



“Right Care, Right Person”: Tensions between policy aim and operational reality in mental health emergency response

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HISTORICAL CONTEXT AND PREVIOUS REFORMS

In the absence of a response service for mental health emergencies (MHE) equivalent to those available for physical health, crime, serious road accidents, or fire, the police have long been one of the first agencies called upon to respond. Police across the world have an obligation to protect life and specific powers related to mental health unrelated to any suspicion of the commission of an offence, meaning officers can detain a person on the basis that their mental state appears to be presenting a risk of harm to that person or others. These powers have long and contentious histories.

In England and Wales, the early 2010s saw a period of intense scrutiny of police involvement in mental health, including a seminal report into mental health-related deaths in police custody for London’s Metropolitan Police, which unequivocally stated that “mental health is one of the core parts of police work” (Adebowale, 2013, p. 4). This assertion was widely accepted at the time and coincided with the proliferation of mental health triage schemes (sometimes called “street triage”) in which police and health professionals worked closely through co-responder models or by locating mental health professionals in police control rooms. Regardless of the model, these schemes aimed to better support the police, improve access to appropriate care for those experiencing MHE, and reduce the rising number of police mental health detentions. Elsewhere, the Memphis Crisis Intervention Team approach of specially trained police officers was adopted. Nonetheless, many assert that police involvement in MHE is detrimental and should be minimized (Randall et al., 2024).

RIGHT CARE, RIGHT PERSON: AMBITION AND IMPLEMENTATION DEFICIT

Right Care, Right Person (RCRP), rolled out across England and Wales from 2023, aims to release police capacity to focus on crime prevention and investigation by diverting MHE calls to other agencies deemed more appropriate (Home Office, 2023). RCRP is being widely hailed as the solution to police over-involvement in mental health and is now under consideration in many territories worldwide, as was discussed in multiple conversations at LEPH2025. However, neither the data from Humberside’s 2019 pilot nor any since the national roll-out have been made publicly available. Furthermore, a comprehensive evaluation has yet to be conducted, with two rapid evaluations conducted by Ministry of Justice and Home Office urging more comprehensive assessment of the approach (Home Office and Department of Health and Social Care, 2024; Jefferson et al., 2024).

Officers’ lived experiences highlight gaps between the policy’s intended outcomes and the realities of delivery, and like many policies before it, RCRP was developed and adopted without consultation of those who have experience of MHE. Preliminary consultations have indicated that people in need of support want to be treated with respect and understanding rather than a specific agency to respond (Faulkner, 2025).

Mental health work forms an unavoidable element of frontline policing, with officers estimating that the majority of calls have a mental health component even when not explicitly identified during the initial request for service. RCRP’s ambition to redirect such cases towards healthcare is therefore substantial in scale and relies on alternatives having the capacity and responsiveness to absorb demand. However,

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in the absence of immediate, responsive healthcare capacity, police may remain the default responder, undermining the attempt to reduce unnecessary police involvement or ensure the “right” response. This echoes concerns raised in previous policy research that a lack of investment in health services risks gaps in provision rather than seamless handovers (Kane et al., 2018).

Effective interagency working depends on clearly defined roles, trust, and timely communication, elements that RCRP presumes are in place. In practice, there are persistent barriers to information sharing and role clarity, with notable variability in local partnerships. RCRP’s reliance on partner agencies assumes a level of consistency and capacity that may not always exist. Without mechanisms to ensure that healthcare partners are consistently resourced and available, the framework’s operational effectiveness is undermined, potentially resulting in delayed responses or unsafe outcomes. This aligns with Redgate et al.’s (2025) realist review, which found that the success of joint crisis responses hinges on local context and pre-existing inter-agency infrastructure.

UNINTENDED CONSEQUENCES FOR SAFETY

Chief Constables have consistently given assurances that RCRP would not remove police involvement from situations where they have obligations under the Human Rights Act 1998: where there is an immediate risk to life (Article 2) or an immediate risk of serious harm (Article 3). However, there are currently at least eight inquests pending in which RCRP is likely to be raised as relevant, in addition to at least 19 fatalities since its inception where it has been either directly cited during the inquest or in subsequent Preventing Future Deaths (PFD) notices, which are issued by Coroners where they determine action is required to avoid future deaths (M. Brown, personal communication, October 6, 2025). Two of those inquests were completed before RCRP had become operational in the relevant police force but may be evidence of what the UK mental health charity Mind called “a soft launch” in February 2024, when their CEO gave evidence to the London Assembly, which scrutinizes the city’s administration (London Assembly, 2024). A “soft launch” refers to forces or individual staff acting as though a policy has already come into practice.

Thirteen PFD notices issued in these cases criticize partnerships, protocols, implementation, or training and 13 of the inquests indicated a lack of police response where it would appear to have been necessary according to the RCRP “threshold” for police attendance (Home Office, 2023). Eight of those PFD notices noted that calls to the police were deflected to the ambulance services, but the London Ambulance Service stated that only 20% of RCRP-deflected demand is suitable for paramedics (London Assembly, 2024).

The Authorised Professional Practice on Risk (College of Policing, 2013) is the police service’s approach to managing, rationalizing, and reviewing risk decisions, consisting of 10 principles overall. It encourages a “*more positive approach to risk by openly supporting decision makers and building their confidence in taking risks.*” (College of Policing, 2013). RCRP raises questions about the interpretation and application of Principle 4, which states:

“Harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome. It is in the nature of risk taking that harm, including serious harm, will sometimes occur... The fact that a good risk decision sometimes has a poor outcome does not mean the decision was wrong... Similarly, it cannot be assumed that a decision was right just because no harm occurred.”

An under-responsiveness to established risk is apparent in 11 of the 19 highlighted inquests. The current dearth of published data means it cannot be known how often flawed decision-making has factored into incidents which have not ended in fatalities, but it can be inferred from the Department of Health that health and social care professionals are seeing this regularly (Jefferson et al., 2024).

SUSTAINING THE POLICE WORKFORCE

Although RCRP shifts certain responsibilities away from police, this must not be taken to mean officers no longer require mental health training. Policing remains a public-facing profession in which officers will inevitably encounter people in distress. Inconsistent or inadequate training can weaken intended safeguards, particularly when officers are called to situations in the absence of specialist health responders. Lack of standardized, evidence-based training carries a dual risk: members of the public may experience retraumatization or even fatal outcomes during poorly managed interventions and officers may themselves develop post-traumatic stress disorder following repeated exposure to distressing incidents without adequate preparation or debriefing (BBC News, 2018; Brewin et al., 2022). These impacts on officers may be compounded by the moral distress of being called to handle incidents that they are no longer deemed the “right person” to attend under RCRP. Organizational support is critical in mitigating such stressors; without targeted well-being initiatives during RCRP’s roll-out, these pressures could intensify.

Overall, a tension exists between the goals of RCRP and the operational environment. The framework seeks to address a situation in which the police had, in practice, become a *de facto* mental health response service. The international focus on RCRP offers an opportunity to take a much-needed public health approach to revise the current dangerously siloed systems, as others have called for (e.g., Pepler & Barber, 2021). Robust healthcare capacity, strong interagency communication, and clear role boundaries are essential. National strategies, such as that of the National Police Chiefs’ Council (2022), advocate for the concurrent development of these elements. Yet, without a genuinely collaborative, carefully phased, and adequately resourced approach, RCRP could fall short of its intended objectives, as it depends on the readiness of partner agencies, the maintenance of police competencies for residual mental health contact, and the provision of consistent officer well-being support. Without these, RCRP risks shifting responsibility in name more than in practice, potentially leaving both the public and frontline responders more vulnerable to life-threatening harms.

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The authors have no conflicts of interest to declare.

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