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PRACTICE
IMPROVEMENT

Guidance on

**RESPONDING TO
PEOPLE WITH
MENTAL
ILL HEALTH
OR LEARNING
DISABILITIES**

2010

Produced on behalf of the Association of Chief Police Officers
by the National Policing Improvement Agency

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First published 2010
National Policing Improvement Agency
10-18 Victoria Street
London SW1H 0NN

The National Policing Improvement Agency (NPIA) is committed to making a valuable contribution to improving public safety. ACPO and the NPIA would like to express their thanks to all those involved in the drafting of this document. All of the responses during the consultation phase of this project were appreciated and contributed to the final document.

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Preface

The Association of Chief Police Officers (ACPO) is committed to improving the service the police provide to people experiencing mental ill health or who have learning disabilities. These people live in every community and every police force works with them. Many have a number of other problem areas in their lives such as drug or alcohol problems, difficulty in forming and sustaining relationships, poor housing or homelessness, poor physical health, family breakdown, early experiences of abuse or childhood trauma, a history of institutionalisation and social exclusion.

Given that police officers and staff are often the gateway to appropriate care – whether of a criminal justice or healthcare nature – it is essential that people with mental ill health or learning disabilities are recognised and assisted by officers from the very first point of contact. The police, however, cannot and indeed are not expected to deal with vulnerable groups on their own. When responding to people with mental ill health or learning disabilities, the police will often have to work with a variety of statutory social and healthcare agencies as well as the voluntary sector. These relationships are critical to ensuring an appropriate response in what can be challenging circumstances. The 2007 thematic inspections by the HMIC and **Bradley (2009) The Bradley Report** found a real need to improve the coordination of services and responses locally across the spectrum of vulnerability. This has been reiterated in the national delivery plan of the Health and Criminal Justice Programme Board **Department of Health (2009) Improving Health, Supporting Justice**. Obtaining full benefits from this multi-agency approach requires better liaison and greater clarity between the police and other agencies regarding each other's respective roles and responsibilities so that the needs of those with apparent mental health issues can be addressed effectively within a health-led system.

The development of this guidance has provided an opportunity for the police to engage in a meaningful dialogue with other agencies operating in the field of mental health and criminal justice. These include the Department of Health (particularly Offender Health) and the Welsh Assembly Government. When used in conjunction with generic and specialist training and the process of assisted implementation for police forces, the guidance should provide a robust mechanism for the development and improvement of police responses in the field of mental health, and the continuation of discussion and decision making in this area.

1

Introduction

This ACPO guidance on police responses to people experiencing mental ill health or who have learning disabilities provides an overview of the subject, including some of the myths and challenges surrounding this area of police business. This section outlines the scope of the guidance, provides definitions of some key terms and sets out the main benefits and limitations.

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1.1 Scope

This guidance provides advice on police responses to people who:

- Are experiencing mental ill health;
- Have a learning disability;
- Have both mental ill health and a learning disability;
- Have developmental conditions such as autism, Asperger syndrome and attention deficit and hyperactivity disorder;
- Have multiple needs relating to mental health.

The guidance addresses the needs of these individuals where they arise:

- In a **criminal justice** capacity – where the person is a victim of crime, a witness to crime or is suspected of or known to have committed a crime;
- In a **healthcare** capacity – where the police may be
 - acting in support of healthcare agencies dealing with someone experiencing a mental health crisis (for example, by using police powers)
 - supporting a person experiencing mental ill health until healthcare professionals are involved
 - responding to families and carers of people with mental ill health or learning disabilities who have concerns about them
 - responding to members of the public seeking a service from the police in relation to suspected mental ill health or learning disabilities on the part of an individual.

1.2 Overcoming Discrimination and Stigma

People with mental ill health or learning disabilities often suffer discrimination and stigma because of their condition – from low-level incidents of harassment, name-calling and casual bullying through to serious violence and even murder. They can also be particularly vulnerable to patronising and negative attitudes, being taken advantage of and receiving unequal treatment from public services. This may prevent them from seeking help when they need it and make them feel unsafe in their own communities.

The damaging attitudes towards mental ill health and learning disabilities exist because the reality is often misunderstood by the public and misrepresented by the media. Myths include:

- The stereotype that those with mental ill health are dangerous. In fact, people with mental ill health rarely commit serious crimes and are at greater risk of becoming victims of crime than the general population. In addition, greater danger to the public is posed by groups other than those with mental ill health, particularly those who misuse alcohol.

- The linking of the perception of dangerousness and resulting stigma around mental illness with negative stereotyping related to other areas of diversity, such as race. This is particularly damaging and there is no evidence to support this stereotype.

To avoid adding to existing discrimination and stigma it is vital that the police respond appropriately to people who are experiencing mental ill health or have learning disabilities. While officers and staff are not required or expected to reach the level of diagnostic expertise of clinicians and trained healthcare professionals, they are expected to be able to recognise behavioural and other signals which could alert them to consider that special support and care is required in dealing with a particular individual. This is for the safety of the person, the officer or staff member, and the wider public. It is also to protect the evidence-gathering process and the individual's rights to justice. For more information see **3.1 Recognising Mental Ill Health or Learning Disabilities**.

1.3 Benefits

Adoption of this guidance will have both specific and general benefits, some of which are set out below.

1.3.1 Specific Benefits

- A freeing up of police resources through better implementation of the provisions of the Mental Health Act 1983, especially sections 135 and 136 (for example, more people with mental ill health being detained in health facilities rather than police custody);
- An effective response to **Bradley (2009) The Bradley Report** recommendations on diversion, disposal and offences in healthcare settings;
- Improved operational responses to victims, witnesses, suspects and offenders with mental ill health or learning disabilities, thereby leading to a reduction of repeat victimisation and repeat offending;
- Improved working relationships with statutory and voluntary social and healthcare agencies;
- Increased reporting to the police of offences against people with mental ill health or learning disabilities (including discrimination, victimisation and harassment);
- Improved information sharing leading to a reduced risk of harm to vulnerable people;
- A police culture that views people with mental ill health or learning disabilities in terms of potential vulnerability and needs.

1.3.2 General Benefits

- Improved service delivery and higher public satisfaction;
- An enhanced organisational reputation;
- More confident and professional decision making and action;
- Improved investigation and evidence gathering;
- A defence for individuals and forces from unreasonable criticism, complaints, legal action and public inquiries.

1.4 Challenges

The Police Service does not have primary responsibility for every task relating to people with mental ill health or learning disabilities and should not assume, directly or indirectly, responsibility for dealing with all related issues that the public or other agencies may present them with. Other partner agencies are often better placed to deal with certain situations, and may in fact have statutory responsibility for them. The police, therefore, should always be ready to support, guide and assist, but not necessarily to lead. For further information see **3.7 Identifying, Assessing and Managing Risk** and **ACPO (forthcoming) Guidance on Managing Operational Risks**.

1.5 Other Sources of Information

Many reports and official documents contain general information that is relevant to the way police respond to people experiencing mental ill health or who have learning disabilities. Examples include:

- ***Criminal Justice System (2007) Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures.***
- ***ACPO (2010) Guidance on the Management of Police Information.***
- ***ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody.***
- ***ACPO (2007) Update to the Guidance on the Management, Recording and Investigation of Missing Persons 2005.***
- ***ACPO (2007) Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders.***
- ***ACPO (2008) Guidance on Investigating Domestic Abuse.***

- ***ACPO (2009) Guidance on Investigating Child Abuse and Safeguarding Children.***
- ***Ministry of Justice (2009) MAPPA Guidance, Version 3.***
- ***ACPO (2009) Manual of Guidance on the Management, Command and Deployment of Armed Officers.***

This guidance refers to, but does not repeat, information held in other documents.

1.6 Police Personnel with Mental Health Needs

The guidance does not include issues relating to police officers and staff with mental ill health. That issue is an employment responsibility included in human resources policies and guidance. The police, for example, are subject to the requirements of the Health and Safety at Work etc Act 1974 and related legislation and codes of practice and have obligations as employers under the Disability Discrimination Act 2005. For further information see ***Department of Health (2007) Line Managers' Resource: A practical guide to managing and supporting people with mental health problems in the workplace.***

2

Definitions

This section defines some of the main terms associated with the police response to people experiencing mental ill health or who have learning disabilities. In particular, it notes:

- **That mental ill health**
 - is not usually apparent in the early years
 - can be episodic, occurring between periods of being well
 - does not usually permanently reduce intellectual functioning
 - can involve complete recovery with treatment;
- **That a learning disability**
 - is usually present from early childhood
 - affects intellectual functioning
 - remains constant
 - does not have periods of recovery.

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2.1 Definitions of Mental Ill Health and Learning Disabilities

Terminology relating to people with mental ill health or learning disabilities can be complex and changes over time. Views as to the most appropriate terms will depend on the individual, group or agency. This guidance promotes the view that service delivery should be a response to the needs of individuals and should be mindful of specific vulnerabilities. It does not focus on legalistic or technical definitions, or the diagnosis of particular conditions. Some discussion of the main terms, however, may be useful to readers.

2.1.1 Mental Ill Health

The term mental ill health is used broadly in this guidance to refer to all those matters relating to mental health problems, including mental disorders, mental illness and mental health needs, and many of the issues that fall within the Mental Health Act (MHA) 1983 definition of mental disorder (see **2.1.1.1 Mental Disorder**) and the PACE definition of mentally vulnerable (see **2.1.1.2 Mentally Disordered or Otherwise 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 are accessing mental health services.

Mental ill health can include those conditions which are severe and enduring (for example, psychotic disorders, schizophrenia, personality disorders and bipolar affective disorder or manic depression) and other more common problems (for example, anxiety, depression, phobias, obsessive compulsive and panic disorders and post-natal depression). In fact, mental ill health is likely to affect everyone at some point in their lives whether personally or due to the experience of someone close to them or a member of their community. The impact can be personal, social and economic, creating a major policy issue affecting all areas of policing. This guidance is based on the assumption that mental health can be extremely complex and that people live their lives on a continuum of mental wellbeing.

2.1.1.1 Mental Disorder

The MHA 2007 changed the definition of mental disorder in section 1(2) of the MHA 1983 to simply 'any disorder or disability of the mind'. This change removed the separate definitions of 'mental impairment', 'severe mental impairment' and 'psychopathic disorder' and means that the same criteria apply regardless of diagnosis and no one fails to get the treatment they need because they do not happen to fall within particular categories.

A mental disorder can be either temporary or permanent and not all mental disorders meet the criteria for the exercise of powers under the MHA. Examples of mental disorders include conditions such as schizophrenia, depression, bipolar disorder, anxiety disorder, obsessive-compulsive disorder, personality disorders, eating disorders, and dementia.

2.1.1.2 Mentally Disordered or Otherwise Mentally Vulnerable

Paragraph 11.15 of the PACE Code of Practice for the detention, treatment and questioning of persons by police officers (PACE Code C) refers to a person who is 'mentally disordered or otherwise mentally vulnerable'. When suspected of committing a criminal offence, such a person must not be interviewed other than in the presence of an 'appropriate adult' (see **7.5.4 Appropriate Adults** and **7.5.11 Interviewing Suspects**). The term 'mentally vulnerable' applies to detainees who, because of their mental state or capacity, may not understand the significance of what is said to them (for example, in the form of questions) or of their replies. If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally vulnerable, then in the absence of clear evidence to dispel that suspicion, the person must be treated as such for the purposes of the Code (note 1G and paragraph 1.4). For signs of possible mental ill health or learning disabilities, see **3.1 Recognising Mental Ill Health or Learning Disabilities**.

2.1.1.3 Self-Harm and Suicide

The mandate to protect the public and safeguard human rights includes people at risk of harm to themselves from their own actions including self-neglect, self-harm and suicide. Self-injury or self-harm is deliberate injury inflicted by a person upon his or her own body without suicidal intent. It is frequently prejudicially labelled as 'attention seeking'. Understandably, police officers may find self-harming behaviours unusual, distressing or anxiety provoking. All police staff, especially custody staff, should be trained in self-harm awareness. For further information see ***Department of Health (2002) National Suicide Prevention Strategy for England*** and ***Welsh Assembly Government (2009) Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014***.

2.1.1.4 Social Model of Disability

ACPO supports the 'social model of disability', which recognises that the barriers created by society are often far more 'disabling' than an individual's particular condition. The model argues that society creates disability through its discriminatory practices (for example, barriers and attitudes) against people with disabilities.

2.1.2 Learning Disabilities or Difficulties

Section 1(4) of the MHA 1983 now defines learning disability as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.'

Learning disabilities are sometimes referred to as intellectual disabilities or learning difficulties. There are many different types of learning disability and they are caused by the way the brain develops either before a baby is born, during birth or because of a serious illness in early childhood. A learning disability may be mild, moderate or severe and affects the way a person learns and communicates. It results 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. Most people with a learning disability look physically the same as the general population although some may have clear physical characteristics, for example, people with Down Syndrome (which is classed as a learning disability).

Those with mild learning disabilities may not receive any formal support or may not have had their disability identified before contact with the police; and their needs and disability may not be obvious. Other people have profound and multiple learning disabilities and their needs will be considerable.

When in contact with people with learning disabilities, the police need to be aware that these people may be extremely vulnerable and suggestible and can have difficulty with many everyday tasks, such as filling in forms, understanding information (written or spoken), concentrating and remembering, telling the time, knowing dates and using public transport. For more information see <http://www.mencap.org.uk>

Learning disabilities frequently co-occur with mental health problems, which may complicate the effective response of mainstream agencies.

2.1.3 Developmental Conditions

People with developmental disabilities/conditions do not fit the definition of mental ill health or learning disability. Their intellectual capacity may affect the way they interact with the police, as well as the response they receive from the police. Often described as neuro-diverse (ND), these people differ from others in the way they process information (see the Developmental Adult Neuro-Diverse Association website <http://www.danda.org.uk/> and **Chown (2009) *Do you have any difficulties that I may not be aware of?***). Common developmental conditions are autism and Asperger syndrome (see **2.1.3.1**), dyslexia and dyspraxia (see **2.1.3.2**), and attention deficit hyperactivity disorder (see **2.1.3.3**).

The police should be aware that neuro-diverse people may have difficulty in processing visual information (including words on paper, facial features and expressions, distance and light), aural information, (including spoken words, pitch and tone) or information involving touch and sensation (including texture and fabric).

One of the problems with developmental conditions is that they are widely under-diagnosed. This means that those with the conditions often have no idea they have them and indeed have developed their own coping strategies or have simply got used to hiding the degree of their difficulties. Developmental conditions can, therefore, present issues of vulnerability that the police need to recognise and respond to appropriately. Some dyspraxics and dyslexics, for example, will need advocacy. Others may be overly sensitive to light, noise, touch or temperature. See also **3.2.2 Communication Aids**.

2.1.3.1 Autism and Asperger Syndrome

Autism and Asperger syndrome are known collectively as autistic spectrum disorders (ASDs) and are developmental conditions. This means that they occur during a child's early life, affecting how they develop. Many people are diagnosed early in life but others may not receive a diagnosis until they are adults.

People with ASDs have difficulties in three main areas – social communication, social interaction and social imagination. This can manifest as very specific behaviour such as taking phrases and words literally, having obsessions, avoiding other people and social situations, resisting change, disliking new situations and preferring routine. People with an ASD often have difficulty recognising or understanding other people's emotions, feelings and needs, and expressing their own. This can make it difficult to fit in, engage with others or, potentially, to explain their needs to a professional.

The terms 'high functioning autism' and Asperger syndrome are used to describe those people who may well have average or above average IQs but who still struggle with the three areas of social behaviour mentioned above to varying degrees.

There is no evidence of an association between ASD and criminal offending. For further information see **National Autistic Society (2008) Autism: A Guide for Criminal Justice Professionals.**

2.1.3.2 Dyslexia and Dyspraxia

Dyslexia and dyspraxia are two 'hidden disabilities' that are over-represented in the offending population. People with dyslexia often have excellent communication skills, a good understanding of the working of things such as machinery, computers and circuitry, or an extraordinary visual-spatial awareness, and they are often creative, innovative and lateral thinkers. They may have significant problems, however, with reading, writing, spelling and numeracy as well as many of the difficulties in processing information mentioned above (see **2.1.3 Developmental Conditions**). In contrast, dyspraxia is an impairment or an immaturity of the organisation of movement. This is often key to difficulties with body movement, speech and language and visual problems.

2.1.3.3 Attention Deficit Hyperactivity Disorder

The terms attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) refer to a range of problem behaviours associated with poor attention span, including impulsiveness, restlessness and hyperactivity, as well as inattentiveness. People with ADHD may exhibit confrontational defiant behaviour and temper tantrums. ADHD is commonly diagnosed in young people (and increasingly in adults) and can prevent children from learning and socialising well, and lead to anti-social or offending behaviour. Young people diagnosed with ADHD frequently receive other psychiatric diagnoses in later life. See also **3.1.1 Signs of Mental Ill Health or Learning Disabilities.**

2.2 Definitions of Other Key Terms

Key terms used in this guidance have the following definitions. They are presented in alphabetical order.

2.2.1 Advocates

It is not the responsibility of the police to make new referrals to advocacy services on behalf of service users – this should be done through mental health services. However, when responding to a person with mental ill-health or learning disabilities, the police may well have contact with two different types of statutory advocates:

- **Independent mental health advocates (IMHAs)** – the role of the IMHA is to ensure that service users who are detained under the longer-term provisions of the MHA understand the Act and their rights and safeguards. This includes people subject to a Compulsory Treatment Order in the community and all those detained in hospital for assessment or treatment. The IMHA may, if service users request, also support them in other matters which could include the police and criminal justice response, but should not act as the appropriate adult for the purpose of PACE Code C. Being detained under section 136 of the MHA does not give a person the right to an IMHA.
- **Independent mental capacity advocates (IMCAs)** – where a person lacks capacity in relation to decisions about serious medical treatment, long-term hospital or care accommodation, or case reviews, and only has professionals involved in supporting them, an IMCA can provide support to that person. IMCAs can also help and support persons who lack capacity in relation to protection of vulnerable adult (POVA) matters, and case reviews. It is only in relation to POVA matters that the police are likely to have contact with IMCAs.

In addition to IMHAs and IMCAs, the police may engage with independent mental health advocacy as practised in the health and social care sector. Such advocates provide help and support to patients in hospital, as well as people receiving care and treatment through secondary and specialist mental health and learning disability services. Such advocates can assist in identifying a person's needs and helping with communication.

2.2.2 Approved Mental Health Professionals, Approved Clinicians and Responsible Clinicians

An 'approved mental health professional' (AMHP) was formerly known as an 'approved social worker' or ASW. The key aspects of the AMHP role of relevance to the police response are:

- Considering whether or not an application for detention in hospital of an individual should be made;
- Making arrangements for the admission and conveyance of patients to hospital;
- Information gathering and initial risk assessment in pre-planned assessments under the MHA, including undertaking a risk assessment to consider if a request for police assistance is required (and sharing appropriate information with the police to help with their risk assessment) – see **6.2 Mental Health Act 1983, Mental Capacity Act 2005 and Police Involvement**);
- Decisions about 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 persons to undertake the transfer).

Forces should ensure that multi-agency protocols include clear arrangements for supporting, where relevant, AMHPs to conduct out-of-hours assessments. For more information see **6 Use of Police Powers under the MHA 1983 and the MCA 2005**.

If a person is detained for assessment or treatment in hospital, or in the community under supervised community treatment (SCT), the person with overall responsibility for their case is known as the 'responsible clinician'. The responsible clinician must be an 'approved clinician', ie, approved by the Secretary of State (in relation to England) or the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of the MHA.

2.2.3 Child

Sometimes the police will have contact with children about whom there is concern relating to mental ill health or learning disabilities. This may be because of their behaviour or symptoms, or because of the behaviour and symptoms of a parent or carer. Where issues concerning the safeguarding of children arise, including concern about a child in need or who may be suffering or at risk of suffering significant harm, officers should follow local procedures and the guidance in **ACPO (2009) Guidance on Investigating Child Abuse and Safeguarding Children** and **HM Government (2006) Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children**.

For more information see **5.4 Special Measures** and **6.4.5 Children and the Use of Section 136**. Also see Chapter 36 of the MHA Code of Practice for England and Chapter 33 of the MHA Code of Practice for Wales for information about the application of MHA powers to children and young people under the age of 18; and **HM Government (2006) Youth Crime Action Plan**.

2.2.4 Dual Diagnosis

The terms dual diagnosis and co-morbidity are used to describe situations in which an individual is suspected to have or has been diagnosed as having both a mental health condition (including mental ill health or a learning disability) and a condition relating to alcohol or substance use (including alcohol and/or drugs, illicit or otherwise).

Understanding and responding appropriately to the combined effects of both mental ill health and drugs or alcohol can be difficult for all professional groups, including the police. For example, there is a risk that serious mental ill health may go unrecognised when there is coexisting substance misuse, as sometimes psychotic symptoms and challenging behaviour will be attributed solely to the substance use. The converse can be true. Where a person is known to have mental ill health, any violent behaviour may be blamed on this, with other causes, such as the misuse of drugs, being overlooked. This could have serious implications for an investigation.

According to **Bradley (2009) The Bradley Report** dual diagnosis in people with mental ill health or learning disabilities is so prevalent that it should be regarded as the norm rather than the exception (for example according to research, seventy-five per cent of users of drug services and eighty-six per cent of users of alcohol services also experience mental health problems). For further information see:

- **Department of Health (2002) Dual Diagnosis Good Practice Guide;**
- **Department of Health (2006) Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings: Guidance on the assessment and management of patients in mental health inpatient and day hospital settings who have mental ill health and substance use problems;**
- **Scan (2008) Substance Misusing Clients with Mental Health Problems: A Brief Practitioner's Guide for Criminal Justice Integrated Teams.**

2.2.5 Intermediaries

The Youth Justice and Criminal Evidence Act (YJCEA) 1999 provides for the examination of a witness to be conducted by an intermediary approved by the courts (see YJCEA, sections 16, 17 and 29). This special measure was introduced in April 2007 to assist witnesses who need help to communicate their best evidence (eg, children aged under 17 years, individuals who have a mental disorder within the meaning of the MHA or individuals who have significant impairment of intelligence and social functioning).

While a function of intermediaries is to communicate to the witness the questions that the court, the defence and the prosecution teams ask, and to communicate the answers that the witness gives in response, they can also provide communication assistance to the police in the investigation stage. This assistance can be crucial in successfully detecting and prosecuting a crime. Police forces can contact the NPIA's Specialist Operations Centre (soc@npia.pnn.police.uk) for advice and operational support in relation to the communication needs of witnesses. They operate, for example, the Witness Intermediaries Scheme, a specialist unit which matches communication specialists to the special needs of witnesses.

In relation to vulnerable suspects, the Coroners and Justice Act 2009 includes a provision for intermediaries for this group. An implementation plan is being developed by the Crown Prosecution Service, although it is envisaged that this provision will not be in place until Spring 2011.

2.2.6 Vulnerable Adult

A vulnerable adult is defined by the Law Commission in **Lord Chancellors Department (1997) Who Decides: Making decisions on behalf of mentally incapacitated adults** as a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.' In relation to the safeguarding of vulnerable adults, officers and staff should follow the guidance contained in:

- (England) **Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse** (this guidance is currently being reviewed);
- (Wales) **Welsh Assembly Government (2000) In Safe Hands: Implementing Adult Protection Procedures in Wales.**

Documents dealing with the police response to vulnerable victims and witnesses include:

- ***Office for Criminal Justice Reform (2007) Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures***
- ***Vulnerable Witnesses: A Police Service Guide***
http://frontline.cjsonline.gov.uk/_includes/downloads/guidance/victims-and-witnesses/Vulnerable_witnesses_police_service_guide.pdf
- ***Victims Charter***
<http://www.homeoffice.gov.uk/documents/victims-charter.html>
- ***Criminal Justice (2005) The Code of Practice for Victims of Crime.***

3

General Operational Guidance

This section deals with general areas, from both a criminal justice and healthcare perspective, relating to police responses to people experiencing mental ill health or who have learning disabilities. These issues, which are inter-related, are:

- Recognising mental ill health or learning disabilities;
- Communication;
- Information management;
- Information sharing;
- Pathways to care;
- Multi-agency partnerships and protocols;
- Identifying, assessing and managing risk;
- Intervening in a crisis;
- Diversity considerations;
- Media and communication strategies.

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3.1 Recognising Mental Ill Health or Learning Disabilities

Early police recognition of the possible mental ill health or learning disabilities of people they come into contact with is crucial to ensuring an appropriate and effective response – whether the matter requires a criminal justice response, a social or healthcare response or a combined response.

3.1.1 Signs of Mental Ill Health or Learning Disabilities

Although police officers and staff are not expected to be able to identify the specific nature of mental ill health or learning disabilities, it is important that their training enables them to recognise warning signs. This recognition can occur at any point in their interaction with people, whether at the stage of an emergency call, giving an initial witness statement, in custody or any other stage.

3.1.1.1 Indicators of General Concern

Things that should act as, or may be perceived to be, general warning signs include:

- Irrational conversation or behaviour;
- Talking about seeing things or hearing voices which cannot be seen or heard by others;
- Removing clothing for no apparent reason;
- Confusion and disorientation;
- Paranoid beliefs or delusions;
- Self-neglect;
- Hopelessness;
- Impulsiveness;
- Inappropriate or bizarre behaviour;
- Obsessional thoughts or compulsive behaviour;
- Inappropriate responses to questioning;
- Apparent suggestibility;
- Poor understanding of simple questions;
- Confused response to questions;
- Speech difficulties (eg, poor enunciation, slurring words or difficulty with pronunciation);
- Difficulty reading or writing;
- Unclear concepts of times and places;
- Problems remembering personal details or events;
- Any suggestion or indication that a person is in touch with mental health services (eg, psychiatric medication or appointment card);
- Poor ability to cope with interruptions;
- Poor handwriting that is difficult for others to read;
- Difficulty with filling out forms;

- Inability to take down correct information or follow instructions correctly;
- Talking continuously, or slowly and ponderously;
- Repeating him or herself.

3.1.1.2 Indicators of General Concern for Safety of the Individual or Others

Behaviour which should raise concern about people's risk of harm to themselves or to others includes:

- Putting themselves in danger (eg, walking into the path of moving traffic or on railway lines);
- Asking for help with their mental health;
- Engaging in threatening behaviour towards others for no obvious reason;
- Threatening or engaging in self-harm;
- Attempting or threatening suicide (eg, expressing ideas, intentions or plans relating to suicide);
- A high level of volatility;
- Being unresponsive to others;
- A tendency to trip, fall over or bump into things;
- Hyperventilating (over-breathing);
- Showing physical signs of severe malnourishment and self-neglect.

This list is not exhaustive.

3.1.1.3 Indicators of Concern about Ability as Victim, Witness or Suspect

Some aspects of an individual's condition may affect the person's ability as a victim, witness or suspect unless it is recognised and managed appropriately. For example, people experiencing mental ill health or who have learning disabilities can:

- Be highly suggestible;
- Be eager to please;
- Give answers they think are wanted;
- Confuse the source of their memories;
- Report fewer details in free recall;
- Forget things more quickly;
- Be highly influenced by the nature of questioning;
- Be easily distracted;
- Have difficulty with concepts of time and quantity.

Practitioners should be aware that the above ‘indicators’ are seldom definitive proof of mental ill health or learning disabilities. For example, the fact that someone is slurring their words might well indicate that they are using anti-psychotic medication that affects speech, but it may equally be the case that the person is intoxicated or affected by a medical condition. For more information see **5 Operational Police Responses to Victims and Witnesses** and **7 Operational Police Responses to Suspects and Offenders**.

3.1.2 Other Issues to Be Aware of

The nature and effects of mental ill health or learning disabilities can be diverse. There are a number of issues that the police need to be aware of.

- **Difficulty in approaching the police** – people with mental ill health or learning disabilities might find it difficult to approach the police for help because they do not know how to complain, are afraid they will not be believed or will be perceived to be a nuisance, have difficulty in communicating, have low self-esteem, are unaware of their rights or are afraid of having to cope with a stressful environment or situation. In cases of abuse, it may be because they are dependent on the person who is abusing them.
- **Reluctance to disclose** – due to perceived stigma, personal embarrassment or previous negative experiences, some individuals may be reluctant to self-identify their mental ill health or learning disabilities and will make efforts to ensure that these remain undetected or are actively concealed. This may be because they are afraid or self-conscious, or do not wish to be ‘labelled’ in a particular way and treated differently from others.
- **Hidden or obscured impairment** – in contrast with severe mental ill health, some mental health conditions and learning disabilities are not readily identifiable. The possibility of less obvious conditions should always be considered. In addition, signs of impairment can often be obscured by expressions of distress, anxiety, aggression or anger, the effects of drugs or alcohol, or co-existing social or behavioural problems.

- **Need for appropriate communication** – notice of rights and entitlements may need to be given in different ways which are more easily understood by individuals with particular needs. Not everyone communicates using speech – for example, some use British Sign Language, Makaton (a unique language programme using signs and symbols), communication boards and pictures to support text and other messages. Police officers and staff should seek advice if they are not familiar with the individual's preferred method of communication, particularly for people with a known or suspected learning disability, as communication difficulties are a defining feature of those conditions.
- **Cultural differences** – some behaviour may be a common occurrence in one culture but appear odd in another (for example, in some religions a prayer must be spoken out loud, but this can give the impression of someone talking to themselves). Practitioners must take care not to make assumptions about a person's cultural background, language and beliefs. Instead, they should ask service users directly and sensitively about their cultural and religious needs and how these should be met.
- **Lack of awareness** – some people may be unaware that they have mental ill health or a learning disability. For this reason, where the police suspect that the person is displaying signs indicating that extra support is required they should use sensitivity and discretion in all their interactions.
- **Scope of vulnerability** – this can be large, incorporating continuums along social, emotional, behavioural and cognitive dimensions. Given that many types of mental ill health are not permanent, an individual's position on that continuum will vary according to their condition on a particular occasion.
- **Comprehension and understanding** – the police need to be aware that people's ability to understand information and make decisions may fluctuate. For example, the difficulties exhibited by an individual during a period of mental ill health may be entirely absent when in good mental health. In addition, police officers and staff should not assume that if people are unable to communicate or are in distress and having difficulty communicating, they cannot understand what is being said or do not mind their personal details being discussed.

- **Others reasons for a person's behaviour** – some circumstances may appear to indicate that a person has mental ill health or learning disabilities but could actually be the result of: physical illness (eg, diabetes, epilepsy, urinary tract infection, encephalitis or sickle cell disease); physical injury (eg, head injury); physical disability (eg, deafness or the effects of a stroke); drug or alcohol misuse; or frustration due to not being listened to. Sometimes more than one of these factors will be relevant.
- **Involving those close to the person** – people who know the person with mental ill health or learning disabilities (for example, parents, carers, family and friends) are often key to understanding and responding to that individual's needs.
- **Multiple needs** – mental ill health or learning disabilities can easily be overlooked when an individual has a more immediately recognisable need such as drug misuse. Where officers do not recognise mental ill health or learning disabilities, or the fact that the person may have multiple needs, and they fail to take appropriate action (for example, make enquiries to establish the nature of any issues). The potential consequences can be terrible, including the death of a person in police custody, the failure of a prosecution involving a vulnerable victim, or the wrongful conviction of a vulnerable suspect who has not been given access to legal protection. All officers should receive appropriate training and have a basic understanding of the range of possible issues involved in dealing with individuals within the criminal justice system who have mental ill health or learning disabilities.

3.2 Communication

Any contact with members of the public requires good communication techniques. These may need to be adjusted when dealing with people experiencing mental ill health or who have learning disabilities. In particular, police should recognise that difficulty with communication is a defining feature of having a learning disability.

3.2.1 Good Practice

When interacting with people with communication difficulties, the police should ensure that they provide constant reassurance and information about what is happening and why, as well as clear information about the person's rights in the particular situation. This may help to alleviate some of the concerns and anxiety people often feel, whether as a victim, a suspect or someone detained under section 135 or 136 of the MHA 1983.

Officers and staff should also be careful about the terminology they use to describe mental ill health or learning disabilities, and be willing to take advice from other agencies on this matter. For example, when officers have little awareness of appropriate terminology, they may use language that causes offence and sometimes distress. Conversely, some officers may know all the 'correct' terminology but have attitudes that are negative or patronising.

Additional help in facilitating communication may sometimes be necessary. Assistance could be sought from:

- Parents, family and carers;
- An intermediary (for a witness);
- An appropriate adult (for a suspect);
- A mental health professional;
- Someone who knows the person well;
- A specialist adviser (as in a hostage or firearms situation);
- A specialist voluntary agency.

For further information on effective communication, see ***Office for Criminal Justice Reform (2007) Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures*** (particularly Chapter 3: Planning and Conducting Interviews with Vulnerable Adult Witnesses) and ***Criminal Justice System (n.d.) Vulnerable Witnesses: A Police Service Guide***.

3.2.2 Communication Aids

'Crisis cards' are sometimes carried by people who have communication difficulties or who may find it difficult to communicate when in a crisis. The cards provide a range of information, from personal details of the individual and those of a trusted person to be contacted in a crisis or emergency to advice on how to respond to, and communicate with, the individual (for example, details of approaches a person finds helpful to alleviate distress).

While the development of crisis cards has not been a police-led initiative, they have clear advantages for the police (eg, reducing the time needed to deal with a particular situation) and those forces that have access to them are supportive of the concept. Officers and staff should be aware of any local use of crisis cards and work with partner agencies to get the most from their use (eg, be involved in their design to make information as useful as possible to all parties).

A number of police forces currently use other types of communication aids including:

- PECS (Picture Exchange Communication System) – an approach that has proved useful in communicating with children with ASDs;
- The ASD Attention Card Scheme (eg, Autism Cymru in partnership with each of the four police forces in Wales);
- Keep Safe Cards (eg, Leicester Learning Disability Partnership Board).

3.3 Information Management

3.3.1 Primary Reference

The national framework and principles for managing information for policing purposes is set out in **ACPO (2010) *Guidance on the Management of Police Information, Second Edition***.

3.3.2 The Individual as an Information Source

When the police are in contact with people with mental ill health or learning disabilities, the most important source of information will be the individuals themselves, some of whom will carry information about their circumstances and needs (see **3.2.2 Communication Aids**). In many instances the individuals in police care will be able to provide the name and details of persons to be contacted. Before seeking information from other people, however, the police should always obtain the individual's consent. There may be various reasons why someone would rather certain people were not involved. A case of domestic abuse, for example, where the parent or carer is suspected of being the offender, may make it inappropriate to contact that person. Even with the individual's consent, the police should take care with what they reveal about the person to others.

In exceptional circumstances, the police do not have to obtain an individual's consent to them obtaining or sharing information. For example:

- In order to fulfil their statutory duties relating to the protection of the individual and others;
- If it would hamper the prevention or investigation of a serious crime;
- If it would put a child at risk of significant harm or an adult at risk of serious harm.

3.3.3 Information from Parents, Carers, Family and Associates

Parents, carers, family or others who know the individual with mental ill health or learning disabilities can be a vital source of information and support in a range of situations, for example:

- Where the police are trying to identify the person's needs;
- Where an individual is in crisis or otherwise has difficulties communicating;
- When the police are planning action involving the individual (for example, assisting healthcare professionals by using police powers under section 136 MHA).

Consulting people who know the individual well – for example, about things such as the best way to approach the person, their habits or the layout of their home – is likely to help the police deal with the situation in a way that causes as little added distress as possible. An attitude that is sympathetic and considerate is likely to gain the person's trust and cooperation and achieve a better outcome.

The police should, where practicable, always seek the views of the individual in question when interacting with their parents, carers, family and associates. They should also be aware that the people providing information may also require support and advice about what is happening and why, and what they can expect from the whole process.

3.3.4 Police Information Systems

Where appropriate, national information systems should be checked for information on individuals with, or thought to have, mental ill health or learning disabilities. These include the Police National Database (PND), the Police National Computer (PNC), the Impact Nominal Index (INI) and the Violent Offender and Sex Offender Register (ViSOR). Searches should be in accordance with **ACPO (2010) Guidance on the Management of Police Information, Second Edition** and other related documents.

3.3.5 From other Agencies

Many people with mental ill health or learning disabilities will be known to statutory health and social care agencies or the voluntary agencies dealing with mental health problems (or both). These agencies will, therefore, be a useful source of information for police officers fulfilling any statutory function. See also **3.4 Information Sharing**.

3.3.6 Medical Records

Medical records may be an appropriate source of information. As information about a person's health and treatment for ill health is confidential, however, the police should first ask individuals if they agree to the records being handed over. They should be told the reason for the request and what can happen to the records if they are handed over. As illustrated in **3.3.2 The Individual as an Information Source**, the individual's consent may not be required.

3.3.7 Contact Information

Police forces should identify relevant local multi-agency services to facilitate appropriate signposting and referrals and ensure that officers and staff have access to adequate and up-to-date information. This includes contact information for key agencies, such as managers of community mental health teams, managers of community learning disability teams, mental health units and places of safety. Options include producing, preferably in partnership with other agencies, an electronic contact directory of the relevant agencies available to provide support and services to people with mental ill health or learning disabilities in a particular force area. Where possible, this should include the contact details of individual practitioners. Such a resource may already exist, for instance, in the local witness care unit (WCU) or in force control rooms. See **Appendix 3 Useful Websites**.

3.3.8 Recording Information

A record of police contacts with individuals with mental ill health or learning disabilities is important in terms of:

- Assessing and managing the risk of harm and preventing the escalation of problems;
- Ensuring appropriate responses in any further contacts with the individual;
- Helping those in the criminal justice system, such as the Crown Prosecution Service (CPS) and courts, who rely on police information to make their decisions.

Any concerns the police have, including things the person has said and behaviour observed, should be recorded, and be based on facts rather than guesswork or opinion. These details are crucial to the ability of the police and other agencies to provide an appropriate and effective response to the individual's needs.

3.4 Information Sharing

Sharing information about people is central to effective care and service provision. This has been emphasised by high-profile national failures where organisations have not shared information (for example, Victoria Climbié and the Soham murders). In addition, most service users expect that their personal information will need to be shared between the parties who are providing them with services. They also expect that sharing is safe, secure and only involves information that is relevant.

The sharing of information can be summarised into three distinct groups:

- That required by or under statute (statutory obligation);
- That permitted by or under statute (statutory power);
- Those requests made under common law to support the policing purposes, including information sharing and dissemination.

In relation to sharing information about people who are experiencing mental ill health or have learning disabilities, protocols between agencies will enable any legal complexities and misunderstandings, particularly around the Data Protection Act, to be overcome.

3.4.1 Primary Reference

Guidance for the Police Service on information sharing is contained in **ACPO (2010) Guidance on the Management of Police Information, Second Edition**. Section 6 Information Sharing outlines that policing requires information to be shared within the service, with partner agencies and the public, and that information sharing agreements (ISAs) between the Police Service and partner agencies should be used to ensure consistent and proportionate sharing.

Guidance on information sharing is also contained in the Data Protection Act (DPA) 1998. The rules include the legal requirement for sharing to have lawful authority, be necessary, proportionate, relevant, accurate, and timely, keep information safe and secure and be accountable. Force data protection officers can provide further specific advice on the DPA.

Another useful reference is the **Welsh Assembly Government (2008) The Wales Accord for the Sharing of Personal Information (WASPI)**.

3.4.2 Duty of Confidentiality

The duty of confidentiality is central to the work of all public bodies and is underpinned by Article 8 (the right to privacy) of the European Convention on Human Rights as incorporated by the Human Rights Act 1998 and the Data Protection Act 1998. While respecting the concern of health agencies in relation to the duty of confidentiality, there are occasions where police priorities – such as the duty to protect the public from risk of harm – must take precedence. These matters should be covered in joint protocols, but if problems consistently arise at the frontline level, they should be referred to the force information manager.

3.5 Pathways to Care

People with mental ill health or learning disabilities are much more likely to need access to social or healthcare services than to police services. If the multi-agency responses are working effectively, the police should seldom need to be involved. There will be cases, however, where the police will need to assist individuals (and their families and carers) in accessing pathways to appropriate care services by directing or formally referring them to particular agencies. This subsection does not detail the treatment available for various mental health conditions but explains some of the pathways for accessing this care. It should be read in conjunction with other available information about local services and referral pathways which, in turn, should include clear information about access to both emergency and less urgent treatment.

3.5.1 Treatment and Support in the Community

Examples of the types of community-based treatment, care and support that is available include:

- Accident and Emergency Services;
- Acute Mental Health Services;
- Assertive Outreach Services;
- Child and Adolescent Mental Health Services (CAMHS);
- Community Development Workers (CDWs);
- Community Forensic Teams;
- Community Learning Disability Teams;
- Community Mental Health Teams;
- Crisis Resolution and Home Treatment Services;
- Early Intervention Services;
- Out-of-Hours Services;
- Primary Care Mental Health Services;
- Residential Homes;
- Specialist Services and Support Groups.

3.5.2 Voluntary and Community Sector

Many social care services are provided by voluntary or community sector organisations. These are sometimes referred to as non-governmental organisations or the Third Sector, and are essential to the delivery of local services to adults with mental ill health or learning disabilities. Sometimes, small local groups are in a better position to understand and meet community needs, particularly in relation to those who are less likely to access statutory services, such as people from minority ethnic groups. For example, local Mind associations (see <http://www.mind.org.uk>) provide a range of services including drop-in services, day centres, home visits, outreach work, counselling, complementary and alternative therapies, employment, debt or benefit advice, advocacy, support groups and leisure and social activities. Such voluntary groups perform a vital function in delivering services and support to those who face potential discrimination when they enter the criminal justice system. Each force should have a robust engagement process with the agencies from the Third Sector who work with people with mental ill health or learning disabilities. This will ensure that the police provide appropriate services both as an individual organisation and as part of an effective multi-agency partnership.

The Third Sector (ie, voluntary organisations) may be able to provide advocacy services, but these are not available to all forces. Where provided, these services comprise independent advocates who provide help and support to individuals in accessing specialist mental health services (see also **2.2.1 Advocates**).

3.5.3 General Practitioner

General practitioners (GPs) are often gatekeepers for specialist mental health services and have an important role in coordinating care both for people with mental ill health and those with learning disabilities. GPs are often the best first point of contact for non-emergency assessment and care as they will usually be the professional most familiar with the individual. Some practices provide specialist mental health or substance use interventions.

3.5.4 Care Programme Approach

The Care Programme Approach (CPA) is a health and social care services framework for coordinating care for those who have been accepted as requiring specialist mental health services. It allows for a multi-agency response which includes criminal justice agencies where appropriate and can ensure coordination and continuity of care, including the planning, implementing and monitoring of care and treatment given.

For the role of the CPA in relation to offenders, see ***Department of Health (2006) Offender Mental Healthcare Pathway***. For information in relation to the policy in England, see ***Department of Health (2008) Refocusing the Care Programme Approach: Policy and Positive Practice Guidance***. In relation to the policy in Wales, see ***Welsh Assembly Government (2003) The Care Programme Approach for Mental Health Service Users: A Unified and Fair System for Assessing and Managing Care***.

3.5.5 Accident and Emergency Departments

Emergency care sections of hospitals (for example, A&E departments) can have a number of roles to play in relation to the response of the police to people experiencing mental ill health. For example:

- In some areas A&E departments are the recognised 'place of safety' for people detained under the MHA;
- Where the recognised place of safety is located elsewhere than the local A&E department, section 136 detainees who require treatment for physical injuries will normally be taken to A&E before being transported to the designated place of safety;
- People at risk of serious harm who have been restrained by police officers under the MCA 2005 are normally taken to A&E departments for assessment and/or emergency treatment.

3.5.6 Inpatient Hospital-Based Services

Inpatient hospital-based services can be used by people who are voluntary patients or compulsorily detained under the MHA. For more information see **6 Use of Police Powers under the MHA 1983 and the MCA 2005**.

3.5.7 Substance Misuse Services

Some individuals with mental ill health or learning disabilities, including those with dual diagnosis (see **2.2.4 Dual Diagnosis**), may exacerbate their difficulties by substance use. In this case, substance use services will be a key aspect of their care. These deal with drug and substance abuse and misuse, drugs services, drug dependence, chemical dependency, gambling, alcohol dependence and abuse, alcohol addiction, alcoholism and addictive behaviours. Forces should maintain a list of local substance use services offering referral and a range of treatment provision to clients with mental ill health or learning disabilities.

3.5.8 Mental Healthcare for MAPPA Offenders or Potentially Dangerous Persons

Health agencies have a duty to cooperate with the Multi-Agency Public Protection Arrangements (MAPPA) process under section 325 of the Criminal Justice Act 2003. A MAPPA offender is an individual with a conviction or caution for a criminal offence who falls within one of the three MAPPA categories (see **ACPO (2007) Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders** and **Ministry of Justice (2009) MAPPA Guidance, Version 3**). A Potentially Dangerous Person (PDP) is someone 'who has not been convicted of, or cautioned for, any offence placing them into one of the three MAPPA categories but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm' (see **ACPO (2007) Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders**).

Offenders, suspects or PDPs with mental ill health or learning disabilities who are considered to fall within one of the MAPPA categories should be given access to appropriate health and social care and be subject to public protection measures through the criminal justice system, in accordance with the guidance documents mentioned above.

Management of PDPs with mental ill health should, wherever possible, take place within the CPA (see **3.5.4 Care Programme Approach**). Force areas should have processes in place to ensure that if risk of harm to others is identified through the CPA risk assessment, appropriate referrals take place between agencies.

3.5.9 Ambulance Service

The National Health Service has primary responsibility for responding to the health needs of people with mental ill health or learning disabilities. In some circumstances, however, the Ambulance Service may request assistance from the Police Service and vice versa. For example, ambulance staff or mental health professionals may need police assistance to transport a person safely – such as in situations where there is a significant risk of harm to the person or others. Assistance from the police may be requested by either a mental health professional or an ambulance staff member. In other situations, the police may need to request assistance from the Ambulance Service; for example, in a police emergency requiring medical help and/or transportation of individuals.

The roles of ambulance service staff include contributing to the care of patients and their physical and mental wellbeing, sharing information with the police as appropriate and passing on relevant information or documents to the hospital or mental health unit from the police or other professional on arrival.

A police vehicle should only be used for transport after all other transport options have been considered as not suitable (see **6.6 Transporting and Conveying People with Mental Ill Health**).

3.5.10 Fire Service

The Fire Service regularly comes into contact with people with mental ill health or learning disabilities and is expected to provide an appropriate response to whatever situation exists. Statistically, people who experience mental health problems are more likely to suffer death or injury caused by fire than others in the community. This makes it crucial for the Fire Service to work with the police and other statutory and voluntary agencies to help at-risk groups from the dangers of fire. For more information see the Chief Fire Officers Association website at <http://www.cfoa.org.uk>

3.6 Multi-Agency Partnerships

The most effective way for the police to meet the needs of people with mental ill health or learning disabilities who are in contact with the criminal justice system is through a partnership or multi-agency approach, whether at a strategic, operational or individual level. Multi-agency partnerships will:

- Enable the provision of appropriate places of safety and other health-related services;

- Ensure that respective roles and responsibilities are understood so that police resources are called on only when absolutely necessary (for example, where police powers are required);
- Facilitate longer-term responses to the circumstances and challenges of particular individuals, which may prevent the escalation of problems and the repeated involvement of the police;
- Ensure effective referrals and improved service delivery;
- Contribute to the appropriate and efficient use of the resources of the police and other agencies;
- Ensure that more strategic and sustainable approaches to multi-agency issues become embedded in practice.

Bodies and organisations that should be able to offer support and assistance to individual police forces as they develop their response to mental ill health and learning disabilities include the following.

- Primary Care Trusts (England only);
- Strategic Health Authorities (England only);
- NHS Confederation;
- Local Health Boards (Wales only);
- Local specialist voluntary sector service providers and advocacy organisations;
- Housing associations and local authority housing teams;
- Mental health trusts;
- Ambulance trusts;
- Directors of social services.

While police forces are expected to work in partnerships with other agencies, it is unacceptable for situations to consistently arise in which the police are involved in providing responses because other agencies, are not meeting their rightful responsibilities. Every attempt should be made at the local level to establish effective relationships. If areas of dissension cannot be resolved locally, they may need to be escalated to, and addressed at, a higher level for a regional or national response. If effective partnerships cannot be achieved, or where other agencies are not willing or able to deliver the implementation of agreed protocols, forces should ensure that contingency plans are in place.

More detailed information about the roles and responsibilities of other agencies in particular contexts is provided in **6 Use of Police Powers under the MHA 1983 and the MCA 2005** and **7 Operational Police Responses to Suspects and Offenders**. See also *Home Office (2010) Safe and Confident Neighbourhoods Strategy: Next Steps in Neighbourhood Policing*.

3.6.1 Engagement with Partner Agencies

The National Health Service Act 2006 and the National Health Service (Wales) Act 2006 place duties on health and social care bodies (such as local authorities, PCTs and Local Health Boards) to make services available and to work in partnership to deliver health and social care. Such duties provide a strategic opportunity for police forces to influence the targeting of services towards those with mental ill health or learning disabilities who come into contact with the criminal justice system as victims, witnesses, suspects or offenders.

Tools that enable the prioritisation of the health needs of local populations include Public Service Agreements, Local Area Agreements, joint strategic needs assessments, Crime and Disorder Reduction Partnerships, Drug and Alcohol Action Teams, Multi-Agency Public Protection Arrangements, Multi-Agency Risk Assessment Conferences, Community Safety Partnerships, Substance Misuse Action Teams, Criminal Justice Mental Health Teams and other locally agreed arrangements.

Forces should ensure that local arrangements are in place for multi-agency partners to review current arrangements and existing protocols, including any barriers to implementation (see **3.6.2 Multi-Agency Protocols**). This should include engaging as fully as possible with implementing Criminal Justice Mental Health Teams (CJMHTs) where these exist (particularly in the format as recommended in **Bradley (2009) The Bradley Report**). It should also include initiatives relating to the Offender Health partnership between the Ministry of Justice and the Department of Health, to improve the standard of healthcare for offenders (including the structural arrangements for Regional Offender Health Teams). See also <http://www.dh.gov.uk/en/Healthcare/Offenderhealth/index.htm>

When multi-agency protocols are agreed with statutory health and social care bodies, consideration should be given to how to deal effectively with boundary issues where the boundaries of police forces are not coterminous with those of health and local authorities.

While partnerships between the police and outside agencies at the strategic and operational level are vital to providing effective responses to people with mental ill health or learning disabilities, the role of individual police officers in joint working cannot be overstated. This type of intervention can be especially helpful in working with those with multiple needs who may face difficulties in accessing services. Sometimes help in persuading agencies to recognise their responsibilities is necessary. This can at times be usefully provided by individual police officers working with other services to prevent people from spiralling into a cycle of crisis, crime and mental health problems.

3.6.2 Multi-Agency Protocols

Any multi-agency protocol should outline the more general aspects needed to help agencies assess and manage the risks associated with working in partnership. These could include: purpose; benefits; roles and responsibilities; risk management procedures; constraints (legal and otherwise); governance; resourcing; administrative processes; information sharing; data collection, monitoring and dissemination; contacts; terminology; interdependencies with other partnerships, systems, processes or projects; arrangements for dealing with unforeseen events. For clarity, it would also be useful to consider less tangible aspects such as expectations, practical concerns and attitudes towards the presence of observers and volunteers.

Protocols specifically relating to a multi-agency response to people with mental ill health or learning disabilities should also address matters such as: the operation of sections 135 and 136 of the MHA 1983; transportation issues; application of the MCA 2005; restraint; responses to requests for police assistance; access to appropriate health and social care services; dealing with emergencies; support structures for victims and witnesses; ensuring sufficient doctors are approved under section 12 MHA; responses to offending and allegations of offending in a healthcare or social care setting; arrangements for responding to anti-social behaviour; support to AMHPs to allow them to conduct mental health assessments; accessing appropriate adults; and contact details for interpreters and specialists in communication.

Protocols should also outline arrangements for communicating and supporting the implementation of the protocol (eg, through training and monitoring) and arrangements for reviewing the operation of the protocol and capturing and reviewing lessons learned.

All multi-agency protocols should be documented, publicised to appropriate staff and made readily available for reference. They should also form part of training and induction. Some protocols may be better aimed at force level (for example, because of the number of health trusts); others may be better at basic command unit (BCU) level (for example, to nominate local places of safety).

3.6.3 Multi-Agency Health Promotion and Harm Reduction Initiatives

Where possible (for example, where it does not deflect resources from areas of more direct responsibility), forces should contribute to local multi-agency health promotion and harm reduction initiatives which relate to people with mental ill health or learning disabilities. Examples include suicide prevention initiatives which focus on suicide hot spots or target particular groups such as young people.

3.6.4 Performance Monitoring

The monitoring of police and multi-agency performance is a key element to ensuring appropriate responses to people with mental ill health or learning disabilities. The English and the Welsh MHA Codes of Practice and documents such as *Royal College of Psychiatrists (2008) Standards on Use of Section 136 of the Mental Health Act 1983* and *Royal College of Psychiatrists (forthcoming) Standards of Use of Section 136 of the Mental Health Act 1983 in Wales* support this, and recommend that implementing and monitoring the response to people with mental ill health or learning disabilities, and the operation and effectiveness of protocols should be the responsibility of a local multi-agency forum that includes the key agencies, service users and carers (including BME community representatives).

A key role for such forums would be to ensure that lessons are learnt from individual situations or local initiatives where there have been either positive or negative experiences. It may be necessary to put mechanisms in place to capture these experiences. There should be strategic links with other related multi-agency arrangements, including Local Criminal Justice Boards (LCJBs), MAPPAs and DAATs to assist in the sharing of resources and performance information, and prevent duplication of effort.

The collection of data should not involve disproportionate administration. Existing multi-agency monitoring forms should be used where possible. National Intelligence Model (NIM) Level 2 analysis can be used to map issues which need to be addressed, such as the use of powers under the MHA and the offending behaviour of particular individuals whose problems may need to be dealt with by more than one agency.

3.6.5 Performance Measures

Continuous records on police interactions with people experiencing mental ill health or learning disabilities can help lower the risk of harm and assist police forces and other agencies in monitoring the effectiveness of their responses. Examples of potential measures of police and multi-agency performance include:

- Use of section 136 MHA – including timescales adhered to in the process, numbers of people (including demographic details and psychiatric history), reason for use of the power, length of time in police custody, whether any criminal offences were involved, whether restraint was used (and details), the outcome of police referrals (including diagnosis following assessment and repeat usage), details of any transfers between places of safety and details of discharge;
- Requests by AMHPs for police assistance at assessments on private premises – including number of requests, number of incidents where warrants under section 135 MHA were used, those requests not met (and the reasons) and any issues encountered by the agencies involved;
- Patients reported to be absent without leave from mental health establishments – including number, the outcomes of reported absences and the nature and effectiveness of preventive strategies;
- Requests for the police to assist in the management of patients in mental health establishments – including the number of requests, the nature of requests, the role of respective agencies in managing incidents and the action taken;
- Referrals to health and social care agencies – including the number of and timeliness of referrals – and where possible, the outcome of referrals (to help ascertain whether referrals are being acted on);
- Measures relating to diversion and multi-agency responses to suspects and offenders at different stages of the criminal justice process and their outcomes;
- Arrested persons identified with both mental ill health and the influence of alcohol or drug use – including the number of individuals;
- Use of special measures for victims and witnesses with mental ill health or learning disabilities – including the number of times special measures were used (by type of special measure, such as the use of intermediaries);
- Use of appropriate adult schemes for individuals who are ‘mentally disordered or otherwise mentally vulnerable’ – including the number of times an appropriate adult was required (by type of mental ill health problem or learning disability).

3.7 Identifying, Assessing and Managing Risk

The risk of harm in the context of mental health is complex, partly due to the multiple factors underlying a person's behaviour and the way these may interrelate. For example, the risk of violence can depend on the diagnosis, nature and severity of symptoms, whether the person is receiving treatment and/or care and whether there is a history of violence. Aggression can also be associated with the side effects of medication. It is crucial, therefore, that decisions relating to the risk of harm should be made with other agencies wherever possible.

The accurate identification, assessment and management of risk in responding to people with mental ill health or learning disabilities relies on the exercise of professional judgement, in partnership with colleagues and other agencies. Knowledge and understanding as described in **8.3 Staff Training** is a prerequisite for effective decision making. So too is an understanding of the risk principles adopted by ACPO for application by the Police Service (see **ACPO (forthcoming) Guidance on Managing Operational Risks**).

Officers and staff should keep in mind that the Police Service is not responsible for all forms of risk relating to people with mental ill health or learning disabilities and should not assume, directly or indirectly, responsibility for dealing with all problems that the public or other agencies may present them with. They should consider whether it is appropriate for them to accept responsibility for a particular situation when there are more appropriate agencies or methods of tackling the problem. Police should always be ready to assist partner agencies but not to take on their responsibilities.

3.7.1 Identifying Risk

Risk management is a process comprising three distinct stages – identification, assessment and management. It is important in the identification stage to clearly 'name' the risk, ie, identify the nature, type and parameters of the situation being dealt with. The simplest method is asking questions such as: What is the key problem to be dealt with? Is this a police problem or are other parties responsible for responding/finding a solution? The amount of time available for identifying someone at risk because of mental ill health or learning disabilities will vary significantly, and is likely to affect the quality of any subsequent decision.

3.7.2 Assessing Risk

The matters considered during the assessment stage will form the basis for the rationale around any decisions. To avoid misperceptions (for example, that members of BME groups are more likely to be dangerous) and where there is time, the police should attempt to assess the risk against a set of constant parameters. These could include:

- Any history of offending, including the severity of offences;
- Any evident deterioration in the person's mental health, such as experiencing delusions, having violent thoughts or hearing destructive voices;
- Any history of substance and/or alcohol use;
- The stability of the person's living conditions, relationships and wider environment;
- The existence of significant events (eg, recent separation) or dates (eg, anniversaries);
- The person's history of compliance with previous treatment, management and supervision;
- Any factors known to increase or mitigate the risk the person may pose.

The next step is to carefully examine the situation for factors such as:

- The benefits to the person with mental ill health or a learning disability from any decisions made by the police, and the probability of those benefits occurring (for example, if the police do such and such, what good is likely to come from it?);
- The harms that could occur, and the probability of that harm occurring;
- The likely seriousness or imminence of any harm;
- The availability of information/intelligence about the situation, including the wider context in which it is occurring;
- Any circumstances that might increase or decrease the risk.

The final part of the assessment stage is to identify suitable responses to the situation. These will depend on factors such as:

- The apparent seriousness of the incident;
- The amount of time available to consider what action to take;
- The training and prior experience of similar situations that decision makers have had;
- The decision maker's knowledge of relevant powers, policies and legislation;
- What operational support is available;
- Whether management systems and structures are adequate, including planning, resourcing and access to reliable information.

When a risk situation has been identified and assessed, it should be clearly documented and communicated as appropriate in accordance with information-sharing protocols (see **3.3 Information Management** and **3.4 Information Sharing**). In a broad sense, and where practicable, this should be in a way that captures the options considered, the rationale associated with each option and the reasons for decisions made. Any such documentation will facilitate the monitoring and review of the decisions taken.

3.7.3 Managing Risk

To be effective, the management of risk should include the following components:

- **Selection** – once suitable responses have been weighed up, the police must select and implement the one that appears to have the greatest likelihood of success against least likelihood of harm.
- **Implementation** – if satisfied with the selected action (ie, it is more likely than not to achieve the hoped for benefits), the decision maker should act. ‘Action’ in this context can include a deliberate decision not to act (for example, wait for further assistance or information).
- **Recording** – where deemed necessary, the selected action should be recorded. When doing this, the decision maker should include the reasoning behind it. This will take time, but will help immeasurably in any subsequent audit of decisions taken. With a written record, those scrutinising decisions will be less influenced by hindsight and less likely to believe alternative explanations. Recording the rationale for actions taken will also help the decision maker learn from the process.
- **Monitoring** – once a decision to take or not take action has been put into effect, there will be consequences (positive or negative). Thus the risk situation and the response made must be monitored to check the effect of the response, watch for signs that the situation is improving or deteriorating, and reassess and take further action if necessary (including escalating the matter).
- **Evaluating** – being confronted by and having to deal with the risk of harm needs to be seen as a learning opportunity. The evaluation stage occurs once the situation has been dealt with and can be done jointly by the decision maker and his or her supervisor.

It is important not to see risk assessment and risk management as purely linear in nature. It is increasingly recognised that they are iterative, and part of an integrated and continuing decision-making process (see, for example, ***National Probation Board (2008) Managing High Risk of Serious Harm Offenders with Severe Personality Disorders***).

3.7.4 Emergencies and Dilemmas

Many operational situations present a dilemma to decision makers or constitute an emergency. It is an emergency if, because of the circumstances, there is insufficient time to obtain or consider all the relevant information one would want for making a professionally competent decision. It is a dilemma if, whatever the officer decides, harm will result – in which case it is not a question of balancing harm against benefits but choosing between degrees of harm.

In situations such as emergencies and dilemmas, the normal standards of decision making cannot be expected, and in law are not expected (ie, the legal standard of care will take into account the circumstances which existed when the decision had to be taken). If the law is to apply a lower standard of care, however, the situation must be a genuine emergency or dilemma. Officers are still required to act reasonably and professionally. Putting off a decision, perhaps through fear of the consequences, and causing harm by that delay, is unprofessional. See ***ACPO (forthcoming) Guidance on Managing Operational Risks***.

Section 139 MHA provides that no civil or criminal proceedings can be brought against any person in any court in respect of an act purporting to be done under the MHA without the leave of the High Court or the Director of Public Prosecutions; for such proceedings to succeed, the court must be satisfied that the person acted in bad faith or without reasonable care. The protection includes the police but does not apply to organisations such as NHS trusts.

3.7.5 Risk Tools

There may be time for proactive risk identification and assessment using a risk instrument developed for the purpose. For example, a Neighbourhood Policing Team may wish to formally identify, assess and manage those who are vulnerable to victimisation or offending owing to their mental ill health or learning disabilities. This could involve using a formal risk tool but care needs to be taken in choosing and using such tools. For example, decision makers should be certain that the evidence base is transparent (ie, that the data source and assessment method of each risk factor are clearly identified) and that the instrument has been independently validated. In addition, decisions should never be based exclusively on a risk tool; the decision maker always has to manage the situation and may, therefore, use other considerations and professional judgement to minimise the limitations of any formal risk tool.

3.7.6 Department of Health Guidance

For further information about managing risk in the context of mental ill health or learning disabilities, see ***Department of Health, National Risk Management Programme (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services***. This describes in detail the meaning of positive risk management in terms of awareness that risk can never be completely eliminated and that management plans by health professionals will include decisions that carry both the risk of harm as well as success. It also establishes one of the key principles of risk management in the context of mental health as the need for care teams to work collaboratively with service users and carers to reduce risk (for example, by empowering individuals to identify and manage personal risk triggers). The police should support that approach although where there is an immediate risk to the person or to others the police may not have time to involve others before taking action.

3.8 Intervening in a Crisis

In an emergency situation it may be necessary to restrain an individual. To minimise the risk of harm, officers should follow national and local procedures on safe restraint. See, for example, **ACPO (2009) Personal Safety Training** and **ACPO (forthcoming) Personal Safety Manual**. The police should also have regard to the Code of Practice MHA 1983 (2008) but are not bound by it. The **National Institute of Health and Clinical Excellence (2005) Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments** also provides useful guidance on tactics involving physical intervention. In considering how to manage an individual with evident mental ill health, the police need to challenge the stereotype that mental ill health equals dangerousness and that, because of this, restraint techniques are more likely to be required.

3.8.1 Enforced Administration of Medication

When asked to restrain service users (patients) for the purpose of clinical intervention, such as the enforced administration of medication, the police will need to use their discretion. For example, the police response may differ according to whether the assistance is required for something that should have been pre-planned or has occurred as an emergency. Where it was known that the administration of medication would be required, the hospital has responsibility to arrange sufficient restraint and should not have to call on the police. In an emergency, the grounds for the police to restrain the patient may include their responsibility to protect life and property or to prevent a breach of the peace.

3.8.2 Medical Emergency

If there is any concern about symptoms displayed by the person, for example, the onset of Acute Behavioural Disturbance (ABD) or Excited Delirium (ED), the officer should treat the situation as a medical emergency and summon an ambulance to take the person to an emergency care department. This is regardless of local place of safety arrangements and regardless of whether that A&E thinks it is right. It is about discharging legal obligations to vulnerable detained patients and the management of this issue should be specifically addressed in local protocols. In all cases the provision of emergency medical care takes priority over the provision of mental healthcare.

For further information see **ACPO (2008) Guidance on the Handling and Treatment of Persons Suffering with Acute Behavioural Disturbance** and **Home Office Circular 17/04, General Principles to Inform Local Protocols between the Police and Health Services on Handling Potentially Violent Individuals**.

3.9 Diversity Considerations

The Police Service is committed to equal access to services for all groups, particularly in relation to age, disability, gender, race, religion or belief and sexual orientation. This means that all actions undertaken or recommended by the police, and all policies and procedures, will be sensitive and responsive to people's differences and needs and will integrate this understanding into the delivery of their functions to ensure that nobody is disadvantaged as a result of their belonging to a specific social group.

3.9.1 Black and Minority Ethnic (BME) Groups

Specific issues highlighted by research (for example, **Nacro (2009) *Liaison and diversion for BME service users***) that relate to mental ill health or learning disabilities among BME communities include the following factors:

- **Late recognition** – people from BME communities who suffer from mental health problems are much more likely than their white counterparts to be referred to mental health services through the criminal justice system. This suggests that it is only when they become involved with the law that they first access the help they need.
- **Stereotypes** – there is an unsubstantiated perception that BME individuals with mental health issues are more dangerous than other people and present greater risks to the general public.
- **Communication** – there is a lack of interpreters and other means of translation for BME individuals who may have mental health needs but do not speak English.
- **Treatment** – in the mental health system, black individuals have a higher compulsory admissions rate to hospital.
- **Stigmatisation** – an unwillingness in many BME communities to acknowledge mental health issues can lead to individuals being reluctant to disclose their difficulties in case of prejudice and negative attitudes.

The police should work in partnership with health and social care agencies, and particularly with specialist local voluntary agencies engaging with specific BME communities. This will support early recognition, early intervention and, where appropriate, diversion in relation to BME individuals with mental ill health or learning disabilities. National and regional bodies operating in the health and social care field which may be able to support the work of the police in this area include ROTA (Race on the Agenda) <http://www.rota.org.uk> and the crime prevention charity Nacro <http://www.nacro.org.uk>

In addition, there is a network of community development workers (CDWs) across England, linked to primary care trusts (PCTs) who are tasked, among other things, with forming links between BME communities and local mental health services to improve access for these groups and encourage social inclusion. See also **4.1.2 Equal Access to Justice**.

3.10 Media and Communication Strategies

Police forces should work with partner agencies, including voluntary and community sector service providers, to implement a multi-agency media and communication strategy which promotes positive messages about mental ill health or learning disabilities. The strategy should include the importance of avoiding the use of inaccurate and misleading stereotypes or language which acts to increase stigma. It should also aim to minimise the extent to which the press report speculatively or inaccurately on the mental health of those accused of serious violent crimes. There is some evidence that media reporting of suicide can trigger copycat suicides; therefore, sensitive and responsible coverage is crucial. For further information see ***National Institute for Mental Health in England (2007) Sensitive Coverage Saves Lives: Improving Media Portrayal of Suicidal Behaviour*** and ***National Institute for Mental Health in England (2007) What's the Story? Reporting Mental Health and Suicide: A Resource for Journalists and Editors***. Also see <http://www.time-to-change.org.uk/about-us/who-are-we/mental-health-media>

4

Mental Health Principles

This section identifies the key principles on which the police role in responding to people experiencing mental ill health or who have learning disabilities should be based.

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4.1 Mental Health Principles

In any situation in which the police respond to people with mental ill health or learning disabilities, the following principles apply:

- Promoting mental health for all;
- Promoting equal access to justice;
- Achieving responses by the most appropriate agency;
- Managing information to facilitate appropriate responses;
- Protecting all persons and safeguarding human rights;
- Preventing and investigating crime, and tackling offending behaviour;
- Promoting social inclusion;
- Helping to tackle differences in health status.

4.1.1 Promoting Mental Health for All

All police responses take place in the context of the Human Rights Act 1998, which incorporated the European Convention on Human Rights (ECHR) into British law, and anti-discrimination legislation (see <http://www.equalities.gov.uk> and **Appendix 2 Relevant Legislation**). Promoting mental health for all is a means of combating discrimination against individuals and groups with mental ill health, and promoting their social inclusion. This will assist in both recognising mental ill health at an early stage and enabling individuals to access the services that meet their needs. The Police Service is well placed to contribute to this aim as it has direct contact with a number of groups who are at particular risk of mental ill health, such as victims and survivors of abuse including child sexual abuse, people who misuse drugs and alcohol and socially excluded groups such as offenders.

This guidance is based on the assumption that effective community responses (of which the police are a part) can act as protective factors against the deterioration of mental health. There is also the expectation that those working in the Police Service should act as role models to the community through their own behaviour and attitudes to the mental ill health and learning disabilities of others.

4.1.2 Equal Access to Justice

All individuals are entitled to equal access to justice.

4.1.2.1 Disability Discrimination Act (DDA) 2005

Under section 49A of the DDA 2005, the police have a duty to carry out their functions with regard to the need to eliminate unlawful discrimination and promote equality of opportunity for disabled people, including those with mental ill health or learning disabilities. This includes the need to make reasonable adjustments to meet people's needs and provide equality of service. In responding to individuals according to their needs the police should:

- Avoid stereotyping (especially in relation to the ability of individuals to communicate or to give credible accounts);
- Recognise that some minority ethnic groups are disproportionately represented within the mental health system and the criminal justice system;
- Recognise that some women, and people from minority ethnic groups, or those with complex needs, can face particular barriers to accessing services. For example, people from minority ethnic groups may feel alienated from mainstream mental health services (possibly having already experienced discrimination) so tend to present later to those services.

The police response should, where possible, accommodate individual needs, promote mental health and ensure that people receive the support they need before they reach crisis point.

4.1.2.2 Disability Equality Duty (DED)

The Disability Equality Duty (DED) creates a framework to help authorities promote fairer treatment within their own organisations and reduce discrimination. The DED applies to all public authorities when they carry out their functions, such as providing social services or healthcare. They have to give 'due regard' to:

1. Promoting equality of opportunity between disabled people and other people;
2. Eliminating discrimination that is unlawful under the DDA 2005;
3. Eliminating all forms of harassment related to disability – including harassment that is unlawful, and other unwanted activity that is not unlawful – by means of policies such as community safety strategies or recording disability-related hate crime;
4. Promoting positive attitudes towards disabled people;
5. Encouraging participation by disabled people in public life;
6. Taking steps to meet disabled people's needs, even if this means treating them more favourably than non-disabled people. Public authorities do not have to treat everyone the same – they can treat disabled people more favourably if this is how they give due regard to people's disabilities.

4.1.2.3 Cultural Differences

Police officers and staff must take care not to make assumptions about a person's cultural background, language and beliefs. Instead, they should ask service users directly and sensitively about their cultural and religious needs and how these should be met.

Good practice includes:

- Recognising that attitudes to, and understanding of, mental ill health vary between cultures and that stigma may be attached to this;
- Providing, where practicable, a member of staff from the same or similar minority ethnic group to interact with the service user;
- Respecting and meeting the specific needs of women – for example, it may not be appropriate for a male member of staff to interact with a woman on her own;
- Understanding and respecting people's routines, the lives they lead, the clothes they wear and the beliefs they have, and interacting in a sympathetic way, taking their cue from the service user;
- Considering – both proactively and reactively – the involvement of specialist agencies, particularly where service users from BME communities are involved;
- Considering interpreting services when there appears to be a potential language barrier.

4.1.2.4 Interpreters

Providing communications support to people with mental ill health or learning disabilities is a legal requirement and not an optional extra. Legislation such as the DDA 1995, the Race Relations (Amendment) Act 2000 and the HRA 1998 requires public organisations to provide language and other communications support to individuals requiring help. As such, the use of interpreters must be seen as an integral part of the service the police provide. It should be recognised that using interpreters to facilitate communication may not be an easy task when people are unwell and where English is not their first language. Forces should ensure they have a list of interpreters who might be used. BME voluntary sector organisations should be actively considered as they provide a potential source of interpreters. Where such local services are not available or are likely to take a long time to put into place, practitioners should consider using Language Line or a similar telephone interpreting service. Language Line can be contacted on 0800 169 2879 or at <http://www.languageline.co.uk>

4.1.3 Responses by the most Appropriate Agency

Most people with mental ill health or learning disabilities are likely to have minimal contact with the police. In general, therefore, responses to their needs should be provided by health and social care services.

The unnecessary and non-essential use of the police in responding to individuals because of their mental ill health or learning disabilities creates a number of problems. Using police officers and police facilities is not in an individual's interests when they need mental health services rather than criminal justice services. Not only can this increase stigmatisation of an individual by giving the impression that the person is suspected of having committed a crime, but it can be dangerous if appropriate medical care is either not available or is delayed. All of this may cause distress and anxiety to the person concerned, and affect that person's future cooperation with various agencies.

There will always be exceptional circumstances where police resources are necessary to ensure a person's safety or wellbeing or to protect others, and it is in these situations that the police have a duty to act. For further information see **6 Use of Police Powers Under the MHA 1983 and the MCA 2005**.

In most cases, instigating a criminal investigation should not be seen as an alternative to a healthcare response. If there is a need for both, the two responses should take place in parallel. For example, where someone is in police custody following arrest for an offence, the investigation and case disposal process can still continue and run alongside any mental health assessment that takes place at the police station. Following a mental health assessment in police custody, the suspect could be detained under the MHA 1983 and still be charged; the suspect would then be released into the care of the detaining hospital.

4.1.4 Managing Information to Facilitate Appropriate Responses

All police information relating to people with mental ill health or learning disabilities should be managed in accordance with **ACPO (2010) Guidance on the Management of Police Information, Second Edition** and any other national or local guidance to ensure the provision of appropriate services (see **3.3 Information Management** and **3.4 Information Sharing**). Police forces should ensure that the information management requirements relating to people with mental ill health or learning disabilities forms part of the development and implementation plans for local and national systems, such as INI and PND.

4.1.5 Protecting the Public and Safeguarding Human Rights

The public sometimes hold inaccurate preconceptions about the danger posed to them from people with mental ill health, particularly where a person is severely unwell. This can lead to a disproportionate focus on the need for the police to become involved. Despite widespread fears of dangerousness, the majority of people with mental ill health are much more of a threat to themselves – through self-neglect, self-harm and suicide – than to others. For example, the ***Department of Health (2002) National Suicide Prevention Strategy for England*** states that suicide is the main cause of premature death in people with mental illness and that mental illness is a risk factor for suicide.

The right to life and the right to protection against inhuman and degrading treatment and punishment are enshrined in Articles 2 and 3 of the European Convention on Human Rights, and in the Human Rights Act 1998. These articles place obligations on the Police Service to take reasonable steps to protect the life of people where there is a real and immediate risk to them from their own acts or the acts of another. Any police action to protect these rights should be based on the circumstances of each case and be proportionate and necessary.

4.1.6 Preventing and Investigating Crime and Tackling Offending Behaviour

In fulfilling the police role in preventing and investigating crime and tackling offending behaviour, offenders or suspects with mental ill health or learning disabilities should, generally, be dealt with through the criminal justice system as any other offenders or suspects are. It is in the public interest that the criminal justice system sets behavioural boundaries and requires individuals to confront the unacceptability of their offending. In situations where there are public protection issues, a criminal conviction may be the only way to ensure appropriate management of an individual (for example, using MAPPA).

While criminal justice sanctions can act as a powerful learning tool for individuals, there will be cases where it will be more appropriate for mental health services to be provided outside the criminal justice system. The CPS takes decisions about prosecution based on the ***CPS (2004) The Code for Crown Prosecutors*** and mental ill health is one issue for consideration when deciding whether it is in the public interest to prosecute. For further information see **7.4 Diversion from a Criminal Justice Response** and **7.10 Crown Prosecution Service**.

4.1.7 Promoting Social Inclusion

This principle seeks to promote social inclusion by improving access and service delivery to vulnerable individuals and communities. Many people with mental ill health or learning disabilities are 'socially excluded', ie, prevented from participating in 'normal' social activities or accessing services, for various reasons. Where this results from targeted violence and hostility on the basis of disability, the impact can be physical, psychological and emotional. It can also be long lasting, causing vulnerable people to structure their lives to minimise the risk of harm.

Social exclusion, however, is not always self-imposed. For example, others around the person with mental ill health or learning disabilities may sometimes advise victims to avoid putting themselves at risk rather than reporting matters to the police, leading some perpetrators of violence against people with mental ill health or learning disabilities to think they can get away with it. Avoidance and acceptance behaviours by people with mental ill health or learning disabilities and by those around them may thus vindicate such perceptions. This type of acceptance (by the person) and conditioning (by others) encourages low expectations and low aspirations and makes it difficult for people with mental ill health or learning disabilities to get equal access to justice or to lead their lives to the full.

The agenda of promoting social inclusion is, therefore, one which is fundamental to the work of many community-based statutory and voluntary sector organisations, including the police. Social exclusion can be tackled in a number of ways, including improving service delivery and service access in deprived areas and to particular groups, developing the capacity of local groups and communities to participate within society, and promoting local social and economic regeneration.

4.1.8 Helping to Tackle Differences in Health Status

Tackling differences in the quality of health and healthcare between different population groups is another area which is fundamental to the work of many community-based statutory and voluntary sector organisations. Health inequalities are particularly relevant to policing as offenders have poorer health and access to healthcare than the general population, and poor health can be a factor contributing to reoffending (see ***Social Exclusion Unit (2002) Reducing Re-Offending by Ex Prisoners***). An example of current policy designed to address health inequalities for people with mental health problems, and with relevance to policing, is the Delivering Race Equality programme which is funded by the Department of Health. This has established a national network of CDWs, linked to PCTs, who are tasked, among other things, with forming links between BME communities and local mental health services to improve access for these groups and encourage social inclusion. For further information see

<http://www.mentalhealthequalities.org.uk/our-work/delivering-race-equality/community-development-workers/>

5

Operational Police Responses to Victims and Witnesses

This section provides information on issues relating to the operational police responses to people with mental ill health or learning disabilities who are victims of, or witnesses to, crime. It focuses on the role of the police and the limitations of that role in terms of what the police can and cannot do. More detailed information about particular aspects of police responses is provided in 6 Use of Police Powers Under the MHA 1983 and the MCA 2005 and 7 Operational Police Responses to Suspects and Offenders.

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5.1 Victims and Witnesses

All victims of crime and witnesses to crime, including those with mental ill health or learning disabilities, are entitled to an equitable quality of service. This includes full explanations of what is happening – such as information about court hearing dates, the outcome of pre-trial hearings and the verdict and sentence. To ensure that responsibilities to victims and witnesses are met, the service provided should be tailored to fit their individual requirements. For full information about the help and support victims and witnesses can expect to receive at every stage of the criminal justice process, see **Office for Criminal Justice Reform (2007) The Witness Charter: Standards of Care for Witnesses in the Criminal Justice System** (which is non statutory) and **Office for Criminal Justice Reform (2005) The Code of Practice for Victims of Crime** (which is statutory).

5.1.1 Concept of Vulnerability

The Youth Justice and Criminal Evidence Act 1999 defines a vulnerable adult as a person whose quality of evidence is likely to be diminished because they suffer from a mental disorder (as defined by the Mental Health Act 1983), otherwise have a significant impairment of intelligence and social functioning (learning disability) or have a physical disability or are suffering from a physical disorder.

Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse, provides a wider definition of a vulnerable adult as ‘a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation’.

Abuse is defined in **Welsh Assembly Government (2000) In Safe Hands** (the equivalent guidance published by the National Assembly for Wales) defines abuse as follows:

Abuse is a violation of an individual’s human and civil rights by another person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Welsh Assembly Government (2000) In Safe Hands

The vulnerability of a victim or witness with mental ill health or learning disabilities can arise through the person's condition. The police, as evidence gatherers, must take note of this vulnerability in the way they investigate reported crime and extract evidence. Vulnerability can also refer to the person's product, ie, their evidence. Thus, legislation stresses the need for special measures in and around a person's court appearance where there is a significant risk that the quality of his or her evidence may be diminished as a result of having to appear in court. This is predicated the determination that use of special measures would be likely to improve the quality of the evidence given by the witness.

5.1.2 Early Identification

The police want people with mental ill health or learning disabilities to feel confident about approaching them for help, and to feel confident and capable of giving their best evidence. Although police officers and staff are not expected to diagnose specific conditions, early recognition of victims' and witnesses' mental ill health or learning disabilities is key to accessing appropriate support so these aims can be achieved. This support can make the difference between a person giving evidence which enables a conviction, or a case being discontinued by the CPS. It may also affect whether crimes are reported in the first place.

Good practice

A key source of information is the person – he or she is likely to be able to provide most of the information needed from their own point of view. **'Do you have any difficulties that I may not be aware of?'** is the question the National Autistic Society has proposed should be asked by police officers during initial contact with a person if the officer 'has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally vulnerable' (see PACE 1984, Code C (1) (1.4)).

5.2 Victims of Crime on Basis of Disability

People experiencing mental ill health or who have learning disabilities may be particularly vulnerable to victimisation related to their condition. This can range from serious crime to lower-level anti-social behaviour and harassment. All such incidents can create alarm and fear in the victims and have a detrimental effect on their quality of life. It is important when responding to disability-related incidents and crimes that the police take a holistic view as to the nature and circumstances of each incident and place a clear emphasis on intervention at the earliest stages. As well as establishing accurate reporting and recording procedures to capture information on these types of crimes and incidents, the police should strive to find imaginative solutions, including considering responses that require the active cooperation of partner agencies and community representatives.

5.2.1 Victims of Disability Hate Crime

Disability Hate Crime is covered by section 146 of the Criminal Justice Act 2003, and applies to offences committed in either of the following circumstances:

Section 146(2)(a)(ii) At the time of committing the offence or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on a disability or presumed disability of the victim.

OR

Section 146(2)(b)(ii) The offence was motivated (wholly or partly) by hostility towards persons who have a disability or a particular disability.

Research (for example, ***Mind (2007) Another Assault***) and current Home Office statistics point to the fact that disability hate crime is significantly under-reported and under-identified by the police and other criminal justice agencies, and that it can have a major impact on the victim's quality of life. It is essential, therefore, that the police identify such crimes as quickly as possible and manage them appropriately. Where it is possible to show the existence of hostility, victims and/or their families are entitled to benefit from the enhanced service from the criminal justice system that this type of case warrants. Empathy, sensitivity and respect are key parts of this response.

Special care will be needed in responding to incidents where the victim's disability may be such that they have not recognised the behaviour against them as a hate crime.

If there is evidence of a disability hate crime or incident, the police should consider an 'Achieving Best Evidence' (ABE) interview of the victim at an early stage in the investigation. They should also bring the disability to the attention of the CPS so that it can be a factor in charging decisions (see **7.10 Crown Prosecution Service**). In addition, highlighting the part that disability played in the offence may mean the court not only sentences offenders accordingly but also sends the message that criminal acts arising from hostility will not be tolerated.

Detailed information on the investigation and prosecution of disability hate crime and the application of section 146 of the Criminal Justice Act 2003 is provided in:

- ***ACPO and Home Office (2005) Hate Crime: Delivering a Quality Service: Good Practice and Tactical Guidance;***
- ***CPS (2008) Prosecuting Cases of Disability Hate Crime.***

5.2.2 Victims of Exploitation

Not all crimes against people with mental ill health or learning disabilities are motivated by hostility towards their condition. It could be a matter of exploitation because the person committing the offence sees the person with mental health issues as someone who is easy to take advantage of. As with disability hate crime, this type of offending where someone befriends a person with mental ill health or learning disabilities in order to exploit them is under-reported and can lead to further, more serious victimisation.

As well as taking any such reported offences seriously, the police should also ensure that a person with mental ill health or learning disabilities who is involved in this kind of incident automatically receives a follow-up visit by a community safety team. This will help to increase the victim's confidence in the police and decrease repeat victimisation.

Where there is evidence of an offence, the police should ensure the victim's vulnerability is brought to the attention of the CPS so that it can be a factor in charging decisions. It should also be brought to the attention of the court so the judge or magistrate can bear it in mind when considering the level of 'culpability' or fault of the offender and the harm caused or risk being caused to the victim. The level of fault is considered to be higher where the offender deliberately targets a vulnerable victim.

For further information on this topic, see **HMIC (1997) *Winning the Race: Policing Plural Communities*** and **Home Office (2010) *Safe and Confident Neighbourhoods Strategy: Next Steps in Neighbourhood Policing***.

5.3 Interviews and Statements

5.3.1 Taking a Witness Statement

When considering taking a witness statement from either a victim of crime or witness to a crime, the police should establish whether there are any indicators of mental ill health or learning disabilities and whether the witness needs additional support. Before embarking on the statement itself, completing the initial needs assessment on the reverse of the MG11 form will help officers consider the needs of the individual and enable early identification of particular issues. This includes seeking the views of the individual about 'special measures' (see **5.4 Special Measures**) and assessing whether an electronic statement may be more appropriate than a written statement. For those who fall within the definition of a vulnerable victim or witness under section 16(2)(a) of the Youth Justice and Criminal Evidence Act 1999, this should include consideration of whether special measures might assist them to give best evidence.

5.3.2 Interviewing Vulnerable Witnesses

The quality of a vulnerable witness's evidence is less a function of the person than of the interviewer. While most people with mental ill health or learning disabilities suffer from cognitive and social impairments, research has consistently indicated that the evidential value of their testimony can be greatly enhanced through the methods used by interviewers. There is ample guidance in this area; for example, the document ***Criminal Justice System (2007) Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures*** contains a detailed section for police and other agencies involved in criminal investigations on planning and conducting interviews with vulnerable and intimidated witnesses. See also ***ACPO (2009) National Investigative Interviewing Strategy***.

5.3.3 Victim Personal Statements

Apart from the usual witness statement, victims of crime can, if they wish, make a Victim Personal Statement (VPS). This gives the victim (or the victim's family in some cases) the chance to explain the effect that the crime has had on them physically, emotionally or financially. The police should ask victims if they would like to make this additional statement, but victims do not have to agree if they do not want to. In the case of people with mental ill health or learning disabilities, the police must take care to ensure that victims understand their choice in the matter.

The VPS is about giving victims the opportunity to make their views and feelings known directly to the criminal justice system. Having explained its function and possible content to the victim, the police should record the VPS in the victims' own words. It may contain information such as:

- Whether the crime has had an impact on the victim's lifestyle;
- Whether the victim feels vulnerable or intimidated;
- If the victim is worried about the defendant being given bail;
- Information about any compensation that the victim might wish to claim for.

For practical details on how to take a VPS, practitioners should see ***Criminal Justice System (2009) Victim Personal Statements: A guide for police officers, investigators and criminal justice practitioners.***

5.4 Special Measures

For some people the process of giving evidence in court can be particularly difficult. If a victim or witness is identified as vulnerable or intimidated, there needs to be consideration and explanation of special measures that can be made available to make giving evidence less stressful. These include video-recorded evidence-in-chief, live TV links, screens, evidence given in private, removal of wigs and gowns by judges and barristers, the use of intermediaries and aids to communication such as an interpreter or learning disability specialist.

5.4.1 Early Consideration

The police and prosecutor should consider as early as possible whether a witness with mental ill health or learning disabilities would benefit from special measures. The police officer should explain the special measures, ask witnesses if they would like to meet the prosecutor to talk about special measures and make a note of their views. People with mental health issues are usually experts in their own strengths and support needs. If they are required to give evidence in court as a witness, they are usually best placed to decide whether or not they will be able to cope. Guidance on early special measures discussions is provided in ***Office for Criminal Justice Reform (2009) Early Special Measures Discussions Between the Police and the Crown Prosecution Service.***

The MG2 form is used by the CPS to apply for special measures. This needs to be completed and force procedures for obtaining support followed. In some cases a psychiatrist or psychologist will have to be asked to conduct an assessment of the witness's situation and the likely effect of the criminal justice process on them. For further information see ***Office for Criminal Justice Reform (2008) Victims and Witnesses Matter*** and ***Office for Criminal Justice Reform (2008) Early Identification of Vulnerable and Intimidated Victims and Witnesses: A Guide for Police Forces.*** See also resources such as the leaflet developed by ***Voice UK (nd) Vulnerable Witnesses: Their Right to be Heard.***

5.4.2 Special Measures Meeting between Witness, Police and Prosecutor

If a vulnerable or intimidated witness wants a meeting with the prosecutor to discuss special measures, it should be arranged by the police, the Witness Care Unit or the prosecutor. The meeting can be held at a police station, a CPS office or the court where the case will be heard. If a witness has particular access or other requirements then the prosecutor should consider holding the meeting somewhere else, for example at social services premises. The witness can attend the meeting with a relative, carer or supporter. If an interpreter or intermediary is required, that person will also need to attend.

5.4.3 Witness Unable to Give Evidence Even with Special Measures

Where a victim or witness is unable to give evidence even with special measures or enhanced support, the police should look for evidence other than the individual's so that, in appropriate cases and where possible, the case may proceed without relying on that person's evidence. This may involve seeking information or evidence from other agencies, for example, social services, NHS, specialist charities supporting people with mental health issues or learning disabilities or the Care Quality Commission.

Other useful sources of information or evidence to enable the case to proceed include: care plans, visitor records, medication records, previously reported incidents involving the same victim or suspect, and other related investigations or proceedings pending or concurrent in which other agencies may be involved (for example, local authorities). This type of information may help the police and CPS to make decisions (for example, about an offender's bail conditions so as to avoid the potential for witness intimidation).

5.5 Witness Care

Continuity of support, and communication about that support, is important for all victims and witnesses, particularly those who are vulnerable. Police forces provide support through Witness Care Units (WCUs), specialist vulnerable witness care officers or family liaison officers. Victims and witnesses with learning disabilities are likely to need support throughout their contact with the police, for example, from a learning disability specialist or carer. Services such as Victim Support work closely with the Police Service to help victims and witnesses cope with crime and the processes associated with crime.

5.5.1 Witness Care Units

WCUs are run and staffed jointly by the CPS and the police, although witness care officers are neither lawyers nor police officers. Their job is to provide a single point of contact for witnesses. They also provide information to witnesses about the progress of court cases and make sure that witnesses have the support they need to let them give their best evidence.

5.5.2 Therapeutic Assistance Prior to Trial

For information about therapeutic assistance for victims and witnesses prior to a criminal trial, see **Home Office, Crown Prosecution Service and Department of Health (2001) Provision of Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial: Practice Guidance**. See also **Home Office, CPS and Department of Health (2006) Provision of Therapy for Child Witnesses Prior to a Criminal Trial: Practice Guidance**.

5.6 Perceptions of Credibility

It is often assumed that people with mental ill health or learning disabilities will not make credible or reliable witnesses and that they will not be able to cope with the court process. These perceptions have been proved to be both unfair and inaccurate, but where they exist can result in fewer cases progressing to trial and obstruct fair access to justice. In addition, poor treatment during the criminal justice process may make people with mental ill health or learning disabilities feel insecure and anxious and, therefore, unable to give their best evidence or exercise their rights.

In fulfilling the police role to provide full information to the CPS about the credibility and reliability of victims and witnesses, officers and staff should ensure prosecutors receive robust evidence about anyone believed to have mental ill health or learning disabilities (so that, for example, victims are not denied access to a trial automatically because they have a mental health problem). This may include evidence about the person's mental health history and diagnosis, and how it affects their memory, understanding of events and their ability to communicate and to interact with other people. The police should seek information from the person directly and, with the victim's consent, from friends or family and their medical professionals. This information is extremely sensitive so officers should ensure that they achieve consent, observe data protection rules, and do not delve unnecessarily into personal information. They should be guided by the prosecutor on what evidence will support good decision making.

For further information see **CPS (2009) Supporting victims and witnesses with a learning disability**, **CPS (2009) Supporting victims and witnesses with mental health issues** and **CPS (2009) Prosecutor's Pledge**.

5.7 Other Issues

5.7.1 Risk of Self-Harm and Suicide

Police officers can be a key point of contact for people at risk of self-harm and suicide. Where such people have mental ill health or learning disabilities, communication may be a particular problem. Dismissing self-harming or suicidal behaviour as some form of manipulation or attention seeking is dangerous. Unless the situation is an emergency, and decisions have to be taken immediately, early assistance from a trained person or someone who knows the individual should be sought. (For more information see **3.2 Communication**.)

5.7.2 Victim no Longer Wants the Case to go to Court

Sometimes victims with mental ill health or learning disabilities will ask the police not to proceed further with the case and state that they no longer wish to give evidence. There may be a number of explanations for this. Taking a non-judgemental approach, the police should do all they can to find out why the person does not want the case to go to court and then decide what action to take. They must take into account that most people experiencing mental ill health or who have learning disabilities can still make their own decisions even if the police or others do not agree with those decisions. See **6.3.2 Principles of the MCA 2005** and **6.3.4 Police Use of the MCA 2005**. The decisions that the person makes should be supported if the police are satisfied the person understands the implications of those decisions. The police should ensure that victims know that their withdrawing a complaint on one occasion does not mean that they cannot call the police if something similar happens again.

5.7.3 Claims for Compensation

If they have been injured or their property has been damaged or stolen, victims can make a claim for compensation from the defendant. This will be handled by the police and the CPS, with the court deciding how much compensation should be awarded. The victim will need to provide evidence of the injury as well as receipts or anything that can prove the value of the things damaged. Where the victim making the claim has mental ill health or learning disabilities, the police and CPS may need to provide extra assistance, including reassurance about concerns relating to the defendant and/or payment of the compensation.

In cases involving violence, victims can also make a claim for compensation through the Criminal Injuries Compensation Authority (CICA). Contact details for CICA can be found on the Victim of Crime leaflet that should be provided to victims of crime. It would be helpful for the police to inform victims with mental ill health or a learning disability that Victim Support provides a service which helps victims complete the CICA claim form.

5.7.4 Accessible Reporting of Victimisation

Any allegations made or questions raised by a person with mental ill health or learning disabilities must be dealt with consistently in a serious and professional manner. Many people find it difficult to report an incident to the police, and for a person with mental ill health or a learning disability this can be even harder. Some specific challenges include being given relevant information and advice, having appropriate support when giving testimony or being interviewed, and being spoken to in an appropriate tone and manner. 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. Their stories suggest that the response varies from location to location, with forces placing different stock on issues such as the reliability of the testimony of people with mental ill health or learning disabilities (see **5.6 Perceptions of Credibility**). As outlined in **3.1.2 Other Issues to Be Aware of**, this can 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 accessible ways for people with learning disabilities to report incidents to the police (for example, producing information in easy-to-read, photographic or video format). They should also monitor the effectiveness of such initiatives.

5.7.5 Official Documents

Published material that holds useful information includes:

- ***Office for Criminal Justice Reform (2007) Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures*** (particularly Chapter 3);
- ***Vulnerable Witnesses: A Police Service Guide***;
- ***Office for Criminal Justice Reform (2006) Working with Intimidated Witnesses: A manual for police and practitioners responsible for identifying and supporting intimidated witnesses.***

6

Use of Police Powers Under the MHA 1983 and the MCA 2005

This section provides information on issues relating to the use of police powers under the Mental Health Act 1983 and the Mental Capacity Act 2005 and the relationship of those powers to multi-agency responses. It focuses on the role of the police and limitations on that role in terms of what the police can and cannot do.

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6.1 The Mental Health Act 1983 and the Mental Capacity Act 2005

6.1.1 Legal Power for Admission, Assessment and Treatment

The MHA 1983 allows compulsory admission to and detention in a hospital, of people with mental health problems. This can be via a civil admission or via the courts or prison.

6.1.2 Mental Health Act 1983 and Codes of Practice

The police should take the MHA 1983 and the MHA Code of Practice for England and the MHA Code of Practice for Wales into account when they need to provide people with mental ill health or learning disabilities with access to a place of safety, play a role in transporting the person (for example, to hospital) or support to an MHA assessment (as opposed to a mental health assessment).

Although the police are expected to consider the Codes, the MHA does not place a statutory duty on them to have regard to it. Where the Codes address areas that are relevant to policing – such as searches of patients in hospital – police officers will continue to be governed by the primary legislation which provides the relevant power. Whenever restraint is required in the exercise of MHA powers, relevant local and national guidance should be followed.

6.1.3 Mental Capacity Act 2005 and Code of Practice

The Mental Capacity Act (MCA) 2005 provides a statutory framework for people who lack capacity to make specific decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It also covers temporary incapacity due to drug or alcohol abuse and mental ill health. The MCA sets out who can take decisions, and in which situations, and how they should go about this.

The legal framework provided by the MCA is supported by a Code of Practice (which applies in both England and in Wales), which provides guidance and information about how the Act works in practice. The Code has statutory force and certain categories of people, including the police, have a legal duty to have regard to it when working with adults who may lack capacity to make decisions for themselves.

In certain circumstances (for example those that are life-threatening) section 5 of the MCA and Chapter 6 of the MCA Code of Practice give the police and other agencies the powers to detain, restrain and remove people to hospital (including from private premises) and to use reasonable force where necessary. Compulsory removal may not be justified in less serious circumstances.

Local protocols should agree the role of the police when another agency (for example, a general practitioner or the Ambulance Service) invokes powers under the MCA.

6.2 Mental Health Act 1983, Mental Capacity Act 2005 and Police Involvement

Responding to individuals with mental ill health or learning disabilities is primarily the responsibility of health and social care agencies. There are a number of different situations, however, where partner agencies may expect police involvement in, or support for, achieving a clinical objective; for example, relating to detaining a person in hospital, applying the MCA or transporting a person from one health setting to another. It is in the interests of individuals and the public that the police are only involved where their particular powers, training or skills are necessary.

Each case will need to be considered on its merits but local multi-agency protocols can assist in ensuring that all parties are clear about the factors to be considered when deciding if police involvement is necessary in a particular situation. For example, agencies can agree criteria which indicate whether a situation is low, medium or high risk in terms of the likelihood of it resulting in violence and the nature of that violence.

6.2.1 Factors to Be Considered

Factors indicating a medium or high-risk situation where police involvement would be appropriate either in support of health staff, or as a police-managed situation, could include:

- Recent violence and whether that was relatively minor or serious;
- Previous violence towards the police or staff in partner agencies;
- Previous active resistance to the exercise of compulsory powers under the MHA or MCA, or other indications of resistance from the individual;
- Information about access to, or use of, weapons including firearms and improvised weapons;
- Particular risk of escape.

Information about these and other relevant factors can come from the information systems or observations of the police or other agencies. 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. Local protocols need to agree the kind of factors that indicate the situation requires:

- Police-led intervention;
- Health-led intervention with police support; or
- No active police involvement.

This will help to ensure that all agencies are clear about expectations and that appropriate resources are in place to respond to particular situations. In some cases, for example, forces can support health agencies by sharing resources relating to training in de-escalation techniques and restraint. In some cases critical incident policies and **ACPO (2007) Practice Advice on Critical Incident Management** may be relevant.

6.3 Applying the Mental Capacity Act 2005

6.3.1 Introduction

The MCA gives a legal basis for providing care and treatment for people aged 16 years and over who lack the mental capacity to give their consent to such care and treatment. The Act protects decision makers where they take reasonable steps to assess someone's capacity and then act in the reasonable belief that the person lacks capacity and that such action is in their best interests.

Although the MCA is primarily aimed at health and social care professionals and carers when making decisions about a person's welfare, it will in some circumstances be applicable to police officers. In such cases officers will usually need to make immediate decisions while awaiting further input or direction from a health or social care professional.

6.3.2 Principles of the MCA 2005

The following five principles of the MCA should govern police responses:

1. A person must be assumed to have capacity unless it is established that he lacks capacity;
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision;
4. An act done, or decision made, under this Act for, or on behalf of, a person who lacks capacity must be done, or made, in his best interests;

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Mental Capacity Act (MCA) 2005, Section 1

6.3.3 Points to Note

- The MCA applies to both public and private locations.
- An apparently irrational or wrong decision does not, by itself, provide evidence of lack of capacity.
- If a person does have mental capacity, there is no power to treat them without their consent.
- Some people will experience fluctuating capacity, which can affect their ability to understand information and make decisions at particular times.
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making decisions that concern them.
- If there is a chance that the person may regain capacity to make a particular decision, and the matter is not urgent, then the decision should be delayed until later.
- Officers should always weigh up the risks of forcing help on an unwilling person against the benefits it may offer.
- In situations where health or social care professionals are on the scene, police should defer to their expertise and provide support as appropriate and in accordance with local protocols.
- Restraint and use of force are possible under section 5 of the MCA to prevent a serious deterioration in health (for example, an immediate risk of serious self-harm or an attempted suicide). The officer must reasonably believe that an act is necessary to prevent harm to the individual and the act must be a proportionate response to the likelihood of harm and the seriousness of that harm.
- The power to restrain a person under the MCA does not interfere with existing powers of arrest for criminal offences or detention under section 136 of the MHA.

- Sections 5 and 6 MCA 2005 work together to provide protection from criminal and civil liability for acts done in connection with care or treatment which can, in limited circumstances, include restraint.
- The purpose of conveying a person to hospital under the MCA in circumstances of serious self-harm or suicidal intent is to allow an assessment to be carried out (as per the **NICE (2004) Guidelines for the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care**). This includes a professional assessment of capacity and/or assessment under the MHA where appropriate. Where staff decide the person neither lacks capacity, nor meets the criteria for detention under the MHA then the person may be discharged from hospital (or can choose to remain there voluntarily).

6.3.4 Police Use of the MCA 2005

The MCA is most likely to be necessary in emergency situations when officers are faced with someone lacking mental capacity, whose life may be at risk or who may suffer harm if action is not taken. Examples include people attempting and threatening suicide, victims of serious assaults, casualties of major incidents, and individuals with serious injuries who decline medical aid. In non-emergency situations, such as a pre-planned mental health assessment, other powers and tactical approaches may be more appropriate (see **6.8 Pre-Planned Mental Health Assessments on Private Premises**).

When faced with a situation where death or serious harm may occur to someone who refuses treatment or help, the following steps will provide guidance to help in decision making. In many such situations officers will not have time to discuss, negotiate or explain their actions.

1. Determining someone's mental capacity

Everyone is presumed to have capacity unless there is evidence that they cannot make a decision because of an impairment or disturbance in the functioning of their mind or brain because of: mental ill health; significant learning disabilities; dementia; brain damage; physical or mental conditions that cause confusion, drowsiness or loss of consciousness; delirium; concussion following a head injury; the symptoms of alcohol or drug use.

People are unable to make a particular decision if they cannot do one or more of the following four things:

- Understand information given to them about the decision to be made;
- Retain that information long enough to be able to make the decision;
- Use or weigh up that information as part of the decision-making process;
- Communicate their decision.

Questioning along the lines of; 'Do you realise you have an injury?' and 'Do you realise how serious it is?' and noting responses will help officers decide if the person concerned has capacity to make decisions at that time about their need for emergency treatment. In addition, such questions will help officers benefit from the safeguards provided within the Act against allegations of unlawful restraint or assault.

2. Determining what is in someone's best interests

The term 'best interests' is not actually defined in the Act. This is because so many different types of decisions and actions are covered by the Act, and so many different people and circumstances are affected by it. It is generally accepted, however, that in an emergency situation attempts to save someone's life or prevent someone from suffering serious harm will normally be in that person's best interests. The MCA Code of Practice provides that 'In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay' (paragraph 6.35).

Where a person who is threatening suicide appears to know exactly what they are doing and why, others may be reluctant to conclude they lack capacity – basing this judgement on principle 3 of the MCA 2005 (ie, a person is not to be treated as unable to make a decision merely because he makes an unwise decision). However, it is not the decision to take their own life that necessarily evidences lack of mental capacity, but rather their inability to consider or fully think through alternative options such as counselling, medical assistance or help from statutory or voluntary agencies.

3. Restraint

In situations where someone is reasonably believed to lack capacity it is lawful to restrain them. Before using restraint, however, officers must:

- (a) reasonably believe restraint is necessary to prevent harm to the person who lacks capacity; and

- (b) ensure the amount and type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of harm.

Officers should also consider the risks of aggravating the individual's condition, especially if forcing help on an unwilling person.

4. Recording decisions about mental capacity

Having assessed someone as not having mental capacity, and taking action in their best interests, officers should supply a rationale for their decisions. The record should include:

- The information used to decide the person lacked capacity including questions asked and the person's replies;
- What options were considered (including each one's potential benefits and harms, and whether each one was lawful, necessary and proportionate);
- Any other factors taken into account (eg, powers and policies);
- What action was taken;
- The effect of the action taken.

6.3.5 Public and Private Locations

If a person is attempting or threatening suicide in a public place, it may be more appropriate to use section 136 MHA as a means of preventing harm and ensuring prompt mental health assessment at a place of safety than to rely on the MCA (see **6.4 Section 136 of the Mental Health Act 1983 and Places of Safety**). In relation, however, to incidents in a public place involving people who are clearly seriously injured (eg, victims of serious assaults or casualties of major incidents) but who decline medical aid, it would be more appropriate to use the MCA. While section 136 is a route to a place of safety, the mental capacity legislation is simply a way of allowing the police to take decisions in connection with the care and treatment of someone who the police reasonably believe is not currently able to make such a decision in their best interests due to their – in most cases – temporary lack of capacity.

When an incident involving an immediate threat to life occurs in a private place, it is appropriate to use section 17 PACE to enter the premises to save life or limb, and then consider relying upon the MCA where appropriate (eg, where it is necessary to restrain an individual due to their lack of mental capacity). If the MCA is used, officers should ensure they record the steps they took to establish that the person lacked capacity.

6.3.6 Multi-Agency Protocols

To encourage consistent application of the MCA, police forces should ensure that local protocols with health agencies, including the Ambulance Service, include consideration of how the Act is applied by different professional groups or individuals (for example, the extent of each agency's role).

Protocols should also establish referral processes to ensure an appropriate multi-agency response to particular situations. The MCA Code of Practice provides guidance on the powers to use, what questions to ask, how to make a basic assessment and what to record.

In some situations where partner agencies use the MCA, they will request that the police be involved. Local protocols should ensure that the legal obligations of those who initiate action under the MCA are clear and there should be agreement about when and how the police become involved.

6.3.7 Supporting Someone Who May Lack Mental Capacity

People should be supported as much as possible to make their own decisions before officers conclude that they lack capacity. For example, consideration should be given to:

- Consulting relatives, partners, friends, or anyone else the person wants contacted;
- Offering assistance to the person to ease any practical concerns they have, eg about childcare or the welfare of their pets, or that their property is secure;
- Using an independent advocate to help with communication, or using different communication aids such as pictures, signs, audiotapes or easy-to-read material.

6.4 Section 136 of the Mental Health Act 1983 and Places of Safety

6.4.1 Wording of Section 136 MHA

Section 136 of the MHA provides:

- (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135.

- (2) A person removed to a place of safety under this section may be detained there for a period not exceeding seventy-two hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.
- (3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of seventy-two hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.
- (4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of seventy-two hours mentioned in that subsection.

Mental Health Act 1983, section 136

6.4.1.1 Place to Which Public Have Access

A 'place to which the public have access' (see (1) above) is not defined under the MHA, but has been considered by case law. It has been taken to mean places to which the public have open access (eg, a highway), places to which the public have access if a payment is made (eg, a cinema) and places to which the public have access at certain times of the day (eg, a public house) but does not include places such as a front garden (where members of the public only have access by virtue of being visitors to private premises).

A place to which the public have access includes at least part of an A&E department of a hospital, if not all of it. Decisions about whether a particular hospital ward, A&E itself, or any part thereof, is a place to which the public have access should be made on a case-by-case basis and will be influenced by the physical configuration and the way in which the staff operate access to different areas.

6.4.1.2 Place of Safety

A place of safety is defined in section 135(6) as '...residential accommodation provided by a local social services authority ... a hospital ... a police station, an independent hospital or care home or any other suitable place, the occupier of which is willing temporarily to receive the patient'. The latter might include the home of a relative or carer, if there appear to be no risks to that person's safety.

In recent years, as a response to an injection of capital funding in 2006, a number of health trusts have established dedicated mental health suites as the primary place of safety for people detained under section 136. These units allow police to make a fast, efficient and safe handover of the detainee from police care to more appropriate healthcare. Core features include:

- Being fit-for-purpose (with an office, waiting room, interview room and en-suite bedroom);
- Providing an appropriate low-stimulus environment;
- Having adequate numbers of trained staff to receive and manage the patient;
- Having the same staff for police and patients to become familiar with;
- Allowing consistent data collection and monitoring.

6.4.1.3 Scope of Police Power

The police can use section 136 when someone is found in a public place and is deemed to be in need of 'immediate care or control'. This sets in motion the requirement for an assessment to decide whether the person detained should be admitted to hospital (under section or voluntarily), or simply released with or without a plan for future care and treatment.

Where someone is experiencing a mental health crisis on private premises, it is inappropriate for an officer to invite the person to join them in the street outside their house in order to use section 136 to detain them. The power is to remove someone **found** in a public place, rather than someone put or encouraged there by the police. For situations where an individual in crisis is on private premises, see **6.9 Spontaneous Mental Health-Related Incidents in Private Premises**.

6.4.1.4 Conveyance to a Place of Safety

Following detention by a police officer, immediate consideration should be given to calling an ambulance. Not only is ambulance conveyance the preferred method by which to convey any patient detained under the Mental Health Act (see Code of Practice paragraph 10.17) but ambulance service staff have skills to assist in assessing the medical condition of the person. Mental health conditions, drugs or alcohol and disturbed behaviour may in fact be physical or medical health conditions which require treatment in an A&E Department in which case assessment by ambulance staff may be key to early identification of such problems (see **6.4.2.3 Obtaining Emergency Medical Attention**).

6.4.2 Identifying Places of Safety

The choice of a place of safety can have an impact upon the patient and the outcome of the assessment process. Police officers should be mindful that taking someone into police custody can have the effect of criminalising them for what is essentially a health need and that a police station environment may exacerbate an already fragile mental state. Protocols between the police and partner agencies need to identify local facilities as suitable places of safety so that police stations are no longer used for this purpose except in exceptional circumstances.

6.4.2.1 Police Station as Place of Safety on Exceptional Basis Only

Statistics indicate that police stations are commonly used as the first resort rather than the last. For example, **Docking, M., Grace, K. and Bucke, T. (2008) Police Custody as a “Place of Safety”:** **Examining the Use of Section 136 of the Mental Health Act 1983** estimates that 11,500 people were detained in police custody as a place of safety in 2005/06, compared with about 5,900 people in a hospital environment that year.

This guidance endorses the MHA Codes of Practice for both England and Wales that a police station should only be used as a place of safety for section 136 detainees on an **exceptional basis**. Chapter 10 of the MHA Code of Practice for England sets out that:

- A hospital, rather than a police station, should be the first choice of a place of safety;
- A police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available;
- If the first choice is not available, other options such as a residential care home or home of a relative or friend who is willing to accept the person temporarily should be considered before any decision is made to take the person to a police station;
- A police station should only be used on ‘an exceptional basis’, for example, where the person’s behaviour poses an unmanageably high risk to others.

Similar guidance is given in Chapter 7 of the MHA Code of Practice for Wales.

Although the police will sometimes agree that it is appropriate to take the person to a police station (for example, if the individual is violent), at other times they are having to do this because NHS facilities are unwilling to detain the person. This has significant implications for policing. For example, when police cells are used as places of safety, the police have obligations under Articles 2, 3, and 8 of the ECHR to protect the safety of people detained in this way. Among other things, this requires psychiatric assessment and treatment and expert monitoring – standards which are difficult for police custody suites, even the best equipped, to meet. In addition, most section 136 detainees arrive in police custody as a place of safety outside normal office hours, and so can be adversely affected by any delays as fewer people are readily available to carry out the assessment process.

This situation is clearly not the intent of the MHA Codes of Practice and all forces should ensure they have access to suitable **non-police** places of safety. This may require significant discussion and cooperation between police and healthcare trusts to ensure not only sufficient places of safety across each entire force area but also the provision of sufficient resources.

ACPO has endorsed **Royal College of Psychiatrists (2008) Standards on Use of Section 136 of the Mental Health Act 1983** and **Royal College of Psychiatrists (forthcoming) Standards on Use of Section 136 of the Mental Health Act 1983 in Wales** and encourages all forces to work with local partners to deliver those standards through local protocols.

6.4.2.2 Transfers between Places of Safety

If the person has already been detained at one place of safety under sections 135 or 136 MHA, that person may be subsequently transferred to another place of safety if appropriate. This can be done without the individual first being seen by a doctor or an AMHP. An AMHP or appropriate healthcare professional should, however, confirm that the transfer will not have an adverse risk on the patient's health (MHA Code of Practice for England, paragraph 10.38). Any moves between places of safety should be kept to a minimum and must be in the best interests of the patient rather than for expedient operational reasons. For more information see **6.5 Transfers between Places of Safety** and **Home Office Circular 007/2008 Police stations as places of safety**.

6.4.2.3 Obtaining Emergency Medical Attention

In a physical medical emergency the police should take the individual experiencing mental ill health immediately to an A&E department. In such circumstances, the treatment of the person's medical needs takes priority over mental healthcare. A mental health assessment will be arranged once the individual's condition has stabilised either in A&E or after transfer to another place of safety.

Some Ambulance Service areas have access to 'pre-hospital doctors' who can provide medical intervention at the scene and on the journey to hospital. If they are available, the assistance of pre-hospital doctors should be sought in instances where the paramedics or police officers believe the patient's condition or behaviour requires a higher level of medical oversight than they can provide themselves.

Conditions which should indicate to the police that A&E is appropriate as the first place of safety include physical injury, physical illness, attempted self-harm or an acute psychiatric crisis (eg, Excited Delirium).

6.4.3 Multi-Agency Protocols on Section 136

The MHA Codes of Practice for England and Wales both state that jointly agreed local protocols and policies should be in place covering all aspects of the use of section 136 of the MHA (paragraph 10.16 onwards, and paragraph 7.11 onwards, of the Code for England and for Wales respectively).

6.4.3.1 General Responsibilities

The local protocol should define responsibilities for:

- Identifying and agreeing appropriate places of safety;
- Providing prompt assessment (with agreement on timings) and, where appropriate, admission to hospital for further assessment or treatment;
- Securing the attendance of police officers where appropriate for the patient's health or safety or the protection of others;
- The safe, timely and appropriate conveyance of the person to and between places of safety – by use of the Ambulance Service as the first choice;
- Deciding whether it is appropriate to transfer people from the place of safety to which they have been taken, to another place of safety;
- Dealing with people who are also under the effects of alcohol or drugs (eg, at a non-police facility where individuals can be safely detained and assessed with police officers present if necessary);
- Dealing with people who are behaving, or have behaved, violently;

- Arranging access to a hospital emergency care department for assessment where necessary;
- Ensuring the availability of appropriately trained health staff so that police officers are released as soon as possible after arriving at a place of safety (subject to a joint risk assessment);
- Record-keeping and monitoring in accordance with any nationally agreed monitoring form and audit of practice against policy;
- The release, transport and follow-up of people assessed under section 136 MHA who are not then admitted to hospital or immediately accommodated elsewhere, for example, specifying which agencies are responsible for transportation and/or costs (for example, for taxis) in different circumstances.

6.4.3.2 Police Station as a Place of Safety

When a police station is used as a place of safety (in exceptional circumstances only), local protocols should cover the following:

- The time period within which the police are to request an appropriate professional to attend the police station;
- The time period within which the appropriate professional is expected to attend the police station (for example, within three hours of being contacted by the police);
- What will happen if an appropriate professional is not available within the specified time;
- The time period within which an individual is to receive an initial assessment under the MHA (for example, within three hours of the individual arriving at the police station) – and where this has not occurred, recording of the reasons why (for example, the individual was under the influence of drugs or alcohol);
- Access to qualified mental health staff who can stay with individuals while they are detained;
- Arrangements made to transfer the person to an alternative and appropriate place of safety within locally agreed timescales;
- The development and provision of information leaflets about section 136 and the individual's rights – accessible in relevant languages and formats;
- Arrangements for those who need assistance with transport to return home after being assessed and discharged from the place of safety (including where the National Assistance Act 1948 may apply);
- How situations should be managed if, upon arrival of the individual at the police custody suite, the custody officer determines (according to paragraph 9.5 and Annex H of PACE Code C) that the patient should be transferred to hospital for 'appropriate clinical attention'. If an ambulance has brought the person to the police station it may still be available, but if not, one should be called.

Where a timeframe is given in the examples above, this is based on the standards in *Royal College of Psychiatrists (2008) Standards on Use of Section 136 of the Mental Health Act 1983* and *Royal College of Psychiatrists (forthcoming) Standards on Use of Section 136 of the Mental Health Act 1983 in Wales*. Both documents are particularly useful in agreeing local protocols.

6.4.4 Decision to Use Section 136

Either finding or being directed towards a person allegedly with a mental disorder in a public place is not enough in itself to detain someone under section 136 of the MHA. Three conditions must be fulfilled before the police take action:

- 1) The person must appear to the officer to have a mental disorder;
- 2) The person must appear to the officer to be in immediate need of care or control;
- 3) The officer must consider it necessary to remove the person in his or her own interests or for the protection of others.

It is up to the officer to exercise his or her professional judgement in deciding whether the three conditions have been met.

A key question for an officer is: **based upon the individual's current behaviour and what is known about the individual, what is the risk of harm if this person is not detained?**

Officers should consider the possible explanations for the behaviour, including mental ill health, physical illness or other disability. Intoxication alone or behaving in an unusual way is not sufficient to satisfy section 136 of the MHA and is not a reason for the police to interfere with people's freedom to go about their lawful business in a public place.

While police officers and staff are not expected to diagnose an individual's particular health issue to satisfy section 136 of the MHA, an officer should believe in good faith that all three requirements of the section have been met, and record the reasons for that belief. This information will be taken into account when decisions are reviewed. Where time permits, information from police and other agencies' information systems, or from friends, relatives, neighbours and professionals with previous knowledge of the individual concerned can help in assessing the need for removal using the section 136 power.

In emergency situations, the behaviour of the person will demand immediate action. Indications include a stated intention by individuals to carry out acts of harm to themselves or others, a high level of distress being experienced by the person, or the content and strength of irrational thoughts or beliefs.

While it may be generally the best approach, even in an emergency, to get the person's agreement to an assessment, officers should be mindful of the small number of previous cases where section 136 could have been used but was not, leading to adverse consequences. In one case, for example, police officers found a person in a distressed state and could have used section 136 but did not because the person agreed to attend hospital with them voluntarily. Later, at hospital, he decided not to cooperate with the assessment procedure and walked out. As he had not been detained under section 136 he could not lawfully be prevented from leaving. He was later found drowned in a river. Section 136 should, therefore, be a strong consideration where people in a public place behave in a way that meets the threshold to trigger their detention and removal under that Act. A decision not to do so may place staff at the place of safety in a difficult position both legally and practically.

6.4.4.1 Arrest for Criminal Offence or Detention under Section 136

Where a criminal offence has been committed by the individual for whom detention under section 136 may be used, both the power of arrest for the criminal matter and section 136 are available to the police officer.

Where Section 136 is not used at the time of the original arrest, it will not be lawful to arrest for Section 136 at a later stage while the person is in the custody suite. In these situations there is no longer any power to hold the person who must be released. Clearly it is not in the interests of either the person concerned or the police to release such an individual without the person first being seen by a doctor and an approved mental health professional in accordance with S136(2). It is therefore advised that wherever possible both the substantive power and the powers under Section 136 are used simultaneously.

As a guide, where an offence is relatively low-level, possibly victimless or the offending is most likely related to the person's mental ill health, it is preferable to detain the individual under section 136 and take him or her to a health-related place of safety. If considered appropriate, the criminal offence can be dealt with later.

Where criminal offending is more substantive, particularly if it involves violence, it is preferable to arrest people and take them into custody. Appropriate arrangements can then be made for a mental health assessment while the criminal matter is being dealt with. In this instance, once case disposal has been achieved for the criminal matter the person can then be transferred to a suitable place of safety using section 136(3) and (4) MHA if applicable.

Where a power of arrest for a substantive matter arises (eg, a criminal offence such as ABH, a warrant or failing a breath test) and the person also exhibits behaviour justifying the use of Section 136 then it is sensible to consider arresting under **both** powers. This practice provides safeguards for both the detainee and the Police.

For example, if, following arrival at the custody suite, the substantive matter cannot be proceeded with (perhaps because the victim withdraws the allegation, it turns out to be mistaken identity or the suspect provides a breath sample below the limit) the custody officer can continue lawful detention using Section 136 and thereby provide the person with the care they require - including access to a mental health assessment. In many cases it will be preferable to transfer the person immediately to a place of safety provided by the local health trust.

While there is nothing in law, however, to prevent police officers from using section 136 and the power of arrest for a criminal offence in the same case and at the same time, this can sometimes create difficulties. For example, arresting for a criminal offence will normally require the person to be taken to a police station whereas with detention under section 136 the person should be taken to a health facility (where such a facility exists). In these instances officers should use their professional judgement.

6.4.5 Children and the Use of Section 136

Children of any age may be detained using section 136 of the MHA, and any person under 18 years of age may be taken into police protection using section 46 of the Children Act 1989. Information about the application of MHA powers to children and young people under the age of 18 is provided in Chapter 36 of the MHA Code of Practice for England (similar guidance is in Chapter 33 of the MHA Code of Practice for Wales). Where the child appears to be mentally ill, section 136 would be the preferred option but where he or she seems to require safeguarding (eg, because of behavioural problems), taking the child into police protection may be more appropriate.

In practice, officers are usually faced with a situation that requires a fairly rapid decision and may not be able (and should not be expected) to differentiate mental illness from behavioural problems. Where officers have the option to use both statutes, the preferred option is a police protection order under the Children Act 1989 as this is more likely to ensure that the child is not unnecessarily institutionalised or over-stigmatised by the process. The overriding consideration is the welfare of the child, ensuring protection from harm and access to assessment where appropriate. For further information see **ACPO (2009) Guidance on Investigating Child Abuse and Safeguarding Children** and **Home Office Circular 017 / 2008 The duties and powers of the police under The Children Act 1989**.

6.4.6 Legal Effects of Detaining Someone under Section 136 of the MHA

- Although the word arrest is not used in section 136, detention or removal under section 136 of the MHA is a preserved power of arrest under schedule 2 of PACE and reasonable force may be used.
- The person is to be taken to a place of safety to be medically examined by a doctor and assessed by an AMHP.
- From the time the person is detained until the time the examination and assessment are completed, the person is deemed to be in lawful custody and can be detained at the place of safety by the police and/or members of health staff.
- The person may be transferred from one place of safety to another for the purposes of carrying out the assessment.
- To enable this assessment to take place the person can be detained at the place of safety for up to seventy-two hours (which commences at the time of arrival at the initial place of safety), although it is not necessary within section 136 of the MHA for a police officer to be present during this period.
- The person is entitled to legal advice (under section 58 of PACE and PACE Code C) regardless of which place of safety they are taken to.

- Under section 56 of PACE and PACE Code C, the detainee is entitled to have one person who is known to them, or likely to take an interest in their welfare, informed of their whereabouts. However, officers should ensure that, wherever possible, others are also aware of the situation if the detainee requests this. If the person is in a police station, the police must do this under PACE.

6.4.6.1 Where PACE Applies

While it is the hospital's responsibility to ensure that an individual detained in hospital has access to their rights, for example, to legal advice, PACE can still apply. For example, having detained someone who is violent and aggressive under section 136, police officers may use section 32 to search the person once they have arrived at the hospital. The person's behaviour may provide the officer with reasonable grounds for believing that he or she presents a danger to themselves or to others and can search for anything which might be used to assist in escape from lawful custody. This will usually be for weapons or harmful substances rather than evidence as would be the case when arresting for a criminal offence.

Section 28 of PACE requires that people must be told that they have been arrested and the grounds for the arrest as soon as is practicable. This is particularly important when a person is being detained because of mental ill health. Arrest or detention by the police is normally associated with suspicion of criminal behaviour; therefore telling someone, without any further explanation, that he or she has been arrested or is being detained may cause considerable additional distress. This is likely to be exacerbated if the person is taken to a police station instead of a more appropriate place of safety.

6.4.6.2 Explanations to Detained Person

When using section 136, it should be made clear to people that they will have to come with the police because of the officer's concern for their wellbeing, and that they have no choice in the matter. Using professional judgement of the circumstances, the officer should explain to the individual in a sympathetic manner:

- Why they are being removed under section 136 of the MHA;
- Where they are being taken to; and
- What is likely to happen.

There is no requirement to caution a person detained under section 136 of the MHA and this should not be done.

6.4.6.3 Rights

Individuals detained under section 136 of the MHA should have access to the same rights under PACE and other related legislation as any individual who is arrested. This includes access to an appropriate adult when the person is in police custody, and the rights to dignity and respect. See also **7.5.6 Legal Rights**. An individual's treatment at a hospital, however, and his or her access to relevant rights and protections is a matter for hospital managers and not the police. If a constable remains at the particular health-related place of safety, this should be for reasons of public safety and not to safeguard the rights of a person detained under section 136 (see **6.4.7 Action Following Detention Under Section 136**).

As long as the criteria for detention are met (see **6.4.4 Decision to Use Section 136**) nothing in law prevents a constable deciding to detain someone under section 136 MHA who is already a mental health patient living in the community. Once someone on leave of absence from hospital (eg, under section 17 MHA, on supervised community treatment (SCT) or who has been conditionally discharged) has been removed to a place of safety, the professionals undertaking the assessment should consider whether to contact the person's responsible clinician with a view to arranging for their recall to hospital.

6.4.7 Action Following Detention under Section 136

Forces should use local protocols and SLAs to clarify the various roles and responsibilities in relation to action following detention under section 136 MHA. For example, once a person has been detained, the MHA Codes of Practice require that the officer doing the detaining is responsible for notifying the place of safety in advance of the person's arrival and notifying the local social services authority.

6.4.7.1 Transport

The responsibility for ensuring an individual is taken to an initial place of safety lies with the police officer who initiated the detention (because of the duties set out in section 136(1) MHA). Wherever possible, this should be by ambulance (as per paragraph 10.17 Code of Practice MHA for England). Where police transport has to be used, a member of the ambulance crew can be asked to be present in the police vehicle and the ambulance requested to follow behind to enable a response to any medical emergency.

Once the individual is at a place of safety, responsibility for securing any required transfer to a subsequent place of safety sits with either the AMHP or the police (or a person authorised by them) depending on the current place of safety the individual is being held in.

Some areas have dedicated section 136 mental health suites; others have agreed places of safety such as a local mental health facility or the emergency care department of the local general hospital (which, although not necessarily the ideal place of safety, is able to deal with any physical injuries or illnesses).

Chapter 9 of the MHA Code of Practice for Wales requires that the 'reasons and justification for the transfer are clearly thought through' and that consideration must be given to 'the most appropriate method of securing transfer, taking into consideration the patient's views as well as the need to manage any risks to the safety of the patient or others.' The Code notes that it is not always necessary for a transfer to be by ambulance, 'but where this is most appropriate, an ambulance should be provided'. Similar guidance is given in the MHA Code of Practice for England.

Where an ambulance is used, the police should use risk assessment to decide whether they accompany the person in the ambulance or provide a police escort to the ambulance. See **6.5 Transfers between Places of Safety** and **6.6 Transporting and Conveying People with Mental Ill Health**.

6.4.7.2 Need for Physical Assessment and Treatment

Where the designated place of safety is not located at an emergency care department, and the person detained is suffering from a physical condition (for example, injury or apparent illness) then it may be necessary for the person to be taken to the emergency care department for his or her physical condition to be treated. This decision will be made by the ambulance staff (see **6.6 Transporting and Conveying People with Mental Ill Health**). The decision will also be facilitated by transferring people in accordance with sections 135 or 136 MHA (see **6.5 Transfers between Places of Safety**).

6.4.7.3 Remaining with the Individual at the Place of Safety

Differences of opinion can arise between the staff at places of safety and the police about how long the police should remain with the individual, or who has the legal power or responsibility to continue detaining them while waiting for, and carrying out, an assessment. The power to remove under section 136(1) has the word 'constable' in it, but the power to detain the person at the place of safety under section 136(2) does not specify that this does indeed apply to a police constable. Hospital staff can detain a person removed to a place of safety using reasonable force if required under the powers given by section 136(2). There is normally no reason for the police to stay with people during an assessment when they are in an agreed place of safety at health premises. In general, the police should only need to stay where, in their professional judgement, there is a medium to high risk of violence or breach of the peace (see **6.2 Mental Health Act 1983, Mental Capacity Act 2005 and Police Involvement**).

In response to a request to stay at the place of safety, the police should consider any local policies and protocols on the matter and make a risk assessment of the likely harms and benefits of their decision. In exercising professional judgement, the police should include what is known about the detainee, for example, from police information systems and those of other agencies. See also **3.7.2 Assessing Risk**.

6.4.7.4 Refusal to Accept at Place of Safety

Police responsibilities under section 136 of the MHA are to determine that an arrest is required and to remove that person to a place of safety. This requires a decision about which place of safety should be used – an issue that should be outlined in a local protocol. The assessment of the person following arrival at a place of safety is the responsibility of health and social care agencies. Responsibility should, therefore, pass as quickly as possible from the police to such agencies, subject to any ongoing support required to manage aggression, resistance or risk of flight.

In some cases health staff may refuse to accept a person at the place of safety on the grounds that:

- The facility is full;
- The person is violent;
- The person is under the influence of alcohol or drugs and cannot be assessed until in a fit condition.

The locally agreed protocol for section 136 of the MHA should set out how these issues are resolved locally (see **6.4.8 Resolving Issues**). Taking the person to a police station should not be the automatic or default second choice and violent behaviour should not necessarily of itself lead to containment in police custody pending assessment. In particular, individuals who are suffering from drug or alcohol intoxication or are acutely disturbed or floridly psychotic (such as those suffering from Excited Delirium) may be at significant medical risk of underlying medical problems if they do not receive medical care from trained professionals. On rare occasions this need will be urgent and will preclude safe detention in police custody.

Staff refuse to accept because the place of safety is full

If the proposed health-related place of safety is full, the person in charge at that location may assist the police officer to secure an alternative place of safety and advise on what arrangements are best for the person. As the detained individual is not yet at a place of safety, the duty to remove the person to a place of safety remains with the police at this time.

Staff refuse to accept because the person is violent

It should not be automatically assumed that because a person is violent the police station is an appropriate place to detain them. Violent behaviour may be connected to conditions for which appropriate medical assessment and treatment is required. The respective Codes of Practice for England and for Wales set out that training programmes should be in place to equip healthcare staff to effectively manage patients who exhibit challenging behaviours. It is, therefore, expected that hospital staff working in areas where they may be exposed to violence will have been adequately trained to deal with violent incidents or persons.

Where necessary, a police supervisor can work with the person in charge at the place of safety to explore other options such as the use of an alternative, more secure place of safety, the assistance of more hospital staff to help restrain the person or a rapid assessment with police assisting in securing the detainee at the scene. These are all preferable alternatives to taking the person to a police station. Where there is a risk of serious violence or danger to those tasked with the care of the person, a police station may have to be used.

Staff refuse to accept because the person is under the influence of alcohol or drugs

The fact that someone is intoxicated is not sufficient grounds on its own for a refusal to accept a person at a health-related place of safety. Where people with apparent mental ill health or learning disabilities are so intoxicated as to represent a health risk to themselves, the police should follow normal 'drunk and incapable' procedures (eg, take them to hospital for medical assessment). If, however, intoxicated people present such a risk of harm to themselves or others that they cannot be safely managed at the health-related place of safety, they should be taken to a police station. If necessary, arrangements should then be made for a mental health assessment while they are detained at the police station.

6.4.8 Resolving Issues

To avoid later problems and to forestall arguments and improvisation at the time of an incident, the police and other agencies need to use their local protocols to be as clear as possible on each other's relevant roles and responsibilities (see **3.6.2 Multi-Agency Protocols**). Where problems occur, the police may need to take action at the time, but the details should be forwarded to the Mental Health and Learning Disabilities Liaison Officer for follow-up at multi-agency meetings (see **8.2.3 Mental Health and Learning Disabilities Liaison Officer**). Where problems occur repeatedly or cannot be resolved, the Mental Health and Learning Disabilities Liaison Officer should refer the matter to the BCU commander (see **8.2.2 Basic Command Unit Commander**) or ACPO lead (see **8.2.1 ACPO Lead with Responsibility for Mental Ill Health or Learning Disabilities**).

6.4.9 Record Keeping

Records should be kept on the use of section 136 of the MHA and associated decisions in accordance with local and national systems (for example, agreed monitoring forms). Individual officers should always be prepared to account for their decisions and to show that they were justified in doing what they did and that they acted reasonably within the scope of the law, organisational policies and expectations and their own professional judgement (see **ACPO (forthcoming) Guidance on Managing Operational Risks** and **3.6.5 Performance Measures**).

The use of section 136 in any particular area should be kept under regular review. This is a position endorsed by both the MHA Code of Practice for England (paragraph 10.42) and the MHA Code of Practice for Wales (paragraph 7.46). In many forces this is accomplished through a Strategic Monitoring Group for section 136 action, but it could also be accomplished by a local multi-agency group in each mental health trust area or BCU.

6.4.10 Powers of Compulsory Detention by Mental Health Professionals

Under the MHA, an AMHP may make an application for an individual's detention in hospital based on medical recommendation(s) given by doctors. These powers can be invoked following the exercise of section 136 of the MHA by the police, or separately, including where the criteria allowing detention by the police have not been met.

6.4.11 Aftercare Plans and Preventive Outreach

Repeated use of section 136 for the same person is to be avoided. As a means of preventing this, and to assist individuals in accessing appropriate care and treatment, forces should consider the development of aftercare plans and preventive outreach services with partner agencies. For example, nurses based in police custody areas can provide specialist outreach to individuals and arrange mental health assessments and referrals to other agencies (see **7.3 Healthcare in Police Custody**). Joint funding arrangements between the police and others (for example, PCTs, local health boards, mental health trusts or NHS commissioners) can increase staff availability outside working hours (see **3.6 Multi-Agency Partnerships**).

6.5 Transfers between Places of Safety

During the period of detention of up to seventy-two hours, a person detained under section 136 MHA in a place of safety may be transferred to one or more other places of safety and detained there. This also applies to people detained in a place of safety under section 135(1) MHA.

6.5.1 Circumstances Allowing Transfer

A person may be transferred:

- Before his or her assessment by the doctor and AMHP has begun;
- While the assessment is in progress;
- After the assessment has been completed and the individual is waiting for arrangements for his or her care or treatment to be put in place.

In theory there is no restriction on the number of times that a person may be transferred. However, repeated transfers are unlikely to be in anyone's interests; therefore the agreement of staff at the place of safety the person is to be taken to should always be sought prior to the transfer taking place.

Once section papers have been completed for admission to hospital under sections 2 or 3 of the MHA, the person is no longer detained under section 136 MHA (as arrangements for further care will have been made). The police should not automatically be expected to take and convey the patient.

Section 6 of the MHA says that where an application has been made for compulsory detention in a psychiatric hospital, the applicant (normally an AMHP) and any person authorised by the applicant has authority to take and convey the patient. The police can be authorised by the AMHP, but so too can staff from other agencies including doctors, nurses, ambulance staff, other social workers and even privately employed or hospital employed security staff. In these circumstances it is section 6 that provides the police with the authority to transfer the person to the hospital set out in the application papers.

6.5.2 Choice of Transport for Transfer between Places of Safety

For occasions where people are detained under both sections 135 and 136 of the MHA, local multi-agency agreements should ensure that ambulances are the primary source of transport. As outlined in **6.2 Mental Health Act 1983, Mental Capacity Act 2005 and Police Involvement**, police transport should only be used in exceptional circumstances, for example, due to the seriousness of the risks posed by violent behaviour.

Sometimes the police can take someone to a hospital, but they can later be requested to help with transferring that person to another hospital. Decisions about whether the police will make the transfer, and, if so, whether it will be in a police vehicle or the police will provide an escort for an ambulance, should be made by the police supervisor on duty.

The power to transfer should not be used purely for reasons of administrative convenience. For example, where a person is detained under section 136 and is taken to a hospital, the healthcare staff should not request a transfer to another place of safety simply for convenience.

If the police are requested to undertake transfers in circumstances which appear to be administrative, the police supervisor should consider declining to transfer. The details should be referred to the Mental Health and Learning Disabilities Liaison Officer, who may, if appropriate, escalate the matter to the BCU commander or ACPO lead (see **8.2 Staff Roles and Responsibilities**) for resolution at the strategic level. Taking on others' responsibilities can set up other risks for the police.

6.5.3 Agreement and Authority to Transfer between Places of Safety

Before a person is transferred from one place of safety to another (for example, to hospital premises), it is good practice for the police to obtain the assessment of an AMHP, a doctor or another healthcare professional as to whether the transfer would put the person's health or safety, or those of other people at risk. The assessment should be recorded in accordance with local protocols.

Where the person has been transferred to a police station as an alternative place of safety, the custody officer should ensure that a healthcare professional (for example, a forensic physician, a hospital doctor or nurse, an AMHP or custody nurse) has agreed that the transfer may take place. The name of the person agreeing to the transfer should be written in the custody record. Only a police officer, an AMHP or a person authorised by them may actually take the person to an alternative place of safety (section 135(3A) or 136(3) MHA).

Where police officers are involved in the transfer of a person from one place of safety to another, it is appropriate for the agreement of a police supervisor to be sought prior to the transfer taking place. The purpose of the supervisor being involved is to ensure a risk assessment takes place which considers risks to the patient's health and safety as well as risks to police officers and others. In cases where the person is being moved from a police station as a place of safety, the authority will usually be given by the custody officer.

In rare cases of emergency where police are involved in the transfer (for example, urgent first aid is required or there is serious violence), no such agreement or authority from either healthcare professionals or police supervisors is necessary. To reduce the risk of harm, the person may be taken immediately to the most appropriate place of safety.

6.5.4 Recording Transfers between Places of Safety

When a transfer between places of safety takes place, officers should record the relevant details:

- The time that the person left one place of safety and arrived at the next;
- The name and details of the healthcare professional agreeing to the transfer;
- The name and details of the authorising officer;
- The reason for the transfer.

6.6 Transporting and Conveying People with Mental Ill Health

A person who is subject to an application for admission to hospital under the MHA is liable by virtue of section 6 of the MHA to be conveyed there and is in 'lawful custody' by virtue of section 137. Taking patients to and from hospital for treatment and/or assessment is supported by guidance in the English and the Welsh Codes of Practice to the Act. Forces should ensure that local arrangements with private and public sector providers reflect both the Codes and this guidance.

6.6.1 The Use of Police Vehicles

Paragraph 9.12 of the MHA Code of Practice for Wales states that 'where a... patient is likely to be violent or dangerous, the police should be asked to help. Where possible an ambulance should be used, otherwise the police may be asked to provide a suitable vehicle.' Similar guidance is given in Chapter 11 of the MHA Code of Practice for England.

The use of police transport for such purposes raises a number of risks. These include:

- The potential to increase stigmatisation of individuals through association with crime rather than health;
- The risk of collapse and death of the detainee due to prolonged restraint where that person has been violent or identified as potentially violent;
- The lack of trained medical staff and resuscitation equipment to deal with medical emergencies.

For these reasons, hospitals and ambulance trusts should arrange suitable and safe transportation facilities rather than rely on the police.

Local protocols will need to outline the circumstances in which a police vehicle should be used. For example, an individual should only be taken to a place of safety by police transport in cases where there is:

- Extreme urgency;
- A risk of violence or other danger;
- An unreasonable delay in the availability of alternative transport (which could affect safety);
- The risk of harm to the detainee owing to inclement weather conditions;
- The potential need for restraint because of the individual's increased agitation;
- Potential risk of harm to the public or police personnel.

Police vehicles should not be used simply because it is more convenient or quicker. Discussions at management level may be needed to reach agreement on this issue.

6.6.1.1 Responsibility for Transport

The responsibility for transfers between psychiatric hospitals, or transfers to emergency departments for treatment following an illness or injury to the patient rests with the hospitals concerned rather than with the police. The responsibility for transfers in respect of patients detained in hospitals following a conviction at court for an offence warranting detention in hospital for treatment rests with the courts rather than with the police. The court, however, may direct the police to convey the patient to hospital.

If a police vehicle is used for such purposes, the police are effectively taking on medical risks that should lie with healthcare agencies. In addition, there are no general legal powers for police officers to transfer existing detained patients between hospitals, and such transfers require specific authorities to be in place before the police become involved.

6.6.1.2 Unmarked Vehicles and Non-Uniformed Officers

Where it is necessary to use police transport to convey people with mental ill health, it is preferable that unmarked vehicles and non-uniformed officers are used. This will help to reduce stigma and preserve the dignity of service users.

6.6.1.3 Planning and Preparation

When the police are to be involved in the transport and conveying of an individual, all staff involved should be briefed as fully as possible (for example, on what to expect from the situation and the individual concerned, the vehicle to be used, mode of dress and police powers to be used). When the transported person reaches the new location, the police should pass all information and documents to the staff authorised to receive them on arrival.

6.6.2 Protocol for Taking and Conveying

Section 137 (2) states that:

A constable or any other person required or authorised by or by virtue of this Act to take any person into custody, or to convey or detain any person shall, for the purposes of taking him into custody or conveying or detaining him, have all the powers, authorities, protection and privileges which a constable has within the area for which he acts as constable.

Mental Health Act 1983, section 137 (2)

Once a person has been assessed and a decision has been taken that he or she should be subject to detention under the MHA (sections 2, 3 and 4), section 6 of the MHA provides a power for an applicant (eg, usually the AMHP) to take and convey the person to hospital.

Individuals will be in legal custody during the period of taking and conveying them. Section 6 also provides the same power to anyone authorised by the AMHP to convey, including ambulance staff and the police. The effect is that others besides police officers are empowered to use force, if necessary, to take and convey detained patients.

Each force area should have an agreed transport and conveying protocol with relevant service providers. These protocols should address the following points:

- Patients should be taken and conveyed to hospital by ambulance;
- A police escort may be provided to accompany the patient in ambulances, subject to an appropriate risk assessment by the police;
- In exceptional circumstances (for example, due to the threat of violence) patients may be conveyed by police vehicle with an ambulance following behind and an ambulance crew member present in the police vehicle;

- The dignity and safety of individuals being conveyed to or between places of safety is a central concern;
- Delays in the operational process should be kept to a minimum in order to avoid distress to individuals and their families, and to reduce the risk of harm;
- Transfer of individuals between places of safety is primarily a health service responsibility, although there may be exceptional circumstances that require a patient to be accompanied by police officers (such as where the patient's behaviour poses an unmanageably high risk to ambulance staff);
- When someone is in police custody, the police are responsible for taking them to a place of safety. They can expect support from ambulance services to provide a suitable vehicle, but the responsibility remains with the police (because it is only the police who have the power to remove the person to a place of safety).
- The role of the police and police vehicles when ambulances are used to transfer an individual who is likely to be violent or dangerous.

6.6.3 Risk Assessment

A key consideration in weighing up whether to transport people with mental ill health in a police vehicle should be the risk posed to the individual patient and others. The risk assessment should take into account factors such as:

- Information available to the police about dangerousness;
- The distance to be travelled;
- Alternative transport available from other agencies;
- Current demands on police facilities and other police resources.

6.6.4 Role of Police Supervisors in Decisions Relating to Transportation

In relation to requests for the police to assist with transport, local protocols should detail the role of police supervisors. For example, supervisors:

- Would normally be responsible for carrying out a dynamic risk assessment, deployment of police resources where appropriate and ensuring that police action is proportionate, legal and necessary;
- Would not normally be required to authorise the transportation of patients detained under section 136 or following execution of a section 135(1) warrant for assessment on private premises.

6.7 Assistance with Mental Ill Health Assessments on Private Premises

Police frequently become involved with incidents involving the assessment of persons with mental ill health on private premises. This usually occurs when there are concerns that an individual's mental health has deteriorated to the extent that they are now in crisis and are a risk either to themselves or to others.

6.7.1 Types of Police Involvement with Assessments on Private Premises

Involvement falls into three categories:

- Pre-planned mental health assessments where an AMHP contacts the police in advance requesting support for an assessment he or she is planning for a person on private premises (eg, at home);
- Spontaneous incidents notified to the police by a member of the public – such as where neighbours or relatives call the police because they are concerned about people's unusual behaviour in their own home – or when the police are in contact with a person on private premises for another reason and it becomes apparent that the person is experiencing a mental health crisis;
- Spontaneous incidents notified to the police by a health professional, for example, where a member of the community health team visits a person at home and finds them in crisis and calls for police help due to the level of risk.

6.7.2 Entering Private Premises

Entry to private premises is only legal if:

- Consent is given by the individual or a co-occupier. Consent can be withdrawn at any point, in which case the AMHP and others should leave. If, however, prescribed forms for compulsory detention have already been completed, the process can continue;
- A warrant has been granted under section 135(1) of the MHA. This authorises a police officer to enter premises, if need be by force, and remove a patient to a place of safety to enable an application to be made under Part 2 of the MHA, or for making other arrangements for the person's treatment and care.

In most circumstances, to enter without consent or without a warrant is trespass (see **6.9.1 Police Powers at Spontaneous Incidents** for exceptions). Where there is no consent and no warrant, it is inappropriate for officers to invite the person to join them in the street outside their house in order to use section 136 MHA to detain them (see **6.4.1.3 Scope of Police Power**).

While Sections 2 or 3 of the MHA do not include any power to enter private premises, they do enable an AMHP, through an application based on the written recommendations of two registered medical practitioners, to complete papers which permit someone to be compulsorily admitted to, and detained in, hospital for assessment. As long as the AMHP or others are already on the private premises legally, such powers can be used in any place, including a private home.

6.8 Pre-Planned Mental Health Assessments on Private Premises

6.8.1 Introduction

The police are frequently asked by mental health professionals to provide assistance when carrying out pre-planned mental health assessments on private premises. The status, role and function of the police means that there is an implied expectation that they will provide security and safety at any mental health assessment they attend, even in circumstances where the AMHP has not obtained a section 135(1) warrant. Unless a warrant exists, however, police attendance is discretionary and there is no mandatory requirement for the police to attend as a matter of course.

6.8.2 Major Considerations

When asked to provide assistance with a mental health assessment on private premises, a police supervisor should conduct a risk assessment to determine whether there is sufficient reason to justify police attendance. The primary consideration will include the reason for police support, for example, to manage risks or promote cooperation.

Police attendance to manage risks

Police assistance may be sought to manage one or more of the following risks:

- That entry to the premises will be refused;
- That the person to be assessed or anyone else inside the premises will become violent;
- That the person to be assessed will harm him or herself;
- That the person to be assessed will abscond before the assessment or the application for compulsory admission to hospital has been completed;
- A risk of attack by an aggressive dog or other dangerous animal present inside the premises.

In order to manage risks, the police are able to attend an MHA assessment either with or without a warrant under section 135(1) MHA 1983. With a warrant, the police have the power to:

- Enter the premises, using reasonable force to execute the warrant if necessary;
- Restrict the movement of those in the premises while the premises are being searched;
- Remove the individual to a place of safety for seventy-two hours and assess them at that place instead of their own home.

Where, however, the police attend assessments without a warrant, their powers to take control and ensure the safety of everyone present are limited. These points are illustrated in the following examples.

A risk that the individual who will be the subject of the assessment, or anyone else inside the premises, will become violent

Where the police and mental health professionals are inside private premises without a warrant, they are present by consent only. In these circumstances anyone within the premises is at liberty to move around unimpeded. This includes access to areas where items are kept that could be used to cause injury (eg, hot liquids, kitchen utensils and similar equipment). Although police officers can rely, for example, upon section 3 Criminal Law Act 1967 to use reasonable force to prevent crime, the fact that a person is simply walking into a kitchen is unlikely to provide grounds under this legislation to prevent such movement. The existence of a warrant, on the other hand, would permit the officers to lawfully contain the person subject to assessment in a safe area of the premises and give them some ability to control or restrict the movement of others inside the premises, thereby preventing or at least reducing exposure to the risk of harm.

A risk that the person to be assessed will harm him or herself

While sections 5 and 6 MCA 2005 allow restraint to be used to prevent self-harm, there are limitations to when it can be used. Where no warrant exists, officers will often feel compelled to rely upon this legislation regardless of the grey areas around its use. The existence of a warrant, however, not only puts the matter beyond doubt since it provides a power to restrain the service user (and remove them where thought necessary) but also permits preventive action (such as containing the person subject of the assessment in an area away from possible weapons, windows and balconies).

A risk that the person to be assessed will abscond before the assessment or the application for compulsory admission to hospital has been completed

Where no warrant exists, the police officers and mental health professionals present will be powerless to prevent the person leaving the premises. This applies when the individual absconds or where a decision has been made to detain the person but the paperwork to authorise compulsory detention has not yet been completed. In these circumstances the person is clearly at increased risk of harm. When a warrant has been obtained, the restraint of the person to prevent them leaving the premises is allowed.

These examples illustrate that where police attendance is sought because of concerns about safety then it is preferable that a warrant be sought.

Police attendance to promote cooperation

Police assistance is also sometimes sought to promote the cooperation of the person to be assessed. These are generally situations where previous experience suggests that the person will be significantly more cooperative if a police officer is present. However, this is not necessarily sufficient reason for the police to attend. Other relevant factors will include how much information is available, the availability of officers, possible tactics in relation to various scenarios (for example, entry with consent, entry executed by warrant and rapid entry), and the effect on current operational demands.

6.8.3 Overall Responsibilities

- The AMHP has overall responsibility for coordinating the process of assessment (unless it has been agreed otherwise locally);
- The AMHP is responsible for briefing all non-police personnel (such as medical practitioners) on the situation;
- The police are responsible for controlling the operation for the purposes of entry into the premises;
- The police are responsible, where a warrant exists, for ensuring the safe containment of any risks;
- The AMHP is responsible for making and implementing any application for admission to hospital.

6.8.4 Joint Planning Process

Planning the mental health assessment on private premises can be by any means (for example, by telephone or in person) and should involve discussing the following points:

- Whether entry is to be by means of a warrant or by consent;
- If entry is by warrant, the method by which the police will gain entry and secure the premises;
- That if entry is without a warrant, the police will only enter and remain on the premises if they are satisfied that they are doing so with consent, until the AMHP has completed the admission papers and the person is deemed to be in legal custody;
- The possibility of passive resistance and the planned response;
- Consideration of equality, diversity and human rights issues;
- When and how the AMHP will brief non-police personnel to ensure that each participant is fully aware of the plan for carrying out the assessment, including dealing with contingencies, and the role of each agency;
- How any contingencies will be managed, for example, if the person leaves the premises before the completion of the assessment, or consent is refused or withdrawn at any stage, or spontaneous risks arise in situations where a warrant does not exist.

6.8.5 Powers for Police Attendance without a Warrant

Where the police agree to attend a mental health assessment on private premises without a warrant, the preventive powers accompanying a warrant will not apply. Officers who attend in these circumstances, can, however use the following powers in response to spontaneous situations where the risk of harm is likely (for example, events involving violence, self-harm or absconding).

- **Section 17(1)(e) Police and Criminal Evidence Act 1984** – permits entry to premises to save life or limb;
- **Section 3 Criminal Law Act 1967 3(1)** – ‘A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large’;
- **Sections 5 and 6 Mental Capacity Act 2005** – provides protection for decision makers who decide to use restraint in certain circumstances, including where necessary to prevent self-harm.

6.8.6 Addressing Concerns about Warrants

Health and social care professionals have expressed a number of concerns about warrants.

Executing a warrant can create unnecessary tensions

The existence of a warrant does not mean that it must be executed, either immediately or at all. Where officers assess that the warrant does not need to be executed on arrival, the decision is theirs. If officers later assess that lawful access to the premises is required (perhaps because permission to be there has been withdrawn) they can decide to execute the warrant at that point.

Where a warrant exists, police officers will immediately remove the person to be assessed from the premises – as is permitted under section 135(1)(b) – and take the person to a place of safety

Officers should not normally remove the person to a place of safety prior to completion of the assessment. They should only do so if there is a valid and appropriate reason for immediate removal – such as extreme violence, serious medical risks or other grave dangers.

Where consent to entry is given or likely to be granted, a warrant is not required and an application for a warrant in such circumstances would be unlawful

This is not the case. The presence or absence of consent for access is not relevant to whether a warrant is granted under section 135(1). When an application for a warrant is made, it is necessary only to satisfy the court of the matters stated in that subsection. However, because entry in this way is an interference with a person's private and family life it must be justified under Article 8(2) of the ECHR. As such, where a section 135(1) warrant is being sought and consent to entry has been given or is likely to be given, then this should be clearly explained to the court (see over).

6.8.7 Applying for a Section 135(1) Warrant

Although it is the responsibility of the AMHP to apply to the court for a section 135(1) warrant under the MHA 1983, the police can increase the likelihood of the warrant being granted by providing information to help construct a report to magistrates in support of the application. Topics could include:

Subject

- Show full details.

Grounds

- What information is known to demonstrate that this subject has been violent, has threatened violence, has self-harmed or absconded or attempted to abscond?
- What information is known to indicate that other people likely to be present on the premises may increase these risks or be violent themselves?
- What causes you to believe that the above risks apply, for example, recent information from contact with the person, the person's, family, neighbours or friends?
- What other information is known that highlights further areas of risk, for example, the person is known to carry or use weapons?
- In light of the above risks, set out that a warrant is sought for the following reasons and quote all that apply:
 - a warrant will allow the person to be restrained or contained in an area of the premises, thereby preventing the person entering other areas of the property where access to balconies/weapons may be obtained (refer to *R Regina (Munjaz) v Mersey Care NHS Trust and Others*; *Regina (s) v Airedale NHS Trust and Others* [2003] EWCA Civ 1036, [2004] QB 395);
 - a warrant will permit a degree of control of others within the premises to ensure the safety of everyone present, thereby reducing the risks highlighted earlier in this application (refer to the case of *DPP v Meaden* [2003] EWHC 3005 (Admin), [2004] 1 WLR 945, 953 and the case of *Connor v Chief Constable of Merseyside Police* (2006) EWCA Civ 1549 [2007] HRLR 6);
 - in the event of attempting to abscond or self-harm, a warrant will allow immediate removal of that person.

Other considerations

- Where it is expected that consent to entry will be granted – particularly in the case of shared premises where a co-occupier permits access – point out to the magistrates in the application that a warrant is not being sought to gain entry but to permit the management of the risks highlighted that cannot safely be managed without a warrant.
- It could also be pointed out that if violence occurs and a warrant is not available, the police would need to detain for a breach of the peace or a criminal matter. This would mean the service user would be taken immediately to a police station, which is a less suitable environment and would delay any mental health assessment.

6.8.8 A Section 135(2) Warrant

A warrant under section 135(2) allows the police to enter and take someone already liable to be detained (for example, someone who has gone absent without leave (AWOL) from hospital). This warrant can be obtained by a constable or someone else authorised by the MHA to take a patient to any place or to retake a patient. In practice this could be, for example, a member of staff from the hospital where the person went missing.

When an application under section 135(2) is made (eg, for entry to retake an AWOL patient), it is necessary to satisfy the court that entry has been refused or refusal can be anticipated.

6.8.9 Executing Section 135 Warrants

According to section 135(4) MHA 1983:

- When executing a warrant issued under section 135(1) a constable **must** be accompanied by an AMHP and by a registered medical practitioner;
- When executing a warrant issued under section 135(2) a constable **may** be accompanied by a registered medical practitioner.

The law, therefore, allows the officer to be accompanied by someone with the power to retake the patient, and good practice is that they should be accompanied by such a person.

6.8.10 Passive Resistance and Refusal to go to Hospital once Detention is Authorised

Even when papers have been completed authorising detention in hospital, a person sometimes refuses to leave the premises and go to the ambulance. The person may not display or threaten violence but simply declines to go. Effective, prior joint planning should previously have considered how passive resistance and other contingencies will be dealt with. Examining the following factors may assist in resolving the situation:

- Reason for the person refusing to go to hospital;
- Any concerns the individual has, such as security of their home or care for a relative or animal;
- Any medical or physical factors that need to be taken into account;
- Physical risks to the patient by lifting them against their will;
- Risks of not immediately removing the person to hospital;
- Risks posed to others (such as the police or healthcare professional) should they lift the person.

Common sense and respect for the individual indicates that persuasion should be the first option. If persuasion fails, however, and the person remains passively resistant, there are further options:

- The police can stand by to prevent a breach of the peace while the AMHP and/or ambulance staff lift the person and remove him or her from the premises;
- The police can lift and remove the person from the premises if authorised by the AMHP (as the applicant) and under their guidance. Where ambulance staff are in attendance, any police intervention of this kind should be undertaken in their presence.

Where no violence is exhibited or threatened, it does not have to be the police who physically lift or remove the person. Ambulance staff or members of other health and social care agencies can also be authorised by the AMHP to do this. Although the AMHP can authorise removal by a police officer, they cannot direct the police to act. The decision whether or not to use the delegated power rests with the police officer.

All agencies should have an agreed protocol in place which makes clear the legal powers of individual agencies and sets out who will be responsible for physically dealing with passive resistance incidents.

6.8.11 Hostels and Hotel Rooms

The requirement for a warrant to enter rooms within hostels and hotels to carry out an assessment can generate considerable debate between the police and mental health professionals. Where a part of the premises is exclusively occupied by an individual, the consent to enter that person's particular area is not always clear. The case *R v Rosso (Rosario)* [2003] EWCA Crim 3242; [2003] MHLR 404 provides some helpful guidance when deciding on the requirement to obtain a warrant in these kinds of situations.

In this case the subject of the assessment was detained by the police, who forcibly entered a room without a warrant. The room entered was not exclusively occupied by the subject and was, in fact, a TV room that others could also use. The test applied by the court (at paragraph 19) as to whether a warrant would be required included the following considerations:

- Does the occupant have a right to exclusive occupation of the room?
- Does the occupant have a right to exclude others from the room?
- Does the occupant have the right to deny access?

It could be argued that where a hostel or hotel room is occupied exclusively by the occupant, that person does have the right to exclude others from the room; and in the absence of clear legal advice to the contrary, a warrant would be required for a mental health team and accompanying police officers to enter without consent. Tenancy agreements may be used by hostel managers to provide access to hostel rooms; this might include, for example, reasons such as to carry out cleaning and maintenance. Even where an agreement exists, it may not necessarily allow the entrance of a team of police officers, ambulance crew and community mental health team staff without the occupant's consent. Where doubt exists, a warrant should be sought and the application for the warrant should clearly set out the access and consent issues in relation to the premises, leaving the court to decide.

6.9 Spontaneous Mental Health-Related Incidents in Private Premises

Spontaneous mental health incidents in private premises can come to attention in various ways:

- Occasions when the police are called by the occupier of private premises, or another member of the public, to assist with a person with mental ill health;
- While already on premises dealing with other issues, it may become apparent to an officer that a person with mental ill health is in crisis;
- An AMHP may have visited a person in the community to conduct an assessment without the police, and unforeseen circumstances such as violence or threats of violence make it necessary to call for police assistance.

6.9.1 Police Powers at Spontaneous Incidents

Entry to private premises is normally only legal if consent is given by the individual or a co-occupier, or a warrant has been granted under section 135(1) of the MHA (see **6.7.2 Entering Private Premises**). Where no warrant exists, however, police do have limited powers in relation to entering premises to deal with spontaneous incidents. For example, where a breach of the peace is in progress or anticipated, entry is possible to arrest the individual or prevent the breach. Similarly, entry is justified under section 17 of PACE where there are sufficient grounds to arrest for an indictable offence and under section 17(1)(e) of PACE for 'saving life or limb or preventing serious damage to property'.

Where circumstances do not necessitate the use of the powers outlined above, it is unlikely that power to enter and deal with the person without their consent will be available. In these cases there will be various options, including:

- Where the AMHP is present, the police should be guided by the AMHP's advice;
- Where police are present at premises without an AMHP, they can refer the person to an AMHP and then leave the premises;
- The officer might be able to persuade the owner of the premises (or possibly the person him or herself) to permit the police to enter the premises, and request an AMHP to attend urgently.

6.9.2 Supervision

Where an AMHP is unable to attend quickly and the use of police powers is inappropriate, it will normally be unreasonable to expect officers to remain for a long period waiting for an AMHP to arrive. In these types of circumstances (ie, no powers to enter and no AMHP is immediately available) a police supervisor should make decisions about whether the police should remain. The supervisor should consider the risks to the individuals themselves, police officers and others. Where the MCA applies, consideration can be given to using this, although use of the MCA should always be the final resort, and used in the least restrictive way. It should not be used to circumvent the application for and use of a section 135(1) warrant. Local multi-agency protocols should address this kind of situation.

6.10 Missing Persons and Individuals Absent Without Leave Who Are Subject to the MHA

Multi-agency arrangements for police responses to people who are missing or absent without leave from mental health establishments should reflect **ACPO (2010) Guidance on the Management, Recording and Investigation of Missing Persons, Second Edition** and **ACPO (2007) Update to the Guidance on the Management, Recording and Investigation of Missing Persons 2005**. In some cases **ACPO (2007) Practice Advice on Critical Incident Management** may also be relevant. In all cases policies on the use of national information systems, for example, PNC, should be followed to ensure that information is recorded appropriately, particularly when individuals present a risk to themselves or others.

As a matter of good practice, the police need to be aware that persons reported as being missing from home are often also reported as being depressed and suicidal. Thus, when a report of a missing person is received, the police should always consider whether the person missing has or might have mental ill health or learning disabilities as this could affect any risk assessment and response to the report.

6.10.1 Definition of Absent Without Leave

Within the context of the MHA, the meaning of absent without leave in relation to patients detained in hospital is if the patients:

- Have left the hospital without their absence being agreed by their responsible clinician; or
- Have failed to return to the hospital at an agreed time or when their leave of absence has been revoked; or

- Are absent (without permission) from a place where they are required to reside as a condition of their leave of absence from the hospital.

The term can also be applied to supervised community treatment (SCT) patients who have failed to return to hospital when recalled, or who subsequently abscond from hospital. In the context of SCT, recall occurs when the patient's responsible clinician requires the person to return to hospital. Revocation of an SCT order occurs when the patient's responsible clinician requires the patient to be subject to detention in hospital once more. Patients subject to guardianship are considered to be absent without leave when they are absent (without permission) from the place they are required to live by their guardian.

Chapter 22 of the MHA Code of Practice for England (and Chapter 29 of the MHA Code of Practice for Wales) describes the powers of a range of professionals and individuals in such circumstances, including apprehending the person and returning them, and the use of restraint and sedation where necessary for safe transport.

6.10.2 Multi-Agency Protocols on Patients Who Are Missing or Absent Without Leave

Through multi-agency protocols, police forces should work with other agencies to reduce repeat reports of missing persons and ensure more effective multi-agency responses. This includes the appropriate use of systems for reporting people missing and recording unauthorised absences (for example, people that have not returned at an agreed time).

While the focus should always be on the vulnerability of the individual, reports can usefully distinguish between:

- Those who are repeatedly missing;
- Those for whom being missing is unusual;
- Those who are late returning and are not necessarily missing.

Protocols should ensure that risk assessment and management are linked to a reporting strategy that ensures that a report of someone missing does not trigger an automatic response. It should be expected, for example, that all reasonable steps have been taken to discover the whereabouts of patients before reporting them missing to the police.

When an individual overstays his or her authorised absence, the situation should be evaluated. In some cases the hospital may extend leave to allow the individual to return – for example, where an individual’s transport arrangements are delayed or where family circumstances have caused a delay. However, if the risk assessment indicates the person’s discovery to be critical, the police should be notified immediately and local protocols followed (including, where necessary, a press strategy).

Protocols should include:

- Timescales for reporting particular kinds of cases and details of the nature of any local preventive strategies and measures of their effectiveness;
- Communication strategies so that partner agencies understand the effects on police resources of reporting someone missing;
- Agreements about actions following the return of a missing person, including a debriefing process which involves checks relating to the individual’s safety and wellbeing, his or her whereabouts and behaviour while missing and that there are no ongoing concerns, such as allegations of abuse in the institution or any offending while the person was missing.

6.10.3 Information Required by the Police

When the police are involved in a situation where individuals subject to compulsion under the MHA are absent without leave, it is vital for them to have access to all information necessary to make an effective response. While the decision to share information remains with the health professionals, the police may, for risk assessment purposes, quite properly request some of the following information:

- The circumstances of their absence;
- Exact conditions and circumstances of their detention;
- Description and photograph;
- Details of any medication, effects of its withdrawal and the consequences of not taking medication;
- Social history (for example, family, friends and other contacts);
- Any significant recent events which could be relevant including the behaviour of the individual prior to going missing;
- Details of any risk assessment (for example, any individual at risk as a result of the person’s absence or risk to the missing persons themselves);
- Whether MAPPAs are involved with the individual;
- Enquiries which have taken place to establish the person’s whereabouts.

6.10.4 Searches of Mental Health Establishments

In general, the police should not need to search the establishment from which the individual is missing. This should be undertaken by the person(s) responsible for the establishment, who will be familiar with the location including potential hiding places. They will then confirm to the police that the person is missing and identify any information (for example, a suicide note or letter from the person) about where they may possibly be or their intentions.

6.10.5 Powers to Detain Individuals Who Are Absent Without Leave

Where a patient is absent without leave (within the meaning of the MHA) the police powers to detain the missing patient arise out of section 18 of the MHA. The police power is purely to return individuals to the hospital from which they went missing (or the place where they are required to reside). There is no power to hold people at a police station or to remove them to another place of safety.

The section 18 MHA power to detain people who are AWOL and return them to hospital also applies to an AMHP, any officer on the staff of the hospital or any person authorised in writing by the managers (such as a private security firm). Local protocols should, therefore, ensure that the police are only involved in such situations in exceptional circumstances.

6.10.6 Powers of Entry Relating to Individuals Who Have Escaped or Are Absent Without Leave

Where the police wish to enter private premises to detain a person who is AWOL and return them to the place from which they are AWOL, they should attempt, wherever possible, to secure entry by permission. Without such permission, entry may only be made under the terms of a warrant obtained under s135(2) MHA 1983. Although such a warrant can only be executed by a police officer, the officer may be accompanied by healthcare professionals connected with the patient's care.

6.10.7 Police Involvement in Detaining and Transporting Individuals Who Are Absent without Leave

Police assistance in returning a patient to hospital should not be considered a matter of routine. According to the MHA Code of Practice for England, responsibility for the return transport arrangements rests with the hospital, as follows:

Where a patient who is absent without leave from a hospital is taken into custody by someone working for another organisation, the managers of the hospital from which the patient is absent are responsible for making sure that any necessary transport arrangements are put in place for the patient's return.

(Paragraph 11.27)

When making arrangements for the return of patients temporarily held in police custody, hospital managers should bear in mind that police transport to return them to hospital will not normally be appropriate. Decisions about the kind of transport to be used should be taken in the same way as for patients being detained in hospital for the first time.

(Paragraph 11.29)

If the patient's location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.

(Paragraph 22.13)

Similar guidance is given in Chapter 9 of the MHA Code of Practice for Wales.

If a person is returned to the hospital from which he or she is absent without leave and no bed is available, this is also a matter for the health staff and not the police. In general, the individual should be left with the health staff. In certain circumstances, for example, where a high level of risk exists, the police may decide to remain with the patient until a bed is made available.

Despite the clarity around responsibility (that it does not lie with the police), the police may encounter a situation where the hospital from which the patient is absent without leave declines to provide transport to collect the individual. If negotiation between the officer and person in charge of the hospital does not achieve a suitable resolution, the police may have to decide to take the lead at that time and transport the individual to the hospital (from which he or she is AWOL). The police should ensure that the issue is taken up at a strategic level in line with local protocols.

6.10.8 Police Role in Supervised Community Treatment (SCT)

Supervised community treatment (SCT) under the MHA enables detained patients to be released from hospital for treatment in the community, effectively permitting them to live at home. The patients are still under the care of a responsible clinician and the hospital managers are responsible for them, but they are permitted to live in a community setting. The order releasing them from hospital and placing them into the community is known as a Community Treatment Order (CTO).

Recall occurs when the responsible clinician requires the person to return to hospital in response to evidence of relapse or high-risk behaviour relating to mental disorder before it becomes critical and leads to the patient or other people being harmed. The recall notice can be served:

- By hand to the patient, in which case it is effective immediately;
- By first class post to the patient's usual or last known address, in which case it is effective on the second business day after posting;
- By hand to the patient's usual or last known address, in which case it is effective on the day after being delivered, ie, after midnight on the day it was delivered.

Once the recall notice has been served, the patient is immediately liable to be returned to hospital under section 18 of the MHA in the same way as a patient who is absent without leave. The power of arrest under section 18 is available if required.

Responsibility for coordinating the recall lies with the patient's responsible clinician. If the patient's location is not known, however, it may be entirely appropriate for the police to be involved in the search and to take the patient into custody if they find them.

6.11 Police Involvement with Patients Presenting Management Problems

Health authorities may ask for police assistance in relation to patients presenting management problems. Whenever the police are involved in reports from health settings, they should consider, among other things, the potential vulnerability of those patients and service users (for example, their susceptibility to abuse).

6.11.1 Requests for Police Assistance

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.

It may be appropriate to call for police assistance when:

- Insufficient numbers of trained staff are available to cope with the situation (for example, in emergency cases of sickness absence);
- The situation is clearly beyond the capability of the staff to manage the patient safely (for example, because the person is armed, or a hostage situation has arisen);
- A breach of the peace or other offence is anticipated;
- It is an emergency and the person needs to be detained in a place of safety that is not the current facility.

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.

6.11.2 Decision Making Relating to Patients Presenting Management Problems

Where a patient presents management problems, factors indicating a situation where police involvement might be appropriate are outlined in **6.2.1 Factors to Be Considered**. In addition, the following issues should be considered before deciding on the police response:

- Whether the person is a voluntary inpatient or detained in hospital under the MHA;
- The risk of harm to the patient and others;
- Risks presented by the hospital environment (for example, balconies, windows, medical equipment);

- Full circumstances leading to the call for the police;
- Details of assistance that hospital staff require from the police;
- Powers that healthcare staff are acting under;
- Whether healthcare staff trained in control and restraint are available;
- Whether the patient has a weapon;
- Whether information about the individual is held on police information systems;
- Risks that exist if the police restrain the patient;
- Any medical issues, including those that could be exacerbated if restraint is used;
- Whether there are any medical staff present at the scene to cope with a medical emergency (for example, if the patient collapses);
- Whether healthcare staff are making a criminal complaint and how this may best be investigated (see **7.7 Criminal Offences in Health and Social Care Settings**).

If at all practicable, and to avoid improvising at the scene, partner agencies should meet before going to an address so as to share information and intelligence, plan and agree the command structure and set up contingencies.

6.11.3 Police Responses and Powers to Intervene

There are no explicit sections within the MHA that empower the general restraint, search or control of hospital patients. Following a number of case law findings, however, **hospital staff** do have implied powers to control, restrain and search patients detained under the longer-term sections of the Act (for example sections 2, 3, 37). This particular authority does not extend to police officers. In general, it will be police powers to preserve order and prevent crime which are relevant in such cases.

Provided it would not increase the risks involved, containing the risk of harm and negotiating with the individual should be considered. It may be useful to consider requesting a hostage negotiator for advice or to attend the scene in accordance with local arrangements. In some cases it will be appropriate for the police to stand by to prevent a breach of the peace while a healthcare control and restraint team restrains the patient.

Where it is necessary for the police to become actively involved in the restraint, there are four main options: detention and restraint for the prevention of a crime under section 3 of the Criminal Law Act 1967; breach of the peace powers to detain, where harm or damage to property is likely to be done; restraint and use of force under section 5 of the MCA to prevent a serious deterioration in health; arrest where a criminal offence has been committed.

In the case of the first three points above, once the person has been restrained and is under control, responsibility for the person should be handed back to hospital staff. In the case of the last point, with the advice and consent of the clinician in charge, the patient can be taken to the police station, preferably accompanied by a member of the healthcare staff to assist in his or her care.

6.11.4 Administration of Medicines

Police assistance should not normally be required to enable medical staff to administer medication, even when restraint is used. The legislation requires health organisations to have sufficient trained staff to handle such situations. However, if medication needs to be given to an individual by force, and certain conditions exist (see **6.11.1 Requests for Police Assistance**), or there are other exceptional circumstances, police help may be needed to assist medical staff with restraint.

6.11.5 Recording Information about Patients Presenting Management Problems

Any request for police assistance, and the action subsequently taken by the police should be recorded. Where restraint has been used, or an injury is apparent or alleged, it may be necessary for a doctor to document any injuries. The Mental Health and Learning Disabilities Liaison Officer should review these records regularly, and where necessary (for example, for appropriate action at a strategic level) bring them to the attention of the BCU commander or ACPO lead (see **8.2 Staff Roles and Responsibilities**).

7

Operational Police Responses to Suspects and Offenders

This section summarises the police responses to suspects or offenders experiencing mental ill health or who have learning disabilities, particularly when they are in police custody. It should be read in conjunction with relevant national and local guidance, including:

- *Office for Criminal Justice Reform (forthcoming) Guidance on the Balance Between Criminal Justice Action and Mental Health Care;*
- *ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody.*

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7.1 Responses to Suspects or Offenders with Mental Ill Health or Learning Disabilities

The most important consideration for the police when dealing with a suspect or offender with mental ill health or learning disabilities is whether the situation requires:

- A criminal justice response alone;
- A social care or healthcare response alone;
- A combination of responses.

Once this is clear, the nature of that response can be decided (including arranging assessment by trained mental health professionals where necessary). Recognising mental vulnerability as early as possible provides the best opportunities for improving responses to suspects or offenders who have mental ill health or learning disabilities (see **3.1 Recognising Mental Ill Health or Learning Disabilities**).

7.2 A Combined Response

When a suspect is experiencing mental ill health or has a learning disability, conducting a criminal investigation should not be seen as an alternative to a healthcare response. If there is a need for both, the two responses should take place alongside each other. For example, where someone is in police custody following arrest for an offence, the investigation and case disposal process can still continue and run alongside any mental health assessment that takes place while the person is in custody. For more information see **6.4.4 Decision to Use Section 136**.

7.3 Healthcare in Police Custody

Police custody is a key stage at which an individual's mental health needs can be identified and assessed. Healthcare professionals currently working in police custody areas include Forensic Medical Examiners (FMEs), private healthcare providers, directly employed custody nurses, paramedics, ambulance staff and liaison services. Outreach services can be facilitated by community psychiatric nurses (CPNs).

7.3.1 Protocols and Support

Forces should ensure that local protocols make it clear that it is the role and function of health professionals in the custody environment to assist the police in accessing relevant healthcare facilities when required. For example:

- Where an assessment is being carried out at the police station under the MHA for a person detained under section 136, doctors approved under section 12 of the MHA should be available in order to enable speedy assessments;

- Where the police or a healthcare professional in the custody suite have recognised that an individual has mental ill health or learning disabilities, the services of an appropriate adult should be obtained as quickly as possible.

Support may need to take a number of forms. For example:

- Given the high level of speech, language and communication needs among young suspects and offenders, forces should consider the availability of speech and language therapists to assist in communications in police custody, in partnership with PCTs and Children and Young People's services. Similarly, those providing translation and interpretation services should include individuals with experience of mental health issues.
- National Occupational Standards for healthcare professionals in police custody have been developed by Skills for Health (see <http://www.skillsforhealth.org.uk>). For further information see **ACPO (2006) *Guidance on the Safer Detention and Handling of Persons in Police Custody*** and PACE 1984.
- Drug or alcohol arrest referral workers in the police custody environment can assist by
 - providing support to those with mental health issues in terms of referring them to services (see also **2.2.4 Dual Diagnosis**).
 - providing advice to police personnel on matters relating to mental health services. In some cases this will require additional training and a review of the role of such workers.

7.3.2 Commissioning and Budgetary Responsibility

Healthcare in police custody is currently a police responsibility. Among other shortcomings, the interventions commissioned by police forces and carried out by FMEs in custody suites have few links to provision in the community. **Bradley (2009) *The Bradley Report*** and **Department of Health (2009) *Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board*** have recommended that the NHS and the police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS at the earliest opportunity. Such arrangements should:

- Enable healthcare provision that takes place within police custody to be conducted to standards operating in community health services (with provision for the specific nature of medical care in police custody);

- Enable referral and diversion to community based health and social care agencies where this is appropriate, thereby overcoming current barriers to effective diversion caused by the limited and disconnected provision of healthcare within police custody.

7.4 Diversion from a Criminal Justice Response

7.4.1 Definition

This guidance supports the definition of diversion from **Bradley (2009) The Bradley Report:**

‘Diversion’ is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence.

The Bradley Report, 2009, p 16

The term diversion is predominantly used in the context of those suspected or convicted of criminal offences and can apply at different stages in the criminal justice response. For example:

- Diversion from the criminal justice system altogether by: a decision not to invoke the criminal law (for example, by concluding that a criminal offence has not occurred); by recording a criminal offence according to National Crime Recording Standard (NCRS) but not taking any further criminal justice action; or by discontinuing a prosecution (for example, following a decision by the CPS that charging is not in the public interest);
- Diversion from prosecution by use of a fixed penalty notice, caution or conditional caution, reprimand or final warning;
- Diversion from prison by a hospital order, guardianship order, non-custodial sentence, fine or discharge.

Diversion at the first two stages involves decisions by the police and CPS but may involve other agencies at various points depending on the circumstances. Diversion from prison involves decisions by the court, which should be supported by information from the police, CPS and other relevant agencies.

7.4.2 Change of Emphasis

All diversion decisions involving people with mental ill health or learning disabilities require a balance between the rights of the suspect and the victim and the protection of the public. They also require multi-agency collaboration at some level (for example, referral to community health or social care services, voluntary admission to hospital or compulsory admission under the MHA). It is this multi-agency working that achieves effective long-term responses to people's mental ill health or learning disabilities – the emphasis being on what they are diverted **to** not **from**.

7.4.3 Criminal Justice Liaison and Diversion Schemes or Services

There is no agreed definition of what constitutes a liaison or diversion scheme as the services they offer can vary. Not all geographical areas are supported by such services or teams and there is no national list of such schemes at the moment. In **Bradley (2009) The Bradley Report** Lord Bradley identifies four main types of scheme (although many teams combine one or more of these tasks):

- Assessment – focuses on identifying and assessing people at an early stage through the police or courts to minimise the need for assessment while remanded in prison;
- Liaison – offers advice and support to those with mental ill health or learning disabilities and to other agencies and may also be involved in supporting a person through the criminal justice process;
- Diversion – focuses on increasing the identification of mental ill health or learning disabilities and accelerating transfer to hospital or secure health facilities where assessed as appropriate;
- Panel – brings together a range of agencies including the police, health, social care and probation to agree a coordinated package of care for the consideration of the CPS and courts usually in relation to mentally disordered suspects or offenders with mental health problems.

Liaison and diversion schemes can operate in police stations, in courts or in both. Such services are relevant to victims, witnesses, suspects and all people with mental ill health or learning disabilities with whom the police have contact, particularly in relation to ensuring continuity of care. All schemes should be integrated into mainstream policing services as appropriate in order to make maximum use of resources.

7.4.4 Benefits

These schemes can provide support, advice and other services to both the police and individuals with mental ill health or learning disabilities at all stages of the police response, for example, those accessing such services (including appropriate adults, custody officers and neighbourhood policing team officers), those taking reports and hearing complaints from members of the public, duty solicitors and those working with victims and witnesses. The schemes can assist them in supporting individuals and can become a conduit for information exchange, contribute to training and assist in monitoring police responses.

Other benefits can include:

- Early screening and identification of mental ill health or learning disabilities, including the completion of an initial assessment that can be subsequently built upon by other professionals;
- Early identification of particular needs, for example, an appropriate adult for a suspect or special measures for a victim or witness;
- Information and advice to a range of CPS, probation and court staff, including those making sentencing decisions;
- Providing a central coordinating point for information sharing between agencies and multi-agency arrangements (eg, MAPPA);
- Informed decision making in relation to charging and prosecution, risk assessments and court decisions (including those relating to fitness to plead, bail, remand and sentencing);
- Savings in police time as a consequence of not having to prepare a criminal justice file.

7.4.5 The Bradley Report and 'Improving Health, Supporting Justice'

Bradley (2009) The Bradley Report recommends that all police custody areas have access to liaison and diversion services, and recognises the benefits of an arrangement that involves joint funding, secure budgets, an active steering group, a development plan and the ability to access a large number of clients.

As a suggestion, Lord Bradley recommends the extension and enhancement of the Criminal Justice Mental Health Team (CJMHT) concept. In England the requirement for a CJMHT is included in the standard NHS contract for mental health and learning disabilities, but only on a non-mandated basis. While there is little consistency in either make-up or mode of operation, these teams are currently supported by a number of police forces. They typically comprise an integrated, multi-disciplinary arrangement that:

- Provides assessments in police and other custodial environments for persons who have, or are suspected of having, a mental health need;
- Works with, and accepts, referrals from police and others (such as FMEs, forensic psychiatric services, court cell security staff, probation, solicitors, court personnel, prison staff, inpatient and community mental health services);
- Provides specialist education sessions and teaching packages to:
 - raise awareness within the criminal justice and mental health professions;
 - assist in the facilitation of appropriate care and supervision of mentally disordered offenders within the community and custodial environments.

The national delivery plan of the Health and Criminal Justice Programme Board, 'Improving Health, Supporting Justice' (2009), reiterates the function of the criminal justice mental health teams, as described by Lord Bradley, but suggests that the precise nature of delivery and service configuration must be determined by local needs and priorities. Liaison and diversion services, together with the other reforms to health and criminal justice systems will help to address the objectives that Lord Bradley identified for these teams. With this in mind, forces should examine their existing arrangements to ensure they operate effectively.

7.4.6 Forms of Diversion for 'Mentally Disordered Offenders'

Home Office Circular 66/90 requires that diversion for mentally disordered offenders be considered before a decision on charging is made, and that mentally disordered offenders should, wherever possible, receive health and social care as an alternative to being punished by the criminal justice system.

Diversion requires collaboration between the police and health and social care agencies, and could take the form of:

- Removing the suspect to a place of safety under section 136 MHA;
- Arranging for psychiatric assessment to be carried out;
- Referring the suspect to community health services;
- Facilitating the person's voluntary admission to hospital.

7.5 Criminal Justice Response

The basic elements of the criminal justice response (for example, arrest, caution, detention, legal rights and interviewing) are the same whether or not a suspect has mental ill health or learning disabilities. In circumstances, however, where individuals are experiencing mental ill health or have learning disabilities they may have additional rights, for example, to be interviewed in the presence of an appropriate adult.

7.5.1 All Available Information

To be Bichard-compliant, managers need to ensure that, when the police investigate someone over an allegation of criminal offending, pertinent information is captured. Even in cases where some form of diversion is being considered, information systems should be in place to record relevant details and to ensure that a full history can be built up to assist in both current and future decision making by the police and other agencies. In instances, however, where the police have decided to divert someone from a criminal justice response to a mental health response (and have, therefore, concluded that no further criminal justice action will be taken), the amount of information recorded will be **limited**. Careful consideration will be required before disclosing any of that information, or using it for other criminal justice purposes.

Some specialist multi-agency liaison (or diversion) schemes which operate in a range of locations (including police stations) may have their own information systems that hold relevant details about a particular person.

In general, where a decision involves a diversionary rather than a criminal justice response (by the police alone or with other agencies) the views of any victim should be considered. In some instances this may result in a situation where a decision to divert ends up being contrary to the victim's wishes.

7.5.2 Consideration of Individual Circumstances

There should not be a presumption either for or against prosecution, but each case should be judged on its individual circumstances. This position is consistent with **Office for Criminal Justice Reform (forthcoming) Guidance on the Balance between Criminal Justice Action and Mental Healthcare**. It entails consideration as far as possible of all aspects of people's behaviour and history – including present and previous offending – and their health needs.

7.5.3 Application of PACE Code C

The conditions of police custody are governed by PACE Code C and detailed national guidance is contained in **ACPO (2006) Guidance on The Safer Detention and Handling of Persons in Police Custody**. Most of the statutory provisions with respect to police detainees apply to all suspects, regardless of any mental ill health or learning disabilities. These include the restrictions on periods of detention, and suspects' legal rights. The statutory provisions for detainees that have most specific relevance to suspects with mental ill health or learning disabilities are those relating to medical attention and the provision of appropriate adults (AAs) to support vulnerable detainees, particularly during interviews.

According to PACE Code C:

If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as such for the purposes of this code.

(Home Office, 2006, PACE Code C, Paragraph 1.4)

7.5.4 Appropriate Adults

Whenever they consider or have been told in good faith that a suspect may be 'mentally disordered or otherwise mentally vulnerable', custody officers must request an appropriate adult to be present (see paragraph 11.15 PACE Code C). This duty remains even if a medical professional's view is that an individual does not meet the formal definition (see **7.5.7 Recognising Mental Ill Health or Learning Disabilities in Suspects**).

Note IG of PACE Code C states that where the custody officer has any doubt as to the mental state or capacity of a person detained, the person should be treated as mentally vulnerable and an appropriate adult called. The appropriate adult can provide support, advice and assistance to the suspect and be present at any interview conducted by the police. This individual can be someone who knows the suspect (for example, their carer, relative or social worker) but it is good practice to use an independent, trained appropriate adult from the local panel. For more information on the role of appropriate adults see **Home Office (2003) Guidance for Appropriate Adults**.

7.5.5 Custody Policies, Procedures and Protocols

Forces should ensure that policies and procedures are in place to manage risk relating to individuals in custody who are experiencing mental ill health or have learning disabilities. In addition, local multi-agency protocols should provide custody officers with information about advice and support available from other agencies. This information may signify previous involvement with mental health services and help to determine the most appropriate response.

7.5.6 Legal Rights

The particular consideration with respect to suspects with mental ill health or learning disabilities is whether they are able to understand and thereby exercise their rights. The police should inform patients detained in police custody as a place of safety that their detention is under section 136 MHA 1983 and is for a period not exceeding seventy-two hours for the purpose of:

- Enabling them to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional, and
- Making any necessary arrangements for their treatment or care.

In relation to people detained in police custody, PACE 1984 requires that the police inform them that another person may be notified of their whereabouts (PACE section 56) and they have the right to free legal advice or access to a solicitor (PACE section 58). All people detained in police custody are entitled to consult a copy of the PACE Codes of Practice and the custody record.

7.5.6.1 The Right to Silence

Under PACE, minor variations in the wording of the caution are permitted, and 'if it appears that a person does not understand the caution, the person giving it should explain it in their own words' (PACE Code C, notes for guidance 10D). To be fair to the suspect and to avoid any confession evidence obtained in the course of a subsequent interview being ruled inadmissible, officers should make every effort to ensure the person has understood the caution. When in doubt, and where practicable, the interviewer should consider an early assessment by an expert, such as a clinical psychologist, a speech and language therapist or a psychiatrist, to avoid compromising any evidence.

7.5.6.2 The Right to Legal Advice

Section 58 of PACE gives a detainee the right to consult a solicitor, in private, at any time and Section 6 of PACE Code C sets out some of the detail with regard to this right. Police officers should ensure that vulnerable people are aware of and able to access the legal safeguards which are meant to protect them during police detention and interview. These are best ensured by the presence in the station and at interview of a legal adviser – ideally someone with experience of working with mentally vulnerable suspects.

7.5.6.3 Other Considerations

Officers and staff should be aware that:

- The presence of an appropriate adult is not an adequate substitute for legal advice, although an appropriate adult may help to obtain that advice;
- A mentally vulnerable detainee may require extra time and help in understanding the legal process;
- A suspect with mental ill health or learning disabilities is very unlikely to ask for a solicitor.

Sources of advice are contained in **ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody** and the forthcoming NPIA Safer Detention Learning Programme.

7.5.7 Recognising Mental Ill Health or Learning Disabilities in Suspects

The point of initial detention in police custody is often the pivotal moment at which critical decisions and judgements about a suspect need to be made. Where vulnerability owing to mental ill health or learning disabilities is recognised, these decisions will then dictate the nature of any subsequent care and medical intervention the detainee receives. Matters to be aware of include the following:

- Custody staff are expected to have sufficient mental health awareness to recognise that an individual is vulnerable to mental ill health or learning disabilities (see **3.1 Recognising Mental Ill Health or Learning Disabilities**);
- The responsibility on custody officers to identify mental ill health and learning difficulties is for both criminal justice reasons (such as fairness) and to ensure the person's dignity is protected and support is provided;
- As far as possible, forces should ensure that the custody environment is such that individuals are encouraged to disclose their mental ill health or learning disabilities and related concerns.

7.5.7.1 Welfare

The statutory requirements relating to general conditions of detention in police custody are set out in section 8 of PACE Code C. They are also summarised in the 'notice of rights and entitlements' which all detainees are provided with. The key welfare provisions (ie, standards of care) contained in this notice relate to having someone told about the individual's arrest as well as information to the individual themselves about the cell, clothes, food and drink, exercise and what to do if he or she feels unwell. These provisions may have particular significance for suspects with mental ill health or learning disabilities, especially if they have difficulties with communication. In addition, their condition can mean that physical and environmental issues can be as great a source of anxiety and distress as other matters such as legal rights. Of note, people who have autism or Asperger syndrome are often highly sensitive to their environment and, for example, loud noises or bright lights can cause distress and possibly even aggressive behaviour.

7.5.7.2 Clinical Attention

If the detainee appears to have a mental disorder, the custody officer – under PACE Code C, paragraph 9.5C – must make sure the person receives appropriate clinical attention as soon as reasonably practicable. Under paragraph 9.5A, this applies even if the detainee makes no request for medical attention. Clinical examinations must be carried out by an appropriate healthcare professional which, under recent revisions to the PACE code of practice, can include a nurse or paramedic as well as an FME. (See **ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody** and **Home Office Circular (020/2003) Healthcare professionals in custody suites – guidance to supplement revisions to the Codes of Practice under the Police and Criminal Evidence Act 1984** on the roles and responsibilities of healthcare professionals in custody suites.) Each police force should develop a policy on inter-agency working with health services to ensure that mentally disordered detainees receive such clinical attention as they require (see **Home Office Circular (12/95) Mentally Disordered Offenders: Inter Agency Working**).

7.5.8 Fitness for Detention and Interview

A suspect's identifiable mental health issue or learning disability may or may not, in itself, necessitate medical attention, or the disability may be associated or co-exist with physical or psychiatric problems that do need attention. The key issues to be addressed by the custody officer are whether the detainee is fit to be detained and, if so, whether he or she is fit to be interviewed. Healthcare providers in custody can provide advice regarding fitness to be detained or interviewed (see **7.3 Healthcare in Police Custody**).

7.5.8.1 Fitness for Detention

According to **British Medical Association (2009) Healthcare of Detainees in Police Stations** (paragraph 1.4), the specific issues to be addressed in assessing fitness for detention are as follows:

- Assessment of illness, injuries and drug and alcohol problems;
- Advice to the custody officer on general care whilst in custody;
- Provision of necessary medication;
- Referral to hospital;
- Admission under mental health legislation.

As the thresholds for fitness for detention and fitness to plead are different, prosecution may still be appropriate if a person is assessed as not fit for detention.

Custody records should record whether fitness to be detained or interviewed has been assessed, and these records should be made available to the CPS so that they are aware of any potential mental ill health and/or learning disability (see **7.10 Crown Prosecution Service**). For more details see **British Medical Association (2009) Healthcare of Detainees in Police Stations, Second Edition**.

7.5.8.2 Change of Fitness Status

In a case where an individual is not fit for interview and is in the care of a hospital, local protocols should be in place to ensure that medical staff inform the police as soon as the individual is deemed fit for interview or charge. Appropriate arrangements can then be made to interview the person at the hospital, or for the person to be brought to the police station for further interview and/or further investigation.

7.5.9 Access to Support while in Custody

Forces should ensure that all individuals in custody have access to support and care as appropriate. Custody officers should be familiar with the availability of, and means of contacting, individuals and groups such as:

- Local appropriate adult schemes;
- Medical staff;
- Drug and alcohol arrest referral workers and any other systems established by DAATs;
- Local voluntary and community agencies that work with people with mental ill health or learning disabilities (see **Appendix 3 Useful Websites**);
- Other support services.

7.5.10 Information Sharing in Custody

Relevant information about individuals in police custody and the circumstances in which they came to be in custody should be collected and included in custody records. It should also be included in the Person Escort Record (PER) form, which provides a standard system for listing and assessing risks associated with individual detainees when they are escorted or transferred between locations. Where people are experiencing mental ill health or have a learning disability, this information will help with decisions such as those around fitness to plead and the need for remand in custody, bail or hospital. For more information see **ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody**.

When the police have reason to believe an individual in police custody has mental ill health or learning disabilities, they should ensure that they share that knowledge with key criminal justice professionals, including legal advisers, approved mental health professionals (AMHPs), appropriate adults and the CPS.

Any passing of information to other agencies should be in accordance with local information-sharing protocols (see **3.4 Information Sharing**).

7.5.11 Interviewing Suspects

General provisions relating to the police interview are contained in paragraph 11 of PACE Code C. The particular vulnerability of some suspects in police interviews is explicitly recognised in paragraph 11C:

Although ... people who are mentally disordered or otherwise mentally vulnerable are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information that may be unreliable, misleading or self-incriminating. Special care should always be taken when questioning such a person.

(Home Office, 2006, PACE Code C, Paragraph 11C)

For reasons made clear in the above paragraph, a suspect who is 'mentally disordered or otherwise mentally vulnerable' should only be interviewed in the presence of an appropriate adult.

7.5.11.1 Fitness for Interview

Not all those with mental ill health or learning disabilities will be vulnerable interviewees or would wish to be treated as such.

According to **British Medical Association (2009) Healthcare of Detainees in Police Stations, Second Edition** (paragraph 1.4) the specific issues to be addressed in assessing fitness for interview are:

- Assessment of competence to understand and answer questions;
- Where the patient is mentally ill or mentally vulnerable, advising on the need for an appropriate adult;
- Advising on any special provisions required during interview.

Annex G of PACE Code C deals specifically with fitness for interview; paragraph 3 states that the following should be considered in any assessment:

- How the detainee's physical or mental state might affect their ability to understand the nature and purpose of the interview, to comprehend what is being asked and to appreciate the significance of any answers given and make rational decisions about whether they want to say anything;
- The extent to which the detainee's replies may be affected by their physical or mental condition rather than representing a rational and accurate explanation of their involvement in the offence;
- How the nature of the interview, which could include particularly probing questions, might affect the detainee.

The healthcare professional's advice to the custody officer with regard to the suspect's fitness for interview should be made in writing and form part of the custody record. If a person with mental health problems is judged by a healthcare professional to be fit to be interviewed, and then has to wait some time to be interviewed (perhaps because it is at night), special care should be taken to ensure that they are not unduly distressed – or at risk of harm – bearing in mind the person's vulnerability.

7.5.11.2 Interviewing Style

The quality of an interview depends heavily on the skills of the interviewer. Where the police know or suspect someone they want to interview has mental ill health or learning disabilities, they should treat them as vulnerable and provide care and support as appropriate. Suspects with known or suspected learning disabilities, for example, will always require support during an interview in order to ensure they understand what is being said and to facilitate their participation. The use of a communications expert may be required.

Guidance on how best to interview vulnerable people can be found in **ACPO (2009) National Investigative Interviewing Strategy**.

7.5.12 Bail Arrangements

People with mental ill health or learning disabilities have the same right to bail as anyone else and, in the same way, each case must be examined on its merits. The police must ensure that sufficient information is available to the CPS so that prosecutors can recommend the appropriate course of action to a court in connection with the decision whether or not to grant bail.

Where people are to be bailed and have been assessed as having mental ill health or learning disabilities, the police must ensure that they understand:

- The conditions of their bail conditions (for example, that they can tell the time in order to meet curfews);
- What the conditions mean in practice;
- The consequences of disobeying the set conditions.

For further information see Bail Act 1976, Bail (Amendment) Act 1993 and **CPS (2008) The Director's Guidance on Charging**.

7.5.13 Custody Exit and Aftercare Strategies

All forces should ensure that this guidance is considered as part of their implementation of the custody exit and aftercare strategies arising from **ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody**. For example, forces should agree with partner agencies an exit and aftercare strategy for those released from custody which includes, as appropriate, an assessment of a particular individual's vulnerability and potential mental health or social care needs and referral to appropriate services (see **3.5 Pathways to Care**).

Protocols should be in place with partner agencies to ensure that the services and support offered by agencies to individuals on their release from custody are agreed. This will allow intervention to be provided to those who cannot find it for themselves or are not supported to do so. As well as being positive for the individual concerned, this referral will impact on the possible offending stimuli for that individual and thus reduce reoffending and future demand on the police.

Such protocols should take into account the fact that release is not to be delayed pending the provision of a relevant service from another agency. For example, where someone is arrested for a (minor) criminal offence and the decision is taken in police custody to divert them to health, the person should be diverted from the police station as soon as possible, and, in any event, within twenty-four hours of their arrest. A supervisor's intervention and other types of assistance may be necessary to liaise with health and social care agencies in situations where many hours (or even days) are likely before a bed is available. Any delay puts the police in a difficult legal position and should be avoided.

7.6 Disposal

After arresting a suspect and undertaking initial investigative work, the police will be required to choose between possible courses of action. The police often exercise a considerable degree of discretion in determining the disposal and if the suspect has mental ill health or learning disabilities, this can, but does not necessarily, impact on the decision taken.

The major options available are as follows.

- Police can **discontinue** the investigation because of lack of evidence or because prosecution is not believed to be in the public interest.
- The suspect can be released on **police bail** pending further investigation, in the expectation that further evidence may be forthcoming.
- A formal **caution** can be issued, if the suspect admits the offence and gives informed consent to a caution and the offence is not serious. CPS guidance states that the use of cautions for suspects with mental ill health or learning disabilities can be difficult because of the requirements for the suspect to admit the offence, agree to the caution and understand its implications. If there are doubts about a suspect's level of understanding or the truthfulness of his or her admissions, a caution is inappropriate.

- The suspect can be **charged** where sufficient evidence is available and prosecution appears to be in the public interest. If the case is minor and straightforward, the police can charge; otherwise, the case must be referred to the CPS for the decision on charging. Following the charge, the police must decide whether to remand the suspect in custody or release him or her on bail pending the first court appearance – unless the suspect has been compulsorily or voluntarily admitted to hospital. As an alternative to charging, the CPS has the option of issuing a **'conditional caution'**, to which restorative or rehabilitative conditions are attached.
- Police can liaise with local health and social care services for the purpose of **diverting** the suspect into treatment or support, in view of their particular psychological or psychiatric needs. Some forms of diversion could be combined with a formal caution.

7.6.1 Charging Decisions

There should be no undue delay in charging decisions. If the suspect is mentally disordered or otherwise mentally vulnerable, PACE Code C (Annex E, paragraph 11) specifies that where the decision has been taken to proceed with a prosecution, the resulting action – primarily the charging – should be undertaken in the presence of an appropriate adult. The appropriate adult's presence is required, however, only if that person is already at the police station. There is no power under PACE to detain a person and delay action solely to await the arrival of the appropriate adult (PACE paragraphs 16.1; 16C).

7.6.2 Penalty Notices

Penalty notices for disorder are sometimes issued in relation to incidents when an individual is exhibiting distressing or alarming behaviour. When deciding whether to issue a caution or penalty notice in such circumstances, or to apply for an anti-social behaviour order (ASBO) (see **7.6.4 Anti-Social Behaviour Order**), it is vital that the police ensure the person actually understands the conditions of any notices or restrictions. They should, together with the CPS where appropriate, obtain information about an individual's possible mental ill health or learning disability prior to a penalty notice being issued, or for the pre-sentence report if the penalty notice for disorder is breached. For further information see **Home Office (2005) Criminal Justice and Police Act 2001 (s.1-11) – Penalty Notices for Disorder: Police Operational Guidance**.

7.6.3 Cautions and Conditional Cautions

In relation to decision making when issuing cautions, appropriate information can be found in ***CPS (2008) Legal Guidance on Prosecuting Mentally Disordered Offenders***. This includes the following:

A caution or conditional caution will not be appropriate if there is any doubt about the reliability of any admissions made or if the defendant's level of understanding prevents him or her from understanding the significance of the caution or conditional caution and giving informed consent. It should not be assumed that all mentally disordered offenders are ineligible for cautioning or conditional cautioning, but there is no definition of or restriction on the particular form of mental or psychological condition or disorder that may make an admission unreliable.

(*R v W* [1998] Crim LR 211).

The police are responsible for collecting information which will enable decisions about cautioning to be made.

A person's particular health or social care need(s) may also be relevant when deciding on conditions when a conditional caution is considered appropriate. Conditional cautions were introduced by the Criminal Justice Act 2003 and cannot be issued by the police (see ***Home Office (2004) Conditional Cautioning: Criminal Justice Act 2003, Sections 22-27: Code of Practice and associated annexes***).

7.6.4 Anti-Social Behaviour Order

An ASBO may be considered appropriate for someone experiencing mental ill health or with learning disabilities if a case concerns relatively minor nuisance behaviour that is part of a pattern (see ***Home Office (2002) Implementing Anti-Social Behaviour Orders: Messages for Practitioners***). When considering an ASBO for people with mental ill health or learning disabilities, the police should consult partner agencies (for example, to help develop an acceptable behaviour contract for the suspect). The contract should focus on positive aspects of the individual's behaviour, and should be written in a way which is clear for the individual to understand.

The ***Sentencing Guidelines Council (2009) Definitive Guidelines on Breach of ASBOs*** states that 'mental illness or disability' is a mitigating factor in the breach of ASBOs.

Bradley (2009) The Bradley Report recommends that ‘Information on an individual’s mental health or learning disability needs should be obtained prior to an Anti-Social Behaviour Order or Penalty Notice for Disorder being issued, or for the pre-sentence report if these penalties are breached’. For further information see **Sainsbury Centre (2007) Briefing Paper – Anti-Social Behaviour Orders and mental health: the evidence to date**.

7.6.5 Ancillary Orders

Where there is a risk of further offences, prosecutors should consider what ancillary orders it may be appropriate to apply for, such as restraining orders. For example, Section 12 of the Domestic Violence, Victims and Crime Act 2004, which came into force in September 2009, enables the court to impose a restraining order in a wide range of circumstances – other than just on conviction for any offence and on acquittal, as was previously the case. In suitable cases the police may also liaise with victims or their carers or the social services as to whether to seek a civil injunction under section 3 Protection from Harassment Act 1997, a Part IV order under the Family Law Act 1996, or an Anti-social Behaviour injunction under the Housing Act 1996.

7.6.6 Statements of Evidence

In cases where the police have reason to believe a prosecution is plainly needed, but the suspect appears to have mental ill health or learning disabilities, it may be appropriate to obtain an independent medical report. The police should encourage health professionals to put their views in writing, but they have no legal obligation to do so in the form of a ‘statement of evidence’.

According to **CPS (2008) Legal Guidance on Prosecuting Mentally Disordered Offenders**

It will not usually be necessary for the information about the defendant’s mental state to be in the form of a statement before it can be considered. However, the information should be in writing and prosecutors must be satisfied that it is reliable before taking any decision based on it.

The CPS guidance, however, recognises that some serious cases require a more formal response. In particular, this relates to cases where a prosecution is plainly needed but there is clear evidence that continuing the case would be likely to result in a permanent deterioration in the defendant’s condition. In order to satisfy the prosecutor’s requirement for **clear evidence**, the medical report about the defendant’s mental state should be in the form of a statement of evidence.

If health professionals will only express a verbal opinion, the police should make a written summary of what was said so that it can still be considered by the CPS.

7.6.7 No Further Criminal Justice Action

Where officers have identified an individual with mental ill health or a learning disability – and use their professional judgement to decide that no further criminal justice action is appropriate, or they have given the individual a formal warning – then they will usually need to liaise with local health or social care services, and either direct the individual to those services or make a formal referral in line with local agreements. Forces should ensure that officers have the appropriate training and knowledge about any such local agreements.

Although this type of routine multi-agency working is key to all aspects of the criminal justice response – and no further criminal justice action is appropriate in many instances – some learning disability agencies report that their members are repeatedly not charged for petty crimes because of their condition and consequently are not learning why what they did was wrong. Liaising with support services can provide the officer with more information as to the individual's history of offending behaviour so that the most appropriate response is provided.

7.7 Criminal Offences in Health and Social Care Settings

People with mental ill health or learning disabilities who are living in a therapeutic setting may commit criminal offences or have offences committed against them. Others may witness offending and victimisation. In general, normal investigative processes should be used. Owing to particular vulnerabilities and challenges, however, forces should ensure that local multi-agency protocols address the matter of suspected abuse in institutions to be reported and investigated (including how evidence from patients and service users will be facilitated). Local protocols should also cover audit trails for recording requests for information and police assistance at health-related facilities (and the responses to those requests). For more information see **3.6.2 Multi-Agency Protocols**.

7.7.1 Violent and Sexual Offences

Forces should ensure that multi-agency protocols on violent offences in health and social care settings reflect existing national guidance, for example, **ACPO (2005) Guidance on Investigating Serious Sexual Offences**, **ACPO (2007) Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders** and **ACPO (2009) Practice Advice on Investigating Stalking and Harassment**.

7.7.2 Drugs Offences

Substance use in health and social care settings can have a dangerous and disruptive impact on service users and mental health environments. Local agreements between police forces and other agencies about the police response to drugs offences in such settings should reflect this and include arrangements for reporting and monitoring possession and use of illegal drugs, collecting evidence, searching patients and disposing of confiscated substances and paraphernalia.

For further information see **Department of Health (2006) Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings: Guidance on the assessment and management of patients in mental health inpatient and day hospital settings who have mental ill-health and substance use problems**.

7.7.3 POVA and other Safety Considerations

The Protection of Vulnerable Adults (POVA) list was set up under the Care Standards Act 2000. Since January 2009, it has been administered by the Independent Safeguarding Authority (ISA). The list contains the names of care workers who have harmed a vulnerable adult, or placed a vulnerable adult at risk of harm, whether or not in the course of their employment. These people are then banned from working in a care position with vulnerable adults. In cases where a care worker working in a registered care home, a registered domiciliary care agency or a registered adult placement scheme has been dismissed, transferred or suspended on grounds that he or she has caused harm or posed a risk of harm to a vulnerable adult, the police should check that the necessary referral has been made to the ISA to place the person on the POVA list.

In October 2009 ISA launched a new vetting and barring scheme covering all those working directly with children and vulnerable adults, not just those in occupations covered by the present list. It is now a criminal offence for individuals barred by the ISA to work or apply to work with children or vulnerable adults in a wide range of posts – including most NHS jobs, Prison Service, education and childcare. Employers also face criminal sanctions for knowingly employing a barred individual across a wider range of work. The POVA list will be replaced in 2010 by a new ISA-banned list. Further information about the ISA and the vetting and barring scheme can be found at <http://www.isa-gov.org.uk>

7.8 Court Orders and Sentences

The police and the CPS have a key role in providing information that will be relevant to the decisions of courts and others in relation to sentencing, the use of orders and the release of offenders, and for making arrangements with other agencies for the enforcement of sentences and orders. As well as providing information, the police will sometimes need to be given information – for example, about the potential risks of an individual being released on conditional discharge (see **7.8.1 Hospital Order and Guardianship Order**).

The courts have specific guidance relating to sentences and court orders (see **Ministry of Justice (2008) Mental Health Act 2007: Guidance for the courts on remand and sentencing powers for mentally disordered offenders**). Police personnel should understand the meaning of court orders relating specifically to people with mental ill health – and their limitations – so they can carry out their responsibilities in connection with them.

Information about court orders available for the protection and care of children is provided in **ACPO (2009) Guidance on Investigating Child Abuse and Safeguarding Children**.

7.8.1 Hospital Order and Guardianship Order

Hospital Orders and Guardianship Orders (under section 37 of the MHA) allow a court to (a) send a person to hospital for treatment or (b) make a person subject to guardianship when otherwise the outcome might have been imprisonment, a fine or a community order. The orders can be made by a crown court or magistrates' court. Relevant issues are as follows.

- Under section 37(3) of the MHA, magistrates can make a Hospital Order or Guardianship Order without recording a conviction if the offender has a mental disorder and they are satisfied that the individual committed the act as charged. There is no minimum age for a hospital order, but there is a minimum age of 16 for guardianship.
- Under section 37 of the MHA, a Hospital Order or Guardianship Order will only be made if the court is satisfied, on the written or oral evidence of two doctors, that the offender has a mental disorder of a nature or degree that makes detention for medical treatment appropriate and that the appropriate medical treatment is available for him or her. The court must also take into account all the relevant circumstances, including the past history and character of the offender and alternative methods of dealing with him or her, and establish that a hospital order is the most suitable option.
- When the crown court imposes a Hospital Order, it may also make a Restriction Order under section 41 of the MHA, where it is necessary to protect the public from serious harm. This order puts restrictions on the patient's discharge, transfer or leave of absence from hospital without the agreement of the Secretary of State for Justice. Magistrates do not have the power to make such an order but can commit a person aged 14 or over to the crown court for such an order to be attached (see section 43(1) of the MHA).
- A person subject to a Restricted Hospital Order can subsequently be discharged conditionally into the community, subject to recall to hospital by the Secretary of State. The Mental Health Casework Section in the Ministry of Justice is responsible for overseeing the management of these offenders including applying delegated powers relating to conditional discharge under section 42 of the MHA. Conditionally discharged patients will usually be supervised by both a clinical supervisor and a social supervisor. Supervisors are responsible for submitting updates to the Ministry of Justice, reporting on compliance with conditions, current mental state and the current level of risk.

Police forces and partner agencies should use the MAPPA process to ensure that details of those subject to Hospital Orders or Guardianship Orders with or without restrictions are recorded and referrals made to MAPPA as appropriate. These details should include information about impending leave arrangements, tribunal hearings and discharge plans.

The mental health unit responsible for an individual subject to a Hospital Order and Restriction Order under the MHA should inform relevant police forces about actions relating to conditionally discharged patients that may affect communities, including the nature of conditions, supervision and support measures in place, nature of the mental ill health and the current level of risk.

Where possible, such information sharing should take place as part of the MAPPa process to ensure that there is an effective police and multi-agency response in place. Where a single point of contact (SPOC) system exists between health agencies and MAPPa this can be used to coordinate the information shared with other agencies including the police.

If individuals breach the conditions of orders and are recalled by the Ministry of Justice, they become detainable under section 18 of the MHA in the same way as any other patient.

7.8.2 Community Order with Mental Health Treatment Requirement

Under the Criminal Justice Act 2003, courts can develop bespoke Community Orders. The Community Order replaced all previous community sentence options in 2005, and gives judges and magistrates a choice of options to issue to offenders as an alternative to prison. These include issuing a mental health treatment requirement (MHTR) where a person aged 16 years or over who has been convicted of an offence agrees to undergo medical treatment for their mental health condition (see sections 177 and 207). The courts must be satisfied that the individual is 'susceptible to treatment' but does not need to be admitted compulsorily to hospital under the MHA and that arrangements have been, or can be, made for treatment to which the offender has given consent.

Police forces and partner agencies should use the MAPPa process to ensure that details of those subject to MHTRs are recorded and referrals made to MAPPa as appropriate.

Although the MHTR could potentially serve a significant proportion of offenders on community sentences, there has been little uptake of the MHTR in England and Wales since its implementation in 2005 (see ***Sainsbury Centre for Mental Health (2009) A missed opportunity? Community sentences and the mental health treatment requirement***).

From November 2009, the Youth Rehabilitation Order (YRO), a generic community sentence for young offenders which will combine a number of existing sentences into one basic and flexible sentence, replaced almost all other community sentences for people under 18. This more individualised risk and needs-based approach sets out eighteen requirements that can be added to the construction of a YRO. One of these is a mental health treatment requirement. For more information see <http://www.yjb.gov.uk/en-gb/practitioners/CourtsAndOrders/CriminalJusticeandImmigrationAct/#yro>

7.9 MAPPA and Offenders with Mental Ill Health or Learning Disabilities

In a small number of instances, some people with mental ill health or learning disabilities may also be sexual and/or violent offenders or PDPs. Information about the management of such individuals can be found in *Ministry of Justice (2009) MAPPA Guidance, Version 3* and *ACPO (2007) Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders*.

In accordance with *Ministry of Justice (2009) MAPPA Guidance, Version 3*, the local MAPPA coordinator should be informed whenever a MAPPA offender is released from a secure mental health unit. Other circumstances in which information sharing and multi-agency action will need to be considered in the context of an offender with mental ill health or learning disabilities include:

- Evidence of increasing risk behaviour including offending linked to risk of harm to others and any serious adverse incidents involving dangerous behaviour;
- Any police contact (for example, relating to section 136 of the MHA);
- Complaints from the public about the individual's behaviour;
- Any court orders in relation to the individual including ASBOs, restraining orders or injunctions.

Some areas have developed a SPOC system to coordinate the link between the health agencies and MAPPAs. This SPOC can act as a source of advice, liaison and support between MAPPA and healthcare professionals, including assisting with referrals to MAPPA and decisions on information sharing. As part of the MAPPA process, consideration will be given to providing victims of crime with relevant information, for example, when an offender is discharged from hospital (see **7.8.1 Hospital Order and Guardianship Order**).

7.10 Crown Prosecution Service

Decisions made by the Crown Prosecution Service (CPS) are pivotal to the effective working of the criminal justice system. Some CPS areas have specialist prosecutors for offenders with mental ill health or learning disabilities. In addition to ***CPS (2004) The Code for Crown Prosecutors***, the CPS uses ***CPS (2008) Legal Guidance: Mentally Disordered Offenders***.

In cases of minor offences where the police have taken the initial decision to charge, the CPS may decide to discontinue a prosecution. Under the ***CPS (2004) The Code for Crown Prosecutors*** (paragraph 5.10(g)), this can happen if the defendant is an older person or is, or was at the time of the offence, suffering from significant mental or physical ill health (unless the offence is serious or there is a real possibility that it may be repeated). The CPS takes account of the views and recommendations of health and social care professionals, but their agreement is not required as the basis for decisions about prosecution.

In cases where the CPS has responsibility for making the decision to prosecute, the police need to provide as much information as possible to enable consistent and fair decisions. This includes any information they have on an individual's mental ill health or learning disabilities. The information provided to the CPS should include:

- Whether the offence is serious and relates to public protection or relates to a minor infringement of the law;
- Whether the offence is part of a series of offences or a pattern of offending behaviour which requires intervention by the criminal justice system for the protection of the public;
- Whether the mental health issue has affected the individual's criminal responsibility for his or her actions;
- The views and personal statement of the victim (where appropriate);
- The views of other agencies and whether the individual's needs would be better addressed by an appropriate health or social care response.

It would also be useful to provide the following, where known:

- Diagnosis (if any) and the date and result of any assessment (eg, by CJMHTs, FME or MHA practitioner);
- Details of current or planned treatment and involvement with mental health or learning disability services – especially whether the suspect or offender is receiving treatment as an informal or voluntary inpatient;
- Details of any additional services provided to the offender, such as the assistance of a speech and language therapist during interview.

The police should work with the CPS to ensure that victims are kept informed by explaining to them any decisions made which affect the criminal justice process. Relevant guidance can be found in ***CPS (2008) Legal Guidance: Mentally Disordered Offenders***.

7.11 Roles of other Agencies in Decision Making

Partner agencies (within the criminal justice system and outside it) have a key role to play in decisions relating to suspects and offenders with mental ill health or learning disabilities. One method of ensuring effective decision making, information sharing and action is to establish a multi-agency panel with representatives from a range of criminal justice (including Youth Offending Services) and health and social care agencies.

There are useful lessons to be learnt from MAPPA and Regional Offender Health teams (which, among other things, tend to screen and monitor offenders for mental health problems). The multi-agency panel could, for example:

- Consider the circumstances of the offence and the alleged offender;
- Determine the most appropriate action in each case (on the basis of agreed referral criteria);
- Make decisions which balance the needs of the individual with those of society in general;
- Provide support for the use of pre-court disposal methods, for example, diversion and restorative justice – see **7.4 Diversion from a Criminal Justice Response**.

Such a panel could be used as a multi-agency information sharing forum for complex cases of suspects or offenders with mental ill health or learning disabilities and could identify areas where needs are not being met. When decisions about a suspect have been made, the panel could also ensure that any victim of the offending is provided with support and an explanation of such decisions. The panel could also usefully provide advice for decisions made by the CPS.

8

Managing Police Responses

In relation to the police role in responding to people experiencing mental ill health or who have learning disabilities, this section describes:

- **Their major roles and responsibilities;**
- **The training structures and systems which should be in place within police forces to ensure the effective management of such responses.**

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8.1 Approach

It is vital that the police provide a nationally consistent, fair and effective response to people with mental ill health or learning disabilities. This includes recognising their needs, providing support and referring them to other agencies as required. The guidance is relevant to all operational officers and police staff involved in direct service delivery in this area of policing, managers, supervisors and chief officers. It will also be used by police authorities, the Inspectorates (for example, HMIC), the Independent Police Complaints Commission (IPCC) and others to monitor the quality of police responses to people with mental ill health or learning disabilities.

Chief officers should consider:

- Incorporating this guidance into force policies, standard operating procedures and existing multi-agency protocols between the police and other agencies as they relate to police responses to people with mental ill health or learning disabilities;
- Developing and sustaining new partnerships and protocols with both statutory and voluntary health and social care bodies, to enable more effective responses to people with mental ill health or learning disabilities;
- Ensuring that all officers and staff are able to recognise signs of mental ill health or learning disabilities and provide the necessary level of support (eg, in accordance with the forthcoming NPJA Mental Ill Health Learning Programme);
- Ensuring this guidance, or a summary of its key points, is disseminated to staff.

8.2 Staff Roles and Responsibilities

8.2.1 ACPO Lead with Responsibility for Mental Ill Health or Learning Disabilities

Appropriate support at a senior level is essential to the development of effective responses to people with mental ill health or learning disabilities, both within the Police Service and in partnership with other agencies. To ensure such responses, each force should appoint an ACPO officer with lead responsibility for this area. This individual should provide strategic leadership within the force by ensuring the following:

- Multi-agency protocols are established and implemented (see **3.6.2 Multi-Agency Protocols**).

- Appropriate links are made at a strategic level with healthcare, social care and housing agencies. Examples include engagement with the executive director lead for mental health in local health boards (in Wales), the directors of the PCTs and mental health trusts (in England) and directors of adult social services and children's services. A mental health and learning disabilities liaison officer and/or BCU commander could assist with this role as appropriate.
- The force is actively involved in regular strategic multi-agency meetings, such as DAATs, LCJBs, MARACs, CDRPs (England only), community safety partnerships (CSPs) (Wales only) and MAPPAs. Responsibilities should include oversight of the issues listed in **3.6 Multi-Agency Partnerships**.
- The role of a force mental health and learning disabilities liaison officer (eg, working to an action plan approved by the senior management team).

8.2.2 Basic Command Unit Commander

BCU commanders have the following responsibilities:

- Internal performance monitoring within the BCU area to ensure consistent and appropriate police responses, including ensuring the monitoring of performance as suggested in this guidance (see, for example, **3.6.4 Performance Monitoring** and **3.6.5 Performance Measures**);
- Leadership to ensure that all staff in his or her area of responsibility fulfil their responsibilities as set out in this guidance and local procedures, and are supported with the appropriate training and knowledge to do so.

Depending on the arrangements within a force, a BCU commander may also take responsibility for some of the multi-agency issues listed as responsibilities of the ACPO lead. For example, each BCU should consider, if it has not done so already, establishing a police, mental health services and ambulance liaison committee, with representatives from each of the services, as well as consumer and carer representatives. It would be good practice to include the Fire Service and voluntary agencies that specialise in mental health. The committee should meet on a regular basis to discuss local issues regarding the interaction between services and discuss and resolve problems that may arise. In particular, the committee should review all cases in their area which involve a person being transported by the police rather than by ambulance, and discuss options to help minimise this.

8.2.3 Mental Health and Learning Disabilities Liaison Officer

It is good practice for forces to appoint a mental health and learning disabilities liaison officer; each force that currently does not have one is expected to strongly consider this. The liaison officer's role is to ensure appropriate police responses to issues relating to mental ill health or learning disabilities at the level of the force and BCU, including partnership working, risk management, problem solving and effective internal and external communication.

Depending on the local arrangements and role profile within a force, this role may be undertaken by one or more individuals. For example, there may be a lead on strategic issues and a lead with responsibility for operational responses, or responsibilities may be divided geographically.

According to local force requirements, responsibilities may include:

- Acting as a single point of contact (SPOC) for internal and external queries relating to mental ill health or learning disabilities;
- Disseminating relevant information and guidance within the force and to other agencies as appropriate;
- Promoting understanding and good practice relating to mental ill health or learning disabilities within the police force;
- Monitoring compliance with national and local guidance and policies in relation to service provision and outcomes;
- Maintaining operational links with partner agencies (including the CPS) and resolving any difficulties at an operational level (see **3.6 Multi-Agency Partnerships**);
- Working with partner agencies (including AMHPs, hospitals and ambulance services) to agree and monitor performance, such as that required by the MHA Code of Practice for England and the MHA Code of Practice for Wales in relation to sections 135 and 136 of the MHA 1983;
- Developing and maintaining contact details of staff in key partner agencies (for example, those at designated places of safety and local mental health services);
- Providing advice on engagement and links at the force level with agencies that support and advise people with mental ill health or learning disabilities;
- Ensuring that force training, in conjunction with the NPJA, remains relevant and up to date and is delivered to all staff as appropriate;
- Reporting to senior management on national initiatives and development relating to this guidance;
- Raising with senior managers any problems which cannot be resolved at the operational level.

In some forces the Custody Inspector already fulfils many of these duties, being in a good position (and having the knowledge and experience) to resolve issues quickly and effectively.

8.2.4 Supervisors

Supervisors are responsible for encouraging, facilitating and monitoring the professionalism of their staff. In relation to police responses to people with mental ill health or learning disabilities, supervisors need to ensure that the behaviour, attitudes and performance of those under their control reflect organisational ethics, values and standards, and thereby enhance the force's reputation. More importantly, effective supervision is crucial to ensuring that people with mental ill health or learning disabilities receive the service they deserve.

8.2.5 Frontline Officers and Staff (including Police Community Support Officers and Specials)

Police officers are often the first on the scene of incidents involving people with mental ill health or learning disabilities. According to their particular roles and responsibilities, all officers and staff need to contribute to ensuring an appropriate response. This includes assessing different types of risk (for example, to self and others). While the diagnosis of specific conditions is an unreasonable expectation, all staff in direct contact with the public should know how to recognise the possibility of mental ill health or learning disabilities and how to respond appropriately. See **3.1 Recognising Mental Ill Health or Learning Disabilities** and **3.2 Communication**. The type of training in this area will vary depending on the person's role. For further information see **8.3 Staff Training**.

Staff should also have access to, and be aware of, the local health and social care services as appropriate to their role. This should include awareness of referral pathways and protocols for facilitating appropriate access to health and social care and children's services (see **3.5 Pathways to Care**).

Effective force policies and procedures and multi-agency protocols (see **3.6.2 Multi-Agency Protocols**) can provide support to staff in exercising their responsibilities, as can formal risk assessment tools and aides-memoire.

All managers and policy leads who make strategic decisions about frontline policing should also have adequate training in this area.

8.2.6 Neighbourhood Policing Teams

Neighbourhood policing teams (NPTs) have a key role to play in helping to improve the police response to people with mental ill health or learning disabilities. NPTs should focus on:

- Conducting an inventory of multi-agency services available to support people with mental ill health or learning disabilities within their area, including how these can be accessed and how they fit and work together, for example, referral processes and SPOCs (see **3.5 Pathways to Care**);
- Establishing and maintaining effective working relationships with statutory and voluntary health and social care agencies where such relationships do not already exist;
- Identifying individuals in their area who may have mental ill health or learning disabilities and facilitating access to, or help from, other agencies where support or treatment is not already in place;
- Identifying, assessing and managing situations where individuals are a risk to themselves or others;
- Identifying services to support victims and witnesses with mental ill health or learning disabilities when they have to appear at court (see **5.1 Victims and Witnesses**);
- Involving relevant agencies in local community consultation events;
- Sharing information about particular individuals as appropriate;
- Including establishments such as sheltered housing projects, care or nursing homes and day projects in patrol and engagement planning. (Schemes such as Hospital Watch can be helpful in this context.)

Some forces have established formal partnerships between their NPTs and specialist outreach workers to facilitate referrals to health services.

8.2.7 Custody Staff

The primary references for the roles and responsibilities of custody staff are PACE Code C, **ACPO (2006) Guidance on the Safer Detention and Handling of Persons in Police Custody**, and the forthcoming NPIA Safer Detention Learning Programme.

Key responsibilities of the custody officer are to determine the grounds and fitness to detain a person and their fitness to be interviewed. In reaching these decisions the custody officer is required to ensure that the necessary safeguards and protections under PACE are applied (PACE Codes C and H in particular). These include access to healthcare and to an appropriate adult where required.

In assessing capacity and risk, custody officers need to be aware that many people are hesitant about disclosing their mental ill health or learning disabilities (see **3.1.2 Other Issues to Be Aware of**). If they identify people as having mental ill health or learning disabilities, they must then ensure that individuals' privacy is protected while at the same time they receive an appropriate response to their needs.

The custody officer is also responsible for determining if a person can be released from custody. A pre-release risk assessment should be carried out and the person informed of relevant support which may be available to them. Where possible, referral to another agency should not take place without the explicit consent of the person but in some cases, in order to protect the individual or others, there will be a legal obligation to inform others. For further information, see **7 Operational Police Responses to Suspects and Offenders**.

Force processes for recruiting healthcare staff such as nurses to police custody areas, should consider the value of a background in mental healthcare (also see **7.3 Healthcare in Police Custody**).

8.2.8 Call Handlers and Contact Management Staff

Police officers and staff in control rooms and call centres, and on public enquiry desks, are often the first to have contact with people with mental ill health or learning disabilities. It is vital that they know how to recognise signs that someone is vulnerable due to such conditions, and that they are able to respond appropriately (see **3.1 Recognising Mental Ill Health or Learning Disabilities**). The majority of those who take up the most police time in relation to calls to police emergency and other police numbers are experiencing mental ill health. Many forces maintain a risk register of such callers so that efforts can be made to work with them to meet their needs while at the same time decreasing any unnecessary use of police resources.

8.2.9 Specialist Policing or Multi-Agency Teams or Services

Besides the groups mentioned in **8.2.5 – 8.2.8**, there are many specialist policing and multi-agency teams or services which may be relevant to the police response to people with mental ill health or learning disabilities. These include:

- Public protection officers (ie, child protection officers or domestic abuse specialists);
- Public protection management teams;

- Investigators – including investigating officers, detective investigators, specialist investigators (ie, child abuse, domestic abuse, hate crime or rape investigators), crime scene investigators and senior investigating officers;
- Specialist investigative interviewers;
- Family liaison officers;
- Firearms officers – Gold Command, Silver Command and Bronze Command;
- Covert and surveillance officers;
- Those in kidnap, hostage and negotiation roles;
- Police trainers (ie, personal safety trainers);
- Police search teams and advisers;
- Police school liaison officers;
- Those on multi-agency public protection panels and other multi-agency forums (for example, youth offending services and drug and alcohol arrest referral schemes).

This guidance should be incorporated into the learning programmes, policies and working practices of all these services (and any others deemed necessary).

8.3 Staff Training

It is not the role of training to provide police officers with clinical skills, but rather to provide sufficient knowledge and awareness to respond confidently to situations involving mental ill health or learning disabilities. Training should include:

- Generic training;
- Specialist training in accordance with particular roles;
- Joint training involving staff from health and social care agencies to promote more effective collaboration between the police and staff from these different agencies.

In ensuring that staff are adequately trained, police forces should take a flexible approach – involving such methods as staff briefings, e-learning, the intranet, supervision processes for individuals and formal training input. Police forces should use national ACPO or NPIA approved training materials where available and appropriate. The forthcoming NPIA Mental Ill Health Learning Programme is particularly relevant and has been developed in partnership with a range of partner agencies.

8.3.1 Foundation Training

The forthcoming NPIA Mental Ill Health Learning Programme sets out the parameters of the national training programme that will be provided to all staff. Forces who wish to do so, are able to provide any additional training to complement the national programme.

Refresher training should also be available to staff to enable them to maintain and enhance their skills and knowledge in relation to mental health. Training should also be provided to police staff in civilian roles, for example, call handlers and front desk staff.

8.3.2 Specialist Training

More specific police training should accompany certain specialist roles. Options for learning include experiential placements with mental health services or attending specialist sessions run by voluntary agencies (for example, Mencap's workshop about communicating with people with profound and multiple learning disabilities who pose specific communication challenges).

8.3.3 Joint Training, Including with Third Sector and Service Users

There is benefit in developing or delivering training in partnership with other agencies. This minimises duplication of effort, maximises the use of training resources, facilitates partnership working and ensures that information is up to date. Similarly, a range of experiences for practitioners that involves interaction with people experiencing mental ill health or have learning disabilities can help to dispel misconceptions and build practitioners' confidence in responding effectively to situations they find themselves faced with. Such training may be especially helpful in relation to developing joint responses to people from BME communities with mental health problems.

This engagement should be at a strategic and policy-making level, and on a day-to-day operational basis. Both formal and informal routes for feedback should be available. A central part of such a framework should be engagement with community groups representing, and providing services and support to, people with mental ill health or learning disabilities (ie, the Third Sector). In addition, service users with mental ill health or learning disabilities should be involved in the planning, development and delivery of training; although appropriate safeguards must be in place to prepare and support such individuals.

8.4 Resources

Members of the Police Service who come into contact with people experiencing mental ill health or who have learning disabilities should have access to:

- A range of places of safety to allow for the most appropriate option to meet the needs of individuals detained under section 136 of the MHA1983;
- A Directory of Services providing information about local services and how to access them, for example, community mental health teams, drug and alcohol teams and crisis teams;

It would be useful for the police to support (where this does not already happen):

- The use of cards (such as crisis cards) that provide summary information about the person in question as well as help to identify a nominated friend or carer;
- A Witness Care Unit (WCU);
- The appointment of a mental health and learning disabilities liaison officer.

8.5 Joint Protocols

Multi-agency partnerships and joint protocols are key to the police providing an effective response to people with mental ill health or learning disabilities (see **3.6. Multi-Agency Partnerships**).

8.6 Service User Consultation and Contribution

As part of the police commitment to citizen-focused services, police forces should ensure that there is an appropriate local framework for service user consultation and feedback on police responses to service users as victims and witnesses, as suspects and offenders or when subject to sections 135 or 136 of the MHA.

Apart from improving service provision and providing opportunities for positive engagement with the police, genuine service user involvement can help recovery, with more people having control over their own lives. Working collaboratively and collectively can help people with mental ill health or learning disabilities feel valued, increase their self-confidence, raise self-esteem and help to reduce the social exclusion that many experience.

To ensure that police obligations and procedures around mental ill health or learning disabilities are properly understood and effective, ideas for forces to consider include:

- Conducting periodical user and carer satisfaction surveys and providing feedback to those involved;
- Establishing a clear and accessible complaints procedure;
- Holding focus groups and listening events;
- Establishing regular 'surgeries' where service users can talk to specific police practitioners about anything crime-related that may be bothering them;
- Working with voluntary agencies;
- Developing systems of short term placements for police officers to spend a time (for example, two days or a week) in either statutory or voluntary local mental health services, as a means of gaining better awareness and greater empathy towards the issues experienced by people with mental ill health problems or learning disabilities;
- Encouraging and supporting service users of mental health and learning disability organisations to sit on police partnership boards (it should be the remit of a senior officer to ensure that this takes place).

8.7 Complaints Relating to Police Responses

Complaints relating to police responses to people with mental ill health or learning disabilities should be subject to the same standards of response as other complaints against the police (whether the complainant is the individual concerned, an onlooker, a carer, family member or a representative of another agency). Some complainants will need particular support through the process to enable them to make use of the complaints process.

Where it is suspected that an individual's repeated use of the complaints system is malicious or vexatious and related to their mental ill health or learning disability, then consideration should be given to seeking advice from the Independent Police Complaints Commission (IPCC). Referral to other specialist agencies may also be necessary.

Forces should consider arrangements to assist with situations that may not involve a formal complaint (for example, someone wants to register that they are not happy with the service received but do not want to make a formal complaint).

For further information about the police complaints system, see ***Independent Police Complaints Commission (2005) Making the New Police Complaints System Work Better.***

8.8 Cooperation between Police Forces

Some situations involving people with mental ill health or learning disabilities require cooperation between police forces (eg, between bordering forces). These may include:

- Missing persons with mental ill health or learning disabilities;
- Those absent without leave from mental healthcare facilities where more than one force is involved (see **ACPO (2007) Update to the Guidance on the Management, Recording and Investigation of Missing Persons 2005**);
- Cases where the police are involved in transporting a person from one force area to another;
- The transfer of court cases involving victims or witnesses with mental ill health or learning disabilities from one WCU in one force area to another in a different county area.

The decision about who accepts responsibility for a particular policing issue should, in general, be decided on the basis of which force is likely to achieve the most satisfactory outcome in terms of a criminal investigation or other matter (for example, securing the safe return of a missing person, providing an appropriate response for the victim).

Police forces also need to consider issues relating to situations where their boundaries are not the same as those of health and local authorities (see **3.6 Multi-Agency Partnerships**). Given that every police force has different geographical aspects to consider, there may be a need for protocols or SLAs to deal with these issues on a regional basis.

8.9 Force Policies and Procedures

Forces should ensure that effective policies and procedures are in place to deliver the requirements and suggestions outlined in this guidance and the many other national documents referred to here. The needs of people with mental ill health or learning disabilities, and others affected by these issues such as carers and families, may also need to be addressed through related policies and strategies (eg, force strategies relating to diversity and disability issues) and standard operating procedures. The guidance also provides information of use to forces in re-negotiating existing protocols or establishing new ones.

Appendix 1

Abbreviations and Acronyms

Abbreviations and Acronyms

ACPO	Association of Chief Police Officers
ADHD	Attention Deficit and Hyperactivity Disorder
A&E	Accident and Emergency
AMHP	Approved Mental Health Professional
APACS	Assessments of Policing and Community Safety
ASBO	Anti-Social Behaviour Order
ASD	Autistic Spectrum Disorder
ASW	Approved Social Worker
AWOL	Absent Without Leave
BCU	Basic Command Unit
BMA	British Medical Association
BVPI	Best Value Performance Indicator
CAIU	Child Abuse Investigation Unit
CCTV	Closed-Circuit Television
CDRP	Crime and Disorder Reduction Partnership
CJS	Criminal Justice System
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CRB	Criminal Records Bureau
CSP	Community Safety Partnership
DAAT	Drug and Alcohol Action Team
DPA	Data Protection Act 1998
DSPD	Dangerous and Severe Personality Disorder
ECHR	European Convention on Human Rights
FME	Forensic Medical Examiner
HMIC	Her Majesty's Inspectorate of Constabulary
HRA	Human Rights Act 1998
IMHA	Independent Mental Health Liaison Advocates
INI	IMPACT Nominal Index
IPCC	Independent Police Complaints Commission
ISA	Independent Safeguarding Authority
IT	Information Technology
LAA	Local Area Agreement
LCJB	Local Criminal Justice Board
LSP	Local Strategic Partnership
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
NCRS	National Crime Recording Standard
NGO	Non-Governmental Organisation
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NPIA	National Policing Improvement Agency
PACE	Police and Criminal Evidence Act 1984
PCT	Primary Care Trust

PDP	Potentially Dangerous Person
PER	Person Escort Record
PHA	Protection from Harassment Act 1997
PNC	Police National Computer
PND	Police National Database
POVA	Protection of Vulnerable Adult
PPAF	Policing Performance Assessment Framework
PSA	Public Service Agreement
SCTO	Supervised Community Treatment Order
SLA	Service Level Agreement
SMAT	Substance Misuse Action Team
SPOC	Single Point of Contact
UK	United Kingdom
ViSOR	Violent Offender and Sex Offender Register
WCU	Witness Care Unit

Appendix 2

Relevant Legislation

Relevant Legislation

Legislation pertinent to this guidance includes (in alphabetical order):

- Crime and Disorder Act 1998;
- Criminal Justice Act 2003;
- Data Protection Act 1998;
- Disability Discrimination Act 1995 (Amendment) Regulations 2003;
- Disability Discrimination Act 1995 as amended by the Disability Discrimination Act 2005;
- Equality Act 2006;
- Human Rights Act 1998;
- Mental Capacity Act 2005;
- Mental Health Act 1983 and Mental Health Act 2007;
- Mental Health Act 1983 Code of Practice for England;
- Mental Health Act 1983 Code of Practice for Wales;
- Police and Criminal Evidence Act 1984 and PACE Codes of Practice;
- Police (Health and Safety) Act 1997;
- Race Relations Act 1976 (Amendment) Regulations 2003;
- Race Relations Act 1976 as amended by the Race Relations (Amendment) Act 2000;
- Section 146 Criminal Justice Act 2003;
- Sex Discrimination Act 1975 (Amendment) Regulations 2008;
- Sex Discrimination Act 1975 as amended by the Equality Act 2006;
- Youth Justice and Criminal Evidence Act 1999.

Relevant Legislation (continued)

The following legislation, parts of legislation or offences may also be relevant to the implementation of this guidance:

- Medicines Act 1968 sections 58 and 63 – supplying, administering or altering the substance of medicinal products;
- Fraud Act 2006 section 4 – abuse of position;
- Domestic Violence, Crime and Victims Act 2004 section 5 – causing or allowing the death of a vulnerable adult;
- Health and Safety at Work etc Act 1974;
- Care Standards Act 2000 sections 24 and 25 – failing to comply with conditions/contravention of regulations;
- Corporate Manslaughter and Corporate Homicide Act 2007 – gross breach of duty of care causing a person’s death;
- Safeguarding Vulnerable Groups Act 2006 – created the Independent Safeguarding Authority (ISA) and vetting and barring scheme for those working with children and vulnerable adults; replaces POVA and Proceeds of Crime Act schemes;
- Public Interest Disclosure Act 1998 – protection for whistleblowers;
- National Assistance Act 1948 – removal of a person from their home if suffering chronic disease or unsanitary conditions and not receiving proper care or attention;
- Health and Social Care Act 2008 – created a new integrated regulator, the Care Quality Commission, for health and adult social care, bringing together existing health and social regulators into one regulatory body, with powers to ensure safe and high-quality services.

Appendix 3

Useful Websites

Useful Websites

The website <http://www.mentalhealth.org.uk/information/organisations-and-websites/> maintains an extensive directory of organisations and websites that deliver mental health services or offer support and information. These organisations and websites cover international, national and local services. They include:

- Alzheimers (national care and research charity)
<http://www.alzheimers.org.uk>
- Developmental Adult Neuro-Diverse Association (Danda)
<http://www.danda.org.uk>
- Hafal (Wales)
<http://www.hafal.org>
- Mencap
<http://www.mencap.org.uk>
- Mental Health Alliance
<http://www.mentalhealthalliance.org>
- Mental Health Equalities
<http://www.mentalhealthequalities.org.uk/>
- Mind
<http://www.mind.org.uk>
- Nacro
<http://www.nacro.org.uk>
- National Attention Deficit Disorder Information and Support
<http://www.addiss.co.uk>
- Neuro-diversity and 'hidden disabilities'
<http://www.key4learning.com>
- Rethink (National Schizophrenia Fellowship)
<http://www.rethink.org/>
- Revolving Doors Agency
<http://www.revolving-doors.org.uk>
- Sainsbury Centre for Mental Health
<http://www.scmh.org.uk>
- Time to Change Anti-Stigma Programme
<http://www.time-to-change.org.uk>
- Victim Support
<http://www.victimsupport.org.uk>

Appendix 4

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