

Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative

A report prepared by

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Glossary (including abbreviations)

ADANZ	Alcohol Drug Association New Zealand
AOD	Alcohol and Other Drug
Assessment	Health professionals undertake different forms of assessments. The 'assessments' undertaken by watch-houses take the form of screens or brief assessments.
Brief intervention	A brief intervention usually consists of five components: providing feedback about the behaviour (e.g. AOD use); recommending a change in behaviour; presenting options to facilitate the change; checking and responding to the client's reaction; and providing follow-up care.
Crisis Team	Mental Health Crisis Team at the Counties Manukau DHB. The District Custodial Unit (or watch-house) at Counties Manukau Police Station is within the Crisis Team boundaries.
CAT Team	Mental Health Crisis Assessment and Treatment Team at the Capital and Coast DHB. The watch-houses at Porirua and Wellington Central Police Stations are within the CAT Team boundaries.
CADS	Community Alcohol and Drug Service
CDHB	Canterbury District Health Board. Christchurch is based within the CDHB.
CMDHB	Counties Manukau District Health Board
CMHC	The Community Mental Health Centres based in the Counties Manukau DHB.
C&CDHB	Capital and Coast District Health Board
DAO	Duly Authorised Officer under the Mental Health (Compulsory Assessment and Treatment) Act 1992
DCU	District Custodial Unit. The watch-house at Counties Manukau Police Station is known as the District Custodial Unit.
DHB	District Health Board
EAG	Evaluation Advisory Group
ED	Emergency Department (of a hospital)
GP	General Practitioner

HCC	The Health Care Communities computer system at Counties Manukau DHB.
Hillmorton	Hillmorton Hospital is a Christchurch-based hospital which provides an acute psychiatric inpatient service.
HSMP	Health and Safety Management Plan (formerly PMAF). A plan outlines the actions that need to be undertaken for a detainee assessed as in need of care and provides a record of subsequent actions taken.
MHA	The Mental Health (Compulsory Assessment and Treatment) Act 1992
MI	mental illness
NIA	The National Intelligence Application is the NZ Police national computer system.
NGO	Non-governmental organisation
PES	Psychiatric Emergency Services at the Canterbury DHB. The watch-house at Christchurch Central Police Station is within the PES boundaries.
PMO	A Police Medical Officer is a general practitioner whom Police may call on to attend to medical matters at a watch-house. Medical matters include attending to injuries, forensic examinations of victims and taking bloods of people suspected of EBAs. A PMO may also be called to assess the risk of a person with a suspected mental health issue or to check AOD detoxification when the WHN is not on duty.
PMAF	Prisoner Management Assessment Form (now replaced with HSMPs)
PNHQ	Police National Headquarters
WHN	Watch-house Nurse

Executive Summary

The Watch-house Nurse (WHN) initiative began operating at the Christchurch Central and Counties Manukau Police station watch-houses on 1 July 2008 and 1 August 2008 respectively. The initiative is intended to run as a pilot project until 30 June 2010. The initiative places appropriately qualified nurses within these two watch-houses to assist the Police to better manage the risks of those in their custody who have mental health, alcohol or other drug (AOD) problems. Where appropriate, the nurses also make referrals for detainees to treatment providers.

This final evaluation report presents the findings about the WHN initiative during its first 18 months of operation. In doing so, it addresses the main objectives of the pilot, and intended outcomes of these objectives in turn.

The evaluation design included comparative analysis of the pilot sites with two similar sites, Wellington Central Police Station and Porirua Police Station. The evaluators gathered information from a variety of sources using a range of methods including: a document review; key stakeholder interviews; analyses of WHN, Police and DHB databases; a cohort study that followed samples of detainees for one year; and six illustrative case studies of detainees at the pilot sites.

The WHN initiative is meeting its main objectives at each WHN site.

Objective 1: assess and assist in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody

There is overwhelming evidence that the WHNs are meeting this objective. The WHNs undertook a total of 5,836 assessments over an 18 month period with detainees in Police custody:

- 3,850 assessments of a total of 17,659 persons detained at the Christchurch Central Police watch-house – or about one in every five detainees
- 1,986 assessments of a total of 27,272 persons detained at the Counties Manukau Police District Custodial Unit – or about one in every 14 detainees.

The WHNs assist a broader range of people in the watch-house than would normally receive attention from a health professional which provides an opportunity for increased identification of issues and early intervention. WHNs assess detainees for whom Police have mild concerns about mental health issues as well as those who meet the threshold of calling a member of the Crisis Team (Counties Manukau) or a PMO (Christchurch). They assist people with AOD issues only (no suspected mental health issue) who would not be seen by emergency mental health services, providing them with brief intervention (advice, education, information) and referrals.

WHNs also assist detainees by:

- More timely access to being assessed by a health professional and consequently, where appropriate, quicker triage out of Police custody.
- Increased access to mental health services for Christchurch detainees. WHNs there directly refer detainees to PES, making appointments for them which PES will follow-up on if they do not show up. (PMOs assess risk while in custody but only make the occasional referral to PES.)

- Where consent is provided WHNs facilitate referrals and follow-up care by encouraging family/whanau to ensure attendance at appointments and by notifying their GP and key workers.
- More effective management of detainees' medications while in custody.
- Improved provision of information about AOD services and referrals to AOD services, particularly in Counties Manukau where CADS will follow-up on detainees whom the WHNs have referred.
- Reconnection with Mental Health Services and AOD services brought about by WHNs notifying detainees' case workers.
- Enhanced prisoner transfer process of passing on information about a prisoner's mental health risk. This is safer for prisoners.
- Providing a 'listening ear' for detainees.

Objective 2: reduce the risks of harm to detainees in Police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders

There is strong evidence, especially from feedback from Police custodial staff, that the WHNs are reducing the risks of harm to detainees and staff. WHNs continue to assess detainees' risk of harm throughout their time in Police custody and are on hand to check on them and upgrade or downgrade their monitoring regimes in response to their changing risk levels. Police custody staff told the evaluators that they feel more supported and less at risk having immediate access to WHNs and their clinical knowledge, skills and judgement.

The numbers of section 13 notifications of serious self harm to detainees and injuries to Police custodial staff were too small to draw useful conclusions.

Objective 3: liaise with other service providers, and make referrals of detainees to treatment providers

Feedback from key stakeholders and analyses of the WHN databases provides strong evidence that the WHNs are liaising with other service providers and referring detainees. Service providers they have liaised with include Emergency Mental Health Services, Community Mental Health and AOD services (such as CADS in Counties Manukau), a range of NGO mental health and AOD service providers, and Forensic Services (both Prison and Court).

Over the 18 month period:

- 38 percent of all assessments of Counties Manukau detainees and 11 percent all assessments of Christchurch detainees resulted in referrals being made by a WHN to a treatment provider. This difference in referral rates can be mainly attributed to different working definitions of 'referral', with Christchurch WHNs using the term in a more restricted sense.
- Over six in ten referrals that the WHNs proposed for detainees were to the local emergency mental health services (63% to the PES in Christchurch and 65% to the Crisis Team in Counties Manukau).

The WHNs are constrained in the numbers and types of direct referrals they can make due to service capacity issues and limited service options (particularly AOD service options in Christchurch) which are outside their control.

Objective 4: provide on-going education to the Police regarding the identification and management of mental health and addiction disorders.

Feedback from Police custodial staff and the WHNs themselves provides evidence of the on-going education to Police particularly on an informal basis. In Counties Manukau, the WHNs have provided training to DCU staff to assist them with their evaluations of detainees using the Police Health and Safety Management Plan (HSMP) form. DCU staff report this has enhanced their ability to make a more informed decision about whether detainees are 'in need of care'.

Police and mental health staff interviewed were clear about their different roles and that training Police to better recognise and work with detainees with mental health issues was not a substitute for the knowledge and expertise of mental health and AOD professionals. Police have a duty of care for the health and safety of people in their custody but their role does not include the provision of mental health assessment, triage and brief intervention which is provided by the WHNs.

The WHN initiative is meeting the outcomes set for it to varying degrees.

Outcome 1: reduced repeat detention of Police detainees with mental health and/or alcohol and other drug (AOD) problems

We think that the WHNs' ability to affect detainees' behaviour in this regard is very limited. Nevertheless, there is some evidence that the WHN initiative is contributing to the expected outcome of reduced repeat detentions among detainees with mental health and/or AOD problems but the evidence is not strong.

The cohort samples of detainees in the two WHN sites appeared to fare no better than those in the comparison sites of Wellington and Porirua in terms of reduced repeat detention rates over one year compared with the previous year. There may be many reasons for this, including differences in site detention base rates, case mix of charges (including seriousness of charges) and the impact of variations in Police policies, practices, and initiatives.

Within the WHN sites, however, those detainees presenting with mental health issues only had the highest reduction in repeat detentions or no change in the number of detentions in the year that followed their contact with the WHN compared with the year before. These results are promising, given the importance of diverting people with mental health issues away from the criminal justice system.

Outcome 2: reduced alcohol and drug related harm for detainees

Feedback from key stakeholder interviews, especially with Police custodial staff provides good evidence that the WHNs are contributing to reduced alcohol and drug related harm for all detainees whilst they are in custody. The numbers of section 13 notifications of serious self harm to detainees in custody in the 18 month periods examined were too small to draw useful conclusions in relation to this outcome while the collection of related information on the WHN assessment form was considered unreliable for evidentiary purposes.

Outcomes 3 and 5: improved health status of detainees with mental health and/or AOD problems and reduced risk of harm to detainees with mental health and/or AOD problems.

The evidence is stronger that the WHN is contributing to expected outcomes of improved health status and reduced risk of harm to detainees with mental health and/or AOD issues. The attendance rates of detainees with mental health and/or AOD problems as clients at other health services also provide a proxy measure of their improved mental health status or reduced risk of alcohol and drug related problems.

Almost all clients referred by WHNs were seen by the Crisis Team at the DCU in Counties Manukau, which is to be expected as people are still in custody. The different service model in Christchurch means the WHN refer people to attend an appointment at PES. About three in ten clients with relatively high mental health risk are not showing up for their appointments with the PES. Police in Christchurch do take people with suspected mental health issues who have no charges directly to PES (or ED) and these people are only detained at the watch-house if there are safety concerns.

The WHNs also make referrals to Community Mental Health Services and the rates of clients showing up to referral appointments are likely to have increased as a consequence of the initiative.

In Counties Manukau where WHNs have the option of being able to directly refer clients with AOD problems to Community Alcohol and Drug Services (CADS) a low one in ten actually turned up. We were unable to obtain figures from NGOs who treat AOD that the WHNs refer to in Christchurch.

The WHNs provide brief intervention to those people they come into contact with including education, advice and motivational discussions about seeking treatment. Across both pilot sites they provided about 1,900 people with pamphlets and information about mental health and AOD services for self referral over an 18 month period. In Counties Manukau they also keep a stand of pamphlets on the DCU receiving counter for detainees to take and have had some printed in te reo Māori and some Pacific languages.

The case studies also provide insights into the contribution of the WHN initiative to improving the health status and reducing the risk of harm of detainees with mental health and/or AOD problems. In each case a WHN was able to provide them with immediate assessment, advice and information while they were in the cells. The treatment information provided by a WHN led to better mental health outcomes for several of the detainees. One of the case studies illustrated the difficulties accessing mental health services for some people with co-morbid AOD issues and the WHN was able to assist with this. Two of the case studies also illustrated the motivation for change that lead people to successfully engage in treatment for AOD related issues.

Outcome 4: improved knowledge and skills of Police custodial staff regarding mental health/AOD issues

Feedback from key stakeholder interviews, especially with Police custodial staff and the WHNs, provides evidence that Police custodial staff have improved their knowledge and skills regarding mental health/AOD issues through working alongside the WHNs and the WHNs educating them on an informal basis.

Key benefits of the WHN initiative that are being realised are set out below.

KEY BENEFITS OF WATCH-HOUSE NURSE INITIATIVE		
<p>Detainees</p> <ul style="list-style-type: none"> timely access to assessment by health professional & reduction in risk of immediate harm more quickly triaged out of Police custody where appropriate receive brief intervention eg advice, education, information on services and where appropriate referral someone skilled to listen to them, reassurance early intervention with increased identification of MH/AOD issues & less risk of 'falling through the gaps' increased access &/or knowledge about services support/ advice available to family/whanau/ support people reconnection with key workers at MH & AOD services 	<p>Health services</p> <ul style="list-style-type: none"> provision of more timely service to consumers more appropriate referrals to health services reduce referrals to Crisis Team and PMOs while WHN on duty WHN conduit to pass information to other health services to inform future assessment, treatment and follow-up support minimise service duplication or people falling through the gaps improve ongoing management of mental health/ drug and alcohol conditions improved relationships between DHB & Police 	<p>Police</p> <ul style="list-style-type: none"> know detainees/offenders are receiving skilled assessment and support (and reduces stress for Police officers) save Police time as WHN attend to detainees and liaise with health professionals Police freed up to focus on crime prevention and detection reduction in risk of immediate harm for detainees (and reduced risk to Police in failing to meet custodial care) reduction in risk of immediate harm for Police staff formal & informal WHN training increase knowledge and skills in working with people with MH/AOD issues. improved relationships between DHB & Police

The Independent Police Conduct Authority provided positive feedback about the pilot after their visit to Christchurch Central Police station. They stated,

The Authority endorses effective initiatives that enable custody centres to provide for the needs of detainees affected by mental illness, drugs, or alcohol-related issues. Such initiatives ensure that Police are able to foster confident, safe, and secure communities and that New Zealand fulfils its international obligations under OPCAT [the Optional Protocol to the Convention Against Torture] and other international human rights law instruments. The fundamental principle of OPCAT, which is a principle that also underpins public health policy and healthcare in New Zealand, is prevention. Programmes such as the Pilot Initiative can, with appropriate planning and support, ensure that vulnerable members of our community are understood, respected, and cared for when they need treatment the most: at the earliest possible opportunity, by qualified, committed Police and specialised health practitioners.

Suggested actions in relation to the current WHN initiative

In the short term, we suggest that the following actions be taken in relation to the current WHN initiative to help cement its place within the custodial environment:

Increase coverage of hours to include Sundays and night shifts. Ideally, WHN coverage would increase to full 24/7 or at least extend to include day shifts during the weekend and complete seven day night shifts.

- Provide the WHNs with better support. Staffing, rostering and remuneration issues need to be addressed to ensure the sustainability of the pilot.
- Standardise WHN recording practices & refine the assessment form (for example, by providing additional tick boxes to capture data related to the sectioning under the MHA of detainees with serious mental health issues).
- Consider the entry level criteria of WHNs. Feedback from both sites suggests that while having someone in the role with DAO qualifications was an advantage, it was not essential.
- Monitor the impact of the WHN on PMO workloads. If possible, the monitoring should include areas of work being undertaken by the PMOs.

In the longer term, problems relating to mental health and AOD service gaps, service capacity issues, limited referral options (particularly in relation to AOD services) and issues relating to service integration between mental health and AOD services need to be addressed.

Some key lessons for any future WHN initiatives are:

- Use a design that fits the local operational context. The evaluation found key differences in Police facilities and operational policies along with different emergency mental health service delivery models at the pilot sites. This impacted on the way people with mental health are processed by Police and health services and the implementation of the WHN initiative.
- The pilot sites had Service Level Agreements between the Police and DHBs and these were found to be useful to clarify expectations of the WHN role, resourcing and operational processes. The SLAs could be revisited as the process develops and other stakeholders may be included or interface protocols developed (eg between Forensic Service, Court Liaison Nurse and WHN).
- The pilot sites established steering groups which were found to be very useful for the initial set up of the pilots and building relationships between key stakeholders. The inclusion of key stakeholders from the AOD sector such as CADS was identified as really important for buy-in to the pilot and establishing referral pathways.
- Recruit the right people for the WHN position in terms of qualifications, experience and flexibility to work in the watch-house environment. At the pilot sites Police personnel were included on the interview panels and this was thought to be important to help recruit people who could work alongside Police.
- Hold relationship management meetings with treatment providers and other key stakeholders prior to implementation of the pilot to identify and establish referral pathways and how different organisations will interface with the WHN initiative.
- Be able to access the relevant IT from day one as the WHN access to their DHB database provides invaluable historical information for conducting assessments and liaising with other health care providers; and
- Monitor WHN resourcing levels such that they are appropriate to need.

1 Setting the scene

1.1 Background

The WHN pilot initiative had its beginnings in Effective Interventions proposals to enable the then Government to 'stay tough, and be smarter' about crime and punishment.¹ The proposals were designed to take a cross-sector and strategic approach to reducing crime, re-offending and imprisonment. The proposals recognised that there was no simple solution to reducing crime and imprisonment in the short term, at minimal cost, while maintaining community safety.

In December 2006, the Ministries of Health and Justice organised a Police focus group to discuss issues for Police when dealing with people with mental health and/or alcohol and other drug (AOD) problems. The Police considered the most serious situations occur when they are holding people with mental health and/or AOD problems in their watch-houses. The main issues they identified were:

- While Police officers are trained in first aid and custodial management, the level of care required of intoxicated people and those with mental health conditions often exceeds their expertise.
- No detoxification centres exist. Police are the only agency that presently provides a place for intoxicated people to be held.
- Arrested or detained people with mental health problems are often difficult and time consuming for the Police to manage.
- The Police cell environment is likely to be detrimental to the wellbeing of people with mental health problems. It may result in an exacerbation of their problems.

The Rotorua Police Station had a mental health nurse in their watch-house in recent years to assist with the care of people with mental health issues (although not AOD issues) held in their cells. The then Cabinet agreed that the Rotorua initiative be reviewed,² and that two additional pilot initiatives based on a more comprehensive version of the Rotorua initiative be established in two other Police stations. The pilot would test whether such a role would be useful to the Police, to local DHBs, and to people held in Police watch-houses.

The key overarching strategy document to which initiatives such as the pilot being evaluated relates is the Te Tāhuhu: Improving Mental Health 2005-2015 document³ that sets out ten leading challenges and outcomes that the Government expects the mental health and addiction sector, state services and other agencies to pursue during this timeframe. Within the 'Building Mental Health Services' challenge an emphasis was placed on 'broadening the range of services and supports that are funded for adults' and within the 'Promotion and Prevention' challenge an emphasis was placed on 'improving understanding of the nature of addictive behaviours and the use of early interventions to prevent or limit harm.'

¹ See Effective Interventions: Review of the Interface between Mental Health and Alcohol and other Drug Services and the Criminal Justice System paper, Paper Two: The Police Setting. Accessed in July 2009 at http://www.justice.govt.nz/effective_interventions/cabinet_papers/paper-two-mental-health-alcohol.asp

² Carswell S & Paulin J. (2008) *Evaluation of the Mental Health Initiative at the Rotorua Police Station*. Report prepared for the NZ Police. <http://www.police.govt.nz/resources/2008/rotorua-mental-health-evaluation/>

³ Minister of Health (2005) Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan. [http://www.moh.govt.nz/moh.nsf/0/F2907744575A9DA9CC25702C007E8411/\\$File/tetahuhu-improvingmentalhealth.pdf](http://www.moh.govt.nz/moh.nsf/0/F2907744575A9DA9CC25702C007E8411/$File/tetahuhu-improvingmentalhealth.pdf)

Expected outcomes of the strategy include that people with experience of mental illness and/or addiction should have equal opportunities with other people to participate in everyday life of their family/whānau, community and society. A related document Te Kokiri⁴ sets out the action plan to progress the leading challenges in Te Tāhuhu, including actions to strengthen the linkages between services, and increase service responsiveness.

A report on submissions to the Drivers of Crime Ministerial meeting in April 2009 recognised that alcohol and drug problems and undiagnosed mental illness were 'significant facilitators and precursors to criminal offending.'⁵ In October 2009, in relation to the illegal drug methamphetamine (or P), the Government announced that it was adopting a 'multi-pronged approach' to fight P and an approach that included 'better routes into treatment.'⁶

A 2009 Law Commission Issues Paper found gaps in treatment availability for people with alcohol-use disorders coming into the courts, correction system, social welfare system, primary care and emergency department services.⁷ An Issues Paper that followed in 2010 referred to difficulties for people trying to access drug and alcohol treatment services.⁸

The Watch-house Nurse (WHN) pilot initiative is one response to addressing some of these ongoing concerns. The initiative is led by Police and funded by Health and Police. If successful, it is anticipated that the initiative would be extended to other major Police stations in New Zealand, subject to workforce availability.

1.2 The Watch-house Nurse Initiative and Evaluation Objectives

The WHN initiative began at the Christchurch Central and Counties Manukau Police station watch-houses on 1 July 2008 and 1 August 2008 respectively. The initiative is intended to run as a pilot project until 30 June 2010.

In brief, the initiative places appropriately qualified nurses within these two watch-houses to assist the Police to better manage the risks of those in their custody who have mental health, alcohol or other drug (AOD) problems. Where appropriate, the nurses also make referrals for detainees to treatment providers.

⁴ Ministry of Health (2006) Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015. [http://www.moh.govt.nz/moh.nsf/pagesmh/5014/\\$File/te-kokiri-mental-health-addiction-action-plan-2006-2015.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/5014/$File/te-kokiri-mental-health-addiction-action-plan-2006-2015.pdf)

⁵ Ministry of Justice (2009) Drivers of Crime Ministerial Meeting. 3 April 2009. Parliament Buildings. Report on submissions. <http://www.justice.govt.nz/policy-and-consultation/drivers-of-crime/documents/drivers-of-crime-ministerial-meeting-report-on-submissions>

⁶ As reported in the National Business Review on 10/11/2009. 'Government uses 'full arsenal' to fight P.' <http://m.nbr.co.nz/article/government-uses-full-arsenal-fight-p-112741>

⁷ The Law Commission (2009) *Alcohol in Our Lives. An Issues Paper on the Reform of New Zealand's Liquor Laws*. Issues paper 15. See especially paragraphs 11.94 – 11.101. http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_154_437_Alcohol%20in%20our%20lives%20-%20Issues%20Paper%2015.pdf

⁸ The Law Commission (2010) *Controlling and Regulating Drugs*. Issues paper 16. See especially paragraphs 16.54 – 16.56. http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_143_455_IP16%20-%20Controlling%20and%20Regulating%20Drugs.pdf

Its complete objectives are to:

1. assess and assist in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody;
2. reduce the risks of harm to detainees in Police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders;
3. liaise with other service providers, and make referrals of detainees to treatment providers; and
4. provide on-going education to the Police regarding the identification and management of mental health and addiction disorders.

In keeping with the initiative's objectives, its intended outcomes are:

1. reduced repeat detention of Police detainees with mental health and/or alcohol and other drug (AOD) problems;
2. reduced alcohol and drug related harm for detainees;
3. improved health status of detainees with mental health and/or AOD problems;
4. improved knowledge and skills of Police custodial staff regarding mental health/AOD issues; and
5. reduced risk of harm to detainees with mental health and/or AOD problems.

We – Dr Sue Carswell and Judy Paulin – were commissioned by the New Zealand Police to evaluate the WHN initiative in December 2008. The main objectives of the evaluation are to:

1. describe the operation of the Watch-house nurse initiative in two sites, including the impact of any contextual differences;
2. assess the extent to which the Watch-house nurse initiative is meeting its objectives (as listed above);
3. assess the contribution of the initiative to the intended outcomes (as listed above); and
4. identify any strengths and areas for improvement that may be made to the Watch-house nurse initiative to inform potential extension of the initiative to further sites.

The evaluation is expected to contribute to building evidence about what works in the New Zealand context and to inform ongoing and future developments.

1.3 Assessments of detainees by WHNs

Between 1 July 2008 and 31 December 2009 WHNs made a total of 5,836 assessments with detainees – 3,850 (66%) assessments at the Christchurch Central Police watch-house (or ‘Christchurch’ for short) and 1,986 (34%) assessments at the Counties Manukau Police District Custodial Unit (or ‘Counties Manukau’ for short).

The Christchurch site became fully operational on 1 July 2008. Since then, the monthly number of assessments by Christchurch WHNs has shown an upward trend peaking at 266 in December 2009 (Table 1.1 and Figure 1.1).

The Counties Manukau site became fully operational one month later on 1 August 2008. The monthly number of assessments by Counties Manukau WHNs has fluctuated over the 18 month period, being lowest in August 2009⁹ and highest at 182 in October 2009 (Table 1.1 and Figure 1.1).

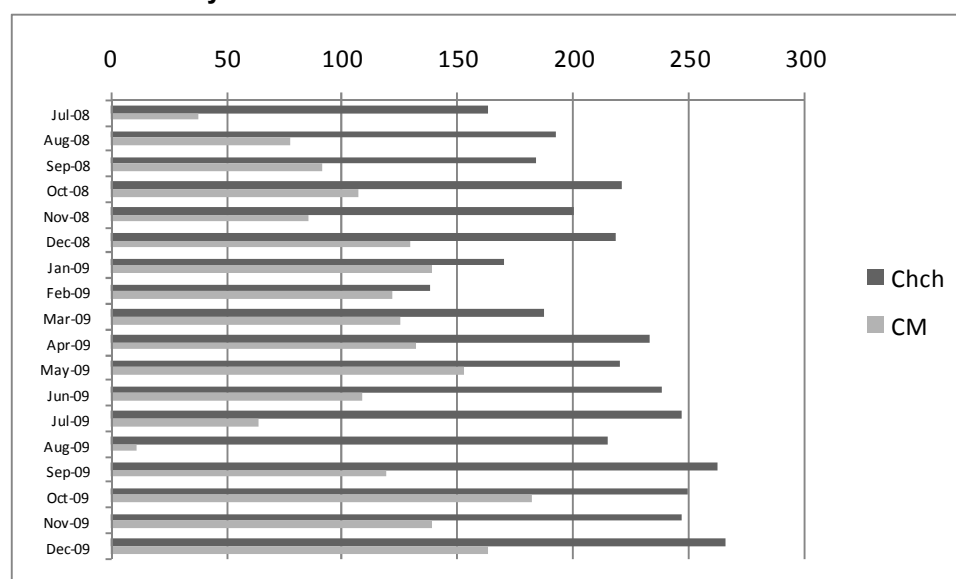
Table 1.1: Number of assessments of detainees by WHNs each month, July 2008 – December 2009

Month	Christchurch	Counties Manukau
July 08	163	38
August 08	192	78
September 08	184	91
October 08	221	107
November 08	200	85
December 08	218	129
January 09	170	139
February 09	138	122
March 09	187	125
April 09	233	132
May 09	220	153
June 09	238	109
July 09	247	64
August 09	215	11
September 09	262	119
October 09	249	182
November 09	247	139
December 09	266	163
18 months total	3,850	1,986

Source: Extraction from WHN site WHN databases. Please note that there are some slight differences in some monthly figures from those in the Interim Report, and from the monthly spreadsheet figures provided by Police National Headquarters.

⁹ One WHN was on holiday leave and the second WHN position was vacant most of the month.

Figure 1.1: Number of assessments of detainees by WHNs each month, July 2008 – December 2009



Source: Extraction from WHN site databases.

Christchurch WHNs assessed about one in every five people charged or otherwise detained at the Christchurch watch-house during the first 18 months. They made 3,850 assessments of a total of 17,659 persons charged or detained.

Counties Manukau WHNs assessed about one in every fourteen people charged or otherwise detained at the Counties Manukau Police District Custodial Unit (DCU) during the same 18 months. They made 1,986 assessments of a total of 27,272 persons charged or detained there.

1.4 Content of this report

The Final Evaluation Report can be read as a 'stand-alone' report. It makes use of information obtained for the 18 month period 1 July 2008 to 31 December 2009, with an emphasis on the presentation of new information – particularly new information relating to changes in WHN processes and on outcomes – obtained since the publication of the Interim Report in July 2009.¹⁰ Readers are referred to the Interim Report for more detailed information about the sites and stakeholders' initial views about implementation of the WHN initiative at the sites.

The remainder of this Final Evaluation Report is organised around the four objectives we were tasked with evaluating.

- **Chapter 2** provides a detailed description of the operation of the WHN initiative at the Christchurch and Counties Manukau sites, including the likely impact of some contextual factors (such as policies, facilities, and mental health and AOD services), and sets out the characteristics of the detainee populations whom the WHNs assessed over the full 18 month period. Processes and experiences at the comparison sites of Wellington Central and Porirua Police Stations are also described.

¹⁰ Paulin J & Carswell S. (2009) *Evaluation of the Mental Health/Alcohol and Other Drug Watchhouse Nurse Pilot Initiative: Interim Report*. ISBN 978-0-477-10307-7.
<http://www.police.govt.nz/sites/default/files/resources/evaluation/2009-09-15-WHN-Interim-report-FINAL.pdf>

- **Chapter 3** looks at the extent to which the WHN initiative is meeting its set objectives. WHNs are tasked with assessing, assisting and managing those in Police custody who have mental health and/or AOD problems, liaising with other service providers and making referrals for those detainees who need them, and educating the Police in the identification and management of detainees with these sorts of problems.
- **Chapter 4** looks at the WHN initiative's contribution to its intended outcomes, including its contribution to reducing repeat detentions among detainees with mental health and/or AOD problems, reducing their risk of harm and improving their health status.
- **Chapter 5** identifies the strengths and benefits of the WHN initiative for key stakeholders and key lessons learned that may inform the possible extension of the initiative to further sites.
- Finally, **Chapter 6** rounds off the report by weaving the findings together and making some concluding remarks.

Appendix 1 contains details relating to the approach, methodology and analytical techniques the evaluators used, Appendix 2 contains the research tools, and Appendix 3 shows the clinical pathways through which detainees with mental health/AOD issues may progress through the watch-houses and beyond.

2 The WHN pilot initiative in detail

2.1 Introduction

This Chapter provides an overview of the WHN initiative pilot as it has been set up and implemented at the Christchurch and Counties Manukau watch-houses. It also describes some site-specific contextual factors – policies, watch-house facilities and the availability and capacity of mental health and AOD services that are likely to impact on intended outcomes for detainees with mental health and/or AOD issues – and characteristics of the detainee populations whom the WHNs assessed over an 18 month period.

More detailed information about the sites and some key stakeholders' initial views about implementation of the WHN initiative at the sites can be found in the Interim Report.¹¹

2.2 Overview of its establishment

The WHN pilot initiative began operating at Christchurch Central Police Station on 1st July 2008 and at the Counties Manukau District Custodial Unit (DCU) one month later on 1st August 2008.

2.2.1 Staffing and management structure

Both sites have two full-time WHN positions. Christchurch WHNs must be Duly Authorised Officers (DAOs)¹² while Counties Manukau WHNs need not be DAOs but must be either registered comprehensive nurses or registered mental health nurses.¹³

Christchurch WHNs are part of the frontline service team at Psychiatric Emergency Services (PES) and report to the PES Clinical Manager. PES has endeavoured to backfill WHNs leave with other PES members whenever possible. As the WHNs are part of a team and other members have been trained to relieve their position this has enabled the Christchurch site in the later stages of the pilot to rotate the WHNs back into PES for a few weeks at a time. This was in order to strengthen WHN ties with PES. It could also be seen to have the advantage of ensuring sustainability as other staff were trained to do this role. A 'spin-off' has been that it has provided an opportunity for these other staff to build their working relationships with Police and increase their understanding of Police processes.

Counties Manukau WHNs are responsible to the Service Manager Core Adult Services at Counties Manukau DHB, and are supervised by the Clinical Nurse Director Mental Health. A WHN thought it would be a good idea in the long term if the Crisis Team could rotate the position as there was a danger the WHNs would be dislocated from their clinical pathways and relationships with the DHB.

¹¹ See footnote 10 for details.

¹² See glossary for the explanation of the term. The Service Level Agreement for the Provision of Mental Health/Alcohol and other Drug Watch-house Nurses between the Canterbury District Health Board and Canterbury Police District (March 2008) specifies that WHNs must be DAOs.

¹³ Service Level Agreement for the Provision of Mental Health/Alcohol and other Drug Watch-house Nurses between the Counties Manukau District Health Board and Counties Manukau Police District (February 2008).

The longer I'm away the more I am away from changes in staff and relationships etc. Any project that continues on would have to have strong ties with the DHB. You couldn't be a nurse here, a police nurse and do the same job without the links with the DHB. (WHN Counties Manukau)

Any rotation model would have to be on a voluntary basis to ensure mental health workers' buy-in and continuation of good relationships that have been built up between the WHNs and Police.

Shift hours

Christchurch WHNs work shifts providing coverage 80 hours a week: Monday to Friday 07.30 – 16.00, late shifts on Wednesday 14.00 – 24.00 and on Thursday to Saturday 17.00 – 03.00. Some WHN shifts finish at 3am when a lot of people are being brought in by Police, particularly on Friday and Saturday nights. Interviewees identified that in the future development of the initiative, resources permitting, it would be useful to cover the full night shift and cover the days on Saturday and Sunday to allow for assessment of people who were too intoxicated to assess at night.

Counties Manukau WHNs also work shifts providing coverage 80 hours a week: day shifts on Monday, Wednesday, and Saturday, and late shifts Wednesday to Saturday 17.00 – 03.30. There is no WHN coverage in the 'early' hours of Saturday and Sunday mornings when a lot of people are being brought in by Police. CMDHB based their rostering on when the highest volumes of detainees were coming into the DCU balanced with what cover could be resourced. Like Christchurch, interviewees at Counties Manukau identified in the future development of the initiative it would be useful to cover the full night shift and cover day shift on Sunday to allow for the better assessment of people after they have had the chance to sober up.

When a WHN takes annual or sick leave, limited coverage may be provided for the WHN role in Christchurch but in Counties Manukau there is no coverage.

2.2.2 Screen and brief intervention

The WHN's role at both sites includes the conduct of a screen or brief assessment with selected detainees to help with their management while in custody and, where appropriate, triage to other health services. Christchurch WHNs use a locally developed brief assessment tool while Counties Manukau WHNs use tools such as a standard mental health risk assessment tool and 'wheel of change' for AOD assessment. Based on their brief assessment of detainees the WHNs may facilitate their referral to an appropriate treatment provider or provide information for self-referral.

Research has found that conducting a screening may play a role in reducing alcohol consumption and could act as an impetus for change and further research is needed to better understand and the impact of screening (Kaner et al. 2007; Nilsen & Kaner et al. 2008; McQueen & Howe et al. 2009).

The service provided by the WHNs includes more than screening and triage and can be termed as 'brief intervention'. Brief interventions usually consist of five components: providing feedback about the behaviour (in this case AOD use); recommending a change in behaviour; presenting options to facilitate the change; checking and responding to the client's reaction; and providing follow-up care. It is out of the WHN scope of practice to personally provide follow-up care. Their role includes providing people with information about services where they can access treatment and support where appropriate referring people on to care.

2.2.3 Scope of role regarding medications and medical matters

WHNs are not expected to provide general medical treatment or take blood tests. In Christchurch, where they have had cases of diabetics coming into custody without their insulin, the WHNs also have a testing device to monitor diabetics' blood sugar levels. A WHN from Counties Manukau commented that minor dressings would also be a helpful addition to duties.

In Christchurch the WHN completed a two day Physical Health Assessment Course to upgrade their skills in triage of health conditions so that the WHN could help Police to decide whether a PMO is to be called or the detainee requires more urgent attention at ED.

WHNs administer detainees' medication within the strict limits of the law on dispensing medication (for example, if detainees bring their medication in with them). The WHNs may also access a new prescription for a detainee through a Medical Registrar or their DHB case manager/key worker or get either of them to come to the cells to administer drugs.

For example, in Christchurch the Police procedure for detainees on methadone involves contacting the Methadone Programme or Kennedy Unit after hours to confirm dosage. A script is then faxed by Kennedy staff to the WHN and to the Urgent Pharmacy so Police can access the methadone and a WHN or a PMO administer it. Methadone is only accessed over a weekend as it is understood that a person in need of it can miss one day's dose without it being too devastating but to miss two or more days can cause some serious withdrawal symptoms. A WHN said they are unable to access any drugs for use when people are suffering from withdrawals from other drugs. However, if someone is known to the mental health services and they are able to confirm their prescription, they can contact the Duty Registrar who may prescribe medication that the WHN can give to people in custody over a weekend. Similarly in Counties Manukau the WHN will try and access drugs for withdrawal when necessary (see example box in section 2.3.2).

Symptoms of alcohol withdrawal vary in severity depending on how heavily people drink everyday and symptoms may increase if they have other medical problems. In the more severe cases seizures may occur within 6-18 hours of discontinuation of alcohol. A Christchurch WHN said that generally people do not suffer serious withdrawals from alcohol until 2-3 days after they stop drinking so no drugs are prescribed for people withdrawing from alcohol while they are in the watch-house.

2.3 Operational context

2.3.1 Custodial operational policies

If Police evaluate a detainee is at risk of self harm while in custody they follow the national procedures for monitoring of people in custody and prisoners outlined in the Police policy P203 (Ten-One 223/12, 290/27). The policy specifies two monitoring regime levels for those assessed in need of care. Frequent monitoring means that Police need to directly observe a person at least five times per hour at irregular intervals. Persons identified as needing constant monitoring because of warning signs indicating suicidal tendency or adverse health or presentation with a mental condition are observed directly without interruption. This does not include CCTV as a method of constant monitoring.

Police can only lower the level of monitoring on the authority of a DAO or contracted health professional who has assessed the detainee/arrestee. A person's health and safety is not static and Police Policy P203 recommends reassessing whenever their status changes.

Christchurch

During the July 2008 – May 2009 information collection phase for the Interim Evaluation report, the Canterbury Police District was operating under two policies for the identification and assessment of detainees with suspected mental health issues in relation to suicide risk. Police first applied the criteria from their local policy, the Canterbury Custodial Suicidal Management Policy, which specified that all detainees who had an alert for self harm or suicide on their National Intelligence Application (NIA) Police record was deemed 'in need of care' and had to be assessed by a health professional. This policy applied no matter how old the alert was. The national policy for Custodial Suicide Management, Police Instruction P100, was then applied to manage the detainee.

In December 2009 Canterbury Police revised their local policy and removed the requirement for all detainees with an alert for self harm to be seen by a health professional. Police found that some people were being seen when it was not strictly necessary. The Watch-house Senior Sergeant now has the discretion based on his/her assessment of a detainee as to whether or not the detainee is to be assessed by the WHN.

It is too early to tell what impact this change of local policy has had on WHN assessment numbers to 31 December 2009 (the end date for the information collection phase for the evaluation). In the longer term, it will be interesting to monitor the impact of the change not only on WHN assessment numbers in Christchurch but also on PMO call-outs. A WHN commented that watch-house Senior Sergeants were still referring a lot of 'flagged' detainees to the nurses for screening.

Counties Manukau

Policy in relation to custodial suicide management at the Counties Manukau Police District remained unchanged throughout the entire 18 month period. There, not all detainees with alerts for self harm or suicide on NIA are necessarily required to be assessed by a health professional. Counties Manukau Police are guided by standard operating procedures in regard to prisoner

welfare. The onus is on the Custody Sergeant to determine whether a detainee is 'in need of care'.

However, in November 2009 Counties Manukau Police started implementing its Alternative Resolutions strategy which encourages Police to exercise their discretion to use a formal caution in accordance with the law and District guidelines. The stated purposes of alternative resolutions are:

'Alternative resolutions provide an opportunity for an objective and consistent application of guidelines when determining whether to proceed to charge an arrested person.'

Alternative resolutions are the application of police discretion for arrested persons received at the District Custody Unit (DCU) which results in the issue of a formal caution to an arrested person.

Alternative resolutions contribute to an increased policing ability to make Counties Manukau a safe place.

Alternative resolutions may go some way to addressing an over-representation of both Maori and Pacific peoples in the formal criminal justice process; where each have a higher rate of prosecution per head of population than any other ethnic group.¹⁴

This policy has resulted in an increasing number of people being brought to the DCU for less serious offences and lower levels of intoxication. This has provided the WHNs with increased opportunities for early intervention but it has also presented issues for them in terms of workload. It is impacting on their ability to connect with increasing volumes of people who are being processed speedily by DCU staff. The WHNs have placed a rack of pamphlets on AOD services in the receiving area and are developing a package of take home wallet cards containing information about CADS and the Alcohol Helpline for DCU staff to give to appropriate people.

A WHN stated that after several months of this policy being in place the WHNs had noted a trend among these sorts of people to being less receptive to discussing their AOD use. Many were angry that they had been picked up by Police and did not consider that they had any AOD issues. This is in contrast to others who are charged with an offence(s) and who are generally more contrite, particularly when they have sobered up.

Police operational policy changes can have an impact on the WHN service and an ongoing challenge will be how the WHNs can work in with Police to connect with the people who need assessing.

¹⁴ Business Rules for Alternative Resolutions, Counties Manukau Police District.

2.3.2 Facilities and environment

The Christchurch Central WHNs operate within a traditionally designed watch-house in the basement of the Police station whereas their Counties Manukau counterparts operate within a new open-plan District Custodial Unit (DCU) with glass fronted observation cells.

The designs are very different and impact on the way the WHN can identify detainees to assess, with the WHNs in Counties Manukau more able to observe detainees while they are being received. The efficiency of the DCU which is able to receive four people at time as opposed to Christchurch which can receive two people 'at a push' means the WHNs in Counties Manukau can miss some detainees if they are to be bailed. A WHN there said that they prioritise making contact with those who are going to be released on bail because they only get the one opportunity to talk to them to assess their mental health or AOD status. The DCU design is such that the ability of DCU staff to observe detainees is maximised, with three cells for those at risk of suicide that are directly observable by them and the WHN, and two cells for those in detox.

The Christchurch WHNs use a small office as a base while the Counties Manukau WHNs are situated in the open plan receiving area. In Counties Manukau some Police and Crisis Team interviewees thought it would be beneficial for the WHNs to also have their own office/interview room (similar to the Rotorua station). They thought that such a room would be more appropriate for interviewing people with mental health issues and for privacy reasons. (There is an interview room the WHN can use that can be placed under camera surveillance for security reasons.) However this would have to be balanced against the advantages of the WHNs currently being able to identify people in the receiving area and the opportunities this provides to be able to quickly assist the Custody Sergeant and staff. Many also commented that having the WHNs in the same area facilitated relationships with custodial staff and 'team' work.

Nearly all Christchurch interviewees familiar with the Christchurch watch-house commented on its outdated design and grim environment. However, while the Christchurch WHNs had their own office in the watch-house this did not seem to hinder relationship building with Police. It was still easily accessible to staff and centrally located by the Watch-House Senior Sergeant's office.

WHNs at both sites have electronic access to their DHBs' mental health databases. Significant changes in Counties Manukau are that the WHNs' computer is now located in the DCU receiving area and the CMDHB's Health Care Communities (HCC) computer system was introduced in July 2009. The WHNs have access to this system at the DCU and find it excellent for accessing more comprehensive information about detainees and sharing information with key workers at mental health services and CADS. It means that they can now access assessments and case notes of patients at a number of different services including their DHB mental health services, CADS, regional Forensic Services (including the Court Liaison Nurse).

Both WHNs there said that while it was still important to do an independent assessment of 'where a person is at on the day' the better access to information via HCC helps them to do a better triage and informs their risk assessment and management plan. Furthermore, it enables them to input assessment information directly into the HCC which is more easily accessible to other clinicians than hard copy notes. The HCC also provides useful templates for referral letters (for example, to GPs.)

The advantages of sharing assessments include starting the assessment from a more informed basis as well as building up a picture of a person's triggers and stressors which could be useful for their key workers when they were doing an overview. There was also potential for reduced some duplication of other professionals asking consumer same questions. A WHN said:

'For the consumer they get a better triage so the right person will come in the right way and the right time to deal with them if we can't deal with them here.' (WHN Counties Manukau)

Example: A woman addicted to benzodiazepines had gone into voluntary withdrawal but was also drinking and had become out of control and consequently came to Police attention. The WHN was able to look up HCC and see her history with CADS and her GP's details. The woman's GP confirmed her addiction to benzodiazepines was at a high level and was happy to send a covering script for two days while the woman was in the DCU. This made the woman a lot more comfortable and calmed her right down.

Prior to HCC the woman would have had to wait a lot longer. The Crisis Team would have been called and then possibly her GP contacted. During that time waiting she would have continued to be totally out of control and may have had to have been double cuffed to manage her.

The advantage for health professionals sharing assessment information is that they provide a baseline for future assessments and contain information on triggers and stressors that DHB key workers doing an overview find helpful. Sharing can also reduce duplication since other health professionals do not have to ask patients the same questions.

2.3.3 Frontline Police practice re people with mental health issues only

A key difference between the sites is that Police in Christchurch will only take people with mental health issues only (ie no charges) back to the watch-house if they have particular safety concerns about them. These concerns may relate to these people's aggressive behaviour or level of intoxication being too high for a mental health assessment to be undertaken. Otherwise Police will take them to PES during the day or to the Emergency Department after hours.

In Counties Manukau people who come to Police attention with suspected mental health issues and no criminal offending are taken to the DCU to be assessed by a Crisis Team member. There are no other suitable mental health facilities for Police to take them to. A Crisis Team member said that sometimes Police try to take people to an inpatient unit but there is no one there to assess them and they have to wait for a Crisis Team member to turn up. It is the same situation if they take them to the Emergency Department. So by default they bring them back to the DCU.

These differences in practice help explain why only one percent of detainees assessed by Christchurch WHNs but 30 percent of detainees assessed by Counties Manukau WHNs were found to have been detained for mental health reasons over the 18 month evaluation period (see Table 2.2 and Figure 2.2).

2.4 Liaison and referral options

The screening conducted by the WHN determines the triage decisions and there are a number of different referral pathways. Please refer to diagrams in Appendix 3 for an overview of the different clinical pathways for detainees.

There are some differences between the pilot sites which reflect the mental health and AOD services available in each area. The services available are discussed below.

2.4.1 Mental health services – liaison and referral options

The WHNs' assessment of detainees' risk levels may result in those with the highest risk being sectioned under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) or directly referred to emergency mental health services. Those with lower risk are usually provided with information about services for self-referral.

The sites differ in terms in the service delivery model they have to respond to psychiatric emergencies. In Christchurch WHNs can refer detainees to the Psychiatric Emergency Service (PES) which provides a 24 hour emergency service at their premises but does not have a mobile crisis team. Although PES staff can attend callouts when people cannot be brought to their premises, it takes time to mobilise staff. PES callouts are mainly for MHA applications. This model is more cost effective than a mobile crisis team which requires more staff to operate.

In Counties Manukau there are four Crisis Teams – one each in four area Community Mental Health Services – which share a joint roster to provide a mobile 24/7 service to the entire region. The WHNs can call the Crisis Team and they will send a staff member to the DCU to fully assess and pick up detainees and take them to the appropriate mental health service.

For a small number of detainees who need to be 'sectioned' under the Mental Health (Compulsory Assessment and Treatment) Act 1992 for compulsory assessment and treatment WHNs assist by arranging for a doctor to examine the detainee and issue a certificate to accompany the application for a detainee's assessment (section 8B) and for a DAO from the local Mental Health Crisis Team to come to the cells to transport the detainee/patient to the mental health facility for further assessment. In Counties Manukau the Crisis Team doctors are mobile so tend to conduct section 8B-related processes and the PMOs are only called to undertake these if there is a problem or delay. In Christchurch PMOs are more frequently called to conduct section 8B-related processes.

The current WHNs may also initiate some of the paperwork (sections 8A and 9). A Christchurch Police Medical Officer (PMOs)¹⁵ interviewed for the evaluation was of the view that the Christchurch WHNs' assistance had reduced a doctor's average two hour involvement in sectioning a detainee/patient at the cells down to 30-40 minutes.

¹⁵ Police Medical Officers (PMOs) are general practitioners whom the Police call on to attend to medical matters, including attending to injuries, forensic examinations of victims and taking bloods of people suspected of EBAs. They may also be called to assess the risk of a person with a suspected mental health issue or to check AOD detoxification when the WHN is not on duty.

While Counties Manukau WHNs are not expected to be involved in transporting patients to mental health facilities for further assessment, Christchurch WHNs sometimes are involved when there is no one available at the local Mental Health Crisis Team (PES).

WHNs at both sites may also offer detainees information about services provided by Non Governmental Organisations (NGOs).

2.4.2 AOD services – liaison and referral options

AOD referral options in Christchurch are very limited as the local Community Alcohol and Drug Service (CADS) and a number of NGO providers will not accept referrals of detainees facing charges in court. Recently CADS has also excluded self-referrals. The WHNs provide detainees with information about a couple of NGO treatment providers and also about ADANZ, an advocacy service for negotiating access to AOD treatment services.

There appear to be capacity issues with all the Christchurch AOD services which are resulting in waiting lists and increasingly stringent access criteria being applied. The WHNs inform Māori men about He Waka Tapu (HWT), a Kaupapa Māori AOD counselling service. HWT has a policy of seeing anyone who walks in straight away. However, if they have a high number of referrals they will waitlist those people who are going before the courts. Usually those on the waiting list have only a short wait.

In contrast, Counties Manukau WHNs can make direct referrals of detainees to CADS. CADS will then contact these people to arrange their appointments. The service provides a 'one stop shop', with separate programmes for Māori, Pacific, Asian, pregnant women, under 20 year olds and over 65 year olds.

AOD service gaps include a lack of or limited medical detoxification services. (Christchurch's Hillmorton Hospital has one six bed inpatient unit.) This means that Police cells are continuing to be used for detoxification of detainees.

Other AOD service gaps include limited services to provide ongoing support for people once they have detoxified, particularly for those who are severely dependent and may benefit from residential treatment, and AOD services for youth.

2.4.3 Police medical officers

A feature of the Christchurch site is their higher call-out rate of Police Medical Officers (PMOs). If the Police there judge that a detainee needs a psychiatric assessment when a WHN is not available, they will either call in a PMO or transport them to the Psychiatric Emergency Services (PES) or Christchurch Hospital Emergency Department. Prior to the WHN initiative the PMOs had expanded from four to five doctors to meet increasing demand. A PMO said that they looked on the WHN pilot favourably as it made their work more sustainable. They had been becoming overloaded with work.

In Counties Manukau the Crisis Team has limited mobile doctors available. The Crisis Team generally uses DHB psychiatrists or registrars in psychiatry, who are mobile if necessary, but not always immediately available at any given time. After hours the Crisis Team have limited access as there is one mobile doctor for the whole service who works on a priority model. On occasion Police doctors (contracted GPs) are used by DAO's for section 8 medical assessments for the sectioning of a person under the Mental Health Act.

2.5 Overview of processes at two comparison sites

Ways in which the Police get involved

At the two comparison sites, the Wellington Central and Porirua watch-houses, Police not uncommonly come across people with mental health and AOD issues too. They may receive a phone call from a whānau/family member or flatmate asking for Police assistance to come to a private house to deal with a person who has attempted suicide or who the caller believes is at risk of attempting suicide. If the person has also committed an offence (such as smashed up furniture) the Police may arrest the person and take the person to the Police station. If the person has not committed an offence, the Police may encourage the person to voluntarily accompany them to the Police station. Police then arrange for a member of the Capital & Coast Crisis Assessment Team (CAT) team to come to the station to make a crisis assessment of the person with suspected mental health problems. (The person must be assessed by a member of the CAT team before the person is able to access inpatient mental health services.)

Alternatively, a whānau/family member or flatmate or friend may phone the Mental Health Line for urgent assistance to deal with a suicidal person. Sometimes the Mental Health Line is engaged, and the caller receives a recorded message indicating that the CAT team is too busy to provide an immediate response and suggesting that the caller phone the Police. As a result of their phone call to the Police, the Police or the whānau/family member or flatmate etc may bring the person to the Police Station. As above, Police arrange for a member of the CAT team to come to the Station to make a crisis assessment of the person.

Police may also respond to a phone call from a concerned member of the public about a person whose behaviour out on the streets suggests that s/he is mentally disordered and in need of assistance, or frontline Police may in the course of their work come across such a person themselves. Under section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 frontline Police may arrest the person and take him/her to the Police station. Police then arrange for a doctor to make an assessment.

Wellington Police also receive some requests from DAOs to escort mental health patients from the Wellington Hospital Emergency Department to Te Whare O Matairangi (Ward 27), a distance of only about 200 metres.

How they manage those with suspected mental health/AOD issues in custody

Those with suspected mental health issues are managed within the custodial environment according to how the Police assess their risk levels and whether they have been arrested or held without charge.

Wellington Police said they find it easier to manage those they have arrested with suspected mental health issues than with AOD issues because they can place them in Police cells. Those people Police judge to be 'at high suicide risk' are placed in monitored 'pink' cells. Monitoring of people in these cells was described as 'labour intensive and mentally intensive'. On Friday and Saturday nights Police may use private security guards to undertake the monitoring.

Those who have voluntarily accompanied the Police cannot be placed in cells. Police try to contain them in interview rooms near the cells. However, detainees may get agitated, get up and walk out notice.

Police interviewed thought that the symptoms of alcohol overuse were more easily recognised than drug overuse. If a person is suffering from alcohol poisoning and that person is unresponsive, the Police will make a judgement as to whether they take him/her to the Hospital Emergency Department or call the Ambulance Service. If a person is 'toasted' (but not severely alcohol poisoned) they will be placed in a monitored cell. It was Police experience that usually 'toasted' people fell asleep quite fast. However, custodial staff still needed to be alert to the small risk of a person drowning in their own vomit.

They thought managing those with suspected drug issues could be more difficult since Police usually did not know the drug or combination of drugs a person had taken. A person who the Police suspect to be on 'P' would usually be placed in a monitored cell, with a small proportion being placed in an 'at risk of suicide' cell. It was Police experience that usually persons with suspected drug issues did not fall asleep but paced around.

If the Police need information about a person's mental health history/status, they contact a member of the CAT team, sometimes through the Mental Health Line. Police interviewed did not consider they had any issues receiving information they were entitled to under the Privacy Act 1993.

Their main costs in regard to managing arrestees/detainees with mental health and/or AOD issues were monitoring these people whilst in custody, particularly those they assessed as needing 'constant monitoring'. They generally assigned their most junior staff to monitoring tasks, on half hour turnabouts. They thought they spent only a very minor amount on security guards and very little at all on calling on medical assistance.

Assistance/Services not provided to those with suspected mental health/AOD issues in custody

While the CAT team will assist persons in custody with suspected mental health problems, persons with AOD problems at the comparison sites are not provided with advice about AOD service options. The fact that there is no health professional based at the watch-house means that there is very limited potential for early intervention among those detainees for whom Police custodial staff members have only mild mental health/AOD concerns.

Police interviewed identified the distribution and location of arrestees'/detainees' medications as potential problem areas. Some arrestees have their medications on them when they are arrested. They are required to hand these over to custodial staff. However, an instruction on a medication saying 'take as required', leaves a custodial staff member with a problem as to how frequently to distribute the medication to the arrestee. The Police do call CAT for assistance in this regard. Most, however, do not have their medications on them when they are arrested. Their medications may be at home, in which case the Police sometimes go there to pick them up.

Police interviewed generally felt that they were well informed enough about the health services that are available for people with mental health and/or AOD issues. They remarked that there were very few service options (for example, the Salvation Army Bridge programme) for those with alcohol-related problems.

Some but not all Police interviewed were envious of their counterparts in Christchurch and Counties Manukau who have the WHN initiative operating.

2.6 The detainee populations whom the WHNs assessed

The profiles of detainees assessed by WHNs at each site over the full 18 month period, July 2008 to December 2009, were very similar to those of detainees assessed over the shorter period covered by the Interim Report.

2.6.1 Their demographic characteristics

Over the full 18 month period Counties Manukau detainees assessed by WHNs were slightly more likely to be female than Christchurch detainees (28% compared with 22% in Table 2.1 and Figure 2.1). The age profile of detainees assessed by Christchurch and Counties Manukau WHNs was similar, with at least seven in ten being aged less than 40 years.

The ethnic breakdowns of detainees assessed by Christchurch and Counties Manukau WHNs differed. A higher proportion of detainees whom the Christchurch WHNs assessed were European while higher proportions of detainees assessed by Counties Manukau WHNs were of Māori, Pacific, or another non-European ethnicity. Differences in the ethnic profiles of the general population living around the two sites explain some of this difference in case mix.¹⁶ Differences in the prevalence rates of mental illness/addictions among ethnic groups (with rates being generally higher among Māori and Pacific peoples) are another likely explanation.

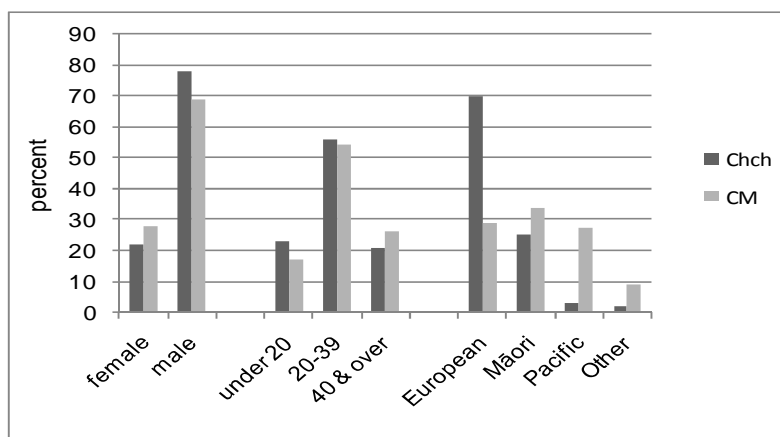
¹⁶ Only nine percent of people living within the Canterbury DHB boundaries are of Māori or Pacific ethnicity compared with 37 percent of people living within the Counties Manukau DHB boundaries. See Ministry of Health. 2004. *Population-based Funding Formula 2003*. Wellington: Ministry of Health. ISBN 0-478—28211-7 (Internet). Accessed in June 2009 at <http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/9ec525446f3acc8ccc256e9000125381?OpenDocument>

Table 2.1: Demographic characteristics of detainees whom the WHNs assessed over 18 months

Characteristic	Christchurch (N=3,850)		Counties Manukau (N=1,986)	
	n	%	n	%
Sex				
female	852	22%	558	28%
Male	2,995	78%	1,361	69%
unknown	3	0%	67	3%
Total	3,850	100%	1,986	100%
age group				
14 & under	62	2%	22	1%
15-19	823	21%	322	16%
20-39	2,162	56%	1,071	54%
40-59	752	20%	477	24%
60 & over	51	1%	36	2%
unknown	0	0%	58	3%
Total	3,850	100%	1,986	100%
Ethnicity				
European	2,707	70%	578	29%
Māori	959	25%	683	34%
Pacific	107	3%	535	27%
Asian	35	1%	45	2%
Indian	12	0%	91	5%
Other	27	1%	29	1%
unknown	3	0%	25	1%
Total	3,850	100%	1,986	100%

Source: Extraction from WHN site databases.

Note that this and the following tables and figures are based on **assessments**, of which some detainees have had more than one. Also, column percentages in this and other tables will not always add up exactly to 100% due to rounding of individual percentage values to whole numbers.

Figure 2.1: Demographic characteristics of detainees whom the WHNs assessed over 18 months

Source: Extraction from WHN site databases.

2.6.2 History of being detained

For 341 (or 9%) detainees assessed by Christchurch WHNs and for 213 (or 11%) detainees assessed by Counties Manukau WHNs it was their first experience of being arrested or detained in a Police cell.

2.6.3 Reasons for their detention

As for the Interim Report, detainees who were assessed by WHNs over the 18 month period had been detained at Christchurch and Counties Manukau Police stations for a range of reasons related to their offending and/or health status (Table 2.2 and Figure 2.2).

Detainees assessed by Christchurch WHNs were much more likely to have been detained in relation to criminal charges, arrest warrants and bail breaches, whereas detainees assessed by Counties Manukau WHNs were much more likely to have been detained for reasons relating to their mental health (30% for Counties Manukau compared with one percent for Christchurch) and for detoxification (36% for Counties Manukau compared with 13% for Christchurch).

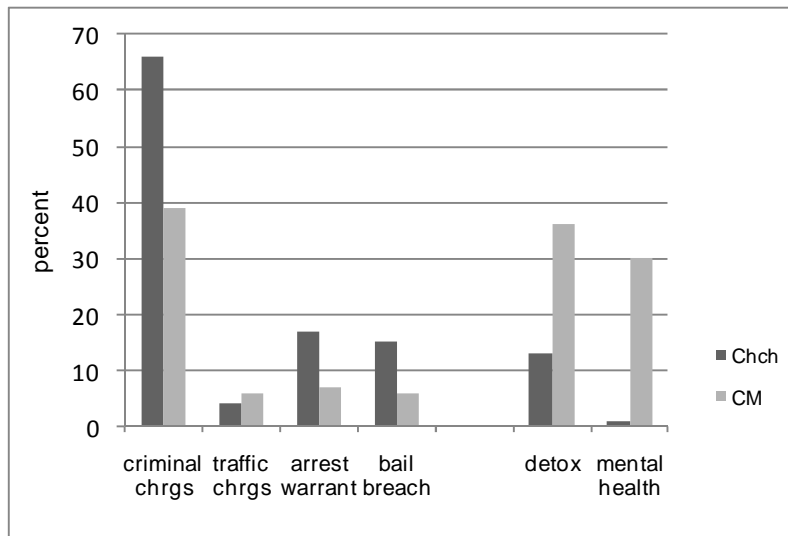
The lower rate of Christchurch detainees being held for reasons relating to their mental health only (not shown) is likely to be due to Police practice of only detaining such people in the watch-house if there are safety issues (such as they are being very aggressive or intoxicated). Otherwise Police will take them to PES during the day or to the Emergency Department after hours (see section 2.3.3)

Table 2.2: Reasons for detaining those whom the WHNs assessed over 18 months

Reason	Christchurch (N=3,850)		Counties Manukau (N=1,986)	
	n	%	n	%
Criminal charges	2,523	66%	767	39%
Traffic charges	168	4%	111	6%
Arrest warrants	650	17%	140	7%
Bail breaches	592	15%	121	6%
Mental health	47	1%	597	30%
Detoxification	515	13%	716	36%
Corrections	5	0%	14	1%
Immigration	10	0%	10	1%
Breach of peace	8	0%	216	11%
Other	19	1%	31	2%

Source: Extraction from WHN site databases.

Figure 2.2: Reasons for detaining those whom the WHNs assessed over 18 months



Source: Extraction from WHN site databases.

Sixty six percent of detainees assessed by Christchurch WHNs were detained in relation to criminal charges. Most commonly, they were charged with drugs/anti-social offences (28%), dishonesty offences (25%) or violent offences (24%) (see Table 2.3).

In Counties Manukau, a lower 39 percent of detainees assessed by WHNs were detained for criminal offending. Most commonly, they were charged with drugs/anti-social offences (23%) or violent offences (13%).

Table 2.3: Types of criminal charges laid against detainees the WHNs assessed over 18 months

Offence groups	Christchurch (N=3,850)		Counties Manukau (N=1,986)	
	n	%	n	%
violence	915	24%	251	13%
sexual	105	3%	18	1%
drug/anti-social	1,082	28%	452	23%
dishonesty	952	25%	90	5%
property damage	294	8%	77	4%
property abuse	220	6%	37	2%
administrative	44	1%	16	1%

Source: Extraction from WHN site databases.

Sixty one percent of detainees assessed by Counties Manukau WHNs and 44 percent of detainees assessed by Christchurch WHNs were judged to be under the influence of alcohol (Table 2.4). The comparable figures for drugs were both nine percent.

The offending of 67 percent of detainees assessed by Counties Manukau WHNs was likely to have occurred while detainees were under the influence of alcohol or other drugs. The comparable figure for detainees assessed by Christchurch WHNs was 49 percent.

Table 2.4: Extent to which detainees were judged to be under the influence of alcohol and other drugs

	Christchurch (N=3,850)		Counties Manukau (N=1,986)	
	n	%	n	%
Under the influence of				
alcohol	1,681	44%	1,213	61%
drugs	346	9%	182	9%
solvents	22	1%	13	1%
other	11	0%	10	1%
Offending likely to have occurred while under the influence?				
Yes	1,885	49%	1,326	67%

Source: Extraction of data from WHN site databases.

2.7 Summary

The Chapter has provided information towards the evaluation's first objective of 'describing the operation of the Watch-house nurse initiative in two sites, including the impact of any contextual differences'. The two sites, Christchurch and Counties Manukau, were operating under different custodial operational policies for almost all of the evaluation period but are now the same.

The key differences between the WHN sites are summarised in the text and table below.

- **Facilities:** The WHNs operate within very different physical environments. Christchurch Central WHNs operate within a traditionally designed watch-house in the basement of the Police station. Counties Manukau counterparts operate within a new open-plan District Custodial Unit (DCU) with glass fronted observation cells.
- **Emergency Mental Health service delivery model:** In Christchurch WHNs can refer detainees to the Psychiatric Emergency Service (PES) which provides a 24 hour emergency service at their premises but does not have a mobile crisis team. In Counties Manukau WHNs can call the Crisis Team and they will send a staff member to the DCU to fully assess and pick up detainees and take them to the appropriate mental health service. Another feature of the Christchurch site is their higher call-out rate of Police Medical Officers (PMOs).
- **Police options response to Emergency Mental Health service delivery model:** Frontline Police in Christchurch will only take people with mental health issues only (i.e. no charges) back to the watch-house if they have particular safety concerns otherwise they are taken to PES or ED. Whereas in Counties Manukau nearly all such people are taken back to the DCU for mental health assessment.
- **Types of clients and types of needs:** While the age profiles of detainees assessed at both sites were similar, those in Counties Manukau were slightly more likely to be female, and more likely to be of Māori, Pacific, or another non-European ethnicity than their Christchurch counterparts. Detainees assessed by Christchurch WHNs were much more likely to have been detained in relation to criminal charges, arrest warrants and bail breaches, whereas detainees assessed by Counties Manukau WHNs were much more likely to have been detained for reasons relating to their mental health (30% for Counties Manukau compared with one percent for Christchurch) and for detoxification (36% for Counties Manukau compared with 13% for Christchurch).

- **Alcohol and Drugs referral options:** There are only very limited AOD referral options in Christchurch where the local Community Alcohol and Drug Service (CADS) and a number of NGO providers will not accept referrals of detainees facing charges in court. In contrast, Counties Manukau WHNs can make direct referrals of detainees to CADS.

Table 2.5: Differences in service delivery and client types between sites

Differences in service delivery and client types between the two pilot sites is summarised below.

	Christchurch	Counties Manukau
Facilities	Traditionally designed watch-house in the basement of the Police station	New open-plan District Custody Unit (DCU) with glass fronted observation cells designed to minimise risk of harm
Police Custodial Policy	Local Canterbury District Policy directed anyone flagged 'at-risk' of self harm to be assessed by a health professional (WHN or Police Medical Officer (PMO)). This changed in December 2009 and now is at discretion of WH Senior Sergeant.	Person to be assessed by health professional was at discretion of DCU Senior Sergeant.
Emergency MH support Service Model	Psychiatric Emergency Service (PES) 24 hours service at their premises, where people receive frontline assessment & review by consultant. Will respond to call out but takes time to organise as no mobile crisis team.	Crisis team sends someone to DCU to assess and take detainees to appropriate mental health service.
Police options – response to Emergency MH support Service Model	Police only take people back to the watch-house with mental health issues only (ie no charges) if there are safety concerns. When WHN not on duty the Police call PMO to assess risk in custody.	Take people who come to Police attention with mental health issues only (ie no charges) to DCU. When WHN not on duty call Crisis team to assess risk in custody and take to appropriate facility if necessary.
Client type/needs	More likely to be detained for criminal charges, warrants, bail breaches, less for mental health only (1%) as would be taken to PES or ED or detox (13%)	More likely to be female, Maori, Pacific or other, detained for mental health (30%) or detox (36%).
AOD Referral options	Very limited AOD referral options, CADS and a number of NGOs will not accept referrals of detainees facing charges in court.	WHNs can make direct referrals of detainees to CADS.

At the two comparison sites, the Wellington Central and Porirua watch-houses, Police come into contact with people with mental health and AOD issues in a variety of ways. Those detained with suspected mental health issues are normally assessed at the watch-houses by a member of the CAT team. Police interviewed said they find it easier to manage those they have arrested with suspected mental health issues than those with suspected AOD issues. They thought managing those with suspected drug issues could be more difficult since Police usually did not know the drug or combination of drugs a person had taken. Their main costs in regard to managing arrestees/detainees with mental health and/or AOD issues were monitoring these people whilst in custody, particularly those they assessed as needing 'constant monitoring'.

While the CAT team will assist persons in custody with suspected mental health problems, persons with AOD problems at the comparison sites are not provided with advice about AOD service options. The fact that there is no health professional based at the watch-house means that there is very limited

potential for early intervention among those detainees for whom Police custodial staff members have only mild mental health/AOD concerns.

Comparison Police interviewed identified the distribution and location of arrestees'/detainees' medications as potential problem areas, and highlighted the few service options for those with alcohol-related problems. Some but not all Police interviewed were envious of their counterparts in Christchurch and Counties Manukau who have the WHN initiative operating.

Some of the benefits of the WHN initiative are made clear by contrasting processes in the WHN initiative sites with those in the comparison sites.

Table 2.6: Summary of differences between Pilot sites and comparison sites

WHN initiative sites	Comparison sites
The co-location of the WHNs at the watch-houses means that detainees with mental health/AOD problems are assessed more quickly by a health professional, and, if appropriate, triaged more quickly out of Police custody.	If the Police custody officer evaluates a detainee as being at risk of self harm and in need of care/care and constant monitoring, a health professional is usually called in to make a crisis assessment of him/her. The response times of these health professionals are longer since they include travelling time, and consideration of their other work.
WHNs provide detainees with AOD problems with a brief intervention that includes education, advice and information about AOD service options and can make direct referrals to some AOD services on detainees' behalf. These services will follow-up on detainees whom the WHNs have referred to facilitate their engagement with these services.	Detainees with AOD problems do not receive advice or information about AOD self-referral service options.
WHNs provide an opportunity for early intervention through their assessment of detainees for whom Police have mild concerns about their mental health/AOD status but would not necessarily call in a health professional.	There is virtually no potential for early intervention among those detainees for whom a Police custodial officer has only mild concerns.
Where consent is provided, WHNs facilitate detainees' referrals and follow-up care by co-opting family/whānau members to get detainees/clients along to their referral appointments. WHNs may also notify their GPs and health key workers of their clients having been recently detained in the watch-house, thereby helping reconnect them with health services.	GPs and health key workers are much less likely to be informed about their clients having been recently detained in the watch-house since the health professionals' role in relation to the crisis assessment of detainees is more narrowly prescribed.
The WHNs have immediate access to health history information about detainees.	Access to health history information is likely to be slower. Police may contact a member of the CAT team, sometimes through the Mental Health Line, to access health history information about some detainees they may be concerned about.
WHNs provide more effective management of detainees' medications.	Some Police interviewed identified the distribution and location of detainees' medications as potential problem areas.
Custodial Police have direct access to WHNs' knowledge and expertise in dealing with people with mental health and AOD issues.	Some Police interviewed acknowledged that managing detainees with suspected drug issues could be problematic.

3 Meeting the WHN initiative's objectives

3.1 Introduction

This Chapter is organised around the objectives of the WHN initiative and examines each in turn. This may be somewhat artificial since the objectives are overlapping, but it serves to ensure they are all addressed.

3.2 Assessment and assistance provided by WHNs

This section provides evidence relating to the assessment of the extent to which the WHN initiative is meeting its first objective. Accordingly, WHNs are charged with:

'assess[ing] and assist[ing] in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody.'

3.2.1 Identifying detainees for assessment

WHNs assist Police in the watch-houses with the identification of detainees who may benefit from a WHN assessment. The other three main ways that detainees are identified as suitable for a WHN assessment are:

- Police officer observation of the detainee, including concerns after screening for health and safety risk;
- the detainee is flagged as being 'at risk' of suicide or self harm on the Police National Intelligence Application (NIA) computer system; or
- the detainee is known to have an AOD/MH issue.

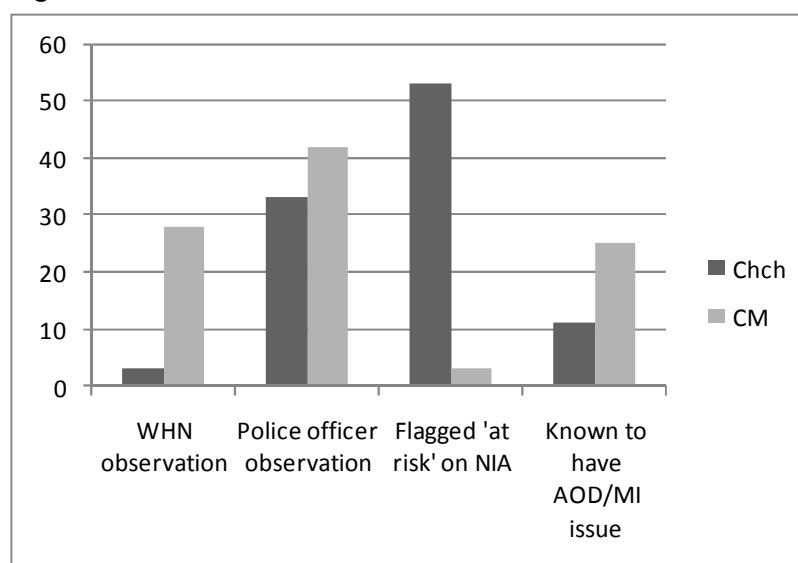
There were two notable differences in the way detainees are identified that are related to differences in facilities and policies at the sites. Of all the assessments undertaken, nearly three in every ten (or 28%) by Counties Manukau WHNs but just three in every hundred (3%) by Christchurch WHNs were initiated because of their direct observations of detainees' behaviour (Table 3.1). This difference is likely to reflect differences in watch-house design, with the Counties Manukau DCU receiving area being open plan and Christchurch not.

In line with their operational policies (see section 2.3.1 above), just over one half (53%) of assessments by Christchurch WHNs were undertaken because detainees had 'at risk' alerts on NIA. This compares with a figure of only three percent of assessments undertaken by Counties Manukau WHNs.

Table 3.1: Reasons for WHNs' assessments of detainees over 18 months

Reason	Christchurch		Counties Manukau	
	n	%	n	%
WHN observation	100	3%	561	28%
Police officer observation	1,279	33%	836	42%
Flagged 'at risk' on NIA	2,056	53%	63	3%
Known to have an AOD/MI issue	415	11%	490	25%
Unknown	0	0%	36	2%
Totals	3,850	100%	1,986	100%

Source: Extraction of data from the WHN site databases.

Figure 3.1: Reasons for WHNs' assessments of detainees over 18 months

Source: Extraction of data from the WHN site databases.

3.2.2 Assessing and assisting with the clinical management of detainees

WHNs undertook a total of 5,836 assessments with detainees in Police custody – 3,850 (66%) assessments at the Christchurch Central Police watch-house and 1,986 (34%) assessments at the Counties Manukau Police District Custodial Unit – over an 18 month period.

Ninety percent of detainees assessed by WHNs in Counties Manukau and 74 percent of detainees assessed by WHNs in Christchurch presented with a mental health or an AOD issue (Table 3.2 and Figure 3.2).

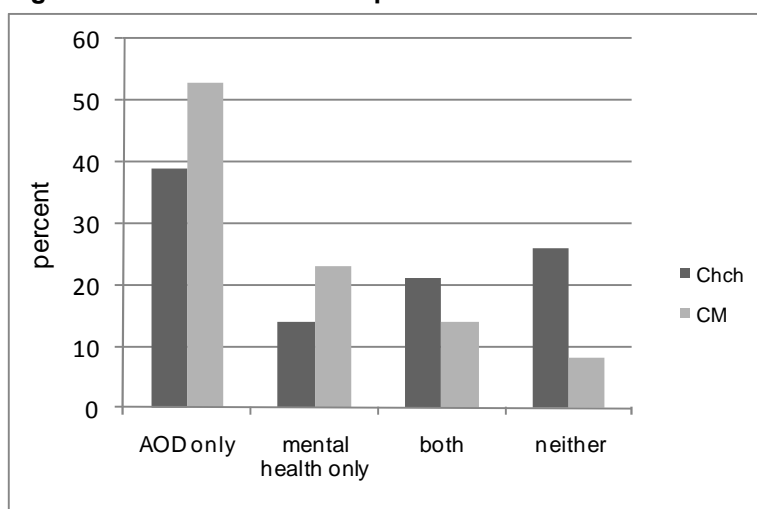
Detainees assessed by WHNs at both sites were most likely to present with AOD problems, either alone (39% in Christchurch and 53% in Counties Manukau) or in combination with mental health problems (21% in Christchurch and 14% in Counties Manukau) (Table 3.2 and Figure 3.2). All up, 60% of assessments with Christchurch detainees and 67% with Counties Manukau detainees were related to AOD problems.

Fourteen percent of assessments with Christchurch detainees and 23% with Counties Manukau detainees were related to mental health issues only.

Table 3.2: Issues detainees who were assessed by WHNs presented with over 18 months

Presenting issues	Christchurch		Counties Manukau	
	n	%	n	%
AOD issues only	1,488	39%	1,057	53%
Mental health issues only	549	14%	456	23%
Both AOD and mental health issues	807	21%	269	14%
Neither AOD nor mental health issues	1,006	26%	162	8%
Not known	0	0%	42	2%
Totals	3,850	100%	1,986	100%

Source: Extraction of data from the WHN site databases.

Figure 3.2: Issues detainees presented with over 18 months

Source: Extraction of data from the WHN site databases.

A relatively high 26 percent of detainees assessed by Christchurch WHNs presented with neither AOD nor mental health issues. This is likely to reflect their local policies of assessing all detainees with 'at risk' alerts for suicide or self harm on NIA no matter how old the alert (see Table 3.2, Figure 3.2 above).

Further analysis was undertaken to look at whether there were any differences in presentation issue(s) profiles among detainee groups with different characteristics. Four of the five characteristics chosen – 'First time arrested/detained in a Police cell', being a 'Youth at Risk', being 'Male' and being 'Māori' – were a sub-set of the standard questions custody officers use nationally to help guide them in their evaluation of a person's likely health and safety needs (including their risk of suicide) whilst in custody. The findings are presented in Tables 3.3 and 3.4 and Figure 3.3.

Table 3.3: Presenting issues among sub-groups of detainee groups assessed by WHNs in Christchurch

Presenting issues	First timers	Aged < 20y	Male	Māori	Pacific	All
AOD issues only	20%	33%	39%	45%	53%	39%
Mental health issues only	21%	14%	14%	9%	8%	14%
Both AOD and mental health issues	20%	16%	20%	21%	8%	21%
<i>Any mental health or AOD issue sub-total</i>	61%	63%	73%	75%	69%	74%
Neither AOD nor mental health issues	38%	37%	27%	25%	30%	26%
Column totals	100%	100%	100%	100%	100%	100%

Source: Extraction of data from the WHN site databases.

Note: The column descriptors do not represent mutually exclusive groups. A detainee could be a first timer and Pacific, for example.

Table 3.4: Presenting issues among sub-groups of detainee groups assessed by WHNs in Counties Manukau

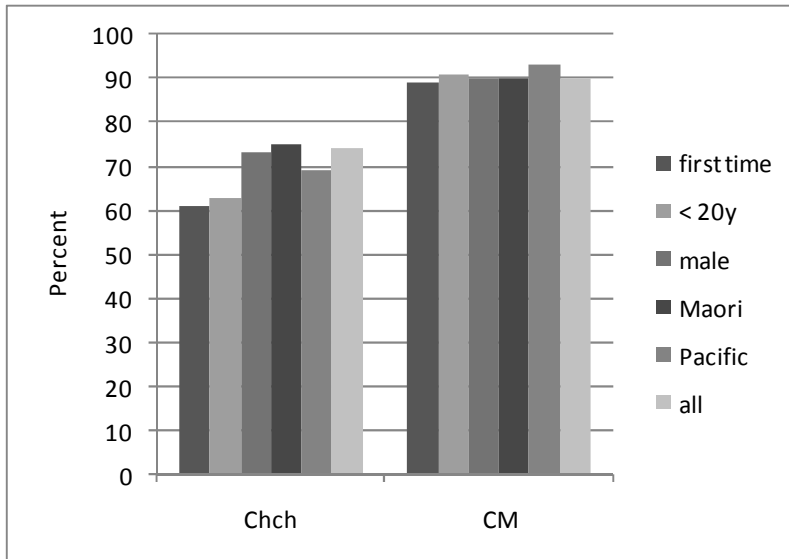
Presenting issues	First timers	Aged < 20y	Male	Māori	Pacific	All
AOD issues only	47%	56%	56%	54%	63%	53%
Mental health issues only	37%	24%	21%	22%	19%	23%
Both AOD and mental health issues	5%	11%	13%	14%	9%	14%
<i>Any mental health or AOD issue sub-total</i>	89%	91%	90%	90%	93%	90%
Not known	3%	2%	2%	2%	2%	2%
Neither AOD nor mental health issues	8%	7%	8%	8%	7%	8%
Totals	100%	100%	100%	100%	100%	100%

Source: Extraction of data from the WHN site databases.

Note: The column descriptors do not represent mutually exclusive groups. A detainee could be a first timer and Pacific, for example.

Figure 3.3 shows differences in presentation rates among detainees with a mental health or an AOD issue (or both) between the sites, with the rates being higher in Counties Manukau. The Figure and the accompanying analysis also suggest that the standard 'key indicator' questions relating to 'First time arrested/detained in a Police cell', being a 'Youth at Risk', being 'Male' and being 'Māori' that Police custody officers are currently using nationally to help guide them in their evaluation of a person's likely health and safety needs (including suicide risk) whilst in custody may not alone be that useful in differentiating risk levels.

Figure 3.3: Percentages of detainees who were assessed by WHNs presenting with a mental health and/or an AOD issue



Source: Extraction of data from the WHN site databases.

The WHNs' assessment of detainees also includes assessment of risk. They assist in managing detainees who are intoxicated and advise when medical intervention is appropriate.

WHNs' clinical management of detainees with mental health issues is informed by their knowledge of detainees' prior history of mental illness. Unlike Police Medical Officers, WHNs have access to their DHBs' mental health services' databases (see section 2.3.2).

3.2.3 Assisting through early intervention and early diagnosis

Frontline Police, particularly in Counties Manukau, are said to feel reassured that if they bring someone with mental health issues back to the station they will get help.

Early intervention

There is growing evidence that WHNs are identifying detainees with less severe mental health and AOD issues and providing them with the appropriate assistance. For those in the early stages of becoming unwell this may help prevent issues from escalating in the future. The potential for early intervention has positive implications for a person's health outcomes as well as reducing offending. An interviewee from the Forensic Service said:

'I think the fact that someone can get assistance for mental health or physical health needs at the earliest possible intervention has always got to be a good outcome because the sooner you can treat something the less likely it is going to become more complicated. So if you can pick someone up in the early stages of becoming unwell their outcome prognosis is possibly shorter because you have nipped it in the bud earlier as opposed to wandering through the system remaining unwell and possibly carrying on offending or offending more seriously. So that has to be a good outcome.' (Forensic Service)

These sorts of detainees were being identified by the WHNs and by custodial Police who are starting to refer to the WHNs more detainees for whom they have some concerns but do not meet the risk criteria for the Police to consider calling in the Crisis Team or a Police Medical Officer. The Police's threshold for referring detainees to the WHNs is now lower because the WHNs are accessible and can provide an opportunity for early identification. A WHN said:

'Because we are here the Police are referring to us a lot more than they would consider calling a doctor in – especially young people with substance abuse problems and for those for whom it's their first time in custody and they are distressed.' (Christchurch WHN)

Early diagnosis

A representative from PES said that the WHNs in Christchurch were providing assistance and treatment options to people who had previously never been identified or accessed treatment with PES and were cycling through the justice system:

'This is a group who were cycling through the Watch-house and the Courts and not touching base with anyone and were being released. Now at least they are touching base with someone (WHN) ... they have some options. The fact is a lot of them do not choose to take up that option but at least now the option is there for them.' (PES)

3.2.4 Assisting through the provision of information about other services

The detainees commonly tell the WHNs of other problems they have such as relationship problems, family violence issues, and other serious unaddressed problems (such as history of sexual abuse). The WHNs may suggest they seek help from social programmes and services such as Stopping Violence Programmes and Women's Refuge and Relationship Services. While there are other Police and interagency processes in place to deal with family violence (for example, the Family Violence Interagency Response System), the WHNs are another source of information and encouragement.

'I think just being able to give them information and encouragement to seek help for anger management, relationship counselling, grief counselling, all sorts of things. [There are] quite a high number of people we see who will tell us they have been sexually abused and they haven't told someone before. This is not a question we will ask...' (Christchurch WHN)

The WHN may also refer people to their GPs for medical conditions. One WHN said that people start to tell you about all the health problems that they need checked out but they have not been to the doctor because they have no money. In one example the WHN was able to ring the GP and discuss payment options to treat a medical condition that was causing a young man severe mental distress.

At Counties Manukau they have found some difficulties in triaging people with intellectual disability whose behaviour has become too difficult for their carers to cope with. These people with intellectual disability do not come under mental health services as they are not mentally unwell. This may highlight a gap in service provision for this group.

3.3 Reduction in risks of harm to detainees and custodial staff

This section provides evidence relating to the assessment of the extent to which the WHN initiative is meeting its second objective, namely:

'reduc[ing] the risks of harm to detainees in Police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders.'

WHNs continue to assess detainees' risk of harm throughout their time in Police custody. The WHNs are on hand to check on them and upgrade or downgrade their monitoring regimes in response to their changing risk levels.

Being in custody can be distressing for some detainees who may act out in ways that place themselves, other detainees and Police custodial staff at risk of harm.

Table 3.5 shows numbers of section 13 notifications to the Independent Police Conduct Authority for allegations relating to serious self harm of detainees whilst in custody in the 18 months prior to the WHN initiative (ie 1 January 2007 to 30 June 2008) and in the 18 months following its implementation (ie 1 July 2008 – 31 December 2009) in the two WHN sites and the two comparison sites.

The total numbers of allegations of serious self harm of detainees are very low. In relation to the objective of reducing risk of harm to detainees in Police custody the number of allegations in the WHN sites in the 18 months following the initiative's implementation reduced by one in Counties Manukau but stayed the same in Christchurch compared with the 18 months prior, while the figures at the comparison sites reduced by four in Wellington and by three in Porirua over the same period.

Table 3.5: Notifications for allegations relating to serious self harm of detainees whilst in custody in the 18 months prior to and post the WHN initiative being implemented according to site

No of notifications re serious self harm	Christchurch		Counties Manukau		Wellington		Porirua	
	18 m pre	18 m post	18 m pre	18 m post	18 m pre	18 m post	18 m pre	18 m post
Cause injury	1	1	0	0	0	0	0	0
Attempted suicide	1	0	1	0	3	0	3	0
Cause death	0	1	0	0	1	0	0	0
Totals	2	2	1	0	4	0	3	0

Source: Extraction of data from file provided by Police National Headquarters.

Table 3.6 shows numbers of injuries to Police custodial staff during custodial supervision on Police premises in the cell block or watch-houses in the 18 months prior to the WHN initiative (ie 1 January 2007 to 30 June 2008) and in the 18 months following its implementation (ie 1 July 2008 – 31 December 2009) in the two WHN sites and the two comparison sites.

The total numbers of injuries to Police custodial staff are also very low. In relation to the objective of reducing risk of harm to Police custodial staff the number of injuries in the 18 months following the WHN initiative's implementation compared to the 18 months prior to its implementation reduced by two in Christchurch but stayed the same in Counties Manukau. In the comparison sites the number of injuries reduced by one in Wellington and increased by two in Porirua over the same periods.

Table 3.6: Numbers of injuries to Police custodial staff in the 18 months prior to and post the WHN initiative being implemented according to site

Number injuries	Christchurch		Counties Manukau		Wellington		Porirua	
	18 m pre	18 m post	18 m pre	18 m post	18 m pre	18 m post	18 m pre	18 m post
Totals	7	5	5	5	1	0	1	3

Source: Extraction of data from file provided by Police National Headquarters.

The numbers of allegations of serious self harm to detainees and injuries to Police custodial staff over the 18 month periods examined were too small to draw useful conclusions about whether the objective of reduc[ing] the risks of harm to detainees in Police custody and custodial staff were met.

The WHN Assessment Form also provides for the collection of information related to risks of harm for detainees and custodial staff. However, the findings are not shown here since they are thought to not properly reflect actual numbers of issues in custody (violence, disruptive behaviour, attempted suicide or self harm, or other) and recording practices probably differ between the sites. Should such information be required for planning or management purposes, further attention needs to be paid to the recording of this information and in a standardised way.

Feedback from detainees interviewed for the case studies and from the WHNs was that having someone to talk to who was focused on their well-being could reduce detainees' anxiety levels. WHNs said:

'Most people like to talk and I think sometimes being able to talk to someone lessens their distress. It doesn't change the environment they are in which adds to their distress but sometimes being heard – just articulating their distress... You can point out 'Do you think your alcohol and drug use may be leading to what is happening here?' They can either deny it or say 'Well, maybe.' It does open the gate and provide some options. Whether they follow through is another thing.' (Christchurch WHN)

'People turning up wanting to talk to us – I think for that to happen it is giving an indication that the detainee is getting some kind of benefit out of talking with us. ... Having someone there who isn't a police officer but just showing an interest in their welfare... someone not wearing a uniform...' (Christchurch WHN)

Police custody staff told the evaluators that they feel more supported and less at risk having immediate access to WHNs and their clinical knowledge, skills and judgement. For example:

'It is fantastic, it [WHN service] gives me an informed opinion on the person's state of mind. I as a Police Officer am trained to investigate and detect and determine offences, they as medical professionals are trained to investigate and detect health issues. I am not qualified to make decisions on state of mind but they can make those decisions and that is fantastic.' (Counties Manukau Police)

'I personally think it is such a good idea and that is from my perspective being a boss in here [watch-house]. It is a comfort for me to know that the [WHN] service is there and so handy and accessible ... You talk to any other Senior Sergeant who works in here. They would say the same thing. ... The times they are not here it is more stressful. (Christchurch Police)

'[We] definitely feel more supported. 'Psyc' matters are hard to predict and we are just not qualified or skilled enough in that field so that is why it is great we can lean on the professionals.' (Christchurch Police)

'It is a bit of a worry when they are not there because we have come to rely on them. They are a loss when they are not there for sure.' (Counties Manukau Police)

'It's all very well knowing that they're [the detainees are] at risk. That is great, but the psyc nurses know their history and know why they're at risk and what they need in the future...' (Christchurch Police)

In Counties Manukau the WHNs used triage techniques to prioritise their work among detainees with changing risk levels. The open plan environment makes it easier for them to observe changing behaviours. They were advising the Custody Sergeant to call in the Crisis Team only if they were really needed.

The WHN role has also impacted on Police who are responsible for transporting and detaining prisoners at Court. A Court Escort Senior Sergeant said from his perspective the WHN pilot has greatly relieved the responsibility on him from a Duty of Care perspective. Having had people seen by the WHN and with a clear plan for their care once they leave Police custody has made his responsibility much easier to discharge, especially when the person needs further assessment at PES or a CMHT. The WHN makes the arrangements for this and has communicated to both him and the service concerned.

3.4 Liaison with other service providers and referrals to treatment providers

This section provides evidence relating to the assessment of the extent to which the WHN initiative is meeting its third objective, namely:

'liais[ing] with other service providers, and make referrals of detainees to treatment providers.'

Throughout this section it is important to note that once a person leaves the watch-house s/he is no longer the responsibility of a WHN.

A person's journey through both the justice system and the health system brings them into contact with multiple services. An important part of the WHN role is liaising with other health providers to assist in the management of detainees' health needs and risk in their next steps in the justice system and on release into the community. The WHNs liaise with a number of health services reflecting the different pathways of detainees including:

- facilitating the sectioning under the Mental Health (Compulsory Assessment and Treatment) Act of some detainees with serious mental health issues;
- notifying Forensic Services at Court (Court Liaison Nurse) and Prison about a detainee's mental health and risk status. The Court Liaison Nurse is not part of a risk management plan as this is not their core role and they do not have the capacity to take responsibility for risk management.
- providing advice and information to detainees about treatment options in the community and, where appropriate, refer them directly to treatment services. This may also include contacting a detainee's DHB case manager and informing her/him about the circumstances resulting in their client being detained in Police custody.

The WHNs at both sites may also liaise with the detainees' family members or GPs to encourage appropriate follow-up care. The scope of their role has actually broadened out to provide information about where to get help for other health issues and social issues (for example, Relationship Services, anger management, grief counselling, Depression Support Network – see also section 3.2.5).

3.4.1 Liaison with health service providers

Emergency Mental Health Services

The WHNs' triage processes impact on emergency mental health services at both sites. The Psychiatric Emergency Services (PES) in Christchurch and Crisis Team members in Counties Manukau reported getting more appropriate referrals from the watch-house when the WHN were on duty. PES reported a modest increase in numbers due to the WHN initiative as although the referrals were more appropriate the nurses were identifying more people. Crisis Team members said their workload was reduced when the WHN were on duty and they had noticed an increase in call outs to the DCU when the WHNs were not there particularly on Sundays.

In Counties Manukau the information the WHN provided the Crisis Team staff prior to their actual arrival at the DCU had enabled them to arrive much more prepared to deal with the detainee. For example, if the person needed to be admitted to a mental health facility they could start arranging that which sped up the process. A Crisis Team member said the WHN role was very beneficial to them as they had triaged the person and done the groundwork.

'You've basically got demographic information and a basic outline so we can formulate a plan before we go and see the person. It shortens what we do. You can go and see them and say: 'This is what we can offer you' rather than stopping the discussion, finding things out and coming back together again.' (Crisis Team)

Crisis team members also thought that the WHN role meant more people were being identified and less were 'slipping through the net'. The WHN initiative also eased any tensions with Police and had strengthened the good relationship between Police and the Crisis Team.

Feedback the evaluators received was that at Christchurch the WHN initiative had improved what had sometimes been a tense relationship between Police and PES. The tension was primarily due to PES's lack of capacity to respond immediately to urgent cases at the watch-house and its inability to attend non-MHA cases there.

'One of the advantages of a Counties Manukau type model is that when a WHN identifies they need someone to be seen by a Crisis Team member ... they can come and see them fairly promptly which is not something we have been able to do in Chch ...' (PES)

The WHNs have helped by negotiating with mental health services on the Police's behalf. Having them at the station had also provided some Christchurch Police and PES staff (especially those trained to backfill the WHN role) with the opportunity to broaden their understanding of each other's roles in dealing with people with mental health issues.

However, at times the WHNs at Christchurch had been frustrated at PES's lack of capacity to respond to non-MHA cases at the watch-house and were concerned when some detainees were released. To mitigate the WHNs' concern the PES Clinical Director had provided them with a written statement to say PES is not able to respond immediately in all situations and that the scope of the WHN role ends when a person leaves the watch-house. This makes clear that the WHNs are not responsible for the outcomes for a person once they leave the watch-house.

A WHN said there was a particular issue in regards to ensuring some people actually attended their PES appointments. These were people who were not sectioned but were high enough risk such that the WHNs had made an appointment for them at PES. A PES Consultant estimated that about 50% of these people did not show up at PES. A WHN said they tried to involve family to help to take them to their appointment.

Emergency mental health services at both sites were very positive about the WHN initiative and regarded it as a success and wanted to see it continue.

Community Mental Health and AOD services

The WHNs at both sites are informing Community Mental Health workers and CADS workers about whether their patients have been detained by Police. Prior to the WHN initiative, these workers had not been getting this information.

In Christchurch a Community Mental Health Service manager said that prior to the WHN pilot there had been very little information passed on to them about their clients who had been held in custody. The WHN pilot had had a major impact on their service as they were now frequently getting information from the WHNs who were contacting people's DHB case managers. This was beneficial in terms of people's management plans enabling case managers to put the right supports in place when patients were going through a crisis. It also helped to inform case managers about where stressors were coming from – something which they previously would not have known about. An interviewee from Community Mental Health Service was very positive about the WHN initiative saying their service found it really good.

'It has been quite major from our perspective because now we are getting information about our clients' contact with the watch-house which previously we may have been unaware of.' (Christchurch Community Mental Health Service)

The other benefit was that the WHN have access to a patient's case notes through the DHB database.

The WHNs and their clinical manager at PES had received a lot of positive feedback from Community Mental Health Services and CADS, particularly the methadone service, about being informed about their patients' contact with the watch-house. A WHN said that sometimes they had not seen the person but saw their arrest sheet and sent through information to mental health service case managers about what they were charged with, what they were like in custody when they saw the PMO, any risks and date of their next Court appearance. Informing case managers about the Court date meant they could try to ensure their patient turned up. Previously, many did not turn up at Court and that resulted in warrants for their arrest and 'around they go.' The WHN update a patient's case notes with a progress note and fax through information to a case manager and also ring them if they have time.

There was variability among the NGO AOD providers about their knowledge of the WHN role. One provider said they did not really know much about the WHN role and another that they referred people to their services. One provider suggested that even a short communiqué when the role started and how a service might interact with the role and a contact number or email address for the person would have been useful. There was also a missed opportunity in asking the NGO providers to record if a self-referral was informed about their service by the WHN.

In Counties Manukau, CADS will follow-up on referrals faxed through to them by the WHNs. An interviewee from CADS said that the referral process from the WHNs works well and those that are directly referred are followed up straight away with several phone calls and finally a letter if they cannot contact them. However there has been trouble with engagement and the uptake of referrals from the WHN has been relatively low (see section 4.2). A positive is that people are now receiving information via the WHN and pamphlets at the DCU about the CADS services to help them with their AOD problems so they have options to self refer at a later date.

The CADS interviewee suggested there were opportunities to enhance engagement by having a specialised AOD worker providing screening and brief intervention at the DCU and also looking at ways that detainees could be diverted into treatment pre-sentencing. The evidence for mandated treatment shows that it can benefit some people by providing an opportunity to engage in treatment. Swan et al. (2007) review of the literature found that most research regarding 'forensic AOD clients, who are typically mandated to attend treatment, are retained in treatment and do no worse than voluntary AOD clients, and better than those not in treatment at all' (Hough, 2002; Hussain & Cowie, 2005; Swan & Alberti, 2004 cited in Swan et al., 2007, p.6).

The CADS Offender Team pilot which works with Community Probation Service to treat offenders sentenced to supervision is showing some promising results. For lower level offenders not sentenced to supervision a Police diversion or pre-sentencing initiative could provide the mechanism to get people to treatment. A CADS interviewee said that particularly with Counties Manukau promotion of formal cautions there is an opportunity to refer those with identified AOD problems to treatment via Police diversion.

The literature on AOD treatment highlights that people have to be motivated to make behaviour changes which is why some services are reluctant to take coerced or mandated clients. However, some studies have demonstrated that the inclusion of motivational interviewing and motivational enhancement therapy can assist in addressing motivational issues (Berends et al. 2007; Swan et al., 2007). There have also been some promising results from evaluations of Police diversion initiatives to address AOD abuse in Australia although more research is required (Heale & Lange 2001; Hughes & Ritter 2008; Pritchard et al. 2007).

Forensic Services: Prison Health Service

In Christchurch the Police, WHNs, and Prison Health Service have enhanced the process of transferring prisoners with mental health issues between agencies. This includes a tightening up of the policy of signing prisoners over from one agency to another, resulting in a clearly recorded chain of transfer with all concerned aware of the category of the prisoner they are dealing with.

The Christchurch WHNs liaise with the Prison Service in order to provide them with access to more information about a prisoner's mental health that will assist in their management and care. The WHNs have instigated a practice of faxing Christchurch Men's prison with a list of people they have assessed and if any of them turn up in any of the local prisons then the WHN arranges that the prison can ring PES and ask them about the person's mental health issues.

The Christchurch Men's Prison provided very positive feedback about receiving information from the WHNs. A representative said that information about a prisoner's risk gave the receiving nurse more of a chance to get background information before the prisoner arrived and to do forward planning such as checking the availability of beds in their at-risk unit. If someone had been identified by the WHN as high risk of self-harm then the receiving nurse would probably see them first to conduct an assessment.

During initial meetings between the Prison Service, Police and the WHNs in Christchurch it had become apparent that Police's use of terminology for identifying self-harm risk status related to their custody monitoring regime was different from that used by the Prison Forensic Service and generally by mental health. For example Police's 'low risk' includes wearing a gown and regular observation which would be regarded as 'high risk' by the Prison. This was now understood by Prison staff. However, several interviewees suggested either standardisation or a standardised statement setting out what Police's 'high risk' and low risk' definitions are. This could prevent potential confusion among new staff members.

Forensic Services: Court Liaison Nurse

The WHNs have had some interactions with the Court Liaison Nurses at both sites. There are clear interfaces between the Court Liaison Nurse and the WHN roles which are important to clarify. In Christchurch there was a lack of consultation with the Forensic Services during the pilot set up. This resulted in some initial confusion over roles and boundaries. A Court Nurse suggested that as part of the service provision frameworks an interface document be developed between the Forensic Service and WHN Service. A crucial issue is where responsibilities for at-risk detainees with mental health issues start and finish and risk management through a detainee's journey from watch-house to Court and then either community or prison.

The Court Liaison Nurse role includes working with the Criminal Procedure (Mentally Impaired Persons) Act 2003 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, in particular determining fitness to stand trial. The other part of the role is liaison with the Court and providing advice around people with mental health issues and how the Court may wish to deal with them e.g. linking case managers with Probation Report writers. It is not the Court Liaison Nurse's role to screen people for mental health risk or take responsibility for at-risk prisoners sent to Court from the watch-house.

In Christchurch prior to the WHN service if a PMO assessed a detainee was at-risk s/he would refer the detainee to the Court Nurse rather than liaise with PES. The Court Nurse consequently became tied up with assessing and dealing with often low risk prisoners rather than undertaking their designated role. Now that WHNs assess people in the watch-house and liaise with PES this has had a large impact on the Court Nurse role and effectively freed them up so they can more effectively do their job. There are still some issues when the WHN is not on duty, indicating that PMOs and Police could be more informed about the Court Nurse's role.

In Christchurch, the WHNs phone the Court Liaison Nurse in the morning to let them know about any detainees of concern, and provide notes where necessary. The Court Nurses find this information very useful, particularly in regards to those who have been seen under the Mental Health (Compulsory Assessment and Treatment) Act and sent to a psychiatric facility. Sometimes those people come into the Court process later on and there may be issues around their mental health status. While the WHN now know the Court Nurse's role the Court Nurse suggested some standardisation on the information they receive about the WHN would be beneficial.

A WHN said:

'It's about giving them a heads up, passing on information, but they [the Court Liaison Nurses] are very clear that we can't expect them [the Court Liaison Nurses] to do anything in regards to their ongoing risk management. They [the Court Liaison Nurses] are not part of that process.'

The Court Nurse identified the WHN role as very important, particularly for those with active major mental illness who are sectioned. They [the WHNs] provide a much more timely service. The Court Nurse commented on what could happen in the prior to the WHN initiative:

'What could happen in the past is that they could get arrested and sit in the cells from Saturday night to Monday morning, quite psychotic and then be sent to Court. I would see them and think they were quite psychotic. The Police would be happy for them to be bailed, so I would get PES down – get a front-liner down to front line them and then get a doctor down and then try and get them called in Court at the same time as we were trying to organise the DAO activity. It was a logistical nightmare. This person who was really unwell would be in this really inappropriate environment – it was awful. So now I'm aware a lot of really unwell people go straight to Hillmorton¹⁷ from the watch-house. I think that is so much more humane.'
(Court Liaison Nurse)

¹⁷ Hillmorton is a Christchurch-based hospital which provides an acute psychiatric inpatient service.

Overall, the Court Nurse thought that the WHN pilot is 'a great thing. It's had a positive impact on my role at Court and for the people going through the watch-house. I really hope they keep it going.' A manager from the Forensic Service said 'it allows us to do our role more effectively and focus on our core work.' The Forensic Service thought the WHN service was a good initiative with benefits to streamlining services for detainees.

3.4.2 Referrals to treatment providers and other types of assistance

Referral numbers are limited to referrals in which a WHN has a *direct* involvement. Detainees/clients may also self refer (for example, to AOD providers) but self referral numbers are not included in the analysis which follows.

It is important to note at the outset that the constraints of the Assessment Form and the different working definitions and recording practices of WHNs regarding 'referrals' make the interpretation of the inter-site comparisons findings in this and subsequent sections 3.4.3 and 3.4.4 somewhat problematic.

Whether a WHN makes a referral for a detainee is tied in with Police processing decisions. If the detainee is to be bailed then the WHN may make a referral or give them information about appropriate services. For instance, in Christchurch the WHN may make an appointment at PES for the person, with their permission ring their family, and ask their family to take the person to PES straight away.

Nearly four in ten (38%) assessments of Counties Manukau detainees and about one in ten (11%) assessments of Christchurch detainees resulted in a referral being made for them by a WHN to a treatment provider (Table 3.7 and Figure 3.4).

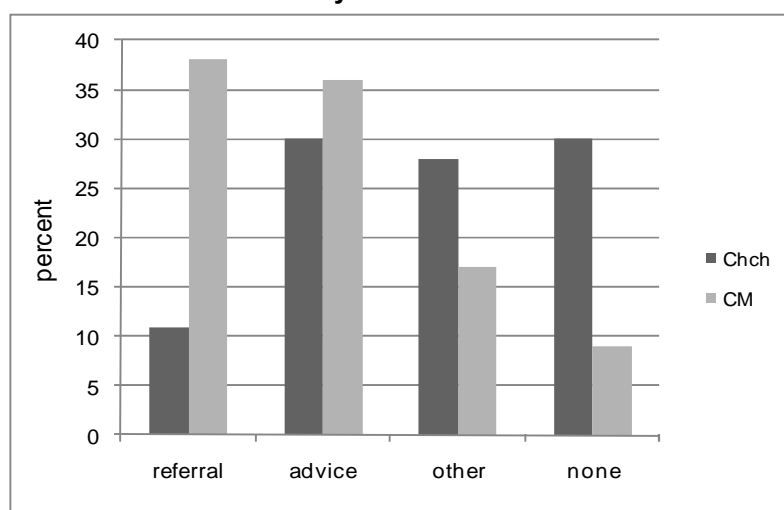
Table 3.7: Referrals and other types of assistance provided to detainees by WHNs over the 18 months

Assistance provided	Christchurch		Counties Manukau	
	n	%	n	%
Referral made (might include advice)	442	11%	750	38%
Advice/pamphlet (no referral)	1,174	30%	721	36%
Other	1,086	28%	336	17%
None	1,148	30%	179	9%
All	3,850	100%	1,986	100%

Source: Extraction of data from the WHN site databases.

Further analysis of some WHN assessment database records revealed that referral rates at both sites were highest for detainees presenting with mental health issues only or mental health issues and AOD issues combined and lowest for those presenting with AOD issues only. Referral rates for those presenting with AOD issues only were especially low in Christchurch where few options for referring to AOD services exist.

Figure 3.4: Referrals and other types of assistance provided to detainees by WHNs over the 18 months



Source: Extraction of data from the WHN site databases.

Counties Manukau WHNs appeared slightly more likely than Christchurch WHNs to provide advice or a pamphlet to those they assessed (36% compared with 33%) whereas Christchurch WHNs appeared more likely than Counties Manukau WHNs to provide detainees with 'Other' assistance (28% compared with 17%).

'Other' assistance took a variety of forms including the WHN: facilitating 'sectioning' under the MHA of a small number of detainees with serious mental health issues; discussing options with detainees to address their issues (especially in Christchurch); liaising with a detainee's DHB case manager and informing them about the circumstances resulting in their client being detained in Police custody (especially in Christchurch); and more generally reconnecting detainees with their treatment providers¹⁸ (see also Table 3.9).

A point worth noting is that the Assessment Form does not provide a specific tick box to capture the WHNs' involvement in the sectioning under the MHA of detainees with serious mental health issues. While WHNs might record this under 'Other' assistance, if this information is particularly important to policy planners and advisors, we recommend that the Assessment Form be amended such that this work has a dedicated tick box.

Christchurch WHNs were very much more likely than Counties Manukau WHNs to judge those they assessed to require no further assistance (30% compared with 9%). As already observed, this is likely to reflect Christchurch's higher proportion of detainees flagged 'at risk' (Table 3.1, Figure 3.1) but who are presenting at assessment with neither AOD nor mental health issues (see Table 3.2, Figure 3.2). Of 2056 detainees whom the WHNs assessed because of an 'at risk' flag, 526 (or 26%) presented for an assessment with neither AOD nor mental health issues and 345 of these 526 (or 66%) were judged to require no further assistance. This could be interpreted as the Police having been possibly over cautious in the use of their policy of all detainees with 'at risk' flags being required to have assessments. As noted in section 2.3.1 this policy was relaxed in December 2009.

¹⁸ Counties Manukau WHNs have adapted the Assessment Form to include the capture of information about whether a detainee is already a client of a mental health or AOD service.

3.4.3 Referrals proposed by WHNs

Generally, direct referrals are not made to AOD NGO providers. Rather, the WHNs provide detainees with information so that they can self refer. As noted in section 2.4.2, in Christchurch CADS do not accept referrals for people going through the Court process.

Seven hundred and fifty assessments (or 38% of all assessments) of Counties Manukau detainees and 442 assessments (or 11% of all assessments) of Christchurch detainees resulted in referrals being made by a WHN to a treatment provider (from Table 3.7 and Figure 3.4 above). To some extent, however, this difference in referral rates is an artefact, arising from different working definitions of 'referral', with Christchurch WHNs using the term in a more restricted sense.

Over six in ten referrals that the WHNs proposed for detainees were to the local mental health crisis services (63% to PES in Christchurch and 65% to the Crisis Team in Counties Manukau, Table 3.8). The WHNs use their clinical judgement as to detainees' risk levels. As noted feedback from the mental health crisis services was that they were getting more appropriate referrals from the watch-houses when the WHNs were on duty.

Table 3.8: Referrals proposed to detainees by WHNs over 18 months

Referrals proposed	Christchurch (n=442)		Counties Manukau (n=750)	
	n	%	n	%
Mental health services				
Mental health crisis team (PES in Chch/Crisis Team in CM)	280	63%	484	65%
Community mental health (Adult Community Psychiatric Services in Chch/Community Mental Health Centre in CM)	19	4%	81	11%
NGO – Mental health	5	1%	11	1%
AOD services				
CADS	1	0%	119	16%
NGO – Non-Mental health	18	4%	10	1%
Forensic services				
Forensic – Court	93	21%	92	12%
Forensic – Prison	75	17%	3	0%
Other health services				
GP	19	4%	29	4%

Source: Extraction of data from the WHN site databases.

Note: An assessment could result in one or more referrals.

In Counties Manukau, where the WHNs are able to directly refer detainees/clients with AOD issues to CADS, about one in six (16%) referrals they proposed were to this service. (This option is not available in Christchurch.)

About one in five referrals (21%) proposed by Christchurch WHNs for detainees were to the Court Forensic Service (Court Liaison Nurse) and just under one in five (17%) were to the Prison Forensic Service.

WHNs at both sites proposed referring relatively small numbers of detainees to general practitioners (GPs) and non-governmental mental health and non-mental health provider organisations (NGOs).

Information about detainees' acceptance rates of referrals and referral outcomes is contained in Chapter 4.

3.4.4 WHNs' reasons for not proposing referrals

WHNs chose not to propose referrals for about nine in ten Christchurch detainees and over six in ten Counties Manukau detainees they assessed.

Christchurch WHNs' top three reasons for not proposing referrals for detainees were:

- 'Other' (45% of those for whom no referral was proposed;¹⁹)
- no referral need was identified (29%); and
- the detainee declined further contact (19%).

At Counties Manukau WHNs' the top three reasons were:

- the detainee declined further contact (51%);
- no referral need was identified (25%); and
- the detainee was bailed or released before an assessment could be completed (15%).

Table 3.9: WHNs' reasons for not proposing referrals to detainees over 18 months

Reasons if no referral proposed	Christchurch		Counties Manukau	
Other (Reconnection with service provider etc)	1,523	45%	61	5%
No referral need identified	970	29%	307	25%
Person declines further contact	651	19%	637	51%
Person terminated assessment early	181	5%	21	2%
Person likely to be remanded in custody	51	2%	32	3%
Person bailed or released before assessment completed	26	1%	185	15%
Total – no referral proposed	3,402	100%	1,243	100%

Source: Extraction of data from the WHN site databases.

¹⁹ Christchurch WHNs' recorded a host of 'Other' reasons for not proposing referrals for detainees, but were mostly around helping facilitate their reconnection with AOD or mental health services by notifying their case managers or their reconnection with their GPs.

The difference in use of parts of the Assessment Form related to referrals suggests that the form (and the accompanying database) could be further developed, for example, by defining a 'referral' and providing space on the form to better capture the sorts of referral type work WHNs are doing – for example, 'referring with a suggested plan' to the Community Mental Health Centre or reconnecting detainees with case managers in mental health and AOD services and their GPs.

3.5 On-going education to the Police

This sub-section provides evidence relating to the assessment of the extent to which the WHN initiative is meeting its fourth objective, namely:

'provid[ing] on-going education to the Police regarding the identification and management of mental health and addiction disorders.'

The Police at both sites are proving they are reasonably good at identifying most people with an alcohol, drug or mental health issue. Of the people whom the Christchurch Police detained in custody for reasons of detoxification over the 18 month period, 95% were found by the WHNs to have an AOD issue and of the people detained for reasons relating to their mental health, 91% were found by the WHNs to have a mental health issue. The comparable percentages for the Counties Manukau Police were similar at 95% and 85% respectively.

Police and mental health staff interviewed were clear about their different roles and that training Police to better recognise and work with detainees with mental health issues was not a substitute for the knowledge and expertise of mental health and addiction professionals. Police have a duty of care for the health and safety of people in their custody but their role does not include the provision of mental health assessment, triage and brief intervention which the WHN provides.

Christchurch

In Christchurch, the WHNs have provided a lot of educational training and advice to Police on an informal basis. This has resulted in increased understanding among Police of some of their clients' needs and a clearer idea of the limits of their own expertise.

'We have a better understanding and appreciation for what our mental health customers need and more often than not the Police can't provide what they need and we don't have the skills to identify or follow-up on what they need...' (Christchurch Police)

Police will ask WHNs about how to deal with people with certain mental health disorders, what the disorder actually is, and how it affects the person.

A WHN said that because they are in the watch-house it has raised awareness among Police and so arresting officers are asking more questions than they previously would have asked (for example, regarding accessing PES or ED). A WHN observed that 'Now they act on little niggles and have lowered the threshold to pass their concerns over [to the WHNs].'

A Christchurch WHN has made a presentation about the WHN initiative to other DAOs and to CADS. Psychiatric registrars, consultants and forensic service staff have expressed interest in the initiative and have requested a presentation too.

As yet, the WHNs have not delivered any formal education to Police. The WHNs and Police Project Manager have discussed options as to how this might be delivered (for example, brief presentations at line-up or on training days Police regularly attend).

Counties Manukau

In Counties Manukau the Custody Sergeant has discretion about whether a detainee is 'in need of care' and a Prisoner Management Assessment Form (PMAF)²⁰ is required. This decision is made based on the evaluation questions asked by DCU staff when the detainee is being received.

The WHN has been providing PMAF training to DCU staff, enabling the Custody Sergeant to make a more informed decision about whether detainees are 'in need of care'. The WHN training has been focused on such things as how to ask the evaluation questions to elicit more information from detainees and to observe what detainees say and how they are acting are one and the same. The DCU manager has been monitoring the quality of decision making with spot checks. Feedback from DCU staff who had received the PMAF training was positive and they found it useful. For example one staff member said,

'There was a bit of confusion and having the nurse able to identify whether a person needed to be constantly or frequently monitored was good as I think we were using more man power than needed to be.'

No further formal training has been delivered to Police since the PMAF training. However, there are several training packages being developed by the nurses. One of the WHNs is adapting the 'First Aid' Mental Health Package to use with Police. The package provides basic information about how to recognise and deal with people with mental health issues. This WHN identified a major gap in Police knowledge was regarding the Mental Health (Compulsory Assessment and Treatment) Act and she had worked with the Custody Sergeants on an informal basis to enhance the knowledge of younger constables in particular.

'A lot of constables think that when you have a mental illness you can't be charged and they are not charging them and they [the detainees] have behaved badly and should be charged. We found they haven't got a mental health issue and then they are being released as they have not been charged... A lot of it is the MH Act and the way we are doing our business has left Police by default struggling with this.' (Counties Manukau WHN)

The other nurse has suggested developing a health training package for Custody Officers. These are new positions without a NZQA level. The WHNs have also been providing informal education to DCU staff via discussions on mental health conditions and how they affect people and information about medications.

²⁰ Health and Safety Management Plans (HSMPs) are replacing Prisoner Management Assessment Forms (PMAFs).

The WHN has undertaken some presentations to mental health services and co-presented with Police at a nurses' conference.

3.6 Meeting international obligations – IPCA feedback

Unbeknown to the evaluators at the time of conducting the evaluation, the Independent Police Conduct Authority (IPCA) as part of its monitoring role regarding the treatment of people held in police cells visited Christchurch Central Police Station. The IPCA provided the evaluators with a report of their observations. Some of their observations are included in the main body of our report since they are pertinent to the evaluation. (The full IPCA report is attached as Appendix 4.)

The IPCA have a role in monitoring the United Nations Optional Protocol to the Convention against Torture (OPCAT) which was ratified by New Zealand on 14th March 2007. The IPCA stated,

Ratification of OPCAT provides a significant opportunity to ensure that all places of detention in New Zealand are safe, humane environments that meet international human rights standards. OPCAT is an international instrument concerned with the prevention of violations and establishes a dual process of international and national monitoring and reporting. (IPCA April 2010 – see Appendix 4)

The IPCA visits thirty or more police stations to monitor the treatment of people held in police cells and is entitled, pursuant to s 28 of the Crimes of Torture Act, to have unrestricted access to all information relating to the number, treatment of, and conditions applying to detainees. The IPCA, along with other national monitoring agencies, developed assessment criteria for site inspections by consulting applicable human rights law instruments. This means that Authority recommendations with respect to custody centres accord with New Zealand's obligations at the international level. The IPCA made the following observations:

The treatment of individuals affected by mental illness or alcohol / drug issues – Authority observations

1. The Authority has, during the course of its site visits, engaged with staff involved in the Mental Health, Alcohol, and other Drug Watch-House Nurse Pilot Initiative ('the Pilot Initiative'). The Authority was advised that the Pilot Initiative allows trained practitioners to work alongside and assist police who conduct detainee risk assessments. The custody centre environment is particularly challenging and presents various risks to staff. It would be unreasonable to expect Police, who are not medically trained, to conduct risk assessments without the support and guidance of qualified practitioners. The Pilot Initiative, therefore, provides assistance that is both necessary and desirable for the safety of police and the welfare of detainees. Staff also explained the methods and systems available for obtaining medical data, medications, and the process of referral to external health providers and other support services. These methods and systems are designed to facilitate effective assessment and care, which contributes to the fulfillment of New Zealand's international human rights obligations.
2. The Pilot Initiative is reported to have been well-received by custody centre and medical staff. It was clear to the Authority that staff realise the importance of having qualified professionals available on site to assist where appropriate and provide the care that vulnerable detainees need

and to which they are entitled. The positive staff response may also be a useful indicator of the long term feasibility of the Pilot Initiative in other centres around the country.

3. Care programmes can only work effectively and deliver the appropriate standard of care to detainees when they are adequately resourced and fully connected with existing health systems. The Authority has observed, for example, that the Pilot Initiative would benefit from a rotation staffing system to ensure that trained professionals are available at any time of the day or night. Staff require robust support systems with effective links to care providers that allow referrals to external mental health, drug, or alcohol residential or community programmes. The programme would also benefit from quantitative data collection of health and systems information. The collection and analysis of this data would allow Police and health providers to monitor the effectiveness of current systems, as well as identify needs and trends for future development.

Further observations made by the IPCA and how they relate to New Zealand's international obligations can be found in their report attached in Appendix 4.

3.7 Summary

The WHN initiative is meeting its complete objectives at each site.

There is overwhelming evidence that the WHNs are meeting the objective of 'assess[ing] and assist[ing] in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody.' WHNs undertook a total of 5,836 assessments with detainees in Police custody – 3,850 assessments at the Christchurch Central Police watch-house and 1,986 assessments at the Counties Manukau Police District Custodial Unit – over an 18 month period. These figures represent the equivalent of about every one in five detainees in Christchurch and one in 14 detainees in Counties Manukau receiving an assessment by a WHN. WHNs' assist these detainees through the provision of direct referrals, reconnections with service providers, advice, information (including about self referral options), and assistance through early intervention and early diagnosis, and facilitation of sectioning under the MHA where this is needed.

There is also strong evidence, especially from feedback from Police custodial staff, that the WHNs are indeed 'reduc[ing] the risks of harm to detainees in Police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders.' WHNs continue to assess detainees' risk of harm throughout their time in Police custody and are on hand to check on them and upgrade or downgrade their monitoring regimes in response to their changing risk levels. Police custody staff told the evaluators that they feel more supported and less at risk having immediate access to WHNs and their clinical knowledge, skills and judgement. The numbers of allegations of serious self harm to detainees and injuries to Police custodial staff in the 18 month periods examined were too small to draw useful conclusions in relation to the objective while the collection of related information on the WHN assessment form was considered unreliable for evidentiary purposes.

Feedback from key stakeholders and analyses of the WHN databases provides convincing evidence that the WHNs are 'liais[ing] with other service providers, and make referrals of detainees to treatment providers.' Service providers they have liaised with include Emergency Mental Health Services, Community Mental Health and AOD services (such as CADS in Counties Manukau), a range of NGO mental health and AOD service providers, and Forensic Services (both Prison and Court). Thirty eight percent of all assessments of Counties Manukau detainees and 11 percent of all assessments of

Christchurch detainees resulted in referrals being made by a WHN to a treatment provider. To some extent, however, this difference in referral rates is an artefact, arising from different working definitions of 'referral', with Christchurch WHNs using the term in a more restricted sense. Over six in ten referrals that the WHNs proposed for detainees were to the local mental health crisis teams (63% to PES in Christchurch and 65% to the Crisis Team in Counties Manukau). The fact that the WHNs are constrained in the numbers and types of direct referrals they can make due to service capacity issues and limited service options (particularly AOD service options in Christchurch) are outside their control.

Finally, feedback from Police custodial staff and the WHNs themselves provides evidence of the WHNs 'provid[ing] on-going education to the Police regarding the identification and management of mental health and addiction disorders.' At both sites the WHNs have provided a good deal of training and advice to Police on an informal basis. In Counties Manukau, the WHNs have provided PMAF training to DCU staff, enabling the Custody Sergeant to make a more informed decision about whether detainees are 'in need of care'.

4 The WHN initiative's contribution to intended outcomes

4.1 Introduction

In keeping with the WHN initiative's objectives, its intended outcomes are:

1. reduced repeat detention of Police detainees with mental health and/or alcohol and other drug (AOD) problems;
2. reduced alcohol and drug related harm for detainees;
3. improved health status of detainees with mental health and/or AOD problems;
4. improved knowledge and skills of Police custodial staff regarding mental health/AOD issues; and
5. reduced risk of harm to detainees with mental health and/or AOD problems.

Evidence is drawn from several sources. The Chapter begins with an analysis of the WHN databases in relation to the intended outcome of improved health status of detainees with mental health and/or AOD problems (outcome 3) and reduced risk of harm to detainees with mental health and/or AOD problems (outcome 5). It includes some outcome information from CADS.

Next, the findings from six case studies and a cohort study following four samples of detainees – two in the two 'active' sites and two in two comparison sites – over one year are used to look at the contribution the initiative makes to meeting intended outcomes of reduced repeat detention of Police detainees with mental health and/or AOD problems (outcome 1), improved health status of detainees with mental health and/or AOD problems (outcome 3) and reduced risk of harm to detainees with mental health and/or AOD problems (outcome 5).

Finally, analysis of key stakeholder interviews are used to assess the contribution of the initiative makes to meeting intended outcomes of reduced alcohol and drug related harm for [all] detainees while they are in custody (outcome 2) and improved knowledge and skills of Police custodial staff regarding mental health/AOD issues (outcome 4).

4.2 Referral acceptance and attendance at other health services

The attendance rates of detainees with mental health and/or AOD problems as clients at other health services provide a proxy measure of their improved mental health status (outcome 3) or reduced risk of alcohol and drug related problems (outcome 5).

This section picks up where section 3.4.3 left off. It analyses data captured on the WHN Assessment Form and held in the equivalent databases to look at detainees' responses to WHNs' proposed referrals for them over the 18 months in terms of referral acceptance and attendance rates to some mental health and AOD services in other settings. The WHNs generally have a greater number of options to directly refer detainees/clients to mental health services than to AOD services.

Those clients with the highest mental health risk are sectioned under the Mental Health (Compulsory Assessment and Treatment) Act or directly referred by the WHNs to emergency mental health services. Almost all clients referred by the WHNs were seen by the Crisis Team at the Counties Manukau DCU (a 97% 'attendance' rate expressed as a percentage of those who accepted a proposed referral) (Table 4.2). It should be noted that Crisis Team members see detainees while they are at the DCU rather than having to attend an appointment at another facility as they do in Christchurch. About seven in ten (69%) attended appointments at the equivalent service – the Psychiatric Emergency Service – in Christchurch (Table 4.1). We think that this figure represents an increase in the rate of clients showing up for referrals to PES compared with the comparable rate prior to the implementation of the WHN initiative in Christchurch.

Attendance rates at community mental health services were also higher among Counties Manukau clients than Christchurch clients (87% and 65% respectively). The corollary, though, is that at least one in ten in Counties Manukau and at least three in ten in Christchurch were failing to show up. The WHNs proposed only a small number of referrals for clients to NGO mental health service providers at each site.

Counties Manukau WHNs have the option of being able to directly refer clients with AOD problems to Community Alcohol and Drug Services (CADS). (Only one detainee with AOD problems was referred to CADS in Christchurch). The figures show that while clients in Counties Manukau expressed high levels of acceptance to be referred, a low one in ten actually turned up. However, this is not unusual for people with AOD issues. It can take quite a few attempts before they seek assistance. This is also an improvement on previous practice where people were not receiving a direct referral to CADS.

CADS' figures show that as at 31 December 2009, CADS had 12 WHN clients on its books.²¹ These clients were receiving a variety of services/treatments through CADS. During the period 1 October 2009 to 31 December 2009, CADS figures show that CADS had opened 34 new referrals from the Counties Manukau DCU, completed contact with 33 clients from the DCU and completed face-to-face contacts with 11 clients from the DCU.

The small number of referrals for clients to NGO AOD service providers reflects WHNs' practice of not directly referring clients to AOD NGO providers. Rather, the WHNs provide them with information so that they can self refer to these organisations.

The rates of WHN clients voluntarily self referring to and actually engaging with NGO AOD services are not known, but are suspected to be quite low. In an attempt to further encourage them to engage with these services the Canterbury DHB has proposed sending a follow-up letter to clients in this group inviting them to contact the alcohol helpline and the Alcohol and Drug Association NZ (ADANZ) for assistance.

²¹ The figures were provided by CADS, Waitemata DHB.

Table 4.1: Referral acceptance by Christchurch detainees and their attendance at other health services

Referrals proposed	proposed	accepted		'attended'		
	n	n	As % of proposed	n	As % of proposed	As % of accepted
Mental health services						
PES	280	262	94%	181	65%	69%
Adult Community Psychiatric Services (ACPS)	19	17	89%	11	58%	65%
NGO – Mental health	5	5	100%	4	90%	90%
AOD services						
CADS (Not Crisis)	1	1	100%	1	100%	100%
NGO – AOD	18	15	83%	4	22%	27%
Forensic services						
Forensic – Court	93	91	98%	72	77%	79%
Forensic – Prison	75	71	95%	43	57%	61%
Other health services						
GP	19	19	100%	9	47%	47%

Source: Extraction of data from the WHN site databases.

Table 4.2: Referral acceptance by Counties Manukau detainees and their attendance at other health services

Referrals proposed	proposed	accepted		'attended'		
	n	n	As % of proposed	n	As % of proposed	As % of accepted
Mental health services						
Crisis Team at DCU	484	481	99%	465	96%	97%
Community Mental Health Centre (CMHC)	81	79	98%	69	85%	87%
NGO – Mental health	11	11	100%	9	82%	82%
AOD services						
CADS (Not Crisis)	119	118	99%	13	11%	11%
NGO – AOD	10	9	90%	9	90%	100%
Forensic services						
Forensic – Court	92	88	96%	20	22%	23%
Forensic – Prison	3	3	100%	2	67%	67%
Other health services						
GP	29	28	97%	8	28%	29%

Source: Extraction of data from the WHN site databases.

Christchurch clients had higher attendance rates at Court-based forensic services (79% compared with only 23% in Counties Manukau) but had slightly lower attendance rates at Prison-based forensic services (61% and 67%).

Less than half of clients show up for GP appointments made for them by the WHNs (47% in Christchurch and 29% in Counties Manukau).

4.3 Findings from some case studies of former detainees

This section includes six case studies of former detainees seen by the WHNs, four case studies from Christchurch and two from Counties Manukau. More case studies were sought from Māori and Pacific detainees but unfortunately of the names provided to the evaluators only one person consented.

The overall purpose of the case studies was to get feedback from former detainees about whether and how the WHNs impacted on their experiences of custody and access to mental health and AOD treatment services. The case studies also provide an illustration of the different types of cases the WHNs deal with and the various treatment service options they can offer. Detainees have been given pseudonyms to protect their identities.

The case studies provide information with which to assess the contribution the initiative makes to meeting intended outcomes of reduced repeat detention of Police detainees with mental health and/or AOD problems (outcome 1), improved health status of detainees with mental health and/or AOD problems (outcome 3) and reduced risk of harm to detainees with mental health and/or AOD problems (outcome 5).

4.3.1 ‘Roger’

Profile

Roger is a 48 year old, Pākeha. He came to Police attention in Christchurch for using offensive language in October 2009. The Police observed that he was quite distressed when he came into custody and asked the WHN to assess him. He presented with mental health issues only. Roger said he was in crisis due to relationship and financial difficulties and was ‘reaching out’ at the time of arrest.

Roger had been convicted of two minor offences previously, with the last conviction being about three years ago.

WHN activities and treatment engagement and outcomes

Roger was seen by a WHN when he first arrived in Police custody where he stayed overnight. The WHN had concerns about his risk and advised his colleague to check Roger the next morning when he started his shift. The second WHN referred Roger to PES and made him an appointment the same day after he had been to Court. Roger attended this appointment and was seen by a psychiatrist who reviewed his medication and offered him respite care and follow-up. Roger said that he had been given medication by his GP and there had been a number of side effects. Roger had increased his dose and then reduced it so a proper review was needed.

Roger accepted the offer of respite care which he attended. He found the respite care really good, especially being able to have contact with other people. It made him think there was ‘light at the end of the tunnel’. PES followed up after the respite care with a phone call at the end of October 2009 where Roger reported he felt good. They arranged an outpatient appointment for Roger at the end of November 2009 which he did not attend. Because Roger did not attend this appointment PES sent him a letter offering another appointment but he did not follow this up so they discharged his case.

The WHN reported Roger had not been in contact with mental health services since the follow-up phone call at the end of October 2009. While it would have been preferable for Roger to attend the outpatient appointment the WHN did not have any major concerns about Roger's wellbeing. The behaviour leading to Police custody was out of character brought on by a stressful situation and the respite care and revision of his medication seemed to have assisted him. Roger is continuing care with his GP.

In the four months since being detained in custody and seeing the WHN Roger has not come to the attention of Police again.

Feedback about seeing WHN while in custody

Roger thought the watch-house nurses who spoke to him in the cells were very good and very professional. He said seeing the nurse helped while he was in Police custody because they were someone willing to listen and it made it easier for him having someone supportive there. Roger said:

'Having the WHN there meant there was a lot more support as you are nervous and frustrated in that situation and you do not know what was going to happen. The WHN made you feel like less of a criminal while you were locked up.'

He remembered the nurse asking questions to assess his risk of suicide. The WHN referred him to PES and arranged an appointment with them. He had previously attended PES a long time ago and lost contact.

Feedback about Police while in custody

Roger said the Police were quite good and talked to him and did not handcuff him. However, he felt really humiliated when they instructed him to strip and put on a gown. This is standard practice when Police have concerns about a person's risk of self-harm (see Police Custodial Management: Suicide Awareness Policy).

What has helped?

Roger said his employer has been a major support to him. He works for a large organization and his manager has been very supportive. He said his employer's support has been 'better than the public service'. As stated above he also found the respite care gave him hope and it was good to connect with other people.

Suggestions for improvement

Roger suggested that the WHN could have visited him again during the night as after they assessed him there was no further contact until the next morning (when the WHN saw him) and he felt like a criminal being locked up.

Roger was generally critical of the lack of co-ordination and liaison between public service organizations and their lack of follow-up.

4.3.2 'Phillip'

Profile

Phillip is a 61 year old Pākehā. He came to Police attention in Christchurch for stealing. He is flagged 'at-risk' on the Police database (NIA) so in accordance with Canterbury Police Policy he was seen by a health professional, in this case the WHN. He presented with problematic alcohol use and depression. The WHNs have seen Phillip four times between March 2009 and January 2010.

Phillip has a sporadic offending history over the past 30 years. The convictions are primarily related to alcohol use with offending under the influence of alcohol (e.g. EBA, wilful damage) or theft to obtain alcohol either directly or by stealing goods to sell. The Police have 8 alerts on their database due to health reasons i.e. depression and suicidal tendency.

WHN activities and treatment engagement and outcomes

The first three times Phillip was seen by the WHN they offered him advice and pamphlets including ADANZ, AOD helpline and Depression Support Network – a self-help group. They identified that Phillip had cyclic depression so when he becomes depressed he drinks and then offends to obtain alcohol or goods to buy alcohol. The fourth time the WHN saw him they asked if they could speak to his GP, which he consented to. The WHN recognised that he was really struggling with depression and that he also had a social phobia and found it very difficult to contact organisations for help.

Phillip's GP made a referral to the Mental Health Services Single Point of Entry service to determine if he would be accepted by Mental Health Services and which was the appropriate service to work with him. This was being processed at the time of writing. The WHN also contacted the Depression Support Network. They said they would contact Phillip and offer to go and see him. The Depression Support Network representative also offered to let the WHN know how Phillip was doing.

Phillip's case highlights the difficulty some people face accessing services when they have a social phobia and the importance of services providing outreach where they contact the client and go and visit them in the community.

Contact with the Depression Support Network via this case has led to arranging a meeting between the WHNs and this organisation to discuss how they could work together in the future.

Phillip first saw the WHN in March 2009 but was not charged with any offence. He next came into Police custody in December 2009 and was subsequently convicted of 7 charges. In January 2010 he came into Police custody twice more and was subsequently convicted of a further 4 charges.

Feedback about seeing WHN while in custody

Phillip said he found the nurse helpful. The nurse gave him pamphlets and a relative is going to help him access services.

Feedback about Police while in custody

No feedback provided.

What has helped?

A family member is helping Phillip including helping him access services.

Suggestions for improvement

Phillip had no suggestions how services could be improved.

4.3.3 'Carol'

Profile

Carol is 36 years old and originally comes from Europe. She came to Police attention in Christchurch for a family violence incident in October 2009. The Police observed she may be at risk as she was taking anti-depressants and asked the WHN to assess her. She presented with mental health issues only. This was Carol's first offence which was brought about due to her feelings concerning a relationship break-up.

WHN activities and treatment engagement and outcomes

The WHN said he thought this incident was 'out of character' for Carol and probably a 'one-off' incident. He provided her with some brief counselling and gave her information about counselling services including Relationship Services and Petersgate Trust. Contacts for PES were provided however the WHN assessed Carol's risk was not high enough to make a referral to PES.

Carol said the WHN left her information about services with her possessions for her to pick-up the next day. She made an appointment with Relationship Services as soon as she got out of the cells and her ex-husband also went along as they both needed to sort out sharing custody of their son. They did not want the custody issue to go through the Courts and preferred to sort it out between themselves. However, they needed help to do this and she found Relationship Services really good. The custody issue 'is all sorted out now'. Prior to the incident she had sought counselling for herself with her GP. Relationship Services was able to assist through counselling her and her husband. Therefore the information about services the WHN provided was useful for Carol. Carol is continuing care with her GP.

The charge for the family violence offence was later withdrawn. In the four months since being detained in custody and seeing the WHN Carol has not come to the attention of Police again.

Feedback about seeing WHN while in custody

Carol said she had never been in cells before and found it quite distressing to be there. Originally a Police woman said the 'psyc' nurse was not going to see her but then they did. (This was after she told them she was on anti-depressants.) The WHN asked her questions

regarding medication, hearing voices and if she wanted to harm herself. She told him she was not crazy. Carol thought it was good the WHN came to see her and provided her with information about services. She said it was a long night in the cell.

Carol's feedback was that she thought having WHNs working at the Police station was very good as everybody is different and some people had mental health issues and needed assessment and advice about where to go for help.

Feedback about Police while in custody

No feedback.

What has helped?

Carol thought the counselling she and her ex-husband received at Relationship Services had really helped them sort out the issues they had.

Suggestions for improvement

Carol said she had no suggestions how services could be improved.

4.3.4 'Simon'

Profile

Simon is a 26 year old Pākeha. He came to Police attention in Christchurch for a family violence incident in October 2009. This was his first time in custody and Police observed that he was distressed and asked the WHN to see him. While he had had a few drinks he was not assessed as having any AOD issues and presented with mental health concerns due to his distress. This was Simon's first offence.

WHN activities and treatment engagement and outcomes

The WHN nurse said that Simon acted aggressively due to a relationship issue which was an extreme situation and the aggressive behaviour was out of character. There was no evidence of a pattern of family violence and the WHN thought this was likely to be a one off incident of wilful damage. The nurse provided Simon with advice and contact details for PES for him to self-refer. The WHN assessed Simon's risk was not high enough to make a referral to PES. The WHN said he thought Simon would have benefited from counselling but there was no great risk to involve PES.

Simon said he did not feel the need to follow-up on treatment. He said 'it was getting the facts from the nurse about what was going to happen to me and I was fine after that'.

Simon was convicted of two offences and ordered to pay for the repair of property he damaged during the family violence incident. In the four months since Simon has not come to the attention of Police again.

Feedback about seeing WHN while in custody

The WHN saw Simon while he was still in the holding cell and took him into a private room for assessment for 15-20 minutes. Simon said the WHN assessment involved a quick psychological evaluation which was good.

'He just explained what the situation was and what was happening and what the possibilities are after it – that there was a bit of help available. He gave me information about the people you can see and talk about it if you need to and he gave me pamphlets.'

Simon said having the nurse there helped 'heaps' because it reassured him about what was going on and what the possibilities are after he was released in regards to support and counselling.

Simon's gave general feedback on the WHN service and said he could see 'the WHN being really helpful for people who have done more serious stuff and helping them come to terms with what they have done'.

Feedback about Police while in custody

Simon was still upset with the way Police treated him and said he was 'disgusted' with them. He did not believe he should have spent the night in the cells and he particularly did not like being in the holding cell with other detainees for the first hour while he was waiting to be processed.

'It was so scary, it was my first time and being in the holding cell with people who have been in jail before. [It was] very scary.'

Simon felt he did not deserve to be there. He accepted that the Police were called. However, he thought he should have had Police bail and been given a date to appear in Court or diversion rather than spending the night in the cells. He said 'staying in the night completely sober it is a long time'.

He went to Court the next morning and then was released on bail to appear the following week. Simon said he was going to go for diversion but the Police did not want it and declined it.

'The duty solicitor read out what I'd done and the Judge couldn't understand why I had been held overnight and the Police had declined diversion. The Police couldn't defend why and the Judge just basically said for your age, you are a full time worker, first conviction, there have been contradictory statements, so the Judge dismissed with fine for damages done.'

What has helped?

Simon did not consider counselling was necessary and did not follow-up with any treatment services. He identified what helped the most was having the Court case over and the Judge's verdict.

Suggestions for improvement

Simon had no suggestions for improvements to the WHN service. He noted he was distraught at the time so he would not have taken in a lot of it so there was no point in having a longer session with the nurse. He said, 'I think the talk with him was just great in itself'.

Simon thought that the Police could evaluate the situation better and make a better call.

'At the end of the day it is their call they do not have to hold you overnight but they chose to and I'd like to know why. The reason they gave was to cool down but when you are not drunk or in a raging state it is stupid. I had already come to terms with what I'd done and I didn't need that on top of it.'

4.3.5 'Greg'

Profile

Greg is a 45 year old Māori. He came to Police attention in Counties Manukau for excess blood alcohol (EBA) for the third or subsequent time in September 2009. The WHN identified he would be suitable for assessment and he presented with alcohol issues only.

Greg has a long offending history starting in 1991 and including previous convictions for driving with excess breath alcohol. He had not had a conviction since 2004.

WHN activities and treatment engagement and outcomes

A doctor came to see Greg while he was in custody to take a blood sample from him for evidentiary purposes. Greg was then remanded in custody over the weekend until his Court appearance. The WHN assessed Greg and provided brief intervention, including discussing his situation and treatment options. Greg said the WHN asked him if he wanted help or support and he said he did want to go to 'rehab'. The WHN made a referral to CADS which CADS accepted.

CADS and the WHN service at Counties Manukau have an agreement regarding referrals including the facility to make after-hour referrals using the CADS online referral form. If CADS accepts the referral they will follow-up with a phone call or letter to the person to arrange a comprehensive assessment.

Greg was very distressed about what was going to happen with his family and employment. He did not want to go to prison, which was a possibility given this was his third or subsequent EBA. He was therefore very motivated to go into treatment. At his Court appearance he was remanded on bail for sentencing and one of the conditions of bail was that he attended an alcohol treatment programme. Greg's employer attended Court with him and was supportive of him attending a programme.

CADS contacted Greg the day after his Court appearance to arrange a comprehensive assessment. Greg attended his assessment and agreed to one-on-one counselling, with treatment goals of abstinence and relapse prevention. Greg's records show that he has been regularly attending one-on-one counselling sessions every week from mid-October to early

December (total of seven sessions including one group session). Greg seems to be engaging well with treatment and there is no record of non-attendance. CADS have also provided the Court with updates on his progress and he is due to be sentenced in February.

CADS also had some contact with Greg's employer over the course of his treatment to check it was alright for Greg to have time off work to attend treatment sessions. Most sessions were able to be conducted after work which was important to Greg presumably to minimise inconvenience to his employer.

In Greg's case the WHNs assessment and referral to CADS has made quite a difference as this facilitated his entry into treatment. Furthermore he was able to enter treatment in a timely way with CADS ringing him the day after he had been in Court, and arranging an assessment and beginning treatment within a month of being in Police custody. It also appears that the Court was prepared to monitor Greg's treatment progress while he was on remand pre-sentencing.

In the five months since being detained in Police custody for excess breath/blood alcohol for a third or subsequent time Greg has not come to the attention of Police again.

Feedback about seeing WHN while in custody

Greg said it was 'awesome' having the WHN at the police station as it was good to have someone to talk too. 'I just told her I was going to go and try rehab.' She goes 'oh yeah, sounds good.' Greg said he had been to alcohol treatment programmes before when he was younger but he 'used and abused it' and consequently got 'kicked out'.

Overall his opinion about the effectiveness of having a WHN at the Police station was that 'It depends on what type of person [detainee] they are, some might not care and they can use that against them – like they can just be using them and spinning a story.'

Feedback about Police while in custody

Greg has a substantial record of offending, although he had not offended for about four years. He was used to contact with Police and on this occasion he said he found the Police good, 'I just go with the flow and I don't give them a hard time or you get it back from them. No they were good they were trying to help me.'

What has helped?

Greg has good support from his partner, family and friends who do not drink. He is trying to stay away from some of his friends who are drinkers as he said it gets him into trouble. His employer is also supporting him and went to Court with him and is prepared to continue to employ him. His employer was also supportive of him attending an alcohol treatment programme. Greg's lawyer has also helped him and he said she knew he was really stressing out about going back to prison.

The records of Greg's attendance at his treatment programme indicate that he has engaged with the treatment and that it is helping him to address his alcohol problem.

Suggestions for improvement

Greg had no suggestions for improving services and said 'I don't know what they could do as you have got to do it yourself'.

4.3.6 'Sophie'

Profile

Sophie is a 36 year old Pākehā. She came to Police attention in Counties Manukau for attempted suicide in September 2009. She presented with AOD and mental health issues. This was Sophie's first time to be held in custody by Police.

WHN activities and treatment engagement and outcomes

Sophie had been dealing with Awhinatia House, Community Mental Health Service, for mental health issues and had been under her GP for a home medical detox for alcohol use. On this occasion she had rung Awhinatia House to talk to a counsellor. Sophie said the counsellor called the Police because she told him 'I've been naughty and cut myself'. She said she was shocked that the counsellor had called the Police. She had not cut herself badly and said it was not an intention to die. Sophie described hearing the sirens coming closer and then there was a knock at the door and the Police were there. 'Basically they were there for my safety but it was a bit of a shock'.

On reflection Sophie thought it was the right thing to do because some people do intend to really commit suicide. 'They don't know which ones are for real and which ones aren't. I consider that I probably wasted their time and their money. That's how I look at it. That is a bit of guilt from me.' Sophie was intoxicated and taken into Police custody for detox and mental health assessment when sober. The WHN assessed Sophie and established that she was already a CADS patient and had been undergoing medical detox under the supervision of her GP. The WHN asked Awhinatia House to follow-up with Sophie to encourage her to attend CADS.

Since being in Police custody Sophie had enrolled in an intensive outpatient alcohol treatment programme through CADS. She said her husband was going to give up work so she could focus on doing that and he will look after everything else. Abstinence is one of Sophie's treatment goals. At the time of interviewing in October 2009 Sophie reported that her alcohol use was nil and this was the only way for her to stay sane as she only has suicidal thoughts when she is drinking.

CADS records show that Sophie has been regularly attending her treatment programme two to three times a week over several months and that she reports being sober for over three months. Her treatment programme reports her progress is going really well and that she is being open and honest and continuing to gain deeper insights and there is currently no risk of self harm.

The WHN's role was primarily risk assessment. The WHN said for Sophie this was to be determined by the sobering up process which is usually 4- 6 hours but in very dependent people can be longer, up to the full 10-12 hours. This was when her impulsivity and suicidal ideation

concurrently diminished with her level of intoxication. The WHN determined whether she required a Crisis Team member to see her or whether she was safe enough to go home with appropriate follow up in place if required. The nurse also asked Awhinatia House to follow-up after her release to her husband's care, by a phone call the next day.

In the five months since being detained in Police custody for her own safety she has not come to the attention of Police again.

Feedback about seeing WHN while in custody

This was Sophie's first time in Police custody and she said she found it hard to get someone to talk to when she wanted to talk at the Police station and she felt that no one was really interested in talking to her. Sophie was put into an observation cell for detox and monitoring self-harm. Sophie said 'there were glass windows and they can see right into where you are – I kept getting up to the glass window and motioning people to come as I wanted a smoke. The Nurse eventually came and said 'no' – that is when she said you'll have to wait for the mental health person and wherever they take you, you can smoke as much as you like'.

The WHN said she actually had several conversations about this with Sophie and she tried to be positive and reassuring. However Sophie might not recall this as she was intoxicated. Smoking is an issue for some detainees and the WHN said they were trying to arrange nicotine supplements (lozenges) to help with this.

Sophie remembers talking to the WHN towards the end of her time in custody. The nurse assessed how sober she was and asked for family members' contact details. Sophie said they talked for just a short time and the nurse told her someone from mental health was going to come in and visit. However, they did not come and shortly after her husband arrived to take her home.

The WHN informed Sophie that she needed to talk with the Crisis Team and her family before making a further decision, and if both were OK she would then inform her of the decision. The WHN was able to make the triage once Sophie was appropriately sober and send her home more quickly than waiting for Crisis to come as would happen if the WHN was not on duty. As this was Sophie's first time in custody she would not have been aware that she had been triaged relatively quickly as potentially she could have been kept in custody for up to 12 hours for detox and then six hours for mental health assessment.

Sophie thought that people could have communicated with her better, 'I know it was an idiot thing to do and I know it is wasting Police time and nurse time – at the same time they looked at me as if I was that idiot and that I didn't deserve to be talked to'.

When asked if the WHN helped her in any way Sophie said the nurse gave her a panadol for a headache. Sophie said having the WHN in the Police station did not make much difference to her.

Feedback about Police while in custody

Sophie thought the Police were just doing their job.

What has helped?

Sophie identified family support from her husband and children as being very helpful. She also found talking to people with the same issues in group treatment sessions was good and expected that the CADS programme she had enrolled in would help her. Sophie had been to treatment before but never dedicated herself to the process. However going through the experience with Police gave her a fright and she said she was determined to try harder this time.

Suggestions for improvement

Sophie suggested follow-up from Awhinatia or the WHN would be good to ensure people are attending treatment etc. She said, 'There was no follow-up from those particular people. I think to prevent it happening again they should have rung up and said have you done this or have you done that? What are you doing to help yourself?' Awhinatia made three follow-up phone calls on three separate days before her file was closed. All were conversations about choices she was making and ensuring she got to the first CADS appointment before her file was closed.

4.3.7 Summary of the case studies

In Christchurch Simon and Carol had never been in Police custody before and Roger only had minor prior offending. All three came to Police attention due to their offending in regards to relationship issues. The WHN thought that these incidents were out of character and probably a 'one off'. To cope with their issues Roger and Carol followed up on the services recommended by the WHN with good outcomes. The WHN made an appointment at PES for Roger which he attended, and Carol made an appointment with Relationship Services herself as soon as she was bailed. They both reported that the treatment and support they received from these services had helped them cope with their problems at that time. Both are continuing care with their GPs. Simon did not feel like he required any extra support.

All three found seeing the WHN reassuring as they were uncertain about what was going on and were nervous being in the cells. Simon found his time in the holding cell with other detainees particularly scary.

None of these three detainees had risk alerts on NIA and it is not certain whether the Police would have called a PMO to see them if the WHN had not been there. PMO's do not generally give additional information about treatment services or make appointments with PES unless someone was to be sectioned under the Mental Health (Compulsory Assessment and Treatment) Act.

In regards to the twin objectives of positive justice and health outcomes it appears firstly that these three people would not be likely to offend again. As for health outcomes the WHN was able to provide them with immediate assessment, advice and information while they were in the cells. The treatment information provided by the WHN led to better mental health outcomes for Roger and Carol. Simon did not feel the need to follow-up on treatment services and was not high risk enough to refer directly to PES.

Phillip is a more complex case with a long history of intermittent offending and cyclic depression. The WHN identified that Phillip requires more assistance to access services and set this in

motion. The treatment access and health outcomes for Phillip were still in progress and given the links to his offending this will also impact on justice outcomes. In sections 2.3.4 and 2.3.5 we mentioned issues in regards to accessing services and Phillip's case illustrates how difficult this can be for someone in his situation.

The two case studies for Counties Manukau highlight two reasonably common scenarios. Sophie's case illustrates Police's role in detaining and monitoring people who are identified as at risk of suicide. Due to her intoxication Sophie was kept in custody until she became sober enough to assess her risk. The WHN role was primarily risk assessment and making a decision as to whether she required assistance from the Crisis team or whether she was safe enough to go home. This was also Sophie's first experience of Police custody and it seems that this experience reinforced the seriousness of her AOD issue. Sophie has subsequently successfully engaged in treatment.

Greg's case illustrates that even with a long offending history, including multiple EBAs if a person is motivated they can successfully engage with treatment. The WHN facilitated this by setting up the appointment with CADS who then followed up with Greg quickly to arrange an assessment and get him into outpatient treatment. The Court played a significant role by giving him an opportunity to attend treatment and monitor his progress before sentencing.

4.4 Findings from the cohort study

This section presents some findings from a cohort study following some detainees over one year which relate to the contribution the initiative is making to meeting intended outcome of reduced repeat detention of Police detainees with mental health and/or AOD problems (outcome 1).

We think it is important to note that the WHNs' ability to affect detainees' behaviour particularly in terms of reducing detentions is very limited. This intended outcome may in fact be unrealistic.

A description of how the samples were drawn, their characteristics, and the analysis of a NIA data extract are documented in Appendix 1. In brief, the four samples – two samples of detainees in the two 'active' sites and two samples in two comparison sites in the Wellington City and Porirua watch-houses – were followed over one year, starting in the period September-December 2008. Over 100 detainees were followed in each sample. Information was also collected on activity in the year prior to their contact with a WHN (or equivalent).

The findings need to be viewed in the operational context in which detainees with mental health and/or AOD issues are managed in custody. How detainees with mental health and/or AOD problems are managed within the 'active' sites where the WHN initiative is operating and in the comparison sites have already been described in section 2.5.

Analysis of repeat 'detentions'

It was not possible to differentiate between arrests and detentions in the NIA data extract obtained from Police so a proxy measure was used based on offences/events and certain 'link names' combinations. Examples of combinations used are:

- 'L201 – Driving While Disqualified' and 'Offender';
- '1X – Attempted Suicide' and 'Subject of';
- '1K – Drunk Custody/Detox' and 'Complainant'; and
- '1M – Mental Case' and 'Subject of'.

These combinations were brought together to form 'detention' entities that occurred on the same date.

The numbers and percentages of detainees at the pilot and comparison sites are shown in Tables 4.3 and 4.4 according to number of detentions in the year before and after their first contact with the WHN initiative (or equivalent).

Table 4.3: Numbers of detainees at the pilot and comparison sites according to number of detentions in the year before and after the initiative's implementation (or equivalent)

Number of detentions	Christchurch		Counties Manukau		Wellington		Porirua	
	WHN		WHN		Comparison		Comparison	
	N=131		N=108		N=126		N=117	
	before	after	before	after	before	after	before	after
0	24	18	32	33	34	34	23	34
1-9	87	97	73	71	85	86	83	78
10-19	19	12	2	4	7	4	10	4
20 or more	1	4	1	0	0	2	1	1
<i>Sub-total – Detained at least once</i>	<i>107</i>	<i>113</i>	<i>76</i>	<i>75</i>	<i>92</i>	<i>92</i>	<i>94</i>	<i>83</i>

Sources: WHN databases (Christchurch and Counties Manukau), charge sheets (Wellington and Porirua), and Police NIA data extract.

In the year before their contact with the WHN initiative 82% of detainees in the Christchurch sample had been detained at least once while in Counties Manukau a lower 70% had been detained at least once (Table 4.4). In the year preceding the equivalent of an intervention 73% of detainees in the Wellington comparison sample and 80% in the Porirua comparison sample had been detained at least once (Table 4.4).

At Christchurch the percentage of detainees who had been detained at least once increased slightly from 82% in the year before to 86% in the year after their contact with the WHN initiative, while at Counties Manukau the equivalent percentages were 70% and 69% respectively.

At the comparison sites of Wellington the percentage of detainees who had been detained at least once stayed the same at 73% in the year before and after the intervention, while at Porirua the percentage of detainees who had been detained at least once decreased from 80% in the year before to 71% in the year after.

Table 4.4: Percentage of detainees at the pilot and comparison sites according to number of detentions in the year before and after the initiative's implementation (or equivalent)

Number of detentions	Christchurch		Counties Manukau		Wellington		Porirua	
	WHN N=131		WHN N=108		Comparison N=126		Comparison N=117	
	before	after	before	after	before	after	before	after
0	18%	14%	30%	31%	27%	27%	20%	29%
1-9	66%	74%	68%	66%	67%	68%	71%	67%
10-19	15%	9%	2%	4%	6%	3%	9%	3%
20 or more	1%	3%	1%	0%	0%	2%	1%	1%
<i>Sub-total – Detained at least once</i>	82%	86%	70%	69%	73%	73%	80%	71%
Column percentage totals	100%	100%	100%	100%	100%	100%	100%	100%
mean	4.9	4.7	2.3	2.5	2.9	3.2	3.8	3.0

Sources: WHN databases (Christchurch and Counties Manukau), charge sheets (Wellington and Porirua), and Police NIA data extract.

Note: Some column percentage totals do not actually add up to 100% due to rounding.

Table 4.4 also shows the mean number of detentions for each group in the year before and after the initiative's implementation (or equivalent).

At Christchurch the mean number of detentions decreased slightly in the year after the WHN initiative's implementation compared with before (4.7 compared with 4.9) while at Counties Manukau the opposite occurred (2.5 compared with 2.3).

At the comparison sites of Wellington the mean number of detentions increased slightly in the year after compared with in the year before (3.2 compared with 2.9) while at Counties Manukau the mean number of detentions decreased (3.0 after compared with 3.8 before).

Next, for each detainee, the number of detentions in the year prior to the intervention of the WHN (or a Health and Safety Management Plan being formulated for detainees in the comparison sites) was summed as was the number of detentions in the year following the intervention (or equivalent). The difference between the sums was calculated for each detainee to determine whether the number of 'detentions' in the year following contact with the WHN initiative (or the equivalent intervention) was reduced/stayed the same/increased relative to the number in the preceding year. Table 4.5 shows the results.

In order of ranking from highest to lowest percent reduction in the number of detentions the sites were Porirua (51%), followed by Christchurch (47%), Wellington (38%) and Counties Manukau (33%). If percentages for reductions and no changes are combined, the ranking changes from Porirua (71%), Counties Manukau (65%), Christchurch (59%) and Wellington (57%). On either measure (reduction, or reduction plus no change) the 'active' sites appeared to fare no better than the comparison sites in terms of reduced repeat detention rates. Those sites with the highest detention rates recorded the highest reduction in repeat detention rates.

The mean differences (after – before) in the number of detentions (after – before) were similar across all sites.

Table 4.5: Breakdown of sites according to differences in numbers of repeat detentions (after – before)

	Christchurch		Counties Manukau		Wellington		Porirua	
	WHN		WHN		Comparison		Comparison	
	N=131		N=108		N=126		N=117	
	n	%	n	%	n	%	n	%
Reduction in number of detentions - after compared with before	62	47%	36	33%	48	38%	60	51%
No change	15	11%	34	31%	24	19%	23	20%
Sub-total – No increase	77	59%	70	65%	72	57%	83	71%
Increase in number of detentions - after compared with before	54	41%	38	35%	54	43%	49	42%
Mean difference in number of detentions after compared with before	-0.2		0.2		0.3		-0.7	

Sources: WHN databases (Christchurch and Counties Manukau), charge sheets (Wellington and Porirua), and Police NIA data extract.

Tables 4.6 and 4.7 show similar breakdowns for the ‘active’ sites, according to detainees’ presenting issues. In Christchurch, those presenting with mental health issues only achieved the highest reduction in repeat detentions or no change (70%), followed by those presenting with neither issue (60%), those presenting with AOD issues only (55%), then those presenting with both issues only (52%).

In Counties Manukau, those presenting with neither issue achieved the highest reduction in repeat detentions or no change (80%), followed by those presenting with a mental health issue only (66%), those presenting with AOD issues only (62%), then those presenting with both issues only (60%).

Thus, of those who presented with a mental health or AOD issue or both, those presenting with mental health issues only achieved the highest reduction in repeat detentions or no change in detentions. These findings are promising, given the importance of diverting those with mental health problems away from the criminal justice system.

Table 4.6: Breakdown of the Christchurch sample according to differences in numbers of repeat detentions (after – before) and presenting issues

	AOD issues only		Mental health issues only		Both AOD & mental health issues		Neither AOD nor mental health issues	
	N=40		N=20		N=21		N=50	
	n	%	n	%	n	%	n	%
Reduction in number of detentions - after compared with before	16	40%	11	55%	11	52%	24	48%
No change	6	15%	3	15%	0	0%	6	12%
Sub-total – No increase	22	55%	14	70%	11	52%	30	60%
Increase in number of detentions - after compared with before	18	45%	6	30%	10	48%	20	40%

Sources: WHN databases and Police NIA data extract.

Table 4.7: Breakdown of the Counties Manukau sample according to differences in numbers of repeat detentions (after – before) and presenting issues

	AOD issues only		Mental health issues only		Both AOD & mental health issues		Neither AOD nor mental health issues	
	N=50		N=35		N=10		N=10	
	n	%	n	%	n	%	n	%
Reduction in number of detentions - after compared with before	18	36%	11	31%	4	40%	2	20%
No change	13	26%	12	34%	2	20%	6	60%
Sub-total – No increase	31	62%	23	66%	6	60%	8	80%
Increase in number of detentions - after compared with before	19	38%	12	34%	4	40%	2	20%

Sources: Counties Manukau WHN database and Police NIA data extract.

Note : The presenting issues of three detainees was unknown.

4.5 Findings from key stakeholder interviews

Finally, evidence relating to the impact of the WHN initiative on reduced alcohol and drug related harm for [all] detainees while they are in custody (outcome 2) was presented earlier in section 3.3, while evidence relating to the impact of the WHN initiative on outcomes of improved knowledge and skills of Police custodial staff regarding mental health/AOD issues (outcome 4) was presented earlier in section 3.5. Feedback from key stakeholder interviews, especially with Police custodial staff provides evidence that the WHNs are indeed positively contributing to outcomes in these areas.

At the comparison sites where Police did not have the benefit of a WHN Police interviewed said that they and their colleagues found it easier to recognise people with severe mental health issues than those with low levels of mental illness. They thought the latter group could sometimes be 'quite persuasive' in presenting as if they had no mental health issues.

Police there also thought that they had become better in recent years at recognising and dealing with people with mental health issues. Since the health policy shift in the 1990s away from helping people with mental health issues in an institutional setting towards helping them within the community, Police were exposed to greater numbers of people with mental health issues. They thought their greater exposure had led to greater expertise, including their ability to more accurately distinguish people with mental health issues only from people with mental health and drug issues, for example.

4.6 Summary

The cohort study and the case studies provide some insights into the contribution of the WHN initiative to reducing repeat detentions of Police detainees with mental health and/or AOD problems (outcome 1). It has to be said that the WHNs' ability to affect detainees' behaviour in this regard is very limited. The evidence is equivocal. The cohort samples of detainees in the two WHN sites appeared to fare no better than those in the comparison sites of Wellington and Porirua in terms of reduced repeat detention rates over one year. There may be many reasons for this, including differences in site detention rates, case mix of charges (including seriousness of charges) and the impact of variations in Police policies,

practices, and initiatives during the year. Within the WHN sites, those detainees presenting with mental health issues only had the highest reduction in repeat detentions/no change in the number of detentions during the year. Five of the six case study detainees were thought to be unlikely to offend again, while the sixth might. The latter detainee was a complex case with a long history of intermittent offending and cyclic depression and difficulties accessing treatment services.

The case studies also provide insights into the contribution of the WHN initiative to improving the health status (outcome 3) and reducing the risk of harm of detainees with mental health and/or AOD problems (outcome 5). In each case a WHN was able to provide them with immediate assessment, advice and information while they were in the cells. The treatment information provided by the WHN led to better mental health outcomes for Roger and Carol. Phillip required more assistance to access mental health services and the WHN had set this in motion. Simon did not feel the need to follow-up on treatment services and was not high risk enough to refer directly to PES. Sophie and Greg had subsequently successfully engaged in treatment for AOD related issues.

The attendance rates of detainees with mental health and/or AOD problems as clients at other health services also provide a proxy measure of their improved mental health status (outcome 3) or reduced risk of alcohol and drug related problems (outcome 5). It has to be said that while the WHNs can make direct referrals, they are not in a position to make them attend. Almost all clients referred by WHNs were seen by the Crisis Team at the DCU in Counties Manukau but about three in ten clients with relatively high mental health risk are not showing up for their appointments with the equivalent service – the PES – in Christchurch. At least one in ten in Counties Manukau and at least three in ten in Christchurch were failing to show up for community mental health service appointments and in Counties Manukau where WHNs have the option of being able to directly refer clients with AOD problems to Community Alcohol and Drug Services (CADS) a low one in ten actually turned up (which is not unusual for this population).

Feedback from key stakeholder interviews, especially with Police custodial staff provides good evidence that the WHNs are contributing to reduced alcohol and drug related harm for all detainees whilst they are in custody (outcome 2). The numbers of allegations of serious self harm to detainees in custody in the 18 month periods examined were too small to draw useful conclusions in relation to this outcome while the collection of related information on the WHN assessment form was considered unreliable for evidentiary purposes.

Feedback from key stakeholder interviews, especially with Police custodial staff and the WHNs, provides evidence that Police custodial staff have improved their knowledge and skills regarding mental health/AOD issues through working alongside the WHNs and the WHNs educating them on an informal basis (outcome 4).

5 Strengths, benefits and suggestions for the future

5.1 Introduction

This Chapter looks at aspects of the WHN initiative that are working well from various perspectives – detainees, mental health and AOD services, and the Police, and the benefits of the initiative for these stakeholder groups. We also identify some areas where we think improvements might be possible in the hope that the identification of these helps inform the current initiative and the potential extension of the initiative.

5.2 What's working well

5.2.1 What's working well for detainees

Detainees are reaping many benefits from the WHN initiative. The presence of the WHNs in the watch-houses means that detainees are assessed more quickly than is the case where health professionals providing an equivalent service are off-site and need to be called in. This is especially beneficial where detainees have acute health needs. Many interviewees reiterated that the Police cells are not a suitable environment for people with mental health issues.

'They are triaged appropriately and acute need is met very quickly and professionally.' (Forensic Service)

'The care people get in the watch-house is more ... timely.' (PES)

WHNs' use of brief assessments is thought to be appropriate, given the pressured and difficult custodial environment in which detainees are held.

'[Detainees are] getting appropriate assessment on the spot which I think is important in terms of things like culpability and how their mental illness may have affected the things they are in the custody for.' (Community Mental Health Clinical Manager)

Detainees appear to view the WHNs as trustworthy people with whom they can open up and discuss their issues. Their non-uniformed appearance helps to set them apart from Police.

More detainees are having their mental health and AOD issues identified or confirmed, particularly those detainees for whom Police custodial staff may have mild concerns that would not necessarily have resulted in them getting assistance from a Mental Health Crisis Team member or a Police Medical Officer. More detainees are also receiving health advice.

'A lot more people get mental health advice than before...' (PES Consultant)

Māori and Pacific peoples are known to have a higher prevalence of some mental health disorders and are less likely than Non-Māori Non-Pacific peoples to make contact with health services for mental health reasons.²² Although it is not an ideal health setting, the WHN's presence within the custodial environment provides Māori and Pacific and indeed detainees of all ethnicities with unmet mental health or AOD needs with another chance for their needs to be identified and managed appropriately.²³

The feedback we received from detainees and other key stakeholders is that the advice and referral options that the WHNs are offering are appropriately tailored to where detainees are at.

'They're getting psychiatric treatment from staff and get the right treatment if they need it while they are there.' (Community Mental Health Clinical Manager)

'They're given good recommendations about what they could do to help themselves - particularly information about AOD help.' (PES Consultant)

The WHNs are also bearing a detainee's ethnicity in mind in offering them referral options. In Christchurch, where the majority of detainees whom the WHNs assessed were of European ethnicity, these detainees were referred or offered information about mainstream services. Māori detainees were provided with information about kaupapa Māori services and Pacific detainees were provided with information about the Pacific Island Trust. Detainees of Asian, Indian and Other ethnicities are referred or informed about mainstream mental health or AOD services since no ethnic-specific services for them exist.

The ethnic and cultural mix of detainees in Counties Manukau is quite diverse, with there being greater proportions of Māori and Pacific than in Christchurch. The WHNs can offer some service choices to Māori and Pacific people via mainstream mental health services and CADS that have ethnic-specific services for Māori and Pacific peoples within their services. There were also a number of NGO providers catering to Māori and Pacific peoples.

Where they can, WHNs are co-opting family members to help make sure that the detainees/clients are keeping their appointments at referral services.

Christchurch detainees with mental health issues now have improved access to mental health services. WHNs there are making appointments for them at Psychiatric Emergency Services (PES) and PES is following up with these clients if they do not show up. In contrast, the PMOs were only making occasional referrals to PES since they were aware that PES would only attend at the watch-house in the most serious cases and for Police to transport detainees to PES tied up Police resources.

²² MA Oakley Browne, JE Wells, KM Scott (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health. ISBN: 0-478-30026-3 (Web). Accessed in June 2009 at <http://www.moh.govt.nz/moh.nsf/pagesmh/5223>

²³ The literature indicates that involvement in criminal justice settings increases the chance of the identification of substance abuse problems, better engages people in treatment and delivers more successful treatment than for people in a general population. See, for example, Slack A, Chandler N, Nana G, Jameson B. 2006. *Interventions by Specialised AOD Clinicians in Justice Settings: A Review of Literature*. ISBN = 1-877373-24-9. Accessed in June 2009 at <http://www.alac.org.nz/PublicationsAndOrders.aspx?dtSavedSearch=6>

The Counties Manukau WHNs are making it easier for detainees with AOD issues to access CADS. The WHNs are directly referring them there and CADS will follow up with these clients if necessary. The Christchurch WHNs are providing information about NGO AOD providers to detainees with AOD issues for self referrals and on occasion ring for an appointment to facilitate their referrals.

WHLNs are both sites are also referring some detainees to GPs for follow-up treatment. We are aware of at least one instance where a WHN negotiated for detainee to access a GP at no cost to the detainee.

Detainees/clients of referral services are also better supported by mental health and AOD services since the WHNs are reconnecting detainees/clients with them by notifying their DHB service case managers about their contact with them in the cells. The support of these services is particularly important when detainees/clients are experiencing crisis situations.

Whether they know it or not, all detainees benefit from the WHNs in the sense that their presence has increased their safety. The WHNs are assisting Police custodial staff by checking on those of highest risk and upgrading or downgrading their monitoring regimes as appropriate.

5.2.2 What's working well for mental health and AOD services

One of the main benefits of the WHN for the mental health and AOD services is that they are now receiving more appropriate referrals – especially for mental health reasons – from the watch-house than was the case prior to the WHN initiative. The receipt of more appropriate referrals means that specialist health professionals and Crisis Team members are using their skills and expertise with clients who most need their assistance and other health professionals are using their skills and expertise to support those whose needs are less pressing.

In Counties Manukau the WHNs are dealing with many of the detainees for whom the Crisis Team would have been called to the watch-house, thus relieving some pressure on that service. In Christchurch the WHNs are easing the pressure on PMOs whose workloads were becoming unsustainable.

In some cases, the WHNs are assessing detainees as not requiring a referral to an emergency mental health service when prior to the initiative the Police would have sought assistance from that source. In these cases, cost savings are made.

There may be other savings too. For example, in Christchurch the WHNs are using their brief assessment tool to identify and differentiate those detainees who need a full PES assessment from those who can by-pass the full PES assessment and go straight to a review by a consultant psychiatrist. It should be noted, however, that this may mean the psychiatrist may need to spend more time with the detainee/client as s/he will not have access to a PES' full assessment.

The WHNs' assessments inform other health services including mental health, AOD and forensic services about detainees' risks to themselves and others so that they can be managed and treated appropriately in other settings. The sharing of information means DHB case managers are better informed when treating their patients and in some cases are reconnected with patients. Their assessments also provide information to clinicians about a detainee's status

at a certain point in time (ie in custody) which is useful for comparing changes in their status and overall diagnosis.

Relationships between health services (mental health, AOD and forensic services) have been enhanced through the WHNs and steering group overseeing the WHN initiative and new relationships have been forged.

The Christchurch DHB manager said that the development of the brief assessment tool by WHNs there had been a really good initiative. The tool is being used by the Mental Health Liaison Nurse position established at Christchurch Hospital ED in August 2009. The manager expected that it was something they will build on in other areas of mental health.

DHB managers at both sites thought the data collected as part of the WHN initiative provided useful information for service planning purposes.

5.2.3 What's working well for the Police

What's working well for the Police is that the WHN initiative is largely working as it was intended. Police can focus on what they do best and what they are trained for/in and what they do best, while the WHNs attend to detainees' needs for those who have mental health or AOD problems. This speeds up Police processes in the watch-houses.

'[WHLNs] speed up Police practices. When someone comes in with a MH issue it can be dealt with by a MH professional. They can speak to their own colleagues and get things done a lot quicker. It leaves the Police officers free to do Police work and the MH nurses free to do their job. The prisoners get a lot better service.'
(Christchurch Police)

When WHNs are on duty they replace Police as the primary liaison with health professionals, particularly mental health emergency services, which saves Police time and facilitates more appropriate referrals.

Police are better informed about how they should manage people with mental health and/or AOD issues in custody. Police interviewees at both sites said that they felt more supported having the WHNs in the watch-house. Their presence had helped relieve Police anxiety levels in managing detainees with mental health or AOD issues and was thought to have reduced the risk of harm to custodial staff.

WHLNs' informal education of Police is contributing towards building their knowledge and skills in working with people with mental health and/or AOD issues.

5.3 Summary of key benefits for stakeholders

5.3.1 Benefits for detainees

- More timely access to being assessed by a health professional and consequently, where appropriate, quicker triage out of Police custody.
- Increased safety brought about by WHNs informing Police about the appropriate way to manage detainees whilst they are in custody. If they are being monitored under the Police Custodial Suicide Management Policy the WHNs can upgrade or downgrade their regimes during the period they are in custody.
- Provision of brief intervention to a broader range of detainees including brief assessment, education, advice, information and referral, where appropriate.
- Early intervention through the increased identification of detainees' mental health issues and their consequent referrals to mental health services. WHNs can assess detainees for whom Police have mild concerns but would not necessarily have called in a member of the Crisis Team (Counties Manukau) or a PMO (Christchurch).
- Increased access to mental health services for Christchurch detainees. WHNs there directly refer detainees to PES, making appointments for them which PES will follow-up on if they do not show up. (PMOs make only the occasional referral to PES.)
- Where consent is provided WHNs facilitate referrals and follow-up care by encouraging family/whānau to ensure attendance at appointments and notifying GP and key workers.
- More effective management of a detainee's medication while in custody.
- Improved provision of information about AOD services and referrals to AOD services, particularly in Counties Manukau where CADS will follow-up on detainees whom the WHNs have referred.
- Reconnection with Mental Health Services and AOD services brought about by WHNs notifying detainees' health case workers.
- Enhanced prisoner transfer processes of passing on information about a prisoner's mental health risk. This makes it safer for prisoners.
- There are indications from most of the interviews with detainees (5) for the case studies that they found talking to the WHN useful. Three detainees said they found it reassuring as they were uncertain about what was going on and were nervous being in the cells. Police and WHNs interviewees noted that the WHN non-uniformed appearance helps to set them apart from Police and detainees often opened up and discussed their issues.

5.3.2 Benefits for health services

- Provision of timely service to consumers and broader range of consumers who do not meet threshold for calling the Crisis Team or PMO or have AOD issues only.
- There are indications that emergency mental health services (Crisis Team at CMDHB and PES at CDHB) are now receiving more appropriate referrals from the watch-house than prior to the pilot due to WHNs' expertise.
- In Christchurch Police Medical Officers are not being called to assess people with suspected mental health issues while the WHNs are on duty which relieves pressure on their service.
- Access to DHB databases at the Police station provided a more informed basis on which to conduct an assessment. This has also benefited the Crisis team at Counties Manukau who can access the database (HCC) at the DCU.
- The WHN's assessment informs other health services including mental health, AOD and forensic services about a detainee's risk (to self or others) so they can be managed and treated appropriately. The WHN's assessment also provides information to clinicians of a detainee's status at a certain point in time which is useful for comparing changes in status and overall diagnosis.
- Furthermore, the WHNs' brief assessments can save health services time. For example, in Christchurch the WHNs inform PES whether a full frontline assessment is required or whether the detainee can go straight to a review by a consultant psychiatrist. Note this can increase the workload for the consultant.
- The WHNs are informing mental health and AOD key workers within the DHBs if they assess their patients in custody. This information means health case/key workers are better informed when treating their patients and in some cases are reconnected with patients.
- Relationships between health services (mental health, AOD and forensic services) have been enhanced through the WHNs and the steering group, and new relationships have been formed.
- DHB managers at both sites thought a benefit of the initiative was the data that was being collected which provided information about the mental health and AOD issues of detainees and who the detainees were in terms of demographics which would assist in service planning.
- The Christchurch DHB manager said that the development of the brief assessment tool had been a really good initiative for them. This tool has since been used in other areas of mental health.

A major benefit identified by Police and DHB stakeholders was the WHN initiative has strengthened relationships between Police and DHB Mental Health Services at both sites and that this has occurred at both frontline and management levels within each site.

The WHNs are developing and maintaining good working relationships with other service providers, such as the mental health emergency services, the prison service and the Court Liaison Nurses, and they have instigated some new practices regarding better sharing of information among them.

5.3.3 Benefits for Police

- Police are better informed about how they should manage people with mental health and/or AOD issues in custody.
- The WHN initiative reduces Police anxiety levels in managing detainees with mental health or AOD issues as the WHNs provide expert assessment and support. This was thought to have reduced the risk of harm to custodial staff.
- The initiative saves Police time as WHNs attend to detainees' needs and are the primary liaison with health professionals.
- WHNs' formal and informal education of Police was contributing towards building their knowledge and skills in working with people with mental health and/or AOD issues.
- Where appropriate WHNs facilitate detainees into appropriate care and out of Police custody faster than previous practice.

5.4 Suggested actions in relation to the current WHN initiative

Do-able in the short term

1 Increase coverage

Detainees, Police custodial staff, and the WHNs themselves would directly benefit from increased coverage by WHNs. A recurring theme among those key stakeholders interviewed was the need to extend coverage to Sundays.

Increased coverage needs to be balanced against increased costs. Ideally, WHN coverage would increase to full 24/7 coverage or at least extend to include day shifts during the weekend and complete seven day night shifts. The latter option would mean that WHNs would be available when need for their services is likely to be the highest. Intoxicated detainees are more likely to be brought into custody late at night and WHNs would be around to assess them when they sobered up the following day.

Any extended coverage would enable more cross-over time between WHN staff, thereby maintaining consistency of practice and promoting the feeling of being part of a team. It would allow for consideration of refiguring the shift structure which had put some prospective candidates off applying for WHN positions. Extended coverage would cost more, with Sunday WHN work rates paid at double time.

2 Provide the WHNs with better support

Many interviewees commended the WHNs for their expertise and enthusiasm for the position and how they had successfully integrated into the watch-house environment.

Interviewees at both sites noted that the WHN position was quite an isolated position and there was a risk of WHN burnout through their working with minimal supports in such an intense environment. Interviewees identified the importance of the WHN position being situated within the community mental health services (such as the Crisis Team or PES) where there are opportunities for professional and peer supervision and rotating the position among staff to maintain strong relationships with colleagues; prevent burnout; enhance knowledge about Police practices; and strengthen relationships.

WHNs must work carefully but quickly simultaneously managing multiple people with health needs and safety risks in the high stress custodial environment. They carry heavy responsibilities and there are serious implications if a suicide occurs on 'their' watch. The pay structure of the WHN positions warrants further consideration to ensure it adequately compensates them for what they do and that senior nurses with the appropriate experience and expertise are retained.

Interviewees at both sites identified risks to the sustainability of the WHN initiative, particularly after the pilot phase, if staffing, rostering and remuneration issues are not addressed.

3 Standardise WHN recording practices and refine the assessment form

Although we think the WHN Assessment Form has been a useful tool for capturing information across the Police/health 'divide' and the accompanying WHN databases can be easily analysed for monitoring and other purposes, it duplicates some information stored elsewhere – particularly on DHB databases. If the Form's use is to continue, we suggest that further work be done to ensure WHNs develop common recording practices (for example, in relation to referrals and issues in custody) and the form be refined in light of WHNs' and others' (for example, policy planners) feedback. We note, for example, that the form does not provide a specific tick box to capture the WHNs' involvement in the sectioning under the MHA of detainees with serious mental health issues. While WHNs might record this under 'Other' assistance, if this information is particularly important we recommend that such work be given a dedicated tick box. We also recommend that the form be tailored to better capture the sorts of referral type work WHNs are doing – for example, 'referring with a suggested plan' to the Community Mental Health Centre or reconnecting detainees with case managers in mental health and AOD services and their GPs.

4 Consider the entry level criteria of WHNs

Feedback from both sites suggests that while having someone in the role with DAO qualifications was an advantage, it was not essential. At least one manager thought the position did not require a senior nurse, particularly once WHN processes were established. However, as already mentioned, the position requires someone with considerable skill and expertise. We think this requires further consideration and if this initiative is to be extended to other sites we suggest the ranking and remuneration be standardised with the ability to review over time.

5 Monitor the impact of PMOs' workloads

Despite expectations to the contrary, there has been no reduction in the numbers of detainees being seen by Christchurch PMOs during the evaluation period. We think that this is likely to be due to Christchurch PMOs' workloads increasing in areas (for example, taking blood samples of people suspected of drunk driving and conducting forensic examinations of victims) other than those usually undertaken by the WHNs when they are on duty. The increasing Christchurch PMOs' workloads may be slowed to some effect by the change to the local Custodial Suicide Policy. We suggest that further monitoring of PMOs' workloads be undertaken, including, if possible, of the areas of work undertaken in relation to the call-outs.

Issues needing to be addressed in the longer term

6 Address large systemic problems in the provision of mental health and AOD services

These problems relate to mental health and AOD service gaps, service capacity issues, limited referral options (particularly in relation to AOD services) and issues relating to service integration between mental health and AOD services. These problems have been documented elsewhere.²⁴ A review of access to mental health acute services was announced in March 2009.

We are aware too that the Christchurch AOD sector, led by Canterbury DHB, is currently working together to develop better service access and ways to enhance clients' engagement with services.

While access has improved, evidence exists that significant numbers of detainees are still not accessing or receiving mental health or AOD services relative to their need for them. Only 286 (7%) Christchurch detainees and 309 (16%) Counties Manukau detainees assessed by the WHNs were already receiving treatment from a mental health provider. The larger numbers of detainees presenting to the WHNs with mental illness only or AOD and mental illness issues (from Table 3.2, 1,336 detainees in Christchurch, 725 detainees in Counties Manukau) suggest that significant numbers of detainees, especially at Christchurch which has the greater throughput, are not accessing or receiving mental health services in response to their need for them.

The service gap is even larger in relation to AOD services. Only 141 (4%) detainees in Christchurch and 144 (7%) detainees in Counties Manukau who were assessed by the WHNs were already receiving treatment from an AOD health provider. The larger numbers of detainees presenting with AOD only or AOD and mental illness issues to the WHNs (from Table 3.2, 2,295 detainees in Christchurch, 1,326 detainees in Counties Manukau) suggest that significant numbers of detainees, especially at Christchurch, are not accessing or receiving AOD services in response to their need for them. They also highlight capacity issues at these services, something beyond the WHNs' sphere of influence.

²⁴ See, for example, The Law Commission (2009) *Alcohol in Our Lives. An Issues Paper on the Reform of New Zealand's Liquor Laws*. Issues paper 15. See especially paragraphs 11.94 – 11.101. http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_154_437_Alcohol%20in%20our%20lives%20-%20Issues%20Paper%2015.pdf And The Law Commission (2010) *Controlling and Regulating Drugs*. Issues paper 16. See especially paragraphs 16.54 – 16.56. http://www.lawcom.govt.nz/UploadFiles/Publications/Publication_143_455_IP16%20-%20Controlling%20and%20Regulating%20Drugs.pdf

Another long standing issue that constrains implementation of the WHN initiative is the limited number of mental health and AOD service options available among these services. Neither of the pilot sites has access to a proper detoxification facility. While Counties Manukau WHNs have the option of being able to directly refer clients with AOD problems to Community Alcohol and Drug Services (CADS), this is not an option for Christchurch WHNs.

5.5 Key lessons for future WHN initiatives

We have identified what we think are some key lessons for any future WHN initiatives.

Use a design that fits the local operational context

Prior to the establishment of the WHN initiative each site had scoped the feasibility and key processes required to ensure its successful implementation. The different operational contexts (policies, facilities, service infrastructure) between just two sites highlight the importance of any future sites doing this to adapt the WHN initiative to their contexts. While we are starting to see some shared elements of good practice a significant finding is that the 'model' has to be flexible rather than 'one size fits all'.

Continue with the use of service level agreements

We encourage the use of service level agreements as a means of documenting the specifications of the WHN and how the relationships are to operate between the DHBs and Police. They worked well in the pilot sites for this purpose. One site set out the exact tasks which the WHNs would perform. While useful, we think it is also beneficial to provide for some flexibility in role, especially as the WHNs become established.

Continue with the use of steering groups

We also encourage the use of steering groups to establish, oversee and monitor any future WHN initiatives. They may also be a forum for discussing inter-agency issues. Feedback from representatives of both pilot site steering groups was that they had worked really well and had enhanced interagency relationships.

We think core members of the steering group should include representatives from mental health services, CADS, the Police, and the WHNs. Partner organisations involved in the care and supervision of detainees/offenders could potentially also include representatives from the Forensic Services (Court Liaison Nurse and Prison Forensic Service) and Community Probation Service and consumer representatives.

Recruit the right people

Recruiting the right staff is crucial to the success of the initiative. People in them need to be able to work autonomously and be able to successfully work alongside Police custodial staff.

Hold relationship management meetings prior to implementation

We think that holding 'relationship' meetings with appropriate personnel in all local mental health and AOD services (DHB and NGO) prior to going 'live' is likely to facilitate successful implementation of the initiative at any additional sites. This could also include developing interface protocols, for example, with Court Liaison Nurses and the Prison Forensic Service.

If meetings with all stakeholders are not feasible key partners should be prioritised for meetings and a communiqué sent to other stakeholders alerting them to the commencement and function of the new WHN service.

Be able to access to the relevant IT from day one

An important lesson from the pilots is ensuring that WHNs have IT access to DHB databases (and Police NIA where agreed) set up prior to going 'live.' Access to DHB information was identified as one of the key factors that allowed the WHNs to quickly assess risk and formulate management plans. It was also a vital link for follow-up care (for example, informing case managers of contact with their clients) and for accessing online some referral services.

Monitor WHN resourcing levels such that they are appropriate to need

We think that the WHN initiative developers will need to carefully monitor assessment volumes to ensure that the WHNs at any future sites are not overwhelmed work-wise. Their workloads will increase with expected increases in detainee volumes and as Police learn of their value in assisting them to manage detainees in custody.

6 Weaving the findings together

This final evaluation report presents the findings about the WHN initiative during its first 18 months of operation. In doing so, it addresses the main objectives – including process and outcome objectives – of the evaluation in turn. The evaluation contributes to building the evidence about what works in the New Zealand context, and is expected to inform ongoing and future developments.

In Chapter 2 we provided a detailed description of the WHN pilot initiative as it operates at each site. The two sites – Christchurch and Counties Manukau – were operating under different custodial operational policies for almost all of the evaluation period but are now the same. The Alternative Resolutions strategy, which was implemented in Counties Manukau in November 2009 is unlikely to have had much impact on the evaluation (with an end date for data collection of 31 December 2009).

The WHNs operate within very different physical environments. The Christchurch Central WHNs operate within a traditionally designed watch-house in the basement of the Police station whereas their Counties Manukau counterparts operate within a new open-plan District Custodial Unit (DCU) with glass fronted observation cells.

WHNs at both sites have electronic access to their DHBs' mental health databases, with ease of access being more convenient in Counties Manukau.

Frontline Police in Christchurch will only take people with mental health issues only (ie no charges) back to the watch-house if they have particular safety concerns about them whereas in Counties Manukau nearly all such people are taken back to the DCU.

The sites differ in terms of the service delivery model the WHNs have to respond to psychiatric emergencies. In Christchurch WHNs can refer detainees to the Psychiatric Emergency Service (PES) which provides a 24 hour emergency service at their premises but does not have a mobile crisis team. In Counties Manukau WHNs can call the Crisis Team and they will send a staff member to the DCU to fully assess and pick up detainees and take them to the appropriate mental health service.

There are only very limited AOD referral options in Christchurch where the local Community Alcohol and Drug Service (CADS) and a number of NGO providers will not accept referrals of detainees facing charges in Court. In contrast, Counties Manukau WHNs can make direct referrals of detainees to CADS.

Another feature of the Christchurch site is their higher call-out rate of Police Medical Officers (PMOs).

While the age profiles of detainees assessed at both sites were similar, those in Counties Manukau were slightly more likely to be female, and more likely to be of Māori, Pacific, or another non-European ethnicity than their Christchurch counterparts.

Detainees assessed by Christchurch WHNs were much more likely to have been detained in relation to criminal charges, arrest warrants and bail breaches, whereas detainees assessed by Counties Manukau WHNs were much more likely to have been detained for reasons relating to their mental health (30% for Counties Manukau compared with one percent for Christchurch) and for detoxification (36% for Counties Manukau compared with 13% for Christchurch).

In Chapter 3 we gathered evidence together relating to the initiative objectives. Our conclusion is that **the WHN initiative is meeting its entire objectives at each site**. There is overwhelming evidence that the WHNs are meeting the objective of ‘assess[ing] and assist[ing] in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody.’ WHNs undertook a total of 5,836 assessments with detainees in Police custody – 3,850 assessments at the Christchurch Central Police watch-house and 1,986 assessments at the Counties Manukau Police District Custodial Unit – over an 18 month period. These figures represent the equivalent of about every one in five detainees in Christchurch and one in 14 detainees in Counties Manukau receiving an assessment by a WHN. WHNs’ assist these detainees through the provision of direct referrals, reconnections with service providers, advice, information (including about self referral options), and assistance through early intervention and early diagnosis, and facilitation of sectioning under the MHA where this is needed.

There is also good evidence, especially from feedback from Police custodial staff, that the WHNs are indeed ‘reduc[ing] the risks of harm to detainees in Police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders.’ WHNs continue to assess detainees’ risk of harm throughout their time in Police custody and are on hand to check on them and upgrade or downgrade their monitoring regimes in response to their changing risk levels. Police custody staff told the evaluators that they feel more supported and less at risk having immediate access to WHNs and their clinical knowledge, skills and judgement. The numbers of allegations of serious self harm to detainees in custody in the 18 month periods examined were too small to draw useful conclusions in relation to this outcome while the collection of related information on the WHN assessment form was considered unreliable for evidentiary purposes.

Feedback from key stakeholders and analyses of the WHN databases provides strong evidence that the WHNs are ‘liais[ing] with other service providers, and make referrals of detainees to treatment providers.’ Service providers they have liaised with include Emergency Mental Health Services, Community Mental Health and AOD services (such as CADS in Counties Manukau), a range of NGO mental health and AOD service providers, and Forensic Services (both Prison and Court). Thirty eight percent of all assessments of Counties Manukau detainees and 11 percent all assessments of Christchurch detainees resulted in referrals being made by a WHN to a treatment provider. To some extent, however, this difference in referral rates is an artefact, arising from different working definitions of ‘referral’, with Christchurch WHNs using the term in a more restricted sense. Over six in ten referrals that the WHNs proposed for detainees were to the local mental health crisis teams (63% to PES in Christchurch and 65% to the Crisis Team in Counties Manukau). The fact that the WHNs are constrained in the numbers and types of direct referrals they can make due to service capacity issues and limited service options (particularly AOD service options in Christchurch) are outside their control.

Finally feedback from Police custodial staff and the WHNs themselves provides evidence of the WHNs ‘provid[ing] on-going education to the Police regarding the identification and management of mental health and addiction disorders.’ At both sites the WHNs have provided a good deal of training and advice to Police on an informal basis. In Counties Manukau, the WHNs have provided PMAF training to DCU staff, enabling the Custody Sergeant to make a more informed decision about whether detainees are ‘in need of care’.

In Chapter 4 we gathered together information about the contribution of the WHN initiatives to intended outcomes. We have to say that we think the WHNs’ ability to affect detainees’ behaviour in regards to

reduced repeat detention is probably unrealistic.²⁵ Nevertheless, our first conclusion in this regard is that we think **the WHN initiative is contributing to the expected outcome of reduced repeat detentions among detainees with mental health and/or AOD problems but the evidence is not strong**. The cohort study and the case studies provide some insights into the contribution of the WHN initiative to reducing repeat detentions of Police detainees with mental health and/or AOD problems (outcome 1). The evidence is equivocal. The cohort samples of detainees in the two WHN sites appeared to fare no better than those in the comparison sites of Wellington and Porirua in terms of reduced repeat detention rates over one year. There may be many reasons for this, including differences in site detention rates, case mix of charges (including seriousness of charges) and the impact of variations in Police policies, practices, and initiatives during the year. Within the WHN sites, those detainees presenting with mental health issues only had the highest reduction in repeat detentions/no change in the number of detentions during the year. Five of the six case study detainees were thought to be unlikely to offend again, while the sixth might. The latter detainee was a complex case with a long history of intermittent offending and cyclic depression and difficulties accessing treatment services.

We think **the evidence is stronger that the WHN is contributing to expected outcomes of improved health status and reduced risk of harm to detainees with mental health and/or AOD issues**. The case studies also provide insights into the contribution of the WHN initiative to improving the health status (outcome 3) and reducing the risk of harm of detainees with mental health and/or AOD problems (outcome 5). In each case a WHN was able to provide them with immediate assessment, advice and information while they were in the cells. The treatment information provided by the WHN led to better mental health outcomes for Roger and Carol. Phillip required more assistance to access mental health services and the WHN had set this in motion. Simon did not feel the need to follow-up on treatment services and was not high risk enough to refer directly to PES. Sophie and Greg had subsequently successfully engaged in treatment for AOD related issues.

The attendance rates of detainees with mental health and/or AOD problems as clients at other health services also provide a proxy measure of their improved mental health status (outcome 3) or reduced risk of alcohol and drug related problems (outcome 5). It has to be said that while the WHNs can make direct referrals, they are not in a position to make them attend. Almost all clients attended appointments made for them via WHN referrals at the Crisis Team in Counties Manukau but about three in ten clients with relatively high mental health risk are not showing up for their appointments with the equivalent service – the PES - in Christchurch. At least one in ten in Counties Manukau and at least three in ten in Christchurch were failing to show up for community mental health service appointments and in Counties Manukau where WHNs have the option of being able to directly refer clients with AOD problems to Community Alcohol and Drug Services (CADS) a low one in ten actually turned up (which is not unusual for this population).

Evidence in the form of feedback from key stakeholders is that the WHN initiative is contributing to the desired outcomes of reduced alcohol and drug related harm for all detainees whilst they are in custody and that Police custodial staff have improved their knowledge and skills regarding mental health/AOD issues. Feedback from key stakeholder interviews, especially with Police custodial staff provides evidence that the WHNs are definitely contributing to reduced alcohol and drug related harm for all detainees whilst they are in custody (outcome 2) and that Police custodial staff have

²⁵ A similar pilot set up in the Hamilton watch-house did not include reduced repeat detentions among its key performance indicators.

improved their knowledge and skills regarding mental health/AOD issues through working alongside the WHNs and the WHNs educating them on an informal basis (outcome 4).

In Chapter 5 we identified aspects of the WHN initiative that were working well from a range of perspectives – detainees, mental health and AOD service providers, and the Police. We also identified the key benefits from a range of stakeholder perspectives. These are summarised in Table 6.1.

Table 6.1: Key benefits of the Watch-house Nurse initiative for key stakeholders

KEY BENEFITS OF WATCH-HOUSE NURSE INITIATIVE		
<p>Detainees</p> <ul style="list-style-type: none"> timely access to assessment by health professional & reduction in risk of immediate harm more quickly triaged out of Police custody where appropriate receive brief intervention eg advice, education, information on services and where appropriate referral someone skilled to listen to them, reassurance early intervention with increased identification of MH/AOD issues & less risk of 'falling through the gaps' increased access &/or knowledge about services support/ advice available to family/whanau/ support people reconnection with key workers at MH & AOD services 	<p>Health services</p> <ul style="list-style-type: none"> provision of more timely service to consumers more appropriate referrals to health services reduce referrals to Crisis Team and PMOs while WHN on duty WHN conduit to pass information to other health services to inform future assessment, treatment and follow-up support minimise service duplication or people falling through the gaps improve ongoing management of mental health/ drug and alcohol conditions improved relationships between DHB & Police 	<p>Police</p> <ul style="list-style-type: none"> know detainees/offenders are receiving skilled assessment and support (and reduces stress for Police officers) save Police time as WHN attend to detainees and liaise with health professionals Police freed up to focus on crime prevention and detection reduction in risk of immediate harm for detainees (and reduced risk to Police in failing to meet custodial care) reduction in risk of immediate harm for Police staff formal & informal WHN training increase knowledge and skills in working with people with MH/AOD issues. improved relationships between DHB & Police

The Independent Police Conduct Authority concluded their report on observations of the WHN initiative with the following endorsement,

*The Authority endorses effective initiatives that enable custody centres to provide for the needs of detainees affected by mental illness, drugs, or alcohol-related issues. Such initiatives ensure that Police are able to foster confident, safe, and secure communities and that New Zealand fulfils its international obligations under OPCAT and other international human rights law instruments. The fundamental principle of OPCAT, which is a principle that also underpins public health policy and healthcare in New Zealand, is **prevention**. Programmes such as the Pilot Initiative can, with appropriate planning and support, ensure that vulnerable members of our community are understood, respected, and cared for when they need treatment the most: at the earliest possible opportunity, by qualified, committed Police and specialised health practitioners. (IPCA April 2010 - see Appendix 4)*

We have also identified some short term and longer term issues that need to be addressed. In the short term, we suggest that the following actions be taken in relation to the current WHN initiative to help cement its place within the custodial environment:

- Increase coverage;
- Provide the WHNs with better support;
- Standardise WHN recording practices and refine the assessment form;
- Consider the entry level criteria of WHNs; and
- Monitor the impact of the WHN on PMO workloads in Christchurch.

In the longer term, problems relating to mental health and AOD service gaps, service capacity issues, limited referral options (particularly in relation to AOD services) and issues relating to service integration between mental health and AOD services need to be addressed,

Some key lessons for any future WHN initiatives are:

- Use a design that fits the local operational context;
- Use service level agreements;
- Use steering groups;
- Recruit the right people;
- Hold relationship management meetings prior to implementation;
- Be able to access the relevant IT from day one; and
- Monitor WHN resourcing levels such that they are appropriate to need.

A further more general point to note that may impact on Police practice is the finding in section 3.2.2. The analysis suggested that the standard 'key indicator' questions relating to 'First time arrested/detained in a Police cell', being a 'Youth at Risk', being 'Male' and being 'Māori' that Police custody officers are currently using nationally to help guide them in their evaluation of a person's likely health and safety needs (including suicide risk) whilst in custody may not alone be that useful in differentiating risk levels.

We also note the difficulty of linking people with AOD problems into treatment. The information gathered as part of this evaluation suggests that self-referrals met with only limited success. There are opportunities to enhance the pilot and the service system more generally to provide early intervention people with AOD issues before they advance through the criminal justice system and require imprisonment or a community sentence with supervision to treat their AOD use.

Two areas of opportunity were mentioned earlier in the report including enhancing the AOD engagement by having a specialised AOD worker providing screening and brief intervention at the watch-house (and we also suggest at the EBA processing section). There is good evidence that brief intervention provided to people with less severe alcohol use can be effective at reducing their use (Moyer et al. 2002; Kaner et al. (2007).

The other area to investigate is models of pre-sentencing diversion into AOD treatment. For lower level offenders not sentenced to supervision a Police diversion or pre-sentencing initiative could provide the mechanism to get people to treatment. There have been some promising results from evaluation of Police diversion initiatives to address AOD abuse in Australia although more research is required (Heale & Lange 2001; Hughes & Ritter 2008; Pritchard et al. 2007).

To further understand best practice in the assistance of people with mental health and AOD issues who interact with the criminal justice system, we suggest that a synthesis be undertaken of recent evaluations of some New Zealand initiatives operating at different points in the criminal justice system. Evaluations that we are aware of that could be included in the synthesis are:

- the evaluation of the Addiction Assessment Service at Tauranga Court Pilot which aimed to identify and assist offenders with addiction issues at Court;
- the evaluation of the Christchurch Youth Drug Court Pilot initiative which aimed to monitor young people's progress in AOD treatment and achieve their Family Group Conference goals;
- the evaluation of the Christchurch Arrest Referral Scheme Pilot while aimed to facilitate arrestees' decisions to access treatment for AOD problems; and
- the evaluations of the Watch-house Nurse Initiatives in Rotorua, Christchurch, Counties Manukau and Hamilton Police Stations.

This synthesis could also be extended to include a review of the latest evidence of the effectiveness of overseas models.

In conclusion, we finish with quotes from Police which illustrate the value and impact of the initiative in the current sites.

'In 18 years of Police this is the best project I have ever been involved in. It really works. It really does. I believe it benefits all three parties – the Police, DHB and the prisoners. Its flow-on effect to us has been huge. We have changed policies over this for the better. We've more contact with our partners like the Department of Corrections over it. For us it works really, really well... I really think it has lots of benefits and the guys downstairs [Police custodial staff in the watch-house] absolutely love it and to get a Police Officer to say something good about something like this is really difficult.' (Christchurch Police)

'Having the nurse to either take on that [WHN] role of interacting with that person [detainee] or to advise you how to do it really is like an angel on your shoulders.' (Counties Manukau Police)

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Appendix 1: Methodology

Introduction

This Appendix outlines the evaluation design and methodology we have used for the Report. A more detailed description of the evaluation methodology is contained in our final evaluation proposal dated 19 December 2008.

The processes we needed to go through to obtain the necessary ethical approvals for the evaluation were not inconsiderable. Approvals were obtained from:

- the Health and Disability Multi-region Ethics Committee on 28 April 2009 (MEC/09/02/014);
- the Maaori Review Committee of the Counties Manukau District Health Board (CMDHB) on 11 May 2009; and
- the Clinical Board of the CMDHB on 19 June 2009 (#715).

The framework that informed planning and conduct of the evaluation is outlined in the following table.

Evaluation framework

Evaluation objectives	Possible measures	Information sources
<p>Evaluation objective 1</p> <p>Describe the operation of the Watch-house nurse initiative in two sites, including the impact of any contextual differences</p>	<p>Qualitative</p> <p>Quantitative - number screened, issues identified, assessed, referred, pathways of detainees post detention, number detained under legislation, needs identified</p>	<p>Police and Health staff focus groups</p> <p>Key informant interviews - Watch-house nurses, Police and Health managers, PET manager, Watch-house Sergeant</p> <p>WHN database</p> <p>Case Studies, including interviews with detainees</p> <p>Observation</p>
<p>WHN Objective 1</p> <p>Assess the extent to which WHNs assess and assist in the management of detainees who are experiencing drug, alcohol and mental health related problems while in Police custody.</p>	<p>Qualitative information - assessment and management of detainees</p> <p>Comparison of custodial and clinical management of detainees in pilot areas and custodial management in comparison area</p>	<p>Key informant interviews</p> <p>Police & Health staff focus groups in pilot and comparison areas</p> <p>Case studies, including interviews with detainees</p> <p>Observation</p>

Evaluation objectives	Possible measures	Information sources
<p>WHN Objective 2 Intended outcome 5 Assess the extent to which the risks of harm are reduced to: a) detainees with mental health and/or AOD problems b) Police custodial staff</p>	<p>Number of incidents in cell block before and after implementation and compared with comparison areas</p> <p>Incidence of suicide attempts and other harms in detention before and after implementation and compared with comparison areas</p> <p>Incidence of injuries to Police staff in cell block before and after implementation and compared with comparison areas</p>	<p>WHN database</p> <p>Watch-house records</p>
<p>WHN objective 3</p> <p>Assess the extent to which WHNs liaise with other service providers and make referrals of detainees to treatment providers</p>	<p>Follow cohort of detainees who are WHN clients for a period of at least a year and compare to detainees with similar reasons for detention in station with no WHN. Examine services referred to services accessed treatment completed</p>	<p>Case studies, including interviews with detainees</p> <p>WHN database</p> <p>CIS PMS MHIS</p>
<p>WHN objective 4</p> <p>Assess the extent to which WHNs provide on-going education to Police regarding the identification and management of mental health and addiction disorders</p>	<p>Qualitative</p>	<p>Key informant interviews</p> <p>Police staff focus groups</p> <p>WHN documentation (document review)</p>
<p>Intended outcome 4</p> <p>Assess the extent to which Police staff skills in managing detainees with mental health and/or AOD problems have improved</p>	<p>Qualitative</p> <p>Perceived and self reported skill and knowledge of staff in pilot areas compared with staff in comparison areas</p>	<p>Key informant interviews</p> <p>Police & Health staff focus groups in pilot and comparison areas</p>
<p>Intended outcome 2</p> <p>Assess the extent to which alcohol and drug related harm for detainees has reduced</p> <p>Intended outcome 3</p> <p>Assess the extent to which the health status of detainees with mental health and/or AOD problems has improved</p>	<p>Qualitative</p> <p>Track a cohort of detainees before and after first assessment by WHN. Examine nature of intervention services referred to services accessed treatment completed alcohol and drug related harms other indicators of health status</p>	<p>Case studies, including interviews with detainees</p> <p>CIS PMS MHIS</p>

Evaluation objectives	Possible measures	Information sources
Intended outcome 1 Assess the extent to which repeat detention of Police detainees with mental health and/or AOD problems who have been assessed by WHN has reduced	Track a cohort of detainees before and after first assessment by WHN. Examine nature of intervention services referred to services accessed treatment completed number of detentions reasons for detention	WHN database Custody/charge sheets NIA
Evaluation objective 4 Identify strengths and areas for improvement to the Watch-house nurse initiative to inform potential extension of the initiative to further sites.	Qualitative	All sources

Document review methods

We accessed and reviewed the following documents to inform ourselves about the WHN initiative operations:

- policy documents;
- Service Level Agreements between the Police Districts and the District Health Boards (DHBs) at the pilot sites;
- job descriptions of the WHN positions;
- data collection tools relating to the WHN initiative; and
- monthly monitoring reports submitted to Police National Headquarters (PNHQ) by the pilot sites.

Observation of WHN processes

To more fully understand the work of the WHNs, their processes, and work conditions one of the evaluators (SC) observed WHN activities for a period of four hours at each site during an evening shift.

Key informant interviews at the WHN sites

The first round of key informant interviews conducted for the Interim report to provide information on the implementation of the pilot during its first nine months. Key informant interviews were conducted with 13 participants, including watch-house nurses and DHB and Police managers.

A further 30 interviews were conducted for the second round of key informant interviews to provide information on the overall implementation of the pilot during 18 months of operation. Key informant interviews were conducted with watch-house nurses, DHB and Police managers and staff and other key stakeholders who worked with the WHN pilot (Table A1).

Table A1: Key informant interviews at the WHN sites (second round)

Agency	Site	Number of interviews
Police	Christchurch	4 interviews with Police managers and watch-house staff
Police	Counties Manukau	7 interviews with Police managers and watch-house staff
DHB	Christchurch	6 interviews with CDHB staff, watch-house nurses & nursing manager, PES and Forensic Service
DHB	Counties Manukau	8 interviews with CMDHB staff, watch-house nurses & nursing managers, CADS, Crisis Team (3)
Other key stakeholders	Christchurch	5 Interviews with Police doctor, Prison Service, AOD NGO Providers

Key informant interviews were conducted with 30 individuals (15 at each pilot site) using a semi-structured interview guides developed in consultation with the Evaluation Advisory Group (EAG) and the wider reference group.²⁶

The interview tools (information sheet, informed consent form and interview guide) are in Appendix 2.

Interviewees gave their written consent to being interviewed, and were given the opportunity to check quotes before they were incorporated into this report.

Case Studies

The purpose of the case studies is to provide an in-depth look at some detainees' assessment and management in the cells, any brief intervention or referrals provided, whether any follow-up treatment was undertaken, and what their subsequent outcomes were (WHN objectives 1&3, intended outcomes 2&3).

We proposed eight case studies – four each at Counties Manukau and Christchurch. Four case studies were undertaken in Christchurch and two in Counties Manukau due to difficulties contacting potential participants. The WHNs at each pilot site provided us with a list of people they had seen relatively recently and the evaluation project manager contacted them to invite them for an interview. A Maori researcher was subcontracted to provide interviewees with a choice of culturally appropriate interviewer. We were given the names of more Maori and Pacific people the WHNs had seen, however only one agreed to be interviewed.

²⁶ The EAG includes representatives from Police National Headquarters and Ministry of Health and representatives from each of the sites including two watch-house nurses and a DHB manager. The wider reference group includes Māori cultural advisors from CMDHB and CDHB.

The interviews were supplemented with relevant information obtained from Police and Mental Health databases, and communications with WHN for the purposes of filling in gaps in information pertinent to a case or for verification purposes.

Analysis

Analysis of the key informant interviews from the WHN sites

Interview content was coded for themes relating to the evaluation objectives and analysed for majority perspectives on implementation and achievement of goals along with learnings and suggestions for improvement.

Analysis of WHN database and Police records

A PNHQ staff member provided the evaluators with a spreadsheet of aggregate data extracted from the WHN databases. We analysed this data in Excel for the period 1 July 2008 to 31 December 2009.

Given operational and other differences between the sites, the general approach we have taken to the presentation of the findings is to provide these separately for each site, rather than to combine them.

We undertook some supplementary analysis from extracts of individual records from the WHN databases provided by staff at each site.

Cohort study

Methods used to form the cohort samples, including the comparison samples at Porirua and Wellington Central Police watch-houses, are described below.

The primary aim of the cohort study is to collect information with which to assess the contribution of the WHN initiatives to:

- reducing repeat detention of Police detainees with mental health and/or AOD problems;
- reducing alcohol and drug related harm for detainees with mental health and/or AOD problems; and
- improving the health status of detainees with mental health and/or AOD problems.

The design we proposed for the cohort study is outlined in Table A2 below. The study comprises four samples:

1. A sample of 150 detainees assisted by a WHN at Christchurch
2. A sample of 150 detainees assisted by a WHN at Counties Manukau
3. A comparison sample of 150 detainees with mental health and/or AOD issues held at Wellington (no WHN)
4. A comparison sample of 150 detainees with mental health and/or AOD issues held at Porirua (no WHN).

Table A2: Proposed characteristics of cohort study design of Police detainees with mental health and/or AOD concerns

Characteristic	WHN initiative samples	Comparison samples
Sample sizes & locations	300 (150 Chch, 150 Manukau)	300 (150 Wgtn, 150 Porirua)
Sampling period	Sept-Nov 08	Sept-Nov 08
Base date	WHN assessment date	Health and Safety Management Plan date
Cut-off for pre assessment period	12 months prior to base date	
Cut-off for post assessment period	12 months following base date	

We have assembled the four samples, some features of which are shown in Table A3.

The WHN initiative samples were derived from the first 150 records in the WHN Christchurch and Counties Manukau databases from 1 September 2008 onwards. The actual sampling period required to reach the target 150 records at the WHN sites was much shorter than originally proposed due to the higher than anticipated volumes of detainees with mental health and/or AOD concerns (especially at Christchurch).

Table A3: Characteristics of cohort study design of Police detainees with mental health and/or AOD concerns obtained

Characteristic	WHN initiative sample		Comparison sample	
	Christchurch	Counties Manukau	Wellington	Porirua
Sample sizes				
Number of records	150	150	148	154
Number of unique detainees	139	137	131	126
Sampling start & end dates	1 – 25 Sept 08	1 Sept - 19 Oct 08	1 July – 31 Dec 08	1 Aug – 31 Dec 08
Sampling period	< 1 month	About 1.5 months	6 months	5 months

Source: WHN databases (Christchurch and Counties Manukau) and charge sheets & related health & safety plans (Wellington and Porirua.)

The comparison samples were formed from charge sheets and accompanying health and safety management plans (HSMPs) at the Wellington and Porirua watch-houses. Like the WHN initiative samples, we aimed for the comparison samples to be around 150 each. To achieve these numbers we needed to extend the sampling period to six and five months respectively.

A search by hand of about 3,200 charge sheets dated between 1 July and 31 December 2008 at the Wellington watch-house yielded 148 (or about 5%) charge sheets linked to HSMPs for concerns related to detainees' mental health and/or AOD status.²⁷

²⁷ In addition, the evaluator noted that some detainees at the Wellington watch-house were too drunk for the Police to be able to evaluate them, and they were placed directly into a cell to detox without the Police formally developing detainees' health and safety plans.

A similar search at the Porirua watch-house of about 1,600 charge sheets dated between 1 August and 31 December 2008 yielded 135 (or about 8%) charge sheets linked to HSMPs for concerns related to detainees' mental health and/or AOD status. An additional 19 were located for detainees in transit from a neighbouring Police station.

Some detainees appear in each sample more than once because they needed to be re-assessed by a WHN during a particular detention period (Christchurch and Counties Manukau only), or they were re-detained for a separate incident during the sampling period.

Most information presented in this section is based on unique detainees using data associated with a detainee's first entry in the sample (or detention in custody during the period of interest).

Characteristics of the cohort samples

Demographic characteristics of the cohort samples

The gender, age and ethnic profiles of the two WHN samples (Christchurch and Counties Manukau) and two comparison samples (Wellington Central and Porirua) are shown in Table A4 and accompanying figures.

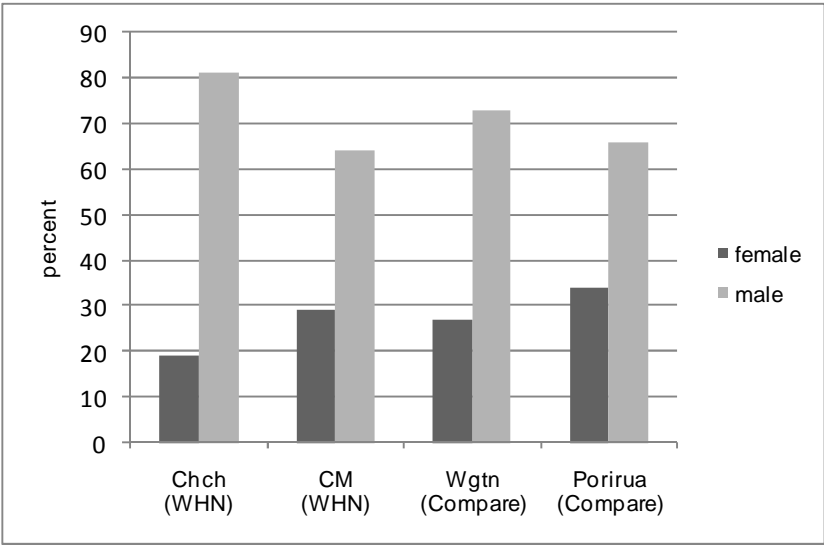
Porirua detainees were the most likely to be female (Figure A1) and youngest (Figure A2). The ethnic profiles were quite different, with the Counties Manukau sample being the most ethnically diverse (Figure A3). The Christchurch and Wellington samples comprised the highest proportion of European detainees, and the Counties Manukau and Porirua samples the highest proportion of Māori and Pacific detainees.

Table A4: Demographic characteristics of cohort samples

	Christchurch (WHN)		Counties Manukau (WHN)		Wellington (Comparison)		Porirua (Comparison)	
	n	%	n	%	n	%	n	%
Gender								
Female	26	19%	40	29%	36	27%	43	34%
Male	113	81%	88	64%	95	73%	83	66%
Unknown	0	0%	9	7%	0	0%	0	0%
Total	139	100%	137	100%	131	100%	126	100%
Age group								
16 & under	5	4%	8	6%	3	2%	21	17%
17-20	30	22%	26	19%	26	20%	26	21%
21-30	46	33%	41	30%	41	31%	26	21%
31-50	50	36%	56	41%	44	34%	41	33%
51 +	8	6%	3	2%	13	10%	8	6%
Unknown	0	0%	3	2%	4	3%	4	3%
Total	139	100%	137	100%	131	100%	126	100%
Ethnicity								
European	101	73%	34	25%	73	56%	56	44%
Māori	31	22%	46	34%	40	31%	46	37%
Pacific	5	4%	44	32%	4	3%	14	11%
Other	2	1%	13	9%	10	8%	2	2%
Unknown	0	0%	0	0%	4	3%	8	6%
Total	139	100%	137	100%	131	100%	126	100%

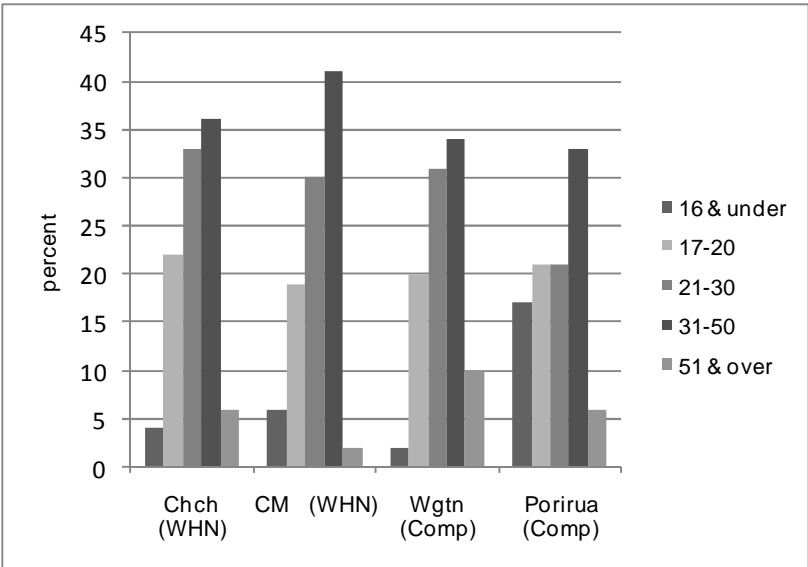
Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Figure A1: Gender profiles of cohort samples

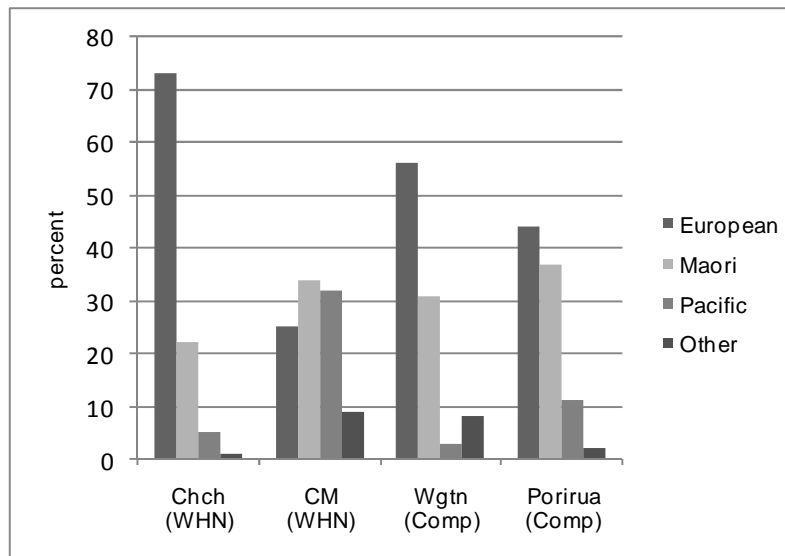


Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Figure A2: Age profiles of cohort samples



Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Figure A3: Ethnic profiles of cohort samples

Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Reasons for their detention

The breakdowns of the reasons for detaining each of the cohorts are shown in Table A5 and Figure A4.

Christchurch and Wellington detainees were more likely to be held in relation to criminal charges than Counties Manukau and Porirua detainees. Conversely, Counties Manukau and Porirua detainees were more likely to be held for reasons related to their mental health than Christchurch and Wellington detainees.²⁸ Only one percent of Christchurch detainees were held for this reason.

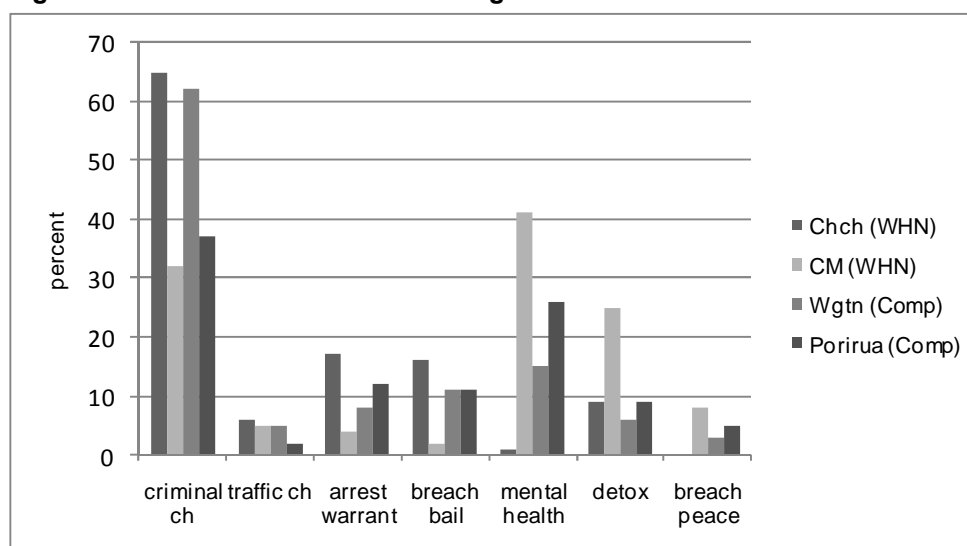
Counties Manukau detainees were the most likely of the four samples to be held for detoxification, while Christchurch detainees were the most likely to be held in relation to an arrest warrant or a bail breach.

²⁸ The Counties Manukau and Porirua samples contain higher proportions of Māori and Pacific peoples. Māori and Pacific have a higher prevalence of some mental health disorders and are less likely than Non-Māori non-Pacific peoples to make contact with services for mental health reasons.

Table A5: Reasons for cohorts being detained

Reasons	Christchurch		Counties Manukau		Wellington		Porirua	
	WHN		WHN		Comparison		Comparison	
	N=139		N=137		N=131		N=126	
	n	%	n	%	n	%	n	%
criminal charges	90	65%	44	32%	81	62%	47	37%
traffic charges	8	6%	7	5%	7	5%	3	2%
arrest warrant	24	17%	6	4%	10	8%	15	12%
breach bail	22	16%	3	2%	14	11%	14	11%
mental health	1	1%	56	41%	20	15%	33	26%
detoxification	13	9%	34	25%	8	6%	11	9%
Corrections	0	0%	0	0%	2	2%	2	2%
Immigration	1	1%	2	1%	0	0%	0	0%
Breach of Peace	0	0%	11	8%	4	3%	6	5%
Other	2	1%	5	4%	6	5%	14	11%

Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Figure A4: Reasons for cohorts being detained

Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

There appeared to be different charge patterns among the cohorts. Christchurch detainees were more likely to be charged with dishonesty offences (25%) than other criminal or traffic offence types while Counties Manukau detainees were more likely to be charged with drugs/anti-social offences (20%). Detainees at the comparison sites were more likely to be charged with violent offences (44% for Wellington and 33% for Porirua respectively) than other offence types (see Table A6).

Table A6: Types of charges for which cohorts were detained

	Christchurch		Counties Manukau		Wellington		Porirua	
	WHN		WHN		Comparison		Comparison	
	N=139		N=137		N=131		N=126	
	n	%	n	%	n	%	n	%
Violence	27	19%	13	9%	58	44%	42	33%
sexual offences	12	9%	1	1%	1	1%	1	1%
drugs/anti-social	26	19%	28	20%	26	20%	19	15%
Dishonesty	35	25%	5	4%	17	13%	6	5%
property damage	20	14%	1	1%	15	11%	7	6%
property abuse	9	6%	3	2%	9	7%	2	2%
administrative	1	1%	1	1%	0	0%	2	2%
Traffic	11	8%	10	7%	9	7%	4	3%

Source: WHN databases (Christchurch and Counties Manukau) and charge sheets (Wellington and Porirua.)

Assessment and Clinical Management

Reasons for assessments among the WHN cohorts

Only the WHN cohort samples have WHN assessment-related information. These WHN samples varied quite markedly in terms of breakdowns of reasons for assessments, generally reflecting the findings for all those assessed between 1 July 2008 and 31 May 2009 at their respective WHN site. A relatively high 44 percent of the Christchurch cohort was assessed because of an 'at risk' flag on NIA (compared with 4 percent of the Counties Manukau cohort). Conversely, a relatively high 27 percent of the Counties Manukau cohort was assessed because WHNs observed detainees there to be requiring one.

Table A7: Reasons for assessments among the WHN cohorts

Reason	Christchurch		Counties Manukau	
	n	%	n	%
Known to have AOD/MI issue	15	11%	56	41%
Flagged 'at risk' on NIA	61	44%	6	4%
Observation by officer	51	37%	35	26%
Observation by nurse	12	9%	37	27%
Not known	0	0%	3	2%
Total	139	100%	137	100%

AOD and mental health issues among the WHN cohorts

A relatively high 37 percent of the Christchurch cohort presented with neither AOD nor mental health issues (Table A8).

Table A8: Presenting issues at assessment among the WHN cohorts

Presenting issue(s)	Christchurch		Counties Manukau	
	n	%	n	%
AOD only	45	32%	61	45%
Mental illness only	21	15%	41	30%
AOD and Mental illness	21	15%	11	8%
Neither AOD nor mental illness	52	37%	13	9%
Not known	0	0%	11	8%
Total	139	100%	137	100%

Actions taken by watch-house keepers & health professionals at comparison sites

The profile of actions taken by watch-house keepers and health professionals for detainees with health and safety plans were reasonably similar across the comparison sites (Table A9). A member of the Capital and Coast (C&CDHB) Crisis Assessment and Treatment (CAT) team attended 48 percent of the Porirua cohort and 44 percent of Wellington cohort.

In only a small proportion of cases did a Police medical officer attend, both a CAT member and the Police medical officer attend (Wellington only), or the CAT helpline was accessed (Wellington only).

In 46 percent of Porirua cases and 40 percent of Wellington cases neither a CAT team member nor a Police medical officer attended detainees with health and safety plans.

Table A9: Actions taken by watch-house keepers and health professionals at the comparison sites

Action taken (at first presentation)	Wellington		Porirua	
	n	%	N	%
CAT team attended	58	44%	60	48%
Police medical officer attended	7	5%	2	2%
CAT contacted (Helpline)	6	5%	0	0%
CAT team and Police medical officer both attended	3	2%	0	0%
Other (hospital, CYP, ambulance, Hutt forensics)	2	2%	4	3%
Neither CAT team nor Police medical officer attended	53	40%	58	46%
Unknown	2	2%	2	2%
Total	131	100%	126	100%

Source: Health and safety management plans (Wellington and Porirua.)

A NIA data extract was obtained relating to activity in the year prior to and following the initiative (or equivalent) and matched with the samples using the NIA number and some demographic information. Matching was only possible for 131 in the Christchurch sample, 108 in the Counties Manukau sample, 126 in the Wellington sample and 117 in the Porirua sample.

It was not possible to differentiate between arrests and detentions in the NIA data extract so a proxy measure was used based on offences/events and certain 'link names' combinations. Examples of combinations used are:

- 'L201 – Driving While Disqualified' and 'Offender';
- '1X – Attempted Suicide' and 'Subject of';
- '1K – Drunk Custody/Detox' and 'Complainant'; and
- '1M – Mental Case' and 'Subject of'.

These combinations were brought together to form 'detention' entities that occurred on the same date and analysis undertaken.

Appendix 2: Evaluation tools

Evaluation of the Watch-house Nurse Pilot Interview Tools

List of tools:

1. Interview tools for persons who have been detained

- Information sheet for persons who have been detained by Police
- Informed consent form for persons who have been detained by Police
- Interview guide for persons who have been detained by Police

2. Interview tools for professionals at pilot sites (Counties Manukau and Christchurch)

- Information sheet for (Police and DHB) staff at pilot sites – invitation to participate in an interview or focus group
- Information sheet for key stakeholders from external services
- Informed consent form for professionals to be used for all staff members from government and community organizations interviewed for this evaluation at pilot and comparison sites
- Interview guide for Police and DHB staff (individual interviews and focus groups)
- Interview guide for key stakeholders from external services

3. Interview tools for Police and DHB staff at comparison sites (Wellington and Porirua)

- Information sheet for (Police and DHB) staff at comparison sites – invitation to participate in an interview

(Informed consent form is the same as the pilot sites)

- Interview guide for Police and DHB staff at comparison sites (individual interviews and focus groups)

Evaluation of the Watch-house Nurse Pilot

Information sheet for people who have been detained by Police

Invitation to take part in an interview

(Appropriate greeting for participants ethnicity e.g. Tena Koe, Kia Orana, Talofa lava, Hello, Bula Vinaka etc)

You may remember talking to a nurse when you were in Police custody. The Watch-house nurse is based at the Police station to assist people who may have mental health, alcohol or drug problems. This is a pilot to see if having a nurse at the Police station helps people in custody and provides them with information or referrals to seek the right treatment.

Dr Sue Carswell and Judy Paulin have been contracted to independently evaluate the Watch-house Nurse pilot to see how effective it is.

Invitation

You are invited to take part in an interview because we think it is very important to get your feedback on the services you received from the Watch-house nurse and the police.

What will the interview involve?

The interview will take about 40 minutes and can be done any time, any place that is good for you, including over the phone. You can have someone with you if you like, such as someone from your family, whānau, a friend or support person. The interviewer will ask you some questions about your experiences of custody and the Watch-house nurse, what you thought was good and if you have any suggestions for improving the service.

Who will interview you?

You have a choice about who you would like to interview you. Sue Carswell can interview you or if you would prefer you can have someone from your own cultural background. All the interviewers are independent researchers and do not work for the police or any health service.

Your choice!

It is your choice whether you take part in an interview and you can also choose not to answer certain questions or stop the interview at any time.

Private and confidential

The interview is private and confidential which means only the interviewer will see your interview and your name will not be used in any reports.

The interviewer will ask you if you mind the interview being audio-taped so that what you have to say is recorded accurately. Your interviewer will only hear the tape and the tape will be kept securely and then destroyed. You can say no if you don't like what you are saying being taped. The interviewer will also ask you if you would like to check any quotes of what you said in your interview before they go into the report. We will not use your name with the quote.

No information you give will be passed on to Police or the health services, unless anything you say indicates that you or someone else is at risk of serious harm.

Follow-up after interview

If we interview you we would like to follow-up with a phone call a day or two after the interview to check how you felt about the interview.

How will this research be useful for you?

We hope that this research will benefit you by:

- giving you a chance to say how you found the services you received from the Watch-house nurse and the police;
- giving you a chance to suggest improvements or ideas about how services could be better;
- providing information that will help people who may have mental health, alcohol or drug problems.

What will be done with the evaluation information?

The Report will be given to the Police and the Ministry of Health. The report will look at how the Watch-house nurse pilot has been operating to see what has been working well and what has not been working so well and make suggestions for improvements. The interviewer will ask you if you would like to receive a summary of the evaluation findings.

Thank you for considering whether to have an interview or not. If you do decide to have an interview we will thank you for your time and effort meeting with the interviewer and will give you a \$25 Warehouse voucher.

Contact information

If you have any questions please contact:

Dr Sue Carswell

Email: sue@carswellconsultancy.com

Telephone: 03 312 8212

Mobile: 021 167 9141

Health and Disability Advocates

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate:

Telephone: 0800 555 050

Free Fax: 0800 2787 7678

Email: advocacy@hdc.org.nz

Useful contact phone numbers for mental health or AOD services [changed to be appropriate for each area]

Psychiatric Emergency Service: 0800 920 092

Alcohol Drug Helpline: 0800 787 797

If you live in Christchurch, some other services you may wish to contact are:

- Single Point of Entry: Te Kuuwaha o te Whakaora Hinengaro, Adult Community Health Mental Health Services: 0800 920 092, 03 364 0482
- Mental Health Services, Hillmorton Hospital, Christchurch (including Te Korowai Atawhai, Maori Mental Health Services): 03 337 7500
- Alcohol Drug Association (ADA) Inc, Christchurch: 03 379 8626

If you live in Manukau, some other services you may wish to contact are:

- Manukau Community Mental Health Centre, Manukau City: 09 261 3700
- Middlemore Hospital, Manukau: 09 276 0000 all departments
- The Cottage Community Mental Health Centre, Maaori Mental Health, Faleola Services (Pacific Mental Health Services), Otahuhu, Counties Manukau: 09 270 9090
- Te Ara Hou – Residential Alcohol and Drug Service, Counties Manukau: 09 267 2914
- Community Alcohol and Drug Services – Medical Detoxification Service, Counties Manukau: 09 845 1818
- Tupu, Pacific Counselling Service, Counties Manukau: 09 845 1818

This study has received ethical approval from the Multi-region Ethics Committee.

Evaluation of the Watch-house Nurse Pilots Informed Consent Form for people who have been detained by Police

I agree to take part in an interview for the evaluation of the Watch-house Nurse Pilot. I have had the evaluation explained to me, and I have read the Information Sheet, which I may keep for my records.

I understand that agreeing to take part means that I am willing to be interviewed by the interviewer. I have had the chance to talk about this study with the evaluator and I am satisfied with the answers I have been given.

I understand that my participation is voluntary, that I can refuse to answer any of the questions asked by the interviewer, and that I can stop the interview at any time.

I understand that any information I provide is confidential, and that no information that could identify me will be used in any reports on this study. I understand that quotations from my interview may be used in reports but that my name or any identifying information will not be used. I understand that I will be given an opportunity to check my quotations.

I understand that no information I give will be passed on to Police or the health services, unless anything I say indicates that I or someone else is at risk of serious harm.

☐ **Please tick if you consent to the interview being audio taped.**

☐ **Please tick if you would like a summary of the evaluation findings.**

☐ **Please tick if you would like to check quotes**

I understand that I will be given quotations from my interview for my approval before these are included in any reports on the evaluation.

I _____ (full name) hereby consent to take part in an interview for the evaluation of the Watch-house Nurse Pilot.

Contact details: _____

Signature: _____

Date: _____

Project explained by: _____

Project role: _____

Signature: _____ Date: _____

Evaluation of the Watch-house Nurse Pilots

Interview Guide for people who have been detained by Police

Instructions for interviewers

- Introductions
- Read through the information sheet and informed consent form with the detainee and answer any questions they may have.
- If they agree to be interviewed ask them to sign the informed consent form.
- Ask the participant if they consent to the interview being taped and assure them that this will be kept confidential. If the interview is not taped take detailed notes.
- Reassure participant that no matter what they say about the Police, mental health services or AOD services in this interview, it is confidential and will not effect how they are treated by the Police or MH services in the future.
- This is a semi-structured interview with open questions that allow the participant to express their perspectives and share their experiences of the WHN pilot. Please adapt the language if necessary to engage with the participant and ensure they clearly understand the questions.

Interview Questions

I'd just like to talk about that time you were in Police custody and were talking to the watch-house nurse.

1. What do you remember about talking to the nurse?

Prompts:

- Did they conduct an assessment with you?
- What else did they do?

2. Did the nurse help you in any way at that time?

Prompts:

- Did the nurse give you any information? How useful was it?
- Did you feel like they gave you enough information about mental health, alcohol and drug issues?
- Did they refer you to any treatment services? Which ones?
- Did you feel like you were given a good choice of services? (for your cultural background, age and needs)

3. Did you go to any treatment services after you were released from custody? If so, can you tell me how you found that and whether it helped you or not?

Prompts:

- Did they meet your needs (cultural, age, health needs)?

4. How did it go when you were in Police custody?

Prompts:

- Did the Watch-house nurse make a difference in any way?
- [For repeat detainees] Was this experience of being in Police custody any different from other times?
- What was different and why?

5. Looking back do you think the things the Watch-house nurse arranged for you have helped you in any way?

Prompts:

- If **yes** - How do you think they helped you?
- What have been the best changes?
- If **no** - Why do you think going there didn't help?
- Have you got any suggestions how they could have helped you more?

6. What other things do you think helped you? What about things that have not helped you?

7. Are you currently receiving any treatment or support with your problems?

Prompts:

- How useful is this?
- If not, what are the main reasons why you are not attending any treatment? [only ask if treatment has been recommended.]

8. How is your [mental health and/or alcohol and drug use] at the moment?

Prompts:

- [AOD issues] Has your use of alcohol/drugs reduced, increased or stayed about the same since you were in custody? Is it more, less, stopped or just the same?
- Can you tell me why you think that is?
- Are there any other reasons why your alcohol and drug use has increased/decreased?

9. Overall what did you think of the service from the Watch-house nurse?

10. Have you any suggestions for what they could do better?

Prompts:

- That the Watch-house nurse could do better?
- That the police could do better?
- That the treatment services could do better?

11. What else do you think would help other people in a similar situation to you?

12. Anything else you would like to say?

Thank them very much for their time and feedback about the Watch-house Nurse pilot and give them the koha. If they have indicated that they would like to check their quotes that will be used in the evaluation report then tell them that we will be in touch with them to do this and make sure we have their contact details.

Evaluation of the Watch-house Nurse Pilot

Information sheet for staff at pilot sites – invitation to participate in an interview

Tena koe

The New Zealand Police have commissioned an independent evaluation of the Watch-house Nurse pilot to assess the extent to which the initiative is meeting its objectives. The WHN pilot aims to provide clinical management of detainees who are experiencing alcohol and other drug (AOD) and mental health related problems while in Police custody. The pilot also aims to reduce the risks of harm to detainees and custodial staff through appropriate clinical management of intoxication, withdrawal and mental health disorders. WH nurses aim to liaise with other service providers, and make referrals of detainees to treatment providers. The intended outcomes are reduced repeat detention; reduced alcohol and drug related harm; and improved health status of detainees. The evaluators who have been contracted by NZ Police to evaluate the WHN are Dr Sue Carswell and Judy Paulin.

Invitation to take part in an interview for the evaluation

You are invited to take part in an interview for the evaluation. As a professional who works in this area it is important to find out your views and experience of the pilot. It is your choice whether you take part in an interview and you can also choose not to answer certain questions or stop the interview at any time.

Privacy and confidentiality

The interview is private and confidential which means only the evaluator will see your interview and your name will not be used in the evaluation report. Quotes from your interview may be used in reports without your name. However, you may be identifiable by your job position and the interviewer will ask you if you would like to check any quotes from your interview before they are used in reports.

Interview time and place

If you agree to be interviewed we will arrange a time and place that is convenient for you during. The interview should take about 40 minutes and if you agree the interview will be taped for the purposes of accuracy. The tape and interview transcript will be kept confidential in a secured location and then destroyed.

What will be done with the evaluation information?

An interim evaluation report and a final evaluation report will be submitted to the New Zealand Police and the Ministry of Health and a summary of the evaluation findings will be available in 2010.

How will this evaluation be useful for Police, Mental Health and AOD services?

The intention of this evaluation is to provide useful and important information such as:

- an examination of why and how the WHN pilot is achieving any changes for detainees ;
- identifying good practice examples relating to the assessment and custodial management of detainees with mental health and/or AOD issues;
- examining how the WHN pilot facilitates referral of detainees to treatment services;
- comprehensive feedback from Police and Mental Health/AOD staff, detainees and other key stakeholders;
- providing an opportunity for reflection on practices and processes.

Contacting us

Please feel free to contact either Sue Carswell the independent evaluator or Alison Chetwin who is the Police Evaluation Manager with any questions you may have.

Independent evaluator: Dr Sue Carswell telephone 03 312 8212
or email sue@carswellconsultancy.com.

Evaluation Manager, NZ Police: Alison Chetwin, telephone 04 474 9568
or email alison.chetwin@police.govt.nz

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Free Fax: 0800 2787 7678

Email: advocacy@hdc.org.nz

This study has received ethical approval from the Multi-Region Ethics Committee.

Evaluation of the Watch-house Nurse Pilot Information sheet for key stakeholders from external services at Pilot sites – invitation to take part in an interview

Tena koe

Watch-house nurse pilot

The New Zealand Police have commissioned an independent evaluation of the Watch-house Nurse (WHN) initiative which is being piloted at Manukau Police Station and Christchurch Central Police Station. The WHN pilot aims to provide clinical management of detainees who are experiencing alcohol and other drug (AOD) and mental health related problems while in Police custody. The pilot also aims to reduce the risks of harm to detainees and custodial staff through appropriate clinical management of intoxication, withdrawal and mental health disorders. WH Nurses aim to liaise with other service providers, and make referrals of detainees to treatment providers. The intended outcomes are reduced repeat detention; reduced alcohol and drug related harm; and improved health status of detainees. The evaluators who have been contracted by NZ Police to evaluate the WHN are Dr Sue Carswell and Judy Paulin.

Invitation to take part in an interview

You are invited to take part in an interview for the evaluation. As a professional who works in this area it is important to find out your views and experience of the WHN pilot. It is your choice whether you take part in an interview and you can also choose not to answer certain questions or stop the interview at any time.

Privacy and confidentiality

The interview is private and confidential which means only the evaluator will see your interview and your name will not be used in the evaluation report. Quotes from your interview may be used in reports without your name. However, you may be identifiable by your job position and the interviewer will ask you if you would like to check any quotes from your interview before they are used in reports.

Interview time and place

If you agree to be interviewed we will arrange a time and place that is convenient for you during _____. The interview should take about 20-40 minutes and if you agree the interview will be taped for the purposes of accuracy. The tape and interview transcript will be kept confidential in a secured location and then destroyed.

What will be done with the evaluation information?

An Evaluation Report will be submitted to the New Zealand Police and the Ministry of Health and a summary of the evaluation findings will be available in 2010.

How will this evaluation be useful for Police, Mental Health and AOD services?

The intention of this evaluation is to provide useful and important information such as:

- an examination of why and how the WHN pilot is achieving any changes for detainees ;
- identifying good practice examples relating to the assessment and custodial management of detainees with mental health and/or AOD issues;
- examining how the WHN pilot facilitates referral of detainees to treatment services;
- comprehensive feedback from Police and Mental Health/AOD staff, detainees and other key stakeholders;
- providing an opportunity for reflection on practices and processes.

Contacting us

Please feel free to contact either Sue Carswell the independent evaluator or Alison Chetwin who is the Police Evaluation Manager with any questions you may have.

Independent evaluator: Dr Sue Carswell telephone 03 312 8212
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or email alison.chetwin@police.govt.nz

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Free Fax: 0800 2787 7678

Email: advocacy@hdc.org.nz

This study has received ethical approval from the Multi-Region Ethics Committee.

Evaluation of the Watch-house Nurse Pilots Informed Consent Form

I agree to take part in an interview for the evaluation of the Watch-house Nurse Pilot. I have had the evaluation explained to me, and I have read the Information Sheet, which I may keep for my records.

I understand that agreeing to take part means that I am willing to be interviewed by the evaluator. I have had the chance to talk about this study with the evaluator and I am satisfied with the answers I have been given.

I understand that my participation is voluntary, that I can refuse to answer any of the questions asked by the researcher, and that I can stop the interview at any time.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be in any reports about the Watch-house Nurse Pilot. I understand that quotations from my interview may be used in reports but that my name will not be used. However, certain professionals may be identifiable by their designation and I understand that I will be given an opportunity to check my quotations.

☐ **Please tick if you consent to the interview being audio taped.**

☐ **Please tick if you would like a summary of the evaluation findings.**

☐ **Please tick if you would like to check quotes**

I understand that I will be given quotations from my interview for my approval before these are included in any reports on the evaluation.

I _____ (full name) hereby consent to take part in an interview for the evaluation of the Watch-house Nurse Pilot.

Contact details: _____

Signature: _____

Date: _____

Project explained by: _____

Project role: _____

Signature: _____

Date: _____

Evaluation of the Watch-house Nurse Pilot Interview Guide for key stakeholders from Police and DHBs at Pilot sites

Instructions for interviewers

- Read through the information sheet and informed consent form with the participant and answer any questions they may have.
- If they agree to be interviewed ask them to sign the informed consent form.
- Ask the participant if they consent to the interview being recorded and assure them that this will be kept confidential. If the interview is not taped take detailed notes.
- Reassure participant that this interview is confidential.
- This is a semi-structured interview with open questions that allow the participant to express their perspectives and share their experiences of the Watch-house Nurse Pilot.
- This is a generic interview guide for Police, Watch-House Nurses and DHB staff so discretion should be used in the way questions are framed.

Interview Questions

Role/contact with WHN pilot

1. Could you tell me about your role and how it relates to the WHN pilot?

Assessment and clinical management

2. Please describe the steps for identifying, assessing and clinical management of detainees from your perspective?
3. How do you think the Police custody processes and facilities impact on the WHN operations?
4. What if any difference do you think the WHN position has made for the detainees with mental health, alcohol or drug issues?

Prompts:

- Has this position made any difference to their experience being held in detention?
- Do you think this has facilitated their treatment in any way?
- Do you think this has affected detainee safety in any way?
- Has it impacted on custodial staff safety in any way?
- Has it impacted on the number of incidents of self harm in the Police watch-house?

Cultural responsiveness

5. In what ways is the WHN able to meet the needs of Maori? Pacific peoples? other ethnic groups?

Prompts:

- Do you think having the WHN available makes any difference to their experience of custody?
- What choice of services is the WHN able to offer to meet the needs of different ethnic groups?

Education role

5. Have you received any education from the Police Consult/Liaison nurse? If so, how useful was this for you and in what ways? What have you learnt? To what extent has your knowledge of mental health/AOD issues increased?
6. [Police] Do you feel more supported in dealing with people with mental health, alcohol or drug issues?

Liaison role and interagency relationships

7. In what ways do services work together in meeting the needs of detainees with mental health/AOD issues? Has this improved since the pilot started? If so, in what ways do you think the role has helped to do this? (explore any changes in Police/Hospital liaison, Courts and Mental Health liaison)

Referral processes

8. Can you describe the referral processes the WHN pilot uses to refer detainees to treatment services?
9. How effective do you think the referral processes to treatment services are?

Prompts:

- Are there any problems with the referral process?
- How do you think this position impacts on referrals in terms of time and service delivery?
- Have you got any suggestions for improving the referral process?

Service gaps

10. Are there any service gaps for detainees with mental health and AOD issues in this locality?

Prompts:

- Are there service gaps or barriers for Maori? Pacific peoples? Other ethnic groups?
- Are there service gaps or barriers for any other groups of people?

Resourcing

11. Are there any issues in regards to resourcing since the WHN pilots started?
12. Do you think the WHN has helped reduce costs in any way?

Strengths and good practice

13. What would you identify as working well in the pilot? How does this compare to previous practice?

Barriers and suggestions for improvement

14. Have you found any issues or barriers to the WHN delivering their service effectively?
15. Have you got any suggestions for areas where the pilot could be improved?

Thank them very much for the interview.

Ensure you have contact details for participant if they would like to check quotes.

Evaluation of the Watch-house Nurse Pilot Interview Guide for key stakeholders from external services at Pilot sites

Instructions for interviews

- Read through the information sheet and informed consent form with the participant and answer any questions they may have.
- If they agree to be interviewed ask them to sign the informed consent form.
- Ask the participant if they consent to the interview being recorded and assure them that this will be kept confidential. If the interview is not taped take detailed notes.
- Reassure participant that this interview is confidential.
- This is a semi-structured interview with open questions that allow the participant to express their perspectives and share their experiences of the Watch-house Nurse Pilot.
- This is a generic interview guide for services who liaise with the WHN in some way so discretion should be used in the way questions are framed.

Interview Questions

Role/Contact with WHN pilot

1. Can we start by you telling me briefly about your organization and your role?
2. What contact have you had with the Watch-house Nurse?

Referral processes

3. Do you receive referrals from the nurse or refer people to them at all?
4. How effective do you think the referral processes are?

Prompts:

- Are there any problems with the referral process?
 - How do you think this position impacts on referrals in terms of time and service delivery?
 - Have you got any suggestions for improving the referral process?
5. What kinds of information are given and how is it passed on?

Perceptions of role

6. Do you think the Watch-house nurse role has made any difference for the detainees with mental health issues or AOD issues?

Prompts:

- Has this position made any difference to their experience being held in detention?
- Do you think this has facilitated their treatment in any way?
- Do you think this has affected detainees safety in any way?

Liaison role and interagency relationships

7. In what ways do services work together in meeting the needs of detainees with mental health/AOD issues? Has this improved since the pilot started? If so, in what ways do you think the role has helped to do this? (explore any changes in Police/Hospital liaison, Courts and Mental Health liaison)

Service gaps

- 8 Are there any service gaps for detainees with mental health and AOD issues in this locality?

Prompts:

- Are there service gaps or barriers for Maori? Pacific peoples? Other ethnic groups?
- Are there service gaps or barriers for any other groups of people?

Strengths and good practice

- 9 What would you identify as working well in this initiative and how does this compare to previous practice?
- 10 Have you found any issues or barriers to the WHN delivering their service effectively?
- 11 Have you got any suggestions for areas where this initiative could be improved?

Thank them very much for the interview.

Ensure you have contact details for participant if they would like to check quotes.

Evaluation of the Watch-house Nurse Pilots Information sheet for comparison sites – invitation to participate in an interview

Tena koe

Watch-house nurse pilot

The New Zealand Police have commissioned an independent evaluation of the Watch-house Nurse (WHN) pilot which is being trialled at Manukau Police Station and Christchurch Central Police Station. The WHN pilot aims to provide clinical management of detainees who are experiencing alcohol and other drug (AOD) and mental health related problems while in Police custody. The pilot also aims to reduce the risks of harm to detainees and custodial staff through appropriate clinical management of intoxication, withdrawal and mental health disorders. WH nurses aim to liaise with other service providers, and make referrals of detainees to treatment providers. The intended outcomes are reduced repeat detention; reduced alcohol and drug related harm; and improved health status of detainees. The evaluators who have been contracted by NZ Police to evaluate the WHN are Dr Sue Carswell and Judy Paulin.

Invitation to participate

You are invited to take part in an interview for the evaluation. In order to better understand what impact the WHN pilot is having the evaluation is comparing practice at Wellington Central Police station and Porirua Central Police Station with practice at the pilot sites. As a professional who works in this area your views and experience working with people who have mental health and/or AOD issues who have come to Police attention are important. It is your choice whether you take part in an interview and you can also choose not to answer certain questions or stop the interview at any time.

Privacy and confidentiality

The interview is private and confidential which means only the evaluator will see your interview and your name will not be used in the evaluation report. Quotes from your interview may be used in reports without your name. However, you may be identifiable by your job position and the interviewer will ask you if you would like to check any quotes from your interview before they are used in reports.

Interview time and place

If you agree to be interviewed we will arrange a time and place that is convenient for you during _____. The interview should take about 40-60 minutes and if you agree the interview will be taped for the purposes of accuracy. The tape and interview transcript will be kept confidential in a secured location and then destroyed.

What will be done with the evaluation information?

An Evaluation Report will be submitted to the New Zealand Police and the Ministry of Health and a summary of the evaluation findings will be available in 2010.

How will this evaluation be useful for Police, Mental Health and AOD services?

The intention of this evaluation is to provide useful and important information such as:

- an examination of why and how the WHN pilot is achieving any changes for detainees ;
- identifying good practice examples relating to the assessment and custodial management of detainees with mental health and/or AOD issues;
- examining how the WHN pilot facilitates referral of detainees to treatment services;
- comprehensive feedback from Police and Mental Health/AOD staff, detainees and other key stakeholders;
- providing an opportunity for reflection on practices and processes.

Contacting us

Please feel free to contact either Sue Carswell the independent evaluator or Alison Chetwin who is the Police Evaluation Manager with any questions you may have.

Independent evaluator: Dr Sue Carswell telephone 03 312 8212
or email sue@carswellconsultancy.com.

Evaluation Manager, NZ Police: Alison Chetwin, telephone 04 474 9568
or email alison.chetwin@police.govt.nz

Health and Disability Advocates

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate:

Telephone: 0800 555 050

Free Fax: 0800 2787 7678

Email: advocacy@hdc.org.nz

This study has received ethical approval from the Multi-Region Ethics Committee.

Evaluation of the Watch-house Nurse Pilot Interview Guide for key stakeholders from Police and DHBs from comparison sites

Instructions for interviews

- Read through the information sheet and informed consent form with the participant and answer any questions they may have.
- If they agree to be interviewed ask them to sign the informed consent form.
- Ask the participant if they consent to the interview being recorded and assure them that this will be kept confidential.
- Reassure participant that this interview is confidential.
- If the interview is not taped take detailed notes.
- This is a semi-structured interview with open questions that allow the participant to express their perspectives and share their experiences of processes for dealing with detainees with mental health issues and/or alcohol and other drug (AOD) issues at Wellington Central Police station and Porirua Central Police station.

Interview Questions

Questions for Police

Current Police practice

1. What are the main types of mental health issues Police come across in Wellington/Porirua?
2. Can you explain to me how you currently deal with detainees/arrestees with suspected mental health issues?

Prompts:

- Find out procedure for dealing with different types of mental health conditions e.g. suicide risk.
- What mental health services do you call on?
- Do you call on any other services like security guards?
- What are the main issues you find dealing with people with mental health issues?

3. How do you deal with detainees with suspected alcohol and drug issues?

Prompts:

- How is intoxication managed?
- What are the main issues you find dealing with people with alcohol and drug issues?

Police training and education about mental health

4. How competent do you think Police at this station are at recognising and dealing with people with mental health issues?

Prompts:

- Do you think they find it easy to differentiate between bad behaviour and people who have a mental health condition?
 - What about recognising the difference between people who are on drugs or intoxicated and those with a medical condition including mental health issues?
5. What kind of training about mental health issues have Police at this station received? How about alcohol and drug issues?
 6. Have you any suggestions for further training or information you would like about mental health or alcohol and drug issues, or procedures and legislation?

Police access to information about mental health clients and knowledge of services

7. If you required information about a person's mental health history/status for your inquiries, who would you contact? Are there any issues obtaining this information?
8. Do you ever refer or contact a service about a person you are concerned about with mental health issues? Alcohol and drug issues? (this question relates to community policing and Police diversion)
9. Do you feel well informed enough about the services that are available in this area?

Questions for key stakeholders in Mental Health Services

10. What are the main types of mental health issues police come across in Wellington/Porirua?

11. Can you explain to me your role with clients who are in Police custody?

Prompts:

- Are there any issues to carrying out your role?
- Have you got any suggestions for improvements?

12. How competent do you feel Police are recognising and dealing with people with mental health issues?

Questions for all key stakeholders**Impact of detention on detainee/arrestee**

13. What kind of impact do they think detention can have on mentally ill people? People with AOD issues?

Prompts:

- Are there any differences for people from different ethnic groups?
- Are there any other factors that can make a difference to detainees experience of custody?

14. Can you identify any areas where this could be improved?

Interagency relationships

15. How do Police and health services currently work together?

Prompts:

- What do you think is working well?
- Do you have any suggestions for improvement?

16. Do you know of any interagency forums Police and Mental Health Services and alcohol and drug services are involved in together in this area?

Resourcing

17. [Police] Are there any issues in regards to resourcing?

Prompts:

- What do you identify as the main costs? (police time spent monitoring prisoners and waiting for services, cost of calling on medical assistance, security guards)

18. [MHS] Can you identify any resourcing issues in the provision of mental health services to Police?

Service gaps

19. Are there any service gaps for detainees with mental health and AOD issues in this locality?

Prompts:

- Are there service gaps or barriers for Maori? Pacific peoples? Other ethnic groups?
- Are there service gaps or barriers for any other groups of people?

Main issues and suggestions for improvement

20. What do you think are the main issues with the way people with mental health issues or AOD issues are dealt with in Police custody?
21. Have you any suggestions for improvements?

Thank them very much for the interview.

Ensure you have contact details for participant if they would like to check quotes.

Appendix 3: Clinical pathways at pilot sites

Diagram 1: Clinical pathways for detainees with mental health, alcohol or other drug needs in custody at the Christchurch Police Station Watch-house. Please note WHNs will notify existing DHB patient's case workers at Community Mental Health Services and Community Alcohol and Drugs Service (CADS) that they have been seen in the watch-house.

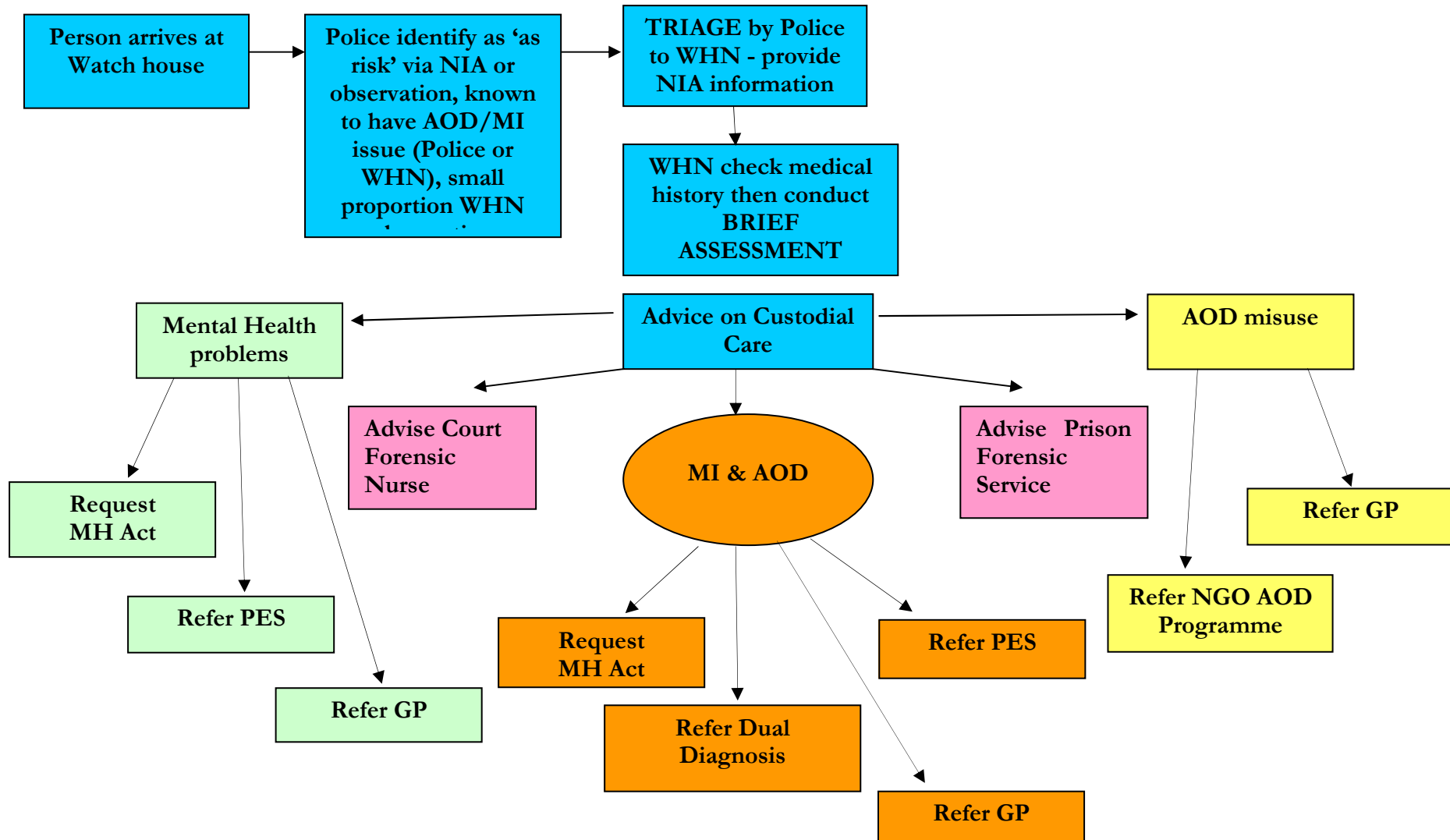
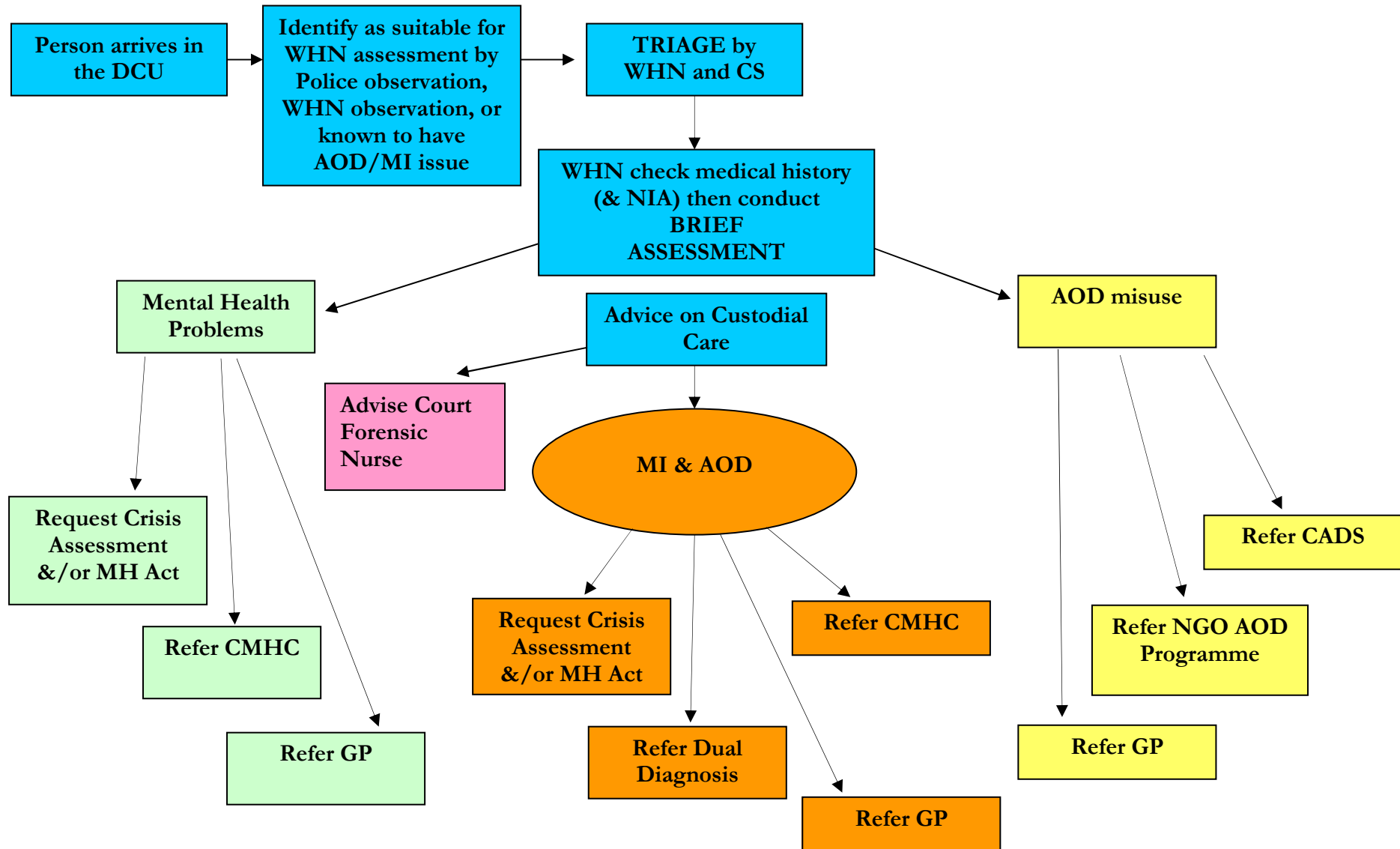


Diagram 2: Clinical pathways for detainees with mental health, alcohol or drug needs in custody at the Counties Manukau District Custodial Unit. Please note WHNs will notify existing DHB patient's case workers at Community Mental Health Services and Community Alcohol and Drugs Service (CADS) that they have been seen at the DCU.



Appendix 4: Independent Police Conduct Authority observations of WHN initiative

The Authority and Optional Protocol to the Convention against Torture

4. The *United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('the Convention') entered into force on 26 June 1987 and is designed to prevent torture and ill-treatment. The *Optional Protocol to the Convention against Torture* ('OPCAT') entered into force on 22 June 2006 and is designed to provide an operational framework for State Parties to meet their obligations under the Convention. Following the enactment of amendments to the Crimes of Torture Act 1989, New Zealand ratified the OPCAT on 14 March 2007.
5. Ratification of OPCAT provides a significant opportunity to ensure that all places of detention in New Zealand are safe, humane environments that meet international human rights standards. OPCAT is an international instrument concerned with the *prevention* of violations and establishes a dual process of international and national monitoring and reporting. In New Zealand, the Authority is one of four designated National Preventative Mechanisms ('NPMs') co-ordinated by the Central NPM, the New Zealand Human Rights Commission. Pursuant to s 27 of the Crimes of Torture Act 1989, the Authority has statutory authority to:
 - Examine conditions of detention and the treatment of detainees (s 27(a)(i) and (ii));
 - Make recommendations to those in charge of detention facilities with respect to the improvement of conditions of detention, the treatment of detainees, and the prevention of torture and other cruel, inhuman or degrading treatment or punishment in places of detention (s 27(b)(i) to (iii)); and
 - Provide an annual report on its statutory functions and findings (s 27(c) and (d)).
6. The Authority is the designated NPM mandated to monitor the treatment of people held in police cells or who are otherwise in the custody of police. Each year, the Authority conducts thirty or more site visits of places of detention; these visits may be announced or unannounced. The Authority is entitled, pursuant to s 28 of the Crimes of Torture Act, to have unrestricted access to all information relating to the number, treatment of, and conditions applying to detainees. It reports its findings to each site and engages with Police at the district and national levels in monitoring the implementation of its recommendations.
7. The Authority has, along with other NPMs, developed assessment criteria for site inspections by consulting applicable human rights law instruments. This means that Authority recommendations with respect to custody centres accord with New Zealand's obligations at the international level.

The treatment of individuals affected by mental illness or alcohol / drug issues – Authority observations

8. The Authority has, during the course of its site visits, engaged with staff involved in the Mental Health, Alcohol, and other Drug Watch-House Nurse Pilot Initiative ('the Pilot Initiative'). The Authority was advised that the Pilot Initiative allows trained practitioners to work alongside and assist police who conduct detainee risk assessments. The custody centre environment is particularly challenging and presents various risks to staff. It would be unreasonable to expect Police, who are not medically trained, to conduct risk assessments without the support and guidance of qualified practitioners. The Pilot Initiative, therefore, provides assistance that is both necessary and desirable for the safety of police and the welfare of detainees. Staff also explained the methods and systems available for obtaining medical data, medications, and the process of referral to external health providers and other support services. These methods and systems are designed to facilitate effective assessment and care, which contributes to the fulfillment of New Zealand's international human rights obligations.
9. The Pilot Initiative is reported to have been well-received by custody centre and medical staff. It was clear to the Authority that staff realise the importance of having qualified professionals available on site to assist where appropriate and provide the care that vulnerable detainees need and to which they are entitled. The positive staff response may also be a useful indicator of the long term feasibility of the Pilot Initiative in other centres around the country.
10. Care programmes can only work effectively and deliver the appropriate standard of care to detainees when they are adequately resourced and fully connected with existing health systems. The Authority has observed, for example, that the Pilot Initiative would benefit from a rotation staffing system to ensure that trained professionals are available at any time of the day or night. Staff require robust support systems with effective links to care providers that allow referrals to external mental health, drug, or alcohol residential or community programmes. The programme would also benefit from quantitative data collection of health and systems information. The collection and analysis of this data would allow Police and health providers to monitor the effectiveness of current systems, as well as identify needs and trends for future development.

Other applicable International Human Rights Instruments and Reports

11. The provision of appropriate support services in detention facilities to the fullest extent possible is envisaged in the *United Nations Principles for the protection of persons with mental illness and the improvement of mental health care*. These Principles were adopted by the United Nations General Assembly under Resolution 46/119 of 17 December 1991.
12. Principle 1 outlines the fundamental freedoms and basic rights of detainees. This Principle may inform the decision as to whether support programmes such as the Pilot Initiative should be implemented for the benefit of detainees in other parts of New Zealand. Principle 1 is unambiguous; the relevant provisions stipulate that:

Principle 1

Fundamental freedoms and basic rights

1. *All persons have the right to the best available mental health care, which shall be part of the health and social care system.*
2. *All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.*
3. *All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*

...

(emphasis added)

13. Under Principle 20, rights and protections afforded to individuals suffering from mental illness who are being treated in a mental health facility extend to individuals who are detained as part of the criminal justice process:

Principle 20
Criminal offenders

1. This Principle applies to persons serving sentences of imprisonment for criminal offences, *or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.*
2. *All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances.* No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.
3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.
4. *Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.*

(emphasis added)

14. Principle 11 applies to individuals detained in the course of criminal proceedings and is particularly relevant to the custody centre environment. It supports the Authority's observation that patients who are detained in custody centres and are suspected of having mental illness should be monitored by qualified staff, such as on-site nurses. It also supports another Authority observation that it is both necessary and desirable for efforts to be made to ensure that individuals suspected of suffering from a mental illness are able to promptly contact a family member or other representative.

Principle 11

Consent to treatment

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. *A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.*

15. Principle 14, while applicable to mental health facilities, cites the need for adequate resources to ensure patient care. It is clear that, in the custody centre context, any programme will require adequate resources and will need to be linked to the appropriate health networks. The ability, for example, to quickly access appropriate medication or prescriptions (or Registrars and other staff who may authorise a prescription), as well as the ability to store, distribute, and transport medications when detainees travel to other locations, is an essential component of ensuring an appropriate standard of care.

Principle 14

Resources for mental health facilities

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:
 - (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
 - (b) Diagnostic and therapeutic equipment for the patient;
 - (c) Appropriate professional care; and
 - (d) Adequate, regular and comprehensive treatment, including supplies of medication.
 2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.
16. In addition to international human rights law instruments, evaluation reports from other jurisdictions are also relevant. In April 2009, Lord Bradley delivered the *Review of people with mental health problems or learning disabilities in the criminal justice system* ('the Bradley Report'). The Bradley Report considered a wide range of issues pertaining to mental health issues in Britain, including those relating to individuals detained in police custody:

Provision of healthcare in custody

PACE sets out guidance for the police in matters involving people detained in police custody and the assessments that should take place. *It states that the police are required to provide clinical attention to those presenting with physical and mental health needs. This requirement is fundamental to the risk management and prevention of deaths in custody.* If a detainee requires medical attention then it is also the responsibility of the custody officer to ensure that healthcare professionals have all the available information relevant to the detainee's treatment.

As we have already heard, many detained in police custody will have multiple and complex needs. They will have had difficulty engaging with mainstream services in the community and the police have become the agency with whom they are most likely to have contact by default.

Health services in police custody are not currently commissioned by the NHS, but by each individual police force. There have been studies looking at different models of such provision that found that they broadly fall into one of, or a mix of, the following categories:

- Traditional Forensic Medical Examiner (FME) services
- Privately provided services
- Directly employed custody nurses
- Liaison schemes.

...

Summary

The exact number of people with mental health needs coming into contact with the police is not known, as there is no national requirement for the police, or any other criminal justice agency, to keep statistics. The poor quality of information is obviously an issue when it comes to estimating the scale of the problem and the planning of services. What we do know, from discussions with stakeholders, is that contrary to the perception of danger associated with offenders with mental health problems, most contact with offenders from this population will be for minor offences.

As well as officers needing assistance from mental health professionals when they are dealing with difficult or complex situations involving persons with a suspected mental health problem, mental health professionals who are working without police support can often feel ill-equipped to handle some individuals presenting particular challenges. It has become increasingly apparent that when people with mental health problems in the community are in crisis, neither the police nor the mental health services alone can serve them effectively and it is essential that the two systems work closely together.

(emphasis added)

17. A key recommendation in the Bradley Report was the establishment of Criminal Justice Mental Health teams (CJMH Teams). In the custody centre context, the Report recommended that the role of the CJMH Teams would be to:

- Screen and assess detainees;
- Provide direct advice to Police officers about individual cases;
- Support the collection, collation and appropriate management of clinical information from this and previous mental health contacts and its transfer to appropriate parties further along the criminal justice pathway;
- Provide knowledge of and links to local services;
- Provide information to CPS [Crown Prosecution Service];
- Provide training for Police and CPS;
- Provide signposting to other services for prisoners following disposal other than custody;
- Provide advice for NHS commissioners about mental health requirements within custody suites;
- Provide follow-up in section 135 and 136 cases [British mental health legislation];
- Advise Police about most effective use of custodial facilities for individuals with mental health problems;
- Provide advice and support to the Police service in the case of dispute with other providers;
- Facilitate transfer arrangements to other service once diversion decisions made; and
- Provide support and advice to Appropriate Adults.

18. The provision of the above mental health services would involve Police, community mental health services, primary care services, Forensic Medical Examiners, Crown Prosecution Service, and third sector / independent health care providers located in police stations.

19. The Bradley Report also commented on the need for adequate data collation and analysis. As identified above, the collection of health and systems data and the identification of trends and solutions would ideally form an integral part of a long term mental health, drug, and alcohol initiative in New Zealand.

20. During the course of its site visits, the Authority has observed that all staff working in the custody centre context need to be effectively trained to meet the specific needs of vulnerable detainees. Staff also require access to updates and 'refresher' courses where available and appropriate. As the Bradley Report observed:

As we are already aware, despite regular interaction with individuals with mental health needs or learning disabilities, the police receive very little specific training in mental health or learning disability awareness. In addition, in many cases they do not have direct access to mental health or learning disability expertise. Where liaison and diversion services have been provided to police stations, many have accepted the responsibility for training and brought together different agencies, including the police, for joint training. Joint training initiatives can not only improve awareness of mental health and learning disability issues but also help to improve partnership working and understanding of each other's roles.

21. The Pilot Initiative in New Zealand may differ in some ways from the British model proposed in the Bradley Report. Notwithstanding this, it is clear that the key to successful care programmes is appropriately-resourced, interconnected, and engaged professional agencies that are committed to fulfilling their human rights obligations. The Authority acknowledges and commends the work currently being done by Police in custody centres. Police have shown commitment to organisational development and have made progress in engaging committed staff, fostering positive and progressive leadership, and improving custody centre facilities.

Conclusion

22. The Authority endorses effective initiatives that enable custody centres to provide for the needs of detainees affected by mental illness, drugs, or alcohol-related issues. Such initiatives ensure that Police are able to foster confident, safe, and secure communities and that New Zealand fulfils its international obligations under OPCAT and other international human rights law instruments. The fundamental principle of OPCAT, which is a principle that also underpins public health policy and healthcare in New Zealand, is *prevention*. Programmes such as the Pilot Initiative can, with appropriate planning and support, ensure that vulnerable members of our community are understood, respected, and cared for when they need treatment the most: at the earliest possible opportunity, by qualified, committed Police and specialised health practitioners.