supportive of treatment
	(32)	South-eastern US	Survey containing three vignettes depicting an escalating situation involving a subject with psychosis completed by CIT trained (n=48) and non-CIT trained (n=87). Data was analysed using repeated-measures analysis of variance.	- CIT-trained officers chose less escalation (ie. less force) than non-CIT-trained officers - Self-report by CIT-officers reported decreasing perceived effectiveness of non-physical action across the scenarios - CIT-trained officers reported a lesser decline in perceived effectiveness of non-physical actions at the third scenario
	(41)	Las Vegas, Nevada, US	Police reports (n=655) were analysed for CIT events to determine each subjects potential for violence to self or others.	- Almost half (n=295; 45%) of the calls CIT officers attended involved suicide crises, and 25% involved a threat to others - For events classified as serious to extreme risk of violence, officers used force in 15% of 189 events - Of events, 485 (74%) were resolved through taking the individual to hospital, whereas only 6 (4%) were resolved through arrest
	(31)	New South Wales, Australia	Mixed methods evaluation, including semi-structured interviews, surveys with trained and non-trained officers, observations and officially collected data from health and police systems.	- Training led to an increased use of de-escalation techniques - Improvement in the sharing of information between police and health services - Good relationships have been developed between Police, Health, Ambulance and NGOs - There was a belief held among mental health consumers that escalation of events related to police fear of mental health consumers
	(42)	Birmingham, UK Alabama; Knoxville and Memphis, US	Police dispatch calls (n=100) from the sites related to MH calls were examined to determine differences in case dispositions, records were also examined for 100 incidents at each site that involved a specialised response.	- Memphis had the largest number of specialised responses on the scene and linking people with treatment when required - A no-refusal policy, crisis drop-off centre for persons brought in by police was considered key to the operations of the Memphis model - All three programs had relatively low arrest rates when a specialised response was made - Birmingham's program was most likely to resolve an incident on the scene, whereas Knoxville's program predominantly referred individuals to mental health specialist

Co-responder model	(38)	Los Angeles, California, US	Retrospective study: data related to demographics, clinical history, arrest history, previous violent behaviour of referrals (n=101) to the SMART was collected and the status of the individuals at six month follow-up were compared.	• Of the 85 referrals followed-up, 22% had been arrested, and 42% had been re-admitted to hospital • The model enabled individuals not be criminalised, even though they came from a population at high risk for criminalisation
	(37)	Melbourne, Victoria, Australia	Mixed method approach that included: 1) qualitative consultations stakeholders; 2) quantitative comparison of an intervention (with a control)	• Individuals referred to hospital using this model had a reduced stay compared to counterparts at comparison site. Perceived to be because of the available information about the referral at the point of transfer • Frontline police officers are relieved by the team and able to attend other duties • More timely treatment access for individual in crisis • More streamlined approach with the assistance of inter-agency information sharing • Data capture reform would assist with future evaluations
	(43)	Georgia, US	Satisfaction of clients (n=54) and families (n=29) who received service from a brief MH substance abuse and mobile crisis service were collected.	• For family members who rated their use of the mobile crisis service, their satisfaction was significantly higher than either the substance abuse client or patients who rated the mobile crisis services
	(44)	Ontario, Canada	Retrospective study, with the analysis of four sets of client records at four different time periods, using a qualitative, text based approach	• The review identified 75% of the program's apprehensions under the Mental Health act are admitted to hospital • Referral pathways have changed, with self-referrals to the service twice the rate (30%) since the program's inception
	(45)	Georgia, US	Retrospective study which examined differences in hospitalisation and arrest rates, and costs for psychiatric emergency situations handled by either a mobile crisis team or regular police intervention. Consumers' and police officers' satisfaction of the model also captured.	• Significantly higher number of cases did not result in psychiatric hospitalisation of the person in crisis when mobile team responded (55%) compared to regular police intervention (28%) • Arrest rates for persons handled by the two groups was not statistically significant. • Mobile team is cost effective, with the average cost per case being 23% less • Both consumers and police officers gave positive ratings to the program

Elements of best practice

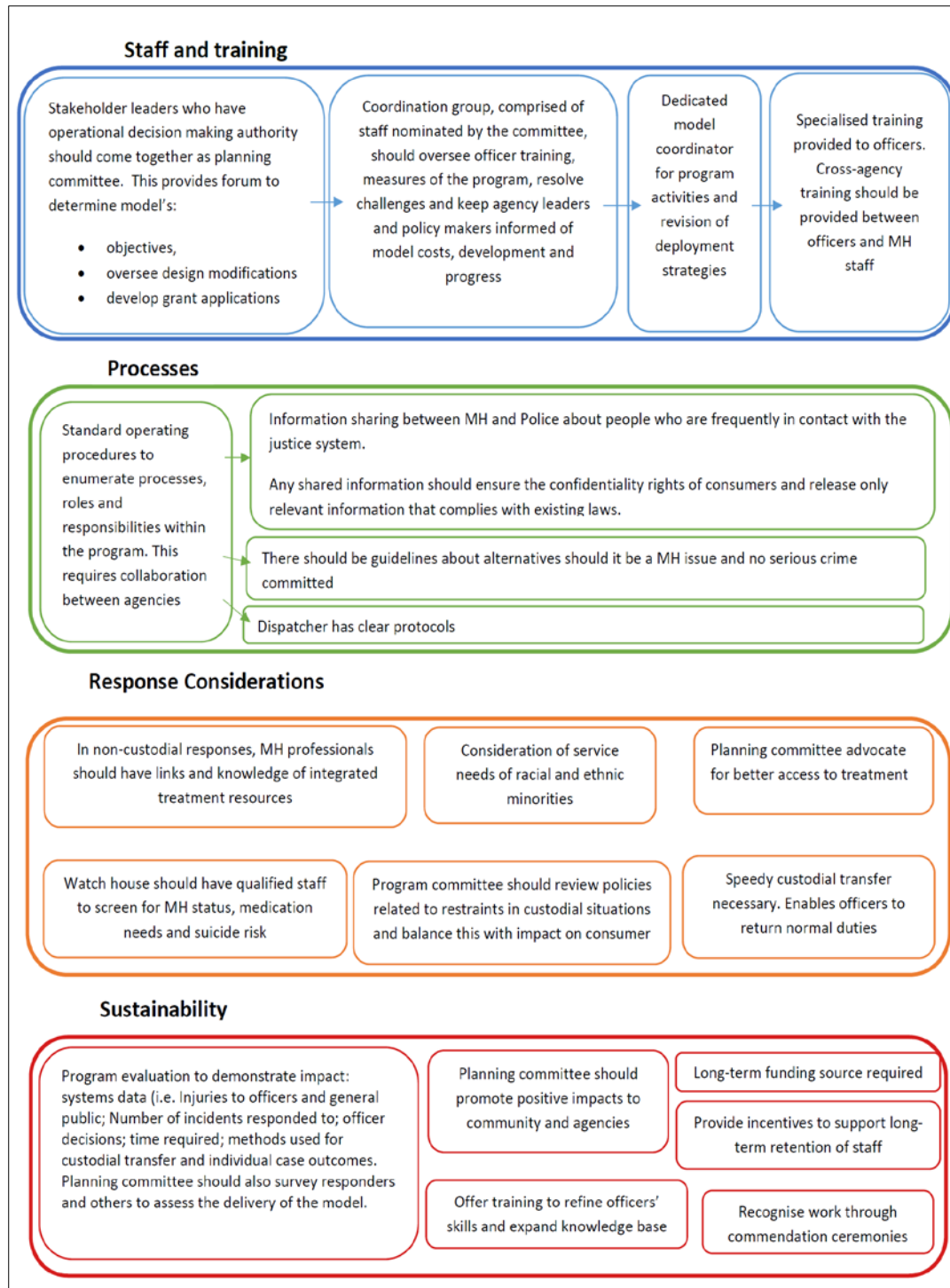
Schwarzfeld and colleagues (36) describe 10 essential elements they believe should underpin the design and implementation of any specialised response program including the CIT and Co-Responder models. The elements are derived from recommendations from law enforcement executives and officers, mental health professionals, advocates and mental health consumers who have been engaged with these models. The elements aim to provide policy-makers with a framework that will promote consistency and sustainability while being mindful of regional needs and resources. The elements, with adjustment to reflect the CMHCP, are described below.

1. *Collaborative planning and implementation:* Agencies and individuals representing a wide range of disciplines and perspectives and with a strong interest in reducing and/or improving police encounters with people with poor mental health and in crisis work together to determine the response program's characteristics and guide implementation efforts.
2. *Program Design:* The planning committee designs a specialised team to address the contributing factors that are impeding improved responses to people with mental illnesses and makes the most of available resources.
3. *Specialised training:* All members of the Co-Responder model team who respond to incidents in which an individual's mental illness appears to be a factor receive comprehensive training to ensure they are prepared for these situations. Dispatchers, call-takers, and other individuals in a support role receive training tailored to their needs.
4. *Call-taker and dispatch protocols:* Call takers and dispatchers identify critical information to direct calls to the appropriate responders, and record this information for analysis and as a reference for future calls for service.
5. *Observation, assessment and appropriate response:* The Co-Responder team de-escalates and observes the nature of incidents in which mental illness may be a factor using strategies focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, the Co-Responder team then determines the appropriate action required to respond to the situation.

6. *Transportation and custodial transfer:* The Co-Responder model team should transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services. This will enable operational patrol officers and ambulance officers to return to other duties or relieve them from attending the incident/call out.
7. *Information exchange and confidentiality:* Police and mental health staff have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.
8. *Treatment, supports and services:* The Co-Responder model connects individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services.
9. *Organisational support:* Leading agencies' policies, practices, and culture support the Co-Responder model and the personnel who further its goals.
10. *Program evaluation and sustainability:* Data are collected and analysed to help demonstrate the impact of and inform modifications to the program. Continuous efforts are made to ensure support for the Co-Responder model is ongoing within the community and the primary agencies (QPS and Queensland Health).

Key processes and activities are: staffing and training; operational protocols and procedures, consideration of responses by police officers to consumers in mental health crisis and program sustainability. These are summarised in Figure 8.

Figure 8: Summary of the 10 essential elements of best practice models of specialised programs responding to mental health crisis in the community



SECTION FOUR: RESULTS

The results for the quality audit of the CMHCP are organised by data sources. A brief descriptor of each data source is given where information was available.

Observation notes from site visits and operational documents relating to the role of Co-Responder team

Co-Responder team staffing

Both QH and QPS positions within the CMHCP team are full-time. The QH staff member, a mental health clinician, is a MHIC, with the role expanded to include Co-Responder activities. Leave for this MHIP-funded position is covered by members of the multidisciplinary ACT. Hours of service are mainly limited to business hours, Monday to Friday. The QPS Police Officer is a gazetted position on loan from another Division, an arrangement that has been ongoing for five years. Providing cover for the police position for leave and mandatory police training is extremely difficult to arrange, at times leaving the project short-staffed and unable to respond to crisis events in the community.

Core duties of Co-Responder Team

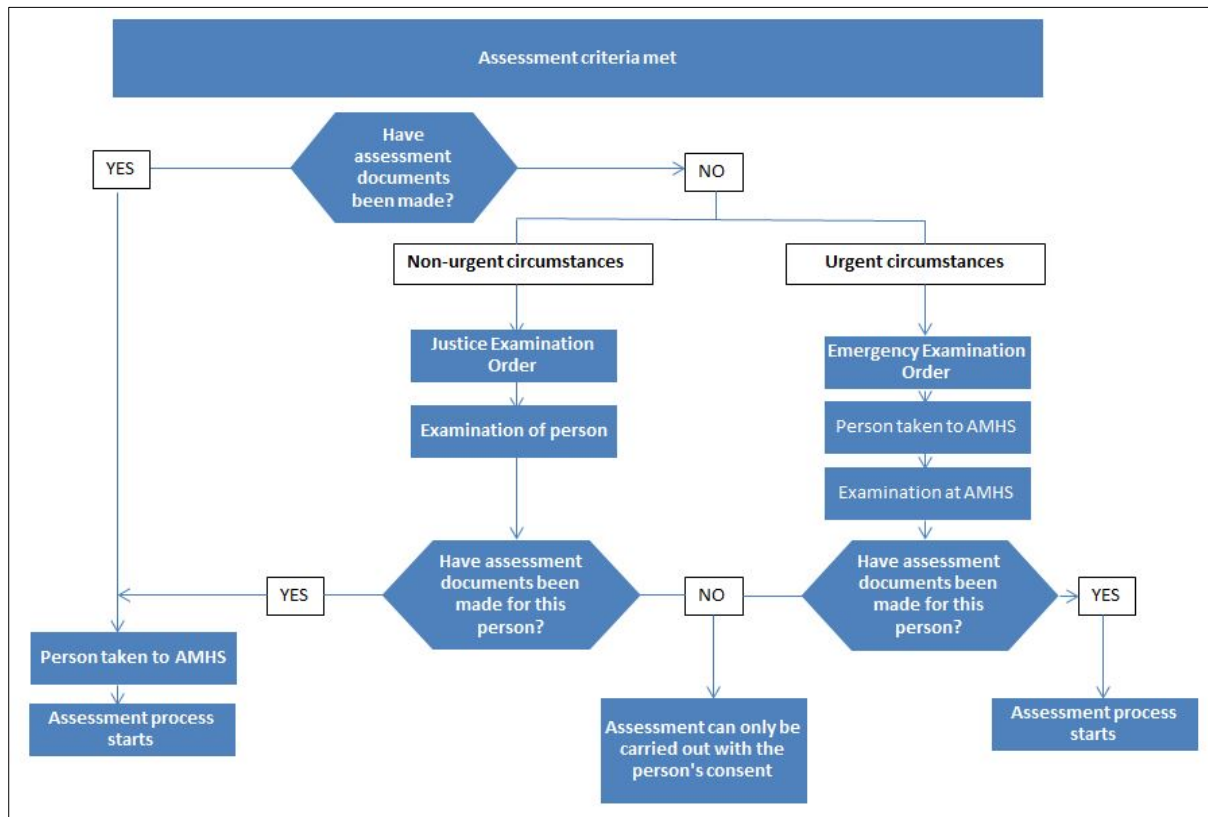
The following core duties were developed by QH for the CMHCP team:

- Home visits for assessment (police initiated) resulting from intelligence checks of the QPRIME system or from tasks/emails generated by police officers. These may result in face-to-face mental health assessment in the community, referral to other services, or determination that no further action is required;
- Home visits for assessment resulting from information from QH staff, including welfare checks and safety concerns of staff (assist case managers with problematic or high risk consumers);
- 000 or other calls to Cairns QPS communications centre relating to subjects with suspected mental health issues who have been assigned to the Co-Responder Team;
- Request and Recommendation may be initiated by Co-Responders or other QH or Authorised Persons. This enables the detention and transportation of the person to the Authorised Mental Health Facility;

- Carrying out Justice Examination Orders for high risk consumers referred by the Mental Health Act. This may result in Request and Recommendation (under the Mental Health Act) and transport to Cairns Base Hospital;
- EEO: where R&R is not appropriate or police have already initiated an EEO and the Co-Responder Team meet the police crew at the job address or at the hospital;
- Authority To Return: initiated by QH staff for consumers under an Involuntary Treatment Order with known high risk requiring assistance or transport by either police or the Co-Responders;
- Meetings with police, QH staff, non-government organisations and other stakeholders;
- Training: Co-Responders provide and receive training for QH, QPS and others;
- Intelligence checks: checks of QPS QPRIME system to detect mental health calls for service that require follow-up as well as checks of QH CIMHA, and;
- Crisis Intervention Planning: high risk consumers may require complex planning to ensure transport to hospital and/or require planning with other Government or non-Government agencies for ongoing management and contact within the community.

Many of these activities have a preventative component and further include: assisting with the provision of depot medication (those given by injection); encouraging voluntary assessments, advising of alternative care pathway options including drug and alcohol and social support services; encouraging people on Involuntary Treatment Orders (ITO) to attend an AMHS before an ATR is issued and attending to deteriorating patients before they are involved in a crisis situations leading to an EEO. However, as indicated by the core duties above, the need for involuntary assessment can arise when a consumer's diminished insight and judgement means they have become too unwell to seek help. The pathways for involuntary assessment are shown in Figure 9.

Figure 9: Flowchart of Involuntary Assessment Processes under The Mental Health Act 2000



This figure is based on Mental Health Act 2000: Brief guide to the Act; Queensland Government, 2000.

Requests for service

Table 3 describes agencies requesting services, requests modes and the type of service required. While no numeric breakdown of requests for service was available, members of the CMHCP advise that QH (Mental Health) and QPS are equally the most frequent referral sources.

Table 3: Referral sources and description of modes and types of calls for service for the Cairns Mental Health Co-Responder Project

Referring Agency	Service or Section/Unit	Mode	Request Type/Details
Queensland Police Service	Communication Room	Radio	Code 503 or 504 dispatches often arising from 000 calls
	Individual Officers	QPRIME*	Formal 'Tasks' involves a paper trail
	Individual Officers	Email	Request: follow-up from CAD; information re Persons Of Interest
	Individual Officers	Phone	As above: No paper trail
Queensland Health Mental Health	- Acute Care Team - Case managers, Community MH teams - Forensic MH - MH Unit - Consultation Liaison team - ED MH Pod		ATRs, EEOs, R&Rs, JEOs and assistance with development of CIPs. Assist with home visits for high risk consumers. Requests for information. Arrange stakeholders meetings.
Queensland Ambulance	Communication Room	Radio Phone	Card 25 dispatches ()
Other Government Departments	- Disability Services QLD - Department of Child Safety - Centrelink - Probation and Parole - Queensland Health (Medical)	Phone Email	Invitations to stakeholder meetings to: develop CIPs; discuss concerns regarding a consumer's risk to self or others or where the consumer's mental health is noted to be deteriorating.
Non-Government Organisations	- MH Fellowship Carers Support Hub - Mission Australia (Supported Accom) - Standby (suicide postvention) - United Care Family Support program - Access Housing - Partners In Recovery - Ozcare (residential facility) - Centacare Mental Health Service - Homeless Hub - Department of Housing & Public Works	Phone Emails	Direct referrals for consumers and families. Direct requests from services to start the referral process. Referrals from other agencies where the consumer's issues were outside criteria for client acceptance.

*The police officer in the CMHCP team also accesses a process in QPRIME whereby consumers with mental health issues who come to police attention are flagged to notify that officer. The officer may then be able to provide information or an intervention.

Queensland Police Records and Information Management Exchange (QPRIME)

Instigated in 2007, this system captures administrative and intelligence information to support policing activities and Information Management. QPRIME records official police crime reports including road crashes, crime (reported crime victims, reported crime offenders, prosecutions of offenders and offender criminal histories), missing persons and domestic violence applications/orders (46). Table 4 provides a breakdown of the activities of the CMHCP. Table 4 was compiled by the CMHCP police officer manually by inspecting QPRIME information where CMHCP activities were captured.

Table 4: Breakdown of activities of the Cairns Mental Health Co-Responder Project for the six month -period of 1 April to 30 September 2015 manually extracted from QPRIME

Month	Non-reportable CAD Occurrences	Intelligence or street checks	Mental Health Act	Other	Refer (non face-to-face)
April	24	12 (in total for the six months)	12	0	9
May	14		11	2	8
June	20		11	0	6
July	16		12	2	12
August	23		13	3	13
September	24		14	2	10

Table 4 provides a monthly breakdown of the activities of the CMHCP. While not shown, for those activities where the Mental Health Act was applied, the team attended to 50 R&Rs, 9 EEOs, 10 ATRs and 4 JEOs. Whereas QPS and QAS may only generate an EEO where there is an immediate risk, the CMHCP team, with the advantage of having an AMHP, has the further option of generating an R&R, which may be the most appropriate and more direct pathway to Involuntary Assessment in some cases. This action will obviously result in saved person-hours for first responders attending the situation. Many potential EEO's resulted in R&Rs instead.

Queensland Police: Computer Aided Dispatch (QCAD) records

QCAD is a dispatch system located in 19 communication sites across the State of Queensland. QCAD is integrated with QPRIME, with most of the information coming through QCAD stored on QPRIME. CAD is the system used when members of the community call for police assistance including 000 calls. QCAD also receives non-urgent calls for service through Police Link where people can report break-ins and wilful damage. Requests for ATRs are also sent to the Cairns Division Communication Room by QH Mental Health staff.

The CAD system displays activities, stores intelligence and critical information, collects task related information and sends out first responders (47). Dispatches are allocated one of five codes denoting the level of urgency and another, of over 800, indicating the type of incident. Codes 503 (attempting/attempted suicide) and 504 (mental health) trigger a check for the availability of the CMHCP team who may be contacted for information from CIMHA that can inform an appropriate response, or the CMHCP team may be requested to attend. When the CMHCP team is on duty they will also be listening to QPS radio for the same codes in order to receive information relating to known consumers and will attend the incident if deemed appropriate, meeting the general police crew at the site.

Dispatch codes may be finalised as another code when entered into QPRIME following finalisation of the event. Examples of this are shown in Table 5 as breakdown of 503 and 504 events for the six- month period for QPS Cairns Division only

Table 6 reports the total number of CADs for 503 and 504 codes for the Cairns, Smithfield, Edmonton and Gordonvale Divisions (n=920). QCAD was not in use in 2011, therefore data permitting comparisons between the six month periods in 2011 and 2015 were not available. Our understanding is that data relating to the number of EEOs generated by QPS during this time would require hand searches from QPRIME. However, EEOs generated by both QPS and QAS staff for these periods have been captured in QH databases and are therefore also reported in Figure 12 in the Queensland Health Enterprise Reporting Service section.

Table 5: Queensland Police Service Computer Aided Dispatches relating to Codes 503 and 504 for Cairns Division from 1 April 2015 to 30 September 2015

Code description	Dispatch and final codes	Finalised Code description	No.
Suicide/Attempt	503 finalised as 838	EEO by QAS	12
Mental Health	504 finalised as 838	EEO by QAS	2
Suicide	503 finalised as 836	EEO by QPS	4
Suicide	503 finalised as 837	EEO by QPS , transport QAS	4
Suicide	503 finalised as 842	Voluntary referral by Person to health	13
	301 finalised as 504	Mental Health	1
Welfare Check	619 finalised as 838	EEO by QAS	12
Suicide	503 finalised as 610	Community Assistance	13
Suicide	503 finalised as 503		41
Suicide	503 finalised as 833	Referral for Domestic Violence (when no breach)	13
Mental Health	504 finalised as 504	Mental Health	271
Disturbance or Dispute	313 finalised as 504	Mental Health	17
Armed Person	301 finalised as 503	Suicide	2
Escort Other	513 finalised as 838	EEO by QAS	11
	313 finalised as 504	Mental Health	4
TOTAL			420

Table 6: Queensland Police Service Computer Aided Dispatches relating to Codes 503 and 504 for Cairns, Smithfield, Edmonton and Gordonvale Division from 1 April to 30 September 2015

Month	No. Dispatches
April	131
May	173
June	149
July	133
August	146
September	188

Total	920
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Queensland Ambulance Service Computer Aided Dispatch System

Queensland Ambulance Service uses the Medical Priority Dispatch System to designate response codes. Card 25 are dispatches for cases designated as: Psychiatric/Suicide attempt/Abnormal behaviour. Table 7 illustrates the number of cases of Card 25 attended by QAS paramedics in the Cairns postcode 4870 (which excludes Smithfield, Gordonvale or Edmonton) for the two 6-month periods in 2011 and 2015. Although occasions where QPS are also on the scene are also reported in this table, no information was provided by QAS as to whether QAS requested QPS, or vice versa. There is also no information provided regarding involvement by the CMHCP team. Although there is a significant increase in Card 25 cases between 2011 and 2015, QAS advises there have been substantial increases in overall demand for ambulance services in the Cairns area over the same time period.

Detailed records of treatment and transportation information for each patient attended by paramedics are collected on Electronic Ambulance Report Forms (eARF). Reported QPS involvement and EEOs mentioned in comments were extracted by QAS from free-text in these electronic patient records.

Table 7: Queensland Ambulance Service Computer Aided Dispatches relating to Card 25 cases for postcode 4780 (Cairns) from 1 April to 30 September 2011 and 2015

24 April to 30 September, 2011 and 2015							
Months							
	April	May	June	July	August	September	Total
2011							
Total Card 25	42	37	44	28	40	39	230
QPS on scene	4	4	9	3	5	2	
EEO mentioned in comments*	3	2	0	1	6	6	18
2015							
Total Card 25	53	60	47	69	56	62	347
QPS on scene	0	4	4	4	2	1	
EEO mentioned in comments*	7	3	4	5	6	9	34

*Does not necessarily mean that EEO was completed, simply that EEO has been mentioned in comments section by attending paramedic.

Queensland Health Consumer Integrated Mental Health Application (CIMHA)

CIMHA is a system that provides reporting for Queensland's Mental Health Services. Developed as a replacement for 21 outdated databases, this tool is used by both clinicians and administration staff. CIMHA allows Mental Health clinicians to access and share all relevant consumer information across Queensland (48). Data examined included reports generated from: Provisions of Service (POS) and Non-Clinical Related Activities (NCRA).

Requests were made of Queensland Health to generate reports from CIMHA relating to the activities of their Co-Responder team member for the six month periods of 1 April – 30 September 2011 and 2015. These were to include both Provisions of Service (POS) and Non-Client Related Activities (NCRA) history. Although the CMHCP commenced in 2011, there was not a unique identifier associated with project activities within CIMHA until 2014. Therefore, the reviewers were only able to access activity reports for the 2015 period.

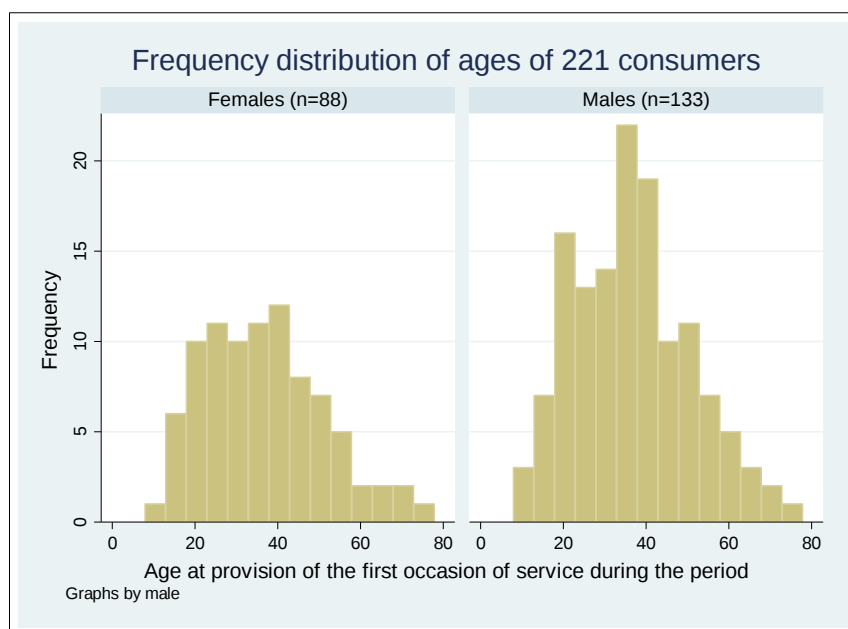
There were 601 POS in the data provided, with some episodes involving multiple POS. For 179 of these POS there was involvement of more than one AMHP in the response. The 422 remaining POS were for 222 consumers.

Characteristics of consumers

Age and gender:

Figure 10 shows the frequency distribution of ages of consumers on their first contact with the CMHCP when providing a service. Of the 222 consumers, 133 (59.9%) were male, 88 (39.6%) were female and there was one intersex consumer (0.5%). The mean ages at first POS during the period were 36.8 years for males (range: 10.4 to 73.0 years) and 36.6 years for females (range: 10.7 to 75.2 years) (Figure 9).

Figure 10: Age and gender of consumers of Provisions of Service by the Co-Responder team from 1 April – 30 September 2015



Indigenous status:

Information about Indigenous status was available for all but one consumer. Of the total of 221, 20.8% (n=46) identified as Aboriginal and/or Torres Strait Islander and 79.2% (n=175) as of other ethnicity. Indigenous consumers tended to be younger on average (32.2 years; range: 10.4 to 64.0 years) than other consumers (38.1 years; range: 11.0 to 75.2 years). The average age difference between male Indigenous and non-Indigenous consumers was around four years. The average age difference between female Indigenous and non-Indigenous consumers was around nine years.

Consumers and episodes of Provision of Service

The QH Acute Care Team staff working as part of the CMHCP team, using the CIMHA system, reported 601 POS for 422 consumers over the six-month period in 2015. Table 8 shows the frequency distribution of POS for 422 consumers. Although the project has a focus

on short term interventions to safely resolve a mental health crisis, half of the consumers had been provided more than one POS.

Table 8: Consumers and episodes of Provisions of Service by the Co-Responder team from 1 April to 30 September 2015 extracted from Consumer Integrated Mental Health Application

Number of POS	Number of consumers	Proportion (%)
1	222	52.6
2	75	17.8
3	38	9.0
4	18	4.3
5	15	3.6
6	9	2.1
7	8	1.9
8	6	1.4
9	6	1.4
10	6	1.4
11	6	1.4
12	4	1.0
13	4	1.0
14	3	0.7
15	1	0.2
16	1	0.2
Total	422	100.0

Characteristics of provisions of service

Total person-time invested in POS by the Co-Responder team over the six-month period in 2015 was 614.1 hours although there were indications in the stakeholder interviews that POS may have been under-reported. The overwhelming majority (81.1%=498.2 hours) involved was in direct contact with the consumer and CMHCP, 47.5% of this total was contact at the consumer's private residence with a further 9.1% contact occurring while the consumer was in transit with the Co-Responder team.

Of the 422 consumers attended to by the CMHCP, 53% had only one POS. However, the remaining 47% had multiple POS. In nineteen of these cases there were more than ten POS. However, a single POS frequently involved multiple interventions. The types of interventions provided to consumers were comprised of those listed below, in descending order of frequency (Table 9). The most common type of interventions provided by the team over the six month period in 2015 were *Service Coordination Interventions*, which included

activities such as: locating a consumer; liaising with family in a non-therapeutic manner to gather information; discussing an intervention plan with a Non-Government Organization (NGO), and: co-ordination of transport or arranging appointments. The next most frequent types of intervention was a range of consumer assessments related to consumer assessment. Time frames associated with each POS were not provided.

Table 9: Types of interventions provided in Provision of Service episodes by the Co-Responder team extracted from Consumer Integrated Mental Health Application

Intervention code and description	Frequency
8011.00 Service coordination interventions	283
1011.00 Triage/initial assessment	78
1021.01 Mental status assessment	48
3051.00 Supportive psychotherapy	41
1021.04 Risk assessment	38
1021.00 Comprehensive mental health assessment	23
1021.03 Triage/emergency assessment	21
5011.01 Drug monitoring	20
3101.00 Family/carer-focussed therapy and interventions	15
8011.02 Liaison with other professionals	10
1021.06 Social and environmental assessment	3
1021.10 Home assessment	3
3011.08 Structured problem solving	3
9011.00 Other intervention not elsewhere classified	3
1021.08 Develop action plan (even if no further services planned)	2
3081.00 Interpersonal psychotherapy	2
8011.05 Other service coordination	2
8011.AA Ad hoc/other review	2
1021.07 Assessment summary and clinical formulation	1
3031.00 Psychoeducation	1
5011.02 Medication management assessment	1
Case Review	1
Total	601

Authority to Return:

Data extracted from CIMHA by QH health staff reported a slight decrease in the number of ATRs but little reduction in the number of individual consumers (Table 10). For the six month periods in 2011 and 2015 the majority of ATRs applied to circumstances where either the consumer was absent from an inpatient facility/AMHS or where an ITO changed from community to inpatient category.

Table 10: Number of Authority to Return issued by Cairns Authorised Mental Health Services for the periods of 1 April to 30 September 2011 and 2015

Count	Years	
	2011	2015
Number of ATRs	173	151
Number of consumers	92	100

Non-Clinical Related Activities

For the period 1 April 2015 through to September 2015, there were 41 occasions of NCRAs related to 14 types of activities, involving approximately 55 hours of QH staff time. A breakdown of NCRAs from CIMHA data reported the most frequent activities were 'Interagency Meeting' (14), 'General Liaison Activity' (8) and 'Cross Sectoral Resource Development' (5). Attendance of Interagency Meetings took up almost 50% of NCRA time. As with the POS, there are indications these may have been under-reported.

The CMHCP team has delivered mental health crisis training and Mental Health Act education in regional centres and rural and remote communities across the Far North Region including Cape York and Torres Strait but the reach and frequency of such training is not captured in CIMHA. There are limited resources to travel outside the Cairns region, however these efforts are enabled by in-kind support from QPS (Figure 11).

Further training by the CMHCP team currently in the planning stages includes:

- Memphis model approach of training and providing ongoing support to interested Police Officers across Divisions in the Cairns region (this has yet to be resourced);
- Training for QH Mental Health staff regarding the appropriate application of components of the Mental Health Act that relate to consumers Absent Without Permission, and;

- Assistance with the training of first responders and QH Mental Health across the Far North region regarding the impending changes to the Queensland Mental Health Act.

Figure 11: Police Air Wing provided to fly CMHCP team to remote locations to provide training for first responders



Photo: S Wallace

Other Queensland Health Co-Responder Project data

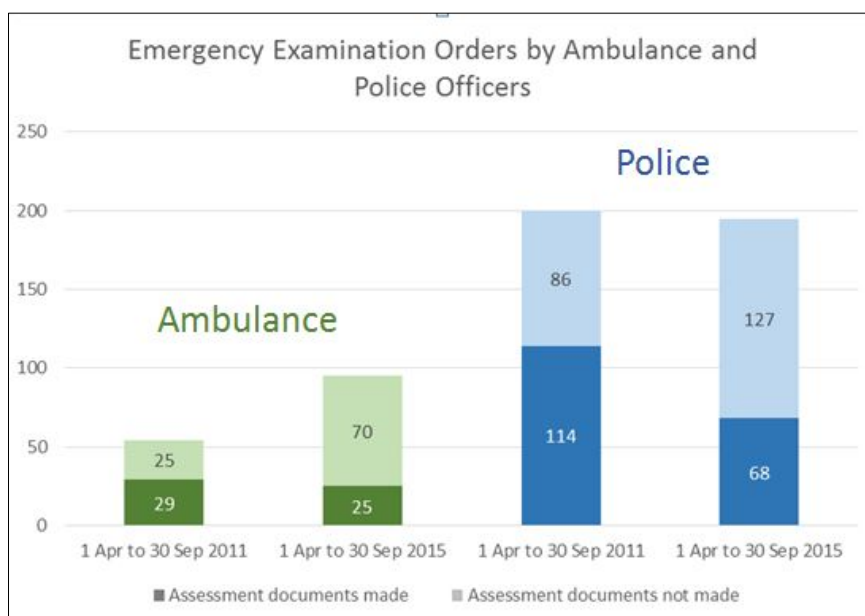
Further data relating to CMHCP activities being captured is taken from a 'journey-board' (spreadsheet) that tracks further details beyond those captured in CIMHA. Details include: whether transport or an EEO by QAS or QPS has been diverted by the team's intervention and whether the consumer has been diverted from hospital, i.e. a community-based intervention by the team has resolved the situation. Diversion from an EEO or the hospital is based on the clinical assessment made by the CMHCP mental health clinician attending. For the six-month period from 1 April to 30 September 2015 there were 290 episodes for 240 de-identified consumers recorded in the journey-board. Where it could be definitively determined, consumers were diverted from hospital on 96 occasions, with transport of the patient by QPS or QAS avoided on 141 occasions. There was no indication from this journey-board as to whether alternative transport had been provided by the

CMHCP team or was not required. Use of an EEO was deemed to have been avoided on 172 occasions.

Queensland Health Enterprise Reporting Service

The Queensland Health Enterprise Reporting Service, or QHERS, is an online application through which Queensland Health employees can access a number of custom made statistical reports. QHERS provides users with the ability to view, print and save reports designed to increase the capability and effectiveness of management reporting. QHERS is used across Queensland Health and can access the information entered into many existing IT systems. This service was used to generate reports for the review related to EEOs. Figure 12 shows the number of EEOs made by QAS has almost doubled whereas QPS EEOs have marginally decreased (this matches the data provided by QAS in Table 7). For both services the proportion of EEOs where assessment documents were not made had increased substantially (QAS by 21%; QPS by 22%).

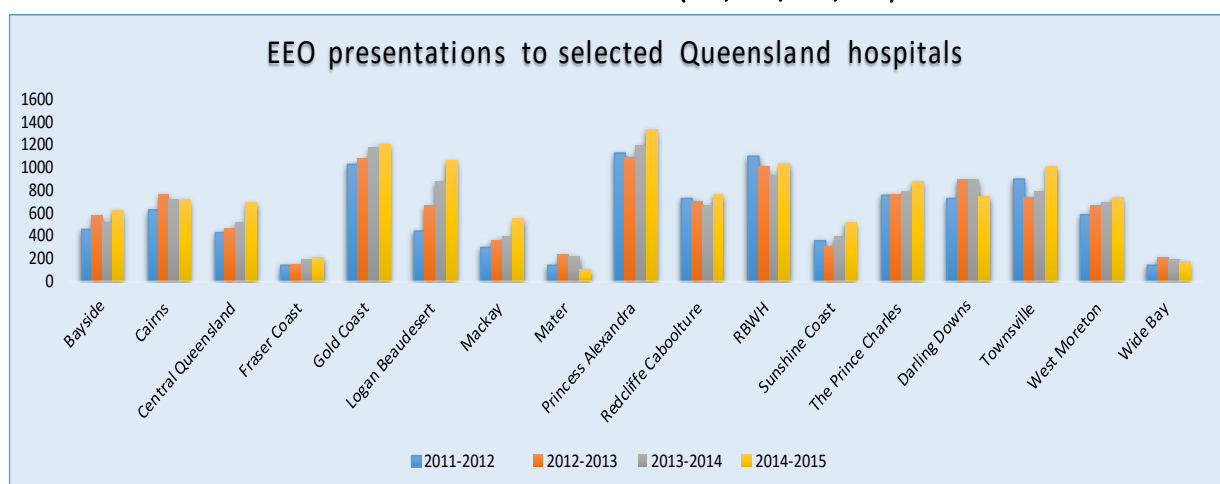
Figure 12: Emergency Examination Orders in Cairns by Queensland Ambulance and Queensland Police Service for the periods 1 April to 30 September 2011 and 2015



This demonstrates that between 2011 and 2015 the proportion of EEOs executed by QAS and QPS together which resulted in assessment documents being made, fell from 56% (143 of 254) to 32% (93 of 290).

A breakdown of annual EEO presentations to hospitals across Queensland generated by police, ambulance and psychiatrists is shown in Figure 13 in order to demonstrate trends across the state. Only a handful of EEOs across the state are reported to be generated by psychiatrists. Figure 13 excludes those hospitals that are AMHS but have indicated no EEO presentations in the reporting period in order to demonstrate statewide trends. The majority of hospitals show an upward trend in EEOs. Those few hospitals reflecting a downward trend include Cairns, Mater (Brisbane), Darling Downs and Wide Bay.

Figure 13: Annual EEO presentations to a range of Queensland Hospitals (AMHSs) between 2011 and 2015 (21, 23, 25, 49)



Implications for cost savings

The initial QA activity report (2011) examined cost savings for QPS through CMHCP involvement in prevention of EEOs and ATRs. This was based on the estimate prepared by police that an ATR takes on average 4.5 hours of police time to complete, from the time the request for an ATR is received by police to finalising the job and completing the associated paperwork. An EEO was estimated on average to take approximately 4.25 hours to complete. These activities involve dispatch of two police officers. We do not have estimates of QAS personnel-hours involved in an EEO. In the six-month reporting period, the team (involving only one police officer) attended to 10 ATRs and 9 EEOs, saving other first responders 42.5

hours and 38.25 hours respectively. At the 2014 hourly cost (plus overheads) of \$63.00 for a Senior Sergeant this indicates a saving of \$5087 in person-hours alone. However, the team also estimated they had diverted use of EEOs on 172 occasions in the reporting period. The diverted EEOs could potentially have involved two general duty police officers committed for around 730 hours. This indicates a potential saving for QPS of \$45,990. A comprehensive cost-effective analysis would require more precise data including total costs across sectors including first responders and health services including the ED.

Stakeholder Interviews

Participants

Participants were recruited by the authors utilising existing networks and acting on advice from Reference Group members. This purposive sampling was coupled with a snowball approach asking each participant at the end of the interview to recommend further participants. Interview participants from both QH and QPS were selected based on their knowledge of the CMHCP in order to capture information regarding the development and implementation of the CMHCP model. A range of hospital and community-based clinicians and operational managers represented QH mental health services. QPS staff included Executive Officers and Senior Non-commissioned Officers across Divisions. QAS staff included senior and executive level staff and one former paramedic. Other participants were selected from a range of social services that were currently engaged with the CMHCP (Table 11). There were 32 interviews undertaken with 39 participants.

The majority of participants were interviewed individually and face-to-face. There were three focus group interviews with 2-8 participants. Ten interviews were undertaken by phone with one of these not recorded at the participant's request. The transcript for this interview was based on the interviewer's handwritten notes. Five participants working outside of the Cairns region were recruited in order to provide perspectives of local management of mental health crisis in other settings, i.e., rural and remote settings and an outer regional town. Four of the interview participants identified as Indigenous. Three interviews were undertaken with mental health support staff placed within Aboriginal & Torres Strait Islander Community Controlled Health Services. Efforts were made to include first responders involved in attending mental health crisis in the community and service providers targeting homeless people, youth and Aboriginal and Torres Strait Islander peoples.

Table 11: Stakeholder groups and services participating in individual interviews and focus groups

Stakeholder Group	Service Type	Identifier Code	Number of Interviews	Number of Participants
Health	QH Mental Health	QH-MH	7	8
	Ambulance	QAS	4	4
Law Enforcement	Police	QPS	10	11
Social Services	Mental Health Support	SS-MHS	5	9
	Mental Health Consumer Advocacy	SS-MHCA	3	3
	Youth Services	SS-YS	1	1
	Homelessness	SS-H	2	6
Total			32	39

Interview themes

The responses provided by interview participants are based on their observations and experiences. Results from interviews were examined by themes imposed by the interview questions (Table 12). Participant comments are presented in italics. They have been selected as those that typify and illustrate emergent sub-themes. A comprehensive selection of participant comments associated with each sub-theme is available in Appendix 1. Selected cases from the interviews are included in boxes as examples of major themes.

Table 12: Major themes and emergent subthemes from stakeholder interviews undertaken for the review of the Cairns Co-Responder project

Themes imposed by questions	Subthemes
Options for crisis mental health responses prior to the CMHCP	Limited options for first responders
	Consumer experiences
Benefits of the CMHCP for consumers	Reduction in use of involuntary assessment procedures
	Improved communication with service providers
	Relationship building with clinicians
	De-escalation
	Reduced stigma
	Reduced use of force
	Support for carers
Benefits of the Cairns Co-Responder project for service providers	Improved inter-agency collaboration
	Saved man hours
	Improved staff safety
	Opportunities for mental health education
	De-escalation
	Reduced EEOs
Essential components of the model	Staff capacity
	Senior/executive level support across participating agencies
	Co-location
	Adequate resources
Challenges to project implementation	Mental health client confidentiality
	Lack of evaluation plan
	Resourcing priorities
	Co-location in a mental health service
Suggestions for project improvement	Extended hours of service
	Designated QPS position
	Better integration with QAS

Options for crisis mental health responses prior to the CMHCP

Prior to the CMHCP, options for police officers responding to incidents where mental health was an issue were limited to transporting the individual to either the watch house or the Emergency Department (ED) of Cairns Hospital. For QAS it was the latter. Two interviews were also undertaken with mental health support service staff working in rural and remote communities to ascertain options for interventions where no authorised mental health inpatient facilities are available. Consumers in rural locations in the Cairns region requiring urgent assessment and treatment and deemed to be at high risk to themselves or others may require transport to an AMHS, involving a round trip for police or paramedics of several hours. For those consumers experiencing a violent psychosis in remote communities “*It would be the jailhouse, the lock-up*”. Such events may involve the total of limited first

responders and key health service providers for many hours, awaiting aero-medical retrieval services from Cairns. In these cases, the consumer is generally unaccompanied by a support person or carer, adding to their trauma.

Benefits of the Cairns Co-Responder project for consumers

Although interviews were undertaken with representatives of consumer advocacy groups, many of the benefits reported in this review are based on perceptions of service providers. Perceived benefits of the CMHCP for consumers included a reduction in use of involuntary assessment procedures, particularly EEOs, due to an assessment out in the community based on the judgement of an experienced mental health clinician: (refer to BOX: *Assessment in the home*). The clinician could be more confident in making a decision that other interventions may be more appropriate.

Assessment in the home

Often times, they feel traumatised I guess by their dealings with the police in the past and the police prior to this probably didn't have all the mental health training that they needed, so they were basically just doing their job. But in regards to people with lived experience who are going through a psychotic crisis it [the CMHCP] has been really, really beneficial for them to have someone who understands what is going on with that. And how they can best deal with you it you know. As far as I am concerned, one of the things I have seen is that it has reduced the amount of people that turn up to the Emergency Department at the Cairns Base Hospital. And it is also a way for them to possibly get a referral to mental health services straight away instead of being incarcerated or whatever it is they get that support straight up...And that community- based setting is hopefully where we want people to go first and foremost because you know, the hospital system, you know, as I say, I've been a frequent visitor in there, I have been in there about 14 times over my lifetime, and to be honest with you, it, I've not always felt it is the best place for me to be. So by having a mental health worker with the police officer she can work on that and you know they can do an assessment pretty much right there on the spot. They are taking it to their home, so they are not extracting people from their homes and then taking them to the watch house or the mental health unit or whatever so I think that has made a big difference as well. SS-MHCA

The mental health clinician was also able to bring to the crisis situation knowledge of the consumer in the context of their mental health history. In a crisis episode the CMHP team members could remain with the consumer for the duration of the episode, from assessment in the community to provision of transport to ED if deemed necessary. Once at ED, they can

relay the relevant information to ED staff, relieving the consumer of the stress of having to communicate to different service providers. Further, the team may have had previous contact with the consumer in crisis and non-crisis situations, providing opportunity to build a relationship of trust. This is also a contributor to the ability for the team to de-escalate situations. Making use of clinical knowledge, combined with experience in managing consumers in crisis and existing relationships, the team can engage in effective communication techniques that can de-escalate the situation and avoid use of force, reducing risk of harm (refer to BOX: *Less use of force*).

Less use of force

There have been numerous deaths where police have used lethal force in response to those incidents and some of those people subject to lethal force were consumers of mental health services and sadly information was not available to responders to indicate that that was the case. So clearly there was an opportunity I think to partner up with not only health practitioners in that mental health space but also Ambulance Services to really look at how we could collectively work with mental health consumers and their key support whether it be family friends or work colleagues and looked at opportunities to prevent them from being involved in high risk situations but also to gain a better understanding from a policing perspective on how to respond to those situations generally.
QPS

The perception of several interview participants, including mental health consumer advocates, was that the attendance of the CMHCP team in an unmarked car, reduced stigma for the consumer. Attendance by the CHMCP team, equipped with prior knowledge and as previously stated, often an established relationship with the consumer, was perceived to be less traumatic. This more positive experience was also thought to contribute to some consumers remaining more engaged with both mental health and police services in the future. A further benefit noted was the provision of support to carers by the CMHCP team in the crisis event (refer to BOX: *Benefits for carers*). Carers including families were also then afforded the opportunity to provide important contextual information and identify effective support strategies for the consumer.

Benefits for carers

Sometimes when we are unwell we tend to turn against our family and then the family doesn't really know what to do in many situations, and at least when the police and the mental health nurse turns up that person, they will talk to the carer as well and include the carer in what is going on. It's actually really beneficial because sometimes when you are put into the mental health unit you might not see your parents for a week or two whatever you might be put in a high dependency unit, you know, you are fully in the lock ward, I think for carers it sort of gives them a sense of relief that what their loved one is going through is very serious. Often times, what happens is for instances they ring what we call the Acute Care Team up here and sometimes they don't get the response that they need and for carers that is absolutely frustrating because they are there to help their loved ones and what I have heard is that when the mental health does turn up they include the carers they include the family they talk to them as well so it's not just about getting that person and dragging them in or whatever, it's about, you know involving the people that are affected by this. Carers need the support to. Often times they don't want to be the ones ringing the police but they might be in a situation where that is what they have to do, and I think, you know, when the mental health worker turns up they kind of breathe a sigh of relief because they know that that person is well trained to deal with these situations and as I say it can take the pressure off them. Plus they can inform the worker who is there about what has been happening, and do it in a way that they are not talking about the person behind their back or anything like that but, it gives the opportunity for the carers to share what is going on with them and basically how they can best support the person they love.

SS-MHCA

Benefits for vulnerable persons

Indigenous consumers were not specifically identified by interview participants. However, interviews were undertaken with staff from two homelessness service providers with client bases that were comprised of 80% and 90% Indigenous peoples respectively. They reported the CMHCP team were able to respond to service requests in a manner suited to this consumer group that provided early interventions on-site to prevent further deterioration of the consumer's mental health. Additionally, working with these services, the CMHP team were able to provide appropriate outreach into specific community settings including town camps and homes in order to assist with consumers otherwise disengaged from mental health and other essential support services (refer to BOXES: *Working with homelessness services* and *Working with homelessness services and Indigenous consumers*).

Working with homelessness services

"When it started, so I think what happened we lost our HOT team, so the Homeless Outreach Team, so that was the Queensland Health Outreach Team that responded...which then left a huge gap in our system because they would actually visit the camps and visit. So for the last 8 years I've worked with primarily rough sleepers and chronic homeless and they [HOT] would actually come in with us to the camps and you know assist us with home visits once we got them into homes, so we lost that which left us with a huge gap, so when the Co-Responder Team came on board we utilised that on many occasions...Look, I, from memory for me it was around, so these people that we work with and the people around this public space issue in Cairns, they are frequent presenters... QPS are

frequently presenting and still are, to assist, or called to a job where it is mental health, probably more so than they are breaking the law, so my understanding of it was, in order to get more of an understanding and less people in the system, then let's try and respond, I guess in a more understanding and meaningful way to these people... and from what I have seen it has absolutely worked because you are not trying to, and obviously it has to be the right person in the Queensland Police that, you know, they have to have an understanding, you know we have police called here all the time and there is a real 'oh it's just them again', same as the hospital, we have got frequent presenters at the hospital you know, we are trying to get another diagnosis or a reassessment because they haven't been assessed for the last 10 years, and they go, 'Oh it's just such and such'. So people like [CMHCP team member] go in and advocate, actually, you know, we all together get information, we will get the last 12 months that we have been living with the person and go actually we don't believe it's behavioural, can we have a reassessment we believe there is something really going on. [CMHCP team member] will actually assist us in advocating for that, so it's that one step further again, so they are not just responding to an area of crisis, then there is that back up service around, ok where are we at with that person, the hospital keep discharging so [CMHCP team member] will advocate to keep that person in there until there is an assessment, even around their meds." SS-HS

Working with homelessness services and Indigenous consumers

...one example is a client that we did have that was actually sleeping in a camp, sleeping rough, you know, we had lots of engagement we were obviously trying to support them into shelters, didn't want to go into shelters so then we were focusing on the long term housing outcome, which is the housing first model that we work by, but um, over every visit you know the mental health got increasingly worse, the client was also getting unwell too, getting skinnier and making less and less sense. It became more and more difficult to have a proper conversation with him. So the case worker came to me because he obviously wasn't quite at that level where you call police out or an Ambulance, and wouldn't go anywhere with him, mental health didn't even want to enter into a conversation around his mental health so we called the Co-Responder Unit, yeah, so [CMHCP team member] and they went straight out that afternoon to the actual camp, which is fantastic, you know, we could never get, I'd argue, the Acute Care Team or even Case Workers it's difficult, we have had some success we go together with them, and around that safety stuff, so I am sure that good thing about having the police and Mental Health together is a relatively safe situation for them to go into almost any situation. So [CMHCP team member] did the assessment, assessed that he was very unwell, he had already been linked in with mental health before so obviously she had some idea of his mental health history and um, yeah he was admitted I guess, forcefully admitted, not by his choice, but [CMHCP team member] had the capacity to do that. Went into the unit, initially we had some conversations with him, he was a little bit cranky with [our service] and that stuff, he understood that we had a bit to do with that, but spent 3 weeks in the unit, got well, got healthy, re-engaged with us. Within 2 weeks I think he did re-enter the camp but for a very short time. We supported him with a few housing applications straight into private rental and he has been there for two years. SS-HS

Benefits of the Cairns Co-Responder Project for service providers

The benefit for services providers mentioned by the most participants was improved inter-agency collaboration, particularly between mental health services and police. This included not only community mental health service and police road crews but a range of specialised units including forensic mental health and Suspected Child Abuse and Neglect (SCAN) teams. The positive collaborations were noted to exist at many levels of the services including senior and executive levels. Major contributors to the improved collaborations were thought to be due to both having a police officer embedded in the mental health service and the regular meetings of the OLC, formed in 2006 as part of the MHIP. Attendees included senior staff and MHICs from Police, Queensland Health Mental Health and senior staff from QAS. The CMHCP is a standing agenda item at these meetings

The two next most frequently mentioned benefits were saved personnel hours and improved staff safety. Where police had noted an increased frequency of calls from a consumer that was out of the ordinary, but not deemed serious, they were able to refer to the CMHCP team to provide assessment in the community leading to an early intervention. Transportation of consumers under an EEO to hospital by the team saved personnel hours for QAS, who may have been held up for lengthy periods ramped at the hospital with a consumer. Police road crews were also released back to attend to other duties in the community. Police were also often able to pass over to the team non-urgent ATRs to attend, dependent on an assessment of level of risk. Involvement of the team also saved personnel hours for both police and ambulance staff providing other alternatives such attending to ATRs (refer to BOX: *Working with police to manage Authority to Return*) or directly taking over service provision at the scene (refer to BOX: *First responder teams freed up for other work*).

Working with police to manage Authority To Return

Alright, so if we determine it to be non-urgent, like this person say they have just missed an appointment, you look at that and go, I'm not going to send a car crew to go and find this fellow he has just missed an appointment it's not urgent, and this is where 80% of our ATRs fall into, only 20% will require an urgent response, but the other 8 out of 10 are deemed to be non-urgent. So what the sergeant there will do then, he will have that ATR he will forward it to the Co-Responder team, [CMHCP team member] will then have a look at it, and she will then filter out, yep we will look after this one, this one this one, this one she will do it in her daily rounds the next day. So they will go around door knock they will check the addresses and they will do all that stuff...they [CMHCP team]

are paired up, they know everything about this person, they are all across it so we are not sending any police resources to that, and that takes a huge workload off our operational staff because 80% of your jobs are going down this line. With the health professional and out, say out of those 80% there is going to be a couple where [CMHCP team member] will go you know what this probably needs a crew to go and find him, and anything left over that [CMHCP team member] can't work with she will send to us, back to Comms with a little email going to follow up, to pursue. What we will do then we will keep the job on our system for the next 5 days, because you are talking about homeless people here you are talking about people that are pretty hard to find... it's not a matter of finding them like that. Yes, and the crews love it because none of us like dealing with mental health jobs, it's not our world of expertise and none of us like being put in that position of trying to de-escalate heated situations with mental health patients... it's a unique skill set that coppers just don't have, they give us all these little bits and pieces but you don't like using them because if you can talk your way out of it that's the way you want to do it. So all of a sudden you have got this, these professionals all across that and know what to do, I know my guys and the guys operation out on the road love [CMHCP team member] and that team because you often hear them on the radio yeah will take that job, we'll take that, off they go you know so it's, they step in. QPS

First responder teams freed up for other work

So then we [CMHCP team] will obviously travel to the job in an unmarked car, that is, we have no extra facilities in that car, we haven't got a screen, we haven't got a siren. It might be a Code 2 [denoting an 'Urgent Matter: Risk of injury to person or property: Proceed with lights AND sirens']. But we can't go Code 2, so we have to just go at normal road speed. Usually when we arrive, say a typical situation is that the police have been given a code as well, so it's gone to 620 [code for the CMHCP Team] and another crew, if there is a high level of risk, is usually there before we get there. So they then determine that the place is safe for us to go into, and then they will possibly give me a brief at the front of the house to say that we have got, for example a 23 year old female who has got a rope around her neck and says she wants to kill herself. After it has been deemed safe I go in and I have face to face with that person, I will assess their mental state. So I do a mental health assessment which includes the triage scale for risk, obviously doing an MSE [Mental State Examination]. During this time I'm assessing whether they are alert, if they are actually psychotic and what sort of level of psychosis etcetera is going on at the time, and from there determine what our next step is going to be. So there again becomes the variable, the situation might require application of the Mental Health Act, and the person taken to hospital. The method of transport depends on the situation. Restraining the person is the worst case scenario. The majority of the time it is the Co-Responders that send that police crew away. We can confidently say, look we have determined that the level of risk is that they are actually not actively going to harm themselves, the crisis was situational. So what we are going to do now is dismiss the police or ambulance, we can deal with it from here. That person might have enough supports around so they don't actually have to go anywhere. They are diverted from hospital and they may be referred to the Acute Care Team here for acute care at home. QH-MH

Essential components of the model

The two most frequently mentioned components deemed essential for the success of the CMHCP were the capacity of the team members and the support provided by senior/executive level staff of the participating services, police and QH in particular. The mental health clinicians were required to have demonstrated confidence and competence in dealing with mental health crises. The police officers acting in the role had an expressed great interest in mental health issues and also brought skills in this area to the position.

The forum of the OLC was noted by several participants as being a major contributor to support of the project. This forum was noted to provide opportunity to identify and resolve operational issues regarding mental health issues in general through the provision of procedural advice and instructions. The resultant increased level of trust between Queensland Health and QPS was vital to the implementation of information sharing processes (covered by the Mental Health MOU of 2007). The Co-Responder Project arose out of discussions by the OLC and this forum also provided progress review and direction for CMHP team. An example of this was ensuring prioritisation of crisis response and problem solving tasks when the team was experiencing high levels of demand including attendance at many inter-agency meetings. Direct supervision of the Mental Health clinician is provided by the Operations Manager for the Adult Mental Health Cluster of the Cairns & Hinterland Mental Health & ATOD Service, Cairns & Hinterland Hospital & Health Service. Direct supervision for the police officer is provided by the Inspector from Operations Support Command who leads the Special Emergency Response Team (Cairns), Specialist Response Group. These supervisors each provide project progress reports to their senior executives. The project is governed by the by the procedural and practice requirements of both QH and QPS. **Operational Liaison Committee**

We [senior staff across QH, QPS and QAS plus MHICS] meet every six weeks [OLC]....we solve problems with regards to, if there is an operational issue police were treated poorly at the ED, Ambulance officers have got a complaint about the way police responded, whatever the case maybe, then what it does it allows us at that senior operational level is to be able to resolve those issues and get the information back to staff involved. And it's been particularly, well from my perspective it's been particularly successful in that regard. QPS

I think you have got to have the buy in of command. The executive has got to be supportive of it to start with. You have got to have a strong OLC [Operational Liaison Committee] to be able to, to govern it, you know and provide that direction and if people, I won't say aren't doing the right thing, but to keep it on track... and a good relationship between the manager of the police officer and the manager of the mental health clinician. QPS

Co-location of the CMHCP team members was also reported frequently as an essential component. This provided an opportunity for the rapid exchange of consumer information between QPS and QH Mental Health, informing appropriate responses in a timely fashion. Each team member accessed their own confidential service data-bases and verbally shared information deemed appropriate (Figure 14). The co-location within the Acute Care Team was also seen as advantageous particularly when there were issues where ACT could contribute to decision-making and resolution. An added stated benefit of the presence of the police officer at this site was the contribution to de-escalation of risky situations with visiting consumers at the service site. Learning opportunities were also provided to the police officer by ready access to other mental health specialists.

**Figure 14: Co-Responder team members
Matt Parry and Senior Constable Angela Evans**

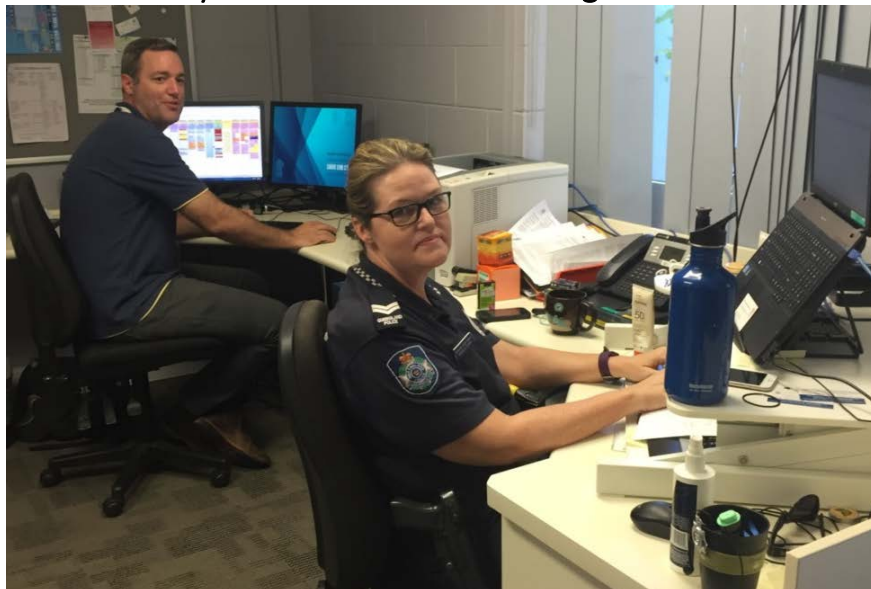


Photo: J Robertson

A further perceived essential component was the provision of dedicated resources to support the activities of the team. This included an unmarked car and other infrastructure such as office space and equipment.

Challenges to project implementation

An initial major challenge to the project identified by interview participants was concern about sharing sensitive consumer information with police. This was identified as being overcome by building relationships of trust with the police component of the CMHCP

team based on observation of their management of situations and resultant improved client outcomes. This trust was enhanced by co-location of the police officer within the broader mental health service.

A further challenge identified was the lack of an evaluation plan for the project. This has included the lack of identification of indicators that accurately capture outcomes of the project.

Competing resource priorities for QH, QPS and QAS was noted to be a challenge particularly in light of a lack of performance indicators to demonstrate the benefit of further investment in the project. Several participants noted QPS had no dedicated funding for the police component of the position which is currently provided through reallocation of existing resources.

Suggestions for project improvement

Almost half of participants who responded to this question recommended the operational hours of the CMHCP be extended. The majority of these suggested two shifts per day would be sufficient, covering from early morning to late evening seven days per week. There was acknowledgement that further QPS staff would need to be trained to fill these extra shifts. A few participants associated the need for extended hours with a recent growth in methamphetamine use and associated mental health crisis.

With the QPS component of the CMHCP team still a gazetted position on loan from another Division, there was mention of this position being made part of a designated unit and at a rank higher than Senior Constable in order to acknowledge the importance of the role and create incentives for the staff member in that position to remain in the role.

Mental health training for first responders

Approximately a quarter of participants providing a response regarding project improvements raised the issue of mental health training for police generally (refer to Box 9). While this issue was not directly related to the review, it reflects on some of the aims of the project that lead to the inception of CHMCP, that is, the state-wide MHIP.

There was a lack of clarity in the interviews regarding the content, reach and frequency of formal mental health training currently being delivered to police officers in the Far North District divisions of Cairns, Smithfield, Gordonvale and Edmonton. Currently mental health training for paramedics is incorporated into their undergraduate studies. Ongoing training for specific issues such as changes to the Mental Health Act is provided through training packages. These packages can present as online modules or delivered face-to-face, dependent on the content.

Mental health training for First Responders

I talked ...about standardising the training so that there is a Queensland set of training for police and those and nurses that supports them in reducing discrimination and increasing understanding of those who have mental health diagnosis... [the training now] It's ad hoc. SS-MHCA

And the absolute necessity is, has shown to be, internationally, as having consumers and carers as being part of that [standardised mental health training for First Responders]. So never just one or the other and never doing the training without them. Because it's actually about respect for these people. SS-MHCA

But I think realistically we are at a stage, mental health is at a stage where it is so prominent in the community and it is so, a regular feature of our work as police that I think all police need to be fully educated. They need to be educated in the various aspects of mental health legislation, what powers we have so they all understand that, but they also need to understand the issues that people suffering mental health have and how to treat them. And I think if that was fully rolled out we would respond better at times as well. QPS

When they started the intervention project [MHIP], which was 2007, police received a full days training which was, which wasn't bad, that was all operational police were meant to receive that. From then, I think apart from the region up here, we still do trainings throughout the year, I don't think any other regions are doing any more trainings so, the training around the state is pretty slack for mental health issues considering how many jobs we attend. But we up here we have continued with the training and we still provide ongoing training to operational police. QPS

I've done a few quals, I've done the New South Wales training course which went over four days, and I think that is the training model that police should really do because it really covers a lot of aspects of a lot illnesses, how to identify them, and a lot of involvement through consumers that gives you an insight in that. So I would like to see a lot more people involvement with people with lived experiences to be able to assist in the training. QPS

Web-based survey of front line service providers

Between September and November 2016, a total of 175 people responded to the survey (2011 survey: n=195). Of those, 10 QPS staff, 4 Mental Health Service staff and 6 QAS surveys were omitted from analysis as they were incomplete. Among the three survey groups in the 155 respondents who completed the survey, there were:

- 69 QPS staff respondents
- 43 Mental Health Service staff respondents
- 43 QAS staff respondents

While it is difficult to precisely determine the response rate, given the number of people who received the survey link from each agency distributing it, the response rate was at least 13% for QPS, 61% for Mental Health Service Staff and 24% for QAS, an average of 33%. Due to technical difficulties the survey link for QPS staff was sent to all staff, when it was intended that only the smaller number of police Officers in the region with direct involvement should be surveyed. This accounts for the apparently-low response rate.

Queensland Police Service Summary of respondents

Over half the QPS respondents (n=47; 68.2%) have been working in the Cairns region for over five years. Fifteen QPS respondents (21.7%) have been working in the Cairns region for between two and five years and seven respondents (10.1%) for less than two years. The rank level of QPS respondents included:

- Constable (17.4%)
- Senior Constable (26%)
- Sergeant (27.5%)
- Senior Sergeant or above (14.5%)
- Administration Officer (8.7%)
- Other (5.8%)

Two in three QPS respondents had completed mental health training (n=53; 67%). The level of training completed was wide-ranging (from one-day training to having completed a relevant undergraduate degree). Some QPS respondents advised it was 5 – 10 years ago they completed mental health training.

Knowledge of the Co-Responder model

The majority of respondents from QPS (n=68; 93%) believed mental health staff and police working together results in better outcomes for mental health consumers.

While the majority of QPS staff also had some understanding of the model (n=62; 89.9%), the extent of their familiarity and knowledge was lower than their Mental Health Service counterparts (described on page 63):

- 30 respondents (43.5%) reported a good understanding of the model
- 22 respondents (31.9%) have some understanding
- 10 respondents (14.5%) have vague understanding

Just seven respondents (10.1%) had no knowledge of the model.

Use of the Co-Responder model

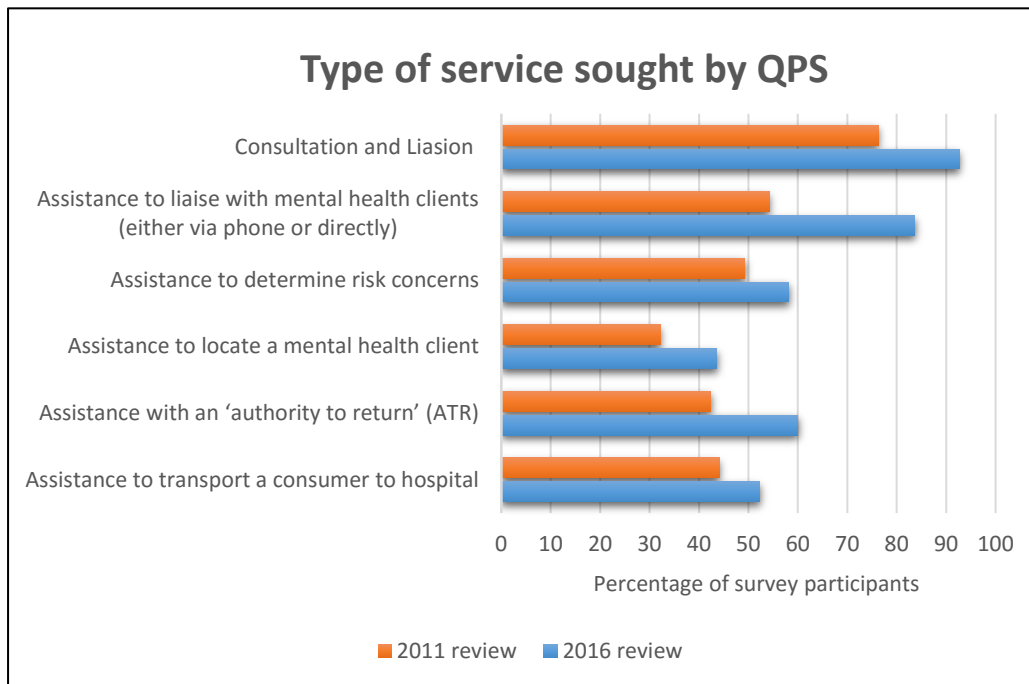
Among the QPS staff, the Co-Responder model team is being used predominantly for:

- Consultation and liaison (n=51; 92.7%),
- Assistance to liaise with mental health clients (either via phone or directly) (n=46; 83.6%)
- Assistance with an 'authority to return' (ATR) (n=33; 60%)
- Assistance to transport a consumer to hospital (n=33; 60%)

Comparing 2011 and 2016 QPS staff responses for type of service sought (see Figure 15), it seems the Co-Responder Model team is being utilised more often for most key services including:

- Consultation and liaison (76.3% v 92.7%)
- Assistance to liaise with mental health clients (either via phone or directly) (54.2% v 83.6%)
- Assistance with an 'Authority To Return' (ATR) (42.4% v 60%)

Figure 15: Comparison between 2011 and 2016 surveys of Queensland Police Service staff responses for type of service sought from the Co-Responder team



Hours saved by using the Co-Responder model

The majority of the QPS staff (n=52; 83.8%) consider the model to also save them time in their day to day work. This is strikingly different to the results in the 2011 report where less than half, 46.3% (n=62) of QPS staff agreed with this question. Compared to their QPS counterparts, the majority of QPS staff consider that they are saving between 1 and 4 hours of work each week.

For QPS staff, the hours saved related to the Co-Responder model assisting with:

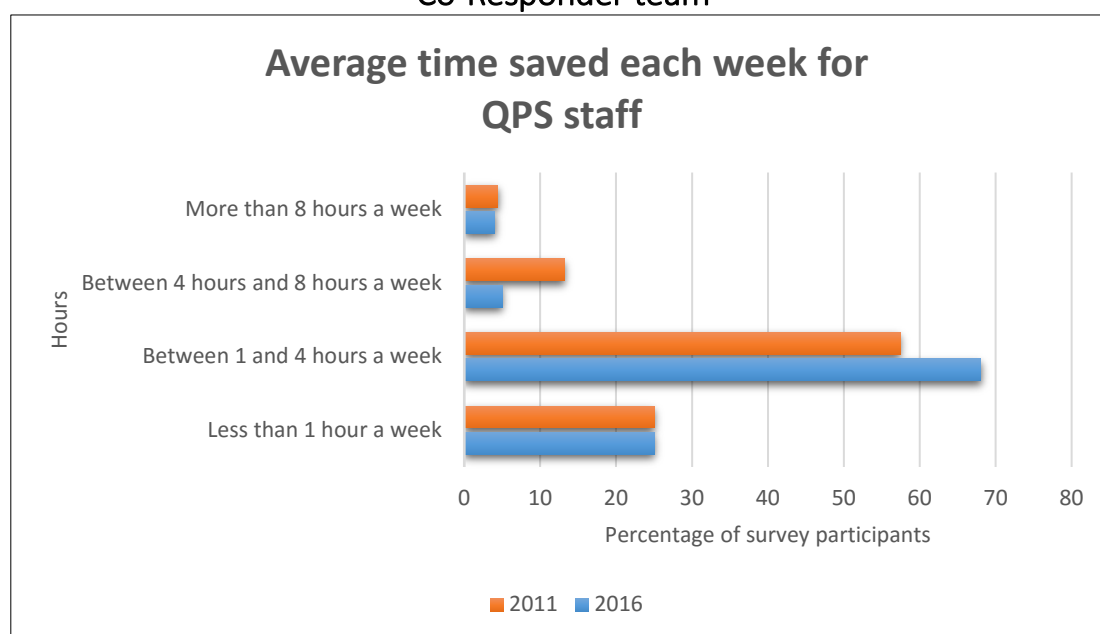
- Calls for service, which divert operational police from attending, as indicated by:
"This model has saved considerable time with QPS staff attending mental health jobs, the Co-Responder model often attends, diffuses and then resolves a large number of mental health jobs without the operational police having to turn up, keeping our operational crews on the road and attending to other more pressing community concerns."
- Scenarios that could escalate with operational police attendance:

“Magnificent response and their skills are invaluable. Very handy. Resolve problems which years ago would have accelerated out into major incidents.”

- More timely completion of assessments:

“Co-Responders familiarisation with regular clients and familiarity with mental health systems allows for more timely execution of EEOs, ATRs etcetera, and more peaceful outcomes; Through early intervention & assistance with EEO process has saved considerable time to operational police officers.”

Figure 16: Comparison of 2011 and 2016 surveys of Queensland Police Service staff responses for average time saved each week by Co-Responder team



Benefits of the model to clients, families and carers

The majority of QPS staff considered (n=58; 93.5%) the Co-Responder model had benefits for clients and/or their families/carers. This level of agreement is substantially higher than for the 2011 period (69.7%). Reported benefits by officers included:

- Expertise of the team leads to appropriate outcome: This can include a more tailored approach for clients and offers alternative outcomes to hospital-related assessments (refer to quote A, Table 13);

- The continuity of staff: Attendance by the same team ensured the response is appropriate and in most cases the team have a long standing relationship with the person in crisis (see quote B);
- Supports opportunities to de-escalate situations (quote C), and;
- Response underpinned as a health approach, rather than a justice or law and order approach (quote D).

Table 13: Selected statements from QPS staff about the benefits of the model to clients, families and carers

Statement	
A	<i>The standard QPS response is to take mental [health] sufferers in on an EEO however the Co responder model offers a more tailored and more efficient approach, without requirement to taking the patient into hospital for assessment.</i>
B	<i>Yes some MH clients do already have some type of rapport with MH Staff, many of these have dislike for police. Using MH Staff to assist helps ease tension with these clients.</i>
C	<i>Having experts means that they are better trained in recognizing and dealing with M.H and de-escalating.</i>
D	<i>A far safer & less invasive model treating clients as patients rather than offenders has great benefits for the client and their families / carers.</i>

Opportunities for improvement

There was strong support from all QPS staff (n=59; 95%) for the model to continue into the future. Notably in 2011, only a quarter (25%) of QPS officers considered that 'maybe' the Co-Responder model should continue.

One in two QPS staff did consider the model could be improved. Among the QPS staff who provided comment (n=26), the main recommendations include:

- The creation of permanent police positions within the Co-Responder model (refer to quotes A-C in Table 14);
- Increase in staffing resources: The primary example was the addition of a second officer (quotes C, D);
- Increase coverage: expansion of coverage hours from Monday to Friday to higher needs times including after business hours and weekends (quote E), and;

- Greater training opportunities: including shadowing opportunities for police officers (i.e. first year Constables), completion rotations through the Co-Responder team, and more formal mental health training (quotes F-H).

Table 14: Selected statements from QPS staff to improve the Co-Responder Model

Statement	
A	<i>Should be a permanent position within QPS with possibly a second officer attached</i>
B	<i>.... the Co-Responder model should be expanded and made a permanent department within the QPS / MHS.</i>
C	<i>The position should be made permanent with the view to having a second police Co-Responder to further relieve the pressure on the already busy general duties crew</i>
D	<i>At present there is only 1 officer performing this role. This causes a gap in the service provided. To function even more effectively, there is requirement for extra officers to be engaged in this role</i>
E	<i>More staff and available across all shifts and weekends.</i>
F	<i>Providing a 24/7 service would be invaluable and more formal MH training for QPS staff</i>
G	<i>Ongoing training, crews assigned to assist [CMHCP team member] even two or three days a week</i>
H	<i>Have FYCs do rotation through the Unit. And/or Supervisors (Duty Sgts).</i>

Mental Health Service Staff

Summary of respondents

The majority (n=38; 88%) of the Mental Health Service Staff have worked in the Cairns region for longer than five years. Key position descriptions included Clinical Nurse, Mental Health Nurse, Social Worker and Psychiatric Registrar. Almost all staff had undertaken mental health training (n=41; 95%).

Knowledge of the Co-Responder model

The majority of respondents from the Mental Health Service (n=42; 98%) believe mental health staff and police working together can result in better outcomes for mental health consumers.

All Mental Health Service staff had some level of understanding (i.e. good, some and vague) of the Co-Responder model, with the majority considering themselves to have a good understanding (n=33; 77%).

Use of the Co-Responder model

The majority of both Mental Health Service staff (n=40; 93%) and the QPS staff (n=55; 88.7%) have utilised the model's services to support their day to day work. Only a small number of QPS and Mental Health Service staff (total=10) reported they had not used the services of the model as the Co-Responder team were busy with another task at the time or the Co-Responder model team was not on shift at the time required.

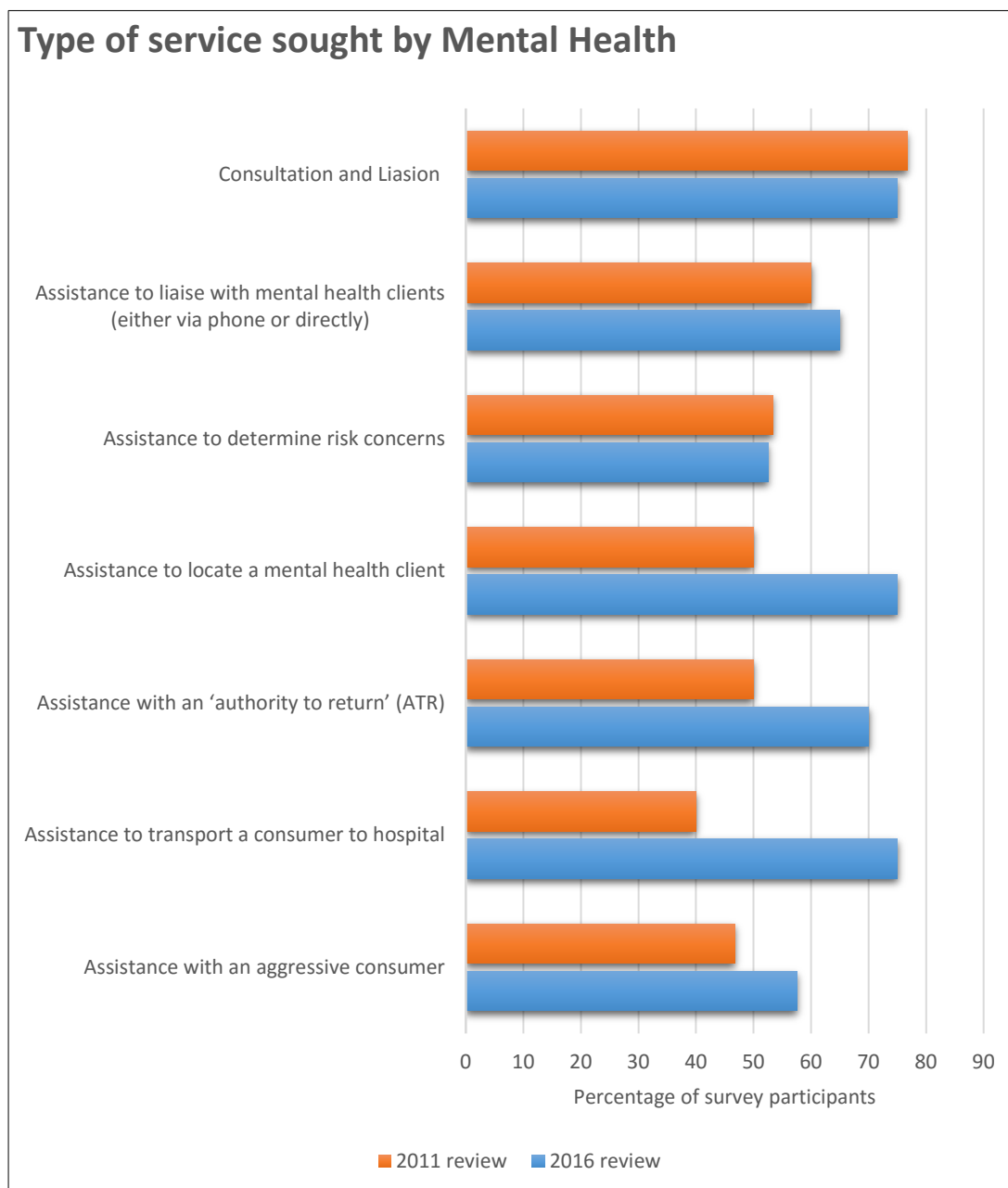
Among the Mental Health Service, the Co-Responder model team is being used predominately for:

- Consultation and liaison (n=30; 75%);
- Assistance to locate a mental health client (n=30; 75%), and;
- Assistance to transport a consumer to hospital (n=30; 75%).

Comparing 2011 and 2016 Mental Health Service responses for type of service sought (Figure 17), the Co-Responder Model team is being utilised by more staff for most services for:

- Assistance to locate a mental health client (50% v 75%);
- Assistance with an ATR (50% v 70%);
- Assistance to transport a consumer to hospital (40% v 75%), and;
- Assistance with an aggressive consumer (46.7% v 57.5%).

Figure 17: Comparison between 2011 and 2016 surveys of Mental Health staff responses for type of service sought from the Co-Responder team



For Mental Health Service staff, the time saved in their day-to-day roles as a result of the Co-Responder model relates to:

- More effective engagement with consumers to complete assessments: *In cases when a client needs to be assessed but is expected to refuse cooperation, the Co-Responders could help with getting the client to the hospital for assessment. This saved me many*

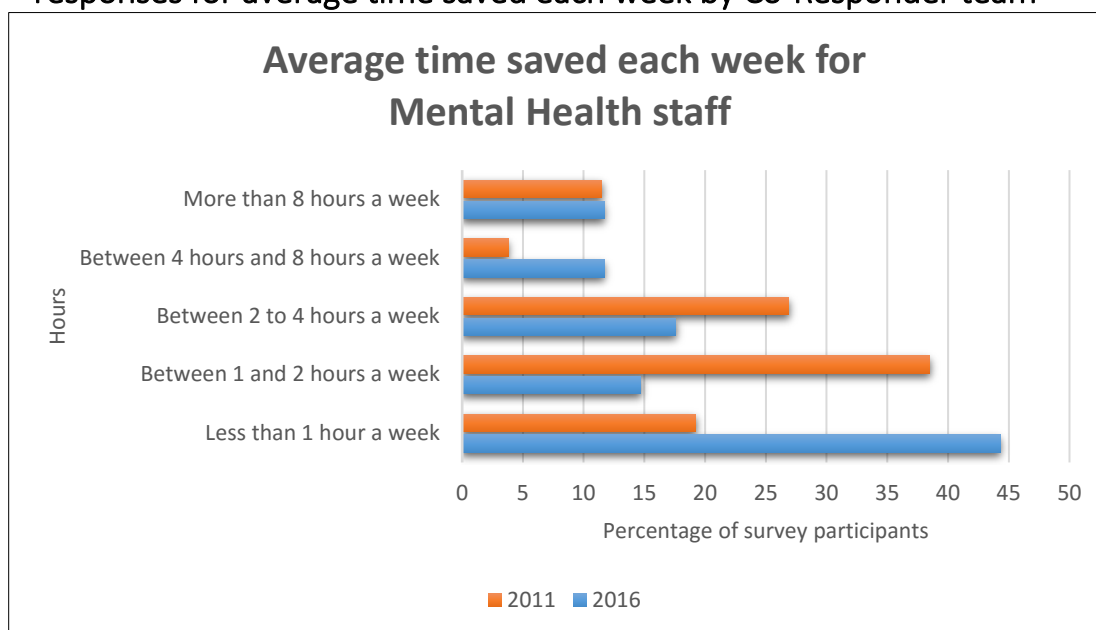
hours of work. The Co-Responders can more effectively engage with clients who feel hostile towards MHS, who refuse treatment but need assessment”;

- Reduction in hospital transfers and admissions: *Minimising unnecessary hospital transfers for assessments and management that can be done in the community;*
- The successful location of mental health consumers by the Co-Responder model team, and;
- Sharing of interagency information to inform effective plans to support mental health consumers.

Personnel hours saved by using the Co-Responder model

Thirty-four (79%) Mental Health Service Staff reported use of the model saved them time in their day to day work each week. As demonstrated by Figure 18, the majority of staff are saving less than one hour each week.

Figure 18: Comparison of 2011 and 2016 surveys of Mental Health staff responses for average time saved each week by Co-Responder team



Benefits of the model to clients, families and carers

There was strong agreeance among Mental Health Service Staff that the model had benefits for their clients and/or their families/carers (n=40; 93%). Clarifying comments described that the Co-Responder model team:

- Hold appropriate Mental Health expertise and are able to assess situations appropriately and de-escalate situations when possible: This results in less consumers being transported to hospital and less admissions to hospital (refer to quotes A, B in Table 15). It also reduces Police and consumer interaction where there is potential for injuries to be sustained (refer to quote C);
- Hold appropriate knowledge of available services: this quality supports more timely treatment for consumers and information for families about treatment options (refer to quotes C, D), and;

Support the improvement of relationships between the consumers and police (quotes E, F). Table 15: Selected statements from Mental Health Service staff about the benefits of the Co-Responder model for clients, families and carers

Statement	
A	<i>They often reduce or avoid the need to transport to Emergency Department, patients seem to settle well when they are not at risks that require hospitalisation, Families appreciate the expertise with which the consumer is reviewed and taken to ED when necessary.</i>
B	<i>With the Co-Responder model we can confidently offer the least restrictive option to people and their families.</i>
C	<i>I think that there are less deadly incidents due to the Co Responder model. Our clients can act erratically, they can wield knives or other weapons due to anxiety and perceived threats. The Co-Responders have a better understanding of the background of their mental state and are able to diffuse otherwise very dangerous situations. Instead of increasing the stress for clients [by shouting, sirens, drawn weapons], they are able to offer reassurance, safety and ensure cooperation from the clients when needed. Co responders are also able to assist clients with matters around safety, [perceived] harassment, bullying or aggression from other people. They take our clients seriously, don't dismiss everything on base of their mental health. They are also very good in advising family members on safety and treatment options.</i>
D	<i>Faster assistance with unwell consumers when available</i>
E	<i>Enables quick and efficient responses to mental health crisis. It also expedites access to treatment and therefore better outcomes in terms of recovery. It can also help de-stigmatise interaction with police.</i>
F	<i>Families appreciate support of Co-Responders and are more appreciative of police services.</i>

Opportunities for improvements

There was strong agreement from Mental Health Service staff (n=40; 93%) for the model to continue into the future. Two in three Mental Health Service staff (n=27; 63%) did consider that the model could be improved.

For those Mental Health Service staff who provided comment (n=23; 53%), recommendations generally relate to:

- The need to extend of hours to be full time coverage (including after business hours and weekends): *“Better staffed and staffed over weekends and after hours.”* It was considered that the model with one team (one police officer and one Mental Health clinician) results in limited availability at times, as demonstrated by quotes A-C in Table 16;
- Greater promotion of the model: This includes to other teams and providing readily available information regarding the availability of the model;
- Training of all acute care staff: This is to ensure that any clinicians can step into the role when required (quote D), and;
- Full assessments of patients transported to the hospital by the Co-Responder model team. It was perceived the Co-Responder model team should be completing full assessments. On occasions the team can be required to attend other crisis calls for service so assessments are not always completed when the patient is transported to the hospital. As illustrated by quote E, one respondent suggests multiple clinicians could be dedicated to one police officer to overcome such circumstances.

Table 16: Selected statements from Mental Health Service staff to improve the Co-Responder Model

Statement	
A	<i>More hours for the police to be on shifts with our team. Ensure fully staffed Co-Responders team.</i>
B	<i>Longer hours availability, more QPS officers available.</i>
C	<i>Often not available, or often only one clinician available.</i>
D	<i>Everyone working on ACT should have the skills, and be able to work with Co-Responders.</i>
E	<i>There is an ongoing issue with pts [patients] being picked up unwell in the community and 'dropped off' in the ED without an assessment because of further emergencies that need to be dealt with. Often that results in a pt [patient] without an assessment waiting in ED for one, or notes being written sometimes several hours later 'back at the office'. I think it would be more useful to have the clinician bringing in the pt [patient] to stay in ED and do/finish the assessment and stay and write in real time the notes.</i>
F	<i>If QPS need to head out to another emergency, they should be able to leave first clinician and head back to act and pick up another clinician and head out.</i>

Queensland Ambulance Service

Summary of respondents

As QAS did not fully access the Co-Responder Service until 2014, a comparison is not included. Two in three QAS respondents have worked in the Cairns region for longer than five years (n=28; 65%). Eight respondents (19%) have worked in the Cairns region for between two and five years and seven respondents for less than two years (16%). The rank of QAS respondents included:

- Advanced Care Paramedic (55.8%)
- Critical Care Paramedic (11.7%)
- Graduate Paramedic (4.6%)
- Officer in Charge (4.6%)
- Other (including Emergency Medical Dispatcher, Clinical Support officer, Operations Centre, ACP LARU) (23.3%)

Two in three QAS respondents have completed mental health training (n=30; 70%). Similar to QPS, the quality of the training varied from 'self-reported 'brief training' to tertiary education standard.

Knowledge of the Co-Responder model

The majority of QAS respondents also had some level of understanding of the model:

- 11 respondents (25.6%) reported a good understanding of the model
- 13 respondents (30.2%) have some understanding
- 14 respondents (32.6%) have vague understanding

Five respondents (11.6%) had no knowledge of the model.

Use of the Co-Responder Model

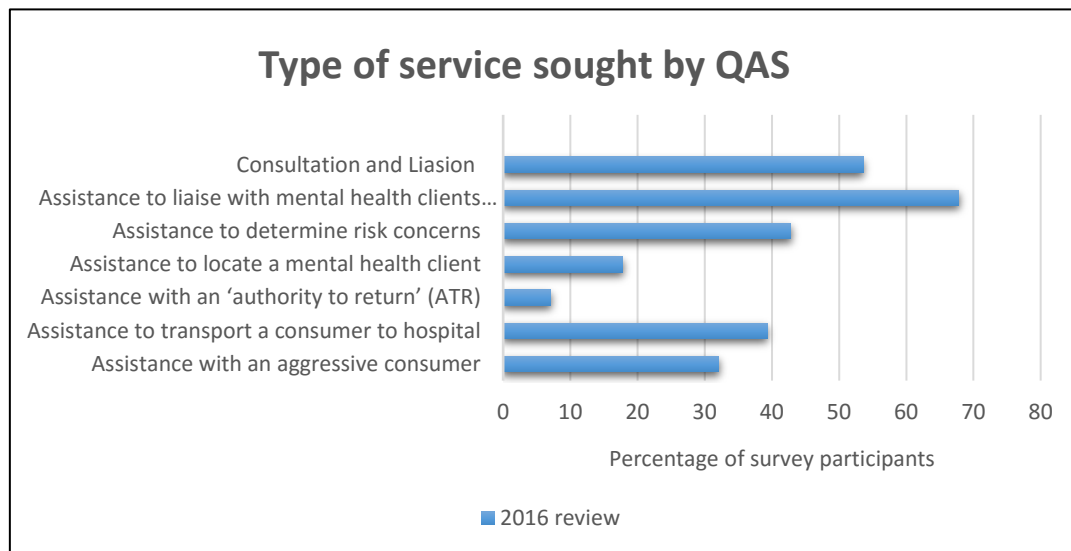
As illustrated in Figure 19, Among the QAS staff, the Co-Responder model team is being used predominantly for:

- Assistance to liaise with mental health clients (either via phone or directly) (n=19; 67.8%)
- Consultation and liaison (n=15; 53.6%),
- Assistance to determine risks (n=12; 42.8%)
- Assistance to transport a consumer to hospital (n=11; 39.3%)

The Co-Responder model team was not used as often for assistance with ATRs or to locate a mental health client.

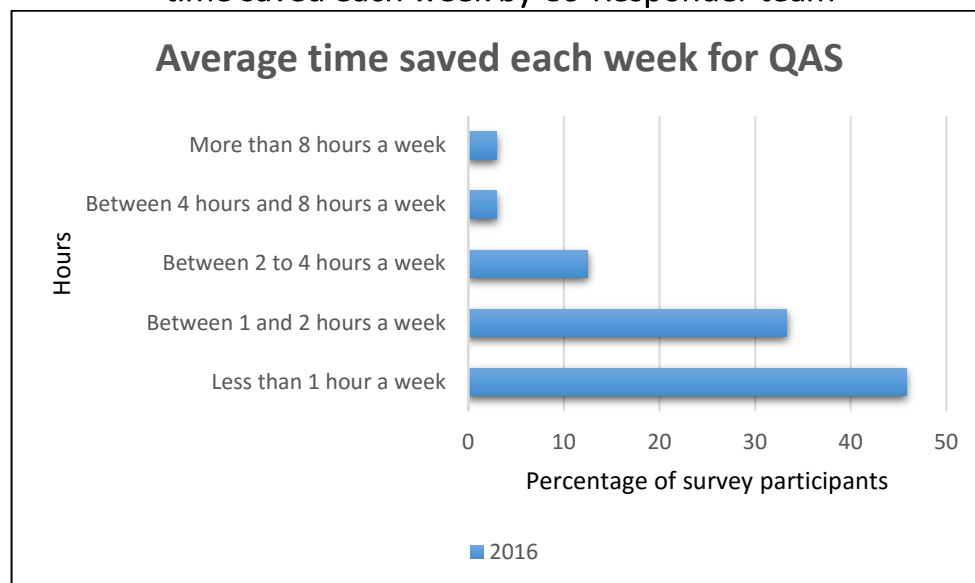
Figure 19: Queensland Ambulance staff responses for type of service sought from the Co-Responder team

Hours saved by using the Co- Responder model



Twenty-four (63%) QAS respondents agreed the Co-Responder team had saved them time in their day to day work (Figure 20). Of those who reported time saved, the majority of respondents saved on average two hours or less a week (n=19; 79.1%).

Figure 20: 2016 surveys of Queensland Ambulance staff responses for average time saved each week by Co-Responder team



Benefits of the model to clients, families and carers

There was strong agreeance among QAS respondents that the model had benefits for their clients and/or their families/carers (n=36; 98%). Clarifying comments described that the Co-Responder model team:

- Improves the experience for consumers through better access to treatment and reduces hospital admission or time spent at the admission phase (refer to quotes A, B in Table 17)
- Provides an appropriate community mental health response (quote C)
- Provides consumers with a continuity of staff (quote D)

Table 17: Selected statements from QAS respondents about the benefits of the Co-Responder model to clients, families and carers

Statement	
A	<i>It by far improves the communication, multi -agency liaison which directly affects the quality of assessment which in turn ensures the best standard and access to treatment improving the flow through the patients' health journey minimising unnecessary delays in ED and the flow through the Health system.</i>
B	<i>It offers more appropriate care from mental health specialists often negating the need for a hospital attendance.</i>
C	<i>It is an added support, especially being able to go out to the communities, instead of being hospital based only</i>
D	<i>Face to face, same ppl [people] instead of multiple para crews – different person every time.</i>

Opportunities for improvements

All QAS respondents (n=38; 100%) agreed the model needs to continue into the future. Four in five QAS staff believed the model could be improved (n=30; 79%). Among the QAS staff who provided comment (n=25), the main recommendations include:

- Extended hours by the model to be operational during high needs times (refer to quotes A-C in Table 18)
- Greater inclusion of QAS within the model, including the a QAS officer incorporated into the model (quotes D-G)
- Growth of the model to include a second team (quotes H, I)

Table 18: Selected statements from QAS staff to improve the Co-Responder Model

Statement	
A	<i>Greater working hours of availability would be of huge benefit, such as weekends and Friday evenings</i>
B	<i>Expand operating hours, perhaps increase numbers during peak times</i>
C	<i>With greater investment and buy in from all partner agencies. A dedicated Ambulance Co-Responder would be the gold standard</i>
D	<i>Fulltime QAS LASN [Local Ambulance Service Network] Mental Health Coordinator</i>
E	<i>Maybe QPS and QAS respond together to the minor superficial injuries so it doesn't tie up valuable QPS and QAS resources</i>
F	<i>QAS officer incorporated into model</i>
G	<i>Often they are busy and unavailable, how many teams are there and should there be another one?</i>
H	<i>More teams, the ability to do phone consults</i>

SECTION FIVE: SUMMARY OF RESULTS and DISCUSSION

Summary of results

The lack of many comparators, in part due to systems changes, has limited the opportunity to fully reflect on changes in the impacts of the CMHCP between 2011 and 2016. However, this report has found generally very favourable views of the CMHCP in terms of its procedures, benefits and outputs.

Notable results:

- A reported decrease by the Project team of use of EEOs and greater use of Request and Recommendations.
- There was an increase in the proportion of EEOs generated by QPS and QAS that have not resulted in assessments being made.
- Interventions by the CMHCP resulted in a large proportion of consumers diverted from hospital, often avoiding the need for transport by police or ambulance. Based on their own estimates of consumer activities, the team determined they had avoided the use of EEOs through the application of other assessment and intervention options.
- Perceived benefits identified by key stakeholders for consumers, included: a reduction in the use of Involuntary Assessment processes due to more accurate assessment in the community rather than the hospital setting; improved communication between consumers and attending services, including members of the CMHCP being able to advocate with other services on the consumer's behalf in time of crisis; less stigma and trauma associated with the resolution of events and reduced need for the use of force by police through de-escalation of the crisis by CMHCP involvement. Continuity of CMHCP staff was also identified as contributing to better relationships and communication with consumers.
- Benefits identified by key stakeholders for service providers included: greater inter-agency collaboration with more streamlined information sharing between agencies; saved man hours for QPS and QAS; improved staff safety for both the CMHCP team and staff from other services along with provision of further access to mental health training for first responders.

- Essential components of the CMHCP identified by key stakeholders included: staff capacity and qualities including the appointment of staff highly motivated to work in the area of mental health with strong clinical skills and demonstrated experience of working effectively in crisis situations; senior and executive level support and governance across the participating agencies and the co-location of the QPS officer and Mental Health clinician at the mental health service.
- Although not directly related to the CMHCP, many stakeholders recommended mental health training be routinely available and undertaken by QPS police officers. A further recommendation was the inclusion in this training of appropriate consumers with lived experience of mental illness in order to increase awareness and reduce stigma.
- Survey respondents from both QPS and QH recommended more opportunities for other staff to participate directly in Co-Responder model or to complete staff rotations through the model. Improvements in resource allocations suggested the resourcing of a second police officer position and the core Co-Responder officer position made permanent in light of the role's contribution to the community and QPS. It was viewed that an additional Co-Responder model team would increase the reach of the CMHCP through extended hours of operation in order to include after business hours and weekends, thereby covering all peak hours of crisis events.
- Survey results indicated an improved awareness and increased use of the model by QH Mental Health and QPS staff when compared to the 2011 Quality Audit. QAS has become more actively involved in response referrals to the CMHP through improved communication strategies implemented in 2014.
- There are indications of a change in the model's role, with more consumer contact services being requested by QPS and Mental Health Service Staff in particular. The biggest increases were the provision of assistance to complete ATRs and to locate a Mental Health client for a range of reasons.

Discussion

The aims of the review agreed upon were to inform: best practice by Co-Responders to situations of mental health crisis in the community; efforts to better resource the model and a formal evaluation design. Essential elements underpinning the design and

implementation of these specialised response programs have been identified in international literature. The development and implementation of the CMHCP are discussed in light of these identified elements:

Collaborative planning and implementation: The CMHCP arose out of an existing collaboration between police and health services including mental health and ambulance which had an initial focus on consultation and liaison. The ongoing collaboration has provided a sustained and energetic inter-agency forum, the OLC, which agreed to trial a model of joint response in the community. Regular attendees of the OLC meetings include CMHCP team and the senior members of QPS and QH who directly supervise them. Although the OLC is not a dedicated planning committee for the project, it is a forum where operational issues are addressed and the Co-Responder model is a running item on the meeting agenda. This forum is ideally placed to refine project strategies.

Program Design: Essential elements of this component include a specialised team to address challenges to the improvement of responses to people in mental health crisis. The OLC as described above performs this function as they address operational issues.

Specialised training: The AMHP team member is a Registered General Nurse with post-graduate qualifications in psychiatric nursing. To date the QPS duty officer has received formalized training in suicide prevention. Location of the CMHCP within a mental health service has provided opportunity for ongoing mental health training through access to regular in-service training available for members of the ACT. Additionally, the daily contact afforded by the project between a police officer and AMHPs has contributed to a reciprocal mentoring process. Nevertheless, despite the professional experience and motivation of the core QPS team member, this position would benefit from further accredited mental health training.

Call-taker and dispatch protocols: The project has utilized existing call-taker and dispatch procedures and protocols of QPS and QAS with little further impost on these systems. During the life of the project, the Cairns QPS Communications Room has further developed protocols and procedures around the implementation of ATRs that more effectively manage such requests and risk assessment, inform appropriate responses and manage their documentation. These formal 'Instructions' also reinforce the standing local directive that the

QPS duty officer attached to the CMHCP is to receive notification of all mental health jobs. The CMHCP QPS police officer also makes daily contact with the Communication Room to advise of her availability. QAS currently contact the CMHCP team on an as-needed basis.

Observation, assessment and appropriate response: The interventions undertaken by the Co-Responders are informed by prior access to consumer information relating to risk. Once team safety has been established the combined skills of the CMHCP team are used where necessary to de-escalate the situation and determine appropriate resolution. The combined presence of a police officer and an AMHP with mental health assessment skills provides a much wider range of options than for first responders alone, including resolution of the situation in the community.

Transportation and custodial transfer: Appropriate and timely transportation of consumers is facilitated by the existing agencies' general policies and procedures. One of the leading benefits reported of the Co-Responder team was their ability to conduct mental health assessments and transport consumers when required, enabling operational patrol and ambulance officers to return to other responsibilities and duties.

Information exchange and confidentiality: The exchange of confidential consumer information relating to risk factors has been facilitated by an MOU at the state level between participating services. The individual QH and QPS data-bases are directly accessed by the respective staff members and information is verbally shared in order to inform appropriate responses. Early reservations at the operational level about sharing this information has to a large degree been overcome by the co-location of project staff and resultant building of more trustful relationships, bolstered by evidence of improved consumer outcomes.

Treatment, supports and services: Through strong community networking practices the Co-Responder team is able to connect consumers to effective and appropriate community-based treatment and support services to address a range of issues, including homelessness, chronic illness and/or substance misuse. Early intervention can occur when the effective communication systems of QPS and other Government and NGO agencies alert the team of signs of possible mental health deterioration. Further there are indicators the model of practice implemented by the CMHCP is suitable for Aboriginal and Torres Strait Islander consumers.

Organisational support: There has been a long-standing commitment to the project by at the executive staff of QH and QPS who are kept notified of project implementation by their respective members attending the OLC. The latter also provide direct supervision to the project team members. This commitment is demonstrated by approvals for the continued re-allocation of existing resources to the project. Since 2014 there has been a strengthened commitment by QAS to more effectively support and utilize the project.

Program evaluation and sustainability: A shortfall of the project has been the lack of an evaluation strategy at the outset. An early quality audit activity, completed in 2011 reported the valuable and significant benefits of this team for QPS and QH Mental Health Service Staff. At present, activities and duties completed by the Co-Responder team are logged using existing agency databases. Current systems data do not fully reflect the preventive and crisis-related activities of the team. Capture of this information would also inform quality improvement processes. While the project has been sustained through the re-allocation of existing resources by QAS and QPS, there is a need to secure funding for dedicated positions, including those to provide leave cover.

SECTION SIX: CONCLUSIONS and RECOMMENDATIONS

The CMHCP aims to resolve mental health crises in the community with greater safety and improved outcomes for service providers, consumers, carers, their families and the community in an outer regional setting. This review indicates not only that these aims have been achieved but that there have been additional benefits to both consumers and service providers. The authors note that this model has proven to be successful within the specific context of an outer regional city with a high proportion of homeless people, including transient Indigenous peoples from remote communities.

This review has clarified the need for a comprehensive evaluation. This should include an exploration of immediate experiences of, and longer term outcomes for, consumers and carers, built on appropriate ethics approvals. There is also a need to identify gaps in data collection including both shared and service-specific indicators in order to more accurately capture outputs, impacts and benefits of the project. Further, despite strong commitment and support from participating services through governance and re-allocation of existing resources, there is currently no strategy in place for project sustainability.

Recommendations

1. An adequately resourced and comprehensive evaluation be undertaken in order to assess project outputs and impacts including a cost-effectiveness analysis;
2. There is a need to directly explore the experiences of the model with consumers and carers in order to determine their experiences, outcomes and recommendations for improvement;
3. Existing data systems should be comprehensively evaluated to identify crucial gaps in data collection including both shared and service-specific indicators. This will entail a collaborative effort between participating services in order to accurately reflect all aspects of Cairns Mental Health Co-Responder Project activity. This should include non-clinical related activities such as attendance of inter-agency meetings and provision of mental health training to other service providers including first responders, and;
4. Consideration be given to ensuring sustainability of the project through resourcing a core QPS position at a designated rank which recognizes the associated high level of

risk and responsibility. This position could be further enhanced by access to accredited mental health training

5. A pool of specially trained QPS staff be available to provide leave cover. Contingent upon resources, further QPS staff could be available to extend the hours of project operation to cover peak times of service need.
6. While acknowledging mental health training for first responders is not core business of the CMHCP, there were strong calls from stakeholders for systematic and ongoing workforce development for first responders regarding mental health issues including crisis management. Recognised best practice in this type of training has been the participation of members of the consumer advocacy community, including individuals with lived experience of being mentally unwell and groups of carers.
7. Further, the proportion of EEOs being generated by QPS and QAS that do not result in assessment documents being made indicate that many of these may not have been required. This indicates a need for additional training for first-responders in the use of EEOs.

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Appendix 1

Interview themes

Results from interviews are arranged by major themes imposed by the interview questions (described in the table heading). Emergent sub-themes, in the right column, are accompanied by participants' comments taken from the interviews, selected as those that typify and illustrate each emergent sub-theme.

Options for first responders dealing with mental health crises prior to the Cairns Co-Responder project

SUBTHEME	Selected Participants' Comments
LIMITED OPTIONS FOR FIRST RESPONDERS	<i>What the police have said to us is 'they've got two options when someone is unwell, watch house or ED at the hospital'... we don't people to have unnecessary criminal records. We don't want people to be locked up in hospital unnecessarily because the hospital's overwhelmed as it is. SS-MHS</i> <i>So, before [the CMHCP] the only option really was for police and ambulance to do an EEO on someone if they had doubts, if they had any concern that there was a mental health problem, or there was a risk, or they were intoxicated, or they were, you know there are all these variables that, they are not the experts obviously so they can't determine necessarily that level of risk, they don't know what to do with that person... there are no other real options for police and ambulance in order to cover themselves. QH-MH</i> <i>There was one pathway [for QS], the golden door straight to Cairns base. QAS</i>
CONSUMER EXPERIENCES	<i>Where they've had the door knocked down and then they've had a pat down done, you know like their being arrested when they've rung for help because they're feeling like 'I want to take my own life'. So that relationship has got to improve by having conversations rather than pat-downs in the kitchen for a weapon. SS-MHSS</i> <i>The person was incredibly traumatised, incredibly traumatised having to go to Cairns [from a regional town] with the police vehicle. SS-MHSS</i> <i>Also we were seeing by the statistics that more often, fairly often, the people that the police were bringing in, we would do an assessment and found that they did not meet the Mental Health Act and they would be released so that trauma caused to the person being bought in by the police or ambulance and then shortly being released after assessment in the ED, the police are often questioning why was it that they were back on the street before we even get back to the station. QH-MH</i>

Benefits of the Cairns Co-Responder Project for consumers

SUBTHEME	Selected Participants' Comments
REDUCED USE OF INVOLUNTARY ASSESSMENT PROCEDURES	<i>Also, it also saved, a lot of people being taken under the Act to the hospital because, obviously having someone with more knowledge of mental health issues could really decide if they needed to go to the hospital or not. QPS</i> <i>So the police officer and the mental health nurse they already know everything about you... know whether to fill in EEOs on you or not... I think in that point the Co-</i>

	<i>Responder Model would definitely reduce the amount of EEOs that go into hospital for that reason. Because they know the patients and they know a bit more about them. QAS</i> <i>A lot more people would have been taken to the Emergency Department on an EEO, an examination order and I think the Co-Responders will probably show you data that the number of actual Emergency Examination Orders have shifted since they have been involved so less unnecessary EEOs and that is not just their direct intervention I think it is a lot of the education they do with the police. But also they get to see a lot more people before they are in hospital, to triage whether or not they should really be under the Mental Health Act. QH-MH</i>
IMPROVED COMMUNICATION	<i>One of the big issue clients have is repeating their story over and over to people, so if they get an assessment on scene on site that's far better than talking to police who are there in their isolation, getting dropped to hospital repeating the story, it's much easier if that one team does it there and if it can be sorted there and then that is fine. QH-MH.</i> <i>...in the past I have heard that quite often there was a problem when clients were in trouble with the law, where the police was called, or the Ambulance, their needs weren't met, and they weren't understood what's going on. And for instance if someone has got an active psychosis and they are just behaving a bit erratically the police will automatically criminalise them and will not understand the issues behind it, so the reason for bringing in the Co-Responder Model is that there is a qualified mental health person on board who can help liaise and negotiate between the police, the Ambulance and the person. SS-MHSS</i>
RELATIONSHIP BUILDING WITH CLINICIANS	<i>I think there is a lot of trust that goes on there... a lot of mental health people are, striking different people all of the time and it is very hard to sort of strike a relationship or trust with that, whereas the Co-Responder Model it's, it's almost the same people each time, so they get to know the Co-Responder's by name a bit of sort of trust that sort of thing... QAS</i>
DE-ESCALATION	<i>... we can deescalate people and bring them in, explain the process and do that with people in a really calm and experienced way so that we don't actually elevate the situation, you know people don't end up being handcuffed and restrained because we can do it in another approach. QH-MH</i> <i>The biggest benefit is it keeps young people out of Watch Houses and out escalating when they don't need to and diffuses things in ways SS-YS</i> <i>If a client go through a crisis be it anxiety or part of psychosis or schizophrenia, they quite often can't respond, they can't think, they are in the moment, and then the Co-Responder person can explain to the police or to the Ambulance what is going on and why the person is behaving in that way and they can diffuse the situation as well. Because quite often when the ambulance and the police are overwhelmed they then go in crisis mode as well. And then everything goes. SS-MHSS</i>
REDUCED USE OF FORCE	<i>There was a reduction in assaults on both police and on consumers, I suppose because we attended with a more professional approach having a clinician with us who I suppose was a lot better in talking patient downs in crisis, so we found there was a reduction in assaults on police and also the consumers who were charged with either assaulting police or who were injured while being taken into custody. QPS</i> <i>There have been numerous deaths where police have used lethal force in response to those incidents and some of those people subject to lethal force were consumers of mental health services and sadly information was not available to responders to</i>

	<i>indicate that that was the case. So clearly there was an opportunity I think to partner up with not only health practitioners in that mental health space but also Ambulance Services to really look at how we could collectively work with mental health consumers and their key support whether it be family friends or work colleagues and looked at opportunities to prevent them from being involved in high risk situations but also to gain a better understanding from a policing perspective on how to respond to those situations generally. QPS</i>
REDUCED STIGMA	<i>I think one of the big advantages is for a mental health case manager and police comes with an unmarked car. Police comes with police cars. It's not good when the neighbours see and everyone knows. QH-MH</i>
LESS TRAUMATIC	<i>...she knew she was protected, she was taken in calmly, she was taken straight through to the psych ward, not the ward the ED part and I think if it had been otherwise she would have been more traumatised and probably could be less accepting of services in the future, or not cooperative. QH-MH</i> <i>...maybe it's less daunting to deal with, not deal with police... dealing with coppers that have all of their kit on, you know the vest, the camera, I mean we don't think about it because that is what we see every day, it is a little bit military... QPS</i>

Benefits of the Cairns Co-Responder Project for service providers

SUBTHEME	Selected Participants' Comments
IMPROVED INTER-AGENCY COLLABORATION	<i>I think it has opened a lot of dialogue between Mental Health and police and a better understanding in general of people with a mental health illness. QH-MH</i> <i>(CMCHCP Team) have built up partnerships, not just for themselves they have built up partnerships for lots of other areas... I now connect really well with Forensic Mental Health and I've also got partnerships with child and youth mental health as a result. They have created all of those partnerships which have blossomed in so many different areas as a result and it's just a spiralling effect outwards. QPS</i> <i>...what happens now you have got people working together, so the level of trust, understanding, confidentiality, both parties understand that well and truly. So I look at it, it's like a portal into each agency. So you have got this direct pathway now into all this information knowledge and experience that the police have, and the same way for the police back into Queensland Health through the Co-Responder, we are tapping into the senior executive all the way down to the nurses on the floor all because we have got a person embedded in their organisation who they trust they can communicate with. Yeah the information sharing is amazing now compared to what it used to be. QPS</i>
SAVED MAN HOURS	<i>That's the big thing is their massively diverting man hours from Queensland Ambulance Service and they have had a significant impact on diverting man hours from QPS in that we are not tied up writing EEOs that are not the gold standard. They are on the scene gaining accurate and timely information about the patient and they give them the best avenue for treatment, it's not straight to ED and straight for an EEO, its community nursing in the community appropriate health in a timely manner and that is the real benefit of them. They are experts in mental health, we are experts in taking people from point A to point B, they are the people we need there. QAS</i>

	so if we determine it [ATR] to be non-urgent, like this person say they have just missed an appointment, you look at that and go, I'm not going to send a car crew to go and find this fellow he has just missed an appointment it's not urgent, and this is where 80% of our ATRs fall into, only 20% will require an urgent response, but the other 8 out of 10 are deemed to be non-urgent. So what the sergeant there will do then, he will have that ATR he will forward it to the Co-Responder team, [CMHCP team member] will then have a look at it, and she will then filter out, yep we will look after this one, this one this one, this one she will do it in her daily rounds the next day. So they will go around door knock they will check the addresses and they will do all that stuff. QPS It just provided a more professional response to the consumers, having that, having a mental health clinician there with you who could do an onsite assessment. It saved a lot of time at the hospital because the assessment would already be done at the scene so we didn't have to wait with the patient while they were assessed, it was just a more streamlined process. Also, it also saved, saved a lot of people being taken under the Act to the hospital because, obviously having someone with more knowledge of mental health issues could really decide if they needed to go to the hospital or not. QPS
IMPROVED STAFF SAFETY	[CMHCP team] have had some situations that are rather nasty you and know and fraught with danger really but they are able to assess the situation, maybe step back, call for back up and then go in again...it really has made things like that quite, smoother, less fraught with danger, because some of our clinicians in the past have been knocked out and been attacked and that has been very traumatic for them and it effects their work forever really. QH-MH I have been to hundreds if not thousands of mental health jobs over the years, the impact of having a police officer there in a uniform can never been underestimated, that is a very, very powerful statement to make and I think we need to make sure that that continues to happen. Because if you just send two people in civilian uniform, even though one of them might be a police officer, people need to see, they need to see the badge, they need to see, you know the uniform carries respect... the key success of the Co-Responder has been in that you have a uniform police officer and then you have a specialist mental health worker which gives you the perfect balance because you have got the security if you need it... QAS
OPPORTUNITIES FOR MENTAL HEALTH EDUCATION	When people are aggressive to them they get violent. She was manic, she wasn't violent. And so understanding the difference, educating the police around that difference is a like what's going to make the difference with the Co-Responder model. SS-MHS ... having LARU [Low Acuity Response Unit] work closely with the ACT team as much as possible, or having that Co-Responder with the ACT we are going to get that better understanding of what's safe mental health, what's unsafe mental health. What's better to be in the community, what needs to be out of the community and how do we deal with it. QAS Yeah so we asked about their role and one thing I didn't talk about was that I am aware that they do a lot of mental health first aid and a lot of training with the police force themselves, which I am imaging if you spoke to the police some of the officers find really quite useful in dispelling myths about mental illness...QH-MH How we manage it is we actually do the training while we are on the job. So while we are there we are educating police and ambulance as to why we are making the

DE-ESCALATION	decision we are making, why we are going to leave them at home and all of that sort of stuff. QH-MH Yes that's right, because the standard response for our guys is the minute they get there, oh well we will take an EEO out and they grab old mate and they take him away. You get to circumnavigate that because you know [CMHCP team members], oh no he's alright we will just book him in for another referral tomorrow so you are not clogging up with the mental health system with cases and of course the best benefit of all we are reducing our sieges and use of force on these mental health issues. QPS ...we were on the up and up and up of the, our siege rate and it was just going through the roof, that's when [QPS Inspector] went right back to the start and started this Co-Responder project and it reduced our sieges and our major incidences. They just plummeted. QPS On the couple of larger occasions where we have used I feel that it is very effective. I think it is spot on in that middle place between full blown acute crisis where you would potentially ring an ambulance or the police and that level of someone walking in and asking for support themselves in the hospital. I think it bridges that gap nicely. SS-HS So we have people being psychotic here or sometimes not here, like when we have gone out to see them or whatever, and then they will come along and negotiate that out. I'm trying to think of a couple of examples, they see our clients, like there are 3 or 4 of them that they see all the time. Sometimes its not psychotic sometimes its just behavioural stuff, suicidality stuff we send the Co-Responders. If someone is losing the plot in here and it's not associated with, like they need those sorts of supports we have called them before, they have come over. They de-fused in our back yard once. SS-HS
REDUCED EEOs	Look if it's a credible EEO you can be upwards of 45 to-50 minutes per document. And I think the big, the big truth is we don't get the kind of quality those documents really require out of ambos on a regular basis, because, we are not experienced in mental health, we are not experienced in writing them on any great scale, so we will spend 45 minutes authoring a document that doesn't quite meet the gold standard of what the doctor is after to make an assessment. Whereas when we activate the ACT team they will quite often use the R&R which is based off a very thorough assessment which means the patient gets the appropriate treatment and the appropriate flow on from that. QAS A lot more people would have been taken to the Emergency Department on an EEO, an examination order and I think the Co-Responders will probably show you data that the number of actual Emergency Examination Orders have shifted since they have been involved so less unnecessary EEOs and that is not just their direct intervention I think it is a lot of the education they do with the police. QH-MH The Co-Responder model seems to have had an effect on EEOs, there's been quite a reduction in the number of them. QH-MH

Essential components of the Cairns Co-Responder Project

SUBTHEME	Selected Participants' Comments
STAFF CAPACITY	<i>I think people who have a genuine interest the subject, a genuine baseline of experience, it's pointless walking in brand new to it and thinking you know, you know about mental health, you have got to be interested in it and you have got to want to effect change in your community...QAS</i> <i>So with the Queensland Police Service it definitely has to be the right person, they, I guess they have to have a passion to work with this cohort. SS-HS</i> <i>Well I think it works so well because we had a couple of things, we had the two right people, [CMHCP team members] were both excellent and had the right skills and passion to make this work and devoted a lot of extra time in to support people and were allowed to do that. The other thing that worked well in Cairns was having those two people work consistently as a team, whereas the PACER model in Victoria we had, it wasn't always the same two clinicians or mental health and police working together, they would be on different shifts so you would have different police officers come and do a shift with perhaps a different mental health clinician, whoever is on that shift, and that is one thing I found didn't work as well. QH-MH</i> <i>I think that is one of the crucial components, you have to have an understanding, a clear understanding of diagnosis around mental health, a clear understanding of the Aboriginal and Torres Strait Islander cohort that we are working with. SS-HS</i>
INTER- AGENCY SENIOR/EXECUTIVE LEVEL SUPPORT	<i>I think you have got to have the buy in of command. The executive has got to be supportive of it to start with. You have got to have a strong OLC [Operational Liaison Committee] to be able to, to govern it, you know and provide that direction and if people, I won't say aren't doing the right thing, but to keep it on track... and a good relationship between the manager of the police officer and the manager of the mental health clinician. QPS</i> <i>We [senior staff across QH, QPS and QAS plus MHICS] meet every six weeks [OLC]....we solve problems with regards to, if there is an operational issue police were treated poorly at the ED, Ambulance officers have got a complaint about the way police responded, whatever the case maybe, then what it does it allows us at that senior operational level is to be able to resolve those issues and get the information back to staff involved. And it's been particularly, well from my perspective it's been particularly successful in that regard. QPS</i> <i>I think the biggest thing is you really need to have that good working partnership with Queensland, between Queensland Police and Queensland Health. You have got to have that trust of being able to share information... QPS</i>
CO-LOCATION	<i>I think it is a lot more efficient to have them sitting in the position with the Acute Care Team, they can come back and forth if they have got a, if they have got a clinical concern we have got set meetings that they can come to talk about if they need some [professional] supervision so that's difficult if you are offsite... if you are onsite you just sort of have a working relationship that you lose once you are in a different building. QH-MH</i> <i>To be honest, I think what we gain, the information we gain here is the vital stuff... the important part of that co-locating is learning, that really fast learning of how to talk to people on their level in their language, and also a lot of my role is translation, I translate mental health to police and I translate police to mental health... QPS</i> <i>[An essential component is that]...we have with the police on site with us. QH-MH</i>

ADEQUATE RESOURCES	<i>Co-location yeah, it makes a big difference yeah. We also found, sorry, in Cairns that having [CMHCP team members] based at the Sheridan Street Unit with the ACT Team that they were often there when, if there was an incident, and there were a couple of times there with incidents of high aggression, people coming in, walking into that building and they were able, right there on the scene ready to respond and help out and deescalated and managed those situations very effectively. QH-MH</i>
	<i>...it needs to be funded and backed. You know that is really the baseline of it is there needs to be positions and vehicles available and people who genuinely want to do it. QAS</i>
	<i>I guess just finding the physical resources available for office space cars, all of that kind of resources infrastructure to make it work and there were, all of those were at a premium. QH-MH</i>

Challenges to project implementation

SUBTHEME	Selected Participants' Comments
MENTAL HEALTH CLIENT CONFIDENTIALITY	<i>Always around people's reluctance about well what's you know, the privacy of clients and what information can be shared. QH-MH</i>
	<i>And also here there was a big adjustment about confidentiality issues and why are we using, why are we having police go talk to mental health patients, that was really, seemed quite against there. QPS</i>
LACK OF EVALUATION PLAN	<i>I think the challenge the whole way along has, is I think when it was set up it was set up without any real idea of how to evaluate it down the track. QH-MH</i>
RESOURCING PRIORITIES	<i>We have got to slice the pie so many ways, you know people on the ground is always the first wish for any ambulance service, they want more vehicles, they want more staff, this is one of those conditions or things where if you treat the small amount here saves you big dollars here... You never see an instantaneous result treating mental health, or, I mean the one thing they would see if it was invested in a bit more is probably the reduction in mental health admissions through ED but that is only like one measureable target, really you are looking at the overall results in the patients like the scope you would have to look at to see the results, it's huge. QAS</i>
	<i>The challenge we have got at the moment is there is no funding, there is no funded position for the job. So as I said we are taking an officer from somewhere else. And I don't think in the short term that we will be given an additional position. QPS</i>
CO-LOCATION IN MENTAL HEALTH FACILITY	<i>Probably the only barrier that took a little bit to overcoming was the police being embedded in the Queensland Health office, that was a bit, I suppose for them (QH staff), they were a bit, what's the word... they weren't, I suppose they couldn't see the benefit of it at the start, but after a month or so when they could see how we operated and what we could do for them I think I was well and truly accepted. QPS</i>

Suggestions for project improvement

SUBTHEME	Selected Participants' Comments
EXTENDED HOURS OF SERVICE	<i>I don't think you could improve on what they do cause they are gold. They literally are gold, I think the only thing we can do is grow it and replicate it. And we just need more of it and we need it available more hours of the day and I think from the ambulance point of view given the growth in mental health and the growth in suicide and the growth in ice addiction. QAS</i> <i>We need to be available more often, and I think two shifts would cover it, I don't think we need to be available 24 hours a day. I think if we were available from 8 til 10 at night that would be sufficient." P: I think it would be beneficial that you have that [extended hours] and it might be the case that you have staff who work to start with a 9 to 5 shift, then you might have staff who work a 2 to 10 shift, you know that is purely up to the capacity of mental health, the Co-Responders from mental health whether they can do late shifts and if they have the capacity to do that. I think what would be beneficial is rotating those staff after six to twelve months. QPS</i>
DESIGNATED QPS POSITION	<i>The concern that I have got is that because we have not acknowledged it [QPS CMHCP role] appropriately within the QPS and created a position and created that role at an appropriate rank...the concern I have got is that if you don't get somebody who fosters those partnerships as well, there is the potential to lose that within Cairns. And that is where I think we very much need to create that position as a proper designated unit and create that role as a sergeant within the QPS. QPS</i>

NOTES: