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Subjective experiences of the first response to mental health crises in the community: a qualitative systematic review

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ABSTRACT

Objective To review and synthesise qualitative studies that have explored subjective experiences of people with lived experience of mental health-related illness/crisis (MHC), their families and first responders.

Design A systematic review of qualitative evidence was conducted. English-language articles exploring the content of interactions and participants' experiences were included.

Data sources MEDLINE, PsycINFO, EMBASE, CINAHL; Google Scholar, SAGE journals, Science Direct and PubMed.

Data extraction and synthesis Two reviewers read and systematically extracted data from the included papers. Papers were appraised for methodological rigour using the Critical Appraisal Skills Programme Qualitative Checklist. Data were thematically analysed.

Results We identified 3483 unique records, 404 full-texts were assessed against the inclusion criteria and 79 studies were included in the qualitative synthesis. First responders (FRs) identified in studies were police and ambulance staff. Main factors influencing response are persistent stigmatised attitudes among FRs, arbitrary training and the triadic interactions between FRs, people with mental illness and third parties present at the crisis. In addition, FR personal experience of mental illness and focused training can help create a more empathetic response, however lack of resources in mental health services continues to be a barrier where 'frequent attenders' are repeatedly let down by mental health services.

Conclusion Lack of resources in mental healthcare and rise in mental illness suggest that FR response to MHC is inevitable. Inconsistent training, complexity of procedures and persistent stigmatisation make this a very challenging task. Improving communication with family carers and colleagues could make a difference. Broader issues of legitimacy and procedural barriers should be considered in order to reduce criminalisation and ensure an empathetic response.

Strengths and limitations of this study

- As far as we are aware, this is the first systematic review bringing together the experiences of all stakeholders involved in a mental health crisis in the community.
- We undertook rigorous searches for the available literature and assessed the quality of the studies.
- Sixty-six of the included studies were assessed to be of 'high' methodological quality (≥9 out of 10) and 13 were of 'intermediate' quality (7 or 8 out of 10).
- The majority of studies were conducted in high-income countries, which could limit the generalisability of the findings.
- This review included studies published in the English language only.

BACKGROUND

Mental health-related crises (MHC) in the community are increasing. This can partly be attributed to increased transitions from institutions to community treatment,[1] while the COVID-19 pandemic also had an impact, with the National Health Service in the UK, reporting a significant increase in urgent and emergency referrals of people in crisis.[2] Police and paramedics are often the first responders (FRs) to an MHC.[3 4] In the UK, 40% of police time is spent responding to an MHC.[5] WHO[6] calls for 'community actors such as police officers' to be trained in empowering people with mental illness (PMI).

However, there are concerns that FRs cannot provide expert support for PMI and report feeling ill-equipped.[7 8] Limited training can result in inappropriate responses,[5 9] for instance, tasers are more likely to be used during an MHC than a criminal arrest.[5] Due to limited resources, the only options available to police have been force and detention.[9] Section 136 (S136) of the Mental Health Act 1983 gives police authority to detain PMI in a safe place, often a cell, which can worsen the crisis.[9 10] Concerns about police capability to make decisions about people's mental health has led to changes in legislation and policy. The Policing and Crime Act 2017 requires that police consult mental health professionals (MHPs) before using S136, use

a health-based place of safety instead of a police station and reduce the period of detention from 72 to 24 hours.[11]

Ways to improve FR response include specific training tools,[12] which mainly involving de-escalation techniques for police, as well as models of triage[7] that aim to improve police officers' ability to provide effective response.[13] Triage includes Crisis Intervention Teams (CIT), where a police member is trained in MHC intervention, and co-response/interagency collaborations between FR and MHPs.[7] The aim is to improve response and to reduce the likelihood of detention.[7] A recent review[13] of interagency collaboration models found that there is a wide range, with different kinds of agencies and services involved at various levels. Co-responder interventions are not routine practice and the majority not evaluated,[13] and high costs, logistics[13 14] and limited access to local mental health services[15] make such models difficult to implement.

Currently, evidence on FR interactions and communication practices in incidents involving PMI is not well documented.[11] Factors that impact on the interactions between FRs and PMI need to be understood better and integrated into training to improve response.[16] Significant research focuses on service development, however there is a need for research on lived experiences and interactions as they unfold in real time, exploring the perspectives of all stakeholders, including companions (family/carers/friends).[17 18] With rises in mental distress and illness worldwide, identifying experiences of the responses to MHC from all people involved is critical. Hence, the aim of this study was to review available qualitative evidence on the subjective experiences of people with lived experience, their companions and FRs, of the FR response to mental health crises in the community.

METHODS

The PICo for qualitative studies (figure 1) was used to identify the *Population* of interest, the phenomena of *Interest* and the *Context*.[19]

Search strategy

A systematic search was conducted using the MEDLINE in Process (Ovid), PsycINFO (Ovid), EMBASE (Ovid) and CINAHL databases. Relevant research was also identified using Google Scholar, SAGE journals, Science Direct, PubMed, Hand searching systematic reviews' reference lists, reference checking and citation chasing of included studies. A search strategy was developed using controlled vocabulary unique to each database and free-term texts including three search groups: MHC; non-mental health emergency responders and qualitative design (online supplemental appendix 1).

Population	Interest	Context
- People with lived experience of a MHC - FRs: police, paramedics, firefighters, emergency medical technicians - Companions present in MHC (e.g. carers, family, friends)	The lived experiences of the response.	The interaction in community settings.

Figure 1 *Population* of interest, the phenomena of *Interest* and the *Context*. FR: first responder; MHC: mental health-related crisis.

Selection criteria

Retrieved articles from the inception for each database to November 2020 were included, if they directly related to all three search groups. Articles published in English were included because there was no multilingual researcher in the team, and finite resources. Studies reporting perspectives/experiences, involving adults (≥18 years) and using a qualitative approach, including mixed methods with a clear qualitative aspect. We only included qualitative articles to allow for understanding of the experiences of all stakeholders involved in these interactions. Studies with exclusively quantitative data, non-adult participants that reported solely on MHPs and the MHC did not occur in the community were excluded.

Screening, data extraction and synthesis

Two reviewers conducted an initial screening of all titles and abstracts against the inclusion criteria to identify relevant papers. Duplicates were removed. Retrieved records were first screened on title and abstract. Reviewers screened the relevant full papers, and studies were independently assessed for eligibility. Disparities were resolved in weekly meetings before proceeding to the next stage. The Critical Appraisal Skills Programme (CASP) Qualitative Checklist[20] was used to appraise the methodological quality of the articles. The extraction and analysis of the qualitative studies was iterative[21] and was reviewed in weekly analytic meetings. Findings of each study, including participant quotations and author interpretations, were examined, extracted and assigned to descriptive codes in NVivo 12. Inductive thematic synthesis was used where findings of primary studies were coded line by line and similar characteristics were then grouped together and given a label to describe the content. These descriptive labels (codes) were then grouped into 'subthemes', which were then developed into descriptive themes. This process was conducted by two authors (PX, CT) and in two further analytic meetings (JD).

Patient and public involvement

Exploratory work in 2019 was conducted with:

1. carers and people with lived experience (South West England);
2. five ambulance service staff;
3. Devon and Cornwall Police lead and for enhanced communication.

FR response was described by carer and PMI as 'hit and miss', 'dismissive' and positive "they [police] always looked after me". FRs described the challenges they face and lack of, or difficulties in following prescriptive training. This led to development of aims of this review and the focus on real-life experiences.

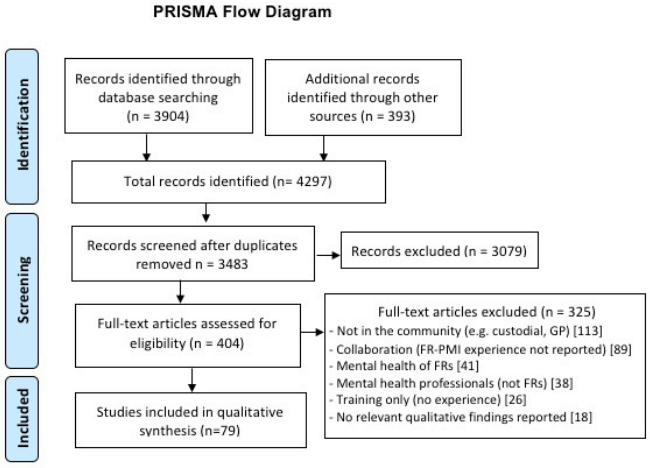

Figure 2 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram of included and excluded studies. FR, first responder; GP, general practitioner; PMI, people with mental illness.

RESULTS

The electronic and hand searches identified 4297 studies (figure 2). Seventy-nine studies, including three unpublished, were included in the review (table 1). These studies used semi-structured qualitative interviews (n=43), focus groups (n=4) and mixed methods (n=32). Studies explored the perspectives of the police (n=35), paramedics (n=13), PMI (n=15), carers or family members (n=8) and multiple stakeholders (n=8). No other FR perspectives, for example, firefighters, were found. The studies were conducted in the UK (n=22), the USA (n=22), Australia (n=15), Canada (n=10), The Netherlands (n=2), New Zealand, France, Sweden, Ireland, Ghana, Slovenia, Portugal and Guyana (each n=1). All scored 7 or higher on the CASP Checklist (table 1), indicating medium to high quality; no exclusions were made on this basis. Reasons for lower scores were: (a) not reporting on the relationship between researchers and participants, (b) limited reporting on ethical issues and (c) not detailed reporting on the analysis.

Table 2 presents the themes and subthemes from the thematic synthesis of the included studies, which all contained first-order themes.

Acknowledging versus criminalising mental illness and procedural concerns

Criminalisation and use of force versus recognition of behaviour relating to mental ill health

Companions and PMI described distress, fear, confusion, humiliation and trauma caused by a large police presence, disproportionate use of S136, involuntary transport and physical restraint[18 22–32]: *"You're confined in this tiny, small box and you go, 'what's happening to you?' They don't speak to you, and the only time they do, they're barking orders at you"* (PMI).[33] FRs were sometimes perceived as threatening: *"I said I am going to call 911, and he said: 'no don't, if you call 911 they are going to kill me'"* (companion).[22] In one study, paramedics describe disliking physical restraint and excessive force, believing their presence alone can be calming.[34] In contrast, police described their 'right to use force',[26] arguing that force and restraint were *"most helpful because they immediately make the situation unpleasant for the individual"*[35] Police felt victimised when criticised for using force.[34–37]

PMI and their family/carers described instances where crises were not resolved. Time delays, use of force and FRs' threatening presence increased their distress[18 24 28 31 32 38]: *"[Six police officers] were standing there with their capsicum spray…I was just sitting there bawling my eyes out…It made me feel one hundred times worse"* (PMI).[32] Impacts of these responses on PMI include fear, mistrust, trauma and post-traumatic stress disorder.[39] PMI felt degraded and traumatised: *"I was handcuffed, led out into the street, head pushed down and into a police car. It is humiliating, the police were scaring me, neighbours witnessed the disturbance, and local youths came out to shout and jeer from the side lines"*.[40] Companions reported being interrogated by police, which exacerbated the situation,[41] and that mental illness was ignored[42]: *"So the victims have become the criminals"* (carer).[22]

In contrast, PMI and companions praised FRs when they used a gentle approach, avoided excessive force by engaging meaningfully with them, using de-escalation and communication techniques.[18 28–32 35 37 40 43–48] They valued FRs being professional, non-judgmental and compassionate, providing reassurance, expressing a wish to help, asking for permission to examine or touch the PMI, and including them in decision making.[18 24 31 32 45 48–51] FRs assumed a non-threatening presence by maintaining eye contact, not standing with arms crossed, altering their tone and taking a low-profile approach to protect PMI privacy, and by not using police uniform or vehicles.[26 30 34 37 40 52] FRs suggested using direct questions to avoid confusion and stress: *"the less you say, and the more you listen, the better the call will go… do you actually need to obtain that information, or is it just agitating"* (paramedic),[40] and using humour to distract and calm the PMI.[30 32 34 35 40 45 53–55]

Accountability, cautiousness and confusion over procedure

FRs expressed concerns and confusion about the law, in detaining PMI, which made decision making difficult[26 30 31 36 37 47 54 56 57]: *"They don't fully understand how to use the Mental Health Act…I think there's a lot of officers out there who have a lack of knowledge of what we can and can't do"* (police officer).[36] Some police officers suggested detainments are voluntarily because,[36 37] and when PMI have crises at home it is illegal to enact S136. They described pressure from colleagues to detain PMI when they did not meet the requirements of S136,[36] and said that they often prioritised the safety of the PMI over the law in order to take them to hospital[30 31 36 54]: *"I'd rather get into trouble ethically for taking somebody against their will than somebody die, and I left them there to die"* (paramedic).[30] During MHC, FRs worried about being blamed, scrutiny, losing their job and pension, and felt they had to cover themselves[17 30 31 35 47 56 57]: *"It's just not worth losing my job over people who don't care about themselves"* (paramedic).[56] Police

Table 1 Summary of included studies

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Adio *et al*[42]	USA	Paramedics	Views of paramedics towards frequent emergency department users and underlying causes.	Mixed-methods design. Survey and interviews.	16 Community Integrated Health Programme paramedics.	9 out of 10
Baker and Pillinger[22]	USA	Family members	To understand how police interactions with PMIs can lead to deaths and families' experiences.	Semi-structured interviews.	16 family members of a citizen who died after police contact.	9 out of 10
Baker and Pillinger[23]	UK	Family members	The police role in providing a de facto service for people undergoing mental health crises.	Semi-structured interviews.	12 family members of a citizen who died after police contact.	8 out of 10
Bendelow *et al*[106]	UK	PMI and companions	To investigate the complexities underlying the high rates of S136.	Mixed methods. Interviews and written accounts.	37 people with lived experience of detention.	8 out of 10
Bohrman *et al*[38]	USA	Police	Police officers assessment for mental illnesses and variation by location.	Semi-structured interviews.	15 officers.	9 out of 10
Boscarato *et al*[88]	Australia	PMI	Consumers' experiences with formal crisis-response mechanisms—police-only and joint responses.	Exploratory study. Semi-structured interviews.	11 mental health consumers.	9 out of 10
Bradbury *et al*[107]	Australia	PMI, carers and service providers	To explore the lived experience of involuntary transport under the mental health act.	Cross-sectional, qualitative research design. Interviews.	16 participants: 6 consumers, 4 carers 6 service providers.	9 out of 10
Brennan *et al*[49]	Australia	Carers	Carers' experiences of mental health crises and responses provided by police and mental health services.	Semi-structured interviews.	9 carers for someone with a mental illness.	9 out of 10
Brink *et al* [89]	Canada	PMI	How PMI perceive and interact with the police.	Participatory Action Research. Focus groups, interview, survey.	60 people with lived experience.	9 out of 10
Booty *et al*[86]	USA	Police	Officer attitudes pre-CIT and post-CIT training.	Mixed-methods study. Surveys, group discussions, interviews.	14 Central District patrol officers.	7 out of 10
Callender *et al*[17]	UK	Police	To compare the processes, experiences and perceptions of mental health street triage.	Semi-structured interviews.	27 police and health service staff.	9 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Canada *et al*[35]	USA	Police	Impact of CIT on police officers' response to mental illness calls.	Qualitative research design. Survey and phone interviews.	216 officers.	9 out of 10
Cheng *et al*[41]	USA	Family caregivers	Needs of family caregivers for early psychosis.	Semi-structured focus group interviews.	20 family caregivers.	9 out of 10
Copeland and Heilemann[69]	USA	Family caregivers	Mothers understanding of violence of their mentally ill, adult children.	Grounded theory methodology, open-ended interviews.	8 mothers.	9 out of 10
Daggenvoorde *et al*[24]	The Netherlands	PMI and families	Lived experiences of patients with a psychotic or bipolar disorder and their families of a mobile crisis team.	Phenomenological study design. Interviews.	10 patients and 10 family members.	9 out of 10
Davey *et al*[65]	New Zealand	Police	E-learning for police with regard to people experiencing mental distress.	Semi-structured telephone interviews.	24 police staff.	9 out of 10
DeJean *et al*[43]	Canada	Paramedics	Paramedics views on appropriate versus inappropriate ambulance use.	Constructivist grounded theory methodology. Interviews.	19 paramedics.	9 out of 10
Dougall[90]	Canada	Police	Lived experiences of frontline police personnel of a mid-sized police service.	Exploratory study, heuristic phenomenology. Semi-structured interviews.	7 police officers, 4 communicators and 3 administrators.	10 out of 10
Dyer *et al*[67]	UK	Police	Implementation of Cleveland Police's pilot ST service.	Exploratory design. Interviews and retrospective analysis of case notes.	16 stakeholders, case notes and administrative data.	7 out of 10
Erdner and Piskator[81]	Sweden	Police	Police officers' experiences of committing individuals with mental illness to the hospital for treatment.	Semi-structured interviews. Qualitative content analysis.	7 police officers.	9 out of 10
Ferguson *et al*[44]	Australia	PMI	Men's experiences of ambulance care for mental health and/or alcohol and other drug problems.	Exploratory qualitative approach. Semi-structured interviews.	30 men.	9 out of 10
Ford-Jones[63]	Canada	Paramedics	Mental health and psychosocial calls encountered by paramedics in the community.	Case study. Interviews.	10 paramedic management/ educators and 5 directors/ physicians.	9 out of 10
Ford-Jones and Daly[91]	Canada	Paramedics	Paramedic service practices that are connecting patients to mental health and psychosocial programming.	Qualitative interviews and observations.	36 paramedics, 5 educators, 5 directors/ physicians.	9 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Gerson *et al*[92]	USA	Family members	Experiences of families seeking treatment for young people with recent-onset psychosis.	Qualitative open-ended interviews.	14 particpants-13 interviews (one pair).	9 out of 10
Gibbs and Haas[50]	Australia	PMI	Experiences of autistic people who had interacted with police.	Mixed-methods design. Questionnaire and interviews.	12 autistic adults.	9 out of 10
Girard *et al*[93]	France	PMI and police	Mental health team and police responding to persons who are homeless with serious psychiatric disorders.	Mixed qualitative and quantitative methods. Focus group. Minutes of meetings.	40 PMI (interactions). Focus groups: 12 police officers.	9 out of 10
Godfredson *et al*[94]	Australia	Police	Contact between the police and people experiencing mental illness.	Survey. Thematic analyses of open-ended responses.	3534 police officers.	8 out of 10
Goodall *et al*[95]	UK	PMI	Process of being detained under S136 of the Mental Health Act (1983, 2007).	Semi-structured interviews.	15 people detained under S136 of the Mental Health Act.	9 out of 10
Green[74]	USA	Police	Police involvement with suspects who have a mental illness.	Mixed methods. Qualitative structured and semi-structured interviews.	11 police officers.	7 out of 10
Gregory and Thompson[52]	UK	PMI	Personal experiences of a service user through a mental health crisis.	Auto-ethnography and interviews. Reflective narrative.	1 service user.	7 out of 10
Haas and Gibbs[70]	Australia	PMI and parents	Impact that autistic characteristics on interactions with police.	Interviews, content analysis.	12 autistic adults and 19 parents.	9 out of 10
Hanafi *et al*[68]	USA	Police	To evaluate the effectiveness of CIT training for police officers.	Qualitative focus group study.	25 officers.	9 out of 10
Herrington and Pope[25]	Australia	Police, NSW Health and NGO representatives	Evaluate the success of the Mental Health Intervention Team.	A multi-phased, mixed-methods design. Interviews, observations.	56 interview participants.	7 out of 10
Holmes[33]	UK	PMI	Missing people with mental health issues and police response.	Qualitative semi-structured interview and free-text narratives.	45 formerly missing adults with mental health issues.	7 out of 10
Keefe *et al*[75]	USA	Paramedics	Paramedics' experiences and perceptions regarding behavioural health emergencies.	Qualitative in-depth interviews.	25 paramedics.	8 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Krayer *et al*[58]	UK	Police; statutory and third sector organisations	Perceptions about joint working between mental health, social care and police services with regard to antisocial behaviour.	Multimethod sequential qualitative study. Police logs; interviews; focus groups.	55 statutory and third sector organisations; 60 cases-narrative police logs.	9 out of 10
Lamb and Tarpey[76]	UK	Police	UK police officers views on their experience of working with people with mental health difficulties.	Social constructionist perspective. Interviews.	10 police officers	7 out of 10
Lane[62]	UK	Police	Forum members discourses on individuals experiencing mental health difficulties.	Discursive psychology and critical discourse analysis.	75 threads—discussion forum for members of the police force.	9 out of 10
Livingston *et al* [45]	Canada	PMI	Experiences of PMI of their interactions with the police.	Semi-structured interviews.	60 PMI.	8 out of 10
Mahmuda *et al* [77]	Canada	PMI (frequent users)	Frequent users' experiences regarding EMS.	A grounded theory approach. Semi-structured interviews.	10 participants.	8 out of 10
Marsden *et al*[78]	UK	Police	UK police officers' experiences of their involvement in mental healthcare.	Qualitative methods. Semi-structured interviews and a vignette.	15 police officers.	9 out of 10
McCann *et al*[56]	Australia	Paramedic	Paramedics' experience of caring for patients with non-medical emergency-related mental health and/or AOD problems.	Framework method. Semi-structured interviews.	73 paramedics.	10 out of 10
McGuinness *et al*[26]	Ireland	PMI	Impact of involuntary hospital admission to a mental health centre and illuminate their lived experience of involuntary admission.	Interpretative phenomenological analysis. Semi-structured interviews.	6 participants.	10 out of 10
McKenna *et al*[59]	Australia	Police, carers, paramedics, MH staff	Perceptions of stakeholders on behavioural escalation service utilisation of people in mental health crisis.	Exploratory research design. Interviews.	17 people (advisors, ED staff, police, ambulance officers).	9 out of 10
McLean and Marshall[51]	UK	Police	Challenges when policing mental ill-health and use of mental health triage in England and Wales.	Interpretative phenomenological analysis. Semi-structured interviews.	9 police officers.	9 out of 10
Morgan and Paterson[36]	UK	Police	Police officers views of working with people with mental health difficulties and their experience of training to equip them for this.	Human rights framework. Semi-structured interviews.	7 police officers.	7 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Myers *et al*[82]	USA	PMI	Real-time decision-making between first hospital admission for early psychosis and treatment engagement or drop-out.	Prospective, longitudinal, ethnographic study. Open-ended, person-centred interviews.	37 people who experienced involuntary admission.	8 out of 10
Ogloff *et al*[96]	Australia	Police	Association among mental disorder, police shootings and other injuries, and police interactions with victims of crime.	Mixed methods. Semi-structured interviews.	25 police officers.	9 out of 10
Olasoji *et al*[66]	Australia	Carers	Experiences of carers as they access mental health services and as they engage with service/health providers?	A qualitative descriptive approach. Focus groups.	19 carers of patients (ie, family members).	10 out of 10
Osafo *et al*[97]	Ghana	Police	Views of the police on persons who attempt suicide and the law criminalising the act.	Qualitative approach. Semi-structured in-depth interviews.	18 officers.	9 out of 10
Oxburgh *et al*[60]	UK	Police	Perceptions of police officers regarding mentally disordered suspects, support provided to MD suspects and current police training in MD.	Grounded Theory. Questionnaire consisting of a mixture of open and probing questions.	35 police officers.	9 out of 10
Prener and Lincoln[98]	USA	Paramedic	Experiences, beliefs and attitudes towards what EMS providers call 'psych calls'.	Semi-structured observational method and interviews.	4×12 hour observations Interviews: 4 EMTs and 16 paramedics.	9 out of 10
Railey *et al*[99]	USA	Police, carer and PMI	Law Enforcement Officers's (LEOs) knowledge of Autism Spectrum Disorder (ASD), interactions between LEOs and individuals with ASD, and training needs.	Constructivist grounded theory approach (interviews and questionnaires).	6 adults with ASD, 5 caregivers and 6 law enforcement officers.	10 out of 10
Rant and Bregar[100]	Slovenia	Paramedic	Paramedics experience suicidal patients.	Qualitative case study, semi-structured interviews.	10 paramedics.	9 out of 10
Rees *et al*[101] AND Rees *et al*[102]	UK	Paramedic	Paramedics' perceptions and experiences of caring for people who self-harm.	Evolved Grounded Theory Methodology. Semi-structured interviews.	11 paramedics.	10 out of 10
Roberts and Henderson[103]	Australia	Paramedic	Paramedics use of resources to support practice and their role when dealing with patients displaying mental illness.	Mixed methods. Focus groups and survey (open questions).	74 survey responders. Focus groups: 20 paramedics.	9 out of 10
Rolfe *et al*[104]	UK	Paramedic	Paramedics managing patients experiencing mental health issues.	Qualitative. Observations and interviews.	21 paramedics and 20 patients with mental illness.	10 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Ross *et al*[57]	Australia	Police	Effectiveness of the masterplan in reducing suicides.	Mixed-methods design. Interviews.	8 police officers.	9 out of 10
Salerno and Schuller[39]	Canada	Police	Interactions between adults with ASD and the police and exploring how individuals with ASD perceive these experiences.	Community-engaged research strategy and integrating both qualitative and quantitative research methods.	35 adults with ASD.	9 out of 10
Schulenberg[53]	Canada	Police	Dynamics of police and PMI encounters versus non-PMI.	Observation and sequential mixed-methods research design. Field notes.	Data on 606 citizens (74 ride-alongs).	8 out of 10
Shaban[54]	Australia	Paramedics	Paramedics accounting for their JDM with respect to mental illness in the emergency care setting.	Ethnographic methods. Semi-structured interviews.	6 paramedics.	9 out of 10
Soares and Pinto da Costa[37]	Portugal	Police	Police officers' interactions in compulsory admissions and in the delivery of involuntary mental health treatment.	Qualitative research. In-depth semi-structured interviews.	10 police officers.	9 out of 10
Sondhi *et al*[46]	UK	PMI	Perceptions of the process for people who have been detained under S136 of the Mental Health Act 1983.	Qualitative design. Semi-structured interviews.	58 people with lived experience detained under S136 and 4 carers.	9 out of 10
Spence and Millott[47]	UK	Police	To explore police negotiators' perceptions of preparation and coping responses related to suicide.	Qualitative design. Semi-structured interviews.	16 police negotiators.	9 out of 10
Stokoe and Sikveland[48]	UK	Police	Methods negotiators use to engage persons in crisis and initiate and maintain productive sequences of talk.	Qualitative design. Conversation analysis.	14 negotiations, 31 hours of audio-recordings.	9 out of 10
Tully and Smith[34]	USA	Police	Officer perception of preparedness after receiving CIT training.	Mixed-methods design. Semi-structured interviews.	8 officers.	9 out of 10
van Steden[64]	The Netherlands	Police	Officers and nurses perceptions of disorderly and confused people.	Qualitative design. Informal conversations, interviews, focus groups, group meetings.	5 policy makers, 17 community police officers and 3 district nurses.	9 out of 10
Wallace[55]	Guyana	Police	Police officers' attitude, response and interaction with PMI.	Mixed-methods design. Open-ended questions of survey.	9 participants responded to open-ended questions.	9 out of 10

Continued

Table 1 Continued

Study	Country	Perspective	Study focus	Study design and methods	Sample size (qualitative)	CASP score
Warrington[27]	UK	People with suicidality	Repeated S136 detentions.	Mixed-methods design. In-depth interviews.	6 participants.	9 out of 10
Watson *et al*[28]	USA	PMI	Dimensions of how police encounters are experienced by consumers.	Qualitative design. In-depth semi-structured interviews.	20 persons with mental illness.	9 out of 10
Watson and Wood[29]	USA	Police	Examination of the CIT model.	Mixed-methods design. In-depth semi-structured interviews.	21 police officers.	9 out of 10
Wells and Schafer[30]	USA	Police	Police officer perceptions of their contacts with the mentally ill and examine outcomes of an innovative police training programme.	Mixed-methods design. Open-ended survey items.	126 police officer respondents.	9 out of 10
White *et al*[40]	UK	PMI	Experiences with law enforcement services, emergency departments and psychiatric services.	Author personal experience— narrative.	One personal account.	9 out of 10
Wood and Beierschmitt[31]	USA	Police	Opportunities for police enhanced upstream engagement.	Mixed-methods design. Focus groups and interviews.	22 police officers.	9 out of 10
Wood *et al*[18]	USA	Police	Officer perspectives on the unmet needs of individuals and their families and the ways in which the mental health and social system environment constrain officers' abilities to be responsive to them.	Qualitative design. Field notes describing observations and ride-along interviews.	57 officers.	7 out of 10
Wood and Watson[32]	USA	Police	The nature of encounters police have with persons affected by mental illness and the ways in which such encounters are resolved by police.	Qualitative design. Observations.	31 ride-alongs. 53 officers observed.	7 out of 10
Young *et al*[61]	Canada	Parent caregiver	Experiences of parent caregivers for adult children with schizophrenia.	Qualitative design. Interviews.	12 parent participants	7 out of 10

CASP, Critical Appraisal Skills Programme; CIT, Crisis Intervention Teams; ED, emergency department; EMS, Emergency Medical Services; EMT, emergency medical technician; MH, mental health; NGO, non-governmental organisation; NSW, New South Wales; PMI, people with mental illness; S136, Section 136; ST, Street Triage.

Table 2 Themes and subthemes

Theme	Subthemes	Studies exploring each subtheme
Acknowledging versus criminalising mental illness	Criminalisation and use of force versus recognition of behaviour relating to mental ill health.	22–24, 26, 32, 34–35, 41, 45, 51, 53–54, 59, 63, 66, 81–83, 87, 90–97. (Canada, USA, UK, Australia, Ireland, Portugal)
	Accountability, cautiousness and confusion over procedure.	17, 62–63, 65–67, 79, 82–83, 85, 93, 95. (Australia, Ireland, Portugal, UK, USA)
Legitimacy and stigma	Non-legitimacy of mental illness and impact on seeking help.	23, 29, 45, 50, 53, 59, 62, 64–66, 79, 81–87, 89, 90–91, 93–95, 97. (Australia, Canada, Portugal, UK, USA)
	Stigma and use of stereotypes.	17, 23, 29, 34–35, 40, 51, 58–60, 62–63, 66, 71, 81–87, 92, 98. (Australia, Canada, The Netherlands, Portugal, Sweden, UK, USA)
First responder capability and skills dealing with mental health crises	Training: impact and requirements.	32, 35, 41–42, 50, 52, 56, 59, 62, 64–66, 70, 79, 81–87, 89, 93–96, 98. (Australia, Canada, Ghana, Guyana, The Netherlands, Portugal, UK, USA)
	Interagency collaboration.	22, 25–27, 34–36, 46, 53, 59, 63, 65–66, 81, 84, 89, 91, 93–94, 96–97. (Australia, Canada, France, Guyana, The Netherlands, New Zealand, UK, USA)
	The value of personal experience.	50, 57, 62, 66, 74, 79, 83, 87, 93–94, 97 (Australia, Portugal, Slovenia, UK, USA)
Impact of response on companions: involvement hindering versus facilitating response	Companions ignored, not informed and impact on them not recognised.	23–25, 29, 33–35, 91, 93–98 (Australia, The Netherlands, USA, UK)
	Companion involvement: hindering response versus leading to better outcomes.	35, 45, 83–86, 94–95, 97, 98. (Australia Canada, USA, UK, Portugal, The Netherlands)

officers shared their anxiety and sense of responsibility for suicide victims and their families.[57]

Impact of perceived legitimacy and public stigma

Non-legitimacy of mental illness and impact on seeking help

Many studies reported how often mental health crises were not considered a 'real' emergency. FRs reported that responding to MHC was 'babysitting', frustrating and a waste of time and resources, reporting that it damaged their public image.[30 31 34 40 45 48 53 58 59] FRs perceived PMI as selfish and taking support from other, more deserving incidents, confronting the PMI[28 34 40 46 47 51 56]: *"Next time you have the urge to pretend to kill yourself do not call us, call someone who can help. Because while we are pampering to your selfish needs there are others who really do need our help who are not getting it"* (paramedic).[34] These encounters often resulted in the PMI feeling ashamed: '*Emotions varied and included shame and embarrassment at having wasted police time*'.[28]

Legitimacy towards PMI was particularly challenged by FRs when it involved frequent users of mental health services: "*we've had patients who attempted to commit suicide every week, just to let out their frustrations…to get our attention. I feel no empathy for such people"* (paramedic).[34] However, FRs also described PMI being frequent users of emergency services due to ineffective health systems overusing services as a 'band aid approach'.[18 27 30 36 37 48 51 52 54 56] PMI were often released from hospital the same day police transported them, leading to future crises requiring police response: *"vicious cycle…you are exposed to that cycle so many times of taking people in, nothing happens, they get released, taking people in, nothing happens, they get released"* (police officer).[36] Additionally, FRs described forming relationships with frequent users, building trust and knowing what to say to reassure PMI.[30 32 55]

Negative interactions with FRs caused PMI and companions to be reluctant in seeking help. Being treated with force and physical restraint, or at worst the PMI being killed during an encounter with FRs, led to many regretting having called for emergency help[27 30–32 40 46 48 49 54 57]: *"I am afraid to call them. They have exasperated traumatic events. They have belittled me for my appearance, so I stopped wearing my helmet"* (PMI).[54] This was also demonstrated in the low standards PMI had for interactions with FRs: *"I didn't get beat up, I didn't get thrown down stairs, I didn't get punched or kicked, I didn't get tazed, that kind of stuff, so, it was good"* (PMI).[24] Family/Carers described feeling guilty and blamed themselves for calling the police[22 37 50]: *"It was that one phone call, that one phone call destroyed everything. If I could just take it back"* (parent).[22]

Person with mental illness dehumanised, use of stereotypes and stigma

Studies demonstrated that the stigmatisation of PMI involved fear and beliefs that PMI are unpredictable, violent, dangerous and lack insight about their illness.[37 47 48 54 60 61] Some FRs also believed PMI were incapable of cooperation and had an 'increased pain

threshold'.[26 29 45 46 49 62] PMI reported being treated in a dehumanised way: *"They just handcuffed me like a dog, they fired me in the back of the van like a dog and they just left me in there"* (PMI).[26] PMI were treated as if they were in control of their mental health, and accused of being manipulative and disingenuous.[40] After police learnt of PMI's mental illness, PMI describe a negative change in their attitude,[24] including not listening or take PMI seriously, using stigmatising language, laughing at PMI and being insensitive, disrespectful and judgemental[18 24 34 54]: *"You can tell right away that they all have the same look and that stuff"* (police officer).[55] However, many studies found that FRs condemned mental illness-associated stigma and believed PMI deserved to be treated with the same urgency and professionalism as physical injuries[18 30 31 34 36 37 40 47 53 54 56]: *"Just because we're cops doesn't mean we're better than them… would you be angry with him if he had cancer?"* (police officer).[53]

First responder capability and skills dealing with mental health crises

Role requirements and training: recognising symptoms of mental illness

FRs often failed to resolve MHC, as they believed MHC response is not part of their role, they have too much responsibility, and they felt let down by inadequate mental health services.[30 31 34 36 37 40 46–48 52 53 57 58] Due to limited hours and resources of mental health services, FRs were often the only service available to deal with MHC. Police felt they have few options when hospitalisation was impossible: doing nothing or arresting PMI for 'breach of the peace'.[32 34 35 40 54 59] A confusion regarding their roles and responsibilities was documented; many FRs believed they had a duty of care[34 36 37 47 51 52 58] while others stated they should not respond to MHC, which was shared by some PMI and family/carers.[36 40 56 58]

FRs felt unequipped to respond to MHC due to their lack of knowledge, resources and time constraints[25–27 31 34 37 40 44 45 52–54 56 57 63 64]: "*training makes it look straight forward and it's dead simple…and then you go out and it's just a different game"* (police officer).[45] Police described their past reluctance to ask PMI direct questions, thinking they would distress them, and instead asked vague questions that overwhelmed and confused PMI.[40] Carers reported that police were unprofessional and, in some cases, refused to take the PMI to the hospital.[18 24 30 32 37 48 50 54] One officer argued that families do not understand the requirements of detainment, but others described incentives and initiatives to reduce use of S136.[35 36] FRs described their mental health training as minimal, unspecific, unhelpful and not prioritised, resulting in poor knowledge and inability to manage MHC.[31 34 36 40 45 47 52 54–57] Paramedics felt isolated during MHC, lacked guidelines to support their decisions and used a trial-and-error approach.[30 31 40 54] A lack of training promotes fear, stigma and stereotypes, putting PMI at risk of excessive force and criminalisation.[24 32 45 47 55]

PMI believed FRs need training in compassion, patience, communication skills, de-escalation techniques, building rapport, asking questions and confidentiality.[24 28 34 45 52] After CIT training, FRs reported better understanding and identification of MHCs, and being equipped to ask direct questions and spend more time with PMI.[25 26 34 35 40 46 47 53] Training reduced the unpredictability of MHC and FRs felt safer, more confident and patient.[35 43 58 65 66] Training normalised mental illness and increased FR empathy by challenging stigma and stereotypes, resulting fewer injuries and arrests and more support for PMI[25 26 34 35 46 47 53 55 67 68]: *"You know, after you come out of CIT training, you understand that it's an illness that's treatable and that, you know, just normal people can suffer from a mental illness"* (police officer).[68] However, a number of FRs reported that training would be of no use without adequate mental health services.[34 46]

Interagency collaboration for crisis response

Paramedics valued police involvement because of their familiarity with the public and ability to encourage patients to go to hospital.[40 46 51] Police valued how collaboration can prevent arrests and challenge agency stereotypes.[30 40 45 46 51] PMI and carers found initiatives such as the Street Triage response friendly, effective and safe,[18 25 28 32] and police felt that it improved relations between paramedics and police, leading to better and faster response.[25 26 28 35 45] However, FRs also described onsite tensions, power struggles and arguments about who should take the PMI to hospital, and which behaviours posed a 'serious threat'.[25 31 36 40 47 55] In addition, police were frustrated at paramedics' low-level priority for PMI and long waiting times that caused distress.[38 69] Sometimes police decided not to call for an ambulance.[36] One PMI reported a lack of collaboration between agencies, and that the multi-agency response was overwhelming.[32] Police also describe how agencies rejecting PMI under the influence exacerbated mental distress and left them no choice but to arrest PMI for their own safety.[18 28 30 46 53] Police did not know who to call or what resources were available.[52] PMI believed that even a gentle response from police, without MHPs present, was irrelevant because police are not qualified.[24 31 45]

The value of personal experience

FRs believe that personal experience of mental illness is more valuable than formal training. They described how personal experience and 'on the job training' aided their responses significantly more than formal training[30 32 34 36 37 40 52 56 57]: *"I don't think there's any textbook that can teach you"* (police officer).[57] FRs described using common sense to guide their approach: *"after 22 years I get a pretty good idea of whether someone's off their… basically mentally incapacitated or not. I don't know I would probably go on a gut feeling more than anything else"* (police officer).[30] Paramedics believed responding to MHC is too complex and that they are always learning on the job.[34 36 37 40 57]

Impact of response on companions: involvement hindering versus facilitating response

Companions ignored, not informed and impact on them not recognised

Companions reported not being informed as to why there was an arrest and what will happen next.[24 28 31 40 49] They described the crisis response as intrusive, terrifying and traumatic.[18 24 30–32 40 61] They reported receiving no support after the crisis, which worsened their suffering: "*No one would ring me up and talk to me. Here I was, a mother in crisis because her son [was in] crisis"* (mother).[49] This lack of support for companions was also reported by FRs.[40] Failure to communicate with PMI/companions worsen the crises: *"If they had sat down with me instead and said 'okay, do you want to tell us what's been going on'…it would have been easier and they wouldn't have needed the handcuffs because I wouldn't have ran"* (companion).[28]

Companion involvement: hindering response or leading to better outcomes

PMI preferred an informal crisis response involving friends and family[32]; however, the interaction between FRs-PMI-companions is complex: '*The family can be very instrumental in helping…sometimes the family is actually more difficult to manage than the patient'* (paramedic).[40] During a crisis, family members felt responsible for the PMI and calling the police was a last resort.[24] FRs reported that family presence can complicate their response, as sometime there may be conflict between the PMI and family members.[32 37 40] When the presence of family prevented PMI cooperation, sometimes due to shame, paramedics separated the family: *"They just don't want friends/family knowing what they're going through"* (paramedic).[31]

However, in many instances, PMI and police described family and friends' involvement as calming and encouraging[40 47]: *"I was sort of like cajoled by my brother and my mate … they said, oh you know they wanted to take me to (the psychiatric hospital), and I said right-oh, no worries"* (PMI).[31] Police obtained information from parents about PMI, for example, whether they are aggressive or cooperative, to enable an appropriate police response[37 50]: *"When it is the first time for us with that person to be transported, the first thing we do is to contact a relative to know about what type of person he is"* (police officer).[31]

DISCUSSION

This review of the qualitative studies aimed to identify and synthesise findings from published studies on the subjective experiences of stakeholders involved in incidents/crises which involve PMI. Findings reflect the variety of experiences and complexity of responding to MHC in the community. Recognising mental illness as a legitimate condition and responding with empathy rather than force and stigmatising attitudes was valued by PMI and their companions. To achieve this, all stakeholders called for further training. FRs highlighted issues regarding the law, procedures and accountability which may constrain the response. Despite the inevitability of their involvement in these incidents, many FRs do accept they should have a role in managing mental illness in the community. Personal experience of mental illness can make a difference in the response as well as collaboration between FR services and mental health services. Finally, the role of third parties present in the interaction, such as family, friends and carers, was recognised by all stakeholders, which adds another level of complexity to these interactions.

Evident in the majority of studies was that while many FRs engaged meaningfully and empathetically to resolve crises, a significant number of interactions involved excessive force, physical restraint and stereotyping, which often humiliated and traumatised PMI and their companions.[18 22–24 27–32 34 35 37 38 40 42 45 53 54 69 70] Previous reviews[71–73] reported FRs' reasons for force, such as their duty of care, bystanders and themselves, and that PMI are likely to be resistant and this would require proportionate force. FRs suggested that using force is required to gain control and central to their profession, and dealing with MHC was not, at least officially, a central part of their role.[25 26 33 36 37 45 51 52 56 58 59 62 68 70 74–78] However, the role of FRs in managing mental ill health in the community is vital and likely to increase due the COVID-19 pandemic,[79] the subsequent economic crisis, as well as climate change, which disproportionally affects vulnerable people and can be the cause for mental illness.[80] Similarly, although interagency collaboration models where MHPs are located in police stations or police cars, can improve response,[18] most of these models are not evaluated, and high costs, logistics and limited access to local mental health services make such interventions difficult to implement.[13] Lack of understanding and inadequate policies and procedures create a somewhat understandable confusion for FRs as well as fear that leads to the criminalisation of PMI.

Issues of stigmatisation and disregarding mental illness as a legitimate health condition were also revealed in the studies.[17 22 24 26 29 34 36 37 45–49 53 54 56 60–62 69 70 77 81] This demonstrates the difficulty of eliminating stigma, unconscious bias and the unintended consequences of attitudes. New studies[82] continue to find stigmatising views among officers. We found that although all FRs wanted to challenge stigma,[18 30 31 34 36 37 40 47 53 54 56] there was a variation in attitudes and practice. A review[83] also found diverse attitudes towards PMI among FRs, for example, more experienced paramedics had more anger towards PMI and saw them as irritating and a waste of time, whereas others found that more experienced paramedics had more empathy. This suggests, perhaps that in order to dismantle prejudices, personal experiences of FRs, PMIs and their companions need to be incorporated in education and training, as *personal* and not necessarily *more* experience can lead to a more empathetic response.

Views from all stakeholders in this review revealed a confusion over whether FRs were the appropriate service for MHC response. Many believed they were not qualified, that mental health services were responsible

and that training is futile with an inadequate health system.[34 46 69] Previous reviews[73 84] also reported that improving these interactions is irrelevant when there are no support services available, which often results in 'frequent attenders', where inadequate response in emergency and in-patient settings leads to a cycle of repeated crises. Stakeholders had conflicting views on interagency collaboration but was overall valued by FRs.[30 40 45 46 51] Although guidance suggests that police 'should expect support from' health and social care services within locally agreed timescales',[6] FRs in the majority of studies emphasised lack in resources. Both paramedics and police viewed dealing with MHC as a superfluous part of their role. Different types of training for police and paramedics could help integrate MHC response into their 'official roles' and alleviate tensions between the PMI needs versus the organisation's needs.

All stakeholders called for training to improve FRs' understanding and knowledge of MHC and to breakdown stigma and stereotypes.[25 26 34 35 46 47 53 55 67 68] FR criticism of their mental health training indicates an interest and need in improving MHC response. In line with other research,[85] we found that personal experience is valued by police officers. 'On-the-job training' was perceived by some as more important than formal training.[30 32 34 36 37 40 52 56 57] Evidence that colleagues sharing their personal experience can help understanding and response, as well as CIT training,[68 86] shows that better strategies that can help FRs are available. This highlights the importance of finding ways for FRs to share their practical knowledge and skills during training or team meetings.

Mental health crises will often take place in a person's home with others, often family, present. In line with research of parents of children with psychosis,[87] companions described the, often traumatic, impact of the FR response and a lack of inclusion and communication.[18 24–30 33–37 39–41 43–60 62–70 74–78 81 82 86 88–104] Our findings reflect that of previous studies,[105] which show that family/carers experience distress, guilt, reluctance to call FRs, fear of disproportionate use of force and relief for having FR support. From the FR perspective, the presence of companions during the crisis complicates the response, necessitating attempts to calm the PMI while acknowledging family/carers distress. FRs described both the invaluable presence of companions in terms of giving information, and how their involvement could hinder their response, for example, when the PMI does not trust or wants the companion involved. Future research should explore how FRs navigate these complex relationships and use a compassionate and constructive/beneficial approach when third parties are involved.

Strengths and limitations

This review used a rigorous methodology, including a comprehensive literature search, clearly defined inclusion criteria and independent screening and data extraction. Of the 79 included studies, 41 were published since 2015 indicating that most research on this topic is contemporary. All of the nine subthemes were consistently reported by at least 12 studies and all included studies used first-order interpretation (direct quotes from participants) strengthening the analysis. However, only studies published in English were included and the focus of the review was limited to interactions and personal experiences and did not include effectiveness studies of interventions to improve MHC response. This study did not explore specific mental health problems. Further research could investigate whether FRs' response to people with different diagnoses varies and how. Differences between countries was not systematically explored. Despite potential significant differences in policing and mental health services in the countries where included studies were conducted, analytic patterns of experiences (themes and subthemes) were found *across* different countries. However, the majority of these studies were in high-income countries and studies not reported in English were not included. Further research could explore if there is variation in the response, by country with regard to culture, or regulations.

CONCLUSION

This review demonstrates the variety of experiences and complexity of responding to an MHC and the many diverse challenges FRs face. During MHCs, FRs are responding to the individual in crisis, seeking information and dealing with distressed family/carers, who can either by helpful or obstructive in resolving the crises. Future research is required into how FRs navigate this triadic relationship in the context of an MHC. All stakeholders call for improved training and this review displays instances where training has been effective in eliminating stigma and less use of force. FRs preference of 'on-the-job' training implies the importance of FRs sharing practical knowledge and future research can investigate how to do this in the hectic settings of police and ambulance stations. The belief that FRs are not qualified to respond to MHC is somewhat valid. Training and education in first response to MCH should consider these issues as well as broader issues of legitimacy and procedural/institutional barriers.

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