



Getting the balance right

Efforts to scale back police involvement in mental health emergencies are welcomed in principle. But the complexities of implementation have caused concern, and College has been ensuring it remains a key part of the ongoing discussions.

Ask psychiatrists across the UK about the changing role of the police in mental health emergencies, and you'll likely hear the same cautious response.

Dr Alex Thomson, Chair of the College's Faculty of Liaison Psychiatry and working group on mental health and policing, puts it concisely. When asked about recent changes in police response to mental illness-related call outs, he offers just four words.

"The principles are sound," he says – although his intonation leaves no doubt that a "but" is coming. Those "sound

"People don't want over involvement of police in their mental health, but they don't want to be left with no safety net at all"

principles" are notably encapsulated in the Right Care, Right Person (RCRP) model, originally developed by

Humberside Police and now adopted across England and Wales over the past 18 months.

In England, the approach has been introduced via a formal national partnership agreement between the UK Government, police and the NHS. Whereas, in Wales – where health is a devolved matter but policing and criminal justice are not – there is a statement of intent, with the introduction of RCRP overseen by a national partnership group, which includes the NHS, local government and voluntary organisations alongside the police.

In practice, the model operates similarly in both nations. Police will now only attend mental health-related emergencies if they judge there to be a risk to life, a danger to the public or a crime taking place. This means that formerly routine police tasks, such as welfare checks or searching for patients who have left hospital while detained under the Mental Health Act, are no longer considered police matters. The assumption is they will be picked up by other services.

"The aim is to ensure that where the police are involved in dealing with mental health-related concerns, a healthcare response rather than a law enforcement response is provided wherever appropriate," says Dr Thomson.

This principle in itself gains widespread support. But hesitation and unease soon creep in regarding how this principle has been applied practically.

When the National Police Chiefs' Council in England first announced its plans to roll out RCRP, it estimated it could free up a million hours of police time each year. But with other public services also overstretched, many were left concerned about how the sudden resulting void would be filled.

"The concerns about Right Care, Right Person relate to the risk of police withdrawal from activity at a rate that is quicker than the healthcare service's ability to step in," explains Dr Thomson.

In Wales, the situation feels particularly acute. Ollie John, RCPsych in Wales' national manager, says there was already "constant concern" about the level of workforce coverage available across crisis services in mental health – this has only been compounded since the adoption of RCRP.

"Being able to respond to people in the most appropriate way means you need a properly resourced workforce," he says. "So, before making any changes to the approach, you need to conduct

a thorough impact assessment of the existing workforce and its capacity. You need to make sure those alternative services, who will be stepping in, are there."

But even if alternative provision is in place, there is another practical issue: the system itself is poorly integrated. If someone calls 999 due to a mental health emergency and asks for the police, but the call handler determines the matter is, in fact, one for the ambulance instead, they cannot simply transfer the call over. Instead, the caller is advised to hang up and call 999 again and ask for the ambulance service directly.

In an emergency, that is asking a lot of someone. "You can foresee that in a crisis if someone is told they've called the wrong service and they need to redial, there's a risk they won't make the second call," says Dr Thomson.

Sadly, there is already evidence that such risks become reality, and with fatal consequences. In May, the assistant coroner for West Yorkshire issued a Prevention of Future Deaths report concerning a suicide. A member of the public had called 999 expressing concerns about someone's welfare and asked for the police. They were told to hang up and call again to ask for the ambulance service instead. They did this – but they were then told by the ambulance service that they needed to contact the police. Frustrated, the caller ended the call. No attempt was made to get back in touch with the caller and no emergency services were dispatched. It later transpired that the individual who the caller was concerned about died by suicide, leading the coroner to raise serious concerns about RCRP.

This was not an isolated incident. In June, *HSJ (Health Service Journal)* reported that coroners had issued "multiple warnings" about deaths "linked to police refusing to respond to people in mental health crisis".

"It's been really sad and upsetting to see those coroner reports, but some of us with lived experience were worried this might happen," says Em McAllister, the lived experience representative on the College's Liaison Psychiatry Faculty Executive Committee.

"RCRP seems to be selective in its use of lived experience voices to support the notion that people don't want over involvement of police in their mental health. While it's true, they don't want to be left with no safety net at all either, and I think, at the moment, there is a huge lack of clarity about what the appropriate level of police involvement is," she says.

"It feels as though patients are being caught up in a stand-off between services, and there is always going to be an impact on anyone who gets caught up in that."

Across the UK, the College is working to mitigate those risks. In England, RCPsych representatives contributed to drafting and finalising NHS England's RCRP implementation guidance, published late last year. The College is also represented on the national Right Care, Right Person oversight group.

In Northern Ireland, meanwhile, where RCRP is yet to be introduced, RCPsych in Northern Ireland is playing an active role in discussions about its potential adoption.

Dr Julie Anderson, Chair of RCPsych in Northern Ireland, sits on the country's RCRP Silver Oversight group – a multi-agency group responsible for the planning and implementation of the model. "It's a piece of work that the College has very much been welcomed into, and encouraged to participate in, from a really early stage, which is great," she says.

This began with a meeting with the assistant chief constable in charge of

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wellbeing within the Police Service of Northern Ireland. “We quickly received quite a compelling argument with regard to why things needed to change and RCRP needed to be implemented,” adds Dr Anderson.

“It was a really positive discussion – and there was a shared understanding of the nuances that must be considered within psychiatry and the police alike.”

Yet despite broad agreement on the need for reform, momentum has stalled.

“I think what’s transpired is, ultimately, a hesitation at a strategic level between health, social work, PSNI, ambulance service and other players within this. This is because the workforce situation in all of those sectors is so dire.”

Over in Scotland, RCRP is not being adopted. But the challenges it seeks to address are very much alive.

“There was a lot of debate with the police service about how we progress, because they have similar concerns about the amount of time that is spent on mental health issues,” says Dr Alastair Cook, who, until recently was Principal Medical Officer at the Scottish Government’s mental health directorate.

Police Scotland has opted for a more cautious stance. “They’ve taken a position that we’re much more comfortable with from a College perspective,” he says, namely that the police’s core duty is to ensure community safety and the wellbeing for the people of Scotland.



Dr Alex Thomson

Dr Cook was a member of the partnership development group that worked up a formal framework for collaboration between services including the police, mental healthcare and ambulance, rather than withdrawing from mental health call-outs. “The overriding principle of that work was what we called the ‘no wrong door’ approach.”

Police Scotland has 24/7 access to mental health clinicians through a dedicated mental health hub, for instance. The framework also seeks to encourage collaboration at a health board or locality level. In some areas, this has already paid dividends. Dr Cook is a consultant psychiatrist in Lanarkshire, where the psychiatric liaison nurse service and the police have worked together to deliver an

80% reduction in police attendances at emergency departments.

It is an example that shows, despite all the challenges, the redesign of police involvement in mental health issues can sometimes yield improved local practices. Often, however, that is dependent on pre-existing local relationships. It is clear that the introduction of the RCRP model itself, or of any model to reduce police involvement in mental health call-outs, does not automatically improve the situation.

Mr John suggests it is therefore crucial that “we have a robust way to monitor the implementation of RCRP”. Em McAllister echoes that call, and emphasises the need for person-centric rather than service-centric measures.

“If you look at the monitoring that does exist for RCRP, it’s all about the various service demands. None of it is about what happened to the people who were caught up in this approach.”

Dr Thomson hopes the College may be able to change that. He’s urging members to share stories and experiences of the implementation of the model, particularly where it is felt that a lack of police response led to welfare concerns for patients or for staff.

Ultimately, it comes back to that uneasy balance between principle and practice. “It is important that people with health needs receive a healthcare response without unwarranted police involvement. But it’s also important that patients are appropriately protected and that, in the relatively rare occasions when a patient may be aggressive, that staff are appropriately protected too.”

For now, many argue that achieving that balance remains a work-in-progress.



Making headway

New opportunities have opened up for SAS psychiatrists as a result of commitments made in the College’s SAS strategy. However, the true test of success will be a substantial rise in appointments to these roles and other senior positions.

Speciality and Specialist (SAS) psychiatrists are substantive doctors who make up around a quarter of the UK’s psychiatric workforce. Yet, despite their vital contribution, they remain under-represented in a variety of senior roles, have historically been denied access to many key career opportunities and continue to face a lack of formal recognition and respect – issues that not only impact professional development but also morale, wellbeing and retention. The latest College workforce census found SAS true vacancy rates to be the highest of all psychiatric grades, at 30.3%.

In April 2023, the College took steps to begin to tackle these long-standing disparities by launching its first official policy for SAS psychiatrists – a three-year strategy to support training, leadership, and educational development of SAS psychiatrists, strengthen their involvement with the College and recognise their contribution.

While SAS psychiatrists may not be yet seeing dramatic changes in their day-to-day working lives, Dr Lily Read, Chair of the College’s SAS Committee, is keen to highlight progress that has been made, as well as efforts to lay groundwork for at-scale, longer-term change.

One significant development linked to the strategy has been the 2023 change

to College guidance on recognising and approving trainers, which now allows SAS psychiatrists to become clinical and educational supervisors of psychiatric resident doctors – a role previously limited to consultants. Prior to this change, SAS psychiatrists could only supervise foundation and GP resident doctors.

Changing the supervision eligibility criteria, however, was only the first step – full implementation is still a work-in-progress. “Progress made to appoint SAS supervisors has been slow, but we’re working on it,” says Dr Read. “It will happen.” Behind the scenes, the SAS Committee has been actively engaging with the Heads of Psychiatry Schools and Director of Medical Education (DME) networks to promote not only that SAS psychiatrists are now eligible for these roles, but to highlight their value and capability, shift perceptions and monitor how many of the significant number of GMC-recognised SAS trainers are being allocated psychiatric resident doctors to supervise.

Dr Antonino Curatola, a SAS forensic psychiatrist at Aneurin Bevan University Health Board in Wales, is one of the few appointed so far. He is a clinical supervisor for core psychiatric residents, and also teaches medical students, and foundation and psychiatric resident doctors. He describes the shift as a step forward in recognising the contribution SAS psychiatrists can make to training.

“Enabling us to become educators can only improve the profession and patient care,” he says.

Another change aligned with the strategy’s aims is the inclusion of SAS psychiatrists with the MRCPsych in the eligibility criteria for College examiners. Only two have been appointed so far, but there are others taking part in the current recruitment round process. “It’s still a massive step forward,” says Dr Read. “This was almost unthinkable three years ago.”

The College Leadership and Management Fellow Scheme has also been opened up to SAS psychiatrists, with seven successfully securing places in the 2023/24 intake – the first cohort eligible to apply. In addition, early-career SAS psychiatrists can now apply for the Parliamentary Scholars Scheme, providing a new pathway into health policy and advocacy.

Additional efforts made to optimise communication and networking have involved establishing the national Mental Health SAS Tutors’ Network which meets quarterly with the SAS Committee executive. This enables the SAS Committee to engage locally, while providing a channel for local SAS psychiatrists to contribute to national work. Additionally, an SAS e-newsletter, launched at the end of last year, is hoping to build visibility and community by profiling an SAS psychiatrist each quarter, showcasing good practice from across the UK and highlighting resources, opportunities, important updates, and upcoming events.

Another focus has been removing barriers to inclusion in the College. The College’s Presidential Leads for Equity and Equality have reviewed the eligibility criteria for a range of College roles – including the Presidential Scholars Scheme – to ensure they are now explicitly inclusive of SAS psychiatrists, which they previously were not.

Dr Read is also keen to highlight some other pre-existing opportunities: SAS psychiatrists are eligible to access all College credentials. “We now have several SAS psychiatrists who completed the eating disorder credential and the perinatal masterclass,” she says. “Also those who hold the MRCPsych are eligible to apply for College Fellowship and we recently celebrated our first SAS FRCPsych.”

She also highlights that SAS psychiatrists are eligible for nomination across most categories of the RCPsych Awards, and not just the dedicated ‘SAS Doctor of the Year’ category. Having greater visibility in these various roles is one small way to begin the long overdue recognition of SAS colleagues. “Seeing yourself represented is a very good motivator,” she says.