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TRUST
TAILORING LAW AND HEALTH INITIATIVES TO PROMOTE INCLUSION ON MENTAL ILLNESS
IO1: COOPERATION PRACTICES BETWEEN TRAINING, HEALTH AND LAW - RESEARCH SURVEY

AN INTRODUCTORY STUDY OF THE ISSUES

Report Written by Maastricht University (CAPHRI) partners

Prof. dr. D. Townend, N. Stahl, S. Haque

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1. Introduction

The TRUST project is about helping the police and people with mental health issues to understand each others' needs and situations better. Internationally, as support for mental health services is reduced or targeted into community-based care, many police agencies find that they have to respond to the needs of many citizens with mental health problems as part of or alongside more traditional police work. At the same time, societal attitudes towards mental health issues and people with mental health issues requires, rightly, that the voice of the individual be heard, and that there is a much greater understanding of the experiences of all citizens. TRUST therefore seeks to contribute training packages that help both police and citizens with mental health problems to understand each other better, and to respond to these societal changes.

The purpose of this OI1 study was as a scoping exercise. It was intended to give the TRUST project partners a short initial grounding in the issues as they presented themselves first in the literature and then in practice. It involved a literature survey and then a qualitative survey of attitudes within the police and within the partner organisations working with people with mental health issues. It had limitations because of the time available to undertake the work in the context of the whole project.

2. Literature Survey (Sharmi Haque, Maastricht)

Police officers are increasingly becoming faced with interactions with the mentally ill individuals. In the UK, the Mental Health Crisis Care Concordat (Figure 1) recognises the crucial role that police play in identifying and acting upon the most appropriate course of action in situations involving mentally ill individuals. However, it needs to acknowledge that police force are not experts in mental ill health. The Mental Health Act 1983 allows the police force to remove individuals who appear to be mentally ill and pose a danger to the general public. When evaluating the evidence available, for training for police officers and mental health the research appears to be limited. However, it needs to acknowledge that police force are not experts in mental ill health. The Mental Health Act 1983 allows the police force to remove individuals who appear to be mentally ill and pose a danger to the general public. When evaluating the evidence available, for training for police officers and mental health the research appears to be limited. When conducting preliminary searches, the literature indicates that online learning is the key form of a training for police officers.

Figure 1- The UK Mental Health Crisis Care Concordat

- The Mental Health Crisis Care Concordat is a national agreement between services and agen- cies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.
- In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. Since then five more bodies have signed the Concordat, making a total of 27 national signatories.
- The Concordat focuses on four main areas:
    1) Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
    2) Urgent and emergency access to crisis care – making sure that a mental health cri- sis is treated with the same urgency as a physical health emergency.
    3) Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
    4) Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

UK political interest in evidence based policing (EBP) has further increased following Theresa May's announcement as Home Secretary that policing and crime reduction should have 'the same relentless focus on evidence as our medical and legal professions – where knowledge and research are the foundation of professional practice'. As a result, 'The Police Knowledge Fund' has also increased the UK Government's financial commitment to EBP. £10million funds have been made available to sup- port the development of sustainable education and research collaborations between the police and academia in England and Wales.

The CONNECT trial is part of the Co-Production of Policing Evidence, Research and Training: focus mental health (Connect) project, which was funded by the College of Policing (CoP), the Higher Education Funding Council for England and the Home Office. The Connect trial was conducted between September 2015 and March 2017 and investigated the effectiveness of a face-to-face mental health training intervention, delivered by mental health professionals to frontline officers, in comparison with routine training. The purpose of the training was to enhance officers' ability to effectively identify individuals with mental ill-health and manage incidents with a mental health component. The training aimed to reduce the likelihood of such individuals being involved in future incidents and reduce demand on police resources. The prespecified 1¼ outcome was the number of incidents reported to the police force's control room which resulted in a police response Conducting trials in the police setting can be challenging and poses a number of methodological and practical challenges. However, it is important that RCTs are undertaken to ensure that policing initiatives are informed by a strong evidence base.

Recommendations for the future conduct of trials in the police setting

- *Collaborative approaches*
  - Co-production of evidence between police and academia, is needed to ensure that research addresses policing priorities and is rigorously conducted.
  - Connect trial we ensured that evidence "co-produced"
    1) *Police officers embedded within our Trial Management Group including police practitioners, senior police officers and data analysts. This is essential to ensure that those with detailed knowledge of the context in which research Scantlebury et al. Trials (2017) 18:615 Page 5 of 7 is being undertaken are involved in trial design.*
    2) *Police officers and data analysts were also co-authors on all trial papers and aided with the interpretation and reporting of trial findings. Feedback on lay summaries of trial findings that were then disseminated throughout the police force.*
    3) *'Partners meetings' with key stakeholders (e.g. police, charities, health service providers) throughout the trial period which provided an opportunity for the research team to obtain feedback on the trial design whilst also providing a forum for promot- ing and disseminating findings.*

  - *Police Data Analysts*
    - Complex nature of routinely collected police data, it is advised that future trials obtain engagement from police data analysts throughout the trial period.
    - Police data analysts provided a unique insight into what data is recorded and its accuracy, and undertook data extraction.
    - Police routinely collect large amounts of rich data stored on a number of different IT systems.
    - Police forces may wish to consider re-designing their IT systems so that they are useful for research, analysis and operational purposes and to ensure that data collected is fit for purpose.
    - Future trials in the police setting may benefit from following the
      - ! Medical Research Council's Framework which outlines the process of developing and evaluating complex interventions
        - Series of phases which require significant pilot and feasibility work to not only develop and test the viability of the intervention but key elements of trial design such as recruitment, sample size and outcomes.

- Useful for RCTs in the police setting as interventions are likely to be complex (interacting components) involved numerous obstacles for trial design.

- ***Pragmatic trials should be adopted***
  - Trial design can reflect the evolving landscape of policing and reflect the context to which findings will be applied.
  - Need for research to be conducted quickly if it is to inform policy.
  - Sufficient lead-in time for trial set-up and obtaining necessary research governance approvals is considered when allocating and applying for research funding in this set- ting.

The *Connect* trial showed that undertaking an RCT of a complex intervention in the police setting is feasible within a short time frame, but lessons can be learnt. Future trials need to ensure that there is a reasonable amount of lead-in time before starting data collection to fully understand the policing context and what is possible within the project's scope, whilst also taking into consideration the most appropriate length of follow-up time to show an effect[1].

Teagardin (2012)[2] and Bailey (2001)[1] both observe police officer intervention with a specific mental health focus to some degree. Teagardin (2012) had shown that the core symptoms of autism spectrum disorders (ASD) are likely to affect interactions between law enforcement officers and persons with ASD. It was highlighted that it was important to train police officers to appropriately respond to peo- ple with ASD. If they are not properly trained it can result in unnecessary trauma, injury and fatality. The study aimed to evaluate the effectiveness of a method of police training on persons with ASD[2,1]. 82 police officers participated in this randomized, waitlist-controlled, between-groups study. The re- sults presented significant differences in change scores between groups, with the training group scor- ing considerably better than the control group at post-test. The control group completed training and likewise showed significant improvement. However, post-tests scores for participants in both groups did not indicate superior knowledge of the material. The study does pose limitations; the study was localised to the Ventura County Police Department generalised drawn from this study may not be ap- plicable[2,1].

In comparison, Bailey (2001)[1] reports on the evaluation of an awareness training event conducted by the Royal Ulster Constabulary in terms of the impact on attitudes towards people who were mentally ill individuals held by police officers. The experimental design involved the measurement of partici- pants'

attitudes prior to and following awareness training, and the comparison of these data with a control group of participants who did not undertake awareness exercises. The delivery of the aware- ness training by the Royal Ulster Constabulary (RUC) was aimed at providing opportunities for police officers to participate in positive situations during which it was possible to explore the abilities of people with ID, and in doing so, to challenge stereotypes held by officers. It is important that such

exercises are evaluated in order to assess the effectiveness of the exercise in achieving its aims, gather evidence of the benefits accrued and identify the need for any further refinements. It may help to change attitudes to training by showing, in measurable ways, the value to the organization of invest- ing in this type of training.

With limited studies conducted nationally; international studies have been undertaken to learn more about the whole the police force interacts with the mentally ill individuals. In the US, Compton (2008)[2] had identified that the Crisis Intervention Team (CIT) model is a specialized police-based pro- gram intended to enhance officers' interactions with individuals with mental illnesses and improve the safety of all parties involved within mental health crises. The CIT is an example of the collabora- tion between both the police force and mental health. Furthermore, the CIT is a specialized police response. Other interventions are employed where mental health consultants assist in these police responses. This model could be considered as an effective vehicle in brining mentally ill individuals to the focal point of police attention.

Watson & Fulambarker (2012)[2] was based upon the Crisis Intervention Team Model of Police Re- sponse to Mental Health Crises: A Primer for Mental Health Practitioners. The CIT is a model of 40 hours of specialized training for a select group of officers that volunteer to become "CIT officers". Of- ficers volunteer to receive 40 hours of training provided by mental health clinicians, consumer and family advocates, and police trainers. Training includes information on signs and symptoms of mental illnesses; mental health treatment; co-occurring disorders; legal issues and de-escalation techniques. CIT curriculums may also include content on developmental disabilities, older adult issues, trauma and excited delirium. Information is presented in didactic, experiential and practical skills/scenario based training formats. As part of an effort to improve police interactions with mentally ill citizens, and improve mental health care delivery to subjects in acute distress, the University of Louisville, in conjunction with the Louisville Metro Police, established the crisis intervention team (CIT). CIT is composed of uniformed officers who receive extensive training in crisis intervention and psychiatric issues and who are preferentially called to investigate police calls

that may involve a mentally ill indi- vidual. In an effort to determine the characteristics of the individuals brought to the emergency psy- chiatric service (EPS) by CIT officers, a comparative (CIT vs. mental inquest warrant [MIW, a citizen-

initiated court order to bring someone for psychiatric evaluation because of concerns regarding dangerousness] vs non-CIT. Results illustrated that with the demographics, diagnosis, and disposition of CIT-referred subjects were not different in any way from non-CIT patients. It concluded that CIT officers appear to do a good job at identifying patients in need of psychiatric care.

Herrington & Pope (2012)[12] in Australia had built upon the foundations of the CIT developed in Memphis, USA to create the MHIT. The mental health intervention programme was developed by New South Wales in order to train police force to respond efficiently and effectively with mentally ill individuals. It was concluded that the MHIT has increased confidence amongst police dealing with mentally-ill individuals. However, there was no significant differences between MIHT trained and non-MIHT trained officers in terms of skill. The MHIT model involved a central project team which was responsible for the development and delivery of training.

In Australia, there has been a greater focus point on delivering the best type of training for the police officers and other professionals. A Mental Health First Aid (MHFA) training programme was first developed in Australia to train the public in providing help to adults with mental ill-health problems. MHFA training has been taken up by other countries including UK. There has been an increase in undertaking MHFA training in workplace settings. In order to understand the strength of the available evidence on the effectiveness of MHFA in the workplace to improve the organisational management of mental-ill health, a rapid scoping evidence review was undertaken. The review concluded that there are only a small number of published occupational studies that have addressed mental health first aid (MHFA) and these had design and quality limitations. There is scarce evidence that the content of MHFA training has been adapted for workplace circumstances. There is consistent evidence that MHFA training raises employees' awareness of mental ill- health conditions, including signs and symptoms. However, there is limited evidence that MHFA training leads to sustained improvement in the ability of those trained to help colleagues experiencing mental ill-health. More research needs to be undertaken as there appears to be little to no evidence that the introduction of MHFA training has improved the organisational management of mental health in workplaces[15].

Kitchener and Jorm (2004)[13] had utilised the Mental health first aid training in a workplace setting and conducted a RCT. The mental health first aid was formulated of 3 weekly session of 3 hours each.

The content covers helping in mental health situations. The crisis situations covered included suicidal thoughts and behavior, acute stress reaction, panic attacks and acute psychotic behavior[13]. The men- tal health problems discussed included depressive, anxiety and psychotic disorders. The co-morbidity with substance use disorders is also covered. Participants learn the symptoms of these disorders, pos- sible risk factors, where and how to get help and evidence-based effective help. It was concluded the there was a number of benefits from the Mental Health First Aid. The intervention group showed greater confidence in providing help to others, greater likelihood of advising people to seek profes- sional *help, improved* concordance with health professionals in beliefs about treatment, decreased social distance from people suffering from depression, and improved mental health of the participants themselves. Recognition of disorders in vignettes did not improve, but there was a very high recogni- tion at pre-test, limiting the scope for improvement. The mental first aid training appears to be effec- tive in improving certain aspects of mental health literacy[13].

Other studies include Hansson & Markström (2014)[14] which had conducted a pre and post interven-tion study along with a 6 month follow up of the intervention group. The anti- stigma intervention ap-peared to show improvement in changing attitudes and mental health literacy. However, the study has limitations. The RCT failed to conclude the that the differences between the groups were anti- stigma intervention only. The comparisons were made between police officers attending a psychiatry course with an anti-stigma added on intervention. It must be noted that the intervention employed was fo-cussing on police students not trained officers[14].

Pinfold et al. (2003)[8] explored the concept of stigma within the police force. Stigma is defined as the personal characteristics and socially constructed negative stereotypes. Psychiatric discrimination is pivotal as it directs attention on the individual. Few programme studies have evaluated the impact of mental health training on an adult target groups supported knowledge attitudes and behaviour inten-tions. From the study, offices knowledge of mental illness what is not extensively assessed it was diffi-cult to gauge police officers' knowledge on mental illness. The police force is an important target group mental health educational intervention. Police force need to be further educated on mental health in order to further improve their own emotional health in order to cope with the high stress levels within their career and further enable them to engage effectively with mental health individu- als. However, the workshop program intervention had a small positive impact on the police force per- spective on mental health issues. The workshop program raised police force awareness of mental health issues. It was concluded that psychiatric stigma and discrimination is widespread international problem. Pinpoint

et al (2003)[8] identified that targeted programme intervention may not cause sub- stantial change. The study highlighted that the mental health awareness training left the police force feeling more informed and confident about interactions with mentally ill individuals. There were ob- stacles when conducting the study. Some of the police officers had negative experiences with mental- ly ill individuals. It was important to highlight the police officers own stereotypical views of mentally ill individuals.

3. Methodology

This part of the project used a mixed method, qualitative approach. Interviews conducted from semi-structured questionnaires (Appendix 2) were conducted with police officers in cities in Portugal, and Romania, and with people with mental health issues who were clients of facilities in two cities in Portugal and Romania. A further set of interviews was undertaken with police in the Netherlands. Eight clients from the two facilities for people with mental health issues in Portugal and Romania were also brought together for a week of focus groups in Maastricht. The analysis was undertaken by project members in the department of Health, Ethics and Society in Maastricht University.

The objectives of the studies were to identify: for people with mental health issues, to identify individual experiences of interaction with law enforcement and to reflect on those experiences; to consider how their experiences could inform training in relation to such interactions. The Police participants were encouraged to describe and reflect on their experiences of interacting with people with mental health issues, and to describe and reflect on any training that was or had been available to them for such interactions, and to identify gaps in training and practice and how they could be ad- dressed.

4. Results and Discussion

The findings of the various elements of the study are brought together into the following description and discussion of the results.

4.1 People with mental health issues.

The range of experience between individuals with mental health issues was striking. Some of the participants lived in their own accommodation and attended the institutions for support, others were in sheltered accommodation related to the institutions and without the institutions would be (and in some cases had been) homeless. The level of mental difficulties experience was also broad. The expe- riences related in the course of the discussions were drawn from a wide timeframe. The experiences were, therefore, very different depending on the setting.

Individuals related both difficult and positive experiences when interacting with the police. Some of the

positive experiences related to the police understanding the situation with a degree of empathy and understanding for the situation. The group reported both "professional" experience - for example, when the person relating the experience had broken the law, and the process of law was followed. Others related "unprofessional" behaviour, when the officers involved did not show understanding for the situation of the individual with mental health issues. In a small number of extreme cases, the per- son with mental health issues reported verbal and physical abuse from the law enforcement officers and from other (healthcare) professionals.

In the focus groups, particularly, a strong theme was "trust". Individuals with mental health problems indicated that the basis of the relationship with law enforcement officials was trust - built on a fundamental human rights basis of respect for dignity. A distinction was drawn between interactions when the police were investigating (allegations of) crime where the individual with mental health is- sues was being investigated by the police, and situations where the individual with mental health is- sues was (or felt themselves) to be victims of crime or the unacceptable behaviour of other citizens. Some of the participants expressed the opinion that the police were not for them, others that the police were actively against them. These observations were expressed within a discussion about the nature of society, order and authority, which displayed a strong sense of the necessity of due process in society and of a necessary underpinning normativity as a precondition for respect for dignity.

There was a perception from those with mental health issues that the police had a lot of discretion in the way they operated in different situations. Some acknowledged that the beginning of a police in- tervention with citizens could well be a heated situation, and much of the initial interaction is about calming the situation (although a small number related stories of how the intervention exacerbated the situation for the person relating the experience). It was felt very important that the police should be able to read the signs in a situation; to understand the basis for people's behavior. It was felt to be very important that the police should listen to all sides in a situation. That they should be able to take the heat out of situations. That they should help people to find solutions (through informed decision- making).

It was felt that there was a lot of demarcation in the way that the police (and other services) interacted with the participants with mental health issues. The participants identified a lot of silo-ed understanding and resources in the provision of services. It was felt that there was a lack of communication be- tween services - for example, between the police and social services, or the police and healthcare. There was a sense that the bureaucracy around service delivery created rigid rules where greater flexibility was required. There was a concern that rules were very rigid and prevented access to services. This was

identified to be a particular problem about access to services for those with alcohol-related problems. However, there was a sense that the rules were not bad per se. The discrimination occurred when rules were not applied equally between individuals or groups of individuals (i.e. against individuals with mental health issues). There was a sense from some that there had to be a greater space to apply 'common sense' in the application of rules.

The individuals identified that whereas physical disabilities that some people have are outwardly visible, mental disorders from which people suffer are invisible. There was some discussion about whether individuals with hidden problems should wear some sort of sign to place others on notice of their condition. There were, it was felt, both positive and negative issues with such a sign. Rather, it was felt that it was a matter of educating others; it was felt that generally, in society, there was insufficient awareness about the needs of people with mental health issues. It was also felt that broader so- cial issues also needed to be recognised - for example, the experiences related to homelessness.

Thinking very specifically about police training, it was felt that there was a need that officers should simply spend time on the streets talking to people. (Although it was also recognized that the targets through which the police performance was measured does not necessarily give space for such activity - or to record the more health or social aspects of dealing with people with mental health issues; po- lice activity, it was felt, is about law enforcement and that is how success is measured.) It was felt that there was a need to promote protection of people with mental health issues over punishment; to de- velop a pro-active attitude towards the vulnerable; to acknowledge mental illness as an illness. This would extend to helping and respecting individuals, following-up individuals, supporting their families, operate with a general spirit of neighborliness. It was felt that particular care should be extended to the elderly with mental health problems - particularly in relation to dementia.

4.2 Police experiences

The participants from the police reported that they had a significant (and increased) number of en- counters with people with mental health issues, and they suggested that this was the case with the economic cuts to social welfare budgets. Some of the police noted that there were inter-agency teams set up to respond to the associated problems of dealing with people with mental health issues. This extended in some cases to mixed disciplinary teams on the beat (with social service workers or healthcare workers joining police 'on the beat'). In other places, some general training is available to help officers to understand and prepare for interactions with people with mental health problems. However, there was still a general feeling that officers were under-prepared for working with people

with mental health issues, and that they lack support, knowledge and time for such work.

The police in the study reported that there was a lot of formal requirements relating to encounters with people with mental health issues. For example, there were rules about informed consent, or re- ferring individuals to other agencies. However, there was a lack of practical advice for individuals. A practical example given concerned the rules for the transportation of people with mental health is- sues. Such people, under new laws, should not be carried in police cars. However, in practice such a requirement is not practical in all situations, placing officers in very difficult situations; the law did not reflect the (economic) reality of the situation.

In the Netherlands, it was noted that the police were not there to catch patients, but rather to catch criminals - that there was a change of attitude towards people with mental health issues as having illness that requires care. Some individuals, in a small group within the study, noted that their introductory training had a very general part about dealing with those with mental health issues. They felt a distinct need for specialist support in the area, and enquired (further) training on the issues. Some, however, indicated that they had been able to follow the "first aid mental health" course.

5. Conclusions

From the literature, it is clear that there are training approaches that are available and are used in some jurisdictions that could be made available more broadly. However, much of the difficulty stems from under resourcing of services for people with mental health and for policing. There are clear needs for an increased understanding of the issues faced by people with mental health problems. This is a society-wide lack of understanding, but it is particularly difficult when it is a lack of understanding in the police, given they are in a frontline response to people with mental health issues.

References

1 "Undertaking a randomised controlled trial in the police setting ..... " 22 Dec. 2017, https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-017-2369-6. Accessed 21 May. 2019.

2 Watson AC, Fulambarker AJ. The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. Best Pract Ment Health. 2012;8(2):71.

12 Herrington V, Pope R. The impact of police training in mental health: an example from Australia. Polic Soc. 2014;24(5):501–522. doi: 10.1080/10439463.2013.784287.

13Kitchener BA, Jorm AF: Mental health first aid training for the public: evaluation of effects on knowledge, attitudes and helping behavior. BMC Psychiatry. 2002, 2: 10-10.1186/1471-244X-2-10.

14 . Hansson L, Markstrom U. The effectiveness of an anti-stigma intervention in a basic police officer training programme: a con- trolled study. BMC Psychiatry. 2014;14:55. doi: 10.1186/1471-244X-14-55.

15 Lipson SK, et al. Gatekeeper training and access to mental health care at universities and colleges. J Adolesc Health. 2014;55(5): 612–619. doi: 10.1016/j.jadohealth.2014.05.009.

- Pinfold V, et al. Reducing psychiatric stigma and discrimination--evaluating an educational intervention with the police force in England. Soc Psychiatry Psychiatr Epidemiol. 2003;38(6): 337–344. doi: 10.1007/s00127-003-0641-4
- Herrington V, Pope R. The impact of police training in mental health: an example from Aus- tralia. Polic Soc. 2014;24(5):501–522. doi: 10.1080/10439463.2013.784287.
- Forni C, Caswell N, Spicer J. Delivering mental health awareness training to police officers. Nurs Times. 2009;105(10):12–13
- Bailey A, Barr O, Bunting B. Police attitudes toward people with intellectual disability: an evaluation of awareness training. J Intellect Disabil Res. 2001;45(Pt 4):344–350. doi: 10.1046/j.1365-2788.2001.00339.x.
- Hansson L, Markstrom U. The effectiveness of an anti-stigma intervention in a basic police officer training programme: a controlled study. BMC Psychiatry. 2014;14:55. doi: 10.1186/1471-244X-14-55.

- Teagardin J, et al. Randomized trial of law enforcement training on autism spectrum disorders. Research in Autism Spectrum Disorders. 2012;6(3):1113–1118. doi: 10.1016/j.rasd. 2012.02.002.

- Compton MT, et al. A comprehensive review of extant research on crisis intervention team (CIT) programs. J Am Acad Psychiatry Law. 2008;36(1):47–55.

- Watson AC, Fulambarker AJ. The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Pract Ment Health*. 2012;8(2):71.

- Svensson B, Hansson L. Effectiveness of mental health first aid training in Sweden. A random- ized controlled trial with a six-month and two-year follow-up. PLoS One. 2014;9(6):e100911. doi: 10.1371/journal.pone.0100911.

Appendix 1: Details of Literature Surveyed

Study	Study Design	Training Evaluated	Participants	Comparator	Number of Participants in the Study	Number of participants in analysis
Police Officers Interventions with a Specific Health Focus						
Bailey et al (2001) Northern Ireland UK	Prospective non-RCT Pre and post intervention questionnaire	Awareness raising training on intellectual dis - abilities in general.	Police Officer Trainees	No training	62	57 (27 intervention 30 control)
Teagardin et al (2012) United States of America	Cluster RCT Pre and post intervention questionnaire	Law Enforcement: Your Piece to the Autism Puzzle. Aims to help the recognition and identification of and attitudes towards people with Autism Spectrum Disorders	'in the field' law enforcement officers	Waiting list	82 unclear	81
Police Officers: Interventions with a Broad Mental Health Focus						
Compton (2008) United States	Systematic Review Provides a systematic					

Forni et al. (2009)	Non-comparative study Post training evaluation form	Mental health awareness training to improve communication and understanding; explore common problems and solutions; understand how the Mental Health Unit functions; how MH staff handle violence and aggression; understand common MH problems	Police Officers	Not applica- ble	364 received training	280 returned evaluation forms
Hansson and Markstorm (2014)	Prospective non-RCT	An anti-stigma intervention aimed at improving knowledge behaviour and attitudes towards people with mental illness	Police Officers	No Training	120	105

Herrington and Pope (2013) Australia	Prospective non- RCT Training group: pre, 2 months and 18 months post interventio n questionnai res Control group: questionnaire at 18 months only. Routinely collected data, semistructure d interviews, observational data, focus groups	Mental Health Intervention Team (MHIT) trained uniformed officers as specialists to respond to individuals with apparent MH concern	Front line officers	No training	185	unclear

Norris & Cooke (2000) England	Non-compara-tive study	Training pack-age developed by MH profes-sionals. Aims to provide police officers with understandin g, skills and awareness, and aid the man-agement of mental disorder or mental illness	Police Officers	Not applicable	132 officers trained	57 responses
Pinfold et al. (2003)	Non-compara-tive study	Mental health awareness train-ing developed in house. Aim to reduce negative stereo-typing and dis-criminatory actions	Police Officers	Not applicable	232 were eligi-ble to take part; 163 were trained	119 provided follow-up data

Appendix 2: Questionnaire and Guideline IMPLEMENTATION

OF THE INTERVIEW

The interview will be semi-structured and will adress the individual and his/her interaction, both individuals with mental illness and police officers, with the **contexts bellow** (as in Document OI1 – Tasks and Deadlines: Topic *GUIDELINES FOR THE INTERVIEW SCRIPT*). We propose a **series of open ques- tions** but some may arise from the conversation. If the individual authorizes the recording it would be useful not only for the study but also for the project data collection and also for new and different analysis and projects.

For the participation in the OI1 it has to be signed the Informed Consent (attached) and given authorization for the recording when that is the situation. The project and its aims have to be explained and the clarification of concerns regarding the treatment and protection of the data gathered are mandatory.

Contexts to address in the Interview

1. Home (of origin)/family home;
2. Shelter institutions or temporary shelters;
3. The street;
4. Social Security;
5. Primary Care Services and Hospitals;
6. Workplaces;
7. Schools, universities and other training contexts;
8. Court;
9. Police station (including transport of the individual in a police vehicle);
10. Social solidarity institutions (although training place too), rehabilitation spaces and occupa- tional therapy.

INTERVIEW GUIDE

1. *Is this a context in which you feel difficulty to be heard or cared for in a professional, neutral and transparent way?*

2. *Are these difficulties recurrent?*

3. *Have you ever had any major problems in this context? If so, can you describe the situation* (if several, ask one or two illustrative examples)*?*

4. *To what extent did you feel that you were discriminated by the professional in question, not deserving of the due attention, respect and dignity that any professional should have in attention at his or her workplace?*

5. *Was the technician who you spoke with clear on the information reported to you?*

6. *Did he or she explain your case in detail and the different options to take?*

7. *Are you comfortable in consulting the XXXX services* (changes with the context addressed at the moment)*?*

8. *If not, can you explain why?*

9. *Based on your difficulties, what suggestions can you present to XXXX* (changes with the context addressed at the moment) *technical staff in order to improve their service?*

10. *What was the reason for law enforcement had to intervene?*

Context Specific Questions

ï **Home or Street**

1. *Did the police officers try to obtain information with your relatives?*

2. *Did the police officers verify with you that information or did they just assume it as correct?*

3. *Did they cross-checked information regarding causes and consequences of the conflict?*

Court or Lawyer's office

1. *The language used specifically in law, legal and judicial matters is usually complex and confusing. Has the judge, lawyer, prosecutor clarified that language carefully in order to your particular case be understandable to you, the various options to be taken or future consequences?*

2. *Do you feel well accompanied, supported and enlightened with the*

professionals who ac- company you?

Police car

From the **patient's** point of view:

1. Have you *ever been transported in a police car?*
2. *If so, how did you feel?*
3. *What did you think or what crossed your mind at the moment?*
4. *How do you describe the behaviour and attitude of the police officers during the transportation?*
5. *Have they respected your rights as a person? Would you like to add something else about the transport or is there any suggestion you would like to make?*

From the point of view **of the police officer**:

1. *In what situations can the police directly transport people in a police vehicle?*
2. *Have you ever done a transport of an individual with a visible altered psychological state or a person with psychopathology?*
3. *What did you feel at the moment?*
4. *What did you think or what crossed your mind at the moment?*
5. *Were you aggressive or violent with the individual at any time? Did you feel that you had to be aggressive towards this individual?*
6. *Do you consider that if you had training in psychology and psychopathology and how to deal with people with mental illness, would you be able to handle this or similar situations differently and in a better way?*

Police Intervention

From the **patient's** point of view:

1. *About the police officers called upon to intervene in such a situation, were they correct in their approach?*
2. *Did they start by properly presenting themselves and were they correct in their approach towards you, treating you with respect and dignity?*
3. *Even if they did not know that you had a psychological pathology, were they sensitive in their approach, trying to*

understand the problem before they acted?

4. *How did you feel in a situation involving police officers (comfortable, safe, afraid, neglected, excluded, etc.)?*

5. *Did the police officers, representing the authority on that place, explain to you what had led to the conflict?*

6. *Did they explain your rights as a citizen?*

7. *If you had to point out something that was meant for the training of agents, what would you suggest?*

From the **police officer's** point of view:

1. *In the course of carrying out your activity as a police officer, contact with people in altered psychological states or even psychopathology is inevitable.*

2. *Do you usually intervene in occurrences/calls involving psychiatric patients?*

3. *What kind of intervention, in your role of police officer, do you usually perform or are you trained to perform?*

4. *What do you know about mental illness?*

5. *What do you think a mental illness is?*

6. *Do you consider that specialized training in psychopathology and dealing with situations involving emotional activations and dysregulations or even psychotic outbreaks can be beneficial in your activity as a police officer?*

7. *What would you like to or think it will be important to learn about mental illness for the performance of your duties?*