



**Vulnerability &  
Policing Futures**  
Research Centre

# Mental health and routine police work



## Key points

- Police officers have relevant skills and expertise which can contribute effectively to responding to mental health emergencies.
- Stronger inter-agency working is required to bridge gaps between public services and improve the understanding of different professionals.
- Policy needs to take a whole-systems approach to address public sector support for people with mental health problems.

# Summary

**There is concern within the police that too much of their resource is dedicated to mental health calls. In addition, police are not always the best agency to respond.**

This study aimed to understand the nature of police contact with people with mental health problems and make recommendations for effective practice. Data was collected from observations and interviews in two

police forces, and interviews with partner agencies, service users, and carers. Despite policy initiatives to scale back police responses to mental health-related calls, there are circumstances where it is still required. Police acknowledge that they have a role in mental health-related risks of harm. However, better coordination is needed between police, mental health services, and ambulance teams to ensure a more joined-up and effective response.

## Background

**Mental health problems have become more common in the UK, particularly among women, young people and minoritised ethnic groups.**

Social and economic hardships such as debt, unemployment and social deprivation have contributed to this rising demand. These hardships are also connected with higher police involvement. For example, substance use, homelessness and suicidal ideation often co-exist and can lead to situations that involve police officers.

In comparison to White British people, people from Black British, African and Caribbean ethnic groups (particularly young Black men) are more often detained under mental health legislation in the UK, and data suggests the same groups are more likely to be subject to stop and search by the police. Structural determinants such as poverty and racism impact on both mental health and police involvement, highlighting the intersection of vulnerabilities and perceptions of dangerousness or risk.

A substantial body of evidence exists about police officers and mental health professionals responding together to people during mental health emergencies. However, police officers often encounter people experiencing mental distress in their routine work with no mental health professionals present and need to respond appropriately. This may involve making rapid decisions or de-escalating situations without defaulting to tactics of control and containment typically used when addressing criminal behaviour. The introduction of the Right Care, Right Person policy in England and Wales has made a considerable contribution to the reduction of regular contact with people with mental health problems, but has not eliminated it entirely.

This study aimed to identify good practice in work across police and partner agencies with people with mental health problems and areas for future improvements.

## What we did

**We conducted a scoping review of peer-reviewed literature on routine police work with people with mental health problems. 'Routine police work' is here defined as a non-specialist response to mental health problems encountered in the course of a police officer's work. We extracted and synthesised data from 63 papers around three main themes: policing decisions and actions; coordinating responses with other service providers; and lived experience perspectives.**

We then conducted an ethnographic study of routine police practice in encounters with people with mental health problems in two police forces. This involved 120 hours of non-participant observation and informal conversations with police officers in force control rooms, neighbourhood policing and response teams. This included using the 'ride-along' method where researchers accompanied police officers in the course of their work. We also conducted 43 semi-structured interviews with senior officers, 24 with health and social care professionals and five with people with lived experience (including carers).

# Key findings

Three main themes were generated from the analysis: the first related to how police work with mental health issues, including the process of decision making about response; the second focused on how police and other agencies worked together; and the third theme was concerned with the policy–practice interface.

## 1. Police capabilities and mental health

- Police regularly encounter mental health issues but lack formal expertise.
- There is **variation** in how officers identify and respond to mental health-related incidents.
- Police officers' access to mental health professionals or triage varies, which then impacts on decision-making.
- Officers often face **confusion** between behavioural issues and diagnosable mental illness.
- Decisions around using mental health legislation (e.g., Mental Health Act) or assessing mental capacity are complex and inconsistently supported.
- The **Right Care, Right Person** policy has legitimised some police withdrawal from mental health calls, increasing officer hesitation to engage.

“ Ever since they've [police] pulled back with the Right Care, Right Person, we're getting into more dangerous situations because we're not privy to the same information that the police have got.

Paramedic participant

## 2. Interagency working

- There's ongoing **uncertainty** over whose responsibility mental health crises are.
- Police, paramedics, and mental health professionals often lack mutual trust and full understanding of each other's roles.
- Frontline workers across the relevant agencies report tensions and inadequate communication, despite high-level interagency agreements.
- Risk tolerance varies among these agencies, affecting decisions about safety and appropriate responses.
- Service availability differs by region, leading to inconsistent care.

- **Preventive work** and community-based responses are lacking due to limited resources and prioritisation of reactive policing.

“ I don't feel that people... including the police – understood mental health [...] and the vibe from the police was, “We've got better things to be doing,” and I've been told that like, “Shut up, silly girl – we've got real jobs to do.”

Lived experience participant

## 3. Policy–practice interface (Right Care, Right Person)

- The policy has led to reduced police involvement, but also to mental health and social care services “gaming the system” to elicit police response when needed.
- Approved Mental Health Professionals (AMHPs) face barriers when requesting police support, even with legal warrants.
- Due to ongoing resource pressures, agencies are increasingly focused on managing demand within their own boundaries, which can hinder opportunities for collaborative problem-solving.
- A whole-system approach is needed to manage demand and provide cohesive, coordinated care.

Police expressed frustration that they receive requests from mental health services requesting a welfare check typically on a Friday afternoon (“passing the buck”). However since RCRP has come in, the police can refuse to respond to these requests.

Field interview with police

# Next steps

Despite Right Care, Right Person being implemented, and evidence of local partnerships in both police forces who participated in the project, the study shows that on the ground there is wide variation in its application and understanding across the agencies. This leads to conflict, confusion and even duplicated responses.

## Recommendations for future research

Most of the participants tended to focus on mental health crises (including actual or threats to self-harm). However, we need to understand the role of the police when they come into contact with people with mental health problems during routine work (such as reporting a crime or as a witness). We also need to understand the role of police, especially neighbourhood policing, in detecting vulnerability in relation to mental health, which will facilitate earlier signposting to prevent crisis. Further research with people with lived experience of mental health problems and their carers is required in order to more fully understand the circumstances under which they come into contact with the police, what is helpful and not so helpful, and what alternatives to police are available.

## Strengths and limitations of the study

This is the first UK study to have comprehensive data from police, ambulance and mental health care providers, as well as people with lived experience of mental health vulnerabilities and informal carers (who have had contact with police in the last 12 months). Limitations include the potential for selection bias in police officers with more positive attitudes and practices who chose to be observed and interviewed.

We did not recruit as many carers and people with lived experience as other participants, which must be readdressed in future research.

We would like to acknowledge the participants from police, health and social care, and those with lived experience who gave their time to talk to us. We would also like to acknowledge the important input of our expert advisory group and lived experience advisory group throughout the whole project.

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## For further information

Read more about this project at [vulnerabilitypolicing.org.uk/mental-health-and-routine-police-work](https://vulnerabilitypolicing.org.uk/mental-health-and-routine-police-work)

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