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Informing Policy with Evidence

Exploring Health and Social Care perspectives on the implementation of 'Right Care, Right Person', under the National Partnership Agreement

December 2024

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The Partnership for Responsive Policy Analysis and Research (PREPARE) is a collaboration between the University of York and the King's Fund, producing fast-response analysis to inform developing policy. The research programme is funded by the NIHR Policy Research Programme (grant number NIHR200702).

We appreciate comments on earlier drafts of this report from Bryony Aird, Robert Cochrane, Laura Mitzel and Lorrain Segelman (DHSC), Alex Baylis and Sally Warren (The King's Fund) and Professors Adam Crawford, Charlie Lloyd, Paul Tiffin and Martin Webber (University of York). Errors and omissions remain the responsibility of the authors.

Views expressed are those of the authors and not NIHR or the Department of Health and Social Care.

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Summary

This rapid research project explores the views of health and care staff on the impact of implementing 'Right Care, Right Person' (RCRP), a policy designed to 'end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs.' Based on in-depth interviews with stakeholders in health and social care services across six geographical areas, we report the experiences, hopes and concerns of those tasked with executing this policy change.

The publication in 2023 of the National Partnership Agreement (NPA), a collective national commitment to roll out RCRP, has altered the response to mental health crises in England. Health and social care providers generally welcomed the shift, acknowledging a previous over-reliance on the police. This is, however, an important and substantial policy change, and our interviews reveal numerous barriers to implementation, resource needs, and concerns around potential future impacts.

Across the phases of implementation, health and care organisations are working productively with local police forces to develop policies in response to the RCRP changes. We heard several examples of good practice, clear communication, and strong multi-sector partnerships. This was not, though, the experience of all our interviewees, with some reporting strained relationships, particularly early in the implementation process. Key challenges reported include the over-rapid implementation of RCRP, constraints in health and care providers' capacity and capability, differences in perceived risk, and misunderstandings around legal powers, which risk unlawful actions. Amended timescales and 'soft transitions' have improved health and social care providers' initial impressions of RCRP, and in most instances adapted implementation plans have been based on local needs.

Our participants reported concerns about escalation procedures and differing perceptions of risk and thresholds for police involvement, which can exacerbate problems of timely response and raise safety concerns. Some interviewees believed that the policy shift has changed some police officers' approach to mental health, with some interpreting RCRP as a blanket approach of "*anything to do with mental health, we're not doing it.*" This has resulted in strained relationships between sectors, and we heard examples of inadequate police response, including refusals to respond when there were incidents outside RCRP's scope, even including a risk to life. We heard reports of families, patients, and members of the public being redirected to other services when seeking police support to situations involving people with mental ill-health, and frequently expressed concerns about how patients may 'fall through the gaps' in service provision.

Our interviewees suggested a need for national guidance, produced jointly by health and police authorities, to enable a shared understanding of how different agencies could respond within the limits of their own legal powers and workforce constraints. They indicated that this should include consideration of risk and thresholds for intervention, clear approaches to escalating incidents which need police involvement and joint training to avoid misuse of legal frameworks.

Improvements in data collection and further robust evaluative research, analysing the impact of this policy on patients, carers, health, care, and police staff, are necessary to inform policy longer term.

1. Background

1.1. Introduction

People in a mental health crisis need urgent, compassionate support – to keep themselves and others safe, to co-ordinate assessments and to provide care.[1] At times this will include a police response, but many individuals may be wary of police interactions, and they may also have been through a distressing experience, which can exacerbate symptoms of mental ill-health.[2]

There are increasing reports of police officers being involved when they are not the best people to respond, and of slow handovers of care to a more appropriate professional.[3] Police encounters with people experiencing a mental health crisis create substantial resource implications for police forces. Reported estimates of the volume of such encounters have varied widely.[4] A recent review of policing productivity found that incidents related to mental health were reported to form 8.9 per cent of all recorded police incidents, although data was found to be of variable quality and consistency.[5] Stretched capacity in primary care and community mental health services exacerbates this situation, potentially making it more likely that problems are not addressed early, resulting in people requiring emergency care.[6,7]

Right Care, Right Person (RCRP) is an operational model which originated in Humberside Police in 2019. The objective of RCRP is to end inappropriate police involvement in health and social care-related cases where there is no criminality, risk to life or risk of serious harm.

The National Partnership Agreement[3] outlines a collective national commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England, to 'work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs'.[3] Building on the model developed in Humberside, it focuses on the interface between policing and mental health services, aiming to ensure that responses are provided 'by the right person, with the right skills, training, and experience to best meet their needs'.[3]

Early evaluation of the Humberside model claimed to have found that its implementation was associated with a large reduction in the deployment of police resources, and this claim has been widely repeated.[8] This internal evaluation has not been subject to peer review and remains unpublished. Following wider rollout, similar claims have been made in other areas, for example, six months after implementation in London, the Metropolitan Police has reported freeing up 34,000 hours of officers' time 'to tackle crime'.[9]

The impact of this policy on clinical outcomes, benefits and harms to local populations and health and care services has not been evaluated.[10] Commentators have expressed concerns about the speed of implementation of this policy nationally, the capacity of health and care providers to respond to the increased demand on their services and consequent potential risks to vulnerable individuals.[11,12]

In this report, we describe the findings of a rapid research project comprising an initial exploration of the effect of the implementation of RCRP on health and care services.

1.2. Current legal frameworks governing a police response to mental ill-health

Most people with mental health problems are treated in the community and actively consent to their treatment, independent of any legal powers. In some circumstances, though, a person with a mental disorder may not consent to assessment or treatment, and the Mental Health Act 1983 (updated by the Mental Health Act 2007) (MHA) allows them to be detained involuntarily for these purposes. In emergency situations, if professionals believe that a person is suffering from a mental disorder and needs immediate care, control or assessment, the MHA provides the police with specific powers to detain the person for assessment by mental health professionals in a designated place of safety.

The sections of the Mental Health Act that detail the powers to intervene fall under Section 135 - Warrant to search for and remove a person (from a private place such as their home); and Section 136 - Removal etc. of mentally disordered persons without a warrant (from a public place).

A Section 135 (s135) warrant allows police officers to enter a person's home to bring them to a place of safety for a mental health assessment. The warrant is obtained from the magistrate's court, by an Approved Mental Health Professional (AMHP). Once issued, only police constables have the authority to execute the warrant and, if needed, force entry to a person's home. Police cannot refuse to attend if a s135(1) warrant has been obtained. The reason for a warrant is not, though, solely to gain access. Warrants allow the police the power to remove someone to a place of safety, and without it they have no powers at all in the person's home unless a crime or breach of the peace occurs.

In practice, requests for police to attend mental health assessments in the home are often made without a warrant. Police have no legal obligation to attend an assessment in these circumstances.

Section 136 (s136) has wider powers and permits a police officer to detain and remove someone from a public place to a place of safety for the purpose of a mental health assessment. This is described as an emergency power and is the power used by police when a person appears to have a mental disorder, needs immediate care or control and the police think it is necessary to keep the person or others safe.

One other area where the MHA gives a police constable power to detain a person is Section 18(6), which relates to return and readmission of patients absent without leave (AWOL). This is defined as a patient being 'absent from any hospital or other place and liable to be taken into custody and returned'. For example, if a hospital inpatient, detained for treatment under the MHA, is given a leave of absence (permission to leave the ward for a specified period) but fails to return to the ward as scheduled, even if they remain within the hospital premises, they are considered AWOL. The police can assist health professionals in returning a patient to hospital but there is no legal obligation for hospital staff to contact the police unless the patient falls under one of these categories:

- The patient is considered to be particularly vulnerable;
- The patient is considered to be dangerous, and/or
- The patient is subject to the provisions of part 3 MHA (is serving a sentence for a crime or concerned in criminal proceedings).[13]

A recent change to mental health legislation affecting the police is The Mental Health Act 1983 (Places of Safety) Regulations 2017, made by the Policing and Crime Act 2017. After being detained under Section 135 or 136 of the MHA, individuals are taken to a place of safety (PoS). It was common practice to use police cells as PoS under the Mental Health Act 1983. Following the Crisis Care Concordat and a Care Quality Commission report in 2014,[14] there were widespread calls to end this practice. In response, the Policing and Crime Act 2017 abolished the use of police cells as PoS for children and permitted it only in rare exceptional cases for adults. The 2017 amendments also reduced the maximum detention period by police from 72 to 24 hours.

There are two situations involving mentally ill people where there is no reliance on using the MHA. If a person in a mental health crisis has capacity and consents to treatment, it can be provided under the normal principles of medical law. If a person lacks capacity to make a decision about their mental health, then treatment that is in their best interests can be provided through the Mental Capacity Act (MCA) 2005. In these circumstances, there may be no need for police intervention, although the legal authority to deprive an individual of their liberty may still derive from the MHA.

RCRP does not change the role of the police under the MHA. They will still use specific powers provided by mental health legislation in incidents where there is a real and immediate risk to life, serious harm or a report of a crime.[3]

1.3. Historical perspectives and recent policy trends

Interactions between the law and medical services in relation to those with mental illness extends back even before the establishment of the police service – historically, various authorities were given the power to detain and treat those with mental illness. Two relatively recent changes in law and policy specifically link the police to those with mental illness: the decriminalisation of suicide in 1961, and de-institutionalisation moving to Care in the Community (large scale closures of asylums between the 1960s and 1990s). The most significant legal component underpinning police involvement in mental health, though, is their continued statutory powers under the Mental Health Act 1983.

Over recent years, there have been repeated calls from the police to reduce the amount of mental health-related cases they are attending, often supported by those in the health and care sector who believe that the police are frequently not the right agency to respond to health incidents.

In 2014, 22 national bodies involved in health, policing, social care, housing, local government, and the voluntary sector came together and signed the Crisis Care Concordat,[1] with the aim of working together to improve outcomes for people experiencing mental health crisis. The Concordat report highlighted concerns about the way in which health services, social care services and police forces work together, notably 'at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another'.[1] Various policy and service level interventions have emerged over time which aim to improve service co-ordination, for example street triage,[15] ambulance response cars[16] and mental health professionals in ambulance control rooms.[17]

In 2018, His Majesty's Inspectorate of Constabulary, and Fire & Rescue Services (HMICFRS) published a report entitled *Policing and Mental Health: Picking up the Pieces*,[18] claiming that the police should

be the *last resort* in responding to people in mental health crisis, but instead were often *the first port of call*. The report raised concerns that in responding to mental health problems, the police were working beyond their duty, and while almost all police forces had their own mental health triage teams, there was insufficient emphasis on early intervention to prevent the need for a crisis response. The report concluded that although the Crisis Concordat had been 'a step in the right direction', there needed to be a rethink to guarantee a timely expert response from health services. The report claimed that the system was failing vulnerable people and that other services were overly reliant on the police service. It highlighted key areas where police officers reported that 'the police service is stepping in to fill shortfalls in health services', including transporting someone to hospital because an ambulance isn't available, waiting with someone in hospital until a mental health place is found, and checking on someone where there is concern for their safety.[18] This report marked a shift in attitude. Prior to this the police responded to reviews and recommendations aiming to address their ability to deal with mental health-related incidents,[19,20] but the HMICFRS report was the first to question whether, at times, they should be present at all. This sentiment was echoed in the development of 'Right Care, Right Person' in Humberside, and in the National Partnership Agreement 2023.[3]

1.4. The Right Care, Right Person approach

Right Care, Right Person (RCRP) is an operational model developed by Humberside Police which aimed to deploy police officers only to incidents relating to mental health which involve criminality or a real and immediate risk to life or risk of serious harm. Over a three-year period, a partnership between the police and those in mental health and acute hospitals, and ambulance and social services, developed the RCRP framework. This aims to support the police force through better triaging of calls for service, redirecting mental health calls to healthcare professionals whenever possible, and reducing handover times from police to mental health providers. Humberside Police developed policies and memoranda of understanding with partner agencies, along with a force control toolkit and training packages.[21] Before implementing RCRP, Humberside Police estimated that over 1500 mental health incidents per month were being attended by police officers; this was reported to reduce by 540 mental health related deployments per month after RCRP.[21]

The RCRP approach in Humberside was implemented in a phased manner, based on four categories of mental health incidents (see Table 1).

Table 1: Right Care, Right Person (Humberside Police): implementation phases

Phase	Pre-RCRP Examples	Post-RCRP expectations
Phase one: concern for welfare	Mental health services reporting that an individual hadn't attended their appointment the previous day and they had concerns about them; asking the police to attend.	Welfare check requests from partners are now rare. In managing the change, partners have altered their operating practices to ensure staff are available to carry out their own checks.
Phase two: walk out of healthcare facilities and AWOL patients	Call from emergency department of an acute hospital regarding a male who had left before being discharged with a cannula in his hand. Police were asked to locate him. Sectioned patient had gone AWOL after s17 escorted leave with staff, last seen in the pub. Later located at home address by officers and returned to mental health unit.	Emergency departments (EDs) at acute hospitals no longer call the force where patients leave unexpectedly unless they are deemed to be an immediate threat to themselves or others. Sectioned mental health patients who have gone AWOL are no longer reported as a matter of routine, with partners accepting their legal duty to locate and return these individuals.
Phase three: transportation	Police asked to convey patients (from acute hospital to mental health facilities). Police conveying s136 or voluntary mental health patients to places of safety.	There is now an agreement that an ambulance will be requested for all health-related movements. Where an ambulance is not available, officers are required to seek authority from their supervisor to use a police vehicle instead.
Phase four: Section 136 of the Mental Health Act 1983 and voluntary patients	Section 136 of the Mental Health Act used to detain someone in crisis. Police attend the s136 suite but couldn't handover to clinicians as no one free to accept. Police remained for 12 hours. Voluntary patient taken by police to emergency department of an acute hospital after a minor self-harm episode as no ambulances free. Police were asked to remain as the individual was assessed as potentially suicidal.	All three mental health providers within the force area now have 24/7 dedicated resource for Mental Health Act s136 detentions. This has allowed a timelier handover from police to crisis care staff, reducing additional trauma caused to individuals by prolonged police intervention and freeing up officer resource.

Source: College of Policing. Right care, right person – Humberside Police[21]

1.5. The National Partnership Agreement

In 2023, the reported success of the Humberside RCRP scheme in reducing policing hours informed the National Partnership Agreement (NPA),[3] which outlines a shared commitment between health, social care and policing bodies to national implementation of the Right Care, Right Person (RCRP) approach to mental health incidents. Although previous policies have focused on the interaction between services, RCRP was notable in its scale and its stated aim to proactively withdraw and reduce the involvement of police in responding to mental health incidents where there is no risk to life or of serious harm.[3]

The agreement was signed by the Department for Health and Social Care, NHS England, Home Office, College of Policing, Association of Police and Crime Commissioners and the National Police Chiefs' Council in July 2023, with areas across England undertaking phased withdrawals of police involvement to incidents where there is no legal duty to respond.

The RCRP threshold sets out that police officers would generally be expected to attend a mental health-related incident only in the following circumstances:

- To investigate a crime that has occurred or is occurring; or
- To protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.[3]

Following the publication of the NPA, many police forces stated their commitment to implementing the changes. Several police forces have already implemented RCRP or are in the process of implementing elements of the model. Local areas have discretion over the timing of implementation, and responses and speed of implementation have varied. The announcement of rapid withdrawal of police officers attending mental health-related calls announced by the commissioner of the Metropolitan Police generated considerable media coverage and criticism, and timescales in London and some other locations have since lengthened.

The National Police Chiefs' Council has claimed that if all forces were to adopt RCRP, one million officer hours could be saved.[22] This figure seems to be an extrapolation of an unpublished early-stage internal evaluation of the Humberside model. Time savings to police forces, at whatever scale, have not allayed the concerns raised about patient and carer welfare, potential costs to health and care services, and potential unforeseen consequences, by numerous health sector stakeholders.[11,23,24] The Royal College of Psychiatrists highlighted the lack of evaluation of clinical outcomes,[6] and the Health and Social Care Select Committee has emphasised the need for a national evaluation of the policy's impact on health and social care providers.[25]

2. Aims and objectives

We aimed to assess RCRP, including implementation through the National Partnership Agreement from a health and social care provider perspective, beginning to learn from its implementation in a variety of settings.

In interviews with a range of health and social care stakeholders, we explored the following questions:

- How are health and social care providers implementing RCRP and what are their future plans, including any differences between local areas?
- What resources are required for successful implementation?
- What are the main enablers of and barriers to implementation?
- What has been the experience of partnership working between different agencies?
- Have any early problems been identified?
- Can early impacts be identified, for example in terms of:
    - Changes in the number or nature of mental health incidents involving the police, including handover times.
    - Perceived consequences (positive and negative) for patients and the public.
    - Perceived consequences (positive and negative) for the health and social care system.
    - Perceived consequences (positive and negative) for other stakeholders, particularly charities.
- Can we draw lessons for wider implementation and monitoring?

3. Methods

We employed an exploratory qualitative methodology using interviews and focus groups with a range of health care, social care, and voluntary sector stakeholders from six sites across England.

Preliminary pilot work, a literature review and objectives outlined by policymakers informed the development of semi-structured topic guides to frame discussions (Appendix A). We conducted both interviews and focus groups depending on local area capacity, respondents' preferences and overlap in participants' experiences.

3.1. Sampling

We used published data on mental health and social care expenditure per capita[26] and workforce capacity,[27,28] at area and regional level (where possible contiguous with police authorities) to sample areas according to maximum variation. We obtained high-level information from the Home Office, and published Police Force information about areas' stage of implementation of RCRP. We sampled six case study sites at different stages of RCRP implementation, aiming additionally to reflect variations in:

- The overall size of the police force;
- The capacity of mental health and social services (particularly the mental health and AMHP workforce);
- The local structure of services (including levels of integration and interaction);
- Geographical and area-level characteristics (e.g. urban/rural);
- Population characteristics (socio-economic and ethnic diversity, incidence, and prevalence of mental ill-health).

We targeted interviewees in each site to recruit a diverse range of respondents from key health and social work roles, ensuring that we heard from a range of perspectives. Interviewees included mental health professionals and service leads, Approved Mental Health Professionals (AMHPs) and social care service leads, liaison psychiatry and A&E department leads, senior managers in Ambulance Trusts and representatives from voluntary sector organisations.

Our interviews cover six diverse areas spread across England, with variation in terms of local area demand (using the mental health need index), policing capacity (using policing numbers per 100,000 population) and RCRP implementation (Table 2). We interviewed 29 individuals in total.

3.2. Patient and public involvement

Although we have not collected data from patients, we informed our approach and topics to explore through discussions with two Patient and Public Involvement (PPI) panels. One group comprised four patients with lived experience of mental ill-health and some experience of police involvement, and another group comprised three carers of individuals with such experience.

PPI group discussions informed our understanding of the potential impact of police involvement in mental health-related incidents from patient and carer perspectives. Specifically, this informed the inclusion of additional questions related to patients' concerns about 'falling through the gaps between services' and around training to respond to patients' mental health needs.

Table 2: Case study site and participant characteristics

Characteristic		**Number**
		Number of participants
Role N (%)	Mental health service Social Care Acute Trust Ambulance Trust Voluntary Sector Other	10 6 4 5 3 1
		Number of case sites
Location	South of England Midlands North of England	2 1 3
Mental health need index	≥1.00 <1.00	3 3
Police officers per 100,000 population	≥250 <200	2 4
Stage of implementation	Fully adopted Partially adopted	3 3

3.3 Recruitment and data collection

We recruited participants via email using a Participant Information Leaflet and Consent Form (Appendix B and C). We identified potential interviewees through a range of channels, including emails from NHS England colleagues to key stakeholders at organisations in the target regions, snowballing through existing local and national networks of contacts and direct contact with stakeholders identified through online searches.

Between December 2023 and March 2024, we conducted interviews and focus groups, lasting approximately one hour, using teleconferencing software. Consent for participation was obtained verbally and audio recorded. The topic guide ensured that we covered the key topics during interviews and focus groups, informed by the research objectives and PPI discussions. All interviews were recorded and transcribed verbatim.

3.4 Analysis

Three researchers with topic and methodological expertise (JD, HG and LJ) conducted qualitative analysis, with consultation and discussion throughout to develop and refine the coding framework. We used an iterative approach, although this was led by the policy objectives to inform future practice about what strategies had worked well, and what had not.

Analysis was largely descriptive and thematic, using the principles of Framework Analysis,[29] following five key steps. First, familiarisation of the data was undertaken through the listening and re-listening to transcripts and interview notes. This allowed us to generate an initial coding framework, which was discussed and amended iteratively as we began to sort the data into emerging themes using a framework matrix. We explored relationships between themes and participant/case study characteristics, discussing these amongst the research team, and through a series of iterations the summary of research findings was produced. Findings are contextualised using quotations throughout, while ensuring participant and site anonymity.

3.4.1 Reflexivity

We undertook researcher triangulation (in data collection and analysis) to improve the credibility and reliability of findings, particularly benefitting from the differing perspectives and varied expertise and experience of our research team. This included researchers with particular expertise in mental health research (HG), criminology and policing (JD), policy analysis and evaluation (KB) and qualitative methodological expertise (LJ). We aimed to be reflexive in our approach to the design and analysis of this work, to limit the potential for preconceptions to influence the research findings. This included discussion and debate as the findings developed, to ensure that we considered a breadth of interpretations.

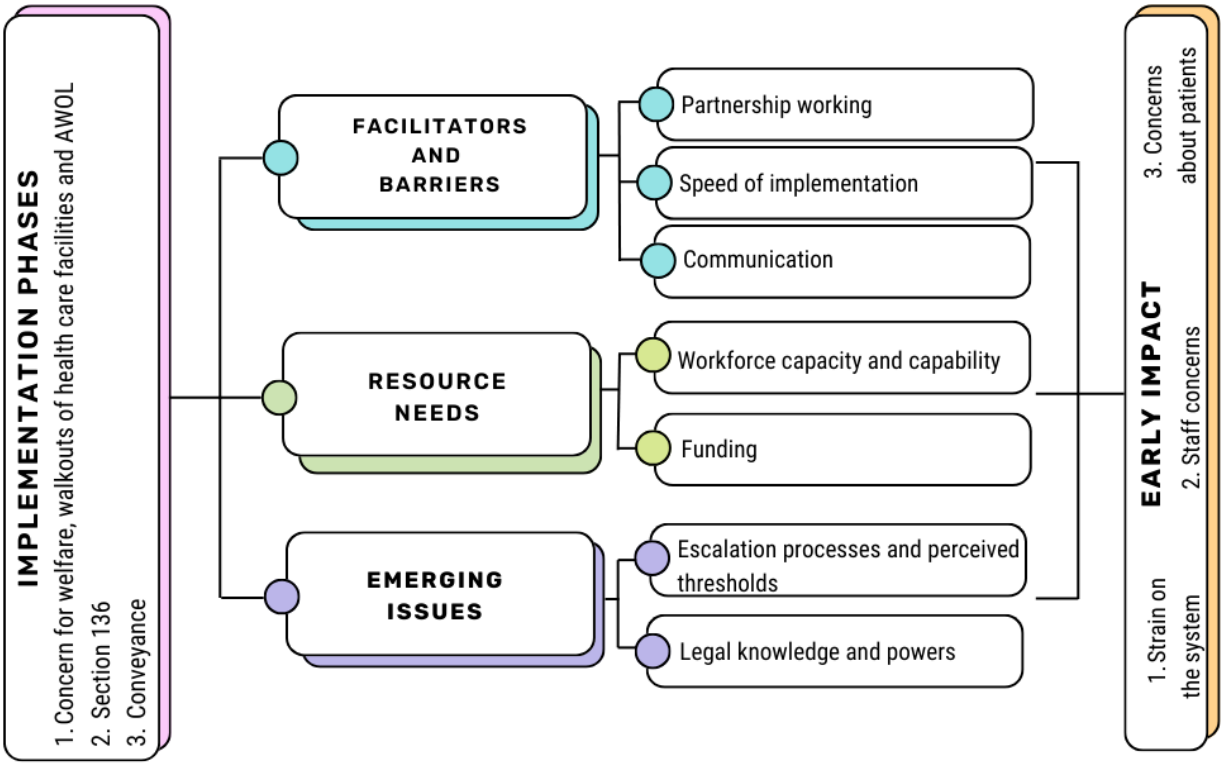
3.5 Ethical considerations

We obtained ethical approval from the Department of Health Sciences Research Ethics Committee at the University of York. The study was classed as service evaluation, so Health Research Authority review was not required. Participants were not obliged to take part and gave informed consent to do so. They were able to withdraw at any time during or after the interview, up until the point of analysis. Participants were anonymised and are not identifiable in any quotations published. Identifiable information was stored securely and retained within the research team at the University of York and The King's Fund.

4. Thematic Findings

Despite sampling sites at varied stages of implementation, geography, capacity and mental health need, we found similarities across them, highlighting common learning and particular challenges to the implementation of RCRP and potential wider impacts. Figure 1 provides an overview of these findings, which we elaborate below. As explained in section 4.1.1, our respondents generally commented on the first two RCRP phases together (phase one – concern for welfare, and phase two – walkout of healthcare facilities and AWOL form a mental health establishment), so we have grouped them into a single theme.

Figure 1: Summary of findings



4.1 Implementation of RCRP

During the development of Right Care, Right Person in Humberside, the police, health and care providers and wider stakeholders categorised areas of care where there would be substantial change. They then developed and implemented local approaches to each sequentially in four phases: (1) addressing concerns for welfare; (2) dealing with patients who walk out of health care facilities or are AWOL from a mental health establishment; (3) support and handover of patients

detained under s136 or voluntary mental health patients; (4) transportation of patients. Following national rollout through the National Partnership Agreement, many other areas agreed to take a similar, four-phased approach. London was a notable outlier, as the Metropolitan Police announced their decision to implement all of the RCRP changes simultaneously.

As part of our interviews, we explored how partners developed and implemented each aspect of RCRP and resulting practices on the ground. Different stages of implementation mean that at the time of our data collection, not all sites had implemented all phases. Most notably, this related to patient conveyance (transportation).

4.1.1 Concern for welfare, walk outs of healthcare facilities and absence without leave

Health providers' decisions to call the police in these instances are generally driven by a concern for the safety and welfare of the person in question, and to address and manage potential risks.

Although the response to walk outs of healthcare facilities, AWOL and concern for welfare represent different 'phases' within RCRP, participants often spoke about them interchangeably. When a patient leaves a health setting prior to being formally discharged, healthcare professionals commonly refer to the person as AWOL, regardless of whether they were subject to detention under the Mental Health Act. Although the police continue to have a statutory requirement to respond to patients detained under the Mental Health Act who are reported to be AWOL, as part of the RCRP approach, health care professionals are expected to undertake additional measures before the police respond. There are often parallels between these measures and those that staff are expected to take in response to people not currently detained under the Mental Health Act, but where there is a concern for welfare. We have therefore grouped these phases, but identifying where findings are specific to one area or the other.

Across sites, there was a consensus that prior to the National Partnership Agreement there had been an over-reliance on the police where there were concerns for welfare, walk outs of healthcare facilities or a patient was AWOL. At a strategic level, areas have developed policies which identify reasonable steps which staff and organisations should take prior to requesting police intervention, and clarifying the basis by which police will respond. Some individual providers have also developed internal protocols for response. Interviewees shared actions they had taken to support implementation (see Box 1).

Interviewees also highlighted the need to assess the nature and level or immediacy of risk as part of this process, including documentation and articulation of risk, to support successful escalation of action. Assessing risk was a more general theme in our interviews and we explore this further in Section 4.4. Some services and organisations reported seeing only minor change as their policies and practices already reflected RCRP policy, while others noted that RCRP had prompted them to develop or update relevant policies.

> *"I think we were doing the welfare checks that we should have been doing. So, we haven't seen a drop off or particularly a huge change to the way that our teams are working there" (Mental health trust, Site F)*

One acute trust leader shared that, despite the new thresholds for police response, where they had a genuine concern for someone's safety, they would not change their response because of RCRP and would continue to escalate concerns, while apparently accepting that the police may not respond.

> *"At the end of the day if we are concerned, we will escalate our concerns and we will continue to do that regardless … We're not going to change what we escalate because the police have changed how they respond. So we will continue to escalate but are obviously mindful that police may not respond." (Acute trust, Site F)*

Box 1: Example actions used to support implementation of response to concerns for welfare and patients reported absent without leave (AWOL)

- Developing policies outlining steps to take and criteria for police response.
- Using scenarios to establish how RCRP proposals will affect professional groups and how they should respond.
- Joint review of calls in police control rooms - adopting a more structured process to triaging calls and ensuring that health and care professionals have taken all steps necessary before deploying the police.
- Using a dedicated link between the police and ambulance computer aided dispatch system to transfer calls directly between agencies when a police response is not required.
- Raising awareness of places where people can access alternative support in a crisis, to reduce the risk of people leaving health care facilities while waiting for care.
- Implementing an AWOL risk management plan on mental health inpatient wards and clearly documenting steps they have taken if there is a decision to involve the police.
- Creating a web-based system which enables health and care staff to directly enter information on missing persons themselves, ensuring that information is accurate.

Issues were raised by ambulance services, often identified as the default response option for concerns for welfare and reported pressures to follow up on AWOL patients.

> *"My concern and, I think, our collective concern, is that inappropriate demand being placed on the police is often being translated into inappropriate demand being placed on the ambulance service" (Ambulance trust, Site D)*

Interviewees from ambulance services noted several operational factors which limit their capacity and capability to provide an effective and timely response. For example, the triage and dispatch system for ambulance services requires a clear location for response, and that there is an identified 'health' need.

> *"Ambulance services have a computer-based algorithm used to triage people, which will determine what the needs are and what category of need so that we can get you a response. If you can't answer any of the questions because you haven't seen the person then there is no identified urgent emergency care need. You've got*

to have a patient to be able to triage, assess and send response. That's where there is a group of people who aren't patients that the police would have gone to." (Ambulance trust, Site A)

In one site, an ambulance response car was used to respond to concerns for welfare and incidents of AWOL where there was an immediate need. In another site the ambulance service lead noted that they would consider a greater role in responding to concerns for welfare and missing persons, but that this needed to be commissioned as an additional service.

The scope of 'concern for welfare' incidents and associated levels of risk are potentially very wide. They can, for example, be requested by both public and non-statutory providers, and they may not even relate to health.

Concerns were raised that people not engaged with statutory services, who often face high levels of inequalities and marginalisation, may not receive an adequate response to concerns for welfare. Situations where someone was routinely attending a service but had not been seen as expected, were also raised as problematic. In both situations, lack of relevant information required to meet the threshold for police response is stated as a contributing factor.

Another limitation to a more comprehensive response from health and care services was the potential risk to staff safety in approaching someone outside of services or attending a place of residence. Interviewees felt they lacked any form of personal protection and were therefore at greater risk without police attendance.

4.1.2. Section 136 and voluntary mental health patients

Like concern for welfare and AWOL, the changed approach to s136 interactions outlined in RCRP prompted some organisations to develop a policy when they didn't previously have one. Others reported already having organisational or local policies which aligned with the RCRP proposals, building on existing programmes of work to improve the mental health crisis care pathway.

Examples of actions taken to support the implementation of s136 proposals are in Box 2. These often aimed to reduce the number of people detained under s136 and improve the police to health care handover time. Some of these actions, although relevant to RCRP implementation, may pre-date the policy change.

Interviewees reported varied responses from the police to requesting their attendance for the purpose of using their powers to enact a Section 136 order. In one area, police were reported to require greater evidence of need to provide support, but participants believed that they would still respond where necessary. In other areas, however, AMHPs reported that police interpretation of RCRP thresholds was reducing police attendance for the purpose of using s136 powers. Reduced confidence that they would attend had led to concerns and breakdown in relationships at times (described further in Early Impact, Chapter 5). One AMHP raised concerns that not being able to secure timely police support when attending someone's place of residence could result in the person subsequently leaving and the risk of more emergency community MHA assessments in public settings.

Box 2: Examples of actions taken to support implementation of response to Section 136 proposals.

- Investing in additional staffing for the health-based place of safety
- Using a mental health crisis line for police to call before they detain someone, to discuss if appropriate and if there is an alternative.
- Developing an app to help AMHPs locate a Section 12 doctor (approved doctors with special experience in the diagnosis or treatment of mental disorder) and speed up their response.
- Considering how to develop a robust rota for s12 doctors.
- Considering wider crisis pathway such as use of mental health response vehicles, alternatives to A&E.
- Working to reduce discharge delays from mental health wards to improve access to beds.
- In one area police had been paying a private nursing service to replace police officers and stay with patients in A&E, however this was discontinued (owing to resource constraints).

In more than one area, AMHPs reported increasing use of Section 135 to secure police attendance. Some interviewees noted that this is easier to organise than risking a need for a section 136, because the requirement to attend at a defined time and date gave services an opportunity to plan, ensuring the timely attendance of all required professionals:

> *"I will say to my AMHPs, just get a warrant, if you think there is any risk or there is an unknown risk… get a warrant because then the police will have to come. Actually, the police are telling me, they won't come without a warrant… I mean I probably did one [warrant] a year five years ago and we're probably doing one a week now" (AMHP lead, Site A)*

In one area, a respondent described a good police response when there was a warrant to enter in place. In contrast, an ambulance trust interviewee noted challenges in coordinating around a given time, given their unpredictable work and the need to respond to emergency calls. Although RCRP focuses on the involvement of police, interviewees from ambulance trusts noted the need for ambulance staff to be present, to undertake a medical assessment and ensure there are no underlying physical health problems that may be contributing to their mental state, or require treatment and transfer to hospital. Their view was that ambulance services were insufficiently involved in this process.

AMHPs raised concerns about their safety when undertaking community-based MHA assessments without police involvement. In one area, the lead AMHP reported that these risks had not materialised, at least up to the point of our interview, while other areas reported taking additional measures to ensure staff safety (described further in Emerging Issues, Chapter 5).

Several participants acknowledged that s136 handover times had been too long prior to RCRP, and that reducing handover delays had been beneficial for both police and AMHPs. One area reported handover times of just outside an hour, having worked on this for some time before the NPA, but

respondents in other areas questioned whether a one-hour handover was workable. Several interviewees noted the need for flexibility, particularly where there is a high risk of harm to self or others. Some areas had an agreement in place that the police would stay in A&E or the s136 suite, if necessary, and others noted that there had always been a negotiation around this. More than one interviewee reported greater 'push back' from the police since RCRP implementation and variations in the approach of different police officers, with some leaving before a formal handover was complete.

A commonly mentioned contributor to effective and timely handover for s136 was the capacity of health-based places of safety. More than one area reported not having sufficient local access to these facilities. Lack of dedicated staffing could result in delays or s136 suites being closed. In one area, issues were raised about access for children and young people. Unlike adult s136 suites, places of safety for children and young people could receive less than one person a day, making it less economically viable to staff these facilities 24/7.

Interviewees noted a range of other causes of delay, including waiting for AMHPs or s12 doctors, availability of a mental health bed, and issues with patient flow in acute care settings. Although some of these relate to health-based places of safety, many related to A&E. In some areas A&E was used as an alternative if the health-based place of safety was not available. Some sites, though, found staff in A&E would not accept handover of a patient if they were waiting for transfer to a mental health unit, as they were not able to provide a member of staff to stay with the patient. In these cases, police would have to remain regardless of RCRP, increasing handover times. Other hospitals were reported to be declaring themselves as NOT a place of safety. Further delays could occur in obtaining an ambulance transfer when a bed was found.

> *"If a patient is needing to come into our trust because of a 136, we do try and support them to be able to transport them quickly but again it all depends on whether or not they can find a bed." (Acute Trust, Site B)*

Our participants reported varied impacts on rates of s136 resulting from RCRP. Some areas reported numbers to have reduced, while others reported no change or an increase. Our own assessment of published data on s136 incidents (see Appendix C) confirms this mixed picture. More than one area reported confounding factors, including a decreasing trend since the COVID-19 pandemic, and the planned implementation of interventions aimed at managing the s136 pathway coinciding with the implementation of RCRP. Decreasing s136 rates were attributed to police potentially not attending some instances. In contrast, in two areas, increases in rates of s136 were noted to be of concern. In at least one of these, subsequent rates of detention under the MHA had not increased, and services noted a greater proportion of people being detained under s136 who were under the influence of drugs and alcohol. Interviewees suggested that the one-hour handover target was resulting in police using s136 more to detain people under the influence of drugs or alcohol and bring them into a s136 suite for assessment, rather than accompanying them to A&E, where the police believed that they may have to wait longer.

4.1.3 Conveyance

Responses to questions on plans and changes to conveyance because of RCRP were less comprehensive than for other phases of RCRP. Unlike the other phases, most participants talked about conveyance arrangements or policies which related to their own organisation or were highly

localised, rather than having an overarching policy. Measures to support conveyance were also discussed in relation to specific functions, such as transport to hospital following detention under s136, or within specific contexts, such as returning a patient who had been reported AWOL (Box 3).

Box 3: Provisions for conveyance identified by participants in their sites

- Patients may be transported by staff (AMHPs) in private vehicles.
- Acute trust staff liaise with mental health staff to organise conveyance.
- Use of acute hospital patient transport for informal (voluntary) patients.
- Use of taxis.
- Use of secure private ambulances.
- Use of ambulance response cars with paramedics and mental health professionals.

The use of ambulance services for conveyance was mentioned by several interviewees. Ambulance services were described as a preferred means of transporting patients under s136 and there were local agreements in place for this to happen. Ambulance capacity and service pressures, however, could mean that they were either unable to transport mental health patients or their response was too slow. In one area, the ambulance response car was designated to respond, while in other areas AMHPs reported only using the ambulance service when transporting people with physical health issues. In some cases, the police remain the only available agency to transfer patients safely to hospital, but even when this was not the only option, we heard reports that the police continued to transport patients, bypassing alternative means for conveyance because it was quicker.

Similar to s136 discussions, interviewees reported delays to conveyance which result from capacity issues in the wider system. These system stresses do not result from RCRP but may constrain its implementation. In one area, an interviewee shared examples of the police arriving at a s136 suite to find that there was no local capacity. In another, ambulance staff were unable to use local streaming services for mental health patients in A&E, leading to waits for check in and onward referral. In both cases, interviewees reported having tried to phone ahead, but that staff were too busy to answer the phone. Interviewees shared that these delays led to examples of poor care, where a patient is locked in the back of a police vehicle while trying to find a place of safety.

More than one area reported investing in the use of a private ambulance service, as they were reported to have the staff with the appropriate training to transport patients who presented a higher risk of harm to themselves or others or who were deemed resistant to care. This was particularly noted in relation to conveyance following detention under s136 or s135. The cost of private ambulance services could be problematic, particularly where risk is escalated, and additional staff may be required. One area reported terminating their contract with a private ambulance service, seeking a more person-centred and cost-effective option.

Interviewees gave several examples about the role of legal powers in relation to conveyance. One area of tension was around the role of the police powers in relation to the MHA. Ambulance staff raised concerns about the police not staying with patients when they were transported, since they did not have training in restraint nor appropriate safety protection, ultimately resulting in police involvement as they would have no power to detain individuals.

A commonly reported issue was use of the Mental Capacity Act (MCA) as a framework for bringing people into hospital. Ambulance staff reported being asked to use the MCA, and acute staff reported the police using MCA to bring people into hospital. Interviewees reported concerns with being able to adequately assess mental capacity for the purpose of MCA prior to conveyance, and use of the MCA in instances where there is a clear concern about the person's mental health, in which case, the MHA should be used. One acute trust told us that they were currently going through legal discussions with the police to address this issue.

A further major concern raised by interviewees in acute trusts and A&E was the conveyance of people outside a legal framework, including people being brought in by the police 'voluntarily' in restraints but not under any specific police power.

> *"We're often asked to bring people back to hospital using the Mental Capacity Act based on the capacity assessment that somebody else has made, probably a few hours before... We get there. We think the person's got capacity. We've got no power to bring them back, but you've got A&E sister on the phone saying "No, need them back. At really high risk". And then our staff are in a very difficult situation where they might be taking somebody who actually does have capacity and is making an unwise decision". (Ambulance trust, Site A)*

4.2 Facilitators and barriers

The implementation of RCRP has required strong partnership working between the police, health, and social care organisations in each locality. The initial quality of partnership relations is likely to have been different across the sites, which has potentially significant implications for RCRP roll-out. Most sites reported that RCRP has been implemented rapidly, and this speed has affected initial perceptions of the policy change as well as hindering implementation due to resource needs and communication challenges.

4.2.1 Partnership working across sectors

Developing partnerships

Partnerships were described by many respondents as initially strained, as the changes were seen as a unilateral process that had been dictated by the police. Persistent discussion, negotiation and *"robust feedback"* from senior health leaders has improved these relationships in several areas, building a shared understanding of each perspective.

> *"Over time, our police force certainly did actually become very collaborative around the process. Initially, everybody felt like we were being 'done to'. But it was helpful because they were receptive to conversations, they could actually understand the complexity." [Mental Health Trust, Site B]*

Where existing relationships were already in place, or there was evidence of strong working relationships and engagement from senior leaders, organisations experienced a smoother transition. In some areas, health and social care providers have been working for some time to move to a more

coordinated health response, reducing police involvement, for example as part of the Crisis Care Concordat.

> *"We had different discrete pieces of work that were trotting along, and what we did is we just started to structure it all, pull it into a single section 136 action plan… the police were just telling us through our existing crisis workstreams, yeah, we're doing okay, it doesn't look there's anything new coming out through RCRP, we're still on the right tracks." [Mental Health Trust, Site C]*

Where present, strong working partnerships between health and police have facilitated understanding and supported change. Often this depends on local relationships with police leaders that model appropriate responses and are actively available should escalation be required. A participant from an ambulance trust working across multiple police force regions was able to make regional comparisons, highlighting the importance of very strong partnership working and highly supportive local police leaders, which had promoted collaboration and built trust.

> *"I feel like we've been very much included in the conversations. Nothing has been done to us, it has been a two-way conversation. I can't say the same for the other forces within the region." [Ambulance Trust, Site B]*

Conversely, there were clear strains in relationships in some sites, affecting their ability to engage in effective partnership working:

> *"I think it's wrong to be rolling something out called a national partnership agreement because as far as I can see, there is no partnership about this. This is a police initiative to remove themselves from what they don't see as their business and I'm unclear about what our partnership is with the police now." [AMHP Lead, Site A]*

Temperature checks to adapt implementation speed

Some areas used temperature checks to assess health and social care partners' readiness for implementation stages. These enabled a strategic approach to identifying initial problems before moving onto further stages of RCRP, building trust between police and health partners and identifying areas for further training or improvement:

> *"There were some things that came out of [the temperature check] around actually police call handlers needed more Mental Health Capacity Act training. [The] Ambulance Service were able to do joint training with police call handlers and ambulance to upskill both sets of staff around that. It was helpful and it built some relationships as well… we were able to arrange for Samaritans to go in and do some training sessions with the call handlers in order to improve decision-making." [Mental Health Trust, Site B]*

Regular and frequent strategic and tactical meetings

Strategic and tactical monthly meetings, with senior involvement, across multiple health and social care providers and the police created opportunities to discuss implementation and make improvements when issues occurred. This was described as giving health partners a voice in the discussions, and promoting collaboration, which was particularly important due to early perceptions that RCRP was a police initiative that was 'happening to them':

"We have been able to communicate directly, straightaway, if we've had any concerns which has made it feel a lot more, where we've had a voice within this rollout and not just that this is coming" [Acute Trust, Site B]

In most areas, strategic meetings were used to develop and refine *policies* for implementation, while tactical meetings focused on *cases,* reviewing specific examples to improve practice. In one of our sites, a series of working groups were used to develop policies (for example on data, and training), with the strategic group retaining overall oversight. Tactical meetings were more problem-focussed, reviewing specific cases, rather than aiming to prevent problems.

"We're not getting it right. So, then [the police] allowed us to work through those little bits of where we phoned them and then [the police] explained it and then it's come back into a strategic [meeting]. We've then brought our learning back… so you're closing the loops at all points." [Acute Trust, Site B]

There was an appetite from multiple stakeholders across sites to use these meetings to build learning, and to highlight system pressures, and potential negative consequences if things go wrong. During early implementation stages, these discussions were important to ensure there was shared understanding around which partner would be responsible in different scenarios, and identifying examples where police would continue to respond:

"[What the police] started doing is bringing case studies of examples. And it's quite interesting because they've actually brought [examples of incidents where] quite a few people have got it wrong, thinking that the police would no longer deploy. And the police are saying, no, we will still deploy to that, this is the reason." [AMHP lead, Site C]

Collaborative roles spanning mental health and policing

In areas where partnership working was described as working well, stakeholders had paid particular attention to embedding health and police working together. In some cases, health professionals and police are co-located, for example mental health staff working in control rooms, or health leaders visiting control rooms during implementation. Some of these initiatives pre-dated the NPA. Closer working between health and police brought about a shared language, helping to navigate different cultures, improving relationships and trust:

"I'm very keen to try wherever we can to introduce Police staff into the world of mental health as well. Not because they need to know it, because it makes relations better." [Mental Health Trust, Site D]

"[The police] have given us a contact of somebody who will then have, I know, reviewed the contact with the control room and looked at the recordings, obviously, of those discussions. And that's what we're also then working on about the language we use and what we need to emphasise for police to be aware of risks, yeah." [AMHP lead, Site E]

Following changes in some regions to remove police street triage services, forces had introduced dedicated mental health police officers to support a coordinated response to patients in crisis. In one location, an additional ten mental health police officers had been employed to support this

move to more collaborative working. Meanwhile, one mental health trust had police co-located on wards and described the benefits this brought:

> *"[Mental health police officers] will also support if we need some advice… they are on site, they are based on the wards. So with the AWOLs, that decision around 'have we done enough, do we need to do more,' they will support some of that and we can have that conversation... so we have the ability to do that... there is a good working relationship... at a more local level" [Mental Health Trust, Site C]*

Strength of community-based services

Across sites, participants gave examples of how community-based services contributed to the response to RCRP changes. This particularly related to community-based crisis services including crisis support lines (including 111 option 2, which provides mental health support 24/7), crisis cafes, street triage and ambulance response cars. Participants describe these services as providing support for patients experiencing a mental health crisis without hospital attendance and avoiding potential gaps in service. Existing dedicated 24/7 support for older persons in one area reduced the perceived impact of RCRP changes on welfare checks and AWOL patients. One site also described collaborating with patients' mental health forums to enhance awareness of support options for patients, which gave them a more grounded understanding of patient perspectives.

Services, such as ambulance response cars, had typically been introduced as part of wider work to improve crisis pathways, but there were ongoing challenges of staffing these with both mental health professionals and paramedics:

> *"We're introducing specialist paramedics in mental health. We have mental health vehicles that are purely there to support patients in mental health crisis, that don't turn up to street addresses in a big yellow ambulance with blue flashing lights on it… I would really like it to be [staffed by] a mental health nurse and a paramedic. I think that would be for me the gold standard… then we've got someone from a mental health perspective that's saying, I'm confident this is a mental health presentation. [Paramedics] as a profession don't necessarily have the knowledge, the ability or skills to make that determination." [Ambulance Trust, Site B]*

A particular challenge raised by participants was a police expectation of common service provision across different geographies, whereas in reality, the function and response of individual services often differed due to different commissioning arrangements. Police expectations of a service's ability to respond to RCRP changes might not match their actual capacity and capabilities, which can result in perceived gaps in the response to people in need.

4.2.2 Speed of implementation

While most interviewees were in favour of reduced involvement of the police in mental health, the speed of implementation and national narrative influenced perceptions.

> *"I think one of the things that surprised me for this rollout was that we moved so quickly. In speaking with Humberside, they are very candid that… it was the softest of soft launches. [They] really had the time to digest what was working well and*

what wasn't. And they explained it as being able to walk to this arrangement rather than having it being foisted upon them." [Mental Health Trust, Site F]

Amended timescales and 'soft transitions' improved the initial impressions, and in some instances implementation plans have been adapted based on local needs:

"[There were] incredibly tight timescales initially and I think maybe our Right Care, Right Person journey started off slightly on the wrong foot and then significantly improved in quite a short space of time. Essentially, the [police] issued this letter out to chief executives… it went to a number of local authorities, it went to health partners, hospital trusts… the proposal was, well, we're going to start doing Right Care, Right Person from two days after the meeting. Obviously, I think that was a policing decision and people within the stakeholder meeting were able to, I guess, robustly fed-back that we may need to renegotiate some of the timelines." [Mental Health Trust, Site B]

4.2.3 Communication

Across all sites, respondents described communication problems as a barrier. There were shortcomings at various levels, not assigned primarily to any one organisation. Our respondents described problems including a lack of guidance by NHS England, impact of media coverage, challenges due to workforce size and culture and failing to capture all stakeholders affected by RCRP.

Lack of national guidance

Related to the speed of implementation, participants describe a lack of national guidance as a key challenge as they navigated how best to implement the changes. Respondents described developing localised tools and processes with very little national guidance:

"Health felt, to me, that it stepped in at a much later point... we had no national guidance around it, that didn't come until August and the letter came out in February…. [we needed] more notice in systems about the intentions and then supplementary guidance in a more timely fashion." [Mental Health Trust, Site B]

Media portrayal of police disengagement from mental health crises, particularly in relation to the Metropolitan Police's response, was described as exacerbating communication challenges and perception of RCRP being a police-led initiative:

"The way it was announced in London was through the press, and it wasn't really the formal comms, so I think that caused a lot of anxiety, because there wasn't the whole context there. So, I think that staff were probably feeling more anxious about whether the police would attend. And I think there [are] still pockets of that actually." [Ambulance Trust, Site F]

Some staff described how this had altered staff attitudes about what constitutes a police matter. While this was mostly discussed in terms of police officers' resistance to supporting mental health crises, in some instances there was a lack of clarity about the conditions in which the police would provide support. These instances were reviewed at tactical meetings between police and health partners, for example:

> *"So, one example [the police] gave was, there is someone who rang the mental health team yesterday and said they were going to take an overdose when they get off the phone. The mental health team went out and saw her and she was quite distressed but agreed to see them the next day. She then rang the team today, saying 'I'm about to hang myself...' Quite a few [AMHPs thought], well, she was seen yesterday, this looks like a conditional kind of threat, it should be the mental health team now. But I think it's because people are now expecting the police to, sort of, not respond to anything. But the police were very clear with us, you know, that's Article Two [right to life], we would respond to that." [AMHP lead, Site C]*

A lack of detailed information communicated about the specific details of the NPA was evident from health service providers' limited knowledge of the RCRP phases. Many participants became aware of the policy change through word of mouth with a lack of information about processes, particularly police thresholds for involvement. Some of our participants were unaware of changes directly relevant to their field of practice.

Size of workforce and organisational structures

Some of the initial challenges of negotiating rapid implementation timescales arose due to each partner's lack of knowledge about the other's system pressures. Health and social care participants suggest that police colleagues did not understand the scale and complexity of the health and care system, relevant pressures which may impact implementation or the potential risks to patients. Processes of adapting policies, providing training, and freeing up time for potentially large numbers of staff to attend, all required time:

> *"The [police] were like, we've done a briefing paper that explains Right Care, Right Person but people are still ringing us, they don't understand. And we were like, we have [almost 100,000] health and social care staff, not everyone is going to get the message the first time… [they] didn't realise there was that many people." [Mental Health Trust, Site B]*

> *"The communications came quite late and then very fast, numerous…ten emails a day type thing. And then it was all a bit of a rush. So, I think there was certainly…I think other people must have said that, there would probably be some learning about communications." [Mental Health Trust, Site F]*

High staff turnover in some organisations and use of agency and locum staff added further complications to communication.

> *"One of our biggest challenges is workforce, so it's not like we're trying to educate everybody in a one-off hit sort of thing, it's something that we need to keep doing repeatedly with clinicians and managers because our rate of turnover, the volume of agency locums." (Mental Health trust, site E)*

Organisational culture

Participants described rapid changes as challenging at times due to working across very different organisational cultures in the police and health spheres. At times this limited communication in meetings where RCRP implementation was being discussed:

"We got a lot of silence on calls; I think people felt like they were getting told off or that it wasn't a psychological safe environment to speak up." [Mental Health Trust, Site B]

Police culture and health culture is very different; police culture is very hierarchical and very command and control, and it's absolutely not like that in the NHS, particularly in mental health. I think they had to understand that we couldn't just say to people, do this, and it happens." [Mental Health Trust, Site B]

Including the full scope of organisations affected by RCRP

Some health and care providers appeared to have been excluded from initial partnership development, causing problems in the later implementation phases. Primary care, emergency departments, private care homes and voluntary and community sector organisations were all listed as key stakeholders that were frequently missed. Voluntary and community sector respondents described themselves as being excluded from much of the communication around the introduction of RCRP, resulting in a lack of awareness of the policy and its potential impact:

"I think [there] needs to be a lot more publicity across the board, so then the likes of voluntary services, especially small ones, who still might be working with individuals, will have that information available to them." [Voluntary sector organisation, Site D]

"The whole thing had been developed without any input or any voice from the charity sector" [Charitable organisation lead, Site D]

The voluntary, community and social enterprise (VCSE) sector is large and complex, and we were unable to interview leaders from VCSE organisations in all areas. Where we did, though, there was a general lack of knowledge of the changes in police response, and concerns were raised about the potential for patients to 'fall through the gaps' in care, particularly with regards to welfare checks.

Some participants cited concerns about the lack of engagement with primary care, whose perspective was not represented in some localities' implementation group meetings:

"I think we did have potentially some gaps around awareness with GPs where it's been a little bit harder to ensure that all GPs were aware" [Mental Health Trust, Site C]

4.3 Resource needs

4.3.1 Workforce capacity and capability

Challenges in workforce capacity and capability were cited broadly in our interviews. Here, we use 'capacity' to refer to issues around workload, and the volume and skills of the workforce that may limit an organisation's ability to respond. We use the term 'capability' to refer to an organisation or individual's ability to respond for different reasons, such as legal remit, and infrastructure, such as access to patient records.

Interviewees from A&E, acute hospitals, ambulance services, mental health services, crisis services and social work all cited workforce capacity as a constraint to being able to actively respond in a

timely manner. Staffing levels were raised as a particular challenge owing to existing staff vacancies (one area faced a 40% vacancy rate). Concerns were raised about responses outside usual working hours, when services typically operate with lower staffing levels and capacity is therefore stretched.

Participants also consistently cited challenges in capability to respond, particularly to people who were AWOL or where there were concerns for welfare. Constraints were related to how well the requirements for response aligned with the functions or operations of the role or service and their ability therefore to respond in a timely manner. For example, one participant described the ambulance services as providing 'urgent and emergency care', and this sentiment was echoed by other ambulance service participants. Similarly, one interviewee described the AMHP service as an 'emergency service'. There was a general lack of understanding, particularly about the appropriate role of organisations in responding to patients who are AWOL, have walked out of health care facilities, or have other concerns for welfare.

Participants from both acute and mental health hospitals reported examples of the police expecting staff (clinical and security) to follow or bring back patients who had recently left hospital premises (walk out of hospital facilities and AWOL). Capacity, capability, and perceived threats to safety often prevent health care staff from doing this. In addition, this can be constrained by the legal framework for detaining people who do not consent to return, and an operational remit which relates to working within the hospital. Some locations used security staff in these circumstances to supplement the capacity of the clinical workforce, but some of our interviewees perceived this as inappropriate.

Low and unpredictable numbers of mental health patients for one Children's Acute Trust was highlighted as creating challenges in being able to stay with a patient requiring a s136 assessment, leading this Trust to use a private company to support such incidents:

> *"The numbers of calls around children and young people are really, really tiny in comparison to the adults… We have got a specialist company we can and have used but mobilising them takes a bit of time and also is a significant cost." [Mental Health Trust, Site C]*

One of the ways that areas sought to disseminate the changes to staff was through training. Sites described a focused effort on training through varied means, though it was stressed that this would take some time to reach all stakeholders affected by the changes. Examples of training and resources can be found in Box 4.

Box 4: Examples of training resources used by sites.

- Localised toolkits or handbooks.
- Online information provision through a staff internet page.
- Reciprocal training between police and health partners.
- Shared training from external providers such as The Samaritans.
- Shadowing for police officers and paramedics following MH crisis teams.

4.3.2 Funding

There has been no specific additional funding to support RCRP rollout, nor any redistribution of cost savings from policing to mental health. Many respondents viewed this as causing challenges for health care providers managing the associated increased responsibilities and workloads.

Where changes have been implemented, other funding sources have been used, for example at one site the introduction of MH response vehicles was funded through the Integrated Care Board under NHS Long Term Plan funding:

> *"[Funding] is obviously something that people bring up a lot. And I suppose I'm in an awkward position where I have to remind people that we have had funding for crisis alternatives and mental health support for the last five years as part of the NHS long-term plan." [Mental Health Trust, Site B]*

In another site, funding had been identified to support 24/7 staffing of the s136 suite through an agency. The funding was reallocated from the staffing budget for the mental health crisis team, which was unable to fill vacancies.

> *"Yes, so where there has been money created, I'm certain that that's at the expense of somewhere else, I don't know but somewhere has lost because that money…the money hasn't been…there is no extra money, it's just been redistributed." [AMHP Lead, Site A]*

Changes in policy as a result of RCRP could lead to increased demand for services, increased workload for staff, or additional staffing demands, with associated financial implications of meeting those needs.

> *"I think it is something that we're aware of because we've seen an increase in calls as well within the Ambulance Service, which obviously has a cost associated to it." [Ambulance Trust, Site F]*

> *"If somebody goes AWOL from a ward, we might try and go and look for them a couple of times in a day, but depending on the nature of the patient we might have to send a team of two or three people, and given that our wards generally might only have five or six staff on at any one point we would be having to get additional staff in in order to be able to conduct those searches". [Mental Health Trust, Site E]*

There are clear trade-offs between different areas of mental health care, and a need for providers to make difficult prioritisation decisions, which raised concerns around the potential impact on preventative activities:

> *"Part of the worry locally is that of course if we end up putting too much money into the crisis bit and into the acute hospitals, it doesn't leave enough money with mental health for us to do some of the core transformation that we need to do. So, things like community mental health, to stop people going into crisis in the first place, we don't want to keep putting all of the investment into crisis care, you've got to try and do that upfront work." [Mental Health Trust, Site E]*

Examples of investments reported by participants to be supporting the implementation of RCRP in local areas are provided in Box 5.

Box 5: Examples of investments to support the implementation of RCRP

- Mental health response vehicles, staffed by paramedics and mental health nurses where possible, to provide a coordinated response.
- Private transport vehicles. Previously supporting movement of patients out of hospital, freeing up acute care flows, these were also being used to locate AWOL/walkout patients.
- Private security services in A&E to support where police presence had been reduced but patients were still attending A&E prior to mental health assessment.
- Additional staffing of the s136 suite - in one area this was increased to 24/7 support.

5. Emerging issues and early impact

5.1. Emerging issues

5.1.1. Unclear escalation processes and perceived thresholds

Participants reported a lack of transparency on the real-time escalation processes by which police review disputed decisions for their involvement, including a control room toolkit developed by Humberside Police, which was generally not shared with health care services. The speed of implementation, views of RCRP being a police initiative, and alarming media coverage all fuelled a perception (and in some cases a reality) that the police would not respond even in instances where health and care partners believed that the RCRP threshold had been met. Escalation processes enabled health and care staff to challenge decisions where the police refused to respond to incidents which fell outside RCRP:

> *"[Police officers are now] saying, carte blanche, anything to do with mental health, we're not doing it, under Right Care, Right Person. So, we almost have to refer back to them, okay, which are the four stages are you referring to? Because as far as I can see this doesn't relate to any of the four parts of [RCRP]. So, we have to challenge back now." [AMHP Lead, Site A]*

> *"Even the police officer on our front door was a bit… quizzing herself about what is the toolkit? Because [it varies] depending who you speak to on the day and how that was then escalated." [Social Care Lead, Site B]*

Early conversations between stakeholders were hampered by different organisational language, differences in perceived risk between individual professionals and organisations, and a lack of shared understanding of appropriate thresholds for police involvement. Whilst health providers acknowledged they had become too reliant on the police for non-police matters, there were indications that the 'pendulum had swung too far' and that the police on occasions were now not attending when needed. Incidents that represented a threat to patient or public safety were described, which would fall outside RCRP, but health and social care providers described needing to escalate incidents to senior police officers due to lack of police response (see Section 5.2.3, 'Concerns about patients'). This appeared to suggest a different perceived threshold or tolerance of risk to patients and the public.

> *"The threshold is quite clear that if there's crime and disorder or if there's a threat to life or a serious risk to the person, police will attend. Doesn't matter what's involved, doesn't matter whether it's a mental health related issue or not." [Mental Health Trust, Site D]*

Participants described some instances where police response was less likely if an individual had a previous history with mental health services. Identical patient behaviours, including risks to themselves or the public, generated a different police response if the individual was known to suffer from mental ill-health:

"As soon as someone mentions a mental health element, whatever the patient is doing, or the person is doing, if suddenly there's like a mental health element to the presentation, then somehow it doesn't become a police issue." [Ambulance Trust, Site D]

The importance of strong partnership working was needed to overcome these challenges, with tactical meetings often being used to review these cases:

"I think that's just made it a bit blurry and it's a bit grey on what we believe as a threat to life to what other people deem it as that and that's still a lot of learning because… we've only just rolled this out in October. So, it's still just ironing those bits out." [Acute Trust, Site B]

"There needs to be a lot more of an understanding, not just, from the police, but amongst alternative services about what are your thresholds at which you think you should be getting involved and what are those processes of escalation? So, a clear understanding about, and it sounds really obvious, but not just about roles and responsibilities, but things like, what is everyone's legal powers? Understanding about what people's capacity is to undertake the work. What's a realistic response? And I think just a lot more clarity about what can be done within the legal framework for people who are, like I said, voting with their feet and just not engaging with services. How much risk are we all prepared to take to run with a degree of uncertainty." [Ambulance, Site D]

To overcome these challenges, health care professionals had sought to articulate how to communicate risk effectively to escalate incidents requiring police response, and development of clearer protocols and staff training:

"We're obviously trying to roll out an education and training package for our staff as well. So, it will be role specific, and it's mainly based on communication and if you need the police to do something, how you communicate that in a way that they will understand in their language." [Ambulance, Site F]

5.1.2 Legal knowledge and powers

Lack of legal literacy and misuse of powers

Varying degrees of legal knowledge pertaining to mental health law and policing powers were identified in our interviews, with some misunderstandings about legal powers in places and general confusion about roles and who was appropriately able to respond. Of particular concern, we were told that call handlers in some force control rooms were incorrectly advising ambulance or fire services personnel that they have powers of entry to people's homes for those with mental distress. In one site, a participant reported that the ambulance service was told they have powers to detain under a Section 136 order:

"One of those occasions the police control room told a mental health worker that they were going to send an ambulance to deal with the situation. And the mental health professional said, I'm not sure they're going to be able to help because this lady wasn't injured. And they said, oh no, 'cos they can detain her under a 136'.

Well, we know that ambulance staff can't detain under a 136, only police can." [AMHP, Site E]

The use of the Fire and Rescue service to force entry was reported for welfare checks, and during the execution of a s135 Warrant, which is not permitted by law. Ambulance service employees also described the lack of awareness of the legal powers as a very concerning issue:

> *"The Mental Health Act is actually, very clear about who has the authority to [detain a patient] and that doesn't include the ambulance service… the bit that the police are missing is the education element. … we don't have those powers, this does not meet the threshold for forcing entry into this house type of thing, that's why we're not going." [Ambulance Trust, Site D]*

> *"[The ambulance service] have no power of entry into properties. The real difficulty that we're having here, is at what point do we say that we're gaining entry to somebody's property and at what point is that reasonable? Because there have been instances where we have utilised fire services to gain entry into properties for us and the property has been empty, and the patients or people have returned whilst we're inside the property. And I don't know about you, but I know how I'd feel if I'd returned home, and I've got emergency service people breaking my door down and inside my house. For what reason? I think there are some legislative aspects that are lacking with regards to agencies who carry these out and who the right agency is. I think it needs to be an agency that is able to gain access to properties, that is able to gain access to undertake these searches. I don't think Fire and Rescue have a role under their search and rescue capabilities" [Ambulance Trust, Site B]*

Lack of legal knowledge was evident across all the stakeholder groups that we interviewed, and we found numerous examples of mental health care providers having limited understanding of the police's legal framework. One participant reported that prior to RCRP legal powers had been used flexibly and potentially beyond their legal remit, and this was no longer tolerated.

> *"[The police] raised a case study where they were asked to do a welfare check, which basically meant they were asked to put the door in and they [the police] refused to do so, and I think completely appropriately, and the mental health team were like 'this meant we had to go and get a warrant, we had to get the AMHP, and all that stuff like that', and yeah… that's how it's supposed to work. There should be a really high bar for forcing your way into someone's house and carting them off to hospital. That should be hard. You shouldn't be able to just phone up your local copper and ask them to come and put a door in." [Ambulance Site, D]*

Gaps in legislative powers

Interviewees expressed concerns about the ability to force entry to a vulnerable individual's property when they have concerns about their safety, but where issues may relate to other local authority functions such as social care or safeguarding. In one area an AMHP described using s135 warrants as a means of gaining entry and ensuring police attend, while recognising a lack of the required evidence of mental disorder:

"*What the police are now saying is PACE [Police and Criminal Evidence Act 1984] can no longer be used. So, I'm concerned that there is actually a legal gap, there is no legal framework to have a power of entry to assess someone who may or may not be vulnerable, mentally unwell, at risk of neglect, apart from a 135 warrant but you have to have evidence that there is a mental disorder present*." [AMHP lead, Site A]

"*So the unintended consequences of that is we've got safeguarding colleagues, social care colleagues ringing up the AMHP service, asking us to use warrants, again inappropriately so, because we don't have evidence that they are suffering from a mental disorder but it's the only way to get in to assess the situation, a safeguarding situation for an adult. I say to my colleagues, just get the warrant and go because I don't want someone to die.*" [AMHP lead, Site A]

5.2. Early impact

While impact has not been formally assessed in most areas, participants expressed concerns about perceived effects. These can be grouped into three overarching areas: *system strains* (largely financial constraints and capacity issues), *staff* concerns (increased workload, safety concerns and tense relationships between staff in partner organisations) and *concerns about patient impact* (in terms of quality and access to care).

5.2.1 System strains

Changes had brought additional strain on the health and care system, which is already facing significant financial, workload and staffing challenges. This had prompted resistance from some agencies, with health and social care providers raising concerns:

> *"Now somebody's got to pick it up. Now if the police aren't picking up, somebody's got to pick it up... who's going to do this thing if [the police] are not going to do it. So, all the services are pushing back, the councils, the [mental health trusts]." [VCSE representative, Site B]*

Capacity and capability of services to adapt to these changes was particularly worrying for health and social care providers needing to balance decisions about where to focus care (capacity) and without the necessary legal remit or infrastructure to support the new expectations being placed on staff (capability).

Some interviewees reported this resulting in unrealistic expectations of staff within services in the context of the role they are commissioned to provide (for example VCSE organisations carrying out welfare checks). Respondents also reported non-clinical staff becoming involved in incidents where police had not attended, or would no longer attend under RCRP, despite these staff lacking appropriate training and legal powers:

> *"I had a situation with a chap that had been in an acute hospital, so the general hospital, very unwell mentally, had left the hospital with the intention of running into a road. Security were outside holding the person and they were trying to get away from security, it felt very unsafe because security aren't the police and when you've got somebody who is mentally unwell, and they are being held and they're*

not trained to do that. I had an AMHP outside because they had just run across from the unit to see what support they could offer. They had rung the police and said, please can you come and assist because we need to move this person to a place of safety, Right Care, Right Person, we're not coming." [AMHP Lead, Site A]

Ambulance Trusts appear to have been notably affected by RCRP. In some areas they have been designated additional functions to respond to mental health-related incidents, for example concern for welfare. In other areas this has not been specified but nevertheless they have faced additional demand, being called to incidents such as welfare checks, despite not having a legal right to gain entry to property if they are unwilling to engage, or subsequently detain them for assessment where required.

"I think [ambulance services] feel like they are the inevitable backstop because they are the other blue light service. I think they think all roads lead back to them. And I think that possibly has been true to a certain extent." [Mental Health Trust, Site E]

Lack of clarity on thresholds for police response within RCRP (previously described) created additional pressures on the system as senior leaders attempted to navigate these rapidly evolving changes without national guidelines and amidst resistance from other partners, each working within their own limited capacity and capability. The consequences of this included staff time and other costs associated with s135 warrants and concerns about duty of care to patients (described elsewhere), and delays to patient care associated with escalation processes to acquire police support:

"I then tried to ring back, I held on for 25 minutes. And again, you know, I had to explain everything over again or maybe I didn't get through or whatever the case may be. Then you think, well, actually is somebody evaluating that individual and that's one of the reasons why we want our operational staff to do that, but that nurse potentially spending 20 minutes to an hour trying to get a police response about one patient, when you've got a corridor full of patients and the patients in the back of an ambulance that actually need nursing care." [Acute Trust, Site E]

5.2.2. Staff concerns, relationships and trust

Interviewees working in health and social care described concerns about staff safety, and experiences where staff members had been at risk. This was related to a lack of confidence in police response to incidents where they would previously have been involved. As a result, some sites described an increased use of s135 warrants to ensure police attendance and in some locations AMHPs are attending all MH callouts in pairs to reduce safety concerns. This was not always possible due to capacity constraints. Participants also described how it was not always appropriate for healthcare professionals to attend in some environments, where the police may still be needed to provide support:

"So, we gave this person leave because they have been able to do X, Y and Z in the last week or so, but we do know that on occasion they may want to go to the pub, and it may then mean that they're in the pub for several hours. It has an effect on their recovery and therefore we may need to involve police in bringing someone back from the pub. We might try and go there ourselves but there are some

environments you just can't expect healthcare workers to be able to attend to. We do need the expertise of the police in some instances". [Mental Health Trust, Site F]

While there appeared to be generally good relationships at a strategic level between the police and health/social care stakeholders, there was some evidence of a deterioration in individual relationships on the ground. This appeared to reflect limited collaboration and trust built between the police and other partners:

"The [police force's] approach to Right Care, Right Person was quite aggressive and not a particularly collaborative launch. There was a great deal of anxiety. Knowing what we know now, I feel much more comfortable with it. But back then, I think there was a great degree of nervousness." [Mental Health Trust, Site F]

Ambulance trusts, working across large regions including multiple police forces and health trusts, were able to draw comparisons between police forces, and highlighted differences in approach. Participants from ambulance trusts reported different responses from police officers in different areas, which undermined confidence in requesting support and obtaining an appropriate response. They raised concerns around incidents where police had not responded appropriately, and potential breakdowns in paramedic-police relationships:

"The [police] didn't attend an incident and it resulted in physical harm to two of our staff…. It was quite traumatic from a crew perspective, and I think the police have recognised that they should have attended that situation… [It] can really create a negative relationship with police colleagues from a ground level. So, crews seeing their direct peers and colleagues being attacked and the police refusing to attend to support them, it creates some animosity between." [Ambulance Trust, Site B]

Trust had been undermined in some locations where police had declined to respond to incidents leading to strained relationships and animosity. Variation in responses led to health and social care providers being concerned about safety of practices, both in terms of patient/public safety (discussed in the following section) and particularly risks to staff:

"[A patient] had assaulted five members of staff, the [health professionals] had her locked in her room for everyone's safety… It was just unmanageable levels of violence… they phoned the police who suggested phoning the ambulance because it was a health matter. And they said [the patient is] being violent and aggressive, there is a risk to others here. And [the police] responded 'you need to ring the ambulance'…. [but ambulance staff have got] no skills in restraint. We've got no powers of detention or arrest. What is it you actually want us to do?… I think she just wanted anyone. And on a compassionate level you absolutely feel for that person, that member of staff, who's now got five assaulted colleagues." [Ambulance trust, Site D]

"We've seen a deterioration in relationships, so our crews are often in situations where they feel they are threatened. They are going into environments where people might have knives and other weapons. That is a daily occurrence right across ambulance services, not unique and really quite stark… they say that's because under RCRP they don't go to health, they'll only go if there's been a crime." [Ambulance trust, Site A]

One respondent from an acute trust described a sense of 'moral injury', feeling that duty of care to patients was being undermined by the RCRP implementation, and particularly that patients were no longer going to be followed up. Other participants expressed similar sentiments. They described challenges around different perceived thresholds for risk (described in Section 5.1.1.) and concerns about new levels of risk and lack of clarity around who is responsible in the absence of a police response. This was highlighted in relation to welfare checks and following up patients who had left hospital without treatment or discharge. Some staff accept the importance of patient autonomy, but other situations are more challenging, particularly where there is a risk of suicide or self-harm:

> *"It's quite hard, isn't it, when somebody is in a mental health crisis and then saying, right I'm going to go and leave the last word is, I'm going to kill myself.... It's hard for staff to then think, have I done everything because [we] would want somebody to follow that person up once they've left the trust. So, it is really difficult just to change that cultural mindset." [Acute Trust, Site B]*

In one emergency department, staff took part in daily 'huddles' to support each other, and to explore potential for learning:

> *"it's just supporting staff and we do that by having daily huddles within ED. We already had that anyway, from a safeguarding perspective but we make sure that if we come across somebody, that we've been aware of, we actually debrief and talk about it with our staff members." [Acute Trust, Site B]*

5.2.3 Concerns about patient impact

While discussion around impact tended to focus on staff and system challenges, several participants shared examples of concerns about patient or public safety when they were unable to access police support to address the identified risk. Patient impact was also inferred as resulting from workforce shortages, delayed or lack of response from police or differential staffing coverage at different times of day. Specific examples of patient experiences described by health and social care providers are given in quotations in Box 6.

Many respondents discussed gaps in response, their own lack of capacity to respond, and their concerns about the potential negative impact on patients where expectations extended beyond their professional roles, in the absence of a police response. One of the underlying issues was a lack of clarity and confidence around who is responsible for responding to the range of incidents where the police are no longer attending:

> *"If the police said it's not them, who picked it up? And I'm not entirely sure that we have got a way of picking that up. So, it's those unintended consequences, you know what you know, are we collecting data on everyone that the police previously would have picked up and where are they going now? Is the [ambulance service] picking them up? Is somebody else? Are they not getting picked up? I don't know." [Mental Health Trust, Site F]*

Although the aims of RCRP were to change the response for police, health and care professionals, across sites we were given numerous examples of members of the public, patients and families calling the police and being told that they are not the right service, and they should redial and call

the ambulance or an alternative service. These reports were also shared from ambulance services triaging calls directly from members of the public.

> *"NPA says that people won't be asked to ring another emergency service if they ring the police. But in reality, that is what we see and hear happening. So, in the case of the missing neighbour, they would ring [the] Police and the police have been telling people to ring 999 again but say ambulance instead of police". [Ambulance Trust, Site A]*

Health and social care providers cited long delays for ambulance services that were exacerbated by RCRP implementation, potentially diverting care away from patients with emergency situations or delaying discharges from acute hospitals:

> *"Sometimes when they arrive at A&E, they're going to have to wait for the AMHP to arrive, they have to wait for a Section 12 doctor. And when the assessment is undertaken, we have problems finding beds because we haven't got enough beds and there are acute care flow issues. And then sometimes when you've got a bed, you can't get an ambulance again" [Mental Health Lead, Site C]*

> *"I'm not saying that there weren't people that may have been missed within that or perhaps not received a timely response." [Mental Health Trust, Site B]*

Nevertheless, many participants support the policy intention of RCRP, stressing that the police are not always the right agency to respond to patients experiencing a mental health crisis - this can aggravate symptoms, lead to escalation and criminalise MH patients. This is summarised by a voluntary sector leader, a strong advocate for the RCRP approach because of his own experiences of mental illness and supporting patients with mental illness:

> *"You're suffering from psychosis, you're hearing voices, think people are witches and wizards, everybody's out to get you, well what turns up, two big, massive police officers, right. All that happens straight away, it puts people's backs up, they start giving aggressive, it sets people's mental health off worse... Don't criminalise me and put me in the back of a van because I've got psychosis. I don't want it and it's not my fault I've got it, so why are you going to put me in a cell when I need to be in hospital." [VCSE representative, Site B]*

Box 6: Examples of concerns for patient and public safety

Patient that had absconded from hospital:

"A patient who was on a section on a mental health ward and had not returned back from their agreed leave time. And then they said, can you go round, because what if she's unwell? And then I spoke to the nurse in charge of the mental health ward and did an assessment, asked about her mental state on the time of her leaving, her physical health, is there any risks, what her historical risks were and then I said, look this doesn't need an ambulance to go. She is AWOL from your ward, so please could you follow your AWOL policy. And then he just said, we don't have enough staff to do that". [Ambulance Trust, Site F]

Serious concern about patient and public safety:

"We're a liaison service that are based in the hospital, we're not community led, and we thought well, there is an immediate risk to life... we spoke with our health colleagues; they didn't want to particular bring him [the patient] back from the physical point of view. We spoke to our crisis team, and they agreed that this is quite significant what he's done, if he's not answering the phone I don't know whether cold calling at the house is going to be worth it, can we get in touch with the police? Right Care, Right Person. And the police were, no, we're not getting involved, it's an ambulance job. But when we rang the ambulance, they were saying, are you going to send us to some address that we don't know whether he's there or not? You're going to send us on a wild goose chase." [Acute Trust, Site A]

Missing person and delayed police response:

"A patient actually went missing from a unit [with no next of kin contact details]... we knew that she had been reported a missing person previously, prior to her admission. So I advised contacting the police to see who reported her. It implied that somebody reported her as missing, so we would have some contact details. The police refused to give the details, quoted Right Care, Right Person, which it didn't fall within at all. Wouldn't assist in locating of the patient either, insisting that if we wanted this, then we would need to email a request. It's not an email job at three o'clock in the morning when the patient can't be found." [Mental Health Trust, Site A]

Danger to the public:

"The police said, no, this is health related. You need to phone the ambulance and get them to come out and detain the patient. Now that was bad advice because [ambulance] don't, the ambulance service doesn't have any powers of detention… the manager of the unit, who was close to tears... had been dealing with [the abusive patient] for about six hours now. In between this… [the patient] had then assaulted a member of the public outside and had then tried to grab the child off another member of the public... Whatever was behind it, this person was, there was at least a breach of the peace." [Ambulance Trust, Site D]

6. Participants' suggestions for improving implementation

6.1. General suggestions

Despite sites being at differing stages of implementation and with nuanced localised approaches, we found common suggestions for strategies to improve implementation and partnership working:

- Investment in staffing levels, mental health services and infrastructure to ensure capacity and capability to respond: *"If we're serious about… handovers and things like that, we need to be properly staffing our environments. … that said, that would be a monumental challenge 'cos this isn't just about money, this is about being able to get those individuals."* [Mental Health Trust, Site D]
- Acute care flow issues - improving access to beds and support ambulance handovers.
- Open communication and partnership, along with a gradual rollout approach to address implementation challenges and early collaboration with all stakeholders: *"start having those conversations at an early, early point. And it's not felt that this is being 'done to' people."* [AMHP Lead, Site E]
- Greater clarity in roles, with improved understanding of legal powers and thresholds for intervention among different agencies involved in the crisis response: *"There needs to be a lot more of an understanding, not just from the police, but amongst alternative services about what are your thresholds at which you think you should be getting involved and what are those processes of escalation? So, a clear understanding about, what is everyone's legal powers? Understanding about what people's capacity is to undertake the work. What's a realistic response?" [Ambulance Trust, Site D]*
- Openness - several participants requested that police share their toolkit so that thresholds for involvement could be better understood.
- Need for consistent standards nationally, reducing inconsistencies in decision-making across police forces and standardising rollout.

6.2. Data, monitoring and evaluation

Participants from several sites reported the need for more information and data in relation to health and social care providers and service users to understand the impact of RCRP.

> *"What they did in Humberside… was all about, "look at how much less police time we're using, look at how many less Section 136s we're using, look at all of these wonderful outcomes because, you know, the police can now use their time better". Which is a good outcome in itself, but it's a very one-sided outcome. It's not evaluated…how has this actually impacted service users?" [Acute Trust, Site E]*

Interviewees reported assessing impact largely based on data that is already routinely collected and available, such as the number of s136s and s135s, rather than data which is

directly relevant to implementation of RCRP. In one site, data was being collated across Trusts, but differences in what and how data is collected created challenges in aggregating and analysing the information. Obtaining this data systematically across Trusts was also viewed as time consuming.

Sites described using data from police rather than health sources to inform their policies. For example, in one site police data for s135 and s136 response had highlighted trends, identifying potential gaps in out-of-hours support that coincided with peak periods:

> *"So, the [busiest period] of welfare concerns received by the police are between… three and six [pm]… Now we go into out-of-hours at half five. So, you know, again, that's an additional concern for us that actually are we going to see more of an impact possibly on out-of-hours when currently we're not configured to do that?" [AMHP Lead, Site C]*

However, healthcare staff noted several limitations with police data. For example, lack of clarity in coding of mental health-related incidents on police systems meant that a road traffic accident could be coded in the same way as someone who may be trying to harm themselves. As a result, it was difficult to distinguish incidents relevant to RCRP from those which were not. A further issue related to the categories health and care providers used to identify ethnicity, since these differ from those used by the police and as a result data was difficult to compare leading to challenges in identifying potential inequalities in impact.

A common issue raised by different stakeholders was being able to attribute any changes in indicators to RCRP, partly because data systems used by NHS trusts do not routinely record police involvement. Workarounds had been explored by one trust, where staff were recording whether care had been affected by RCRP on their Datix system (software used to report clinician and non-clinical incidents). A member of staff subsequently reviewed Datix reports to identify whether the impact was positive or negative. The trust had explored a more systematic approach to recording police involvement but found it to be too expensive.

Stakeholders stressed the importance of ongoing evaluation and research to assess the impacts and effectiveness of RCRP. Improving data collection and sharing across partners was cited not only as important for evaluation, but also planning (for example around staffing levels). Participants described a lack of awareness of patient perspectives, and need for a formal evaluation to explore this to identify the wider impact of the scheme:

> *"That is the, sort of, really worrying situation that I think needs to be evaluated. And I think that that is still one of my biggest problems and also suggestions that there has to be proper evaluation of all of the impacts of this, not only look at how much police time we've saved, which is how I've understood it's been promoted and advocated in the policing community." [Acute Trust, Site E]*

7. Discussion and conclusions

7.1. Summary of findings

We found that health and social care providers welcomed the intentions behind the policy change, supporting the move to a more health and social care led approach to mental health incidents, and often acknowledging a historical over-reliance on the police. Nevertheless, RCRP represents a large-scale policy change, implemented rapidly in many areas. Our findings, from interviews with a range of health and care staff, highlight a number of important facilitators of and barriers to effective implementation, resource needs and concerns around potential future impacts.

Health and care organisations are generally working productively with local police forces to develop associated policies in response to the RCRP changes outlined in the NPA. We heard several examples of good practice, with strong multi-sector partnership working and communication, enhanced by open and, if necessary, robust feedback. This is consistent with research exploring similar cross-boundary partnerships – open and honest negotiation about any conflict is more conducive to partnership working than conflict avoidance.[30,31]

This was not the experience of all our respondents, though, and instances of relationship breakdown were apparent in some locations, particularly early in the implementation process. At a strategic level, relationships were generally positive, but at a local level some sites described an increasing tension between health and care staff and the police.

We identified clear challenges relating to the speed of implementation of RCRP, and wider resource requirements that limit the capacity to bring about change. The scale and scope of incidents the police were previously responding to appears to have been underestimated by some, whilst implementation by health and care staff has been hampered by limited capacity, such as workforce constraints, and sometimes by capability problems. For example, we heard from voluntary and community organisations, who often support people in the community with the highest needs, that they often do not have clinical skills or resources to assess cases and that new expectations are not reflected in their commissioning arrangements.

Misunderstandings around the legal powers of organisations expected to support responses to people in mental health crisis were a further barrier, resulting in police support being needed, despite best efforts to move to a health-led service. Additionally, in some situations, health and social care professionals described risks to the safety of staff and/or members of the public without a police presence.

Fears about escalation procedures, differences in perceived risk and lack of a shared understanding about thresholds for police involvement (at both an individual and organisational level) appeared to exacerbate concerns around timely response when police involvement was requested. Health and social care providers reported some police officers adopting a blanket approach, viewing mental health-related incidents as no longer their responsibility. This hindered police-health relationships and adequacy of response. In some areas, interviewees reported receiving a different response to similar incidents depending on whether the person had documented mental ill-health. They also provided examples of the police refusing to respond to incidents which clearly merited a police

response, regardless of RCRP, even to situations where there was an identified risk to life. In addition, while the RCRP approach originally sought to address the response of the police to health and social care providers' requests for support, our findings indicate that families, patients and members of the public have also been redirected to alternative services when contacting the police for support.

Participants expressed concerns about patients 'falling through the gaps' in service provision, with examples of slow or inadequate response highlighting potential impacts on patients, carers, staff and the wider public. Strong partnership working and ongoing communication to discuss incidents of concern were vital to capture learning and improve pathways.

Our interviewees generally felt that there has been insufficient focus on the impact of RCRP on health and social care service users, staff and systems, with a perception that it is a police-led initiative, and reports of its impact focusing on efficiency gains for the police. They reported a lack of systematic data collection on the impact on health and care, with an over-reliance on existing data sources, many of which are limited in how police involvement is captured. Respondents in several sites described changes (both increases and decreases) to the rates of use of Section 136 powers, although most sites were simply unsure of the impact due to lack of monitoring and evaluation.

Stakeholders emphasised a need for ongoing evaluation, improved data sharing, and incorporating patient perspectives into future research. Our findings suggest there may be impacts at a system level (in terms of financial constraints and capacity issues), on the health and social care workforce (in terms of increased workload and safety concerns) and at a patient level (in terms of quality and access to care). A comprehensive, rigorous evaluation, combining perspectives of all relevant stakeholders, is needed to assess these impacts.

7.2. Strengths and limitations of this research

This is the first study of the implementation of RCRP under the National Partnership Agreement from a health and care perspective, drawing diverse views and experiences across six sites in England. Using a purposive sampling approach, we capture the perspectives of 29 stakeholders, with sites chosen based on mental health need, police force size and stage of implementation.

This is, however, a rapid initial scoping study, with several limitations. Firstly, our timescale precluded us exploring patient views and experiences of the policy change. Our preparatory PPI group meetings with service users and carers, as well as our research findings, highlight the potential impacts of these changes on patients and the need to explore this further. A mixed methods study of patients' experiences in navigating access to care under RCRP and estimating the quantitative impact of these changes on patients would be valuable. Our interviews with staff revealed potential challenges in capturing unmet patient need with the data currently collected via police call centres.

Secondly, our findings suggest that some health and care providers affected by RCRP appear to have been excluded from initial partnership development, causing problems in the later implementation phases. Further research is needed to explore the impact on primary care, emergency departments, private care homes and voluntary and community sector organisations.

Finally, our research focus was primarily on strategic-level health and social care provider roles, but further exploration of the perspectives of health professionals working on the ground, and the impact of this policy on patients and vulnerable people, is crucial.

While our sites varied in stages of implementation from early stages to fully adopted, there remains a need to explore longer-term outcomes and experiences. Our findings highlight the need for prolonged collaboration between police, health and social care partners with continued dialogue beyond implementation. Interviews at sites where RCRP was adopted earlier indicated the potential for evolving relationship difficulties between professionals on the ground, despite initial positive engagement at strategic levels. Longer term evaluation is needed across sites that have fully embedded the policy change for a sustained period.

We selected sites and participant groups independently using a purposive sampling framework, and while we recruited interview participants using varied channels, the majority came through emails circulated by NHS England. This was efficient in our short timeframe, but it is possible that it may have influenced the type of participants that responded, with potential bias towards more positive viewpoints. Our balance of both positive and negative views and experiences of RCRP suggests that participants were open and felt comfortable sharing negative views.

The rapid timeframes dictated by this research meant that it was not possible for researchers to independently multiple code the data, but we engaged in extensive discussions to debate findings and compare interpretations. Data collection and analysis by four researchers with varied expertise in mental health research, criminology and policing, policy analysis and evaluation and qualitative methodologies enabled triangulation across researchers' perceptions of the data, strengthening the reliability of our findings.

7.3. Implications for policy and practice

Need for a system response

Our respondents reflected a general perception that RCRP has been led by police forces and the Home Office, with management of NHS implications viewed as secondary. They noted a need for national guidance, potentially using a 'toolkit' to share resources and approaches that have been useful elsewhere, to mitigate potential risks and support areas in developing their approach to RCRP. They commented on a lack of guidance from NHS England resulting in stakeholders working quickly to develop policies, often duplicating effort and without clear understanding of: (1) how different agencies could respond within the limits of their own legal powers; and (2) workforce training, skills and capacity. A national mapping exercise to identify the range of stakeholders affected by RCRP, and how their capabilities and capacity match expectations, could be informative to predict and address potential gaps in response – which our respondents identified as a key concern.

Shared learning should avoid duplication of effort and fragmentation in responses, particularly where police forces span multiple health providers, and improve understanding between agencies about the boundaries between services, and consideration of how current programmes of work focusing on quality improvement can support local areas. In some areas providers and the police have collaborated across regions to develop shared policies, improving the consistency of response

region wide. Additional support should be considered in areas where partnership working is less well developed.

The strength of community-based support, particularly in the context of crisis pathways, was described as particularly important in reducing gaps and providing signposting options for patients and carers. A recent realist review of the evidence in this field further highlights the complexity of managing this interface between agencies, stressing the need for greater clarity at the boundaries of services to promote seamless and timely referral and transitions trusted by the communities they serve.[32] Local partnerships should consider how they can work with service users and carers to raise awareness of the changes and wider support available, and how to further engage voluntary sector organisations, who play a key role in service delivery, within partnership arrangements.

Thresholds for intervention

Mental health law clearly identifies the police as the appropriate agency to respond to incidents where people are at immediate risk of harm. Our research reveals differences in understanding of risk, related to organisation and stakeholder perspectives. Even when there is an agreed definition of 'imminent risk', perceptions differ. Psychiatrists and mental health professionals have a formal role in assessing risk and may consider several factors to inform their judgement. While staff providing MH support in VCSE organisations may have concerns about people they support, they do not have the skills or capabilities to assess risk in the same way. Alongside national guidance, local areas need to develop clear thresholds for intervention within RCRP, not only the threshold for police response, but also for intervention by alternative services. Alongside the implementation of RCRP, definitions and thresholds need embedding within staff training programme with health, social care, and police staff, to consider and agree appropriate responses in practice.

Mechanisms for escalation

The ability to escalate decisions where professionals believe they have not received an appropriate response enhances the effectiveness of RCRP, particularly given differences in how key concepts such as risk are understood. Examples of good practice, enabling escalation, are outlined in the Humberside toolkit,[33] and will emerge as more local services are implemented, and local policies developed. Escalation processes should be a key part of learning so that identified problems result in local policy adaptations. Local areas need clear approaches to escalation and review of interventions to address any problems.

Mechanisms also need to account for organisational risks at a system level, including instances where a coroner issues a Prevention of Future Deaths report. Where problems are identified, consideration should be given to the level of risk, and decisions to review, delay or halt implementation should be considered to address safety concerns.

Police forces should take action to address situations where RCRP is being used to justify lack of police response to issues which fall outside its remit, or where it is being used across incidents identified as relating to mental health. This is important for patient care quality, staff and patient safety, and also to maintain good relationships between health, care and police partners.

Legislative issues

Implementing RCRP thresholds for police response does not change the fact that there are situations where only the police can exercise particular powers under the law, for example to enter someone's

property. Seeking to identify alternative routes to achieve these outcomes risks misuse of legal frameworks and unlawful action. This needs urgent consideration at a national policy level to ensure that police powers are used in a timely manner when they are required, and investigation by local police forces and/or local health and care providers to address any unacceptable and potentially unlawful actions.

Our findings suggest that individual incidents and overall codes of practice need to be investigated to identify repeated breaches of legislation, or a lack of clarity around the appropriate framework for response. Related issues such as conveyance under the MCA have been highlighted in previous research.[34]

Data and monitoring

At a national level, high-quality, relevant, consistent and comparable datasets across areas and organisations are needed to understand and monitor the impact of RCRP. Ideally this should include options for potential alignment of data across sectors, rather than using different success measures from police and health and care perspectives. This would enable more rigorous evaluation of the effect of this policy change on systems, staff, patients and carers, and better representation and more informed involvement of people with mental health problems and carers in decisions. National bodies should consider how these views are captured robustly to contribute learning and build trust, at both a local and national level. A cross-sector evaluation, exploring system-level effects rather than focusing on either police or health and care organisations, would generate important additional insights.

7.4 Conclusion

Implementing RCRP through the National Partnership Agreement (NPA) has significantly altered the response to mental health crises in England. Previous policies have aimed to improve interactions between services, but this is the first national reform to proactively withdraw police involvement in responding to mental health incidents where there is no crime committed, risk to life or risk of serious harm.

A health-led approach was generally welcomed by our respondents, but the scale and speed of change, without agreed national guidance on implementation, has presented challenges. Multi-sector partnership working can facilitate good progress, but tensions and constraints remain when health and care agencies (e.g. the ambulance service) are expected to substitute for police attendance (e.g. responding to a concern for welfare), sometimes without adequate capacity or appropriate legal frameworks to enable their actions. Health and care staff expressed concerns about timely police involvement and adequate response to mental health incidents. Our interviews raised concerns about patients potentially 'falling through the gaps', with associated risks to safety.

This report summarises a small and rapid turnaround evaluation of RCRP implementation. Improvements in data collection and further robust evaluative research, analysing the impact of this policy on patients, carers, health, care, and police staff, is necessary to inform policy longer term.

Abbreviations

AMHP	Approved Mental Health Professional	ICB	Integrated Care Boards
Article 2 HRA	Article 2 of the Human Rights Act 1998	IOPC	Independent Office of Police Complaints
Article 3 HRA	Article 3 of the Human Rights Act 1998	MOPAC	Mayor's Office for Police and Crime
APCC	Association of Police and Crime Commissioners	NPA	National Partnership Agreement
AWOL	Absent without leave – relates to anyone detained under the Mental Health Act 1983 if they escape hospital or fail to return following authorised leave	NPCC	National Police Chiefs' Council
CoP	College of Policing	PACE	Police and Criminal Evidence Act 1984
CTOs	Community Treatment Orders	PEEL Reports	Police effectiveness, efficiency, and legitimacy
CJS	Criminal Justice System	PICU	Psychiatric Intensive Care Unit
DHSC	Department of Health and Social Care	RCRP	Right Care, Right Person
ED	Emergency Department	S135	Section 135 Mental Health Act 1983
FCR	Force Control Room	S136	Section 136 Mental Health Act 1983
HMICFRS	Her/His Majesty's Inspectorate of Constabulary, and Fire & Rescue Services	THRIVE	Threat, harm, risk, investigation, vulnerability, engagement
HO	Home Office		

Glossary of policy and legislation

Right Care, Right Person, developed in 2019

Originated in Humberside Police in 2019. The objective of RCRP is to end inappropriate police involvement in health and social care-related cases where there is no criminality, risk to life or of serious harm.

National Partnership Agreement 2023 (NPA)

Policy document that details a consensus in the implementation of the RCRP scheme across all police forces, with signatories from the Home Office, the Department of Health and Social Care, the College of Policing, the National Police Chiefs' Council, the Association of Police and Crime Commissioners and NHS England.

Mental Health Legislation

The Mental Health Act 1983 governs the assessment, treatment and rights of people with a mental disorder.

The Mental Health Act 2007

Legislation amending the 1983 Act. Included in the Act is the introduction of Community Treatment Orders (CTOs).

The Mental Capacity Act 2005

Legislation that sets out principles and procedures for protecting and supporting people who lack capacity to make decisions.

The Policing and Crime Act 2017

Legislation that made amendments to the Mental Health Act 1983. Ended the use of police cells being used as a place of safety and police stations no longer to be used for a child as a place of safety. The period of 'permitted detention' at a place of safety was reduced from 72 to 24 hours. A further 12 hours is permitted where a doctor certifies an extension is necessary.

Additional legislation

The Human Rights Act 1998

Legislation to give further effect to rights and freedoms guaranteed under the European Convention on Human Rights. The sections of the Human Rights Act 1998 that are commonly cited around the RCRP include Article 2 (a person's right to life shall be protected by law) and Article 3 (no person shall be subjected to torture or to inhumane or degrading treatment or punishment).

The Equality Act 2010

Legislation defining nine characteristics that are protected against discrimination: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

The Police and Criminal Evidence Act 1984 (PACE)

The legislation governing the general police powers of stop and search; arrest and detention; powers of entry; seizing of evidence; investigation and sample taking.

The Children Act 1989 & 2004

This legislation guides the child protection system in England, placing a general duty on local authorities to promote and safeguard the welfare of children in need in their area. Section 25 of the Children Act 1989 can be used to detain a person with mental disorder, but only if the primary purpose of detention is not to provide treatment for mental disorder (which would require detention under the Mental Health Act 1983/2007).

Appendix A: Topic Guide

National Partnership Agreement: Topic guide for interviews

Introduction and consent process

Thank you for making the time to talk to me today to discuss your experiences of the National Partnership Agreement.

The Department of Health and Social Care has commissioned a research team from the University of York and The King's Fund to undertake a small research project to explore the impact of the National Partnership Agreement. Our aim is to assess the plans and implementation from a health and social care provider perspective. We would like to hear your views and experiences.

The interview will take up to one hour, and there are no right or wrong answers – we are only interested in knowing your thoughts. If there is anything you do not wish to answer, that's fine.

Do you have any questions?

Before we continue, I need to run through the consent form with you, and record that, if that's okay with you. I will press record now

[RECORD]

[Read each section from the form and then obtain verbal consent]

1	I confirm that I have read and understand the information sheet version 5.0 dated 10/10/23 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason. I understand that if I withdraw beyond two weeks from the interview my data may have been included in analysis.	
3	I agree to this consent form and other data collected as part of this research study being kept at the University of York and The King's Fund.	
4	I understand that relevant sections of data collected during the study may be looked at by individuals from the University of York and The King's Fund and from regulatory authorities. I give permission for these individuals to have access to these records.	
5	I agree to the interviews being audio recorded and sections transcribed for analysis.	
6	I understand that direct quotations may be used in publications, but no information will be released or printed that would identify me.	
7	I understand and agree that the research team will securely store my identifiable details in order to contact me in future regarding this study, or other related studies (i.e. by email). Identifiable details, including a copy of the consent form, will be available only to the research team, other than for purposes of monitoring and audit.	
8	I agree to take part in the above study.	

About you

We are interviewing a variety of stakeholders in the health and social care sector, from a selection of geographical locations. Firstly, we'd like to know more about the context in which you work.

- Can you describe your organisation and your role?
  - *Length of time in role*

Involvement in the NPA

We'd like to know about your level of involvement in and awareness of the NPA policy.

- Can you tell me more about your involvement in the changes?
  - *Stage of RCRP*
  - *Decision making and planning*
  - *Implementation*
  - *Future plans*
  - *Funding – current or future investment?*
- We have heard concerns expressed by patients and carers about the changes, and particularly about the capacity of health services to respond in a timely manner to situations where the police are no longer likely to respond. What local strategies do you have in place to ensure that people with a mental health need can expect a response from mental health services, when a police response is not necessary?

Impact

- How are the changes going, in your area?
- What has helped?
- What has been a barrier? Early problems or grey areas?
  - *Wider effects e.g. service users, partner agencies*
  - *Number or nature of mental health incidents*
  - *Handover times*
  - *Effects on members of staff*
  - *Any data?*

Partnership working

We'd like to understand more about partnership working between the NHS, social care, police forces and other organisations.

- What are the main partner agencies that you work with in your role?
- How would you describe the relationships between staff in the local police force and in the mental health service in your area?
- Can you describe your local 'place of safety'?
  - *Location*
  - *Staffing*
- The police and mental health staff have different skills and training around mental health. Do staff understand the changes arising from the NPA?
  - *Plans for further training or support?*
- Some challenges may arise if responding to patients who are resistant to the involvement of mental health services. How will mental health staff transport reluctant or hesitant patients, where the police would have previously been involved?

Your recommendations

- Do you think any changes are needed that you would like to recommend to policy makers?

Closing

Thank you for your time taking part in this study. The information you have given will be treated confidentially and kept anonymous.

- Is there anything else that you feel is important that we haven't yet discussed?
- Would like to receive a summary of the results from this work?

Appendix B: Participant Information Leaflet

Version 6.0 (12/12/23)

THE UNIVERSITY of York The King's Fund

Exploring health and social care provider perspectives on the National Partnership Agreement

Participant Information Sheet

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why this research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

In order to redirect mental health calls where there is no risk to life or of serious harm, a National Partnership Agreement (NPA) is currently being implemented with coordination across police and health sectors to reduce the unnecessary involvement of police in responding to mental health incidents, redirect to healthcare professionals. The NPA, based largely on the Right Care, Right Person (RCRP) approach developed by Humberside Police Force, is now being implemented across several police forces and a wider national rollout is planned with a concurrent Home Office evaluation.

The Department of Health and Social Care (DHSC) have commissioned this research to assess the National Partnership Agreement plans and implementation from a health and social care provider perspective. We are now seeking the views and experiences of a range of health and social care stakeholders across various sites in order to represent the views of NHS, Local Authorities and local Voluntary and Community and Social Enterprise organisations in this evaluation.

Why am I being asked to take part?

As part of the project, we are conducting interviews and focus group discussions with key stakeholders to explore their views and experiences relating to the National Partnership Agreement from a health and social care perspective. This includes exploring how this is being implemented in different locations, enablers and barriers to implementation, experiences of partnership working, and potential impacts of the NPA from patient, system and wider perspectives. You have been selected in your capacity as a key stakeholder in this field and we are keen to hear about your experiences and views in order to inform this research.

What does taking part involve?

If you decide you would like to be involved you will take part in an interview or focus group discussion, depending on your preference, taking place online via Zoom teleconferencing software or by telephone at a time convenient to you. A researcher will approach you to arrange a time to conduct the interview or focus group that best suits you. These will last up to one hour and will be recorded (with your permission) so that we can analyse the discussion.

You will be given a unique study number for the duration of the study, so that your name and organisation will not be used in any publications and will not be made available outside the research team.

During these discussions you will be asked to discuss various topics so we can hear your views and experiences relating to the National Partnership Agreement from a health and social care perspective. A researcher will facilitate each session, answering queries and, in focus groups, facilitating discussions. Please remember, **there are no right or wrong answers** – we are interested in your thoughts and opinions.

What will I need to take part?

To enable us to talk on Zoom, you will need to be able to access an electronic device, such as a computer or tablet with an internet connection. Alternatively, we can conduct the interview by telephone.

Do I have to take part?

No, it is entirely up to you to decide whether you would like to take part. If you have any questions about taking part you can talk to a member of the research team (contact details below). Even if you have agreed to take part, you are free to withdraw from the study at any time, without giving a reason. If withdrawing more than two weeks after your interview or focus group, data analysis will have started so your data will be included in analyses, though no data will identify any participants in any way.

What are the possible benefits of taking part?

Whilst there are no personal benefits to you for taking part, the findings of this study will be shared with policy makers at the DHSC and the Home Office to help shape future policy and guidance relating to the National Partnership Agreement.

What are the possible disadvantages or risks of taking part?

There are no anticipated risks. Participation is completely voluntary and you will not be under any pressure to answer any questions that you do not want to.

Expenses and payments

This study is funded by the National Institute for Health Research Policy Research Programme and there are no participant expenses have been allocated for this study. We will arrange the online discussions at a time convenient to you so that no costs will be associated with you taking part in the study.

What will happen to data that are collected about me?

We will remove all names and other identifying information before the data are analysed and results presented. Any records that identify you will be held separately to the other information we collect and your data will be held in a secure location, in accordance with the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. While we do not anticipate this, in the exceptional event that you disclose information that may represent a threat to patient safety, this will be reported through routine incident reporting procedures.

Only researchers that are part of the research team in York and The King's Fund (who are joint collaborators on the project)[1] will have access to the data. The analysis will be performed by researchers at the University of York and The King's Fund.

Data held by the University of York will be stored for 5 years and data held by The King's Fund will be stored for 7 years, to enable analysis and publication and will then be destroyed. You can find out more about GDPR and data storage on the following University of York websites:

https://www.york.ac.uk/records-management/dp/
https://www.york.ac.uk/records-management/dp/guidance/gdprcompliantresearch/
https://www.york.ac.uk/records-management/dp/your-info/generalprivacynotice/
https://www.york.ac.uk/healthsciences/research/trials/trials-gdpr/
https://www.york.ac.uk/healthsciences/research/trials/trials-gdpr/research-partcipants/

Participants will be provided with a copy of a project specific privacy notice from The King's Fund for further information on GDPR and data storage.

Who has reviewed this study?

This study has been reviewed by the University of York's Department of Health Sciences' Research Governance Committee.

Who is organising and funding this research?

The research is funded by the National Institute for Health Research Policy Research Programme. The research funding covers only the costs of undertaking the research; researchers will not receive payment for conducting the study. Findings will be reported in aggregated form, interviewees and organisations will not be named or otherwise identifiable when findings are reported.

What will happen to the results?

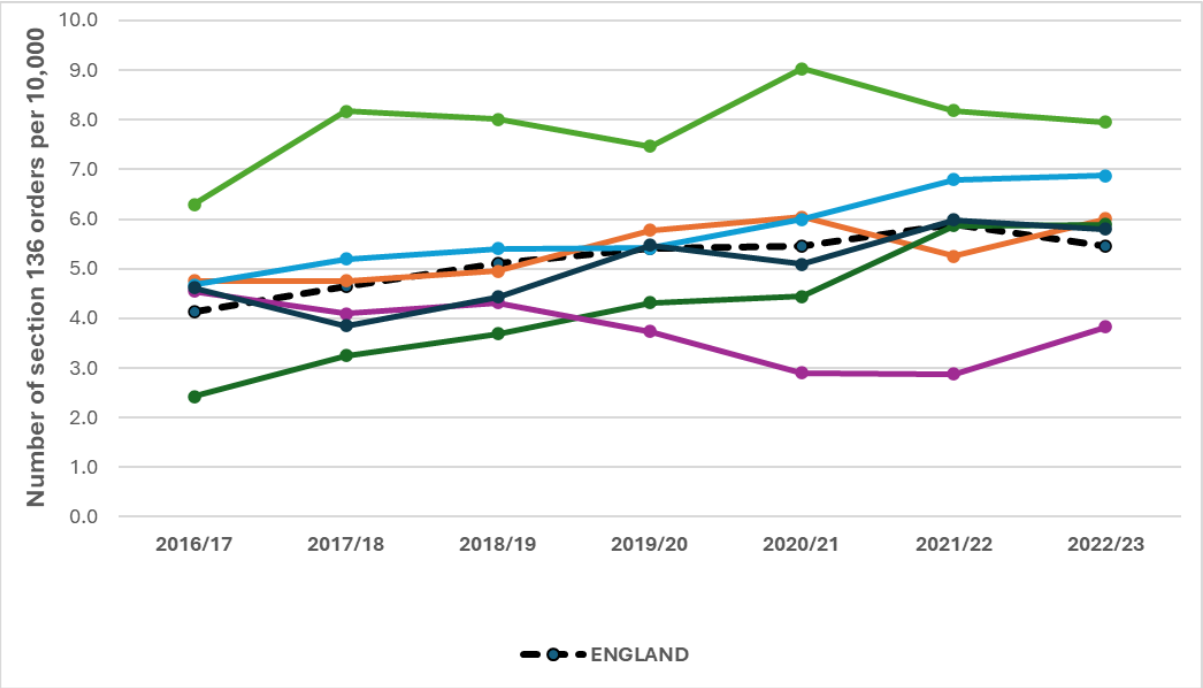
Once the discussions are analysed, we will produce a report of the findings, which will be combined with other research methods we are undertaking on this topic. Participants will not be named or otherwise identifiable when findings are reported. If you wish to receive a copy of the report once it is produced please let our research team know.

Who can I contact for more information?

If you have any queries about the study or would like to take part please contact:	If you need to make a complaint or speak to someone independent, please contact:
Dr Laura Jefferson Research Fellow Department of Health Sciences Area 4 Seebohm Rowntree Building University of York Heslington York YO10 5DD	Prof Catherine Hewitt Chair of Research Committee Department of Health Sciences ARRC Building University of York Heslington York

[1] The King's Fund is an independent charitable organisation working to improve health and care in England: https://www.kingsfund.org.uk/about-us.

Appendix C: Trends in section 136 orders in our case sites, and in England overall



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