Article:
Canfield, Martha, Dimova, Elena, Samuels, Isaac et al. (2026) From Police to Healthcare Provider: A Rapid Review of Transfer of Care Models for Individuals in Mental Distress. Community mental health journal. ISSN: 1573-2789

https://doi.org/10.1007/s10597-026-01665-y

Community Mental Health Journal
https://doi.org/10.1007/s10597-026-01665-y

ORIGINAL PAPER

From Police to Healthcare Provider: A Rapid Review of Transfer of Care Models for Individuals in Mental Distress

Martha Canfield[1] · Elena Dimova[1] · Isaac Samuels[2] · Elizabeth Monaghan[2] · Susan McVie[3] · Martin Webber[4] · Liz Elizabeth Hughes[5]

Received: 10 February 2026 / Accepted: 27 May 2026

Abstract
People in mental distress are best supported by mental health services, yet initial contact often occurs with the police. In many jurisdictions, police may detain and transport individuals at risk to healthcare providers (e.g., emergency departments). This article reviews the literature on models of transfer of care from police to healthcare to identify the types of models reported, the outcomes associated with their implementation and possible factors influencing outcomes. A rapid review was conducted. Embase, Medline, Web of Science, and Google Scholar databases as well as grey literature and hand searches were explored to identify primary research studies published in English during January 2010-January 2025. Eligible articles were empirical evaluations or descriptions of models of transferring of care, regardless of methodology. Twenty-four studies were included, most utilising data from crisis response professionals and administrative records. Identified models tend to fall into one of four categories: co-response models, liaison models, designated places of safety models, and screening tools. A range of outcomes that the transfer of care models might influence has been reported including time under police care, rates of police calls and detention/sanctions, quality of care during call and/or transportation, emergency department utilisation/attendance duration, hospital diversion, and treatment admission. Effective communication and inter-service collaboration were identified as key factors in the effectiveness of the models. The identified models of transfer of care show promising outcomes, however, the absence of robust methodological evaluation indicates that the evidence base is not yet sufficiently developed to demonstrate their broader value.

Keywords Transfer of care · Police · Healthcare · Mental distress · Review

Introduction

Demand on police services arising from mental health related crisis calls (e.g., 999, 911, 101, 000) is frequently cited as increasing and placing pressure on resources. However, the evidence is mixed; while some studies report rising demand (Department of Health, Victorian Government, 2021; Lee & Cohen, 2021; Police & Scotland, 2017; Yang et al., 2020), others suggest that the scale of mental health related demand may be lower than commonly assumed in policy and practice narratives (Kane et al., 2021). Regardless of these differences in scale, there is consistent

✉ Martha Canfield
martha.canfield@gcu.ac.uk

Elena Dimova
elena.dimova@gcu.ac.uk

Isaac Samuels
isaacsociety@gmail.com

Elizabeth Monaghan
lizmon1@hotmail.com

Susan McVie
S.McVie@ed.ac.uk

Martin Webber
martin.webber@york.ac.uk

Liz Elizabeth Hughes
elizabeth.hughes2@worc.ac.uk

[1] Glasgow Caledonian University, Glasgow, UK

[2] Public Contributor, London, UK

[3] University of Edinburgh, Edinburgh, UK

[4] University of York, York, UK

[5] University of Worcester, Worcester, UK

Published online: 18 July 2026

evidence that individuals experiencing mental health crises frequently come into contact with the police. Although mental health professionals are best equipped to address such needs, individuals in crisis frequently encounter the police, who often serve as the first (and sometimes only) responders (Al-Khafaji et al., 2014; Thomas & Forrester-Jones, 2019). As a result, police have become a common gateway to care for many individuals with mental health issues (Rodgers et al., 2019). Addressing these evolving mental health calls is placing increasing pressure on the police service, stretching its capacity and highlighting gaps in resourcing and skill sets (Shore et al., 2019).

Positioning police as a de facto mental health crisis service has also been associated with risks of exacerbating distress or traumatisation for the individual, which can escalate agitation and contribute to the overuse of compulsory treatment orders (Meehan et al., 2012), inappropriate detention in police cells (Independent Police Conduct Authority, 2015), and increased use of force by police (Morabito et al., 2017; O'Brien et al., 2014). Moreover, first responders (e.g., firefighters, police, paramedics) frequently report feeling poorly equipped to manage mental health crises, with police in particular experiencing significantly higher stress levels when responding to these incidents compared to other callouts (Seo et al., 2021).

Typically, the police and ambulance services are often responsible for transporting individuals they believe require urgent mental health interventions to emergency departments (ED) (Al-Khafaji et al., 2014; NHS Digital, 2018). This higher demand in ED can increase/exacerbate challenges in accommodating and providing appropriate care for such presentations. Managing these incidents is not only resource-intensive but also operationally challenging (Bonnet et al., 2020; Smith et al., 2020). Police officers may spend extended periods in ED waiting for clinical assessment and handover (Sweeny et al., 2021; Pascoe et al., 2022). At the same time, the absence of timely and coordinated care risks worsening the health outcomes of people in crisis, perpetuating cycles of repeated crisis calls and police contact (Shafiei et al., 2011). Such challenges highlight the critical importance of investment in appropriate models of care when police deal with mental distress calls including the process of transferring a person in mental distress to a healthcare provider.

There has been increasing international focus on policy initiatives that require health departments to establish jointly agreed policies with other statutory agencies to manage people with a range of mental ill health (e.g., Right Care, Right Person in England and Wales (Department of Health and Social Care, 2023), Mental Pathway in Scotland (Police Scotland, 2024)), and National safety priorities in mental health: A national plan for reducing harm in Australia (Australian Health Ministers' Advisory Council, 2005). In line with these approaches, several initiatives to improve the care of people in mental distress in contact with the police have been developed. These initiatives span across several models including, for example, models where mental health professionals work together with the police officers (e.g., Street Triage (Puntis et al., 2018), Police Ambulance Crisis Emergency Response (PACER) (Huppert & Griffiths, 2015), Integrated Mobile Crisis Response Team (IMCRT) (Kirst et al. 2015a, b), information-sharing agreements (e.g., Multi-Agency Risk Assessment Conferences (MARACs) (Walklate et al., 2021), NSW Police & Local Health Districts Memoranda of Understanding (Donohue & Andrews, 2013) and liaison approaches (e.g., Oldham Phone Triage/Rapid Assessment Interface (Edmondson & Cummins, 2014), Crisis Intervention Team (Ellis, 2014). Across these diverse models, a consistent feature is the central role of multi-agency collaboration highlighting the shared responsibility across policing, healthcare, and partner services. However, variation in how these models are implemented and coordinated can lead to inconsistencies in practice, potentially affecting continuity and quality of care (Kane et al., 2018). Numerous systematic reviews have been carried out (e.g., McGeough & Foster, 2018; Parker et al., 2018; Rodgers et al., 2019; Seo et al., 2021) to establish the feasibility, acceptability and/or outcomes of these models. These reviews offer detailed descriptions of available models and highlight promising outcomes. However, there has been little focus on the process of transfer of care of individuals from police to healthcare services (or another place of safety) and what factors influence its effectiveness and feasibility.

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, we conducted a rapid review of the evidence on models of transfer of care. Effective transfers from police to healthcare providers (or other relevant agencies) are critical to improving processes and outcomes for individuals in crisis. By synthesising the available knowledge, this rapid review not only highlights promising approaches but also identifies critical gaps in evidence. These insights provide an important foundation for shaping future practice, guiding policy development, and determining where further research including a full systematic review would be both feasible and of significant value.

Aims and Objectives

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. Specifically, it examines the types of transfer of care models that have been published, the outcomes associated with their implementation and factors influencing the outcomes. Models of transfer of care are defined in this review as approaches that support the safe and effective handover of individuals from police to appropriate health or social care providers. These may include transportation to a place of safety, formal frameworks or protocols outlining roles and responsibilities, and descriptions of interagency interactions during the handover process.

Methods

Given the increasing focus on the need for improved transfer of care (HM Inspectorate of Constabulary in Scotland, 2023; Scottish Government, 2025), providing information about the issue in a time-sensitive manner is important. As such, a rapid review was chosen as it provides an effective way to consolidate information by following streamlined systematic review methods (Grant et al., 2009). We followed established rapid review guidelines (Dobbins, 2017).

Search Strategy

A multi-faceted search strategy was employed, including database and website searches, consultation with Advisory Group members, and screening of reference lists from included studies and reviews. Searches covered Embase, Medline, Web of Science, and Google Scholar - identified as the optimal combination for coverage and minimising database bias (Bramer et al., 2017) - as well as WorldCat and Open Grey for grey literature. For instance, Medline and Embase capture core biomedical literature, Web of Science provides multidisciplinary and citation tracking coverage, and Google Scholar enhances sensitivity by identifying grey and non-indexed sources. Although only studies in English were included, language filters were not applied. Key terms related to police, crisis, transfer of care, and services were applied (see Supplementary Material T1). Additional sources were identified through Advisory Group input and forward and backwards reference searching of relevant studies and reviews (e.g., McGeough & Foster, 2018; Parker et al., 2018; Rodgers et al., 2019). All results identified by the database searches were collated into Covidence (a software for managing systematic reviews). The search strategy is presented in Fig. 1.

Eligibility of Studies

Studies were included if the full text was available in English and was published during January 2010 – January 2025 to ensure only current and recent practices are included. Studies were eligible for inclusion, regardless of methodology, if focused on any aspect of the transfer of care of a person in mental distress to a place of safety by the police. While study reports were included, 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.

The titles and abstracts of eligible articles were independently screened by two authors (ED and MC) and potentially eligible full-text manuscripts were independently screened against eligibility criteria by three authors (ED, EH, and MC). Discrepancies were resolved through discussion. The main reason for discrepancies included a lack of clarity around the definitions of 'transfer of care' and 'model of care'. These were resolved through iterative team discussions, guided by the review questions and an agreed broader conceptualisation of transfer of care, encompassing referral pathways, practices, and service models. This approach ensured consistent inclusion decisions while maintaining flexibility across diverse study designs.

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), with each study extracted independently by a single reviewer and checked for accuracy by a second member of the team.

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., roles and responsibilities, safety, understanding of professional culture, handover) and characteristics of the models. These were then grouped into types of models and outcomes associated with models as well as factors contributing to the outcomes were identified. The relationships between outcomes were explored, comparing studies that achieved intended outcomes versus those that did not.

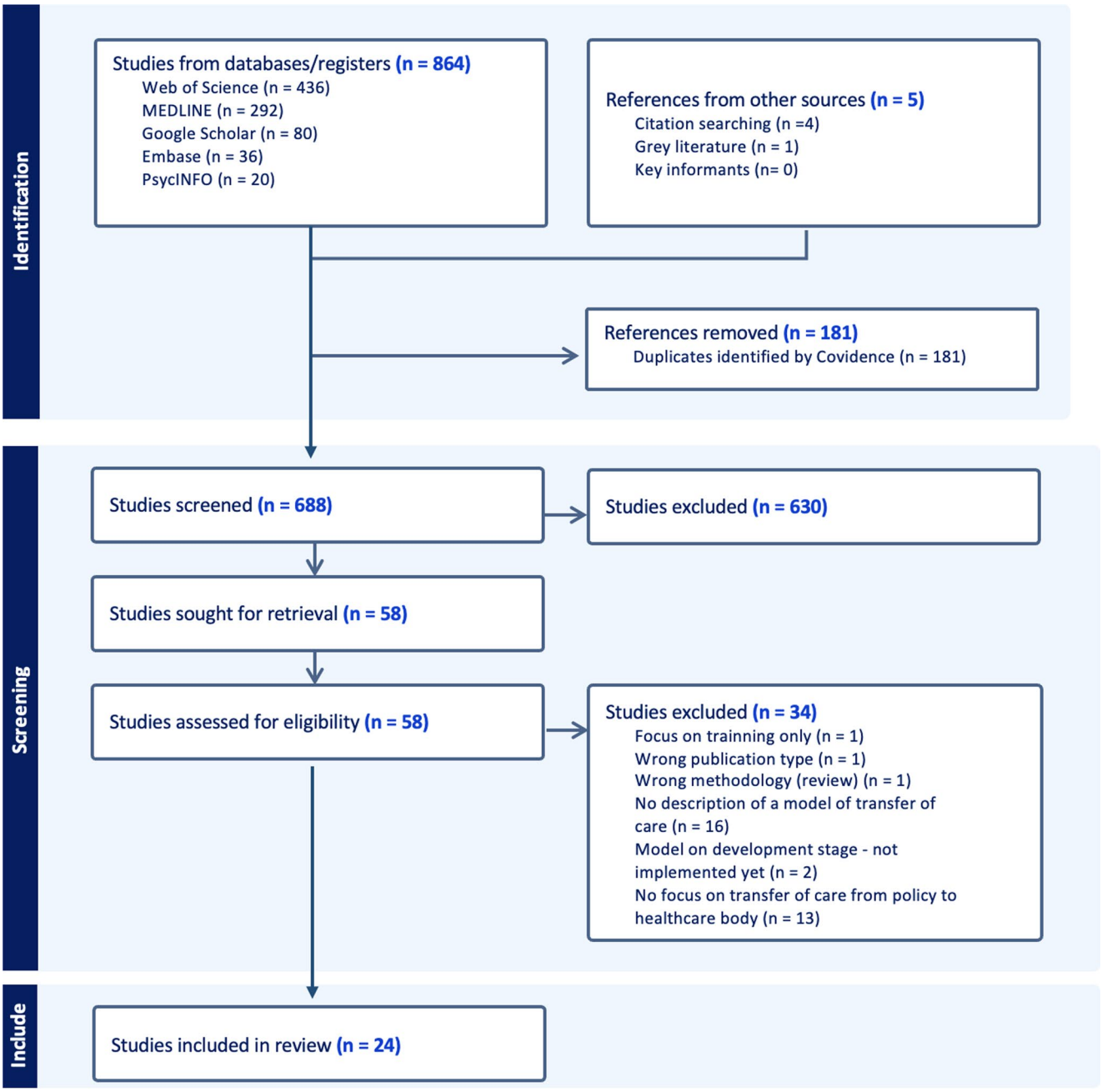

Fig. 1 This data is mandatory. Please provide

Results

A total of 864 records were identified through the peer-reviewed database searches and 5 additional manuscripts were identified from hand-searching reference lists from published reviews and the grey literature database (Fig. 1). After removal of duplicates, 688 titles and abstracts were screened for potential relevance and 58 full-text manuscripts were assessed in full for eligibility. Thirty-four manuscripts were excluded. The main reasons for exclusion of studies were: focus on professional training, no description of a model of transfer of care, no focus on transfer of care from police to healthcare provider, model in development stage, and evidence synthesis. A total of 24 manuscripts met the inclusion criteria.

Description of the Studies

The 24 studies included in this review are described in Table 1. These were conducted in Canada ($n=9$), the UK ($n=5$), Australia ($n=5$), the USA ($n=3$), the Netherlands

($n=1$) and New Zealand ($n=1$). 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 health 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.

Transfer of Care Models

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.

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

Liaison models: Liaison models involve police officers with specialised mental health training or healthcare professionals who serve as the first-line responders to mental health crises in the community. These professionals also act as liaisons to the formal mental health system. Two studies identified in the review examined liaison models: Crisis Intervention Team (CIT) in the USA (Comardin et al., 2019) and the Psychiatric Ambulance (PA) in the Netherlands (Zoeteman et al., 2024).

Designed places of safety models: Designed places of safety models refer to designated locations where individuals experiencing mental health 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. Two studies reported these models: Crisis Centre in the USA (Makin, Carter & Parks, 2023) and Places of Safety legislation in Scotland (Simpson & Eze, 2020).

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. Two studies reported findings from screening tools: the interRail Brief Mental Health Screener (Hoffman et al., 2021) and the Electronic Mental Health Screener (MHS) (Sanders & Lavoie, 2021) in Canada.

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

Outcomes of the Models and Contributing Factors

Table 1 summarises study outcomes by model of transfer of care. Two studies examined co-responding approaches (Every-Palmer et al., 2023; Heffernan et al., 2024), comparing them with usual care (e.g., ambulance only, police only response). Both showed lower rates of coercive treatment or involuntary detention compared to usual care. 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 latter finding did not reach statistical significance. In contrast, the PACER model evaluated by Heffernan et al. (2024) showed an increase in hospital admission rates. Other studies exploring the co-responding approaches suggest that this type of model has the potential to reduce involuntary detention (Broome et al., 2022; Lamanna et al., 2018; McKenna et al., 2015; Semple et al., 2021), ED utilisation (McKenna et al., 2015) and police waiting time at ED/custody (Fahim, Semovski & Younger, 2016; Herrington & Pope, 2014; Horspool et al., 2016; Kiseley et al., 2010; Lamanna et al., 2021; Semple et al., 2021; Zitars & Scharf, 2024). 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.

Communication

Evidence from different countries including Australia (Brandenburg et al., 2024), Canada (Arnaert et al., 2021), the UK (Callender, 2019) and the USA (Hickey et al., 2020) 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 a 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. 2015a, b); and (3) more explicit discussion that outlines the criteria and factors that shape mental health service access decisions (Hickey 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 to reduce police waiting time in ED. Sanders 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 and 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.

Screening Tools

Two studies from Canada 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)(Sanders & Lavoie, 2021). Both screening tools are designed to help police officers 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 comprises five sections. (A) identification and police action; (B) indicators of disordered thought, with brief symptom definitions and ratings of insight and cognitive skills; (C) risk of harm, including history of violence, self-harm, environment, and medication compliance; (D) call and hospital times; and (E) other relevant information. 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.

Participants in a Canadian study of the Mobile Crisis Intervention Teams (MCIT)(Kirst et al. 2015a, b) 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. 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 h 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.

Inter-hospital Transfer

Understanding the process of transfer of people between the police and the hospital (or another place of safety) was explored in only two studies. 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. 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 h before being referred to community-based services.

Places of Safety

Another two studies focused on the potential of specific 'places of safety' to improve transfer of care. 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). Herrington and Pope (2014) recommend the need for investment in PECCs. The authors 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 (Herrington & Pope, 2014).

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 et al. (2023) 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 were the most significant issues 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 (Sanders & 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, Sanders & 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.

Discussion

Summary of Key Findings

We were able to identify diverse models of transfer of care from police to healthcare services for individuals in mental distress in Australia, Canada, the Netherlands, New Zealand, the UK and the USA. The majority of these models involved co-response approaches where there is a shared protocol in which police officers are paired with mental health professionals to respond to incidents. 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. Among these, effective communication and inter-service collaboration consistently emerge as critical influencers of positive outcomes. Investment in training and the use of validated screening tools may further enhance these collaborative practices. Despite promising outcomes, the models lack rigorous evaluation, with no single randomised controlled trial study reported, limiting the evidence of the effectiveness of the models. This absence of higher-quality evaluations mirrors the shortcomings identified in other recent reviews of police responses to mental distress (McGeough and Forster, 2018; Parker et al., 2018; Rodgers et al., 2019), highlighting a persistent evidence gap in the field of policing and mental health. Most studies examined organisational-level outcomes, with relatively few addressing the experiences and outcomes for people living with mental distress. Furthermore, the minimal involvement of individuals with lived experience in the studies represents a significant gap in the evidence base. Also limited was the report of individual and social characteristics of study populations, suggesting that the models largely maintain a 'one-size-fits-all' approach to care transitions.

Context of Research Evidence

Although this review identified a reasonable number of studies ($N=24$), the diversity of methods and the wide variation in outcomes limit the coherence and comparability of the evidence, suggesting that the field is not yet ready for a systematic review. For instance, while ED attendance and duration have been relatively well studied, findings are fragmented by differences in context such as rural versus urban settings. Evidence on longer-term outcomes including follow-up care, repeat crises, and sustained engagement with community-based services remains particularly scarce, highlighting a critical gap in understanding the effectiveness and sustainability of the models. Strengthening the evidence base is essential for identifying when and how these models work best, guiding the development of clear and accountable transfer processes, supporting the case for sustainable funding, and helping expand and improve crisis care services. This evidence base is also vital for informing reviews of mental health legislation, which need to be responsive to different contexts and aimed at improving both outcomes and experiences for people facing mental health challenges.

Implications for Research, Policy and Professional Practice

This review adds to ongoing calls for stronger interagency collaboration across police and mental health services. Collaborative approaches vary in scope, ranging from basic partnerships with minimal 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*)*. Although structured training initiatives have demonstrated value in improving collaboration, the evidence also highlights the importance of sustained learning opportunities. Cross-professional exchanges, case-based discussions, and shared reflections may further support staff in managing complexity and anticipating diverse outcomes. Embedding a deeper understanding of equity, trauma, and their intersection with mental health within mandatory police training could additionally strengthen capacity for more compassionate, empathetic, and confident responses during crises and transfers of care (Brodie et al., 2025; Lavoie et al., 2023). These findings may be difficult to implement in some jurisdictions where police are withdrawing from work involving people experiencing mental distress, such as in England and Wales, where *Right Care Right Person* has been introduced.

Interagency approaches must also prioritise health equity, ensuring that the needs of diverse and marginalised communities are explicitly addressed within service design and delivery. 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 in which 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. 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.

Communication challenges continue to pose a major barrier to effective joint responses between police and mental health services (Juarez et al., 2021; Fisher et al., 2024). Across studies, timely and accurate information sharing consistently emerged as a critical factor. Strengthening this aspect of practice may be achievable through improved mobile technologies that provide real-time access to relevant data (e.g., health records) for both police officers and mental health professionals, enabling faster, safer, and more coordinated decision-making during crises (Hoffman et al., 2021; Sanders et al., 2021).

Most qualitative evidence focused on the implementation of transfer of care models reflected the views of police and mental health professionals involved in delivering the interventions. While some studies suggested that these approaches improved service user experiences compared with earlier practices, direct accounts from service users were limited and inconsistently reported. Moreover, there was a marked lack of robust quantitative evidence on outcomes for service users, including individual mental health improvements, changes in service demand, access to care and follow-up records. To address these gaps, it is essential to meaningfully involve people with lived experience in the design, delivery, and evaluation of services (Veldmeijer et al., 2023). Their contributions are critical to ensuring that crisis responses are person-centred, culturally responsive, and informed by a nuanced understanding of individual needs and social contexts (Hawke et al., 2024).

The rising volume of calls involving people in mental distress presents a growing challenge for police services, placing increasing pressure on resources and highlighting shortcomings in current response models. Meeting this demand requires not only service-level innovation but also the rapid and robust generation of research evidence. Timely studies are critical to assess the impact of different models across diverse contexts and to ensure findings are translated into practice before pressures on police and health services escalate further. Progress in this area has been constrained by methodological limitations, including underpowered single-centre trials and a reliance on retrospective administrative data for follow-up. The scarcity of well-designed studies may reflect the complexity and cost of conducting randomised controlled trials in this field. Overcoming these barriers will require greater investment and innovative methodological approaches (Department of Health and Concordat Signatories, 2014). Importantly, researchers, police, health services, and commissioners need to work collaboratively to build research capacity and develop strategies that support the delivery of more rigorous and scalable studies.

Strengths and Limitations

As the purpose of this review was to describe the existing literature on models of transfer of care rather than evaluate intervention effects, all studies meeting the inclusion criteria were included regardless of methodological quality. Consistent with rapid review methodology (Dobbins, 2017), no formal quality assessment was undertaken. While this approach enabled a comprehensive overview of the evidence base, it may introduce limitations including the inclusion of studies of variable quality and potential reporting biases. As such, the findings should be interpreted as indicative of the scope and nature of the evidence, rather than its strength or effectiveness. In addition, the review focused specifically on the role of police in transfer of care processes, in line with the scope of the study. Although ambulance services are involved in some models, their role was not examined in detail, which may limit the comprehensiveness of the findings in relation to wider multi-agency crisis response. Nevertheless, this rapid review offers an overview of the literature that has not previously been available, providing a useful platform for future reviews and research investments.

The concept of models of transfer of care is complex to define, and the identification of relevant studies in electronic databases is further complicated by inconsistent terminology and overlap with related constructs (O'Mara Evens et al., 2014). To mitigate these challenges, the research team sought inputs from an advisory group comprising individuals with lived experience, police officers, and health professionals to refine the conceptual framework and establish appropriate search terms. This collaborative approach enhanced the rigour of the review by ensuring that the search strategy was both conceptually robust and grounded in diverse professional and experiential perspectives.

Conclusion

A range of different models of transfer of care were described across the 24 studies included in this review. While no universally accepted taxonomy of models of transfer of care exists, the identified models in the included studies tend to fall into one of four categories: co-response models, liaison models, designated places of safety models, and screening tools. Overall, these models show positive organisational-level outcomes such as time under police care, rates of police calls and emergency department utilisation/attendance duration. However, the limited attention to service user experiences and outcomes, as well as the social and individual characteristics of the population included in the studies, restricts understanding of the models' broader impact. The lack of robust methodological evaluation of

the models suggests that the literature is not yet mature enough to demonstrate the far-reaching value of the models. 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, findings offer valuable insights to inform and guide decision-making while underscoring the urgent need for further research investment.

Author Contributions M.C, E.D and E.H wrote the main manuscript text. I.S, L.M., S.M., M.W contribute to data analysis and interpretation of the findings. All authors reviewed the manuscript.

Data Availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

References

Digital, N. H. S., Hospital Accident and, & Activity, E. (2018). September, 2017– 2018. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18

Al-Khafaji, K., Loy, J., & Kelly, A. M. (2014). Characteristics and outcome of patients brought to an emergency department by police under the provisions (Sect. 10) of the mental health act in Victoria, Australia. *International Journal of Law and Psychiatry*, *37*(4), 415–419.

Arnaert, A., Ahmad, H., Grugel-Park, A., Debe, Z., Laizner, A., Larocque, J., … and, & Liebert, J. (2021). Experiences of emergency triage nurses in the police handover of mentally ill patients: A qualitative descriptive study. *Archives of Psychiatric Nursing*, *35*(5), 556–561.

Australian Health Ministers' Advisory Council & National Mental Health Working Group (2005). *National safety priorities in mental health: a national plan for reducing harm*. https://catalogue.nla.gov.au/catalog/3644036?utm_source=chatgpt.com

IndependentPoliceConduct Authority (IPCA) (2015). March Review of Police Custodial Management. https://www.ipca.govt.nz

Bonnet, M., & Moran, N. (2020). Why do approved mental health professionals think detentions under the mental health act are ris- ing and what do they think should be done about it? *The British Journal of Social Work, 50*(2), 616–633.

Bramer, W. M., Rethlefsen, M. L., Kleijnen, J., & Franco, O. H. (2017). Optimal database combinations for literature searches in systematic reviews: A prospective exploratory study. *Systematic Reviews, 6*(1), Article 245.

Brandenburg, C., Thomas, S. D., Lincoln, C., Somerville, A., Heffernan, E., Kinner, S. A., … and, & Crilly, J. (2024). Supporting equitable care of patients transferred from police watch-houses to the emergency department: A qualitative study of the perspectives of emergency doctors. *Emergency Medicine Australasia*, *36*(4), 616–627.

Brodie, Z. P., Gillespie-Smith, K., Goodall, K., Deacon, K., & Collins, K. (2025). The impact of trauma-awareness session on police officers' trauma-informed attitudes in Scotland. *Psychology, Crime & Law, 31*(1), 26–40.

Broome, L., Davies, J., & Lewis, M. (2022). Service evaluation of the South Wales police control room mental health triage model: Outcomes achieved, lessons learned and next steps. *The Journal of Forensic Practice*, *24*(2), 95–110.

Callender, M., Knight, L. J., Moloney, D., & Lugli, V. (2021). Mental health street triage: Comparing experiences of delivery across three sites. *Journal of Psychiatric and Mental Health Nursing*, *28*(1), 16–27.

Comartin, E. B., Swanson, L., & Kubiak, S. (2019). Mental health crisis location and police transportation decisions: The impact of crisis intervention team training on crisis center utilization. *Journal of Contemporary Criminal Justice, 35*(2), 241–260.

Edmondson, D. A., & Cummins, I. (2014). December *Oldham mental health phone triage/RAID pilot project evaluation report*. https://e-space.mmu.ac.uk/609845/2/Edmondson%20and%20Cummins%20%282014%29%20Oldham%20Mental%20Health%20Phone%20Triage%20Evaluation%20Report.pdf

Department of Health and Concordat signatories (2014). Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis. https://assets.publishing.service.gov.uk/media/5a7c1ff0e5274a1f5cc75f09/36353_Mental_Health_Crisis_accessible.pdf

Dobbins, M. (2017). July *Rapid Review Guidebook: Steps for conducting a rapid review*. https://www.nccmt.ca/uploads/media/media/0001/01/a816af720e4d587e13da6bb307df8c907a5dff9a.pdf

Donohue, D. A., & Andrews, G. I. (2013). NSW police force mental health intervention team. Policing and the mentally ill: *International perspectives* (pp. 65–105)

Ellis, H. A. (2014). Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training. *Archives of Psychiatric Nursing, 28*(1), 10–6.

Evangelista, E., Lee, S., Gallagher, A., Peterson, V., James, J., Warren, N., … and, & Deveny, E. (2016). Crisis averted: How consumers experienced a police and clinical early response (PACER) unit responding to a mental health crisis. *International Journal of Mental Health Nursing*, *25*(4), 367–376.

Every-Palmer, S., Kim, A. H. M., Cloutman, L., & Kuehl, S. (2023). Police, ambulance and psychiatric co-response versus usual care for mental health and suicide emergency callouts: A quasi-experimental study. *Australian & New Zealand journal of Psychiatry*, *57*(4), 572–582.

Fahim, C., Semovski, V., & Younger, J. (2016). The Hamilton Mobile Crisis Rapid Response Team: A first-responder mental health service. *Psychiatric Services*, *67*(8), 929.

Fisher, O. J., Donahoo, C., Bosley, E., du Cloux, R., Garner, S., Powell, S., Pickard, J., Grevis-James, N., & Wyder, M. (2024). Barriers and enablers to implementing police mental health co-responder programs: A qualitative study using the consolidated framework for implementation research. *Implement Res Pract*, *8*, 5:26334895231220259.

Department of Health, & Government, V. (2021). February Final Report of the Royal Commission into Victoria's Mental Health

System. https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report
Scottish Government, F. (2025). *Mental Health Partnership Delivery Group: collaborative commitments plan*. https://www.gov.scot/publications/collaborative-commitments-mental-health-partnership-delivery-group/
Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, *26*(2), 91–108.
Hawke, L. D., Sheikhan, N. Y., Bastidas-Bilbao, H., & Rodak, T. (2024). Experience-based co-design of mental health services and interventions: A scoping review. *SSM - Mental Health, 5*, Article 100309.
Heffernan, J., Pennay, A., Li, X., & Gray, R. (2024). The association between the Police, Ambulance, Clinician Early Response model and involuntary detentions of people living with mental illness: A retrospective observational study. *Journal of Psychiatric and Mental Health Nursing, 31*(6), 1007–1019.
Herrington, V., & Pope, R. (2014). The impact of police training in mental health: An example from Australia. *Policing and society*, *24*(5), 501–522.
Hickey, K., Walther, C., King, J., Layne, H., Besler, C., Andrzejewski, V., & Gijada, J. (2020). Connecting law enforcement and emergency department providers to improve access to mental health services. *Journal of Psychosocial Nursing and Mental Health Services*, *58*(8), 24–30.
HM Inspectorate of Constabulary in Scotland (2023). *HMICS Thematic review of policing mental health in Scotland.* https://www.hmics.scot/media/0ltfrgsz/hmics20231018pub.pdf
Hoffman, R., Harman, J., Kinsell, H., & Brown, G. (2021). Costs and savings associated with the police use of the interRAI brief mental health screener. *Frontiers in Psychiatry, 12*, Article 726469.
Horspool, K., Drabble, S. J., & O'Cathain, A. (2016). Implementing street triage: A qualitative study of collaboration between police and mental health services. *Bmc Psychiatry*, *16*, 1–11.
Huppert, D., & Griffiths, M. (2015). Police mental health partnership project: Police ambulance crisis emergency response (PACER) model development. *Australasian Psychiatry, 23*(5), 520–523.
New York City Department of Health and Mental, & Hygiene, N. (2018). Epi data brief – Mental Health Emergency Department Visits among New York City Adults (2015). https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief107.pdf
Juarez, A., Bowen, K. N., & Nhan, J. (2021). Collaborative Efforts Between Law Enforcement and Mental Health Professionals When Responding to Mental Health Crises in the United States. *Justice Policy Journal*, *18*, 1–19.
Kane, E., Evans, E., Mitsch, J., Jilani, T., Quinlan, P., Cattell, J., & Khalifa, N. (2018). Police interactions and interventions with suspects flagged as experiencing mental health problems. *Criminal Behaviour and Mental Health: CBMH, 28*(5), 424–432.
Kane, E., Cattell, J., & Wire, J. (2021). Mental health-related police incidents: Results of a national census exercise in England and Wales. *Criminal Behaviour and Mental Health*, *31*(4), 262–274.
Kirst, M., Francombe Pridham, K., Narrandes, R., Matheson, F., Young, L., Niedra, K., & Stergiopoulos, V. (2015b). Examining implementation of mobile, police-mental health crisis intervention teams in a large urban center. *Journal of Mental Health*, *24*(6), 369–374.
Kirst, M., Francombe Pridham, K., Narrandes, R., Matheson, F., Young, L., Niedra, K., & Stergiopoulos, V. (2015a). Examining implementation of mobile, police-mental health crisis intervention teams in a large urban center. *Journal of Mental Health, 24*(6), 369–74.
Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Canadian Journal of Psychiatry*, *55*(10), 662–668.
Lamanna, D., Shapiro, G. K., Kirst, M., Matheson, F. I., Nakhost, A., & Stergiopoulos, V. (2018). Co-responding police–mental health programmes: Service user experiences and outcomes in a large urban centre. *International Journal of Mental Health Nursing*, *27*(2), 891–900.
Lavoie, J., Álvarez, N., Baker, V., & Kohl, J. (2023). Training police to de-escalate mental health crisis situations: Comparing virtual reality and live-action scenario-based approaches. *Policing: A Journal of Policy and Practice, 17*, Article paad069.
Lee, G., & Cohen, D. (2021). Incidences of involuntary psychiatric detentions in 25 U.S. States. *Psychiatric Services*, *72*(1), 61–68.
Makin, D. A., Carter, P., & Parks, M. (2023). Examining implementation of crisis centers on police officer emergency hold petitions. *Community Mental Health Journal*, *59*(6), 1150–1162.
McGeough, E., & Foster, R. (2018). August *What Works? Collaborative Police and Health interventions for mental health distress.* https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2018/08/works-collaborative-police-health-interventions-mental-health-distress/documents/00537517-pdf/00537517-pdf/govscot%253Adocument/00537517.pdf
McKenna, B., Furness, T., Oakes, J., & Brown, S. (2015). Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *International Journal of Mental Health Nursing*, *24*(5), 386–393.
Meehan, T., & Stedman, T. (2012). Trends in the use of emergency examination orders in Queensland since the implementation of the mental health intervention project. *Australasian Psychiatry*, *20*(4), 287–290.
Morabito, M. S., Socia, K., Wik, A., & Fisher, W. H. (2017). The nature and extent of police use of force in encounters with people with behavioral health disorders. *International Journal of Law and Psychiatry, 50*, 31–37.
O'Brien, A. J., & Thom, K. (2014). Police use of TASER devices in mental health emergencies: A review. *International Journal of Law and Psychiatry, 37*(4), 420–426.
O'Mara-Eves, A., Brunton, G., McDaid, D., Kavanagh, J., Oliver, S., & Thomas, J. (2014). Techniques for identifying cross-disciplinary and 'hard-to-detect' evidence for systematic review. *Research Synthesis Methods*, *5*(1), 50–59.
Home Office, J. (2014). Multi-Agency Working and Information Sharing Project: Final Report. https://assets.publishing.service.gov.uk/media/5a750ddb40f0b6360e472fa5/MASH.pdf
Pascoe, S. E., Aggar, C., & Penman, O. (2022). Wait times in an Australian emergency department: A comparison of mental health and non- mental health patients in a regional emergency department. *International Journal of Mental Health Nursing*, *31*(3), 544–552.
Police, & Scotland (2017). Policing 2026: Our 10 year strategy for policing in Scotland. https://www.spa.police.uk/spa-media/fjghkfo1/policing-2026-final-digital-version.pdf
Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), pb92.
Puntis, S., Perfect, D., Kirubarajan, A., Bolton, S., Davies, F., Hayes, A., Harriss, E., & Molodynski, A. (2018). A systematic review of co-responder models of police mental health 'street'triage. *Bmc Psychiatry*, *15*(18(1)), 256.
Rodgers, M., Thomas, S., Dalton, J., Harden, M., & Eastwood, A. (2019). Police-related triage interventions for mental health-related incidents: A rapid evidence synthesis. *Health Services and Delivery Research*, *7*(20), 1–164.
Sanders, C. B., & Lavoie, J. (2021). Boundary objects and technological frames: Officer's' perceptions and experiences using mental

health screeners on the frontline. *Policing and Society*, *31*(8), 967–981.

Christine, F., Semovski, V., & Younger, J. The Hamilton Mobile Crisis Rapid Response Team: A First-Responder Mental Health Service. *Psychiatric Services*, 67(8), 929–929.

Semple, T., Tomlin, M., Bennell, C., & Jenkins, B. (2021). An evaluation of a community-based mobile crisis intervention team in a small Canadian police service. *Community Mental Health Journal*, *57*(3), 567–578.

Seo, C., Kim, B., & Kruis, N. E. (2021). A meta-analysis of police response models for handling people with mental illnesses: Cross-country evidence on the effectiveness. *International Criminal Justice Review*, *31*(2), 182–202.

Shafiei, T., Gaynor, N., & Farrell, G. (2011). The characteristics, management and outcomes of people identified with mental health issues in an emergency department, Melbourne, Australia. *Journal of Psychiatric and Mental Health Nursing*, *18*(1), 9–16.

Shore, K., & Lavoie, J. A. A. (2019). Exploring Mental Health-Related Calls for Police Service: A Canadian Study of Police Officers as 'Frontline Mental Health Workers'. *Policing: A Journal of Policy and Practice*, *13*(2), 157–171.

Simpson, S., & Eze, J. (2020). Police involvement, characteristics and outcomes of place of safety referrals in the Scottish Highlands. *BJPsych bulletin*, *44*(6), 244–250.

Smith, S., Gate, R., Ariyo, K., Saunders, R., Taylor, C., Bhui, K., Mavranezouli, I., Heslin, M., Greenwood, H., Matthews, H., Barnett, P., & Pilling, S. (1983). Reasons behind the rising rate of involuntary admissions under the mental health act (1983): Service use and cost impact. *International Journal of Law and Psychiatry, 68*, Article 101506.

Sweeny, A., Keijzers, G., O'Dwyer, J., Stapelberg, N. C., & Crilly, J. (2020). Patients with mental health conditions in the emergency department: Why so long a wait? *Emergency Medicine Australasia, 32*, 986–995.

Thomas, A., & Forrester-Jones, R. (2019). Understanding the changing patterns of behaviour leading to increased detentions by the police under Sect. 136 of the mental health act 1983. *Policing: A Journal of Policy and Practice*, *13*, 134–146.

Veldmeijer, L., Terlouw, G., Van Os, J., Van Dijk, O., Van 't Veer, J., & Boonstra, N. (2023). The involvement of service users and people with lived experience in mental health care innovation through design: Systematic review. *JMIR Mental Health, 10*, Article e46590.

Walklate, S., Godfrey, B., & Richardson, J. (2021). Innovating during the pandemic? Policing, domestic abuse and multi-agency risk assessment conferencing (MARACs). *The Journal of Adult Protection*, *23*(3), 181–190.

Wondemaghen, M. (2021). Policing mental illness: Police use of Sect. 136–Perspectives from police and mental-health nurses. *Medicine Science and the Law*, *61*(4), 266–274.

Parker, A., Scantlebury, A., Booth, A., MacBryde, J. C., Scott, W. J., Wright, K., & McDaid, C. (2018). Interagency collaboration models for people with mental ill health in contact with the police: a systematic scoping review. *British Medical Journal Open*, 8(3), e019312.

Yang, Y., Li, W., An, F.-R., Wang, Y.-Y., Ungvari, G. S., Balbuena, L., & Xiang, Y.-T. (2020). Voluntary and involuntary admissions for severe mental illness in China: A systematic review and meta-analysis. *Psychiatric Services, 71*(1), 83–86.

Zitars, J., & Scharf, D. (2024). Matching mobile crisis models to communities: An example from Northwestern Ontario. *The Journal of Behavioral Health Services & Research*, *51*(3), 355–376.

Zoeteman, J. B., de Wit, M. A., de Haas, H. J., Borkent, K. M., Peen, J., Mulder, C. L., & Dekker, J. (2024). Coercion during psychiatric ambulance versus police transport in mental health crises: A pre-and postimplementation study. *Psychiatric services*, *75*(11), 1144–1150.