Feedback form for consultation
Authorised Professional Practice (APP)– Mental health
(11 November – 1st January 2016)

Please complete electronically using MS Word and return by **1st January 2016**

Consultation is available at https://www.app.college.police.uk/consultation/mental-health-consultation/introduction-and-strategic-considerations-consultation/

Notes on Use: Add any comment or suggested change in the appropriate box – note the box will increase in size to hold several lines of text if necessary. Please note this is a draft document and during electronic transmission, formatting anomalies may occur. This will be addressed prior to final publication. In view of this, comment or suggested change should be restricted to areas that will have policy, procedural or other specific content impact.

Whilst reviewing this draft Practitioners should consider:

- Is the length and content appropriate?
- Is it easy to understand?
- Is there any information missing or should anything be removed?
- Is there any unnecessary repetition?

We are particularly interested in responses to the specific questions provided at the start of each template.

The template is intended to help you to structure your comments. You may provide as much, or as little, feedback as you wish. There is no requirement to complete every section. Please provide your answer in the comment box under the relevant section/sub-section.

When finished please, email completed document to: mental.health.project@college.pnn.police.uk

If you have any questions regarding the completion of this form, please e-mail contactus@college.pnn.police.uk

Reviewer's Name:	*Paul Tarbuck*
Position Held:	*Head of Healthcare Inspection*
Organisation:	*HMIP*

Completion date:	*22 December 2015*

1. Introduction and strategic considerations

The purpose of the Introduction and strategic considerations page of APP is to provide an overview of the national and international legal context and principles that govern the police response to Mental illness and vulnerability in England and Wales. The primary audience for this page is strategic leaders and champions for MH within forces.

It is our intention that this page will equip new mental health strategic and tactical police leaders with

- an understanding of their responsibilities;
- the requirement for robust and relevant MHA 1983 Code of Practice protocols;
- a structure for proactive management of multi-agency agreements and working practices;
- enough information to support these MH champions to challenge partner agencies and their own forces to improve their response to MH issues.

This page currently provides guidance on the following topics:

- Definitions
- Multi-agency arrangements and MHA protocols
- Information sharing (in the context of MH response)

- Training

This section begins with reference to international and national legal frameworks including disability discrimination and equality - which is useful.

Question 1

Focusing on the definitions provided for :

1) Patient

2) Mental ill health

3) Mentally vulnerable

4) Learning disabilities and difficulties, and neuro-disabilities

- Are there any other key definitions that you would consider useful here?

The section could also define (in order to exclude) developmental disorders (ie, ADHD and Autistic Spectrum) and personality disorder. Otherwise the four definitions cover the relevant areas. This section helpfully stresses the importance of mental vulnerability. The inclusion of neuro-disability is also helpful as acquired brain injury, for example, can have a significant impact both on presentation and on an individual's comprehension processes.

Question 2

Looking at Multi-agency working and information sharing (5-5.1):

- Is there enough information here to support and improve multi-agency agreements and the development of effective

protocols?

If not, what is missing? Please see below

- Are you able to provide any case study examples that may support this section of the guidance?

We do not have any case examples.

This can be anonymised if necessary and might focus on an example of a time that medical information has been shared appropriately (as proportionate and necessary) and this has resulted in a positive outcome for the service user.

Looking at the 'Media and Communication strategy' paragraph (6.3)

- Are you able to provide any good practice examples/case studies here that may help us demonstrate how the release of information to the media and public (as relates to any MH incident/|AWOL patient/other response) can be handled in a sensitive and appropriate way?

Comment or suggested change:

This section helpfully recognises that inappropriate police involvement can increase stigmatization of people with mental health problems. The focus on "need to know" and information being proportionate is helpful.

1 International and national legal frameworks

No

1.1 Mental health law

No

2 Equality

No

2.1 Disability discrimination

No

2.2 Disability Equality Duty

No

2.3 Equal access to justice

No

3 Definitions and terminology

No

4 Strategic oversight and management

No

4.1 Responses by the most appropriate agency

No

5 Multi-agency working

No

5.1 Information sharing

It would be helpful if there was a link to either an information-sharing policy that could be adapted locally or to an effective and appropriate policy that is already being used effectively.

5.1.1 ‘Need to know’ information

It would be helpful if the section on problem solving- working together linked to examples where this works effectively.

5.2 Legal roles and responsibilities

No

5.3 Mental Health Act 1983 codes of practice protocols

No

5.4 Command and control of police incident response resources

It is helpful that such instances are reviewed within regular multidisciplinary mental health meetings which include attendance from relevant health providers, police, advocacy and NHS commissioners to learn from individual instances and then share that effectively within the force and across forces.

5.5 Requests for police assistance from healthcare partners

It may be helpful to have a clear escalation protocol that clarifies which senior staff should be involved on both the health and the police side to resolve any differences in opinion or issues related to this. Again these instances should be logged and reviewed as 5.4 to identify trends; causative factors and learning.

6 Training

E-learning is a useful adjunct to regular face-to-face training but face-to-face and case discussion is essential with mental health training. This section highlights that forces should be delivering mental health training which is positive, but the guidance needs to specify more clearly the regularity and content of this training. The commitment to improving and extending the provision of mental health focused training and assessment is positive.

2. Mental vulnerability, capacity and illness

Main topic areas covered under this page are:

1) Decision making

2) Communication skills/techniques

3) Assessing threat and risk and developing a working strategy

4) Signs of victimisation, hate crime and exploitation

5) Mental capacity

Operational police decisions should be guided by all available information and intelligence. Access to relevant medical record information that is held by NHS partners (MH response teams/units/GPs/Community nurses) has been recognised as a key benefit of 'Street triage' response models.

Question 1

- What works where you are? Do you have any examples of the efficient and effective mechanisms for improving communication between partners that may be useful as a case study here?

We have seen positive examples of effective joint working where there are embedded liaison and diversion services, established telephone access from the police to a mental health professional for guidance and information and a single point of contact

relating to Section 135 and 136 concerns.

Question 2

This APP has been developed on the basis that it is not the role of the police service to clinically diagnose illness, rather the APP is designed to support the service to recognise behaviours and indicators of concern so that appropriate medical support can be sought. No detailed information pertaining to specific illnesses and symptoms has been included within this guidance. However, the College is aware that some police forces have chosen to provide specific training for certain conditions.

- Do you agree with our approach? If not or if you have any requests for additional guidance please indicate what areas you believe are necessary and why.

This guideline recognises in section one the key role of training on mental illness and vulnerability to increase awareness and improve the ability of individual officers and of forces to recognise and respond to mental illness, learning disability/neuro disability, mental distress and mental vulnerability promptly. Links to e-learning, useful resources/websites and guidance on the training (frequency and content) that forces should offer should be explicit from the beginning but detailed information on individual illness and symptoms is not necessary within this guideline – rather indicators of when to seek advice are more germane.

- If your Police force or organisation currently uses any existing guidance or training materials for the identification of vulnerability (or specific conditions such as Autism) could you please list them so that we may consider whether they should be included within the guidance or development of associated training?

Nothing specific to add.

- Do you consider the list of ‘indicators of general concern' to be a useful tool for practitioners?

It is important to stress that this list is not exhaustive. Some of the language used requires a baseline knowledge such as ‘paranoid’, ‘obsessional thoughts’, ‘compulsive behaviour’. It would be beneficial to explain more clearly what these may look like.

Question 3

Understanding and using the mental capacity act to protect vulnerable people is covered within the final section of the Mental vulnerability, capacity and illness page.

- Do you consider this to be an appropriate place for this information? Logically would you expect to find it here or within an alternative area of APP?

Mental capacity and whether an individual has capacity is a key concept that needs to be considered from the beginning of an intervention and would benefit from being discussed earlier in this section.

- Are there any gaps in the information presented within this section, if so please tell us what additional information you would expect to be covered here?

None identified.

- Do you have any useful reference documents/training materials in your force or organisation that has may support officers when they need to assess capacity and/or deal with life-threatening situations?

No.

Comment or suggested change

1 Decision making

Nothing additional to add.

1.1 Gather information and intelligence

This is a useful section.

1.1.1 Sources of information

This appropriately considers consent and potential useful sources of pertinent information.

1.1.2 The individual as an information source

It may be helpful to arrange this section in a different order. Mental health problems and illness exist along a continuum of severity and even those with severe and enduring mental illness may have episodes of functioning very well and may have episodes of crisis. It would be helpful if the section started with the second paragraph and recognises that they may be able to communicate effectively both their current issues and what they need to help/support them at that time.

1.1.3 Information from parents, carers, family and associates

The section on consent should appear after the individual as an information source.

1.1.4 Police information systems

Nothing additional to add.

1.1.5 Other agencies

It may be helpful for forces to have an information-sharing agreement with these services and contact details including out of hours to access information promptly.

1.1.6 Medical records

Nothing additional to add.

1.1.7 Contact information

Nothing additional to add.

2 Communication

It may be beneficial to discuss language barriers and cultural issues in this section as both will impact.

2.1 Attitude, patience and empathy

This is a useful section.

2.1.1 De-escalation

This is a useful section

2.1.2 Providing reassurance

Generally this is useful and emphasises the need to start from a position of respect. However it includes the following, which may not be helpful as guidance aimed at non-specialists could be damaging if used badly (even if well intentioned): *Two*

research studies, carried out by Castellano-Hoyt (2003) and Ireland (2011) suggest that, depending on the subject's emotional state, asking seemingly irrelevant questions or using humour may help break tension and calm an individual in mental health crisis. While this technique is thought to be useful to distract schizophrenic individuals from their delusional beliefs, it may not be beneficial when interacting with autistic individuals or those with learning disabilities.

2.1.3 Terminology and avoiding offence

It would be useful to clarify that saying it will only take a minute when it will take 10 to 15 minutes as this may cause anxiety and distrust, however this is probably true for everyone, not just those with a diagnosis of autism.

2.1.4 Autism

The inclusion of the West Midlands guidance is very helpful.

2.1.5 Language

The potential need for interpretation is highlighted but does not adequately address the importance of professional interpretation and the need for volunteers to be of an appropriate standard.

3 Assess threat and risk, and develop a working strategy

This is a useful section

3.1 Behaviour

It would be helpful to include physical health issues in the multiple needs section as low blood sugar in insulin-dependent diabetics can present as aggression and confusion; epilepsy can include absences or a confusional state after a seizure etc. Reluctance to disclose may also occur when there is a lack of confidentiality, for example when booking into custody when other

detainees and different unidentified people are close by.

3.2 Signs of mental ill health or learning disabilities

This is a useful section.

3.2.1 Indicators of general concern

This is a useful section, but see comments above.

3.2.2 Risk indicators

This is a useful section.

3.2.3 The consequences of missing mental Ill health or learning disabilities

This is a useful section.

3.3 Medical emergency

Nothing to add.

3.4 Alcohol and drug intoxication

Nothing to add.

3.5 Psychiatric crisis

Useful to have the links to further information beside this section.

4 Signs of victimization, disability hate crime and exploitation

Nothing to add

4.1 Exploitation

The text alludes to safeguarding and vulnerability but does not specifically cover it. It would be useful to add this here including the need to have local clear guidance on making a safeguard and MARAC referral.

5 Mental capacity

It may be useful to put the second section on the Act before the principles so it flows and, as highlighted above, cover it earlier.

5.1 The principles

Nothing to add.

5.2 Mental Capacity Act 2005

Nothing to add.

5.3 Police role applying the Mental Capacity Act 2005

Nothing to add.

5.4 When is police intervention appropriate?

Nothing to add.

5.1 Restraint and use of force

Nothing to add.

5.1.1 Section 4b – removal

As part of annual refresher training DSOL and Mental Capacity training would be helpful to refresh awareness

5.2 Assessing capacity

Nothing to add.

5.2.1 Questions to ask

Nothing to add

5.3 Suicidal intent and mental capacity

Very useful section on recording decisions about mental capacity.

3. Mental health – detention

The Mental Health - detention page of APP will provide a basis for the Legal knowledge that is appropriate for Operational response officers when considering relevant powers and options for dealing with mentally vulnerable people.

It covers legal provisions for:

1) admission

2) detention

3) restraint

4) searching

5) assessment

6) conveyance

Question 1

Looking down the list of legal provisions described within the Mental health – Detention page, are there any police response scenarios (that occur relatively frequently) that you think have not been explained within the legal context.

- Do you consider there to be adequate detail?
- What additional guidance would you consider useful?
- Does your force or organisation use any reference documents/tools/aides memoire to support practitioners/officers with accessing this knowledge, or to support their decision making? If so could this be shared with us?

Nothing to add.

Question 2

- What level/rank of officer and which Police staff do you think should have a working knowledge of these legal provisions?
- To what degree should this knowledge be a requirement for: patrol response officers/Sergeants/ Inspectors/ MH Specialist resources /control room or enquiry office staff?

All ranks of police officer ought to have a basic knowledge of the sections of the Act that directly relate to their work or easy

access to useable information that guides them in their role. All police officers must understand the correct usage of section 135 and 136.

Question 3

- What would you consider to be the most effective way of training this legal knowledge? And how often would you need to revisit and refresh this knowledge?
- Should this knowledge be assessed?

There should be baseline training in induction, including presentations from mental health professionals and experts by experience (service users) if possible. There should then be an annual face to face update tied in with mental capacity and DSOLs.

Comment or suggested change

1 Mental Health Act 1983 hospital admission provisions

Nothing to add.

1.1 Section 2 – Admittance to hospital for assessment

Nothing to add.

1.2 Section 3 – Admission for treatment

Nothing to add.

1.3 Section 4 – Emergency admission to hospital when only one doctor is available

Nothing to add.

1.4 Section 6 – Delegated power to detain and convey

Nothing to add.

2 Powers to enter and detain

Nothing to add.

2.1 Section 18 of the Mental Health Act 1983 – power to re-detain an AWOL patient

Nothing to add.

2.2 Section 17 of the Police and Criminal Evidence Act 1984 – saving life or limb

Nothing to add.

2.3 Section 135(1) – Warrant to enter and remove to a place of safety

Nothing to add.

2.4 Section 135(2) – Warrant to enter and remove an absent patient

Nothing to add.

2.5 Section 136 – Urgent detention in a public place

This section needs to explain more clearly what might constitute exceptional circumstances as just saying it has not been defined is not helpful. It would also help here to link to good examples of local policies used to ensure the numbers admitted to police custody as a place of safety varies widely between forces.

2.5.1 Explanation of detention (avoid the use of ‘arrest’ terminology)

Nothing to add.

2.5.2 Children and the use of Section 136 of the Mental Health Act 1983

Nothing to add.

2.5.3 Calculating the period of detention

Nothing to add.

2.6 Attending a health-based place of safety as a result of section 136 detention

It is useful to stress the importance of using an ambulance rather than police transport. Many boroughs have access to more than one place of safety. We have found it is most effective when the police have a single point of contact who will then identify an available 136 bed as that speeds up the process for the individual and for the force. It is also important to have an effective system to monitor, review and address any issues identified in the use of 136, use of police custody as a place of safety and outcome of assessment. Repeated detention under Section 136 which then does not lead to further mental health treatment should trigger a multidisciplinary case review and action plan for that individual.

2.7 Alcohol and drug intoxication

Useful but may be helpful to specify that this should be clear within the local MOU/policy held with the mental health trust.

2.8 Lack of space or hospital beds

Nothing to add.

3 Mental health applications from police custody

Nothing to add.

3.1 Legal framework

Nothing to add.

3.2 Options when there is no legal authority to hold a vulnerable detainee that requires further support

It may be helpful to incorporate lessons learned into the last paragraph as it is not immediately clear they are connected and it would help if this guidance was clearer as it is a common circumstance in police custody.

4 Restraint

4.1 Police powers to intervene in a hospital or medical facility

Nothing to add.

4.1.1 Administering medicines

Any such instances where police have intervened should be recorded, monitored and reviewed in the local multi-professional meeting.

4.1.2 Hospital patients presenting healthcare management problems

Nothing to add.

4.1.3 Restraint in a hospital setting

Nothing to add.

5 Assessment

It is helpful to have a locally agreed escalation policy to resolve any disagreements or any issues such as extreme delays in assessment or transfer. It is also helpful to have a policy that supports prompt referral to the mental health team for assessments. In some areas the FME has to assess the individual even if a mental health nurse has assessed them, which is unhelpful and delays prompt appropriate care being given to the individual.

5.1 Agreement for assessment

Nothing to add.

5.2 The outcome of the assessment

Nothing to add.

6 Transporting people for assessment and supervision

Nothing to add.

6.1 Transfer between places of safety

Nothing to add.

6.2 Requests from external agencies

Nothing to add.

4.3 Sibling abuse

We do not think this fits in this section.

4. Missing and AWOL patients

Topics covered within the Missing and AWOL Patients page include:

- Powers and the role of the police
- Multi-agency protocols
- Appropriate responses to a range of different scenarios
- Safe and well checks
- Holding Powers
- Other MHA provisions

Question 1

- Do you consider this page to be a logical home for this guidance? Or would you expect to find this MH Patient specific guidance within APP on Missing persons?

It may be logical to appear in both as it is relevant to both.

Question 2

The most appropriate operational response to a report of an AWOL MH Patient will necessarily vary according to local force arrangements and protocols between healthcare services, hospitals, MH Trust facilities, and the police. As such, this guidance focuses on interpretation of the law and the role of the police service.

- Despite this limitation, do you consider this to be a potentially valuable resource?

It is always helpful to link to examples of good practice including an effective policy to put the law in context.

Question 3

- Are you able to offer any case studies from your force that illustrate an effective or model response to an AWOL Patient case/incident report?

Nothing to add.

Comment or suggested change

1 Definition of ‘absent without leave’

Nothing to add.

2 When will the police get involved?

Nothing to add.

2.1 Powers to re-detain an AWOL patient

Nothing to add.

2.2 Re-detention of absconded patients

Nothing to add.

3 Multi-agency protocols on missing or AWOL patients

Nothing to add.

3.1 Police involvement in transporting AWOL patients

Nothing to add.

3.1.1 AWOL patient protocol

Nothing to add.

3.1.2 Voluntary patients

Nothing to add.

3.2 Patients who fail to return after a period of leave from medical facilities

Nothing to add.

3.2.1 Powers and responsibilities

Nothing to add.

4 Safe and well checks

Nothing to add.

4.1 When a patient is found at their home address

Nothing to add.

5 Holding powers

Nothing to add.

5.1 Cross-border absconding

Nothing to add.

6 Other legal provisions under the Mental Health Act 1983

Nothing to add.

6.1 Section 42

Nothing to add.

5. Crime and criminal justice

This page of APP is focused on supporting the police service to take appropriate and legal decisions to tackle offending behaviour by and against people who are mentally vulnerable.

Areas covered include:

- Prosecution decisions
- Concept of capacity
- Powers and protection orders available via criminal courts
- Liaison and Diversion services
- Inpatient offending

Question 1

What (if any) additional guidance topics would you consider relevant and useful within this area of APP?

It may be helpful to have more specific guidance related to custody, including pre-release risk assessments.

Question 2

- Does your force or organisation currently have and use any guidance material that supports the function of Liaison and Diversion teams? Could this be shared?

Nothing to add.

Comment or suggested change

1 Mental health and the criminal justice system

It may be helpful that when health professionals assess detainees and record re fitness to interview and detain that vulnerabilities to be considered on release are also highlighted to support the custody sergeant when completing the pre-release risk assessment. It may be helpful to have explicit guidance around access to appropriate adults and the importance of having timely access to them at all times, including overnight and at weekends.

2 Preventing and investigating crime and tackling offending behaviour

Nothing to add.

2.1 Is there enough evidence to support a criminal prosecution?

Nothing to add.

2.2 Is there a threshold?

Nothing to add.

2.3 Mental capacity concerns

Nothing to add.

2.4 When prosecution is appropriate

Nothing to add.

2.5 Offences within psychiatric inpatient units

Nothing to add.

3 Liaison and diversion services

Nothing to add.

4 Victims of crime on the basis of disability

Nothing to add.

4.1 Special provisions for vulnerable victims and witnesses

Nothing to add.

4.2 Vulnerable suspects

Nothing to add.

General comments about Mental Health APP

Diversity Impact Assessment – Is there any content in the draft document which you consider would have a negative impact on any diverse group?	
Section No.	**Comment**