Introduction and strategic considerations

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International and national legal frameworks

All police responses to people with mental ill health, vulnerabilities and disabilities in society are governed by international and domestic legal frameworks.

The United Kingdom is a signatory to the **United Nations Convention on the Rights of Persons with Disability** (which covers physical and mental disability) and to the **European Convention on Human Rights (ECHR)**, given effect in domestic law in the **Human Rights Act 1998**.

Mental health law

The principle statutes governing state responses to individuals experiencing mental ill health are the **Mental Health Act 1983 (MHA 1983)** and the **Mental Capacity Act 2005 (MCA)**.

More detailed guidance on applying all relevant mental health law can be accessed using the following links:

- **Mental Health Law Online**
- Mental Health Cop blog **'What do all the sections mean'**

Officers and staff should give additional consideration to the various codes of practice issued by the secretaries of state in England and Wales, as appropriate.

- **Code of Practice (2015)** to MHA 1983 for England.
- **Code of Practice (2016)** to MHA 1983 for Wales (English version).
- **Code of Practice (2016)** to MHA 1983 for Wales (Welsh version).
- **Code of Practice (2007)** to MCA (England and Wales).
- **Code of Practice on (2008)** MCA Deprivation of Liberty Safeguards (England and Wales).

The UK Government issued interim **guidance** on the amendments to the Mental Health Act 1983 which were introduced by the Policing and Crime Act 2017 and took effect on 11 December 2017.

Further guidance to support managing the police response to people with mental ill health and vulnerabilities can be found in the following resources:

- **Mind (2013) Police and Mental Health: How to get it right locally**
- **Mental Health Crisis Care Concordat (2014**)
- **Mental Health Crisis Care Concordat for Wales**
- **Suicide risk response: at an organisational level**

Equality

The police have an important role to play in combating discrimination against individuals and groups experiencing mental ill health and those with learning disabilities, and promoting their social inclusion. This involves recognising mental illness at an early stage and enabling individuals to access the services that meet their needs. In addition, there is an overriding duty arising from the **Equality Act 2010** to ensure that all members of society are treated fairly and do not suffer discrimination.

Minority ethnic groups and women are disproportionately represented in the mental health system and are more likely to require intervention when in crisis (**Bhui and others 2003**). The **Mental Health Bulletin, Annual Report for 2014–15 (Health and Social Care Information Centre** indicates that:

- people from the Black or Black British ethnic group are more likely to be detained than other ethnic groups, with 56.9 detentions per 100 inpatients
- women who spend time in mental health hospitals are more likely to be detained than men – for every 100 female inpatients, there were 41.9 detentions, compared to 38.5 among male inpatients

Some women, older people, people from minority ethnic groups or those with complex needs can face particular barriers to accessing services (see **Mind (2013) Mental health crisis care: commissioning excellence for BME groups** and **Mind (2011) Listening to experience**).

The Equality duty

Under the **Equality Act 2010 s 149**, the police have a duty to carry out their functions with regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

This includes the need to make reasonable adjustments to meet people's needs and provide equality of service and equal access to justice. The Act states that compliance with the duty may involve treating some people more favourably than others (**Equality Act 2010 s 149(6)**).

For further information, see **The Equality and Human Rights Commission: The Equality Duty**.

Reasonable adjustments

Where possible, police officers and staff should accommodate and accept individual needs, and help the people they have identified as vulnerable to access the additional assistance they need. This applies equally to police interaction with victims and witnesses of crime, and suspects while detained in police custody or during investigation and case management.

The duty to make reasonable adjustments is both:

- anticipatory – recognising that some people will need certain adjustments and making provision for this before they come into contact with the police service
- responsive – responding to individual needs for adjustments at the time the person presents those needs

A good example of an anticipatory adjustment is having key documents available in a variety of formats (for example, easy-to-read text for people with learning disabilities). When responding to individual needs, however, the police should try to avoid stereotyping (especially in relation to the ability of individuals to communicate or to give credible accounts).

For further information on considerations and reasonable adjustments for detainees in police custody, see **Equality and individual needs,** **Police custody** and **Interview and appropriate adults**.

Understanding the challenges

Voluntary agencies report that people with mental ill health or learning disabilities outline very different experiences and perceptions of dealing with the police – some good, some poor (**Pettitt and others 2013**, see also **Victim Support Summary report**).

Specific examples of factors that have prevented people with mental ill health and vulnerabilities from reporting crime include (from **Pettitt and others (2013**):

- having previously had a negative experience with the police
- fear of the response they may receive from police (being blamed, not believed or not taken seriously) because they had a mental health problem
- fear of being sectioned, or having to go to court
- the impact of the crime, for example, feeling ashamed, foolish or embarrassed
- fear of or loyalty to the perpetrator of the crime

These issues may make people reluctant to approach the police for help, increase their distress and frustration and generally act as a barrier to them getting access to justice.

Forces should establish more accessible ways for people to report incidents to the police (for example, producing information in easy-to-read, photographic or video format). They should also test the effectiveness of such initiatives. Mind and Victim Support (**Mind (2013) Police and Mental Health: How to get it right locally**) have identified the following factors that may help or encourage people with mental ill health or vulnerabilities to report crime:

- police being easily accessible, for example, having a visible presence in the community

- the influence of friends, family and professionals
- the seriousness of the crime and its impact
- a desire to protect others or prevent reoccurrence

Definitions and terminology

Specific terminology

Mental ill health

The term mental ill health is used broadly to refer to all those matters relating to mental health problems. These include mental disorders, mental illness, mental health needs and many of the issues that fall within the MHA 1983 definition of mental disorder and the **Police and Criminal Evidence Act 1984 (PACE) Code C** definition of mentally vulnerable.

It also covers people who are experiencing mental distress at the time they come into contact with the police, whether or not they have been formally diagnosed or have previously received mental health services.

- If an officer or member of police staff has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, they should treat the person as such in the absence of clear evidence to dispel that suspicion.

Mentally vulnerable

The term mentally vulnerable applies to detainees who, because of their mental state or capacity, may not understand the meaning or importance of what is said to them (for example, in the form of questions) or of their replies.

A detainee may meet the definition of being mentally vulnerable under **PACE Code C**, and yet not be considered to be experiencing mental ill health by a health care professional. Under these circumstances, the detainee will still require the support mechanisms that they are entitled to under PACE, for example, the use of an appropriate adult.

Paragraph 11.15 of PACE Code C refers to a person who is ‘mentally disordered or otherwise mentally vulnerable’. Under PACE Code C paragraph 11.15, a person who is mentally disordered or otherwise mentally vulnerable must not be interviewed regarding their involvement or suspected

involvement in a criminal offence or offences, or asked to provide a written statement under caution in the absence of an appropriate adult. There are exceptions to this, however, and these are set out in **paragraphs 11.1** and **11.18-11.20**.

Mental health crisis

In this APP module, the term ‘mental health crisis’ is used to describe any perceived emergency brought about by the experience of mental ill health or distress. There is no legal definition of this term and a person’s perception of a crisis is specific to them. Any police decision to describe an incident as a mental health crisis should be based on all available information, and action resulting from any such decision should be guided by the **national decision model**.

The Joint Commissioning Panel for Mental Health has provided **more information on defining mental health crisis.**

Learning disability

Section 1(4) of the MHA defines a learning disability as ‘a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning’.

A learning disability may be mild, moderate or severe and affects the way a person learns and communicates. It may result in a reduced ability to learn new skills, adapt to and cope with everyday demands, understand complex information or, in some cases, to live independently. Those with mild learning disabilities may not receive any formal support and their needs and disability may not be obvious. They may not have had their disability identified before contact with the police. Other people have profound and multiple learning disabilities and their needs may be considerable.

Some people may have physical characteristics that may help identify a learning disability, for example, people with Down’s syndrome (which is classed as a learning disability).

Learning difficulties and neuro-disabilities

Learning difficulties and neuro-disabilities encompass a range of conditions, and may be caused by a wide range of factors that compromise brain function. Conditions include:

- intellectual disabilities

- specific learning difficulties
- communication disorder
- attention deficit hyperactivity disorder
- autism spectrum disorders
- traumatic brain injury
- epilepsy

Brain function may be compromised by genetic factors, pregnancy-related complications including foetal alcohol and drug syndromes, birth trauma, acute injury and illness. Neuro-disabilities can result in problems with memory and concentration, decreased awareness of an individual's emotional state, poor impulse control and poor social judgement. These and associated problems may make it more difficult for affected individuals to engage effectively in their judicial proceedings or to benefit from traditional forms of rehabilitation.

Common symptoms include:

- communication difficulties
- cognitive delays
- specific learning difficulties
- emotional and behavioural problems
- a lack of inhibition regarding inappropriate behaviour
- muscle weakness

See also the **British Psychological Society position paper: Children and Young People with Neuro-Disabilities in the Criminal Justice System (March 2015**).

Autism

The National Autistic Society (NAS) describes autism as a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. More information is available via their **website**.

The NAS has also produced a **practical guide for all criminal justice professionals** who may come into contact with people on the autism spectrum – as victims, witnesses, suspects or offenders. It is based on the experiences of people with autism and those who work with them, and contains real-life examples and personal accounts by professionals.

A definition and explanation of ‘mental capacity’ is available **here**.

Terms that describe people

When referring to people whose state of mental health and capacity is the subject of police attention, APP uses a range of general terms according to the appropriate context. These include ‘person’, ‘individual’, ‘subject’, ‘detainee’ and ‘patient’.

Patient

For the purposes of guidance, the term ‘patient’ refers to someone who is an inpatient in any hospital or a person who has been ‘sectioned’ by an approved mental health professional (AMHP) under MHA 1983 and is therefore ‘liable to be detained’. A person may be considered an inpatient when they have been admitted to hospital for assessment or treatment. They remain an inpatient until they are formally discharged from hospital, even if they are found to be outside of hospital premises.

Mental health professional

In this APP, the term ‘mental health professional’ is used as a generic term to describe any number of separate professions which provide care or treatment to people with mental ill health who have come into contact with the police. Where a reference is made to a specific profession, this will be reflected in precise terms, including mental health nurse, learning disabilities nurse and psychiatrist.

Approved Mental Health Professional (AMHP)

An AMHP was formerly known as an approved social worker. Forces should ensure that multi-agency protocols include clear arrangements for supporting AMHPs in conducting out-of-hours assessments. Relevant aspects of an AMHP’s role are:

- considering whether or not an application should be made for detaining an individual in hospital
- making arrangements for admitting and conveying patients to hospital
- information gathering and initial risk assessment in pre-planned assessments under **MHA 1983**, including undertaking a risk assessment to determine if a request for police assistance is required (and sharing appropriate information with the police to help with their risk assessment)
- requesting police involvement in pre-planned assessments
- using their authority to transfer a person detained in a place of safety to another place of safety (or authorising other people to undertake the transfer)

Responsible clinician (RC)

A responsible clinician has overall responsibility for a person detained for assessment or treatment in hospital, or in the community under supervised community treatment.

Strategic oversight and management

The following guidance on the role and duty of the police service includes some key strategic considerations on which the police should base their response to mental health and vulnerability matters. It is written for use by senior leaders in policing, and discusses the organisational-level planning necessary to enable an effective and safe response to this demand.

Mental health and policing

A number of national reports have been written in response to ongoing issues in the care and management of people with mental ill health and vulnerabilities and those with learning disabilities or difficulties. These reports focus on managing any such person from the time that they come into contact with the police, examining the use of detention, police custody, and criminal justice processes.

Key national reports:

- **The Bradley Report (2009)**
- **Mind and Victim Support report: At risk, yet dismissed (2013**)
- **Independent Commission on Mental Health and Policing Report (2013**)
- **Criminal Justice Joint Inspection: A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system: Phase 1 from arrest to sentence (2014)**
- **Mental Health Crisis Care Concordat (2014**)
- **The Welfare of Vulnerable People in Custody (2015**)
- **The Prison Reform Trust ‘No One Knows’ reports**
- **The Appropriate Adult Network ‘There to Help’ report on the use of Appropriate Adults (2015)**
- **Department of Health guidance: Positive Practice Positive Outcomes (2011)**
- **HMICFRS – Policing and Mental Health – Picking up the Pieces (2018)**

The primary themes highlighted throughout the reports are a requirement for all police officers and operational staff to have:

- a core basic awareness of mental health issues, learning disabilities and vulnerability
- skills for managing people at the point of contact through the use of effective communication
- de-escalation skills and an understanding of the dangers of using restraint techniques with vulnerable people
- an awareness of liaison and diversion opportunities for people with mental health and learning disabilities
- a good understanding of how to apply mental health legislation and the MHA 1983 codes of practice

In response to these requirements, the College of Policing has compiled the following practice guidance:

- **Mental vulnerability and illness (Decision making, Communication, De-escalation** and **Assess threat and risk, and develop a working strategy**)
- **Referral and risk management**
- **Responding to mentally vulnerable victims**
- **Witnesses who are mentally vulnerable**
- **Suspects with mental ill health and vulnerabilities**

In response to the requirement for a more detailed understanding of the law and police responsibilities under MHA 1984, Mental Health Act codes of practice and MCA, the following guidance has been produced:

- **Mental health – detention (a summary of relevant law and powers under MHA 1983)**
- **Mental Health Act 1983 codes of practice protocols**
- **Mental capacity**
- **Crime and criminal justice**

Additional legal and operational guidance is available in the following resources:

- **AWOL patients**
- **Safe and well checks**
- **Suicide and bereavement response** (and **Sources of support**)

Police Mental Health Related Incident

In order to inspect forces' effectiveness in protecting those who are vulnerable and support victims, HMICFRS looked at the response to and support of people with mental health problems. It was found forces were using different definitions to describe mental health related incidents which made it difficult for them to correctly identify people suffering from mental health problems and to understand the subsequent demand. The report, entitled ‘Picking up the Pieces’, highlighted several areas of improvement including the need to provide a national definition for mental ill health which would help all forces provide a consistent approach to people suffering from such problems and also help them measure their demand and workload against a national standard.

As a consequence, the NPCC and College of Policing have compiled a nationally agreed definition for a police mental health related incident as:

> *Any police incident thought to relate to someone’s mental health where their vulnerability is at the centre of the incident or where the police have had to do something additionally or differently because of it.*

Responses by the most appropriate agency

In general, when there is no reason to suspect that a crime has been, or is likely to be committed, responses to the needs of people with mental ill health and vulnerabilities should be provided by appropriately commissioned health and social care services. The police have a duty to prevent and investigate crime, however, they also provide an emergency response to intervene and protect life and property from harm.

Both the **Independent Commission into Mental Health Policing** and the **Mental Health Crisis Care Concordat** suggest that the inappropriate use of police officers, vehicles and custody facilities are not in the best interest of a person with mental ill health, disabilities or vulnerabilities when they most urgently need mental healthcare and support services.

Successive Independent Police Complaints Commission (IPCC) investigations into deaths of people with mental ill health and disabilities following police contact indicate that delays in access to medical support may have ultimately led to the deaths of people with mental health problems when they are in police care.

Practitioners and service user experience (as described in **Mind (2013) Police and Mental Health: How to get it right locally**) also suggest that a police or criminal justice response to mental illness may increase perceived stigmatisation of an individual by giving the impression that the person is suspected of having committed a crime (where this may not be the case). This may cause distress and anxiety in the person concerned, and affect that individual's future cooperation with the police.

When do the police have a duty to respond?

On receiving a call for police response to an incident involving a person with mental ill health or vulnerabilities, forces must evaluate whether the service requested is that of enforcing criminal law, protecting the public (and preventing disorder) and/or protecting life and limb.

Under any of these circumstances, the police have a duty to respond. Article 2 ECHR requires the state positively to protect the right to life. If the police know or ought to know of real and immediate risk to a person's life from an act or acts of violence, they must do all that can reasonably be expected to prevent the risk from materialising (see paragraph 25 of Sarjantson v Chief Constable of Humberside, 2014, QB 411).

Police powers and expectations

In some cases, the police may not be required to attend an incident as part of their policing duties and obligations. For example, if they are unable lawfully to exercise police powers in a particular situation, or exercise only those powers otherwise available to civilians, they might not have a legitimate role to play in the best interests of the subject or have a duty to attend.

This does not mean that the police are prevented from attending any incident (this is a risk assessment-based decision that should be guided by the **national decision model**), only that doing so may not be required.

In some situations, the police exercise no specific police powers but are nevertheless expected to perform actions open to individuals or other state agents. For example, if a person (who is at risk of harm or poses a risk to the public) goes missing or attempts to take their own life, the police are expected to use reasonable efforts to find them and to escort them to a place of safety.

Such activities may be justified as being linked to preventing crimes (such as murder, trafficking, domestic violence or sexual exploitation). This is, however, better analysed as forming part of the right to life and/or the right not to be subjected to degrading treatment contained in the Human Rights Act 1998 and ECHR (see positive obligations under Article 2).

Similarly, the police are expected to exercise powers when confronted with people experiencing mental disorder, even in circumstances where there is no immediate risk of the commission of criminal offences or breach of the peace.

Section 136 of the MHA 1983 empowers a police constable to remove such a person to a place of safety. This confers a power upon a constable to act, and failure to do so in clear circumstances where the person subsequently dies or takes their own life may result in an adverse finding either by a coroner's court or civil court.

Force mental health policy

Forces should ensure that they have a policy on mental health. Although certain issues are required to be subject to local operating protocols with mental health, ambulance and other providers (as above), there are other issues in policing that should be determined by policy.

A force policy on mental health also ensures that services which operate across multiple health commissioners and providers establish basic minimum requirements to determine the police contribution to any local agreement with other providers.

Force mental health policy considerations

Force policies should include information on (or links to):

- the basic requirements in the four MHA 1983 College of Policing local protocols (see table below)
- use of MCA 2005 (see Mental capacity)
- the operation of locally agreed response and referral models (for example, street triage and liaison and diversion schemes)
- the conduct of 'safe and well' or 'welfare' checks (see **Safe and well checks**)
- policies relating to managing mentally vulnerable people in police custody
- investigating and prosecuting offences (with a specific emphasis on how to take **prosecution decisions** where suspects have been assessed under the MHA 1983 for admission)

- investigating offences which are alleged within inpatient psychiatric facilities
- **acute behavioural disturbance**
- **community treatment orders**
- warrants under the **MHA 1983 s 42**

Portraying mental health in the media

Time to Change is a campaign to end the stigma and discrimination that people with mental health problems face in England, run by the charities **Mind** and **Rethink Mental Illness**, with funding from the **Department of Health**, **Comic Relief** and the **Big Lottery Fund**.

Time to Change has a **Media Advisory Service** that provides support and help when dealing with portraying and reporting mental health.

Further guidance for police force communications is available in the APP on **Engagement and communication** (and forthcoming APP on Media relations).

Multi-agency working

Police officers or staff with responsibility for managing mental ill health and mental vulnerability-based demand at a strategic or tactical level are required to understand and operate in a diverse multi-agency environment.

To encourage consistent application of the relevant Acts and the protection of the public, police forces should ensure that local protocols with health agencies, including the ambulance service, include consideration of how the MHA 1983 and the MCA are applied by different professional groups or individuals (for example, the extent of each agency's role).

Forces may also support health agencies by sharing access to training sessions on risk assessment, de-escalation techniques and restraint.

Commissioning of mental health care services

NHS mental ill health and learning disability treatment and care services are subject to a devolved commissioning model in England and Wales. Clinical commissioning groups (CCGs) operate across nationally defined geographical areas. CCGs are responsible for commissioning local

services in each area and interact with hospitals, mental health units and allied service providers to create a local model for accessing emergency and non-emergency mental healthcare services.

Police forces are required to interact with a range of healthcare service providers according to their local model(s). Each force is likely to have access to a similar but slightly different healthcare infrastructure. Health-based places of safety may be provided in specialist mental health units in some areas and in hospitals or other facilities in other areas.

Equally, mental health emergency response services may be provided in multiple ways according to locally commissioned NHS arrangements. Larger and metropolitan police forces are likely to cover multiple CCG areas and are required to develop working arrangements and joint working protocols that are either tailored to local facilities or align with all relevant services.

Key NHS and mental health service contacts

When developing and managing local multi-agency working practices and protocol agreements, mental health specialist or liaison officers/staff should consider working with the following local service providers:

- the lead mental health services commissioner in each relevant CCG (for England) or local health board (for Wales)
- the lead contact at NHS England for services commissioned by them (for example, secure mental health services, liaison and diversion services)
- the senior point of contact with the adult services mental health care provider
- a day-to-day point of contact with the adult services mental health care provider
- the senior point of contact with the learning disabilities service provider
- a day-to-day point of contact with the learning disabilities service provider
- the senior point of contact with the child and adolescent mental health services (CAMHS) provider
- a day-to-day point of contact with the CAMHS provider
- the AMHP lead in each local authority
- the Care Act lead in each local authority (safeguarding lead for vulnerable adults and children)
- the ambulance service mental health lead
- the contact at each A&E department for mental health matters

More information on the roles played by the different organisations that commission and supply healthcare services in England is available **here**.

Information sharing

All agencies have a positive duty to share essential ‘need to know’ information to protect life and the safety of staff. It is important that the police, with other professionals and services dealing with an ill, disabled or distressed person, know what is needed for managing a crisis and are able to consider any associated risks to the subject and others.

For further information see:

- **Statutory obligation to share information**
- **MAPPA Guidance 2012 Version 4**

‘Need to know’ information

Alongside basic contact detail information for the individual and their carer/relative, ‘need to know’ information that the police might request from health or social care services may include:

- whether the person is already engaged with their GP and/or mental health services and the name of the team and any involved professional
- whether they have a mental health crisis plan, care plan or other advance statements
- any clinical information, for example, prescribed medication, psychological therapy
- any indicators of additional risk to themselves or others (examples include recent self-harm, suicidal ideation, physical aggression, a reason for impaired judgement, or perhaps self-neglect)
- any relevant physical health information, such as the person having diabetes

The information shared between the police and health and social care services should be proportionate to the requirement. Police officers and control room staff should consider sharing risk related information that the police may hold with partner agencies (such as Police National Computer (PNC) warning marker information).

Where possible the individual concerned should be asked to explicitly consent to the sharing of any sensitive personal data (including medical notes).

Sharing of personal information may be considered legally proportionate (See **Data Protection Act Schedule 2 1998** and **Statutory obligation to share information**) if:

- the processing is necessary to protect the vital interests of:

  - the individual (in a case where the individual's consent cannot be given or reasonably obtained)
  - or another person (in a case where the individual's consent has been unreasonably withheld)

- the processing is necessary for administering justice, or for exercising statutory or governmental functions
- the processing is necessary for medical purposes, and is undertaken by a health professional or by someone who is subject to an equivalent duty of confidentiality

Note: 'medical purposes' includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of health care services.

Police officers and staff need to ensure, on a case-by-case basis, that the information they are considering sharing is in the public interest and is:

- proportionate
- necessary
- meets a legitimate aim (under **the ECHR Article 8**)

There is a higher threshold to share personal information about less serious incidents as there is a lower public interest in this information being exchanged. Police forces are encouraged to develop **information sharing agreements** and mechanisms that allow for an efficient and effective flow of health-based information between local mental healthcare services (primary and community healthcare) and the police service.

Problem solving – working together

If the same person presents to police, ambulance or emergency departments repeatedly, all relevant agencies should have an interest in understanding why and knowing how to support that person appropriately in the future. The **Mental Health Crisis Care Concordat** states that, within the requirements of data protection legislation, a common sense and joint working approach should guide individual professional judgements.

When different agencies are providing information, and time allows, it may be useful for each to provide a briefing sheet to the other about the information they hold.

Mental Health Act 1983 codes of practice protocols

The police must have regard to relevant codes of practice to MHA 1983. There are separate codes for **England (2015)** and for **Wales (2016)**.

A code of practice is guidance and not instruction. It should be considered with great care, and only be departed from if there are 'cogent reasons for doing so' **(ruling on the application of Munjaz v Mersey Care NHS Trust, 2005, UKHL 58** (see paragraph 107 of the judgment).

Where the codes address areas that are relevant to policing (tactics and operational practices, such as searching patients in hospital), police officers continue to be governed by the primary legislation (PACE) which provides the relevant power. Whenever restraint is required in the exercise of MHA 1983 powers, officers and staff should follow relevant local and national guidance.

Local multi-agency protocol development

Both the English and Welsh codes require police forces and other partners to agree local protocols for implementing the MHA 1983, covering four main areas.

No.	Protocol areas		
1	Place of safety procedures under the MHA s 135 and s 136	Chapter 16	Chapter 16
2	Mental health assessments in private premises, with or without a warrant under the MHA s 135(1)	Chapter 16	Chapter 16

No.	Protocol areas		
3	Search and recovery of patients who are AWOL, including use of warrants under the MHS s 135(2)	Chapter 28	Chapter 28
4	Transfer and conveyance, although this topic could be covered within the above protocols as it relates to each of those issues	Chapter 17	Chapter 17

Development considerations

Local multi-agency protocols can be written to help ensure that all parties:

- agree the risk criteria (see below) to be considered when deciding if police resources should be deployed to a mental ill health or vulnerability-related incident
- understand which types of incidents and situations will require:
  - police-led intervention
  - health-led intervention with police support
  - health-led response (no proactive police involvement)
- establish referral processes (direct pre-charge referral/criminal justice case diversion referral/liaison and diversion referral mechanisms)
- ensure that the legal obligations of those who initiate action under MHA 1983 are clear, operating procedures are unambiguous and decision escalation procedures are included
- set out an agreed position on the local health and social care partners' definition of a missing patient and what the police regard as a missing or an absent person (to prevent gaps between services)

This will help ensure that all agencies are clear about expectations and that appropriate resources are in place to respond to particular situations. In some cases, critical incident policies and the **APP on critical incident management** may also be relevant.

Multi-agency working models

Potential multi-agency working models may include:

- using ‘street triage’ or ‘crisis intervention team’ joint police/healthcare response models
- widening the use and remit of existing local Multi-Agency Safeguarding Hubs (MASH) arrangements
- using standard referral mechanisms to Multi-Agency Risk Assessment Committees (MARAC)
- using liaison and diversion team/services

While both the crisis intervention team and street triage models are currently the subject of ongoing evaluation, no systematic review of the evidence has been carried out to date that indicates the effectiveness of any of the models described.

Requests for police assistance from healthcare partners

Health authorities may ask for police assistance in relation to patients presenting management problems, or those who are absent without leave (see **AWOL patients**). They might also request a ‘safe and well check’ when an individual with mental ill health or vulnerabilities is outside of medical facilities and it is believed that their safety or health is at risk (see **Safe and well checks**).

AWOL Patients

There should be a mechanism to jointly risk-assess whether it is appropriate for NHS professionals to return a patient whose whereabouts is already known or whether police support will be provided. Factors that may influence such a decision include the time lapse since becoming AWOL, whether or not the person is known to be under the influence of substances or likely to be experiencing the effects of withdrawal from necessary medication. Finally, any known history of resistance, aggression or violence is also relevant.

Safe and well checks

There is no specific or automatic legal requirement for police forces to undertake welfare (or ‘safe and well’) checks simply because another organisation has requested that they do so. The decision on whether or not a check is necessary and proportionate to the risk posed should be routinely based on an informed risk assessment in line with the **national decision model**. When taking such decisions, officers and staff should consider using all available information and intelligence (police/medical/social care and other information).

For further information see:

- **Safe and well checks**
- **AWOL patients**
- **Sources of information**

Patient management problems

Ordinarily, the police should not need to be called to assist healthcare staff in responding to a patient who is presenting management problems. NHS trusts, local health boards and other health service providers have legal obligations under the **Health and Safety at Work etc. Act 1974** to ensure that sufficient numbers of trained staff are available to restrain patients for medical intervention or to place them in isolation for their own or another’s safety where this is necessary. This means they should be capable of dealing with most problems themselves.

Whenever responding to reports from health settings, the police should also consider the potential vulnerability of patients and service users (for example, their susceptibility to abuse).

Responses to requests for police assistance should be in line with local protocols. These should also include details of when supervisors should become involved in particular situations and their role.

Establishing a mutually agreed risk criteria

The police and healthcare agencies can agree a risk criteria which indicate whether a situation is low, medium or high-risk in terms of the likelihood of it resulting in violence or harm, and the nature of that risk. Potential factors indicating a medium or high-risk situation where police involvement may be appropriate (either in support of health staff or as a police-managed situation) include:

- information about access to or use of weapons including firearms and improvised weapons
- evidence to suggest that there is a serious risk to the safety to the individual, staff, or the public (either if they were to escape detention or if they are not found and/or detained)

Information about relevant factors can come from PNC, Police National Database (PND), NHS databases (where accessible), other local information systems or observations of the police or other agencies.

Tags

Mental health