Good Practice in Transfer of Care: A Rapid Review

SIPR | Scottish Institute for Policing Research

Authors

Dr Martha Canfield[1]
Dr Elena Dimova[1]
Mr Isaac Samuels,
Mrs Liz Monaghan
Professor Martin Webber[2]
Professor Susan McVie[3]
Professor Elizabeth Hughes[1]

1 Glasgow Caledonian University
2 University of York
3 University of Edinburgh

Corresponding author
Martha Canfield - martha.canfield@gcu.ac.uk

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Lay Summary

There's been a noticeable rise in 999/101 calls in Scotland related to people in a mental health crisis. Very often, the first people to arrive are police officers, especially if in the middle of the night. Police can find such situations difficult as they lack skills and knowledge and don't always know how best to help. It can be scary for someone in distress to have the police arrive.

To improve response and support for people in mental distress, we need to understand how best police and health services can work together to ensure people receive the right care at the right time. Getting this right can make a real difference to people's lives. When the police transfer a person to a health service (Accident and Emergency Department or designated Mental Health Place of Safety), we refer to this as "transfer of care". Around the world, there are lots of examples of effective and creative transfer of care models that improve how people in crisis are supported. Learning from these examples can help shape better approaches in Scotland.

This project involves looking at what has been published in relation to best practice in how police transfer people in mental health crisis to healthcare or other support services.

We had three questions:

- What evidence exists in the UK and internationally?
- What are the key elements of these transfer of care models?
- And what does a really good transfer of care look like?

We found 24 published articles. Studies generally describe four main types of transfer of care models:

- Co-response models: This is when police and mental health professionals respond together
- Liaison models: These involve either police officers with specialist mental health training responding to a crisis with input from the mental health team if needed, or healthcare professionals serving as the initial responders, with police involvement if necessary.
- Designed places of safety: These are dedicated spaces that police officers can transfer people to for immediate assessment and care.
- Screening tools: These are used by first responders, including police officers, to assess mental state and risks, helping decide the most appropriate next steps

We also looked at the outcomes related to effective transfer of care. The above models have been shown to help in many ways such as reducing the time people spent in police custody, lowering the number and frequency of police call-outs and decreasing the use of detentions. They also showed some promise in improving the quality of care people experience during police contact and transfer of care to a health service, reducing how often emergency departments are used and how long people stay in there, and improving access to specialist treatment including follow-up care and better communication among all staff involved in the transfer of care.

This report highlights the different ways police can transport and support people to health services in various countries, and how these approaches impact people's lives. But what's clear is there's still a huge gap when it comes to solid scientific evaluation in this area, especially within policing and mental health. On top of that, very few studies have asked the people at the heart of it all — those with lived experience of mental health crises and contact with police — for their views. Even so, the findings give us some valuable clues to help guide decisions in Scotland and beyond, while highlighting the urgent need for more research and funding. We need a stronger evidence base to really understand which models work best and when, to develop clear, accountable transfer of care processes, make a case for long-term funding, and improve crisis care overall.

Executive Summary

People in mental distress are best helped by mental health services, however, in some cases the initial contact is by police. The police have the power to transport a person to a "place of safety" if there is a significant risk of harm to self and/or others. However, there are concerns regarding the appropriateness of police transporting someone in a mental health crisis, as well as the location and waiting times for transfer of care to healthcare providers (or other relevant agencies).

The challenges and solutions for transfer of care are especially pertinent to Police Scotland given that a large part of Scotland is considered "rural/remote", which means that services are spread thinly, response times to crisis can be slower, as well as distances needed to travel are often further in comparison to more urban settings.

The Scottish Police Authority, Police Scotland, and the Scottish Government have recognised the need for more coordinated, multi-agency responses and a deeper understanding of effective transfer of care practices for individuals experiencing mental distress. They are committed to supporting a whole-system approach to addressing mental distress and its impact on policing demand. As part of this commitment, a series of initiatives will be developed over the coming years in Scotland.

To inform this work, the Scottish Institute for Policing Research (SIPR) launched a responsive research fund in 2024 to examine transfer of care practices for individuals in mental distress across international policing systems. Around the world, there are numerous examples of innovative and effective models that may improve both the process and outcomes for people in crisis. Synthesising this global knowledge presents a valuable opportunity to shape and enhance future approaches in Scotland.

This rapid systematic review looks at identifying existing research evidence that evaluates and describes models of transfer of care of police to healthcare providers (or other relevant agencies) for individuals in mental distress.

KEY FINDINGS

What information is publicly available in other policing jurisdictions in the UK and internationally to describe the transfer of care for people in mental distress?

- A rapid review was undertaken.
- 24 published peer-reviewed articles that focus on the transfer of care were identified. Of these, eleven studies described transfer of care models applied in urban areas, seven covered both urban and rural areas, and only one covered rural areas alone.
- The majority of the studies included data from professionals working on the crisis model and/or administrative data records. Perspectives and views from individuals with lived experience or/and their carers were presented in five studies.

What are the core elements of practice across the different models for the transfer of care?

- No universally accepted taxonomy of models of transfer of care exists. Identified models in the included studies tend to fall into one of four categories:
  - ***co-response models*** (shared protocol in which police officers are paired with mental health professionals to respond to incidents involving individuals experiencing mental health crises);
  - ***liaison models*** (approaches in which either police officers with specialised mental health training or healthcare professionals act as the primary responders to mental health crises, with support from the other service if required)

- ***designated places of safety models*** (locations where individuals experiencing mental distress can receive immediate care and assessment);
- ***screening tools*** (used in community settings to evaluate an individual's mental state, risk level, and immediate needs).

What does 'good' look like for the transfer of care of people in mental distress?

- A range of outcomes that might be influenced by the transfer of care models has been identified. These include time under police care, rates of police calls, rates of detention/sanctions, quality of care during call and/or transportation, emergency department utilisation/attendance duration, hospital diversion, treatment admission, re-admission/follow-ups, and communication between staff.
- Most transfer of care models involve a trained police officer paired with a mental health professional, typically responding together in the field (co-responding approach). While this model shows promise in reducing involuntary detentions, Emergency Department (ED) use, and police wait times, their effectiveness depends on good communication, community support, and trust between agencies, and there remains a clear need for large-scale, rigorous evaluations to assess long-term impacts and cost-effectiveness.
- International evidence highlights that effective communication and collaboration across services are essential at every stage of a mental health crisis response, from initial joint decision-making to hospital handover and post-discharge support. Without this, care transfers can break down, leading to unmet needs and future crises. While models like A-PACER in Australia show how well-coordinated handovers can enhance continuity of care, many studies point to gaps in communication protocols, legal clarity, and data sharing, suggesting a need for clearer inter-agency guidelines and tools to support consistent, effective information exchange.
- The use of mental health screening tools by police shows promise in improving continuity of care, supporting appropriate referrals, and reducing unnecessary ED visits and involuntary transfers, though their effectiveness for individual clinical assessment remains limited. While more research is needed, initial findings suggest these tools may enhance police decision-making.
- Two studies have examined the characteristics of places of safety, though some highlight their potential to improve transfer of care.
- Overall, there is limited and mixed evidence on whether transfer of care models reduces repeat crises or improves long-term engagement with community-based services, with some studies reporting reduced ED use and others noting higher hospitalisation rates post-intervention.

RECOMMENDATIONS

- Most studies on transfer of care models reflect the perspectives of professionals, with limited input from service users and a lack of robust data on outcomes. To ensure person-centred, culturally responsive crisis care, people with lived experience must be meaningfully involved in service design, delivery, and evaluation.
- Health equity was largely overlooked in the studies reviewed, with limited attention to the experiences of ethnically diverse groups, non-native language speakers, and individuals with neurodevelopmental conditions. Future research and service development must prioritise inclusion and address the needs of underrepresented groups to ensure care is accessible, appropriate, and responsive for all.
- Training can support more effective mental health crisis response and improve care transfers. Beyond structured programs, more investment in ongoing learning through cross-professional exchanges, case discussions and reflective practices is needed. Embedding equity, trauma, and mental health in mandatory police training is essential for more compassionate and confident crisis responses.
- Communication challenges remain a key barrier to effective joint responses between police and mental health services. Timely and accurate information sharing is critical. Improved mobile technology enabling real-time access to mental health data might support faster, safer, and more coordinated crisis decision-making.
- Clear accountability and defined roles are essential in crisis response, especially given differing risk perceptions between police and health professionals. Challenges like substance use and potential violence add complexity. Shared protocols and mutual understanding might help to improve consistency, coordination, and safety in decision-making.
- Investment in structured follow-up after police-involved mental health crises is needed. Steps like a 'next-day call' from a trained officer might offer reassurance, connect individuals and families to services, and show continuity of care. This might improve outcomes and ease the transition to longer-term support.

Introduction

The rising number of crisis calls to 999/101 involving individuals in mental distress poses a growing challenge for police services in Scotland. Although mental health professionals are best equipped to address such needs, individuals in crisis frequently encounter and/or contact the police, who often serve as the first (and sometimes only) responders. As a result, police have become a common gateway to care for many individuals with mental health issues. These incidents can be particularly time-consuming to manage, especially when they require coordination and handover to health services. Evidence from England and Wales suggests that mental health is a factor in approximately 5–10% of police calls (Kane, Cattell & Wire, 2021).

In Scotland, around 600 incidents each day around 600 incidents are recorded, which have a mental health element (Police Scotland, 2025). This demand has raised concerns about the appropriate use of police resources and the adequacy of officers' training, skills, and support when managing mental health-related situations. Moreover, it fosters potentially unrealistic expectations that police should act as the primary experts in mental health care.

Despite these concerns, it is widely recognised that Police Scotland is playing an increasingly significant role in supporting people experiencing such crises (HMICS Thematic review of policing mental health in Scotland, 2023). This includes responding directly to emergency calls and ensuring the safety and well-being of individuals in their care. Notably, less than 20% of all calls received by the police result in a recorded crime, highlighting the growing proportion of police work related to non-criminal events, which may include mental health crises (Scottish Police Authority, 2023).

Addressing these evolving mental health calls is placing increasing pressure on the police service, stretching its capacity, highlighting gaps in resourcing and skill sets and negatively impacting the person in crisis from receiving support from the most appropriate agency at their time of need. Since 2017, key national strategies have been published in Scotland to highlight the need for improving the physical, mental health and wellbeing of those in contact with the criminal justice system (Justice in Scotland: Vision and Priorities), actions to support the criminal justice system to work effectively with local partners to improve outcomes for those with mental health problems (Mental Health Strategy) and a need for supporting vulnerable people or people in crisis (2030 Vision and three years plan). All of these strategies recognise the need for jointly agreed practices between health and police services, which have been consolidated through the 'Policing Together' team within Police Scotland.

In partnership with the Scottish Ambulance Service and NHS24 Mental Health Hub, Policing Together has launched innovative initiatives aimed at enhancing mental health support and easing the burden on emergency services. These efforts include the development of a dedicated mental health pathway (MHP), which facilitates more effective care transitions and timely engagement with mental health professionals (Scottish Police Authority, 2023). However, while the MHP has undergone three initial evaluations, it has not yet been subjected to a rigorous scientific evaluation such as a randomised controlled trial (RCT).

Concerns persist in Scotland about the appropriateness of police transporting someone in a mental health crisis, and the location and waiting times for transfer to a designated "place of safety". In recognition of the need for more coordinated, multi-agency responses and a better understanding of effective transfer of care practices for individuals in mental distress, there is a clear demand for a robust evidence base to guide decision-making and action. Effective transfers from police to healthcare providers (or other relevant agencies) are critical to improving outcomes. Globally, there are numerous examples of innovative and successful care transfer models that enhance both processes and outcomes for individuals in crisis. Synthesising this knowledge offers valuable opportunities to inform and shape the development of future approaches in Scotland.

RESEARCH AIMS

This review aims to identify existing research evidence evaluating and describing models of transfer of care of police to healthcare providers (or other relevant agencies) for individuals in mental distress. The objectives were to identify the evidence available on:

1. What information is publicly available in other policing jurisdictions in the UK and internationally to describe the transfer of care for people in mental distress?
2. What are the core elements of practice across the different models for the transfer of care?
3. What does 'good' look like for the transfer of care of people in mental distress?

TERMS AND DEFINITIONS DEVELOPED IN CONSULTATION WITH THE ADVISORY GROUP

- **Transfer of care**

  The process of moving a person in distress to a place of care when they are experiencing a mental health crisis. This includes handover of responsibility for an individual in crisis from the police to another agency (e.g., healthcare providers)

- **Models of transfer of care**

  Refer to approaches designed to guide the safe and effective handover of individuals in mental distress from police to appropriate health or social care providers. These models might include transportation to a place of safety, defined frameworks/protocols that outline roles, responsibilities, and procedures and a description of agency interaction in the process of handover of responsibility.

- **Mental distress**

  Emotional distress that led the individual to seek or be referred for assistance, but which does not require further assistance from emergency services like police, ambulance, or fire response. However, the person still needs treatment, assessment, or care for their distress, leaving the police to manage and navigate this support.

Methods

This rapid review explores the process of the transfer of care of people in mental distress. Rapid reviews aim to identify in a time-sensitive manner what is already known about a practice issue by using streamlined systematic review methods to search for available evidence (Grant et al., 2009). The current review followed guidelines suggested by Dobbins (2017). This review aimed to describe available literature rather than evaluate its effects, so quality assessment was not conducted.

SEARCH STRATEGY

We used a multi-faceted search strategy that included searching databases and websites, asking key informants for recommendations and screening the reference lists of included studies and existing reviews.

First, we drew on relevant literature identified through an ongoing scoping review on policing and mental health (ESRC study), which served as the foundation for developing the search strategy for the current review. In consultation with the project's Advisory Group, we then developed a refined list of search terms.

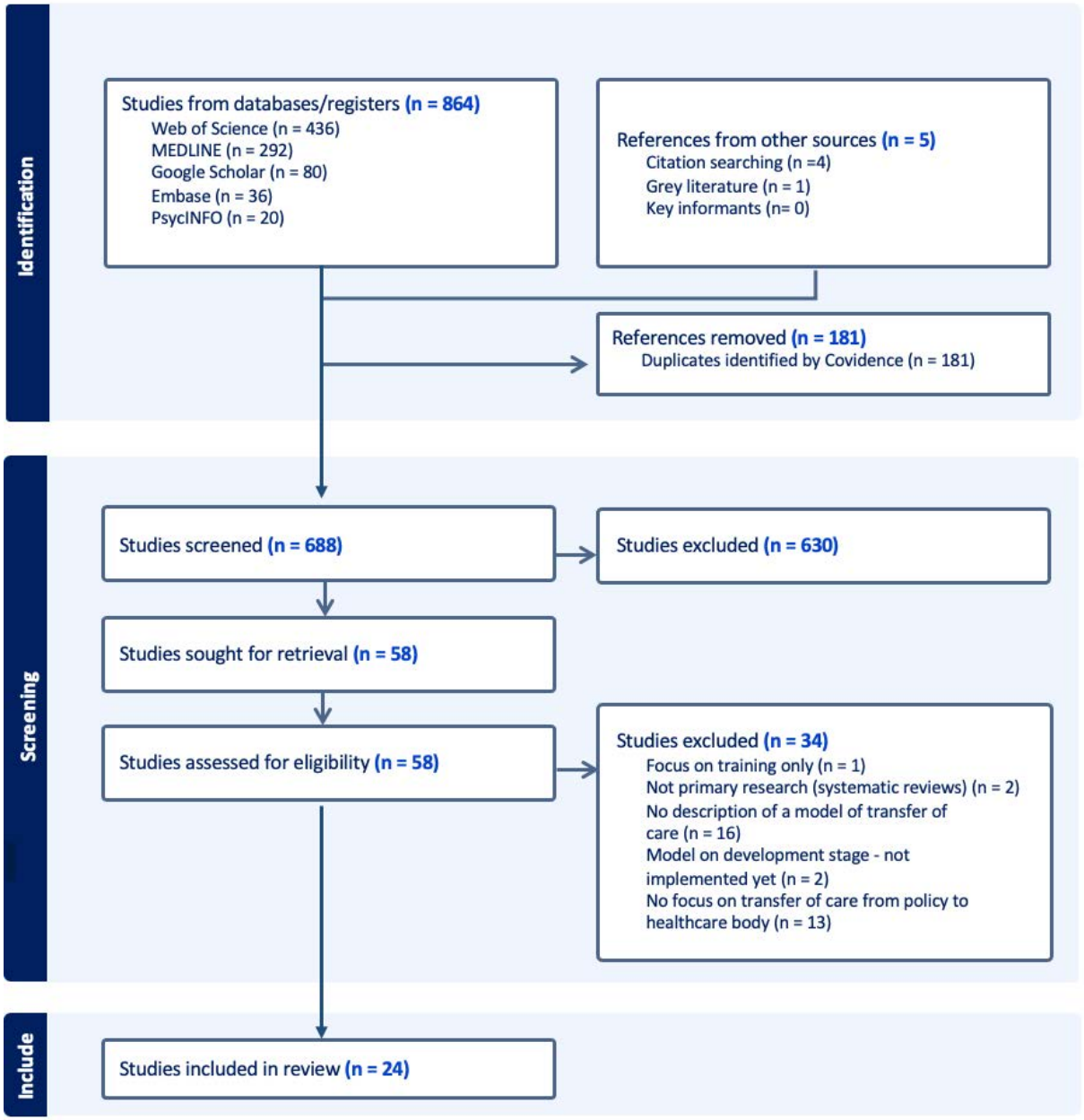
We searched Embase, Medline, Web of Science and Google Scholar, which have been recommended as the optimal combination of databases to guarantee adequate and sufficient coverage (Bramer et al., 2017). We also searched WorldCat and Open Grey to identify grey literature. The search involved a combination of key terms in relation to police AND crisis (e.g., mental health, distress) AND transfer of care (e.g., transfer*, handover, conveyance) AND service (e.g., A&E, emergency department, place of safety). For full search strategy, see Appendix 1. We also asked our advisory group to provide feedback on the identified records and to identify any publications not captured by the search. We also hand searched the reference lists of included studies and of existing reviews on transfer of care (e.g., McGeough & Foster, 2018; Nielson et al., 2020; Parker et al., 2018; Rodgers et al., 2019).

SEARCH PROCESS

Databases were searched in January 2025 in order to identify recent practices in transfer of care. Although only studies in English were included, language filters were not applied. All results, identified by the database searches were collated into Covidence (a software for managing systematic reviews). The titles and abstracts of eligible articles were independently screened by two authors (ED and MC), who marked each article as "include", "exclude" or "unsure" on the basis of the selection criteria. After this, the full text of all articles marked as "included" was obtained and screened independently by three authors (ED, EH and MC). Discrepancies were resolved through discussion. The main reason for discrepancies included lack of clarity around the definitions of 'transfer of care' and 'model of care'. In such instances, we were guided by the review questions and decided to include wider conceptualisations, referring to existing pathways, practices and models, as long as they refer to the transfer of people in mental distress to a place of safety by the police.

Additional searches (e.g., hand searches) were conducted in February-March 2025. This resulted in the identification of 3 studies. Key informants were invited to recommend additional articles until the end of April 2025, however, no further studies were identified. In total, 24 studies were included. The search process is presented in the PRISMA diagram below.

Figure 1 Flow chart of study selection process, adapted from PRISMA



SELECTION CRITERIA

Primary studies were included in the review if they were written in English, published since 2010 (to ensure only current and recent practices are included) and focused on any aspect of transfer of care of a person in mental distress to a place of safety by the police. Although we aimed to include study reports, other sources of grey literature (e.g., student dissertations, conference abstracts, newspaper articles) were excluded as they may be less scientifically rigorous or may not provide sufficient information.

DATA EXTRACTION AND ANALYSIS

A data extraction tool was developed based on the review aims and focused on study information (i.e., author, year, title), country, aims, methods (i.e., design, sample and comparator where applicable), findings about outcomes from transfer of care models, and study authors' recommendations. Data from included studies were extracted in Microsoft Excel by one author (ED, EH or MC). Extracted information is presented in Appendix 2.

The information from the included studies was brought together in a narrative synthesis following guidance from Popay et al. (2006). First, an inductive approach was adopted where studies were read and re-read to identify key aspects of transfer of care (e.g., type of model, communication, training, place of safety). These were then used to develop a preliminary synthesis of factors that may influence the effectiveness and success of the transfer of care. The relationships between these were explored, comparing studies that achieved intended outcomes versus those that did not identify what 'good' looks like for the transfer of care of people in mental distress . The final results are presented as per the review research questions.

ESRC STUDY

The transfer of care project is aligned with the ESRC funded research being undertaken by Professors Hughes and Webber. This is a two-year project focusing on how police officers respond to mental health problems in routine, 'everyday', policing. Much of policing and mental health research has focused on mental health crises and police response (including collaborative initiatives with mental health services and other agencies – known as "street triage" or "co-response"), though most contact with people with mental health problems occurs in everyday situations and it remains unknown how police (police officers and community support officers) understand and interpret mental health problems when they are encountered in routine work. The study consisted of a scoping review of the literature first, followed by a two-part research study:

1. An ethnographic study that will involve observing routine police work across response cars, community policing and in the control room.
2. Interviews with police officers, police staff, people with lived experience of mental health problems and contact with police, and local partner agencies.

The aim was to better understand what knowledge, skills and experience the police draw upon to inform their response, what interpersonal skills they use, and how their response may vary when working with, or informed by, a mental health professional. In addition, data was gathered from the perspective of people experiencing mental health problems as well as partner agencies (such as NHS Mental Health Trusts, Ambulance Service, Adult Social Care, or community or voluntary sector). This data was obtained in two police force case study sites in England; one is predominantly "rural/coastal" and one is more densely populated and urban.

Whilst no transfer of raw data was made between the ESRC project and the Transfer of Care Project, some key quotes that related to the topic of transfer of care were included in this report to supplement the literature review findings. Findings from this review are also being fed into the ESRC project to inform its broader analysis.

Findings

1. What information is publicly available in other policing jurisdictions in the UK and internationally to describe the transfer of care of people in mental distress?

We identified 24 published peer-reviewed articles that focus on the transfer of care. These were conducted in Canada (n=9), the UK (n=5), Australia (n=5), USA (n=3), the Netherlands (n=1) and New Zealand (n=1). We found only five published studies in the UK – two in England, one in Scotland, one in Wales, and in one the nation was not specified.

Of the articles that reported the specific location covered by the study (rural and urban areas) (n=19), eleven were conducted in urban areas, seven covered both urban and rural areas, and one covered rural areas only.

The scope of included studies differed and focused on different aspects of the transfer of care including crisis models, improving communication between police and health professionals, training for police officers, the use of screening tools by police officers when responding to mental distress calls, places of safety and inter-hospital transport.

Study designs included qualitative (n=9), retrospective or secondary data analysis (n=5), quasi-experimental designs (n=4), mixed methods (n=3), one ethnographic study, one cross-sectional survey, and one controlled before and after design. Of the 13 studies that collected primary data from interviews and focus groups, five included service users' perspectives.

The terminologies used to describe the different models of transfer of care, samples and outcomes were directly derived from the included papers. Table 1 provides detailed descriptions of the included studies.

2. What are the core elements of practice across the different models for the transfer of care?

There is no universally accepted taxonomy of interventions in this area. A range of different models of transfer of care was described in the studies. Each of these models tends to fall into one of four categories based on how they were characterised in the studies or informed by consultation with the study's Advisory Group.

a. Co-response models

Co-response models involve a shared protocol in which police officers are paired with mental health professionals to respond to incidents involving individuals experiencing mental health crises. Fifteen studies identified in the review focused on co-response models, including:

- Crisis Response Teams (CRT) in New Zealand (Every-Palmer et al., 2023)
- Mental Health Mobile Crisis Team (MHMCT) in Canada (Kiseley et al., 2010)
- Mobile Crisis Rapid Response Teams (MCRRT) in Canada (Fahim et al., 2016)
- Mobile Crisis Intervention Teams (MCIT) in Canada Lamanna et al., 2018; Kirst et al., 2015
- Co-responding Team (Zitars & Scharf, 2024)
- Police, Ambulance, Clinician Early Response (PACER; Heffernan et al., 2024), A-PACER; Evangelista et al., 2016), N-PACER (McKenna et al., 2015) in Australia
- Mental Health Intervention Team (MHIT) programme in Australia (Herrington & Pope, 2014)
- Crisis Outreach and Support Team (COAST) in Australia (Semple et al, 2021)
- Mental Health Street Triage in the UK (Broome et al., 2022; Callender, 2019; Horspool et al., 2016; Wondemaghen, 2021)

b. Liaison models:

Liaison models involve either police officers with specialised mental health training or healthcare professionals acting as the first-line responders to mental health crises in the community, with support from the other service if required. These professionals also act as liaisons to the formal mental health system. Two studies identified in the review examined liaison models, specifically:

- Crisis Intervention Team (CIT) in the USA (Comardin et al., 2015)
- Psychiatric Ambulance (PA) in the Netherlands (Zoeteman et al., 2024)

c. Designed places of safety models:

Designed places of safety models refer to designated locations where individuals experiencing mental distress can receive immediate care and assessment. These facilities aim to reduce unnecessary hospitalisations and minimise police involvement, while ensuring timely and appropriate mental health intervention. Examples include:

- Crisis Center in USA (Makin, Carter & Parks, 2024)
- Places of safety legislation in Scotland (Simpson & Eze, 2020)

d. Screening tools:

Screening tools are used in community settings to evaluate an individual's mental state, risk level, and immediate needs. These tools assist first responders, crisis teams, and healthcare professionals in determining the appropriate level of care—whether hospital transport is necessary or if community-based support would be more suitable. Examples included:

- the interrail Brief Mental Health Screener in Canada (Hoffman et al., 2021)
- Electronic mental health screener (MHS) in Canada (Stander & Lavoie, 2021)

In addition, we have also identified 3 studies that describe the interface between police and health professionals during transfer of care (Arnaert et al., 2021; Brandenburg et al., 2024; Hickey et al., 2020). These studies described a framework for handover of care.

3. What does 'good' look like for the transfer of care of people in mental distress ?

A range of outcomes that might be associated with the transfer of care models has been identified. This includes time under policy custody, rates of police calls, rates of detention/sanctions, quality of care during call and/or transportation, emergency department utilisation/attendance duration, hospital diversion, treatment admission, re-admission/follow-ups and communication between staff. Table 2 presents information on outcomes from each study according to models of transfers of care.

Table 2. Outcomes reported in the studies

CO-RESPONSE MODELS	*A shared protocol paired police officers with mental health professionals to attend police call-outs involving people with mental distress*
Crisis Outreach and Support Team (COAST), Australia *Semple et al. (2021)*	**Detention/Sanctioned:** Compared to general patrol officers, COAST apprehended individuals less often and spent less time in the hospital when they did have to use that disposition. **ED utilisation/attendance duration:** Officer from COAST team spend less time in EDs (the average amount of time spent in the ED (M = 56.5 min, SD = 24.1) was approximately half that of general patrol (M = 107.0 min, SD = 42.5).)
Crisis Response Team (CRT), New Zealand *Every-Palmer et al. (2023)*	**Policy custody:** reduced police custody time, with a 10:1 risk of transport to cells for usual care vs. CRT responses. **ED utilisation/attendance duration:** reduced ED visits and shortened attendance duration. **Treatment admission:** no impact on admission rates, coercive treatment in the 24 hours following the emergency call, and rates of people experiencing seclusion or restraint in hospital, or in utilisation of compulsory treatment. However, admission to psychiatric unit was lower for people who had presented on days with CRT, but these numbers were small. **Re-admission/Follow-up:** reduction on rates of ED attendance within the 1-month follow-up period
Co-Respond Team, Canada *Zitars & Scharf (2024)*	**ED utilisation/attendance duration:** CRTs often face long wait times. However, where a Memorandum of Understanding between police and hospitals is in place, individuals brought in under the MHA are prioritised for assessment. This agreement reduced wait times—from approximately 150 to 70 minutes for traditional police responders and under an hour for CRTs

Police, Ambulance, Clinician Early Response (PACER), Australia *Heffernan et al.(2024)*	**Police custody:** lower involuntary detention rates than police or ambulance. When police or ambulance paramedics attend the crisis without clinically informed advice, the patients are more likely to be detained but less likely to be admitted. **Detention/Sanctioned:** lower rates of involuntary detentions, more individuals have been transported to the hospital voluntarily rather than by involuntary detention. **Hospital diversion:** approximately half of patients were diverted from hospital as the paramedic or police officer indicated that they would have involuntarily detained them when in their general duties. **Re-admission/Follow-up:** rate of post-detention hospitalisation in the PACER cohort was higher when compared with ambulance and police
Alfred-PACER (A-PACER), Australia *Evangelista et al. (2016)*	ED utilisation/attendance duration: Consumers reported effective handover of information between the A-PACER team and ED/psychiatry staff. Care during crisis/transportation: a) Clinician communication was crucial in calming distress and ensuring a smooth transfer; b) Consumers valued information sharing with case managers, psychologists, or community services after discharge; c) Shared information helped in understanding the crisis and planning for future prevention
Northen Police, Ambulance and Clinician Emergency Response (NPACER), Australia *McKenna et al. (2015)*	**Care during crisis call:** NPACER enhances real-time, face-to-face collaboration between police and mental health clinicians, enabling a coordinated and well-understood approach to managing safety and guiding individuals through appropriate services. Joint access to secure, real-time databases supports accurate information sharing, improving decision-making by combining clinical and justice insights. This integrated process helps create a fuller picture of risk and needs, allowing for timely interventions and smoother transitions toward crisis resolution. **Detention/Sanctioned:** NPACER helped police better understand how mental illness symptoms relate to crisis behaviours, leading to more tolerant, effective responses and reduced use of force. The involvement of a de-escalation-trained mental health nurse allowed for a calmer, less traumatic experience for individuals in crisis. **ED utilisation/attendance duration:** Enhanced communication among police, mental health clinicians, and ED staff helped streamline the care pathway for individuals in crisis. Smoother transition to ED was supported by NPACER clinician contacting the receiving ED in route to prepare for arrival. Diverting those who did not need ED assessment allowed better focus and care for patients with physical health needs **Hospital diversion:** PACER was seen as effective in diverting people to less restrictive alternatives (i.e. to their home, to a GP, or to another community service) Treatment admission: Improved timely admission to the acute mental health inpatient service.

Street Triage, UK *Horspool, Drabble & O'Cathain (2016)*	**Detention/Sanctioned:** individuals were less frequently apprehended than general patrol officer. **ED utilisation/attendance duration:** officers spent 56.5 minutes (SD = 24.1), approximately half the time of general patrol officers, who spent 107.0 minutes (SD = 42.5). **Treatment admission:** During Street Triage hours, a key role of mental health staff was referring individuals to appropriate mental health services. This seemed as a positive element of the programme. 2) However, referrals did not always ensure service users received timely care or treatment. Long waiting times in some services limited what mental health workers could guarantee, highlighting challenges in service availability and accessibility.
Street Triage, UK (South England: Hampshire, Dorset, Avon and Somerset, Wiltshire and Gloucestershire) *Wondemaghen (2021)*	**Treatment admission:** The key factor determining whether a service user is taken to a hospital for treatment or into police custody is the availability of health-based places of safety.
Mental Health Street Triage (MHST), UK Callender (2019)	**Communication:** There are needs to be a more explicit and informative discussion that outlines the criteria and factors that shape mental health service access decisions. In particular, the thresholds for service access should be shared and explained to the police.
Mental Health Intervention Team (MHIT), Australia *Herrington & Pope (2014)*	**Care during crisis/transportation: a)** familiarity and proficiency with de-escalation techniques affects officer confidence, corresponding to greater willingness to spend time with individuals in distress, and being less likely to rush to resolution. b) Interagency cooperation remained challenging, mainly due to resourcing concerns. The removal of police from inter-hospital transports required NSW Health to fund personnel, vehicles, and costs, posing a greater challenge in rural areas with limited resources and larger distances between hospitals. **Police custody:** Reductions time spent by police attending to mental health related calls. **ED utilisation/attendance duration:** reduction in time spent waiting at hospitals.
Mental Health Mobile Crisis Team (MHMCT), Canada *Kiseley et al. (2010)*	**Police/Service response:** there was an increase in the number of mobile visits, however the call-to-door time halved in the 2 years of operation of the service. **Police custody:** the time on-scene for police officers on mental health calls in the intervention area fell significantly each year after the introduction of the enhanced service. At year 2, the time spent on-scene by police (136 minutes) was significantly lower than in the control area (165 minutes). **Treatment admission:** Patients in contact with the mobile crisis service showed greater subsequent engagement with treatment than control subjects as measured by increased outpatient contacts.
Mobile Crisis Rapid Response Team (MCRRT), Canada *Fahim, Semovski & Younger (2016)*	**ED utilisation/attendance duration:** Police wait times remained under an hour, consistently shorter than with a police-only response. **Treatment admission:** Only 20% were discharged without a psychiatric assessment (vs. 53% previously). Of those assessed, 54% required admission—a 29% increase. **Hospital diversion:** Over 12 months, hospital transports for people in crisis reduced by 49% compared to a police-only mode.

Mobile Crisis Intervention Team (MCIT), Canada *Kirst et al. (2015)*	**Care during crisis call:** shared training between mental health nurse and police facilitated better shared decision making. **ED utilisation/attendance duration:** 1) participants highlighted long emergency department wait times as a major challenge. The triage process was seen as ineffective, requiring consumers to be reassessed by a psychiatric nurse despite prior MCIT evaluation; 2) medical clearance by a physician delayed the legal handover, keeping teams tied up and preventing them from responding to other calls while potentially increasing consumer distress.
Mobile Crisis Intervention Team (MCIT), Canada *Lamanna et al.(2018)*	**Detention/Sanctioned:** Co-responding teams were more likely to complete both voluntary escorts and other mandated escorts to the hospital than police-only teams. Yet, police-only team interactions were more likely to result in responder-initiated involuntary escorts. Interviews with service users highlight that the co-responding teams' crisis de-escalation skills play an important part in decreasing the risk of undesirable, adverse outcomes, including being brought involuntarily to an ED, handcuffed, or harmed by police. **ED utilisation/attendance duration:** Co-responding team interactions were more likely to result in an ED escort compared to police-only team interactions. Time spent in the ED during the handover of care was significantly lower for co-responding teams' escorts (median = 60 min) than police-only teams' escorts (median = 75 min).
South Wales Police Mental Health (MH) Triage service, Wales UK *Broome et al. (2022)*	**Detention/Sanctioned:** triage reduced use of S136 (police powers of detention) by providing advice about alternative solutions. **Treatment admission:** Despite generally positive perceptions of mental health triage, service users reported ongoing difficulties accessing follow-up care and signposting services. Limited access to continuing support was seen as part of a broader systemic issue, attributed to cuts in community mental health services. This gap was perceived as potentially undermining the effectiveness of triage and eroding trust in police involvement even when the limitations were beyond their control. Additionally, concerns were raised that police involvement in triage should not create the impression that they can "fast track" individuals into mental health services. Triage may simply provide intermediate support especially out of hours. **Follow ups/Continuity of care:** Difficulties in accessing follow-on or signposted services emerged as the most significant issue with triage. This challenge, largely due to cuts in community services, risks undermining the effectiveness of triage and damaging trust in the police—even when the issue lies beyond their control. Service users also expressed unmet expectations, often hoping triage would provide follow-up or long-term support in the absence of broader service availability. The core concern was that while triage could identify needs and offer initial help, support often ended once the call concluded.

LIAISON MODELS	***Described as involving police officers who had special mental health training / healthcare professionals serving as the first-line police response to mental health crises in the community and acting as liaisons to the formal mental health system.***
Crisis Intervention Team (CIT), USA *Comardin et al. (2015)*	**Care during crisis call/transportation:** officers were more likely to travel longer distances to ensure individuals received appropriate care. **Hospital diversion:** Officers increased referrals to the crisis centre by 21.9%, with CIT-trained officers being 2.8 times more likely to transport individuals there than non-CIT-trained officers (reduction in ED use). 2) The crisis centre received 10 additional officer-initiated referrals per month.
Psychiatric Ambulance (PA) service, Netherland *Zoeteman et al. (2024)*	**Police custody:** PA transport reduced police car transport from 96% to 1%, leading to significant time savings for law enforcement, potentially saving several person-hours per incident. **Detention/Sectioned:** reduction in involuntary hospitalisations **Treatment admission:** hospitalization rates remained consistent between the pre-PA and PA cohorts.
DESIGNATED PLACE OF SAFETY MODELS	***Designated location where individuals experiencing mental distress can receive immediate care and assessment. These facilities aim to reduce unnecessary hospitalisations and police involvement while ensuring appropriate mental health intervention.***
Crisis center in a behavioral health district, USA *Makin, Carter & Parks (2024)*	**Detention/Sectioned:** Inconsistent results with regards the availability of a crisis center and the use of emergency hold petitions. The implementation of crisis centers at the study site may not have successfully met its initial objectives of diversion from the emergency hold system.
Place of safety legislation, Scotland, UK *Simpson & Eze (2020)*	**Care/transportation:** Individuals are often removed from high-risk areas and referrals to police are frequently initiated by individuals themselves. **Treatment admission:** 1) A diagnosis of mental illness or personality disorder predicted hospital admission. 2) Hospital admission is generally avoided for referrals related to social stressors or substance misuse unless deemed necessary. 3) The longer individuals were detained in a place of safety, more likely they were to be admitted to hospital - probably related to service provision in more rural areas, i.e. lack of crisis response teams as well as practicalities in supporting discharge to more rural areas in the evenings and overnight. 4) Presence of senior nursing staff at the assessment, but not the seniority of the doctor, was associated with the outcome of the assessment (no admission).
SCREENING ASSESSMENT TOOL	***Assessment tools used in the community to evaluate an individual's mental state, risk level, and immediate needs. Aimed at assist first responders, crisis teams, and healthcare professionals determine the appropriate level of care and whether hospital transport is necessary or if community-based support is more suitable.***
interRAI Brief Mental Health Screener, used by police services, Canada and USA *Hoffman et al. (2021)*	**Police response:** The number of police response calls for service increased by almost 30% over the study period which could be explained by the fact that police officers were increasingly more aware of indicators of mental health problems and in completing the BMHS. **Hospital diversion:** Fewer persons were taken to the ED - overall decrease of over 30%.. **Detention / Sanctioned:** decrease of 30% for involuntary referrals which may be due to officers having a more informed understanding of when to apprehend a person in crisis.

Electronic mental health screener (MHS), Canada *Stander & Lavoie (2021)*	**Care/transportation:** officers did not view the MHS as an effective tool for individual risk assessment. **Follow-up/ Re-admission:** beneficial for improving care continuity and follow-up in community service referrals, potentially preventing future crises and reducing the burden on police if treatment is successfully engaged.
Interface between police and health professionals	***Framework for handover of care***
Arnaert et al., 2021	**Communication:** highlights the importance of role clarity, communication, and collaboration. Clear police-ED handover protocols that focused on roles and responsibilities, safety and collaboration, are important.
Brandenburg et al., 2024	**Communication:** ED staff highlight that a key strategy for addressing several challenges in providing care to detainees was effective communication with police. Participants described positive experiences of teamwork with police officers, characterised by mutual respect for each other's roles and needs. They highlighted several helpful practices, such as asking police guards to share information about the detainee's presentation, legal status, and the general conditions of the watch-house to facilitate contact with the watch-house, to remove restraints when appropriate, and to step away temporarily to allow for private clinical interactions.
Hickey et al., 2020	**Shared information:** ED staff noted access to inpatient care as the largest barrier and the need for more community resources for individuals with mental health disorders.

In the subsections below, we present a narrative synthesis of findings on what has been identified as effective in the included studies. We also incorporate perspectives from professionals working in mental health crisis response drawn from the ESRC Policing and Mental Health study to illustrate their views on current practices.

Components of transfer of care models

Only two studies investigated the impact of co-responding models including a police officer, a paramedic and a mental health professional (Every-Palmer et al., 2023, Heffernan et al., 2024). Both showed lower rates of coercive treatment or involuntary detention compared to usual care (e.g., ambulance only, police only response). Every-Palmer et al. (2023) also found reductions in emergency department (ED) utilisation, time spent in police custody and a decrease in hospital admissions, although the latest finding did not reach statistical significance. In contrast, the PACER model evaluated by Heffernan et al. (2024) showed an increase in hospital admission rates. As pointed out by Every-Palmer et al. (2023), the joint decision-making and multi-agency collaboration inherent in CRT models enables first responders to deliver more integrated, nuanced responses to emergency callouts involving mental health crises. The importance of such collaboration was also emphasised by a member of staff from the Ambulance Service interviewed in the ESRC study, who highlighted the following:

> *"Sometimes you get individuals who might tell a different story to each service, so it's really good for us to collaborate, we just get a better response, and people know exactly where they stand with us... So that might be someone that we've highlighted to them [Police], this one's obviously in a grey area, it's slipped the net, we're really concerned about this person, the risks are escalating. They'll go out on a joint visit with us."*
>
> ***(Ambulance Service – ESRC Policing and Mental Health Study)***

The other types of models focused on a team of a (trained) police officer and a mental health professional (e.g., mental health crisis worker, mental health nurse, mental health clinician) without the presence of a paramedic. In most cases, the mental health professionals went out in the police car, but in a couple of studies they were in a control room and provided advice to the police officer or spoke directly with the individual in distress (Broome et al., 2022; Wondemaghen 2021).

Although the above studies suggest that some models have the potential to reduce involuntary detention, ED utilisation and police waiting time at ED, they highlight the importance of effective communication and wider community support for intervention effectiveness. Callender et al. (2019) found that the strategic and operational outcomes of Street Triage in England were shaped by levels of trust, belonging and legitimacy between police and health. Within the context of Street Triage, the authors point to the importance of mental health nurses sharing practical insights into mental health presentations and actively supporting police officers in assessing risk and determining appropriate responses (Callender et al., 2019).

It is important to note that only one study included a large-scale evaluation of model effectiveness (Kiseley et al., 2010) and the majority of the studies recommend the need for robust evaluations of the programmes. As Comartin et al. (2015) highlighted there is a need for research to differentiate between the type of mental health treatment referral made by officers and the respective costs of distance, to determine whether models significantly affect referrals to treatment that is more likely to lead to long-term, low-cost services.

Communication

Evidence from different countries including Australia, Canada, the UK and the USA suggests that if effective communication and collaboration between services are lacking, transfer of care becomes ineffective. This applies to each stage of the individual's 'journey', from shared information about roles and joint decision-making between police officers and mental health professionals, through communication between the triage/liaison team and hospital services, to clear signposting and handover between hospital and community services. Additionally, a lack of wider community support may result in future mental health occurrences if the individual's needs are met by the crisis team but their wider needs remain unmet (Broome et al., 2022), highlighting the importance of wider community support for crisis interventions to be effective.

An example of positive communication during the handover of information to ED/Psychiatry staff was reported by Evangelista et al. (2016) with the evaluation of Alfred-PACER (A-PACER) in Australia. Like the PACER model, A-PACER offers a joint secondary response to mental health crisis calls. However, unlike PACER models where team members are co-located at police stations, A-PACER involves a police officer based at a police station and a mental health clinician stationed approximately one kilometre away at the psychiatric triage unit of a tertiary hospital, enabling timely response, ongoing consultation to build police mental health expertise, and continued integration of the A-PACER clinician within the broader mental health team. Referrals to A-PACER are made by first-responding police when a mental health concern is suspected. Operating alongside police officers, mental health professionals can conduct assessments and develop care plans onsite, thereby avoiding lengthy delays in the emergency department. Service users participating in the study reported that the A-PACER model facilitated more effective communication during handover to hospital staff compared to previous experiences, where communication breakdowns had occurred. They also expressed satisfaction with the continuity of care, particularly the timely and coordinated handover of information to their case manager, psychologist, or community services following hospital discharge or crisis resolution.

A few studies focus on the importance of effective communication between different teams highlighting 1) a need for clear police-ED handover protocols that focus on roles and responsibilities, safety and collaboration (Arnaert et al., 2021); 2) consideration of legal recommendations for handover (Kirst et al., 2015); and 3) more explicit discussion that outlines the criteria and factors that shape mental health service access decisions (Hickey, K. et al., 2020). However, specific recommendations on how to improve communication and inter-agency working are limited. Zitars and Scharf (2024) suggest that there should be an agreement between police and ED staff to prioritise individuals brought in by the police in order to reduce police waiting time in ED. Stander and Lavoie (2021) showed that a mental health screening tool can facilitate information sharing between criminal justice and health services, and improve care continuity and follow-up in community referrals, potentially preventing future crises. Simpson & Eze (2020) showed that infrequent recording of events by police using Police Report - Removal To Place Of Safety forms (POS1) in Scotland can lead to individuals not receiving appropriate care and experiencing further difficulties. The following quote from the ESRC study illustrates the need for improving communication including clearer expectations around the roles and responsibilities of different services:

> *"Improving communication - would be helpful to know who we contact and I guess having a bit of a discussion or communication about what do you expect and what do we expect and what's realistic. Because I think sometimes when services clash… we clash when we have unrealistic expectations of each other. (…)*
>
> *Having a conversation and saying: this is what we would like and then the police could say well, that's not possible, but we could offer this and then you sort of compromise, don't you? But at the moment, I don't think we have that."*
>
> ***(NHS Mental Health Psychologist - ESRC Policing and Mental Health Study)***

Screening tools

The potential of screening tools to improve transfer of care requires further investigation. We identified only two studies, in Canada, that explored the potential of screening tools in improving transfer of care in relation to a range of outcomes, such as ED visits, involuntary transfer and improved communication. The interRAI Brief Mental Health Screener (BMHS) (Hoffman et al., 2021) and an electronic Mental Health Screener (MHS) (Stander & Lavoie, 2021) show promising results. Both screening tools are designed to help police officers to assess the behaviour of the individual based on the presence of specific mental disorder indicators. The components of the BMHS are not described in detail, while the MHS is comprised of five sections. Section A is focused on identification information and police action, and includes information such as: date, client name, address, sex, date of birth, incident number and time of response. Section B focuses on indicators of disordered thought: irritability, hallucinations, command hallucinations, delusions, hyper-arousal, pressured speech or racing thoughts, abnormal thought process, socially inappropriate or disruptive behaviour; verbal abuse; intoxication by drug or alcohol. The form provides very brief definitions for each symptom. The section also asks the officer to rate the subject on the degree of insight into the mental health problem and cognitive skills for daily decision-making. Section C is focused on indicators of risk of harm and collects information on variables such as: previous police contact, history of weapons, presence of recent violence; indicators of self-harm; state of home environment; and compliance with medication. Section D records the time the officer arrived at the call, was released from the hospital, and the time the call ended. Section E provides space for the officer to include other information they feel is pertinent to the call. Despite the range of items included in the MHS tool, police officers generally perceive it as limited in its effectiveness for individual clinical assessment. However, the tool is viewed more positively in terms of its contribution to improving continuity of care and facilitating appropriate referrals to community services. When treatment is successfully initiated, the tool may help prevent future crises and reduce the ongoing burden on police resources.

With regards to BMHS, Hoffman et al. (2021) found that over the study period, police service calls rose by nearly 30%, likely reflecting increased officer awareness of mental health indicators and use of the BMHS, while hospital diversions and involuntary referrals each declined by over 30%, suggesting more informed decision-making and reduced reliance on EDs and detention.

Training

Another way to improve transfer of care is to focus on training for police officers and mental health professionals. Three studies focused on training for police officers and/or mental health professionals, who work together as part of the transfer of care. Participants in a Canadian study of the Mobile Crisis Intervention Teams (MCIT) (Kirst et al., 2015) showed that nurses and police officers may have a limited understanding of each other's professional cultures, suggesting a need for more cross-sector training for each group to enhance collaborative work. For example, they suggested that more training on effective consumer engagement, crisis de-escalation, and general mental health system information was needed for police officers, while more training on safety issues and police culture was recommended for nurses.

The other two studies evaluated a training programme. In Australia, Herrington and Pope (2014) found that Mental Health Intervention Team (MHIT) training increased police officers' empathy, patience and confidence during mental health-related events, and improved relations with other health agencies. It is unclear what the MHIT training involved but the authors suggest it is similar to Crisis Intervention Team (CIT) training. In the USA, Comartin et al. (2015) evaluated the effect of Crisis CIT training on officer transport decisions to a mental health crisis centre or a local hospital ED, particularly if the incidents were far away. The training provided police officers with

40 hours of knowledge on identifying mental illness (e.g., covering different mental health diagnoses and psychotropic medications), de-escalation skills, and encouraged the use of the local mental health crisis facility as part of the overall CIT model implementation. The results show increased use of the crisis centre and decreased use of EDs by officers after CIT was implemented. The crisis location affected officer transport decisions, yet CIT officers were more likely than non-CIT officers to travel farther for appropriate linkage.

The need for further investment in training was also highlighted in the interviews from the ESRC study, in particular the need for trauma-informed training and effective communication with individuals during and after experiencing a mental health crisis.

> *" Trauma informed and I'm sure they [police] do lots of training on that anyway, but I think sometimes it's what's effective and safe, trying to do that in a trauma informed way as well. (...)And it is important to do what's effective- but being really transparent with people, being really clear with people and honest with people. Telling people what you're going to do and why you're going to do it. Because I think sometimes when I speak to patients, they're really confused about why something happened I spoke to somebody earlier and he said: 'I willingly said I was going to come to hospital and then they put cuffs on me and I wasn't sure why'. And there probably was a legitimate reason but maybe working on like verbalising that I think is really important."*
>
> ***(ESRC Policing and Mental Health Study)***

Inter-hospital transport

Only two studies focused on the process of transfer to hospital or another place of safety (Herrington &Pope, 2014 in Australia; Zoeteman et al., 2024 in the Netherlands). Zoeteman et al. (2014) explored the introduction of a psychiatric ambulance (PA) to replace police transport for individuals experiencing a mental health crisis. The PA staff can administer sedatives which may be less traumatic for patients than physical restraint. The use of the PA reduced police car transport from 96% to 1%. Hospital admissions remained consistent, but PA use reduced involuntary hospitalisations. Herrington et al. (2014) highlight that inter-hospital transport, especially in rural areas, requires significant resources to fund personnel, vehicles and running costs. They call for investment in Psychiatric Emergency Care Centres (PECC), which offer short-term support for people in distress before referring them to community services.

Place of safety

We did not identify any studies that explored the characteristics of places of safety. Two studies focused on the potential of specific 'places of safety' to improve transfer of care (Makin et al., 2024; Zoeteman). Makin et al. (2024) found that the availability of crisis centres did not lead to diversion from the emergency hold system (i.e., no reduction in emergency hold petitions). Crisis centres specialise in supporting people in a mental health crisis (most commonly suicide or self-harm), substance use problems, or victims of rape or sexual violence. Herrington and Pope (2014) recommend the need for investment in Psychiatric Emergency Care Centres (PECCs). PECCs offer an interim facility for individuals assessed at emergency departments as having a (suspected) mental health concern that requires observation in a controlled environment. PECCs are particularly useful for people who might be in the hospital for less than 48 hours before being referred to community-based services. The authors Herrington and Pope (2014) suggest that PECCs are especially relevant for individuals who do not meet the threshold for admission under the Mental Health Act 2007 but are not considered well enough to be safely discharged into the community.

Follow-ups/continuity of care

Overall, the studies included in this review provided limited evidence on whether transfer of care models influenced repeat crises or ongoing engagement with community-based services. Although two co-responder models attempted to address

it, their results were mixed. For instance, Every-Pater (2021) reported that New Zealand's Crisis Response Team was associated with reduced emergency department attendance within one month of intervention follow-up. In contrast, Heffernan et al. (2024) found that post-detention hospitalisation rates were higher in the PACER cohort compared to those involving only ambulance or police response. In South Wales, UK, professionals (police and health staff) and service users indicated that difficulties in accessing follow-on or signposted services as the most significant issue with Street Triage (Broome et al, 2022). The core concern was that while triage could identify needs and offer initial help, support often ended once the call ended.

There is some emerging evidence, however, that tools such as the Mental Health Electronic Screener (Stander & Lavoie, 2021) may support better continuity of care and follow-up in community referrals, potentially preventing future crises and reducing the demand on police when treatment is effectively initiated. Nevertheless, Stander & Lavoie's (2021) findings are based on an ethnographic study reflecting end-user perspectives of the tool, highlighting the need for more rigorous, longitudinal research to determine the effectiveness of such tools and models on long-term outcomes across diverse settings.

GAPS IN THE EVIDENCE

While the majority of the models presented in this rapid review demonstrated positive outcomes in various transfer of care elements, the lack of rigorous evaluation means their benefits remain scientifically uncertain. There is an urgent need for adequately powered randomised controlled trials; without such evidence, it will remain challenging to demonstrate their effectiveness and persuade policymakers of their broader value. In addition, the lack of an assessment of study quality and synthesis of the findings means we were unable to make conclusions about the impact of individual models. The limited involvement of people with lived experiences in the included studies highlights an important gap in the current evidence base. Likewise, the absence of attention to the individual and social characteristics of study populations suggests that, overall, models continue to adopt a 'one-size-fits-all' approach to the transfer of care.

Conclusion and recommendations

A key strength of this review lies in its identification of diverse models of transfer of care from police to healthcare services across different countries, along with their reported impacts on various outcomes. While several models have been implemented, the study highlights a significant gap in rigorous scientific evaluation within the field of policing and mental health. In addition, few evaluations considered the views of individuals with mental ill health and those who had contact with the police during a mental health crisis. It is also important to note that the studies included in this review were not subject to formal quality assessment, which limits the confidence in the findings and their applicability to practice.

Nevertheless, our findings offer valuable insights to inform and guide decision-making in Scotland and other jurisdictions, while underscoring the urgent need for further research investment. Building a stronger evidence base is essential to understand when and how these models are most effective, to support the development of clear and accountable handover processes, strengthen the case for sustainable funding, and guide the expansion and enhancement of crisis care services. This evidence base is important in reviews of mental health legislation, which must be context-dependent, as it has the potential to improve outcomes and experiences for people experiencing mental distress.

Our findings contribute to the broader body of research, policy, and practice concerning mental health crises, policing, and the delivery of mental health care. This project aligns with ongoing calls to strengthen interagency collaboration across police and mental health services. Such collaboration can take many forms ranging from basic partnerships with limited resource sharing to fully integrated, comprehensive service models (Parker et al., 2018). Regardless of the form and complexity, effective interagency work is typically grounded in three core principles: information sharing, joint decision-making, and coordinated intervention (Home Office 2014). Interagency approaches must also prioritise health equity, ensuring that the needs of diverse and marginalised communities are explicitly addressed within service design and delivery. We summarise below the key recommendations for Scotland from our project aligned with these foundational principles:

- Most qualitative studies offered evidence on the implementation of transfer of care models, largely reflecting the views of police and mental health professionals involved in delivering these interventions. Although some studies reported improved service user experiences compared to previous approaches, direct input from service users was limited and inconsistently captured. There was also a significant lack of robust quantitative data on service users' outcomes, including individual mental health improvements, changes in service demand, or variations in case identification and access to care. To address these gaps, it is essential to **meaningfully involve people with lived experience in the design, delivery, and**

evaluation of services. Their voices are critical to ensuring that crisis responses are person-centred, culturally responsive, and grounded in a deep understanding of individual needs and contexts.

- Health equity was largely absent from the studies reviewed. The experiences of people from different ethnic and cultural groups, individuals whose primary language is different from that of the country they live, and those with neurodevelopmental conditions were not addressed. Even when service user groups were included, their characteristics and social characteristics were often poorly described, limiting the understanding of how different populations experience the transfer of care. To this end, **our report questions whether the identified models are equipped to deliver equitable and effective care across different communities**. Future service development and research must prioritise equity by systematically including and addressing the needs of underrepresented groups to ensure that care is accessible, appropriate, and responsive to all.
- There is some evidence that training for professionals involved in mental health crisis response may improve the transfer of care. While several structured training programmes are available, ongoing learning opportunities such as cross-professional exchanges, case-based discussions, and shared reflections on real-world experiences could further support staff in recognising diverse practices, navigating complex situations, and anticipating varied outcomes. Importantly, **a deeper understanding of equity, trauma, and their intersection with mental health should be embedded as a core component of mandatory police training to ensure more compassionate, empathetic, and confident responses to individuals in crisis and during the transfer of care**.
- Communication challenges remain a significant barrier to effective joint response between police and mental health services. A consistent theme across studies was the critical importance of timely and accurate information sharing. Addressing this barrier may be possible through **the provision of improved mobile information technology that enables real-time access to relevant data (i.e., mental health information) for both police officers and mental health professionals**. Enhancing information flow might support faster, safer, and more coordinated decision-making in crisis situations.
- **Clear lines of accountability and responsibility are essential among all professionals involved in crisis response**. Differences in risk perception exist between police officers and health professionals. These challenges are further compounded by factors such as alcohol or drug use, or the potential for violence, all of which can make it more difficult to determine the most appropriate course of action. Establishing shared protocols and mutual understanding of roles can support more consistent, coordinated, and safe decision-making.
- There is a need for **investment in structured follow-up procedures for individuals and families following a mental health crisis involving police intervention**. A simple next-day phone call from a trained officer offering reassurance and signposting to appropriate services could enhance the experience and outcomes for both individuals in crisis and their carers. Such follow-up would demonstrate continuity of care, acknowledge the emotional impact of the crisis, and help bridge the gap between emergency response and longer-term support.

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Appendix 1

SEARCH STRATEGY*

*The search strategy was amended for each database

Police	Crises	Transfer	Service
Police	Mental health	Transfer*	A&E
policing	Distress	Handover	Place of Safety
	Intoxication	Ambulance	Emergency department
	Suicide	Vehicle	Hospital
	Crise	Transfer of care	Drop-off centre
	Mental Health Emergency	Transfer of responsibility	Police station
	Psychiatric Emergency	Decision making tools	Police holding cells
	Psychiatric Crisis	Risk assessment	Crisis stabilisation unit
	Emotional Crisis	Conveyance	Mental health crisis Center
	Behavioral Crisis		Designated crisis Center
	Psychological Distress		Psychiatric facility
	Mental Health Breakdown		Psychiatric emergency service
	Emotional Disturbance		Crisis intervention unit
			Behavioral health facility
			Emergency assessment unit
			Short-term assessment center
			Temporary care facility
			Secure assessment unit
			Section 136 suite
			Protective custody facility
			Care and treatment center

Appendix II

DETAILED DESCRIPTION OF STUDIES INCLUDED IN THE REVIEW

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Arnaert et al., (2021)	**Country:** Canada **Location:** Quebec. Urban area	**Interface between police and health professionals during transfer of care:** define handover as "the transfer of information (along with authority and responsibility) during transitions in care across the continuum giving the opportunity to ask questions, clarify and confirm information". Clear and accurate communication in the juncture of care between police and ED staff is crucial to initial management decisions. **Service operation time:** not specified	To address lack of knowledge around the experiences of ED triage nurses regarding the handover of a mental health patient by police officers	**Design:** Qualitative study. Semi-structured interviews **Sample:** Seven emergency triage nurses from a single hospital site **Comparator:** no	**Communication:** highlights the importance of role clarity, communication, and collaboration. Clear police-ED handover protocols that focused on roles and responsibilities, safety and collaboration, are important.	Despite the recognised need for interprofessional collaboration among professionals across sectors, there remains a lack of information on collaborative mental healthcare between ED and police services. It has been noted that effective collaboration between these systems in responding to individuals experiencing a mental health crisis is hindered by poor communication, concerns about patient privacy, inadequate training, siloed services, and safety risks for both patients and staff. Further research, both qualitative and quantitative, is needed to explore the experiences and educational needs of emergency department (ED) triage nurses managing acute mental health presentations, not only in urban settings but also in rural hospitals, where support from community mental health teams is limited and in-patient mental health facilities are not available on site

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Brandenburg et al., 2024	**Country:** Australia **Region:** Queensland. Covering both rural and urban areas	**Interface between police and health professionals during transfer of care:** police 'watch-houses' are custodial facilities designed for short- term detention (overnight or for 24 hours or longer) People detained in watch-houses (i.e. detainees), might be under arrest awaiting charges or court outcome (remand or bail), or temporarily transferred from prison for a court appearance. Detainees may experience acute health problems that require transfer to an ED, especially related to alcohol or other drugs, mental health problems and altered level of consciousness. Service operation time: not specified	To explore emergency department doctors' views on the appropriateness of transferring detainees from police watch-houses to the ED, and to examine their experiences and perspectives on managing detainees within the ED setting.	**Design:** Qualitative study of semi-structure interviews **Sample:** Fifteen ED doctors sampled across 5 purposively sampled Eds **Comparator:** no	**Communication:** ED staff highlight that a key strategy for addressing several challenges in providing care to detainees was effective communication with police. Participants described positive experiences of teamwork with police officers, characterized by mutual respect for each other's roles and needs. They highlighted several helpful practices, such as asking police guards to share information about the detainee's presentation, legal status, and the general conditions of the watch-house; to facilitate contact with the watch-house; to remove restraints when appropriate; and to step away temporarily to allow for private clinical interactions	Participants proposed several strategies to support more equitable care for detainees. These included providing education for ED staff, improving communication with the watch-house, standardising documentation, expanding models of watch-house healthcare, and integrating medical records across systems. While some challenges were viewed as inevitable or requiring more complex, systemic solutions, participants emphasised their relevance to clinical practice in the ED. These challenges included uncertainty around legal disposition, the use of police resources during ED visits, and concerns that detainees may not access appropriate healthcare after release into the community. Additionally, some participants highlighted the persistent difficulty of addressing negative preconceptions among ED staff and the importance of building rapport with detainees.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Broome et al., 2022	**Country:** Wales, UK **Location:** South Wales, rurality not reported	**South Wales Police Mental Health (MH) Triage service:** MH professionals (i.e. CPNs) are based within the police control room to offer real-time advice to front-line officers and control room staff on managing mental health-related incidents. Triage staff may also engage directly with individuals by phone to conduct assessments and provide appropriate support and guidance. Referrals into the triage service typically occur through two main routes: i) via control room staff, or ii) from officers responding to incidents. **Service operation time:** Seven days a week, from 9:00 AM to 1:00 AM.	To evaluate the impact of the South Wales Police Mental Health model during its first year of operation with a focus on service quality and inter-agency relationships.	**Design:** Mixed-methods design using quantitative data from administrative datasets (police Control Works system, Home Office and Welsh Government Annual Data Return and Health S136) and qualitative data from semi-structured interviews/focus groups and survey data with police, MH crisis staff and service users **Sample:** - quantitative study: records of 2,058 incidents - qualitative study: 13 participants (seven police representatives, three control room staff, one triage nurse and two MH crisis staff). Focus groups comprised of two triage nurses, one third sector worker, one Detective Inspector, one MH service senior manager and 6 “experts by experience” (4 service users, 2 carers) - Survey data: 49 police and 12 crisis staff **Comparator:** no	**Detention/Sanctioned:** triage used and reduced use of S136 (police powers of detention) by providing advice about alternative solutions. **Treatment admission:** Despite generally positive perceptions of mental health triage, service users reported ongoing difficulties accessing follow-up care and signposting services. Limited access to continuing support was seen as part of a broader systemic issue, attributed to cuts in community mental health services. This gap was perceived as potentially undermining the effectiveness of triage and eroding trust in police involvement even when the limitations were beyond their control. Additionally, concerns were raised that police involvement in triage should not create the impression that they can “fast track” individuals into mental health services. triage may simply provide intermediate support especially out of hours. **Follow ups/Continuity of care:** Difficulties in accessing follow-on or signposted services emerged as the most significant issue with triage. This challenge, largely due to cuts in community services, risks undermining the effectiveness of triage and damaging trust in the police—even when the issue lies beyond their control. Service users also expressed unmet expectations, often hoping triage would provide follow-up or long-term support in the absence of broader service availability. The core concern was that while triage could identify needs and offer initial help, support often ended once the call concluded	Mental health triage is generally viewed positively by both police and service users. However, its broader impact on health and social care systems remains unclear. A longer-term, system-level evaluation is needed to understand its effects on access to care. Without this, triage may risk reinforcing a “revolving door” cycle, potentially diminishing service user trust and confidence in both the police and the wider mental health system.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Callender, 2019	**Country:** England, UK **Location:** Midlands comprising of both rural and urban areas	**Mental Health Street Triage (MHST):** Mental Health (MH) is located within the police control room to provide advice to front-line officers and control room staff on the management of MH incidents. Triage staff may also speak directly to the individual to conduct over the phone assessments and provide appropriate support and advice. Sites differ in Delivery Model - Site 1: Mental health triage car staffed by one police officer and one nurse - Site 2: Control Room-based CPN during the day, one police officer and one nurse available for deployment in MHT vehicle in the evening - Site 3: Two mental health triage cars, each staffed by one police officer and one nurse **Service operation time:** Site 1, Seven days a week from 10am – 2am. Site 2: Seven-days a week from 8 am to midnight. Site 3: Seven-days a week from 4pm to 1am	To understand Mental Health Street Triage (MHST) staff perspectives on the purpose and evolution of street triage operations, including partnership working, practices and decision-making during mental health-related incidents, and views on the future role of MHST within the local area.	**Design:** Qualitative study. Semi-structured interviews **Sample:** 27 police and health service staff in strategic and operational roles **Comparator:** no	**Communication:** There are needs to be a more explicit and informative discussion that outlines the criteria and factors that shape mental health service access decisions. In particular, the thresholds for service access should be shared and explained to the police	- MHST nurses should share practical insights on mental health presentations and support risk assessment for officers. - Clear alternatives to detention under the Mental Health Act should be communicated to officers in both control rooms and the field. - Mental health training should be expanded beyond MHST members to improve police response.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Comardin et al, 2015	**Country:** USA **Location:** Midwestern count, covering both rural and urban areas	**Crisis Intervention Team (CIT):** This model promotes collaboration among police, mental health service providers, individuals with serious mental illness (SMI), and their families to develop tailored, community-based solutions to the criminalisation of people with SMI. Among its ten core elements, full implementation includes 40 hours of specialised police training, the creation of a dedicated emergency mental health receiving facility with minimal wait times, and strong partnerships across community stakeholders. **Service operation time:** n/a	Does CIT training have an impact on officer transport decisions from a mental health crisis location to a crisis centre over an emergency department (ED)? This study examines the behavioral outcomes of CIT training and the impact of distance between crisis locations and treatment services	**Design:** Quasi-experimental quantitative study (pre-post intervention). Retrospective analysis of police call data. **Sample:** records of 1,617 crisis calls, of which 639 were crisis call pre-CIT training and 978 were up to 20months post-CIT training **Comparator:** 16 months of call reports occurring before CIT training	**Care during crisis call:** officers were more likely to travel longer distances to ensure individuals received appropriate care. **Hospital diversion:** Officers increased referrals to the crisis centre by 21.9%, with CIT-trained officers being 2.8 times more likely to transport individuals there than non-CIT-trained officers (reduction in ED use). 2) The crisis centre received 10 additional officer-initiated referrals per month.	- In areas with limited mental health resources, while establishing a crisis centre may be unfeasible, CIT training can still improve connections to appropriate services. - Ongoing evaluation is essential to maintaining and refining the model's effectiveness. - CIT training also helps law enforcement divert individuals with SMI from hospitalization or incarceration toward long-term, stabilizing mental health care

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Every-Palmer et al., 2023	**Country:** New Zealand **Location**: Wellington District – urban area	**Crisis Response Team (CRT):** Three staff (one uniformed police officer, one uniformed paramedic and one plain clothes mental health clinician) form an 'away' unit, attending mental health crisis calls in the field. Two other staff (a mental health clinician and police officer) act as a 'home' liaison team, remaining at base to search records, collate information, provide advice and make referrals. Each CRT member has access to their respective service's records, e.g. the mental health clinician accessed past health documentation. **Service operation time:** four 10-hour shifts a week (generally 08.30am to to 6.30pm)	To evaluate the impact of CRT one year after its implementation with regards to improve outcomes for service users and reduce demand on Emergency Departments (EDs) and first responders.	**Design:** a quasi-natural experiment design using linked de-identified data from police and health data sets. **Sample:** 1273 mental health emergency callouts occurred between March 2020 and March 2021. Of this, 881 callouts occurred on days with co-response availability and 392 on days without. No descriptive information of the sample **Comparator:** Usual care: Police Communications Center would assig mental health–related emergency to a police dispatcher	**Policy custody:** reduced police custody time, with a 10:1 risk of transport to cells for usual care vs. CRT responses. **ED utilisation/attendance duration:** reduced ED visits and shortened attendance duration Treatment admission: no impact on admission rates, coercive treatment in the 24 hours following the emergency call, and rates of people experiencing seclusion or restraint in hospital, or in utilisation of compulsory treatment. However, admission to psychiatric unit was lower for people who had presented on days with CRT, but these numbers were small. **Re-admission/Follow-up:** reduction on rates of ED attendance within the 1-month follow-up period	- The CRT operated for no more than 10 hours per day, and on CRT days, fewer than two-thirds of service users had contact with the team. This limited exposure strengthens confidence that observed group differences reflect true treatment effects rather than confounding factors - The study period overlapped with COVID-19 lockdowns, during which ED presentations declined across the board. As a result, the findings likely represent conservative estimates of CRT benefits - Long-term analysis and implementation across other New Zealand regions are needed to assess sustained benefits and enable investigation of low-frequency outcomes—such as suicide, use of force, and seclusion—that this study was underpowered to detect.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Evangelista et al., 2016	**Country:** Australia **Location:** Melbourne. Hurban area	**Alfred Police and Clinical Early Response (A-PACER):** PACER is a collaborative approach where police officers and Crisis and Assessment Team (CAT) clinicians respond together to deliver a multidisciplinary crisis intervention. The Alfred PACER (A-PACER) builds on this model by providing a joint secondary response. Unlike other PACER models where teams are based at police stations, A-PACER has the police officer stationed at a police station and the A-PACER clinician located 1 km away in the psychiatric triage unit of a tertiary hospital. A-PACER receives referrals from first-responding police when a mental health issue is suspected. **Service operation time:** Seven days a week, from 2pm to 10pm	To examine how consumers experienced their contact with A-PACER, how this was different to previous crisis responses, opinions about police and MH clinicians working together as a team and recommendations for how A-PACER could be improved	**Design:** Qualitative study of semi-structured interviews **Sample:** 12 mental health consumers who had direct contact with the A-PACER team between June 2013 and March 2015 **Comparator:** no	**ED utilisation/attendance duration:** Consumers reported effective handover of information between the A-PACER team and ED/psychiatry staff. **Care during crisis:** a) Clinician communication was crucial in calming distress and ensuring a smooth transfer; b) Consumers valued information sharing with case managers, psychologists, or community services after discharge; c) Shared information helped in understanding the crisis and planning for future prevention	- Investments should be made on training and education for police officers to enhance their ability to respond to and engage with individuals experiencing a mental health crisis including learning about de-escalation techniques. - There is a need for providing more intensive follow-up care for individuals who had interacted with the A-PACER team and had ongoing support needs. Ensuring a smooth handover of information about the crisis to other professionals involved in the consumer's mental health care was considered crucial for effective follow-up. Consumers acknowledged that supporting rehabilitation and helping individuals manage their symptoms would reduce the likelihood of repeat crisis incidents.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Fahim, Semovski & Younger, 2016	**Country:** Canada **Region:** Ontario (rurality not specified)	**Mobile Crisis Rapid Response Team (MCRRT):** Crisis Outreach and Support Team (COAST) program trains regional police using the Memphis CIT model and pairs officers with mental health crisis workers. Unlike typical secondary response teams, MCRRT responds as first-line crisis support. It aims to reduce unnecessary ED visits, connect individuals to appropriate community resources, and divert those with mental illness from the criminal justice system. **Service operation time:** not specified	To describe the redirect people with mental illness who are unnecessarily brought to an emergency department (ED) and link them to the appropriate community resources, urgent services, or crisis beds. In addi- tion, the MCRRT program seeks to divert individuals with mental illness from entering the criminal justice system	**Design:** A pilot quantitative evaluation of police records on responses to mental health crises **Sample**: 650 police- only data on response to mental health crises. Of this, 308 calls responded by a trained MCRRT officer and 342 not trained. **Comparator:** historic police-only data on response to mental health crises	**ED utilisation/attendance duration:** Police wait times remained under an hour, consistently shorter than with a police-only response. **Treatment admission:** Only 20% were discharged without a psychiatric assessment (vs. 53% previously). Of those assessed, 54% required admission—a 29% increase. **Hospital diversion:** Over 12 months, hospital transports for people in crisis reduced by 49% compared to a police-only mode	MCRRT implementation shows that enhanced mobile crisis intervention models can deliver effective and safe care, even in emergencies. It also highlights the need for a continuum of collaborative services, integrating primary and secondary responses with police partnerships.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Hickey, K. et al., 2020	**Country:** USA **Region:** Midwest county in Illinois. Urban area	**Interface between police and health professionals during transfer of care:** Communication process when law enforcement brings individuals in mental health crisis to the ED **Service operation time:** not specified	To assess communication processes when law enforcement brings individuals in mental health crisis to the ED.	**Design:** Quantitative study. Cross-sectional survey **Sample:** 40 Law enforcement officers and ED staff **Comparator:** no	**Communication:** ED staff noted access to inpatient care as the largest barrier and the need for more community resources for individuals with mental health disorders	- Psychiatric mental health nurses (PMHNs) working in emergency departments are well placed to improve communication and collaboration with law enforcement. In addition to providing clinical care, PMHNs can deliver mental health education and lead training initiatives for police personnel. They also play a vital role in establishing and maintaining collaborative relationships with local police services. The integration of key nursing competencies such as education, communication, leadership, and case management, with the clinical expertise of PMHNs offers a strong foundation for promoting shared understanding of the needs of individuals experiencing a mental health crisis prior to hospital admission. - Nurses working in psychiatric–mental health settings are particularly well positioned to contribute to wider police–mental health collaboration strategies to promote information sharing: take it on together and develop shared goals; clarify terminology for shared understanding; and pro- vide training on relevant legal basics.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Heffernan et al., 2024	**Country:** Australia **Location:** urban city	**Police, Ambulance, Clinician Ealy Response (PACER):** this tri-response model brings together a police officer, a paramedic, and a mental health clinician (typically a registered nurse) into a single response team. PACER teams are dispatched together to provide immediate, coordinated care. **Service operation time:** Seven days per week from 2pm to 12 am	To determine the association between three approaches to responding to acute mental health crisis (PACER, police or ambulance as the exposures) and rates of involuntary detentions (outcome).	**Design:** Quantitative study. Retrospective observational design study using records from the computer-aided dispatch (CAD) system, mental health tribunal records and a PACER data collection between December 2019 to December 2020 **Sample:** Records of 8577patients from the Australian emergency services phone system were accessed. Of this, 1227 were from the PACER cohort, 5348 from the police cohort, and 2002 from ambulance cohort. or ambulance for a mental health-related presentation through the Australian emergency services phone system **Comparator:** police and ambulance services.	**Police custody:** lower involuntary detention rates than police or ambulance. When police or ambulance paramedics attend the crisis without clinically informed advice, the patients are more likely to be detained but less likely to be admitted. **Detention/Sanctioned:** lower rates of involuntary detentions, more individuals have been transported to the hospital voluntarily rather than by involuntary detention **Hospital diversion:** approximately half of patients were diverted from hospital as the paramedic or police officer indicated that they would have involuntarily detained them when in their general duties. **Re-admission/Follow-up:** rate of post-detention hospitalisation in the PACER cohort was higher when compared with ambulance and police	- Further research is needed to determine whether tri-response models offer added value over co-response approaches, or if similar outcomes can be achieved more efficiently. Since PACER workers are registered nurses, much of the paramedic care provided may be within their scope. - Studies should also explore patient experiences, especially for those who remained in the community and assess the model's cost-effectiveness through economic modelling.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Herrington & Pope, 2014	**Country:** Australia **Location:** New South Wales (rurality not specified)	**Mental Health Intervention Team (MHIT):** this programme follows principles from the Crisis Intervention Teams (CITs). It involves training uniformed officers as specialists to respond to individuals with an apparent mental health concern. The MHIT model involves a central project team responsible for the development and delivery of training.	To evaluate the success of the Mental Health Intervention Team (MHIT) against its key To assess the successes of the MHIT in meeting its core objectives: reducing injuries to both police and individuals with mental illness during interactions, increasing police awareness and understanding of mental health issues and appropriate responses, strengthening interagency collaboration in supporting people with mental illness, and minimising the time police spend on mental health-related incidents.	**Design:** A multi-phased, mixed methods evaluation design study. Data collected from 2008-2009. **Sample:** quantitative data involves 471 events records from Policing System. Qualitative data involves interviews with 111 MHIT-trained officers, 74 non-MHIT trained officers. Two focus groups were conducted with people with mental health problems (n=17) **Comparator:** non-MHIT-trained site	**Care during crisis:** a) familiarity and proficiency with de-escalation techniques affects officer confidence, corresponding to greater willingness to spend time with individuals in distress, and being less likely to rush to resolution. b) Interagency cooperation remained challenging, mainly due to resourcing concerns. The removal of police from inter-hospital transports required NSW Health to fund personnel, vehicles, and costs, posing a greater challenge in rural areas with limited resources and larger distances between hospitals. **Police custody:** Reductions time spent by police attending to mental health related calls **ED utilisation/attendance duration:** reduction in time spent waiting at hospitals	- Invest in Psychiatric Emergency Care Centres (PECCs), with a focus on expanding access in rural and underserved areas. - Promote a holistic, integrated approach to mental health care that moves beyond siloed responses driven by separate organisational budgets. - Sustainable success depends on formalised interagency collaboration rather than relying solely on voluntary cooperation.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Hoffman et al., 2021	**Country:** Canada **Region:** Ontario. Urban area	**interRAI Brief Mental Health Screener (BMHS):** A 23-item mental health screening tool designed to help police officers identify serious mental health concerns based on observable behaviours—such as disordered thinking and risk of harm to self or others—rather than clinical symptoms or diagnoses. The software, built around the BMHS, allows officers to complete assessments via mobile phones. Using embedded algorithms, the tool evaluates an individual's capacity for self-care and assesses their risk of self-harm or harm to other	To evaluate the costs and cost efficiency of the police response to mental health calls using the interRAI Brief Mental Health Screener (BMHS)	**Design:** Quantitative study analysing secondary data from the use of the screener from 2018 to 2020 **Sample:** Records from 6,727 assessments **Comparator:** Changes between 2018 and 2020	**Police/Service response:** The number of police response calls for service increased by almost 30% over the study period which could be explained by the fact that police officers were increasingly more aware of indicators of mental health problems and in completing the BMHS **Hospital diversion:** Fewer persons were taken to the ED - overall decrease of over 30%. **Detention / Sanctioned:** decrease of 30% for involuntary referrals which may be due to officers having a more informed understanding of when to apprehend a person in crisis	- The BMHS demonstrates strong potential for identifying calls involving serious mental health issues that may warrant emergency department admission. As its use grows among police services in Canada and the U.S., and the tool is further refined, it is anticipated that police, hospitals, and community agencies will gain greater confidence and proficiency in applying it to support informed decision-making and improve outcomes. - Police services might also consider integrating the BMHS with other models discussed in this paper, as its use could provide more accurate data on mental health-related calls for service enabling more robust evaluation of both effectiveness and cost-effectiveness

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Horspool, Drabble & O'Cathain, 2016	**Country:** uk **Location:** 2 locations not named; urban areas	**Street Triage:** The aim of this model is to improve access to mental health services for individuals in contact with emergency services. However, the implementation of the model can vary in its components including: Joint Response Car by a police officer and a mental health professional, mental health presence in police control room, and street triage briefing session (educational sessions for police and mental health staff directly involved in the implementation and management of the service, as well as staff from wider organisations which work alongside police and mental health services) **Service operation time:** for location 1 the Joint Response car was in operation three days per week from 5pm to 1am, whereas in location 2 the control room was in operation on three days per week from 6pm to 2am.	To explore the design and operation of Street Triage and identify potential barriers and facilitators affecting its implementation	**Design:** qualitative study, data collected through semi-structured interviews conducted between September 2014 and January 2015. **Sample:** 14 mental health services and the police from a Street Triage **Comparator:** no	**Detention/Sanctioned:** individuals were less frequently apprehended than general patrol officer **ED utilisation/attendance duration:** officers spent 56.5 minutes (SD = 24.1), approximately half the time of general patrol officers, who spent 107.0 minutes (SD = 42.5). **Treatment admission:** During Street Triage hours, a key role of mental health staff was referring individuals to appropriate mental health services. This is seem as a positive element of the programme. 2) However, referrals did not always ensure service users received timely care or treatment. Long waiting times in some services limited what mental health workers could guarantee, highlighting challenges in service availability and accessibility	Street Triage has the potential to enhance long-term collaboration by fostering role clarity, shared decision-making, and improved local information sharing. However, limited resources may challenge service development, particularly in mental health services, due to increased staffing demands and potential workload impacts on community mental health teams. Future research should explore whether service users find Street Triage an acceptable and effective crisis response. Comprehensive evaluations should assess its effectiveness, considering referral variations and its broader impact on the crisis system.

Study	Country and region (if reported)	Description of Model of Transfer of Care	Study aim	Study methods: design, sample and comparator (if available)	Findings: outcomes from the models	Recommendations (from study authors)
Kiseley et al., 2010	**Country:** Canada **Location:** Nova Scotians. Covering both rural and urban areas.	**Mental Health Mobile Crisis Team (MHMCT):** A mobile crisis service paired mental health clinicians with plainclothes police officers. MHMCT offered phone support, with calls managed by a clinician who responded within 30 minutes if unavailable. Teams responded in person to more acute situations, sometimes with ambulance support. Front-line police received guidance on when and how to engage the crisis team. **Service operation time:** 24/7	To assess the impact of the MHMCT one and two years after its implementation in June 2006, a controlled before-and-after study was conducted.	**Design:** Mixed methods study. Qualitative study involved analysis of administrative data. Qualitative study involved focus groups with service recipients, families, police officers, and health staff at baseline and 2 years afterward. **Sample:** For the quantitative study, records of 3534 service recipients were analysed: 464 involved12 months before the enhanced service, 1414 people in the first year of the enhanced service, and 1666 in the second year. For the focus groups 1 year post enhanced service, 53 participants took part which 16 were service recipients and 4 family members. For the second year assessment, 31 participants took part which 13 were service recipients and 6 family members **Comparator**: a controlled before and after design to compare the intervention area with a similar control area without access to such a service	**Police/Service response:** there was an increase in the number of mobile visits, however the call-to-door time halved in the 2 years of operation of the service. **Police custody:** the time on-scene for police officers on mental health calls in the intervention area fell significantly each year after the introduction of the enhanced service. At year 2, the time spent on-scene by police (136 minutes) was significantly lower than in the control area (165 minutes) **Treatment admission:** Patients in contact with the mobile crisis service showed greater subsequent engagement with treatment than control subjects as measured by increased outpatient contacts	Partnerships between the police department and mental health system can improve collaboration, efficiency, and the treatment of people with mental distress. Success is underpinned by 2 factors: the existence of a psychiatric service with a no-refusal policy for police referrals; and a broad acceptance by police that mental health response is a core element of the police role.

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Kirst et al., 2015	**Country:** Canada **Location:** Not specified	**Mobile Crisis Intervention Teams (MCITs):** Each MCIT is comprised of mental health nurses, and police officers specially trained in crisis intervention. Each team is linked with police divisions in geographical proximity to the hospital and reports to their respective managers in the police division and the hospital management system. Regular, Primary Response Unit (PRU) police officers are dispatched to all mental health crisis calls to assess safety and the suitability of an MCIT response. If considered appropriate by the PRU, the MCIT, involving one mental health nurse and one police officer, is dispatched to the call by the police services communications department **Service operation time:** not specified	To understand processes of implementation of a multi-site MCIT program in a large urban center and to identify program strengths and challenges, as well as levels of satisfaction in service delivery.	**Design:** qualitative study, data collected through semi-structured inter views and focus groups between November 2013 and February 2014 **Sample:** 57 stakeholders at health system, community and consumer levels. In addition to MCIT team members, police dispatchers	**Care during crisis call:** shared training between MH and police facilitated better shared decision making. Need for trust, if a MH nurse says this person is not at risk but police is thinking about impact of something bad happening and IPCC investigation etc. dedicared MH police officers rather than MHST staffed randomly from pool of officers. **ED utilisation/attendance duration:** 1) participants highlighted long emergency department wait times as a major challenge. The triage process was seen as ineffective, requiring consumers to be reassessed by a psychiatric nurse despite prior MCIT evaluation; 2) medical clearance by a physician delayed the legal handover, keeping teams tied up and preventing them from responding to other calls while potentially increasing consumer distress	Strengthening support for MCIT and crisis co-response programs requires greater awareness of their mandate within police divisions to enhance response capacity and resource knowledge. Clear communication with program partners and communities is essential to improve utilisation. This can be achieved through educational sessions and joint training between MCIT teams and police officers. Improved collaboration with hospitals is also needed to streamline care transfers, alongside a clearer understanding of legal barriers affecting handover processes.

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Lamanna et al., 2018	**Country:** Canada **Location:** Toronto. Urban area	**Mobile Crisis Intervention Teams (MCITs):** Toronto's MCIT teams consist of a mental health nurse and a police officer with additional mental health training. They serve as secondary responders, deployed after initial police officers determine that the situation is suitable for MCIT involvement and poses a low risk of violence. In some cases, MCIT may respond directly to calls intercepted via the police radio system. **Service operation time:** not specified	To describe i) rates of injury and arrest in co-responding team interaction, ii) compare response times, escorts to ED and ED handover time between co-responding teams compare and police-only teams and iii) describe service users interaction experiences with co-responding and police-only team.	**Design:** Mixed-methods design including administrative data analysis and qualitative interviews. Data collected between April 2014 to March 2015 **Sample:** For the quantitative study, 4607 records of interaction with MCIT were extracted. For the interviews with 15 service users of this 10 had experienced with both co-responding and police-only team **Comparator:** police-only team	**Detention/Sanctioned:** Co-responding teams were more likely to complete both voluntary escorts and other mandated escorts to hospital than police-only teams. Yet, police-only team interactions were more likely to result in responder-initiated involuntary escorts. Interviews with services uses highlight that the co-responding teams' crisis de-escalation skills were plays a important part in decreasing the risk of undesirable, adverse outcomes, including being brought involuntarily to an ED, handcuffed, or harmed by police. **ED utilisation/handover duration:** Co-responding team interactions were more likely to result in an ED escort compared to police-only team interactions. Time spent in the ED during the handover of care was signifcantly lower for co-responding teams' escorts (median = 60 min) than police-only teams' escorts (median = 75 min).	The relationship between co-response teams and ED referrals remains unclear, partly due to limited data on escort reasons. This study found co-response teams were 2.3 times more likely than police-only teams to escort individuals to the ED, often due to externally mandated escorts under Ontario's Mental Health Act. Two explanations are proposed: (1) co-response teams may encounter more severe cases, leading to higher referral rates, and (2) police-only teams may under refer individuals who need psychiatric assessment. Further research should compare the characteristics of cases that result in ED transport versus those resolved on-site to better understand these patterns.

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Makin, Carter & Parks, 2023	**Country:** USA **Location:** Idaho. Covering both rural and urban areas	**Crisis Centers:** These are specialised facilities designed to provide immediate, short-term intervention for individuals experiencing a mental health or substance use crisis. The principle of this model is to relieve care from psychiatric and specialist care, and shift focus to primary care. **Service operation time:** not specified	To examine the extent to which the presence of a crisis center within a behavioural health district is associated with changes in the frequency of emergency hold petitions initiated by police officers.	**Design:** quantitative study analysing data from petitions submitted by police officers between 2010 and 2020. **Sample:** 22,619 petitions	**Detention/Sanctioned:** Inconsistent results with regards the availability of a crisis center and the use of emergency hold petitions. The implementation of crisis centers at the study site may not have successfully met its initial objectives of diversion from the emergency hold system	- There is a need to better understand the specific contexts and constraints that shape individual officer decision-making. It is important to connect various knowledge systems particularly the on-the-ground insights of officers directly engaging with individuals and the data-driven understanding derived from organisational systems to fully grasp how decisions are made in practice. - The influence of day-to-day realities on police work and decision-making, particularly regarding the use of crisis centre as an alternative to emergency services, warrants deeper investigation. This should include the perspectives of frontline officers who navigate these choices in practice.

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McKenna et al., 2015	**Country:** Australia **Location:** Melbourne, urban area	**Northern Police and Clinician Emergency Response (NPACER):** the model involves a police officer and senior mental health clinician responding to community mental health crises once initial police ensure safety. The team conducts assessments under mental health legislation, aiming to de-escalate situations and divert individuals from emergency departments to appropriate mental health or community services, including direct admission to inpatient care when needed. **Service operation time:** Seven days per week from 3pm to 11.30pm	To describe the perceptions of major stakeholders on the ability of the team to reduce behavioural escalation and improve the service utilization of people in mental health crisis.	**Design:** qualitative study analysing data from semi-structured interviews conducted between January to July 2014 **Sample:** 17 participants who interfaced with the NPACER including consumer advisors, carer advisors, mental health staff, ED staff, police officers, and ambulance officers **Comparator:** stand-alone police	**Care during crisis call:** NPACER enhances real-time, face-to-face collaboration between police and mental health clinicians, enabling a coordinated and well-understood approach to managing safety and guiding individuals through appropriate services. Joint access to secure, real-time databases supports accurate information sharing, improving decision-making by combining clinical and justice insights. This integrated process helps create a fuller picture of risk and needs, allowing for timely interventions and smoother transitions toward crisis resolution **Detention/Sanctioned:** NPACER helped police better understand how mental illness symptoms relate to crisis behaviors, leading to more tolerant, effective responses and reduced use of force. The involvement of a de-escalation-trained mental health nurse allowed for a calmer, less traumatic experience for individuals in crisis **ED utilisation/attendance duration:** Enhanced communication among police, mental health clinicians, and ED staff helped streamline the care pathway for individuals in crisis. Smoother transition to ED was supported by NPACER clinician contacting the receiving ED in route to prepare for arrival. Diverting those who did not need ED assessment allowed better focus and care for patients with physical health needs **Hospital diversion:** PACER was seen as effective to divert people to less restrictive alternatives (i.e. to their home, to a GP, or to another community service) **Treatment admission:** Improved timely admission to the acute mental health inpatient services	- Police-only responses to mental health crises often led to ED transports, causing congestion and frustration for staff and individuals. NPACER offered an effective alternative, enhancing communication, information sharing, and shared expertise - Areas for improvement include increasing access to on-call psychiatric support and providing professional development to better support individuals in crisis from culturally and linguistically diverse backgrounds

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Stander & Lavoie, 2021	**Country:** Canada **Location:** Belview. Urban area	**Electronic mental health screener (MHS):** The aims of MHS is to help officers make informed decisions about emergency psychiatric care while facilitating collaboration among police, ED staff, and mental health providers. Officers complete the screener when encountering individuals showing signs of mental illness, generating a risk assessment score to guide decisions under the Mental Health Act. If apprehended, the MHS is electronically shared with the nearest hospital for ED access before arrival. With consent, it is also sent to a local mental health agency for follow-up. Data is shared with the screener's developer as part of its adoption. **Service operation time:** n/a	To understand how officers' made sense of and used the screener in practice, and how they perceived it to affect mental health calls for service.	**Design:** ethnography study. Data collected over 2 years period **Sample:** Police officers and members of the mobile crisis unit (which either held a police officer and social service worker, or a social service worker who responded on-scene to police MH calls). 200h of ride- alongs with frontline police officers, and another 52h of ride-along were completed with members of a mobile crisis unit.	**Care/transportation:** officers did not view the MHS as an effective tool for individual risk assessment **Follow-up/ Re-admission:** beneficial for improving care continuity and follow-up in community service referrals, potentially preventing future crises and reducing the burden on police if treatment is successfully engaged	- Officers are more open to new technologies and reforms when they align with police culture and practical experience. - Successful implementation also depends on adequate training, as many officers lack the medical knowledge to assess risk. - Understanding officers' perspectives (known as "technological frames") is essential, rather than relying solely on technology for innovation. - As algorithmic tools in policing grow, careful oversight is needed to avoid unintended harms.

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Semple, Tomlin, Bennell & Jenkin, 2021	**Country:** Canada **Location:** rural area	**Crisis Outreach and Support Team (COAST):** This model pairs a mental health professional—such as a social worker—with a specially trained police officer to provide a coordinated response to mental health crises. In this study, the team includes a crisis response worker (CRW) from one of two local community resource centres and an on-duty police officer. Both the CRW and officer operate in plain clothes and use an unmarked vehicle. When the COAST officer responds alone, the unit functions as a secondary responder to crisis-related calls. Typically, both general patrol and COAST are dispatched; once the scene is secured, patrol officers hand over the call to COAST and return to other duties. **Service operation time:** Tuesday to Friday from 10 am and 8 pm (the police officer responds alone 1 day a week when a CRW is unavailable), however it has since expanded to Monday to Friday	This study examines the COAST initiative by describing program use such as time spent on in-progress, referral to community resources, time spent on crisis-related calls, service costs time in emergency departments(ED).	**Design:** Quantitative study. Quasi-experimental design using data from crisis- related calls over a 12-month period from May 2017 to April 2018 **Sample:** Records from 709 crisis-related calls. Of this 287 were with COAST, 211 with a general patrol before COAST and 195 with a general patrol after COAST **Comparison:** general patrol before and after implementation of COAST	**Detention/Sanctioned:** Compared to general patrol officers, COAST apprehended individuals less often and spent less time in the hospital when they did have to use that disposition. **ED utilisation/attendance duration:** Officer from COAST team spend less time in Eds (the average amount of time spent in the ED (M = 56.5 min, SD = 24.1) was approximately half that of general patrol (n = 56; M = 107.0 min, SD = 42.5).)	- COAST reduction in time spent in ED is likely due to improved identification of those needing hospitalisation, more effective communication with hospital staff, and stronger relationships that enhance trust in their judgment. - Future research should explore the circumstances leading to hospitalisations and assess the appropriateness of it

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Simpson & Eze, 2020	**Country:** Scotland, UK **Location:** Inverness . Urban area.	**Place of safety:** this legislation allows police to transfer individuals suspected of having a mental disorder and requiring urgent assessment to an appropriate facility for evaluation. **Service operation time:** n/a	To characterise the nature of police involvement with those detained under place of safety legislation, the demographics of this population and aspects of the assessment process to determine factors that might be associated with admission.	**Design:** quantitative study. Retrospective observational design study analysing administrative data from April 2016 and March 2017 **Sample:** 230 medical records of 185 individuals brough to a Place of Safety **Comparator:** no	**Care during crisis call:** Individuals are often removed from high-risk areas and referrals to police are frequently initiated by individuals themselves **Treatment admission:** 1) A diagnosis of mental illness or personality disorder predicted hospital admission. 2) Hospital admission is generally avoided for referrals related to social stressors or substance misuse unless deemed necessary. 3) The longer individuals were detained in a place of safety, more likely they were to be admitted to hospital - probably related to service provision in more rural areas, i.e. lack of crisis response teams as well as practicalities in supporting discharge to more rural areas in the evenings and overnight. 4) Presence of senior nursing staff at the assessment, but not the seniority of the doctor, was associated with the outcome of the assessment (no admission)	- When police bring individuals to a place of safety, a personalised assessment is essential - Diagnosis plays a key role in decision-making, but the absence of suicidal ideation does not exclude significant mental health needs. - Multidisciplinary assessments should involve experienced practitioners, and junior medical staff must receive strong support from senior colleagues in decision-making.

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Wondemaghen, 2021	**Country:** England, UK **Location:** Hampshire, Dorset, Avon and Somerset, Wiltshire and Gloucestershire, covering both urban and rural areas	**Street Triage:** the model included: control room (nurses assist police over the phone – model presented in the four regions) and control room and face-to-face (nurses assist over the phone and may travel with police – model presented in Dorset and Avon and Somerset) **Service operation time:** not specified	To examine the effectiveness of the pilot street triage scheme by comparing the use of s136 before and after the scheme	**Design:** Qualitative study. Semi-structured interviews **Sample:** 30 police officers and mental-health nurses **Comparator:** no	**Treatment admission:** The key factor determining whether a service user is taken to a hospital for treatment or into police custody is the availability of health-based places of safety.	One proposed solution is the co-location of mental health nurses within police forces, facilitating shared responsibilities and expertise with regards to mental health crisis.
Zitars & Scharf, 2024	Country: Canada Location: Ontario covering a mid-sized city and rural areas	**Co-responder team (CRT):** This model pairs police with mental health professionals to jointly attend crisis calls, aiming to de-escalate situations and provide immediate assessment and support. CRTs also offer follow-up care to reduce future emergency service use and help individuals stay in their communities when safe, avoiding unnecessary hospitalisations or police involvement. **Service operation time:** Seven days per week from 2pm to 2am	To examine factors that influence CRT function in a geographically isolated and northern mid-sized city	**Design:** Qualitative study. Programme evaluation from data from semi-structured interviews, program document review, and ride-along site visits. Program and agency documents included CIT training curriculum, job postings, progress reports (including program statistics for number of calls attended and client outcomes and a quality improvement focus group report commissioned by the mental health agency. **Sample:** 13 participants from the CRT workforce took part in the interviews. **Comparator:** no	**ED utilisation/attendance duration:** CRTs often face long wait times. However, where a Memorandum of Understanding between police and hospitals is in place, individuals brought in under the MHA are prioritised for assessment. This agreement reduced wait times—from approximately 150 to 70 minutes for traditional police responders and under an hour for CRTs.	The study identified gaps in crisis service accessibility due to limited hours, capacity, and restrictive eligibility criteria. As a result, individuals often turned to hospitals, jails, or family, even when these were not suitable options. A dedicated crisis facility could help bridge these gaps and reduce the burden on hospitals and jails. To be effective, such a facility should operate 24/7, follow a “no wrong door” policy, and allow for rapid drop-off by police or paramedics.

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Zoeteman et al., 2024	**Country:** Netherlands **Location:** Amsterdam. Urban area	**Psychiatric ambulance (PA):** this service was introduced to replace police transport of individuals experiencing a mental health crisis. The PA aimed to minimise the use of restrictive measures, reduce violent incidents, and enhance expert patient treatment during transport to a psychiatric emergency service (PES). **Service operation time:** Seven day per week from 8am to 4pm and 4pm to 12am	To evaluate the feasibility of Psychiatric Ambulance (PA) service. Three questions: i) Is replacing police transport with a single PA feasible in terms of coverage, transport mode, wait times, and police assistance needs? ii) Does PA transport reduce restrictive measures (physical/chemical) without increasing patient aggression during transit? iii) Does PA transport improve follow-up treatment, including involuntary admissions, therapy adherence, and coercive measures during hospitalisation?	**Design:** Quantitative study. A quasi-experimental design with pre-and postintervention cohort assessments between October 2013 to October 2014. **Sample:** 498 rides were collected in the 4 months before implementation of the Psychiatric Ambulance (pre-PA cohort) and on 655 rides in the 6 months after. **Comparator:** records from 4 months before PA implementation (pre-PA cohort)	**Police custody:** PA transport reduced police car transport from 96% to 1%, leading to significant time savings for law enforcement, potentially saving several person-hours per incident **Detention/Sectioned:** reduction in involuntary hospitalisations **Treatment admission:** hospitalisation rates remained consistent between the pre-PA and PA cohorts	This study's findings suggest that implementing a specialised PA for patient transport instead of police is feasible, significantly reduces restraint use, and does not increase aggression incidents. Three key steps supported the successful implementation of the Psychiatric Ambulance (PA) model. First, gaining consensus and building motivation among stakeholders—including mental health professionals, police, ambulance services, and local authorities—was critical to transferring transport responsibilities from police to PA. Second, adapting the PA model to local needs, while addressing legal and financial factors, ensured relevance and feasibility. Third, ongoing monitoring and evaluation allowed for timely adjustments to maintain the program's effectiveness

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