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Debate: How much should nonspecialists be involved in mental health care for children and young people when resources are limited? Working with police forces to improve mental health crisis care for young people

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The last few years have seen a mental health crisis for children and young people in the UK, with more young people presenting to services at crisis point. Young people have reported that there is a general lack of support before reaching the point of crisis and police forces in the UK have seen a rise in callouts related to youth mental health problems. We provide an overview of the evidence for joint responses from police and mental health services and highlight the importance of including people with lived experience in the development of crisis services. Most of the available data relates to interventions for adults, with very few studies including children and young people. We outline a new study in the UK aiming to evaluate a joint response for young people experiencing a mental health crisis. Whilst resources for children and young people's crisis services remain limited, joint response models with police forces can help to provide much needed intervention.

Keywords: Crisis; young people; police; co-response

The last few years have seen a mental health crisis for children and young people in the UK exacerbated by the effect of the COVID-19 pandemic, which put significant pressure on an already overwhelmed healthcare system (Health and Social Care Committee, 2022). Due to delays for young people trying to access mental health care (MacDonald, Fainman-Adelman, Anderson, & Iyer, 2018), more young people are presenting to services at crisis point (Edwards et al., 2024). Mental health services for children and young people can be difficult to access at times of crisis, due to different thresholds of eligibility, difficulty in knowing who to contact, financial and logistical implications of travelling to access services, and a lack of collaboration between different services (Edwards et al., 2024). Young people have reported that there is a general lack of support before reaching the point of crisis (Edwards et al., 2024). Police data indicates a rise in contacts relating to youth mental health problems and police forces have described feeling that they are left 'picking up the pieces' of a 'broken' mental health system (HMICFRS, 2018). As with all those in public office, the police do have a duty of care to the public and there are aspects of crisis care that often require police support, such as powers to detain someone in public when there are urgent concerns about their mental health, powers to enter someone's property without their consent or specialist skills to conduct a missing person's search.

Whilst there are accounts of the police providing a supportive response to people in crisis, police officers can feel that they do not have the required skills and training when supporting young people experiencing mental health crises. Responding to mental health crises also diverts police time from routine police duties, which the public consider priorities for police forces (HMICFRS, 2018). In recent years, police involvement in mental health crises has increased, prompting efforts in the UK to improve crisis response and reduce reliance on police detention.

Globally, a variety of co-response models have been trialled in which mental health practitioners work alongside police to respond to mental health crises, provide training to police forces and/or facilitate access to mental health records and onward referrals. In Australia and New Zealand, a co-response model was developed to include a police officer, paramedic and mental health clinician who could respond jointly to crisis calls made to the police or ambulance service for people of all ages. An additional police officer and mental health clinician remained at the base to search records, provide advice and make referrals. This was found to reduce the use of emergency departments at the time of the call out and within the subsequent month (Every-Palmer, Kim, Cloutman, & Kuehl, 2023).

In Canada, a co-response model was designed to involve training police officers in how to recognise and respond to crisis presentations. Additional training was also given to

psychosocial workers who worked within a division of the police department so that they could carry out a suicide risk assessment in liaison with the police officer responding to the call out. The psychosocial worker would then advise on options for management, carry out follow up, transport the service user to hospital and/or make a referral to a community service. This model was used for adults and young people and resulted in a reduction in use of force by the police, an increase in referrals to community services and an increase in the number of service users who remained at home with a friend or family member (Blais & Brisebois, 2021).

To date, observational studies constitute the majority of the evidence-base, which lack control groups and the results have been mixed. Most of the available data relates to interventions for adults in Australia, New Zealand, Canada, and the United States, with very few studies including children and young people or a broader geographical perspective. There is a need for more robust research into the impact of joint response models on patient experience and treatment outcomes. Where joint responses between UK National Health Service practitioners and police officers are available, service users generally report positive experiences of services, citing effective communication, compassion and knowledge of mental health problems as benefits of co-response models (Marcus & Stergiopoulos, 2022).

Including people with lived experience in research and the development of understanding around joint response models for mental health crises is crucial. Individuals who have navigated mental health crises offer invaluable insights into the real-world barriers and challenges within existing systems. Police detention on the grounds of mental health concerns can leave service users feeling humiliated, traumatised and unsafe in their own homes (Centre for Mental Health, 2014). There is disparity in the experiences of police detention between people of different ethnicities, with children from minority ethnic groups overrepresented in police stop and search rates and black service users more commonly reporting use of force by the police (Centre for Mental Health, 2014; Ministry of Justice, 2020). Broader perspectives of those with lived experience can ensure that interventions are not only theoretically sound, but also practically relevant and sensitive to the nuanced needs of those seeking support.

One of the challenges for researchers working in the field of joint responses for children and young people is that the intervention delivery needs to be immediate and nondiscriminatory (i.e. uncontrolled and unrandomised). A new study employing realist methods aims to pragmatically address some of these challenges to robustly evaluate a joint response for young people aged 18-years and under experiencing a mental health crisis. The research study explores the feasibility and effectiveness of a collaborative initiative where a police officer and a mental health practitioner jointly respond to emergency calls involving young people in crisis (www.fundingawards.nihr.ac.uk/award/NIHR158509). The evaluation will not only focus on the immediate impacts of the mental health joint response crisis intervention but also on its long-term sustainability and potential for broader implementation.

In conclusion, resources are limited in crisis services for children and young people, which can leave young people without the care they need and place additional strain on police services. Co-response models show promise in using non-mental health professionals to address the gap in services, but further evaluation is needed, particularly for children and young people.

Conflict of interest

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Ethical approval

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