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Institute for  
Health and Care  
Improvement

# Right Care Right Person in Humber

Findings from small scale  
evaluation

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## Background

Right Care Right Person (RCRP) was introduced by Humberside Police in 2020. It is a phased programme of partnership working and the withdrawal of the police from certain types of demand, aiming to ensure that vulnerable people are given the right care and support when they are in crisis. It is supported by the National Partnership Agreement 2023 between the Home Office and NHS England with significant guidance to police forces on its delivery via the College of Policing Right Care Right Person Toolkit. When there is immediate risk to life or a risk of serious harm, police will still attend. However, when agencies call police about issues which don't meet the threshold for police intervention, they will signpost them to the most appropriate service.

Humber Teaching NHS Foundation Trust (HTFT) delivers mental health services in Hull and the East Riding of Yorkshire. Robust relationships existed between health and social care providers and the police in the Humber region, which made the transition to RCRP possible. The police have reported savings in terms of officer hours saved, yet the impact upon and experience from a health and social care and service user perspective has yet to be evaluated.

HTFT wanted to work with an academic partner to undertake an evaluation of the impact across the whole system, including on the safety of staff and people in crisis and effects on all agencies involved. As a starting point, York St John university has undertaken a small scale evaluation of Right Care Right Person in Humber and this report summarises the findings from this.

## Methodology

We carried out 16 virtual interviews to obtain initial feedback from professionals within the whole system. The professionals interviewed were two each of:

- Approved Mental Health Professionals.
- Community Mental Health practitioners.
- Crisis Mental Health practitioners.
- Mental health social workers.
- Paramedics.
- Police officers.
- Staff on mental health inpatient wards.
- Staff in the ED department.

The interviews were carried out virtually, recorded and transcribed. The transcripts were then analysed thematically.

It is hoped that the findings from this small scale evaluation will form part of a research grant application to measure the full impact of Right Care Right Person in Humber.

## Headline findings

- The general consensus across all professional roles is that Right Care Right Person is the right approach for those with mental health issues, particularly as it is patient-focused.
- However, the Right Care Right Person policy does not always work as it should or is not implemented as intended, and its translation into practice has created a number of tensions and inconsistencies within and across services.
- There appears to be a mismatch between interviewees' perception or understanding of the policy and practice and what is actually in place.
- The majority of interviewees felt that the policy (or the lack of a police presence due to its interpretation or implementation) has sometimes placed staff and patients at risk. Different agencies have different interpretations of risk.
- Responses by the police were inconsistent, often dependent on the officers involved and the police can now be reluctant to or refuse to intervene.
- All agencies highlighted an overall increase in workloads across the whole system which have led to pressures in resourcing, including on the NHS generally - this was often linked to the increase in the mental health workload specifically.
- Mental health professionals have seen an increase in the use of Section 136 or bringing patients into 136 suites by police, including many that were perceived as inappropriate referrals by mental health staff.
- Transporting patients to the 136 suites by private ambulance has been a positive change but may still tie up both police and paramedic resources.
- All of the non-mental health professionals said that sometimes they had difficulty in obtaining support from mental health services.
- Health and care agencies are not trained and/or equipped to deal with difficult or violent situations, with several interviewees stating that only the police have a legal framework to act in such situations.
- Almost all of the interviewees said that there are situations that still require a police presence, but many felt there is a lack of trust by the police in the judgement of mental health staff as to when they need to attend a situation or incident.
- Key barriers to partnership working are a lack of dialogue and communication between different services, a lack of intelligence sharing, differing views on each agency's responsibilities under the policy, differences of opinion between front line staff and managers, and processes and bureaucracy inhibiting decision taking.
- Some police officers do not see mental health as their responsibility or job, and the police can lack understanding of or knowledge about mental health issues or resources, with little training received on these.
- The main improvements suggested were training to build understanding of mental health issues, legal powers and Right Care Right Person – for all agencies - improving co-operation between agencies and/or better communication.

## Discussion

The findings of this study demonstrate that while Right Care Right Person is widely regarded as the right approach in principle, its translation into practice has created a number of tensions and inconsistencies across services. Professionals from health, ambulance and policing all acknowledged the importance of ensuring that individuals in mental health crisis receive a health-based, compassionate response rather than a criminalising one. However, the evidence suggests that the way Right Care Right Person has been implemented has often left professionals feeling under-supported, exposed to risk, and at times working in silos rather than in partnership.

One of the strongest messages across professional groups was the need for improved training and shared understanding. Police officers were frequently described as having limited knowledge of mental health, the role of Approved Mental Health Professionals (AMHPs), and the requirements of the Mental Health Act, while health and ambulance staff acknowledged their own lack of awareness of police powers and constraints. The absence of consistent training has contributed to confusion, variable interpretations of the policy, and at times open conflict about who should take responsibility in particular situations. Joint training programmes were repeatedly proposed as a way to develop a shared language, clarify roles, and foster mutual respect between agencies. Without such training, Right Care Right Person risks being used as a barrier to partnership rather than a framework for it.

The quality of relationships between services was another critical theme. Many professionals spoke of inconsistency in police responses, with helpful and collaborative officers encountered alongside others who were perceived as dismissive or unwilling to intervene. This variability has eroded trust and, in some cases, created a sense of adversarial working. Participants emphasised that better communication, regular joint meetings, and designated liaison roles would be valuable steps towards rebuilding relationships and ensuring decisions are made transparently. A culture of proactive dialogue, rather than bureaucratic exchanges or last-minute disputes over responsibility, was seen as key to making Right Care Right Person work in practice.

Concerns around safety featured prominently in the accounts of health and ambulance staff, many of whom felt at risk when police declined to attend until after harm had occurred. This left staff feeling undervalued and less protected than their police counterparts. Professionals stressed that staff and patient safety must be prioritised equally, and that the presence of police remains essential in circumstances where there is threat to life, the presence of weapons, or significant risk of aggression. While the policy aims to reduce inappropriate police involvement, participants were clear that rigid adherence can create dangerous gaps in support, undermining both the spirit and the safety aims of Right Care Right Person.

More broadly, the challenges described were compounded by resource shortages and system-wide pressures. All agencies reported operating under significant strain, with demand

outstripping capacity and mental health crises increasing in frequency and complexity. Participants emphasised that without additional investment in staffing and crisis alternatives, RCRP places extra burdens on already overstretched services. Expanding the availability of health-based places of safety, investing in specialist crisis pathways, and exploring models such as mental health ambulances or street triage teams were all highlighted as ways of easing pressure while ensuring patients receive appropriate care.

Flexibility in how Right Care Right Person is applied also emerged as a consistent recommendation. Professionals argued that frontline staff should have more autonomy to make decisions in collaboration with colleagues on the ground, rather than having to defer to supervisors not present at the scene. This was particularly highlighted in relation to Section 136, where delays caused by remote authorisation were seen as both impractical and inconsistent with the principle of timely, needs-led care. Allowing attending officers and mental health practitioners to make decisions together would create a more responsive and pragmatic system, aligning more closely with the original aims of the policy.

Overall, the findings suggest that the principles of Right Care Right Person continue to command strong support, but that its success relies heavily on the conditions in which it is implemented. A policy designed to reduce criminalisation and ensure compassionate, health-based responses cannot be delivered effectively without investment in training, resources, communication, and collaborative infrastructure. Participants were clear that these improvements are necessary if Right Care Right Person is to fulfil its intended purpose of providing the right care, by the right person, at the right time — not only in theory, but in the realities of practice.

## Recommendations

We would suggest the following recommendations:

- Revisit the Concordat and jointly agree interpretations of risk, defining situations when police support is needed (such as threats of harm), transportation arrangements, collaboration and information sharing. The aim of this would be to improve the consistency and swiftness of decision making and building relationships and trust between all agencies.
- Continue to communicate the role of the police liaison officer to provide a focal point for other agencies to contact if they need support on a legal or police matter.
- Design joint training on Right Care Right Person and how to implement it uniformly, for all agencies including police officers, paramedics and call handlers. The communications strategy should aim to continuously improve awareness and understanding of the policy and practice.
- Improve the training for all non-mental health service professionals on understanding/ knowledge of mental health issues (including the increasing complexity and number of conditions that fall under a definition of mental health), legal powers and processes.
- Create a clearer pathway for mental health admissions or the use of Section 136, to make sure paramedics are not taking patients who are under 136 to A&E unless there is a medical reason such as an overdose or injury.
- Consider enabling front line officers to use their judgement about decisions about the use of Section 136, to reduce delays in decision-taking, or the transporting of patients to the 136 suites where this would avoid significant delays or wait times.
- Allow the police to transport patients who have gone missing from the inpatient mental health wards who are likely to be violent.
- Continuously communicate the protocol for 136 referrals, arrangements and handovers between the police and mental health services.
- Consider the provision of further Section 136/health-based places for safety within A&E.
- Consider expanding the mental health ambulance provision and creating a street triage team.

## Executive Summary

### **Right Care Right Person as a policy**

There was a general consensus across all professional roles that Right Care Right Person is the right approach for those with mental health issues, with a number reporting that when the approach works, it works very well. However, the policy does not always work as it should or is not implemented correctly.

A significant reason for Right Care Right Person being the right approach, highlighted by ten professionals, is the fact that it is patient focused. Not criminalising patients was also mentioned as being a positive impact by five professionals.

Eight interviewees felt that one positive aspect of Right Care Right Person is that the police do not need to be involved in some cases now. Five highlighted that the mental health team may have a better relationship with patients, many of whom have a poor past experience with the police or other people in authority.

Four professionals mentioned the 136 handover arrangements, and the process whereby the police can hand over responsibility for an individual to mental health staff at the 136 suite, as a positive development. This has freed up time for the police who no longer have to remain with a patient for hours, unless they need to go to the hospital for physical health needs or treatment when they still need to remain with that patient. However, one Approved Mental Health Professional highlighted the fact that sometimes the police may bring people to the 136 suites and leave them without them being under any legal framework and one police officer said that the handover can sometimes take several hours due to lack of staff or the three 136 suites being full.

Three interviewees mentioned that the introduction of Section 136/health-based places for safety was a positive, especially as one member of staff working in A&E highlighted that A&E is not the right environment for someone with a mental health issue.

### **Interpretation and implementation of Right Care Right Person**

Six mental health professionals said that staff could appreciate the logic behind the policy but that its implementation has not worked as intended: rather than being a collaboration it is often being used as an “excuse” for the police not to be involved in situations or incidents. One member of staff working on a mental health inpatient unit said that initially they had access to a police liaison officer who was a focal point for them to contact if they needed support on a legal or police matter. However, this is not the case now. Both paramedics also felt that Right Care Right Person’s implementation was not as intended and that it is not working as well as it could work.

One mental health professional had provided training for police officers and call handlers on Right Care Right Person when it was introduced. Another in the crisis team had invited newly qualified police officers to spend time with them to gain an understanding of how the team

works, but that this had since stopped. However, one (long-serving) police officer said that they had only recently had training on the policy while the other said they had had “an hour or two” of training when the policy was first introduced. Both paramedics said they had had hardly any training on Right Care Right Person.

### **Impact of Right Care Right Person on safety**

All of the mental health, health and paramedic interviewees felt that Right Care Right Person (or the lack of a police presence due to its interpretation or implementation) has sometimes placed staff at risk. This risk to staff safety was often linked to the police not providing support to staff when they needed it, with many professionals saying that the police will only attend if harm has been actually committed, rather than situations where there is a threat of harm or where other professionals are at risk. A number of these interviewees felt that they are treated differently by the police to members of the public, in terms of officers dealing with threats of harm.

All but one of the mental health and paramedic interviewees, plus both police officers also felt that Right Care Right Person (or the lack of a police presence due to its interpretation or implementation) has sometimes placed patients at risk and/or caused issues for them.

Eight interviewees highlighted that different agencies have different interpretations of risk, including differences in assessing mental capacity.

### **Other impacts of Right Care Right Person**

Six interviewees mentioned that their relationships with the police had deteriorated since the introduction of Right Care Right Person.

Six different types of professionals mentioned the impact (in terms of additional work) that the police’s withdrawal from certain situations has had on other services, especially the Ambulance Service. Two of these mental health professionals also felt that Right Care Right Person has created barriers.

Six interviewees mentioned the difference that Right Care Right Person has made in transporting people to the 136 suites or hospital, whereby they are not transported in police vehicles now but by an ambulance. Three mental health professionals felt this was a positive step, mentioning the private ambulance firm that is contracted to convey patients. However, one paramedic felt that they and an ambulance are not the right transport method for some patients (especially with the kit carried within an ambulance) and that sometimes this ties up both a police van and an ambulance since either the police have to wait with the patient for the paramedics to arrive or a police presence is needed to accompany the patient.

One police officer expressed frustration about the policy whereby they have to wait for an ambulance to transport someone to the 136 suites unless they can get permission to transport them from a senior officer.

One professional working on a mental health inpatient unit said that they have a van to pick patients up who have gone missing from the unit, which is the correct approach unless a patient is violent – however, the police are reluctant to transport them in such instances.

Interviewees were asked if they could quantify the impact of Right Care Right Person on their time and resourcing. Two mental health professionals felt that the implementation of Right Care right Person, including in situations where the police are reluctant to or refuse to attend, has directly led to a significant increase in their workload. Another said that it had a direct impact via an increase in the use of Section 136. Both Crisis Mental Health Professionals said that the policy has increased their workload, with one saying it increased their time demands by 50%.

Two mental health professionals have seen a substantial increase in demand on mental health services, and an increase in the use of Section 136, but were not able to attribute this specifically to the Right Care Right Person policy.

Three mental health professionals said that Right Care, Right Person has not saved them any time and that it entailed more work when requiring a police presence or working without police support.

### **System wide pressures**

Nine professionals across all agencies highlighted an overall increase in workloads across the whole system which have led to pressures in resourcing, including on the NHS generally. This was also often linked to the increase in the mental health workload specifically, with five professionals commenting on this. Five interviewees specifically mentioned a lack of staff in all agencies, whereby everyone is overstretched.

Nine professionals mentioned that health and care agencies are not trained and/or equipped to deal with difficult or violent situations. Both police officers interviewed highlighted that police officers are not trained in mental health issues.

Seven interviewees said that only the police have a legal framework to act in situations where there is violence, a risk of violence, or where concerns about someone's welfare requires legal entry into their house. One Crisis Mental Health Professional also highlighted that they have no legal powers to stop someone leaving the inpatient unit if they are in the reception area or another public place.

All of the non-mental health professionals said that sometimes they had difficulty in obtaining support from mental health services.

### **Partnership working**

One mental health professional thought that the “building blocks” are there to facilitate better joint working. Two mental health professionals appreciated having inter-agency meetings in terms of collaboration and information sharing on patients with mental health issues. However, seven interviewees (six mental health professionals and one police officer) highlighted a lack of dialogue and communication between different services and agencies as a barrier to

partnership working. Five of these interviewees mentioned a lack of intelligence sharing as a barrier.

Another barrier, highlighted by six interviewees, is that different agencies have different views on their responsibilities under Right Care Right Person or that even within a service there can be differences of opinion between front line staff and managers. Eight interviewees felt that sometimes processes and bureaucracy inhibit being able to take decisions or take them swiftly.

Eleven interviewees said that their experiences of a response by the Police were inconsistent, often dependent on the officers involved in an incident. Ten professionals said that the police can now be reluctant to or refuse to intervene, with some linking this change to the introduction of Right Care Right Person. Both paramedics felt that Right Care Right Person should not be used as an excuse not to deal with a situation. Three mental health staff interviewed said that the police require a warrant to support mental health staff in risky situations.

Seven interviewees said that they felt that some police officers do not see mental health as their responsibility or job, which was often linked to why they would not intervene. Nine professionals felt that the police lack understanding of or knowledge about mental health issues or resources, with some linking this to a lack of training. One Crisis Mental Health Professional highlighted the increasing complexity and number of conditions that fall under a definition of mental health, with a growing number of people with personality disorder or complex emotional needs that is harder to identify than schizophrenia, psychosis, depression and suicide.

Almost all of the interviewees (13) said that there are situations that still require a police presence. Five interviewees pointed out that they only call the police out if they are needed, and that the police should trust in their judgement. However, ten felt that there is a lack of trust by the police in the judgement of mental health staff as to when they need to attend a situation or incident. Six mental health professionals said that the police do not contact Mental Health Services to discuss cases. Five mental health professionals felt that their relationship with the police is not always good or that it has deteriorated.

### **Use of Section 136 powers**

Interviewees said that they have seen an increase in the use of Section 136 or bringing patients into 136 suites by police, including many that are inappropriate referrals. One police officer felt that mental health staff did not always appreciate their reasoning and that they had used their professional judgement to assess someone and determine that they needed to be brought in under Section 136.

One paramedic, whose team had recently been discussing the potential national move to give 136 powers to certain clinical staff<sup>1</sup>, were concerned that 136 typically involves detention as well as assessing capacity: they may be able to assess capacity but they are not in a position or trained to restrain someone.

### **Improvements suggested**

All interviewees were able to suggest improvements, with the most significant suggestion being around training to build understanding of mental health issues, legal powers and Right Care Right Person: thirteen suggested training for police while twelve suggested training for other agencies. Twelve interviewees suggested improving co-operation between agencies and/or better communication. Five professionals suggested that more resourcing is required.

Four interviewees felt that the police officers seeing the patients on scene should be able to make decisions about the use of Section 136. One member of staff in A&E suggested having a clearer pathway for mental health admissions or the use of Section 136, to make sure ambulance crews are not taking patients who are under 136 to A&E unless there is a medical reason such as an overdose or injury.

Three interviewees (both Crisis Mental Health Professionals and one police officer) suggested having a mental health ambulance or street triage team. Two interviewees suggested having more caring/compassionate behaviours, one that the policy should be informed by frontline staff and one suggested a less rigid interpretation of Right Care Right Person.

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<sup>1</sup> There have been discussions nationally about potentially passing legislation to give healthcare professionals the power to detain someone under Section 136 of the Mental Health Act. Major health and social care organisations have rejected the proposals, citing concerns about dangerous consequences and the potential to increase risk to patients and others. These organisations, including the Royal College of Psychiatrists (RCPsych) and the British Medical Association (BMA), argue that police powers are needed for Section 136 and that transferring them to clinicians requires proper consultation and planning to avoid adverse outcomes

# Detailed Findings

## 1. Right Care Right Person as a policy

There was a general consensus across all professional roles that Right Care Right Person is the right approach for those with mental health issues.

*“The principles I really do agree with. I know that it was countrywide and the idea is to make sure that people in a mental health crisis are receiving an appropriate, I suppose, health-based response. It's brilliant because we do not want people in crisis as far as it's humanly possible to be attended to by the police.” (Community Mental Health Professional)*

*“I think ensuring that individuals are seen by the right professionals rather than police who potentially aren't trained with mental health, I think there are certainly benefits to that.” (Staff on mental health inpatient ward)*

*“And because of the Right Care, Right Person, I can deem that person and say, look, even though I'm going to 136 them, they need the right care, which is an ambulance. They need the right care as in mental health suite. And that's where I think sometimes people don't understand that officers on the ground are making a split decision about something that they're not 100% sure of. They're interested in the care of that person. So Right care and the right care for the right person, that's critical for us.” (Police officer)*

A number of professionals reported that when the approach works, it works very well.

*“I think when it works, it works and you probably don't think about it, as in it's the Right Care, Right Person. Because actually that would just be our role as a crisis service. That's what we should be doing. Do you know what I mean?” (Community Mental Health Professional)*

*“There are times where it does work well... where the Right Care, Right Person comes in to protect them [police] because they don't need to go to that job. And it protects us in some ways because if we see something on the stack going, ‘no, that's nothing to do with us’. Like it's a social job, it needs to go to social services, then we can sort of go: ‘actually no, we're not going because it doesn't sound like it's an ambulance service role’. (Paramedic)*

*“And it does really work, especially when obviously for example, the example I gave you when the ambulance turned up and they took over, that was a hundred percent a really good example of when Right Care, Right Person really, really did work. And it was really beneficial because then not only did the community have two more police officers leave that address back ready to go to another job ready to be for an emergency or anyone*

*that needed help, but then you also had that lady getting the help she needed from the right people... Right Care, Right Person is really, really good in the terms of it is getting that person who needs that help. The right person who is equipped, skilled-wise to deal with that. When it works, it works really well.” (Police officer)*

However, Right Care Right Person does not always work as it should or is not implemented correctly.

*“That was a classic example of how Right Care, Right Person should work because they were there for the criminal activity. So they were the right people. We were the right people because we were there for his mental health and we came together and we did a piece of joint work. That's how I envisaged it would work. Unfortunately, that's not the norm. They're the one-offs. But when it works, it works really well.” (Approved Mental Health Professional)*

A significant reason for Right Care Right Person being the right approach, highlighted by ten professionals, is the fact that it is patient focused.

*“I think it's important this drive towards not criminalising our patients. And particularly when the absconders are very unwell, which is what's making them be acting whatever way they're behaving in, I think it is important not to go straight to that. It feels a bit heavy handed, because I'm a nurse, the police is heavy handed to me. So it feels more patient-centred for us to have Right Care, Right Person. (Staff on mental health inpatient ward)*

Not criminalising patients was also mentioned as being a positive impact by five professionals.

*“If possible for the patient it would be best if they're not detained by the police. I imagine it's not ideal for them. How it makes them feel that they're the criminal in this. In some situations you can't help it because for their safety they have to. We've had many times when there's been six officers having to pin people down because they're in the process of wanting to do something to harm themselves. In those situations it is for their safety.” (staff in A&E)*

*“I think that's so vitally important because it's not good to criminalise people. And people are already going through an absolutely terrible time, when they come to that point in their lives then they should be receiving a very compassionate response.” (Community Mental Health Professional)*

Eight interviewees felt that one positive aspect of Right Care Right Person is that the police do not need to be involved in some cases now.

*“Sometimes you go to a job and the police aren't needed. The police are there because for another reason and they don't need to be there. So, in some ways, yes it works, because it takes that strain off the police.” (Paramedic)*

*“Sometimes it works really well in the sense of police don't even need to go to the job where we can't help anywhere.” (Police officer)*

Five professionals highlighted that the mental health team may have a better relationship with patients, many of whom have a poor past experience with the police or other people in authority.

*“Just being four officers in a uniform can be threatening, especially if somebody's got a history with police or people in authority.” (Approved Mental Health Professional)*

Four professionals mentioned the 136 handover arrangements, and the process where the police can hand over responsibility for an individual to mental health staff at the 136 suite, as a positive development. This has freed up time for the police who no longer have to remain with a patient for hours, unless they need to go to the hospital for physical health needs or treatment when they still need to remain with that patient.

*“The handover period, which is what we were told it was designed for, is absolutely so much better and for the right reasons. Police should be able to bring somebody to a place of safety, do a joint risk assessment, that's important, and then go because it's our business.” (Approved Mental Health Professional)*

However, one Approved Mental Health Professional also highlighted the fact that sometimes the police may bring people to the 136 suites and leave them without them being under any legal framework and one police officer said that the handover can sometimes take several hours due to lack of staff or the three 136 suites being full.

*“I've been in there for hours one time waiting for the AMHP to come down and take the details off us or anyone just to come take details off us so we can be relieved and leave. Because obviously at that point we're passing that individual over to them saying this is now your responsibility.” (Police officer)*

Three interviewees mentioned that the introduction of Section 136/health-based places for safety was a positive, especially as one member of staff working in A&E highlighted that A&E is not the right environment for someone with a mental health issue.

*“I thought the 136 stuff that came before it was really, really important. And having more health based places as a safety. That's being managed to be rolled out and implemented really, really well, and it feels safe.” (Community Mental Health Professional)*

*“There's a room specifically for mental health. The police quite often now will ask for that specific room. They won't just place them in the waiting room. They'll ask if that room's free. If there is anywhere they can go quiet and sit quietly. Because they will obviously won't be staying with them.” (Staff in A&E)*

## **2. Interpretation and implementation of Right Care Right Person**

Nine interviewees had comments to make about the implementation of Right Care Right Person.

Six mental health professionals said that staff could appreciate the logic behind the policy but that its implementation has not worked as intended: rather than being a collaboration it is often being used as an “excuse” for the police not to be involved in situations or incidents.

*“I think the idea behind Right Care Right Person and the sell between Right Care Right Person was this is a collaborative project between health and police looking at areas that need us working collaboratively. It was never about: this is an area where we just don't need police anymore. I just think it needs a lot more work..” (Approved Mental Health Professional)*

*“I think the principles and the values behind it and the ideas, the concept is really, really good. However, my experience of it is kind of a feeling of total isolation and lack of support from the police at times when I have really, really needed it.” (Community Mental Health Professional)*

One member of staff in the mental health inpatient unit said that initially they were told that there would be a police liaison officer who would be a focal point for them to contact if they needed support on a legal or police matter. However, this is not the case now.

Both paramedics also felt that Right Care Right Person’s implementation was not as intended and that it is not working as well as it could work.

*“I think theory of it is quite good. But the implementation of it is not been brilliant because it's now given the police a reason not to go to things.” (Paramedic)*

One mental health professional had provided training for police officers and call handlers on Right Care Right Person when it was introduced. Another in the crisis team had invited newly qualified police officers to spend time with them to gain an understanding of how the team works, but that this had since stopped. However, one (long-serving) police officer said that they had only recently had training on the policy while the other said they had had “an hour or two” of training when the policy was first introduced. Both paramedics said they had had hardly any training on Right Care Right Person.

In terms of interviewees' knowledge and understanding of Right Care Right Person, six mental health professionals and one paramedic felt that they knew the policy fairly well, with one mentioning the Care Concordat also. One mental health professional said that they were told how the policy would work when it was introduced, without any involvement from front line staff, but had only come to understand it better more recently. Another mental health professional felt that there was a lack of understanding on how to respond by both their service and the police service when the policy was introduced. Both police officers had heard about the policy but only really became aware of it around three years ago when it started to be regularly mentioned.

Four interviewees highlighted issues arising from blurred or unclear responsibilities between agencies while three mentioned issues arising from an inconsistent interpretation of Right Care Right Person.

*"A lot of arguing taking place now about who is the Right Person for the Right Care at that time. Not everyone fits into a box. For example, many patients who come into contact with the police maybe in a precarious situation, may need medical attention, may need to be on a 136 or not... So it all gets very grey." (Crisis Mental Health Professional)*

*"The difficulty is, we are getting asked more and more and it's becoming more complex, the jobs that we go to. And it's the side of trying to establish what kind of mental health problems they're having, what requirements they need, what help I can provide and what other agencies can provide is becoming more and more strained for officers like myself when I attend. Because I don't have the experience with mental health and deeming somebody if they are or they aren't." (Police officer)*

*"I think sometimes you get this impression that if - and it probably again will depend on who the duty sergeant is - but it's almost like if it's mental health, well, we're not doing it... Because that might be somebody who's heard a little bit about Right Care, Right Person, and it's like we don't get involved with mental health work. But then other people understand that they do, the police do have actual duties under the Mental Health Act and they can't walk away from them." (Mental Health Social Worker)*

### 3. Impact of Right Care Right Person on safety

All of the mental health, health and paramedic interviewees felt that Right Care Right Person (or the lack of a police presence due to its interpretation or implementation) has sometimes placed staff at risk.

*“And I've really felt a lack of support from my policing colleagues and almost like Right Care, Right Person is being used as an excuse not to support myself and more importantly service users when we've really needed it. And I've certainly felt very at risk at times.” (Community Mental Health Professional)*

*“It's happening within our building, usually obviously in our reception area which is a public place that the Right Care, Right Person is then quoted to us, even though we are explaining that actually there is a risk to, whether it be the patient or to staff.” (Crisis Mental Health Professional)*

*“The impact on staff safety is that we've had patients assaulting staff regularly. Patients who have told staff, you can't do anything to me. The police aren't going to talk to me, the police won't do anything about this, and then to be proven, right, I guess. And now you have staff who are either leaving their jobs because of this or not reporting incidents, which could later lead to greater assaults because I think patients or people admitted into hospital who feel that they are able to assault people and not have any comeuppance from it or any support regarding that are far more likely to do it again in the community.” (Staff on mental health inpatient ward)*

This risk to staff safety was often linked to the police not providing support to staff when they needed it, with many professionals saying that the police will only attend if harm has been actually committed, rather than situations where there is a threat of harm or where other professionals are at risk.

*“There was two services ([Ambulance and Mental Health] ringing asking for help. And it was like, ‘Well, have the paramedics been assaulted? Not yet. Ring me when they have.’” (Crisis Mental Health Professional)*

*“I've heard a lot of crews go in, ‘Oh, we're going to a mental health patient and it says they've got a knife, we've rang the police and they're not coming’... So, the police technically should go because there's threats of a weapon, but then they're not going because, ‘Oh well you can just go and see and if you need us just ring us back.’ (Paramedic)*

*“I had to attend a patient with a history of violence and aggression who lived in a flat with very, very steep stairs, very narrow stairs that went directly into his flat. He was telling us directly that if I tried to go up the stairs, he was going to throw a fridge*

*freezer down the stairs at me.... There was certainly a risk. To us it was a predefined risk. And I was told by the police that they would not attend. I had to go in and something had to happen before they would support me.” (Community Mental Health Professional)*

A number of these interviewees felt that they are treated differently by the police to members of the public, in terms of officers dealing with threats of harm.

*“It's like [the police] don't take responsibility anymore for public safety or the safety of professionals, I suppose which concerns me that I'm seen to be different. And if it was you and you wanting the police because you were feeling that you were at risk of harm, they'd would respond, wouldn't they? Because I'm a mental health professional and it's in the course of my duties, then I'd sometimes get a different response and that concerns me that they're able to make deliberations really.” (Mental Health Social Worker)*

*“I'm not just an AMHP, I'm a mother. Do you know what I mean? I'm a mother, I'm a wife, I've got other roles. I am not just an AMHP. I'm not there to be assaulted. Yet, if they bring somebody into the 136 suite that assaults a police officer it's automatically dealt with. They see it as different. They see us as different.” (Approved Mental Health Professional)*

All but one of the mental health and paramedic interviewees, plus both police officers also felt that Right Care Right Person (or the lack of a police presence due to its interpretation or implementation) has sometimes placed patients at risk and/or caused issues for them.

*“[The police] have just literally left us to it and that's caused significant issues for AMHPs and for vulnerable people that we are engaged in.” (Mental Health Social Worker)*

*“For a mental health act assessment, we know that there's some level of significant risk. Usually it's harm to self, often it's harm to others, but even if it's like self-neglect or even just the terrible impact of experiencing the awful things that some of our service users have to experience on their own without support in an unsafe environment, I think Right Care, Right Person has really negatively impacted that because we're not able to respond as we once were.” (Community Mental Health Professional)*

*“My colleagues had raised it with the police around that there was risk to one baby, it was felt and two staff. And that actually we were in a position where something needed to happen to safeguard baby because we were running out of options. And again, refused to attend even though there was a risk to staff and baby deeming that our*

*staff, further staff should go out to the visit, to check that I was okay.” (Crisis Mental Health Professional)*

*“He was trying to physically run into traffic. So the amount of time it took for us to get somebody to actually respond was just ridiculous. Somebody could or he could have been seriously hurt because he just didn't have a clue what was happening... And I just think we shouldn't have been in that position.” (Crisis Mental Health Professional)*

*“There has been times when there's been questionable decisions made, and sometimes I've not agreed with it. Sometimes it's worked, sometimes it hasn't. And that individual has suffered further down the line because of the lack of police action. But that's all been documented.” (Police officer)*

Eight interviewees highlighted that different agencies have different interpretations of risk, including differences in assessing mental capacity.

*“I have a personal experience a bit in terms of somebody on my caseload where they was presenting very different. However other parts of the services didn't necessarily see the subtle differences and then dismissed the risks and we felt that we know this person really well.” (Community Mental Health Professional)*

*“There are other times when regular attenders, frequent attenders challenge these decision-making processes where these two policies touch, for example, the biggest question tends to be around the use of mental capacity. So one of the first questions that pops into the surface is about assessing someone's mental capacity. And it's difficult because we can't assess a person capacity if we're not there.” (Crisis Mental Health Professional)*

*“One of the incidents was she had self-harmed and there was part of her tendon was hanging out. Now, as far as I was concerned, I know that that they were saying, ‘No, she's not in mental health crisis’, but as an officer that's on the ground there with her, and she's telling me she wants to take her life as she has self-harmed to the point where I would deem as not a normal, rational person... So when you are trying to explain this to them, they're saying, ‘Yes, but she's not under mental health crisis. You need to just take her to hospital.’ That's not my call.” (Police officer)*

#### 4. Other impacts of Right Care Right Person

Six interviewees mentioned that their relationships with the police had deteriorated since the introduction of Right Care Right Person.

*I think relationally in terms of the relationship we have with police, I think it's deteriorated. I think now it feels almost like disconnect. So it's a shame it happened, but I feel it's the significance of this Right Care, Right Person approach has at times placed people at risk. (Mental Health Social Worker)*

*"The other thing that this is about is for anything to work in our job in this sector, it's about relationships. And I think this has further damaged relationships between ourselves and the police." (Community Mental Health Professional)*

*"I'll go into the crew room or maybe at least once, maybe twice a shift I will hear somebody moaning about the police and how they didn't do this or how they didn't do that. And it is quite weird and I try and keep my mouth shut but I find quite strange because we all work for the same thing. We're all trying to do the same thing. We work for the emergency services, we should trust each other. And I think Right Care, Right Person has created a mistrust between services." (Paramedic)*

Six different types of professionals mentioned the impact (in terms of additional work) that the police's withdrawal from certain situations has had on other services, especially the Ambulance Service.

*"Ambulance services, they're massively impacted now. They're getting sent out to a lot of what I guess the police would get sent out to with no powers for anything." (Approved Mental Health Professional)*

*"My understanding now is that the police don't do the welfare checks. If there's a concern for safety or if we have concerns for safety and we've done cold calls and been to the properties, it doesn't sit with police now, it sits with an ambulance crew. So ambulance get deployed rather than police as it used to be." (Crisis Mental Health Professional)*

*"I know we still have a good bond, but you can see there is frustrations between services that we're overlapping on work that we probably shouldn't be doing just because they've now been told... there's 50 jobs on the stack and I'm now here just taxing someone two minutes down the road because [the police] can't." (Paramedic)*

*"[Without a 136 detention] we have to get security involved, which on night-time we only have, two securities for the whole hospital. So once we've taken them, there's nobody to help if something happens in minors or somewhere else. We can have the security of night sitting with a patient, but that takes security from elsewhere so it can affect the rest of the hospital." (Staff in A&E)*

Two of these mental health professionals also felt that Right Care Right Person has created barriers.

*“I think when we spoke about it in depth in the beginning, it made sense. It did make sense. There was a lot of things we were probably heavily relying on police for because we were under-resourced in mental health services. And ambulance, I think heavily rely on police as well. So, I got the purpose of it where to create some clear boundaries, but I think it's just built bigger walls from getting any access to police most times.”*  
(Approved Mental Health Professional)

*“Obviously a huge part of why this was brought in was to reduce police hours being spent on these sorts of things. But actually that obviously creates a need in another area. So I don't know either if there's been allocation of funding for that. I haven't seen a huge increase in spending from a mental health perspective to make up for that.”*  
(Community Mental Health Professional)

Six interviewees mentioned the difference that Right Care Right Person has made in transporting people to the 136 suites or hospital, whereby they are not transported in police vehicles now but by an ambulance. Three mental health professionals felt this was a positive step, mentioning the private ambulance firm that is contracted to convey patients. However, one paramedic felt that they and an ambulance are not the right transport method for some patients (especially with the kit carried within an ambulance) and that sometimes this ties up both a police van and an ambulance since either the police have to wait with the patient for the paramedics to arrive or a police presence is needed to accompany the patient.

*“I think Right Care, Right Person has probably led to better conveyance of people to hospital... they're taken in secure vehicles, or secure mini buses. And with I suppose staff who are more trained in terms of some holds and things like that. Whereas a couple of paramedics aren't necessarily the right people to be in charge of that.”* (Mental Health Social Worker)

*“Police car follows you all the way down to Miranda House. They get there, the same coppers all get out and they take him into the Miranda House unit. We go in as well. We sign over to the nursing staff and say, ‘Look, the coppers are going to sit with him because it's still a 136, we are going to leave’. Apart from being a glorified taxi, there's no need for us to be there. We don't medically check them, because nine times out of 10, they're not there for a medical reason, they've just been detained. A lot of the time, we turn up, it's just transport. That's all we're there for.”* (Paramedic)

One police officer expressed frustration about the policy whereby they have to wait for an ambulance to transport someone to the 136 suites unless they can get permission to transport them from a senior officer.

*"I've had to wait time of six hours before and I've had someone in the back of my car screaming in middle of crisis who I've just 136'd. So, then it got a case of we had to wait 30 minutes, then we've got to ring a supervisor and ask for permission for us to transport that individual to Miranda House, which we ended up doing." (Police officer)*

One professional working in the mental health inpatient unit said that they have a van to pick patients up who have gone missing from the unit, which is the correct approach unless a patient is violent – however, the police are reluctant to transport them in these instances.

*"The police's argument is Right Care, Right Person, you are here and you should be taking them back to the unit because they're your responsibility. However, for us, we're two healthcare staff who have to drive the vehicle for one, and all I can do is ask him to put his seatbelt on. And if he tells me no and he's violent towards me, I don't have any of the ground or rights when I'm in the community... it's good that the policy's in place because it's better for the patient, for us to be retrieving them, but when the risk is too high, it becomes dangerous and it feels like that policy can be used against us." (Staff on mental health inpatient unit)*

Interviewees were asked if they could quantify the impact of Right Care Right Person on their time and resourcing. Two mental health professionals felt that the implementation of Right Care right Person, including in situations where the police are reluctant to or refuse to attend, has directly led to a significant increase in their workload. Another said that it had a direct impact via an increase in the use of Section 136. Both Crisis Mental Health Professionals said that the policy has increased their workload, with one saying it increased their time demands by 50%.

*"All this discussion taking place in police vans on bridges, in situations, using time, waiting on phones and police getting frustrated with us and was getting frustrated with the police. And I think to come full cycle, even just yesterday, the 136 continually in use staffing all the time down there, alarms constantly going off, constantly pulling on people away from the phones. Because we're all downstairs having to deal with somebody in reception." (Crisis Mental Health Professional)*

Two mental health professionals have seen a substantial increase in demand on mental health services, and an increase in the use of Section 136, but were not able to attribute this specifically to the Right Care Right Person policy.

Three mental health professionals said that Right Care, Right Person has not saved them any time and that it entailed more work when requiring a police presence or working without police support.

*"If you do need a police response, it could even take it to the next day to be able to do an assessment because of the extra things that you need to put together and things around ambulances, etc." (Approved Mental Health Professional)*

## 5. System wide pressures

Nine professionals across all agencies highlighted an overall increase in workloads across the whole system which have led to pressures in resourcing, including on the NHS generally.

*“I think putting the onus back onto mental health services, I think you've got the usual negatives of anything like that. You've got overstretched services, people in crisis, not necessarily receiving support in a timely manner. There's fusion regarding roles and responsibility of who is required to do what, and you've got with that delays in decision making, it has pressures on the NHS.” (Staff on mental health inpatient ward)*

*“At police headquarters, and I think standing in their yard, if you like, and looking at the frequency of calls coming through, how many calls they're getting, how many resources they've got, and how they've got to then distribute them, I guess give us an insight into the level of their work.” (Approved Mental Health Professional)*

*“I think the services, the NHS, all services in the UK are overstretched and I think there was a massive lot of overlap. You were getting ambulance and police doing the same thing.” (Paramedic)*

*“In terms of resources, I think everyone's really struggling at the moment. Ambulance staff, you often hear the horror stories of people waiting for an ambulance for hours. Police, we don't have many again, we're on a shortage. We don't have enough of us to deal with this... I just think resource, there's just not enough, especially in terms of mental health.” (Police officer)*

This was also often linked to the increase in the mental health workload specifically, with five professionals commenting on this.

*“Over the years, in terms of resourcing, the pressures that we currently have on our services have been immense and then Covid came along and that just made things even more difficult... our Mental Health Act assessments have gone up by 200%”. (Mental Health Social Worker)*

*I still observe and see more referrals coming in from the police and the ambulance and one thing all the agencies trying to refer people in mental health crisis.” (Crisis Mental Health Professional)*

*“Especially since joining the police, I've really opened my eyes to how much people suffer with their mental health. And it has gone massively up in the last couple of years.” (Police officer)*

Five interviewees specifically mentioned a lack of staff in all agencies, whereby everyone is overstretched.

*"From my perspective, it's about their understanding of what our job role is, and what we can do. Police say, 'I don't have enough staff to do this'. Because nowhere has enough staff. The police don't have enough staff, we don't have enough staff." (Staff on mental health inpatient ward)*

*"[The Police] are overstretched just as much as we, because a lot of the time we hear them and they go, 'We would attend but we can't because we haven't got the officers.'" (Paramedic)*

*"I just think in terms of resources, I think everyone's really struggling at the moment. Ambulance staff, you often hear the horror stories of people waiting for an ambulance for hours. Police, we don't have many again, we're on a shortage. We don't have enough of us to deal with this. And then when we have bed watches it limits the police's numbers even more. So, I just think resource, there's just not enough, especially in terms of mental health." (Police officer)*

Nine professionals mentioned that health and care agencies are not trained and/or equipped to deal with difficult or violent situations.

*"Particularly when we have people of particular risk, it's dangerous for us to go. We have nothing. We're nursing staff, so we come to work in our tunics and trousers and that's what our defence is." (Staff on mental health inpatient ward)*

*"We've had incidents before where we've contacted the police because of incidents on the ward and aggression. And our kind of limit is when patients use weapons. We're not trained to take weapons off patients. And a patient had a weapon and we called the police and they said, 'We don't have anybody to come out to you. You just have to deal with it yourself.' And this patient was actively violent towards us. (Staff on mental health inpatient ward)*

*"I've been on the job long enough now that I like to think and I have done recently talked to people having knives, all sorts of things. But should I be doing it? Especially in a green flimsy t-shirt with a potentially volatile patient?" (Paramedic)*

Both police officers interviewed highlighted that police officers are not trained in mental health issues.

*"It comes into effect when we attend the first instance when we normally arrive on scene or when we get the call to go to a person that's in distress or requires some sort of medical assistance. If we are close by, we get a call to have to go to it first. Which is difficult in some parts, as in we're not mental health experts, we're not really trained in that field." (Police officer)*

Seven interviewees said that only the police have a legal framework to act in situations where there is violence, a risk of violence, or where concerns about someone's welfare requires legal entry into their house. One Crisis Mental Health Professional also highlighted that they have no legal powers to stop someone leaving the inpatient unit if they are in the reception area or another public place.

*"And that's a crucial thing as well, the law, actually who has legal rights to go in and do this stuff. Because there is a real risk that you are working outside the law."  
(Community Mental Health Professional)*

*"[Ambulance crew] were on scene physically fighting with the patient to stop him running into traffic. They were ringing the police to attend because we had no legal framework to hold him, he was in the public place."  
(Crisis Mental Health Professional)*

*"We can't contain people sometimes. We haven't got that ability to contain them in order to be able to give them the care they need."  
(Approved Mental Health Professional)*

All of the non-mental health professionals said that sometimes they had difficulty in obtaining support from mental health services.

*"I was like, 'Her mental health team is closed, she wants to kill herself. She's already done her ligature, she's in a secure home. If I leave her here, she's going to end up doing it again'... And then [the Crisis Team] have said, 'Well no, because we don't want her. She's got her own mental health team, tell her to contact the mental health team in the morning'. And that was it. So, they're not really seeing the people who actually are in crisis point on a Friday night who are not going to survive until the morning or who are going to really struggle to not try and do it again until Monday morning when the mental health team opens."  
(Paramedic)*

*"I think our mental health team are quite supportive. So I don't think it comes from the team within the hospital. There is a delay on psychiatrists, massive delay, which I'm sure is the same all over the country. But we could be waiting 24 hours for a patient in ED to be seen, a decision made, put under the Act. And police are to be there with them the whole time. So that's delaying the police. That's delaying everything really. The patients get more frustrated. Obviously we can't magic psychiatrist part of nowhere, but I think that massively affects the patients in ED."  
(Staff in A&E)*

*"There's an individual that's around here that we frequently see, quite often, and the amount of times that we speak to the mental health suites, they always say she's not in crisis. And one of the incidents was she had self-harmed and there was part of her tendon was hanging out. Now, as far as I was concerned, I know that that they were saying, 'No, she's not in mental health crisis', but as an officer that's on the ground there with her, and she's telling me she wants to take her life as she has self-harmed to*

*the point where I would deem as not a normal, rational person. If I consider myself rational, I would not self-harm and cut my arm out of this. So when you are trying to explain this to them, they're saying, 'Yes, but she's not under mental health crisis. You need to just take her to hospital.' That's not my call." (Police officer)*

## **6. Partnership working**

One mental health professional thought that the “building blocks” are there to facilitate better joint working. Two mental health professionals appreciated having inter-agency meetings in terms of collaboration and information sharing on patients with mental health issues.

*“We have regular professionals meetings and we share what's currently happening for those particular patients and what concerns the police need to be aware of. So for example, one of my patients had disclosed to me that she was sewing blades into the inside of her bra. Which was obviously putting the police at risk and any of the staff on the 136 unit. So obviously I'd appropriately handed it over to other professionals and discussed it in the professional meetings. So what the police officer that attended did, she made sure it was clearly documented on that lady's profile that they have for her mental health notes within the police service. So then when a police officer is having contact with that person, they're fully aware of those risks towards them kind of self, but also what current support that she's receiving from the wider agencies.”*  
(Community Mental Health Professional)

*“The inter-agency way I would actually say it works quite well actually, because we've got links within certain areas of the police, and the fire brigade, etc. that we would go to. So that works quite well... we hold regular CPA meetings, Care Programme Approach meetings. So if a patient was under a MAPA, for instance, then we would have a MAPA rep there. And we do communicate quite well with each other, have regular meetings, and generally I'm the clinical lead of the ward, I link in with them throughout the care, even if they don't have the meetings. And having the link people to go to is really helpful.”* (Staff on mental health inpatient ward)

However, seven interviewees (six mental health professionals and one police officer) highlighted a lack of dialogue and communication between different services and agencies as a barrier to partnership working.

*“There have been issues with the police around just sort of not always being, I don't know, particularly sort of working together. For instance, I can give an example of a case where I was going out to undertake a Mental Health Act assessment, and a relative phoned to say that the police were on site. And I obviously phoned the police to*

*say, 'Can you confirm if this is the case or not?' And the response I got was that you'll have to send us an email. (Mental Health Social Worker)*

*"I think that the difficulty is we're relying on [the police] to follow the spirit of the Mental Health Act and contact the crisis team and have them discussions with practitioners, which is not happening. It's not always happening. And when it does, it's not always the right people answering the phone at the other end. So again, it falls down I think on probably many levels, not just on the police's behalf. (Approved Mental Health Professional)*

*"We found the sort of police liaison officer who would align themselves to my previous hospital was helpful, and they were helpful with this process as well because they were able to tell us what it was about, let us ask questions, came back to us and everything. (Staff on mental health inpatient ward)*

*"With the Right Care, Right Person, things that don't tend to work so well is communication within. Whenever we deal with somebody with mental health, we have to record everything on our body-worn videos. So everything that we do is recorded or it should be. But trying to speak to different departments, there's quite a lot of departments to talk about one individual. And sometimes when you provide information for one unit, they don't communicate with the others." (Police officer)*

Five of these interviewees mentioned a lack of intelligence sharing as a barrier.

*"Having them conversations around a particular individual where we've got quite a good working knowledge of these people and that advice just really being completely disregarded in a lot of instances really." (Crisis Mental Health Professional)*

*"Speaking to them, finding a little bit about them, having that information so that if it helps with their mental health, then fantastic. But it's only information that they've provided either previously or family members have done so. Other than that we won't have any information on anybody about their mental health, any kind of treatments or any treatment plan or anything like that. We won't have any of that." (Police officer)*

Another barrier, highlighted by six interviewees, is that different agencies have different views on their responsibilities under Right Care Right Person or that even within a service there can be differences of opinion between front line staff and managers.

*"We have a process and like I say, it is sporadic. Sometimes it works. Sometimes I would say yes, we do have a partnership and we do have an arrangement, but I think it can be very blurred in terms of what each other's roles and responsibilities are." (Mental Health Social Worker)*

*"I want to say the problem is we see it from our side and I would say, police aren't backing me up on this, so what are they doing? Police are getting us to convey their 136*

*patients round, so what are they doing? I know from their side, they'll be sat with some mental health patient going, 'This is nothing to do with us, this is an ambulance job.' We'll both have the same argument that the other isn't doing what they're supposed to be doing, and it's all potentially because of this Right Care, Right Person that we aren't working together as much as we used to." (Paramedic)*

*"Every single agency has a hierarchy of who's in charge. And our bosses will be down on us saying, well why are they still at that job? That's not a police matter. Then we're at the job saying, well ambulance is saying it is for us to deal with and they're not dealing with it. So, there's always that to and from and supervision, arguing and stuff like that." (Police officer)*

Eight interviewees felt that sometimes processes and bureaucracy inhibit being able to take decisions or take them swiftly.

*"It goes from ambulance to the AMHP service, to the crisis team. We're doing all of this to then escalate it to the sergeant to then escalate it. That could be hours. Hours that you've got an ambulance crew off the road, you've got police off the road, you've got somebody under what legal framework, I don't know, held in the back of an ambulance still on the Humber Bridge just for someone to say to the police, yeah, you can use it, you're allowed." (Approved Mental Health Professional)*

*"Quite often when you have conversations around the use of a 136 with an officer that's on scene, it goes back to the sergeant who's not even there who authorises whether that 136 can be used. And it's like there's an overarch, a decision being made by somebody who's not actually on scene." (Crisis Mental Health Professional)*

*"It's like that old adage of trying to get past the GP's receptionist to speak to the doctor. It's the same. If you can't get past the control room, the police officer doesn't turn up. I think that's the issue. I now have, because of the nature of the job, I've got a direct line to the police control room so I don't have to go through the fluff of ringing our lot anymore." (Paramedic)*

*"If someone's saying that they're going to kill themselves, I think what should happen is literally, as soon as we get that call, we should be deploying ourselves, but also deploying an ambulance rather than wait for me to get there to make that decision. I could be there within ten minutes, but that's ten minutes we've lost of an ambulance arriving or responding, or at least getting somebody to acknowledge that that incident happened, and that may be the mental health ambulance team could be deployed. It might take them 20 minutes to get there, or half an hour, but it's 20 minutes or half an hour rather than 40 minutes or an hour because they've already been deployed at source, which is our control room, their control room." (Police officer)*

Eleven interviewees said that their experiences of a response by the Police were inconsistent, often dependent on the officers involved in an incident.

*“There are times where we've rang the police and they've been very supportive and they have been responsive and helpful and said, yeah, okay, we'll meet you there. And then the next day we could ring up about another query and we get a carte blanche no and send us packing. So it is very sporadic.” (Mental Health Social Worker)*

*“It depends on the police, the experience of the officers and their understanding of the Mental Health Act and indeed their own policy. And indeed there was, so there's a bit of a matrix of grey things that all appear about the right appropriate thing.” (Crisis Mental Health Professional)*

*“Honestly the responses are mixed. I have had a response before which has literally been Right Care, Right Person. So essentially just barking back that this is no longer our responsibility. I have also had police who've been really helpful and guided and advised and taking it more significantly. (Staff on mental health inpatient ward)*

Ten professionals said that the police can now be reluctant to or refuse to intervene, with some linking this change to the introduction of Right Care Right Person. Both paramedics felt that Right Care Right Person should not be used as an excuse not to deal with a situation.

*“We need the police involved. And often the hospital will ring and say police aren't interested. They're not going to look for that person. They're not going to do anything. They will end up and I believe have ended up with death.” (Approved Mental Health Professional)*

*“I would never contact the police in a situation where I didn't really need them. And so my experience of it is just that now if we do contact them, this seems to be being used as a reason not to support us.” (Community Mental Health Professional)*

*“[The police] wouldn't attend for the paramedics. We also tried ringing and was on scene and again, being quoting, well, it's Right Care, Right Person. And it's like, but we're restraining him in the street and an ambulance. And it took probably two hours with the patient's distress, in quite a vulnerable situation. And it was like, we have to be assaulted before police will attend. They did eventually attend. But we get quite a lot of situations like that.” (Crisis Mental Health Professional)*

*“I think it's created a mistrust between services. The police are getting a lot of stick because they're not doing what we think they should be doing. So, they're refusing to come out to things when really maybe you should come out it. There's a lot of mistrust.” (Paramedic)*

Three mental health staff interviewed said that the police require a warrant to support mental health staff in risky situations.

*“When we have to apply for a warrant, they call section 136 warrants, we have to get into a queue to find a slot to present our case to a judge... but that can take time, can take days for that to happen. So whilst all that's happening, we've got a person in crisis. So sometimes we think it could be easily remedied if you were to come with us, if we could get access. Because often one, not when a police officer knocks on the door, they often open it. They don't want their doors getting bashed in. So it does help.” (Mental Health Social Worker)*

*“In the old days, I'd have gone straight on the phone, rung 101 and arranged police support.. Because I don't think it warrants a warrant, but I think we're going to have to use a warrant because police will attend. Police had already stated four times to the community team who had tried no way they're attending. Go in, if he assaults you, yeah then ring us.” (Approved Mental Health Professional)*

Seven interviewees said that they felt that some police officers do not see mental health as their responsibility or job, which was often linked to why they would not intervene.

*“I think sometimes we all feel like we're battling with one another. I think the police will get into a mindset of, this is a mental health patient, so it's not our business.” (Community Mental Health Professional)*

*“They feel that's not their job now. And obviously they've got the Right Care, Right Person to support that. So often we get that thrown at us all the time. That's not within our jurisdiction, it's not within our remit. And it's hard to sometimes persuade them that risk to life. And sometimes we get them responding to us by saying, well, you can't have us, but if you send the fire brigade or the ambulance service, which seems a bit ridiculous to me why he would want to do that. (Mental Health Social Workers)*

*“Some police officers are brilliant and there's some I've come across and their ability to talk to mental health patients is unreal. There's others who are like, ‘Well, this isn't our problem. I'm a copper, I'm not here to look after mental health patients. I'm here to arrest criminals and drug dealers and this kind of stuff.’” (Paramedic)*

Nine professionals felt that the police lack understanding of or knowledge about mental health issues or resources, with some linking this to a lack of training.

*“I think it's a lack of understanding of what our roles are as AMHPs and their lack of understanding about what our legal powers are. And we do have legal powers and we can direct police as you say, it's the only little bit of power we do have sometimes, but I*

*often think we don't always necessarily have to go straight to a warrant.” (Mental Health Social Worker)*

*“I can't assess somebody that's not medically fit. I've got to interview in a suitable manner and somebody that's taken an overdose of 30, 40 paracetamol may die. So I can't interview somebody in a suitable manner and police don't understand that.” (Approved Mental Health Professional)*

*“I did go to the police with one of my colleagues a few years ago to talk to them about the 136 policy I think it was, of all things. And it was a strange reception really their understanding of mental health services is very thin. And the education I think officers get on mental illness is very small.” (Crisis Mental Health Professional)*

One Crisis Mental Health Professional highlighted the increasing complexity and number of conditions that fall under a definition of mental health, with a growing number of people with personality disorder that is harder to identify than schizophrenia, psychosis, depression and suicide.

However, almost all of the interviewees (13) said that there are situations that still require a police presence.

*“In terms of my patient from what I was just talking to about with the blades, and they needed to then call the police and wait for the police to come back and support the staff to be able to get the blades off her.” (Community Mental Health Professional)*

*“It needs to be less rigid is probably the best way to put it. It just needs, the police are required sometimes, ambulance are required sometimes. It needs to be a bit more fluid in how it's used rather than being this. But the problem is because it is quite strict, we find a lot of the time and you read down the jobs and comms will be like, ‘Yeah, police aren't coming.’” (Paramedic)*

*“Some patients need that, they need to have police with them, they're aggressive, they've had weapons on them, they're taking a lot of police effort to keep everybody else safe.” (Staff in A&E)*

*“If someone calls up and says I've got a knife, I'm cutting, ambulance will call the police and a hundred percent I agree, we are there to neutralize that threat because there's a threat not only to the person but to the ambulance staff, to members of the public, whoever else is in the house is that threat. So, we will go to neutralize that, whether that's with taser or that's with dotting someone and to the point we can neutralize it and then let the ambulance staff in to then do what they need to do. That's how I think it goes hand in hand.” (Police officer)*

Five interviewees pointed out that they only call the police out if they are needed, and that the police should trust in their judgement. However, ten felt that there is a lack of trust by the police in the judgement of mental health staff as to when they need to attend a situation or incident.

*“But we clearly do get lots of roadblocks in our way with the police when we ask for reasonable requests. And it's not something we do lightly. We know how pressured they are. We would only do that if we absolutely had enough intelligence to know that person was risky or there was a warning indicator on the system to say we need to be very careful and mindful.” (Mental Health Social Worker)*

*“We need police to not put their hands up and say Right Care, Right Person means mental health services only and it's never police business. We need them to accept that at times we do still need police support and if we're coming to you for police support, it's because we have exhausted all other ways of being able to deal with or manage the incidents that we're trying to manage. And you ring for advice, listen to it.” (Approved Mental Health Professional)*

*I think there needs to be a better understanding of not just support to the service user, but support to the staff, to our health colleagues and equally to our policing colleagues. We are not going to ring for no reason. Wherever possible, they should not be the first response. That is really, really important. But we do need to see a situation where if a crisis practitioner is telling the police, “I am afraid for my own safety, I'm afraid for the safety of this person. We need your help.” That needs to be received with a lot more understanding. And my experience is that it's not, and I think there are strategic reasons for that. (Community Mental Health Professional)*

*“They've asked for our professional opinion and judgment in the decision-making but ignored that and used 136 anyway or vice versa. (Crisis Mental Health Professional)*

Six mental health professionals said that the police do not contact Mental Health Services to discuss cases.

*“Obviously if there's a significant risk to themselves or to others or members of the public, then what we'd expect from the police is for them to give us a call, we discuss it with them, but often they don't always contact us, they just bring them in without a conversation initially.” (Mental Health Social Worker)*

*“I think that the difficulty is we're relying on them to follow the spirit of the Mental Health Act and contact the crisis team and have them discussions with practitioners, which is not happening. It's not always happening. And when it does, it's not always the right people answering the phone at the other end. So again, it falls down I think on probably many levels, not just on the police's behalf.” (Approved Mental Health Professional)*

Five mental health professionals felt that their relationship with the police is not always good or that it has deteriorated.

*"[Right Care Right Person] has created some uncertainty on the ground, more difficult working relationships with us and police becoming frustrated with them. Just using that as a means to just do nothing." (Approved Mental Health Professional)*

*"The hardest part of our job, I would say probably as a crisis nurse and as an AMHP in dealing with the police is if the police do not get the response they want, 90% of the police are not professional in their interactions with us, in the way they speak to us. And the way they deliver information, it's not good." (Approved Mental Health Professional)*

*"There's no point in ringing the police and that relationship needs to be built. Right Care Right Person is fine, but the relationship with the police and mental health services still needs to be improved." (Staff on mental health inpatient ward)*

## **7. Use of Section 136 powers**

Interviewees said that they have seen an increase in the use of Section 136<sup>2</sup> or bringing patients into 136 suites by police, including many that are inappropriate referrals.

*"We've seen as a treble of 136 referrals coming into our services and obviously we do find that a lot of the individuals we get in our 136 suites shouldn't be there in the first place." (Mental Health Social Worker)*

*"The biggest impact it's had without a shadow of a doubt is the 136 suite. The level of 136 is astronomical now. At one point when I first started with a crisis team, there were probably few and far between maybe one or two a week, now as an AMHP as well as a nurse we can be assessing or seeing five people a day. Sometimes the same person two or three times a day that's been seen, assessed, sent home or seen assessed, brought in. The level of 136s has gone through the roof." (Approved Mental Health Professional)*

*"For example, the four 136 that were in yesterday, none of them were detained afterwards. Everyone went home. So the four 136 probably cost over a thousand pounds each to man and operate. And everyone went home and one of them came back on the night on another 136." (Crisis Mental Health Professional)*

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<sup>2</sup> Section 136 of the UK's Mental Health Act 1983 grants police the power to detain someone in a public place who appears to be suffering from a mental disorder and requires immediate care or control. The person is then taken to a "place of safety" for a mental health assessment to occur. This power is to ensure the person's safety and the safety of others, and the detention can last for up to 72 hours, allowing for examination by a medical practitioner and an Approved Mental Health Professional (AMHP).

One police officer felt that mental health staff did not always appreciate their reasoning and that they had used their professional judgement to assess someone and determine that they needed to be brought in under Section 136.

*“I always want to do the best for the individual. And if I deem that to be the Right Care, Right Person, I will use it. I've had arguments with them... and they've said, ‘under no circumstances’. Unfortunately, I deem that person needs to be taken into control, so I've done it, I've done the 136. They've not been happy when we've turned up. And they've clearly demonstrated that, but sometimes the partnership or the understanding of what the officer's dealing with isn't there.” (Police officer)*

One paramedic said that their team had recently been discussing possible moves to give 136 powers to certain clinical staff, and they were concerned that 136 typically involves detention rather than just assessing capacity: they may be able to assess capacity but they're not in a position or trained to restrain someone.

*“I think sometimes gauging a patient's capacity is maybe better off done by us. But again, the 136 doesn't just cover capacity... the problem then becomes as part of a 136, you are detaining someone, and in order to detain someone, you've got to have cuffs, be prepared that they're going to kick off because they don't want to be detained.” (Paramedic)*

## **8. Improvements suggested**

All interviewees were able to suggest improvements, with the most significant suggestion being around training to build understanding of mental health issues, legal powers and Right Care Right Person: thirteen suggested training for police while twelve suggested training for other agencies.

*“I'm not sure that I was ever given any training. We were given information. We agreed and we discussed it in our forums and stuff. But we didn't have any formal training. And it might be beneficial to do something like that together with the police.” (Community Mental Health Professional)*

*“I did go to the police with one of my colleagues a few years ago to talk to them about the 136 policy I think it was, of all things. And it was a strange reception really their understanding of mental health services is very thin. And the education I think officers get on mental illness is very small. It could definitely do with some work on... understanding mental illness, understanding personality disorder, understanding how people behave and those sort of things.” (Crisis Mental Health Professional)*

*"We have no training on mental health. Police have none. The only thing we get really taught on is our 136 power and the power we have to obviously section someone if they're immediate dangerous or we believe they don't have capacity. But in terms of mental health training, we have none." (Police)*

*"I believe the ambulance staff, it would be beneficial if they really got some training around what the police are really there to do. Why you need police on scene, do you need them really? Or what are they actually there to do? And the 136 power we have." (Police officer)*

Twelve interviewees suggested improving co-operation between agencies and/or better communication.

*"Regular meetings and troubleshooting and it being proactive rather than accusation. Because I think, we all get really protective of our profession and we all think we're right and sometimes we miss the bigger picture with that joint working. I think the interface meetings would be really helpful." (Community Mental Health Professional)*

*Well, I suppose put very safely, put very straightforwardly. It would be that we work together better. We would have that mutual support. There would be a better culture around it, I guess. So that comes down to training and integrated working and that sort of thing is, doesn't it? (Community Mental Health Professional)*

*"I think a lot of problems can be solved through communication. And I feel that the implementation of Right Care, Right Person, I agree with the idea. However, I think what should have also accompanied it with this is a designated person who can support mental health services in making the right decisions, providing some reassurance regarding the decisions that they're making, that they will be supported by the police and it is falling in line with the policy as well." (Crisis Mental Health Professional)*

*"I think better understanding for both sides about implementing it. So it's almost like we have a process and a policy and procedure. It's about how can it be effectively bound and put in place that it works. I think there's too much greyness to it. Decision-making needs to be improved and respectful. Communication needs to be honoured." (Crisis Mental Health Professional)*

*"Communication is key. The communication from when I turn up at an instant to getting that person to the right location, sometimes it's a bit of a battle just communicating with people. And we try our best. We don't always get it right or I certainly don't always get it right, but I've always got the best interest of the individual that I'm dealing with because once they're at the right location and they're getting help that they require, I know I've done a good job and they're safe." (Police officer)*

Five professionals suggested that more resourcing is required.

*"I think definitely more resource from all sides." (Community Mental Health Professional)*

*"I just think in terms of resources, I think everyone's really struggling at the moment. Ambulance staff, you often hear the horror stories of people waiting for an ambulance for hours. Police, we don't have many again, we're on a shortage. We don't have enough of us to deal with this. And then when we have bed watches it limits the police's numbers even more. So, I just think resource, there's just not enough, especially in terms of mental health." (Police officer)*

Four interviewees felt that the police officers seeing the patients on scene should be able to make decisions about the use of Section 136.

*"Quite often when you have conversations around the use of a 136 with an officer that's on scene, it goes back to the sergeant who's not even there who authorises whether that 136 can be used... it's not the officers that make the decision on scene, they go, 'Well, I need to speak to my sergeant'. And it's like, but how is that lawful? Because they're not on scene. It should be your decision making with a specialist practitioner, which is what Right Care says, you should be taking advice from a specialist practitioner." (Crisis Mental Health Professional)*

*"It's not always the people with the patients that make that decision, it's [police] team leaders. So I think maybe more decisions could be made from the people with the patients themselves, not the team leaders that aren't actually seeing the patient... We've had police before that have said, 'I'm really sorry but I cannot stay with this person. My team ' said I'm not allowed. So they're not going to be on 136.'" (Staff in A&E)*

One member of staff in A&E suggested having a clearer pathway for mental health admissions or the use of Section 136, to make sure ambulance crews are not taking patients who are under 136 to A&E unless there is a medical reason such as an overdose or injury.

Three interviewees (both Crisis Mental Health Professionals and one police officer) suggested having a mental health ambulance or street triage team.

*"I think it'd be great to see, I think the talk of mental health ambulance at one point or a staff going out with officers on a 136 run. So they could be there, like a street triage thing." (Crisis Mental Health Professional)*

*"I believe there's an ambulance that drives around within, I think East Riding that is a mental health ambulance specifically for mental health. The difficulty is, I've never seen*

*it in my entire time. In the past three years at least, I've never once had an ambulance crew turn up that was the mental health ambulance team. I've never had it." (Police officer)*

Two interviewees suggested having more caring/compassionate behaviours, one that the policy should be informed by frontline staff and one suggested a less rigid interpretation of Right Care Right Person.