LEARNING THE LESSONS

IOPC Independent Office for Police Conduct

Improving policing policy and practice

MENTAL HEALTH

ISSUE 43 March 2024

This publication is produced by the IOPC and supported by

Association of Police and Crime Commissioners · College of Policing · HMICFRS His Majesty's Inspectorate of Constabulary and Fire & Rescue Services · Home Office · NPCC National Police Chiefs' Council · Police Federation · Police Superintendents' Association

WELCOME

Mental ill health and policing: finding the right approach

Mental ill health is one of the most significant issues affecting policing in England and Wales. One in four people experience mental ill health each year and more than 40% of people in contact with the criminal justice system have mental ill health. Of the 23 people who died in police custody in 2022/23, 13 experienced mental ill health.

This issue is devoted to exploring the relationship between mental ill health and policing. It unpacks learning identified in cases we have investigated and reviewed, shares local initiatives demonstrating effective and joined-up responses to looking after vulnerable people, and reflects on initiatives driving significant change.

We are supportive of the need for national change in how policing responds to calls where mental health is a factor, while recognising the police will always have a responsibility to protect the public from serious harm. Many of the articles in this issue describe and digest the national rollout of Right Care, Right Person – an initiative to make sure people in crisis get the right support from the right person with the right skills and training to best meet their needs.

In this issue we also present eight case studies carefully selected to encourage reflective thinking and to spark discussion. They explore the importance of officers and staff being aware of the services available to help their decision-making in incidents where mental ill health is present, and the importance of checking force systems to inform assessments of risk. They also demonstrate the importance of robust local policies in line with national guidance, and of effective partnerships in place with other agencies, including health services. You can find out more about our case studies and why we have selected them on page 7.

We also recognise the importance of mental health support for police officers and staff and recognise the challenging work they engage in each day. We are grateful to the National Police Wellbeing Service for their article highlighting their work in this space. We also welcome contributions from local forces, Rethink Mental Illness, the National Police Chiefs' Council, the College of Policing, among many others in this issue.

The themes, learning and questions posed in this issue are intended to challenge you, ask you to reflect, and to spark discussion. It is hoped by doing so we can help to create the right environment to provide a compassionate service to vulnerable people who may come into contact with the police.

Thomas Whiting

Tom Whiting
Acting Director General, IOPC

Content warning

This issue contains descriptions of incidents involving mental ill health, self-harm, suicide, substance misuse (alcohol and drugs), violence and domestic abuse.

Reading this content can have a triggering impact. You can call Samaritans for free on 116 123 or visit www.samaritans.org if you would like support.

Please see page 44 for more support organisations you can contact if you are affected by this issue.

Key to case topics

- Call handling
- Crime and investigation
- Custody and detention
- Information management
- Mental health
- Personal safety
- Professional standards
- Public protection
- Guidance

Cover photo: iStock

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CASE STUDIES

Contact learning@policeconduct.gov.uk if you would like more detail about the learning recommendations issued in the featured case studies.

ARTICLES

GUIDANCE AND CHECKLISTS

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Supporting compassionate care for vulnerable people

Tarek Rehmatulla shares the IOPC's work on mental health and asks us to reflect on key concerns raised in this issue of *Learning the Lessons*.

Mental health has always been a key theme underpinning the work of the IOPC. Mental health intertwines with all areas of policing and features in a significant number of our cases. Eleven out of the 19 cases we highlighted in the last two issues of *Learning the Lessons* on custody and call handling featured mental health.

Additionally, each year we publish figures on deaths during or following police contact on our website. We began publishing these statistics more than 15 years ago, and mental health continues to be a consistent factor amongst many of the people who died. In 2022/23, 13 out of 23 people who died in or following police custody had mental ill health.

'Six Missed Chances'

One of the highest profile investigations of our predecessor, the Independent Police Complaints Commission (IPCC), related to mental health. It centred on James Herbert, who died aged 25 while in police custody. The IPCC published the 'Six Missed Chances' report following the investigation: www.policeconduct.gov.uk/publications/ipcc-six-missed-chances-report.

The report explored how a different approach to policing people with mental ill health could have prevented James' death. The report made recommendations around the importance of a multi-agency response reinforced by robust local protocols when responding to someone with mental ill health, and the need for verbal de-escalation as the default response to a person in crisis. The report called for national police training to support officers and staff to do this effectively.

The report also highlighted the need for officers to be trained to use containment rather than restraint. It demonstrated how restraint can be the most dangerous response when a person is in a mental health crisis. James' parents Tony Herbert and Barbara Montgomery, both now sadly passed away, actively supported the development of the report and campaigned to raise awareness about the risks of restraint in the prone position.

Concerns about the use of restraint in mental health incidents are not new, and tragically there have been further restraint-related deaths of people with mental ill health since James' death. College of Policing Authorised Professional Practice (APP) on mental health states 'Officers should not use methods of restraint on people with mental ill health or vulnerabilities, however, unless absolutely necessary. They should reserve this for emergencies and circumstances in which the safety of the subject, the public, police officers and other professionals is at risk'.

Use of force training highlights that use of restraint on someone experiencing a mental health crisis such as in the prone position, particularly where such restraint is prolonged, poses an inherent risk to life, including the risk of positional asphyxia. Training reflects this type of restraint should be avoided where possible, and the duration minimised where its use is deemed absolutely necessary. Training also highlights the importance of treating individuals according to how they present, and taking appropriate steps where there may be a medical emergency rather than making assumptions that they may be feigning injury.

> **"Mental health intertwines with all areas of policing and features in a significant number of our cases"**

Although 'Six Missed Chances' was published in 2017, the messages it contains are still relevant today. As you read the case studies in this issue, you will see references to use of force, restraint, and the importance of police and other agencies working together. We continue to regularly identify areas of learning to improve policing responses to people with mental ill health and maintain a keen interest in changes in this area. This brings us to another key theme throughout this magazine – Right Care, Right Person (RCRP).

Right Care, Right Person

RCRP is an approach designed to make sure vulnerable people are responded to by the right person, with the right skills, training, and experience to best meet their needs. RCRP is underpinned by an agreement between policing, health and other partner agencies which aims to make sure people in mental health crisis get the care they need.

The IOPC welcomes initiatives that make sure people in distress receive the right service, from the right agency. We recognise the police service is not designed to provide specialist care for vulnerable people in crisis.

In recent years, we have issued a number of recommendations to police forces to address common issues around 'concern for welfare' calls. Examples of these recommendations include the need for improved multi-agency working and communication between agencies; improved escalation processes; development or introduction of concern for welfare policies; and the importance of appropriate risk assessments.

In 2023, this work culminated in a national recommendation to the College of Policing. We recommended the College update and expand APP on concern for welfare calls. We called for it to include criteria on which mental health incidents police should attend to check on the wellbeing of a member of the public, and to ensure effective communication, partnership working and escalation processes for potential disputes about the best agency to attend. The College accepted our recommendation, and their response indicated the national rollout of RCRP would address our concerns.

Since then, we have monitored developments closely. We have created strong links with the national implementation team and sit on the Tactical Delivery Board to help influence and stay informed of change.

Through our investigation and review functions, we will continue to investigate incidents involving mental health and policing that have resulted in adverse outcomes. This may include incidents which relate to changes arising from RCRP. We will continue to issue learning recommendations where appropriate, if we identify issues relating to process, policy, training, or other organisational needs that should be addressed. To help forces understand our work in this area, we will shortly publish our external position on RCRP and have liaised with the National Police Chiefs' Council in its development.

As RCRP is adapted and implemented across individual police forces, we encourage police leaders and those in health and justice systems to work closely together to improve frontline mental health support. We expect forces to develop robust local policies, operational guidance and escalation policies in line with the national principles of RCRP. We want to make sure forces continue to respond appropriately to incidents involving people in need, and that vulnerable people do not slip through the net and suffer harm.

RCRP is just part of the story around mental health in policing. I ask that you reflect on the questions posed in this issue to make sure you are in the best position to provide a supportive, dignified and compassionate service to vulnerable people who may require police intervention. ■

Tarek Rehmatulla is a Policy and Engagement Officer at the IOPC, and policy lead for mental health

THE IOPC, POLICING AND MENTAL HEALTH

Photo: Alamy

Disproportionality, mental health, and Taser

Paulette Johnson-Clarke provides an overview of the IOPC's Taser report, highlighting concerns about the use of Taser on Black men and people with mental ill health, sparking a closer examination of its use.

In 2021 the IOPC published a report exploring police use of Taser. The report was developed in response to a series of incidents involving use of Taser on Black men and people with mental ill health. The report shared findings from 101 independent investigations carried out by the IOPC and its predecessor between 2015-2020.

The report found that mental health was a common feature across the investigations. In incidents where mental health was recorded as a factor, people were more likely to be subjected to multiple and prolonged discharges of more than 20 seconds.

The report also highlighted insights from key stakeholders about the intersectionality between race and mental health. Stakeholders shared concerns that police officers did not always respond appropriately to Black men with mental ill health, with Tasers drawn too quickly, and a failure to recognise Black men as vulnerable people.

We made 17 recommendations in the report to improve Taser use. Some of the recommendations were directed to different national bodies like the College of Policing, National Police Chiefs' Council (NPCC) and the Home Office. They called for improvements to data collection and for research to be conducted to better understand the intersectionality between Taser use and protected characteristics, including mental health and ethnicity.

You can read the report here: www.policeconduct.gov.uk/publications/review-iopc-cases-involving-use-taser-2015-2020.

Further developments

Changes have been made to the national training curriculum on the use of Taser since the publication of the report, including new content provided by mental health charities.

A research project has also been funded by the NPCC and the Mayor's Office for Policing and Crime, commissioned by the College of Policing, to explore the potential causes of ethnic and racial disparities in the police use of Taser.

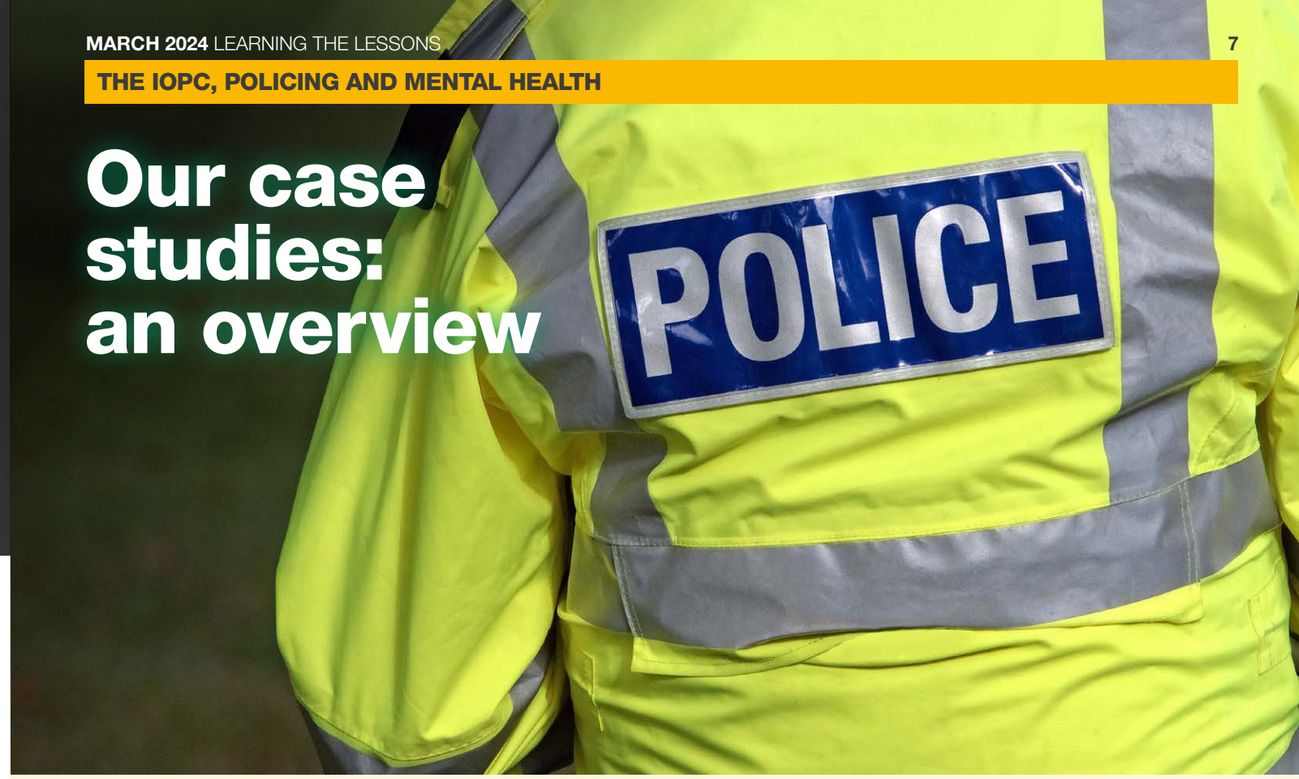
Importantly, the research cited findings from Mind, the mental health charity, demonstrating people from minority ethnic communities are more likely to experience mental ill health but are less likely to have access to mental health services. The research highlighted the importance of recognising such structural issues which can feed interactions between deprivation, race, mental health and policing that must not be ignored.

The research also identified areas where the service provided by the police should be reviewed to address concerns raised by communities in relation to Taser use. This work includes an assessment of Taser policy and practice, including guidance, training, deployment processes, and oversight and accountability mechanisms.

The NPCC have now established multiple technical support groups to deliver on the findings of the report. The groups have set out to address issues of bias, discrimination and use of force. The IOPC are actively supporting this work by establishing a panel of young people to make sure the solutions proposed by the group fully consider the potential impact on young people.

Read the findings of the independent research here: www.keele.ac.uk/media/k-web/k-research/kpac/taserd-report.pdf ■

Paulette Johnson-Clarke is a Policy and Engagement Manager at the IOPC



Our case studies: an overview

The IOPC oversees the police complaints system in England and Wales. As part of our work, we investigate the most serious and sensitive matters involving the police, including deaths following police contact.

The eight case studies included in this magazine are real investigations and reviews the IOPC has completed. They demonstrate the key issues we continue to see through our work around mental health and policing.

Today, police forces across England and Wales are adopting Right Care, Right Person (RCRP); an approach designed to make sure people who need help are responded to by the right person with the right skills, training and experience to best meet their needs. You can read more about RCRP on page 10.

The eight case studies in this magazine predate wide adoption of RCRP by forces, so you will not see references to RCRP in the descriptions of what happened, or in the learning recommendations we made. We have carefully selected these cases because of the opportunities they present to spark debate, discussion and reflective thinking in our readers now, at a time of national change.

As you read them, you may find some case studies which demonstrate a real and immediate risk to life, where the need for police presence and involvement may feel clear. However, some of the cases present a more complex view of risk. They demonstrate the importance of officers and staff, supported by robust local partnership agreements, policies, guidance and training, being equipped to make effective decisions about when the police are the right agency to attend, and the decisions that follow to meet the needs of vulnerable people.

> **"The eight cases demonstrate the key issues we continue to see through our work around mental health and policing"**

If you are a manager, policy maker or trainer in policing, we encourage you to use the case studies to sense-check existing policies and practice, identify opportunities to review training and resources, and consider opportunities to encourage reflective learning among officers and staff.

If you are a frontline officer or member of staff in policing, we encourage you to use the case studies to consider your own knowledge and confidence when making decisions relating to incidents involving mental health, and to identify your own learning needs to make sure you are in the best position to support people in a mental health crisis who may require police intervention. ■

Megan Oliver is the Learning and Improvement Lead at the IOPC

CASE STUDY 1

Vulnerable man with warning marker left alone

This case was independently investigated by the IOPC.

The manager of a homeless accommodation centre called an ambulance. A resident was sitting with half his body outside on the window ledge of his third-floor room. The manager was concerned the man would jump because he had told staff earlier, he *"felt his mental health had gone really bad"* and that he wanted to be *"sectioned"*.

An ambulance was sent and the ambulance control room informed the police due to the immediate risk to life.

College of Policing Mental Health Authorised Professional Practice (APP): Introduction and strategic considerations

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

More information
www.college.police.uk/app/mental-health/introduction-and-strategic-considerations

A police control room operator told the officers on the way to the incident the man had a warning marker for suicide. No additional details were given or requested by officers around this. The suicide marker would have shown the man had tried to take his own life the previous year.

Officers arrived before the ambulance and they entered the man's bedroom. Staff had talked the man back inside. Officers spoke with him, and advised the control room he was *"fully conversational"*. The man told the officers he had mental ill health and wanted to voluntarily go to hospital.

The officers initially considered transporting the man in a police van. However, as the man was under the influence of alcohol and drugs, and had a leg injury, they agreed an ambulance would be safer. The IOPC investigation found this decision reasonable and in line with the force's policy at the time.

The officers updated the man, and he confirmed he would wait for an ambulance. He also stated he would not harm himself in the meantime.

An officer contacted the force control room to ask them to relay information to the ambulance service about the man's condition.

Following a risk assessment, the officers left the man alone in his room. They spoke to the accommodation staff and asked them to look after the man until the ambulance arrived. The staff stated *"they were not here to look after him"* and would just do their regular checks.

The investigation identified that during the officer's risk assessment, they did not consider all sources of information available. This included consulting the force's internal mental health service for advice. The service was available to help officers in cases which involved transport to hospital and facilitated advice from community mental health teams. The service could also speak directly to someone experiencing a mental health crisis and provide general advice to officers at the scene.

The officers later stated that although they were aware of the service, they were unsure how it could assist in this incident. They believed it could only be used to gain the mental health history of someone.

The officers advised the staff they were leaving. The staff expressed concerns that they were *"not trained to deal"* with the situation which was why they had called for an ambulance. The officers said they could not justify staying but encouraged staff to wait with the man for a short period until the ambulance arrived. During the investigation, an officer said *"we had made our assessment, so if we stayed the sergeant would ask us why we were staying"*.

College of Policing Mental Health APP: Suicide and bereavement response

Officers should avoid leaving a potentially suicidal individual alone based on their promise to visit their mental health worker or the hospital and should seek to ensure that family members or significant others are on the scene and accept responsibility for help seeking.

Suicide may be averted if people receive immediate and appropriate support.

More information
www.college.police.uk/app/mental-health/suicide-and-bereavement-response

The officers left. They later stated they believed following discussions with staff that *"the conclusion of the conversation was that they would check on [the man] once we had left"*.

Accommodation staff called the police a few minutes after the officers had left. They said the man had fallen from his window. The man had been left alone in his room. Officers returned and requested an ambulance to arrive immediately.

The ambulance arrived shortly after and took the man to hospital. The man died from his injuries.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do you make sure your policy on police attendance at incidents involving mental health is in line with national guidance and can stand up to scrutiny?
- How do you support officers and staff to understand the importance of identifying and understanding known risks about a person?
- How do you make sure officers are aware of the mental health support and advice available to them, and how it can help in their day-to-day work?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What steps do you take to make sure attending officers are equipped with all relevant information about known risks?
- Do you know how to access services that can support your decision-making when responding to an incident involving mental health?
- What options can you consider to prevent a person who is suicidal from being left on their own?

LEARNING RECOMMENDATIONS AND ACTION TAKEN BY THE FORCE

- The IOPC issued one learning recommendation to the force. It asked them to remind officers and staff about the availability of their mental health advice service.
- The force promoted the use of the service via emails, intranet, shift briefings and posters in every police station. They improved their decision-making process in relation to mental health codes of practice and promoted 24/7 helplines for officers to contact for support about mental health incidents. Additional mental health services were also launched to cover more of the force's geographical area to improve their response to mental health incidents and to support officers to help coordinate deployment of ambulances and joint emergency service response vehicles.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Right Care, Right Person: the what, why and how

Photo: Alamy

Jenny Gilmer sets out the core aims of Right Care, Right Person, and the importance of effective partnerships.

Humberside Police pioneered what we now know as Right Care, Right Person (RCRP). In Humberside and police forces across the country, the demand for police officers to respond to mental health and concern for welfare calls, often on behalf of partners, has risen exponentially. For many years policing had accepted this demand. However, we began to recognise that not only did the police not have a legal responsibility to respond to many of these calls, but police officers did not have the required skills, knowledge or experience to support people in mental health crisis.

Due to this demand, some core functions of policing, the things that only the police can do, suffered, including responding to victims of crime and progressing investigations. The aims of RCRP are two-fold:

- To make sure people who need support receive it from the agency best placed to respond.
- To make sure police time and resources are invested where they are needed most.

RCRP in practice

The RCRP umbrella covers concern for welfare calls, walkouts from healthcare settings, people who have absented themselves from mental health care provisions, and people who need medical treatment. However, this does not mean that policing will no longer attend calls of this nature. RCRP does not represent a wholescale disengagement from any particular area of policing. RCRP is about a structured decision-making process to decide if police attendance is appropriate.

The RCRP national implementation team was established in early 2023. It was created to collaborate with police forces and partners to make sure RCRP is rolled out effectively, is quality assured, and keeps communities and vulnerable people at the heart of delivery.

The police will continue to respond to incidents if there is a risk of crime being committed or crime has been committed, if the Article 2 or Article 3 rights under the *Human Rights Act (1998)* of any individual are at risk, or if the specialist skills or powers of police are needed.

> **“RCRP should result in better care and outcomes for people in mental health crisis who need support”**

Delivering effectively

A change on this scale comes with challenges. There is significant support for the aims of RCRP, but it is so important it is rolled out properly. There are three factors critical to effective delivery:

1. Working closely with partners at a local level to deliver together. This includes making sure there is a clear and shared understanding of what is being done, when and how. Transparent discussions about responsibilities and challenges should be encouraged, and clear and robust escalation and oversight arrangements should be developed to minimise the risk of service failures to allow concerns to be quickly and effectively addressed.
2. Having a clear internal communication strategy. RCRP represents a significant change for officers and staff. They deserve clarity, support and training to allow them to confidently and competently make effective decisions.
3. The balance between consistency and scope for local variation. A ‘one size fits all’ approach is not appropriate as all forces are at different stages of implementing RCRP, with different operating models, demographics, geography, existing services, and relationships with partners.

Resources and support

A number of tools, resources and support mechanisms have been developed to help forces and partner agencies to embed RCRP. This includes the National Partnership Agreement, national legal advice, a national ‘toolkit’, and briefings. Regular engagement also takes place with partners at a national level to reinforce local level engagement.

A Tactical Delivery Board has also been established to make sure the principles of RCRP are consistent and followed during roll out. This includes making sure delivery is completed to a high standard, with the support of partners, and is monitored and evaluated. At an early stage we widened attendance at our Tactical Delivery Board to include both internal and external partners. This helps achieve transparency and allows concerns to be raised. It has been pleasing to see this approach replicated at a local level, with forces generously sharing learning and best practice with each other and seeking support when they encounter challenges.

Monitoring impact

We are carefully monitoring cases where an individual is suggested to have suffered harm as a result of RCRP. We are encouraging all forces to develop robust checks to make sure no-one falls between the cracks. Before going live, forces have been asked to conduct a gap analysis with partners to identify areas where it is unclear who is the best agency to attend, and to develop local solutions. When properly delivered, RCRP should result in better care and outcomes for people in mental health crisis who need support.

One example of good practice in developing robust checks is the Metropolitan Police Service. When they went live with RCRP, they instigated twice daily meetings with partners to review decision-making, put ‘floor walkers’ on duty to support staff in control rooms, and established a 24/7 helpdesk for officers, staff and partner agencies to ask questions or raise concerns.

The future

In 2023, the government announced £150 million to ease pressure on mental health urgent and emergency care services. The NHS Long Term Plan has committed a further £2.3 billion a year for the expansion and transformation of mental health services in England by 2023/24 so that an additional two million people can get the NHS-funded mental health support that they need, from the right people.

Looking beyond the existence of the national implementation team, for RCRP to be sustainable long-term there will be an ongoing need for rigour, quality assurance and governance to be maintained. Putting processes in place to achieve this will be a key focus of the team in 2024.

RCRP highlights gaps in service provision which were previously masked by police attendance. While this will no doubt present challenges, there is potentially a huge opportunity to find appropriate solutions which provide a better service to people in need and allow our collective effort to be focused on those who need the most help. Ensuring the momentum behind this debate is maintained is crucial, and wherever possible, a collaborative approach should be taken. ■

Assistant Chief Constable Jenny Gilmer is the lead for Right Care, Right Person at the National Police Chiefs’ Council

CASE STUDY 2

Changing priority level for a mental health call

This case was locally investigated by the force. The IOPC reviewed the investigation to decide whether there was an indication that a person serving with the police may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings.

A man called the police early one morning. He told the call handler he had intentionally cut himself with glass and was bleeding. The man stated he was scared he may injure himself further and had self-harmed previously. The man also confirmed he was under the influence of alcohol.

The call handler created an incident log and noted the man was suicidal. The call handler also identified existing warning markers for violence and self-harm.

The call handler requested an ambulance. Their documented rationale was that they believed the ambulance were the most appropriate agency to respond. The ambulance said they would arrive within two hours. The call handler marked the incident as resolved.

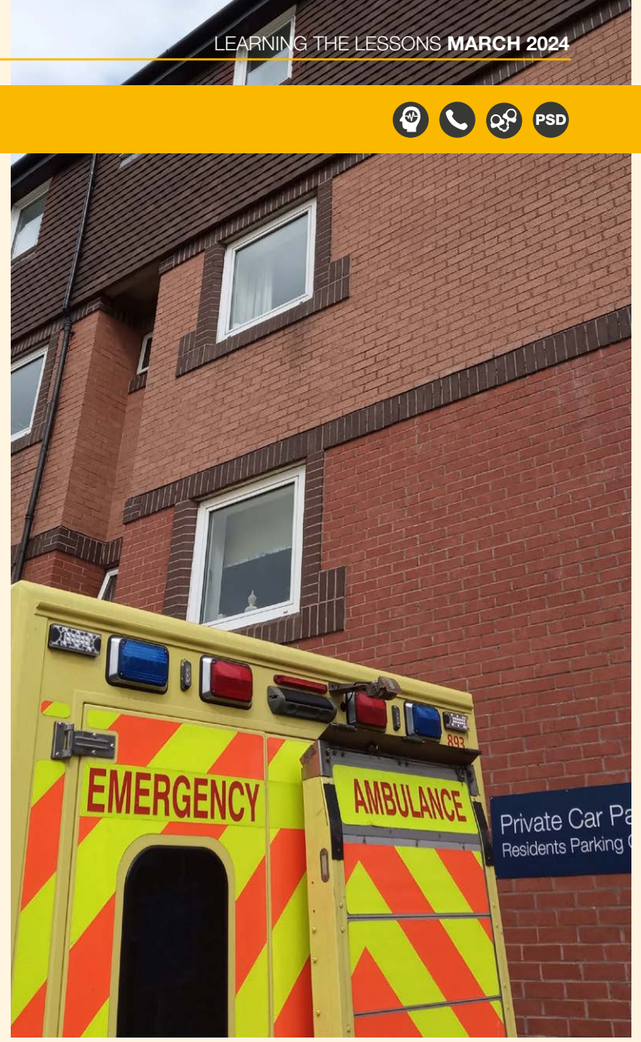
The call handler's decision was not in line with the force's policy at the time, due to the immediate risk the man posed to himself. A THRIVE (threat, harm, risk, investigation, vulnerability and engagement) assessment was also not completed at this stage.

G *Mental Health Act 1983*: Code of Practice - Chapter 16.30

Local authorities, NHS commissioners, hospitals, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises. The objective of local partnership arrangements is to ensure that people experiencing mental health crises receive the right medical care from the most appropriate health agencies as soon as possible.

More information
www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

The force's own investigation into this incident identified a missed opportunity in the call handler not



using the force's mental health service, designed to support incidents involving an immediate mental health crisis. The call handler did not document their rationale for this.

The man made a second call to the police 15 minutes later. He said *"no one's turned up so I'm going to slit my throat, right now"* before ending the call. The second call handler immediately called the man back. The man said he was *"bleeding to death"* before ending the call again.

The second call handler completed a THRIVE assessment, and updated the incident log to note there was an immediate risk to life.

The man made a final call minutes later and told a third call handler that he intended to continue cutting himself until help came.

The priority level was changed to an emergency and the ambulance service were updated. The ambulance service requested the police attend with them due to the warning markers associated with the man.

However, a few minutes later the incident log was updated by an inspector who noted this was a medical incident for the ambulance. The incident was marked as resolved again.

The force's investigation identified that the call should have been graded as requiring an emergency response due to the danger to life.

The ambulance arrived at the man's address. The man was verbally and physically abusive. Ambulance staff moved away from the property and contacted the police again to request their attendance. They confirmed the man had visible cuts on his body.

Two officers arrived and approached the man's front door. The man threatened to shoot them and himself. He then smashed a window and moved towards the officers.

Officers used incapacitant spray and a baton strike to subdue the man. Additional officers arrived and the man was arrested and handcuffed with his hands behind him.

The man continued to use violence as he was being escorted outside. One officer struck the man once in the torso and twice in the face using a closed fist. Body worn video captured the man asking an officer why he had punched him. The officer responded *"if you try and head-butt me, I'm going to punch you"*.

The IOPC review found that the force used in this incident was necessary, proportionate, and reasonable due to the level of risk and the need for officers to protect themselves.

The man was transported to hospital in a police van where it was found he had sustained a fractured eye socket. An officer can be heard on body worn video saying *"he got what he deserved"*. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do you support officers and staff to understand and apply your local partnership agreements to their decision-making?
- How do you promote understanding of what constitutes a real and immediate risk to life or serious harm with control room staff?
- How do you promote the mental health services you have to help officers and staff responding to relevant incidents?
- How do you support officers and staff to understand and confidently apply your policy on call gradings?
- What steps do you take to quality assure decisions made in the control room about call gradings to identify learning needs?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How do you make sure the decisions you make about emergency mental health calls are in line with your force's policy and local partnership agreements?
- Do you know what services are available in your force to help decision-making around incidents involving mental health?
- Why is it important to maintain professionalism, even in the most challenging situations?

LEARNING RECOMMENDATIONS AND ACTION TAKEN BY THE FORCE

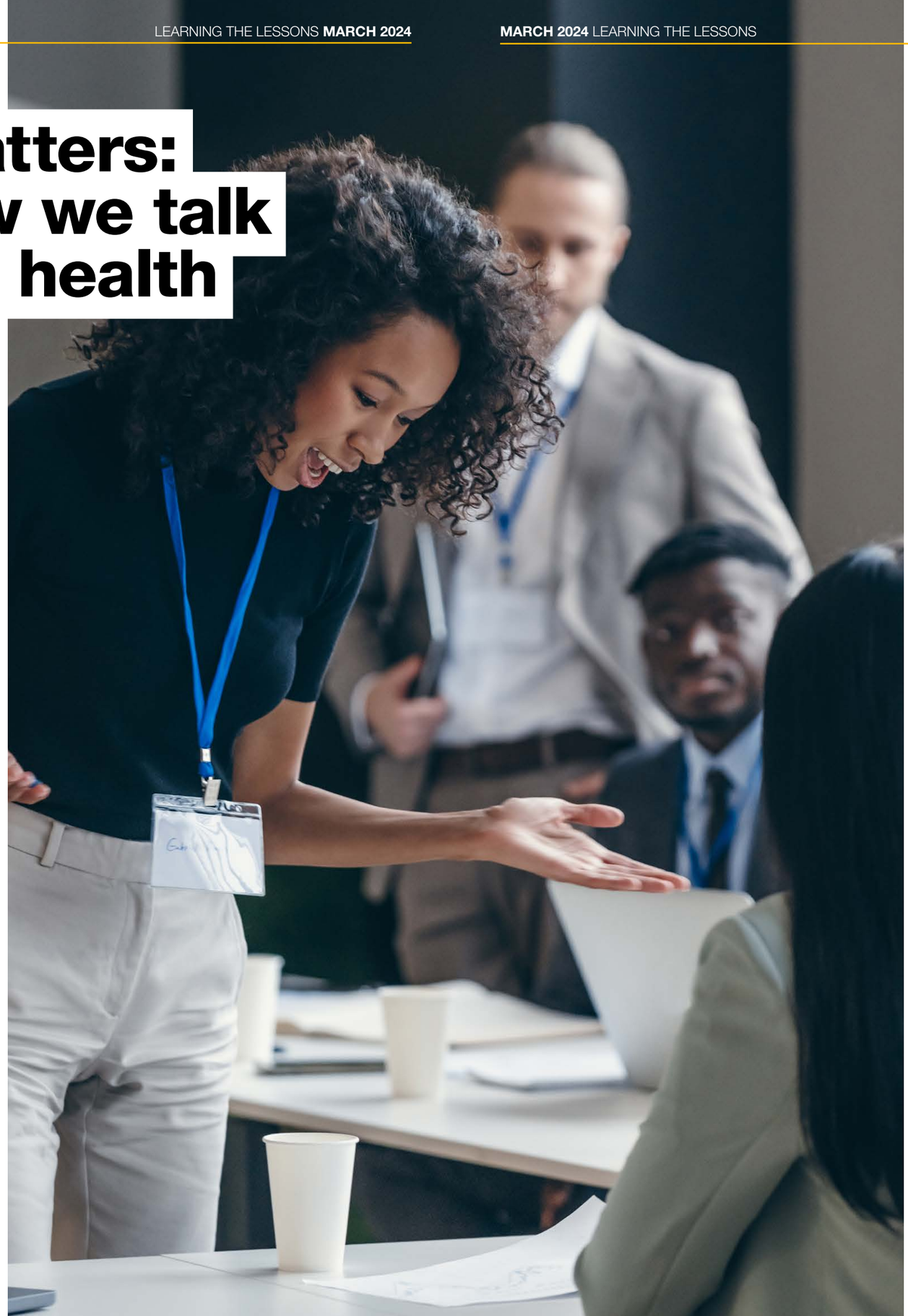
- The IOPC issued one learning recommendation to the force. It asked them to amend their control room training relating to emergency mental health calls to protect life.
- The force updated their training to include an input from the force's mental health lead. The training also refers to Authorised Professional Practice. Force policy has also been updated to reflect these changes. The force now attends quarterly meetings with other agencies to discuss learning from mental health calls and appropriate agency attendance.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.
- The force's investigation noted advice would have been given to the two attending officers about maintaining professionalism when making verbal statements. Both officers resigned from the force for unrelated matters before the investigation was complete.

Language matters: exploring how we talk about mental health

Colleagues from the IOPC share examples of why the language we use around mental health matters.



CONTENT WARNING

This article contains examples of offensive and inappropriate language, used to highlight important learning. Reading this content can have a triggering impact. Please see page 44 for organisations you can contact if you are affected by this article.

Mental health is a wide-ranging term, encompassing a range of experiences and feelings. We can empower people to feel included and listened to when we get language around mental health right. But we can negatively impact a person's wellbeing and damage engagement when we get language wrong.

Mental health language and our work

Working at the IOPC requires us to analyse a high volume of policing documents, audio recordings, transcripts and video footage. Through this analysis, we regularly identify uses of outdated and even offensive language.

And it does not stop there. Inappropriate language used once by a police officer during an interaction can be captured on body worn video, repeated on a referral form, captured in a transcript, quoted in an investigative report, and as below, even end up in an issue of *Learning the Lessons*.

Recognising mental health expertise

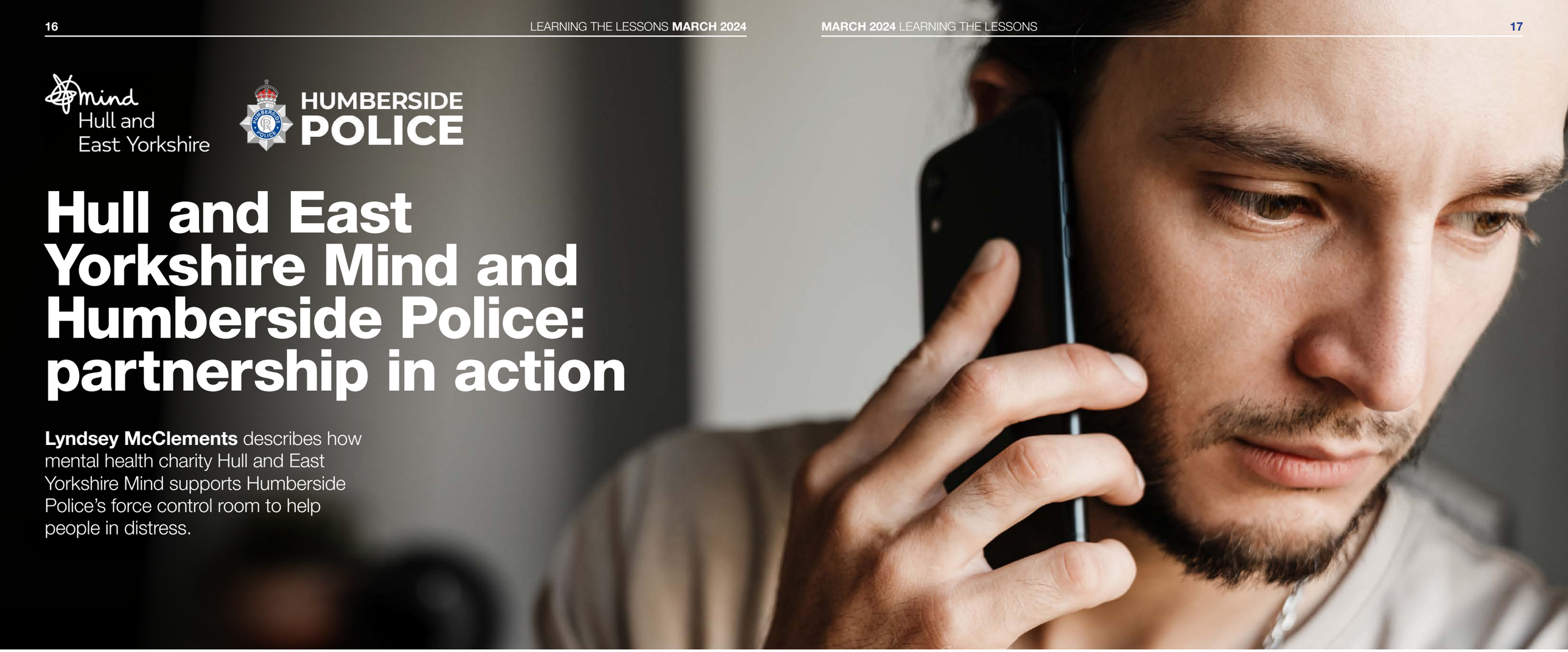
Before we share a handful of examples we have found, we encourage readers to explore expert resources on the topic of mental health language. These include:

- Talking about mental health, The Mental Health foundation. This guide describes why the way we talk about mental health is important, and how it can help reduce stigma and encourage conversation. www.mentalhealth.org.uk/explore-mental-health/a-z-topics/talking-about-mental-health
- Mental health language, Mind. This one-pager provides useful examples about common mental health terms to avoid, and suggestions to try instead. www.mind.org.uk/media/7582/mental-health-language.pdf.

Examples identified by the IOPC	The impact and alternatives
A call handler wrote on an incident log that a person who had called 999 was 'mentally unstable'. This language was not used by the caller.	This language is outdated. Appropriate language includes describing a person as 'experiencing mental ill health' or 'has a mental health condition'.
A custody officer entered on a custody record that a person was 'not in their right mind'. The person had been exhibiting violent behaviour and shouting.	This language is generic and does not recognise individual experience. Appropriate language focuses on the behaviour exhibited, for example 'the person was shouting and screaming and did not seem to understand what I said to them'.
A force investigation report noted that a person had 'committed suicide'.	This is an outdated term. It links back to when suicide, or attempting suicide, was a criminal offence until the 1961 Suicide Act de-criminalised it. Appropriate language now includes describing a person as having 'taken their own life' or 'died by suicide'.
An officer was captured on body worn video speaking with a colleague and referring to a vulnerable child with possible mental ill health as a 'retard'.	This term is offensive and derogatory. It is used as an insult, often aimed at people with learning disabilities. Everyone should challenge offensive language when they hear it.

Ask yourself, could you improve your knowledge of appropriate language around mental health?

Rachel Fenton is a Survivor Engagement Manager and **Roger Kasper** is a Media Officer at the IOPC



Hull and East Yorkshire Mind and Humberside Police: partnership in action

Lyndsey McClements describes how mental health charity Hull and East Yorkshire Mind supports Humberside Police's force control room to help people in distress.

Hull and East Yorkshire (HEY) Mind is an independent mental health charity affiliated to the national Mind network. We were approached by Humberside Police in 2017 to discuss the possibility of allocating a HEY Mind worker to the force control room. The purpose was to support calls that did not necessarily require police involvement, including calls from people in emotional distress.

HEY Mind projects and services cover a large geographical area, and we have supported local people for more than 40 years. Better mental health for everyone is our vision, and our staff, volunteers and trustees are passionate about encouraging people to feel confident to talk about their mental health.

We agreed to the proposition. HEY Mind now operates in Humberside Police's force control room seven days a week. Calls transferred to HEY Mind workers usually involve people in distress who are expressing suicidal thoughts or even engaging in self-harm. We can offer time for people to talk about what is happening and signpost resources that can help.

Good joint working between HEY Mind and Humberside's control room staff is paramount. As a result of our invaluable relationship, calls have been successfully directed to us, and we have even been able to give advice to staff on calls with people in crisis and helped them to better support the person they are talking with. There have also been occasions we have been on calls with distressed individiduals on the way to end their life. In these situations, we can stay on the call while officers are out searching for their location.

Ultimately, there are many factors that contribute to poor mental health, and it is vital we come together as a community to support people. Sometimes we fear that we will not know what to do or say when someone tells us they are unhappy or unwell, but many people just want to be listened to. We can support them by asking questions and reassuring them they are not alone. Part of our role within the force control room is to raise awareness of the importance of mental health with officers and staff, and to encourage people to seek support from the many organisations that exist to help. Sometimes a friendly face or a listening ear is all that is needed.

> **"Part of our role within the force control room is to raise awareness of the importance of mental health with officers and staff"**

For other police forces who may be considering how they develop their own partnerships, it is imperative to acknowledge that each force area is different. Mental health needs and presentations can vary significantly between regions, and knowing your community allows effective and tailored support to be put in place. It is important for forces to understand this so they can develop the right partnerships based on need and establish effective alternatives to police interventions. Sharing knowledge about community needs and demand with health partners will also help them to prepare for future referrals from the police. ■

Lyndsey McClements is a Director of Operations at Hull and East Yorkshire Mind

CASE STUDY 3

Concern for welfare call for a vulnerable woman

This case was locally investigated by the force. The IOPC reviewed the investigation to decide whether there was an indication that a person serving with the police may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings.

A woman called the police and said she was standing at the side of a motorway feeling suicidal. Several members of the public also called the police to advise there was a woman without a car looking distressed on the hard shoulder.

Police officers attended due to the immediate risk to life. They located the woman. She told officers she had tried to end her life three times in the past day and described how.

Officers took the woman to hospital and the mental health crisis team arranged an assessment. Later the same day, the crisis team agreed the woman could go home and agreed a time with the woman to speak on the phone later that evening to check on her wellbeing.

The crisis team called the police in the early hours the next morning to ask them to go to the woman's home to conduct a welfare check. They requested this because the woman had not answered their call or responded to text messages.

A THRIVE (threat, harm, risk, investigation, vulnerability and engagement) assessment was completed by the control room and the call was graded a priority.

Officers went to the woman's home, but she did not answer the door or her phone. The control room also tried to call the woman several times unsuccessfully.

An officer contacted the crisis team a couple of hours later to update them. The officer documented that the crisis team said they had *"no further concern"*. They assumed the woman had gone to sleep. The police closed the incident.

The crisis team called the police again later in the day and spoke to the control room supervisor. They noted they had tried to contact the woman by phone, text message and had also visited her home in the morning and afternoon but received no answer. The crisis team said this was *"very unusual"* for the woman to not respond to the attempts to contact her, and noted she had not been seen by anyone since she left hospital after trying to take her own life which gave them concern. They requested a welfare check.

The supervisor completed a further THRIVE assessment. They also spoke with the force incident manager (FIM). They noted *"a failure in further treatment/engagement with mental health teams does not indicate any immediate concerns for the woman so no powers to force entry at the address"* and there was *"no new information which suggests there is any immediate risk"*.

They also discussed that powers for the police to enter the woman's house under Section 17 of the *Police and Criminal Evidence Act* (PACE) were not appropriate, although the rationale for this decision was not documented.

College of Policing Mental Health APP: Mental health – detention

Under Section 17 of the PACE, a police constable may enter and search any premises for the purpose of saving life or limb or preventing serious damage to property.

… In 2010 the case of Syed v DPP again challenged any justification to enter private property when the reason for their entry was a concern for someone's welfare. The court ruled that this is altogether too low a threshold and that officers need to have reasonable grounds to believe that life or limb is literally and imminently at risk.

More information
www.college.police.uk/app/mental-health/mental-health-detention#section-17-of-the-police-and-criminal-evidence-act-1984-saving-life-or-limb

The supervisor told the caller that the *"police will not be taking ownership of this risk"* and it was for the crisis team to continue to manage. The incident was closed.

The IOPC review noted the crisis team did not have the powers of entry that the police did. The crisis team had *"contacted the police for assistance when the woman's welfare and whereabouts was still unknown"* following their own efforts to try to establish this.

The woman's father also called the police later that day. He had been contacted by the woman's care coordinator. He said she had not replied to her friends' messages, which was unusual.

Following this, police attended the woman's home and found she had taken her own life. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do you help officers and staff to apply your local partnership agreements in their day-to-day work?
- What escalation channels do you have to support staff when the police and health services disagree on the need for police to attend an incident?
- How do you keep in touch with partner agencies to understand how well your local partnership agreements are working in practice, and to identify opportunities for improvement?
- What do your policies and guidance say about circumstances where another agency asks for your help because of the unique powers afforded to police?
- What quality checks do you complete to make sure officers and staff record sufficient rationale for key decisions?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How do you stay informed of your force's local partnership agreements and policies which help identify which incidents it is appropriate for police to respond to?
- How do you continuously assess risk, including making sure risk information is not looked at in isolation?
- How can the advice of other professionals, including mental health teams, help inform your understanding of risk?
- Do you understand why is it important to clearly document your rationale for key decisions?

LEARNING RECOMMENDATIONS AND ACTION TAKEN BY THE FORCE

- The IOPC issued three learning recommendations to the force. They asked them to develop their policies and guidance to support officers and staff with concern for welfare calls; to document rationale when considering powers to enter a person's property; and to review their resourcing messaging from senior management to control room staff to make sure operational policing decisions are evidence-based, and not unduly influenced by concerns over resourcing capabilities.
- The force provided refresher training for control room staff to remind them to document their rationale for not entering a property under Section 17 of PACE. They also clarified their resource messaging to make sure operational decisions are based on an objective assessment of threat, harm and risk.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Right Care, Right Person: the right approach?

Kirsten Taylor-Scarff shares why charity Rethink Mental Illness are calling for change in policing, mental health funding and legislation to enable a whole-sector response to safely meet rising need.

There is no debate about how crucial it is that someone experiencing a mental health crisis is urgently met with the right response. However, the question of what that response should be was put back into the spotlight last year. Police forces across the country began announcing they would be stepping back from responding to mental health calls as they are not the appropriate agency to do so.

The development and implementation of the National Partnership Agreement Right Care, Right Person (RCRP) was announced in early 2023. The Home Office and Department of Health and Social Care guidance was released in July of the same year. Modelled on a strategy adopted by Humberside Police, RCRP is designed to make sure that when someone in crisis calls the police, the police will not attend if there is no immediate threat of harm. Instead, the intention is that the incident will be attended by someone with the right skills, training and experience to best meet their needs.

Rethink Mental Illness, the charity for people affected by mental illness, agrees in principle that most people experiencing acute mental health distress should be met by trained mental health professionals and not the police. However, the police will always have a role to respond to calls where there is risk that someone might harm themselves or someone else. Therefore it is important to consider some key risks that must be countered as this new approach is rolled out.

Risks and considerations

First and foremost, there can be no ambiguity around roles and responsibilities. People need to trust that services can respond appropriately to emergencies when lives may be at risk. Each local Integrated Care Board, responsible for planning and funding most local NHS services, have been tasked with developing a partnership plan with their local police force to detail how calls are responded to. These plans must be clear and robust.

As these agreements are made at local levels, there is a risk of a postcode lottery – that people are treated differently depending on where they live. We have heard from stakeholders that police responses to mental health calls do not always adhere to local RCRP partnership agreements. We are concerned this potentially means police are stepping back from calls when their presence is needed.

It is also important to put RCRP into a broader context. Pressures in policing are well documented, and the need to evolve to free up time and capacity is understandable. But equally, mental health services are struggling to cope with rising demand and face their own challenges with capacity and resource. We are concerned that people in mental health crisis will be left in the lurch as RCRP comes into effect. There are no simple, quick or low-cost solutions on the table to absorb the hours of work the police will no longer carry out through this new arrangement.

Partnership working

We are encouraged that the principle of working in partnership has been emphasised in the debate around RCRP. We believe it is important to monitor the implementation of the scheme so issues can be raised, learning can be shared, and impact can be measured. Local partnership plans should include monitoring arrangements, and these should be collated nationally to allow for comparison and oversight. We also believe plans should be publicly available to ensure transparency around the treatment and responses to people who call 999 in acute mental distress.

But RCRP only addresses part of the problem, and there are other areas that would benefit from partnership working. In particular, the use of disproportionate and excessive force on people from different ethnic backgrounds, especially Black men. As highlighted by INQUEST's *'I can't breathe: Race, death and British policing'* report in 2023, there have been numerous tragic instances where Black men experiencing a mental health crisis have died following police contact.

There is also a role for government, and a desperate need to prioritise dedicated health and social care funding to ensure life-saving support is in place for people in an acute crisis.

The *Mental Health Act (1983)* is 40 years out of date and not fit for purpose. Despite significant investment in the reform process and commitments from the current government to reform the *Mental Health Act* in the current parliament, the issue was not included in the November 2023 King's Speech. This means the government has missed the last opportunity to pass the legislation required before the next election. There is an urgent need for parties to commit to reforming the *Mental Health Act* early in the next parliament.

Proposed changes to this legislation would stop police and prison cells being used as places of safety, alongside other changes that would help make sure people are treated with respect when they are unwell. More broadly, government needs to introduce and resource a long term, cross-government plan for mental health that draws on all government departments and organisations to act on improving mental health. This should include the Department of Health and Social Care, Home Office, Department for Welfare and Pensions, and Ministry of Justice, along with many others.

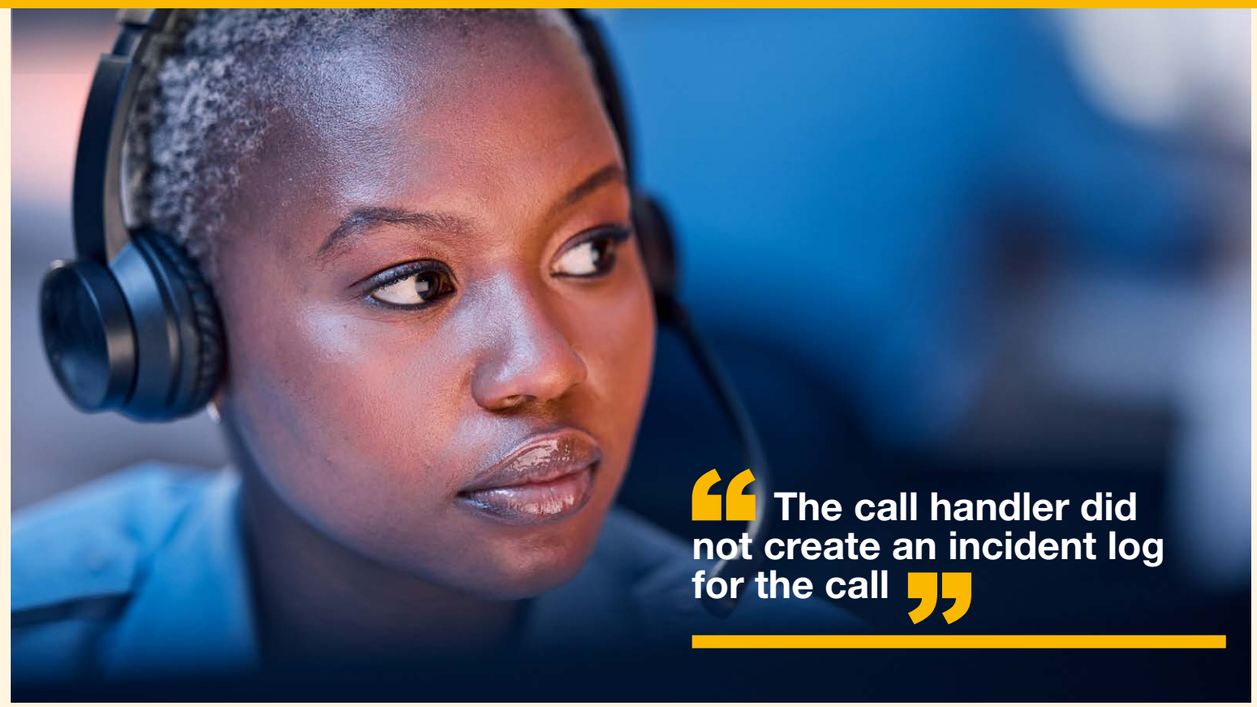
Local partnerships must make sure that every person who needs urgent mental health support receives it in a timely and effective manner; and when police do respond to mental health calls, they must treat all individuals with equity, respect and compassion.

The National Partnership Agreement sets us in the right direction. Yet concerted efforts are needed to make sure its ambitions will be fulfilled and that the funding, workforce and resource will be in place to enable a whole sector response that can safely meet rising levels of need. ■

Kirsten Taylor-Scarff is a Senior Policy Officer for Rethink Mental Illness

CASE STUDY 4

Missed opportunity to identify risk and record a mental health incident



> "The call handler did not create an incident log for the call"

This case was independently investigated by the IOPC.

A woman called 999 one evening requesting the ambulance and police service. She was put through to the ambulance service. She said her daughter was suicidal and had called her in distress and said *"get the ambulance and police here"*. She said her daughter had self-harmed in the past. She suspected her daughter was at home.

The ambulance service made several unanswered calls to the daughter. The incident was marked as requiring an ambulance within two hours.

The woman called the police 45 minutes later after several further unanswered calls to her daughter. She told the call handler her daughter was suicidal, and she thought that the police and an ambulance were going to be sent to her daughter's home.

The woman told the call handler *"[her daughter had said to her] that she wasn't going to be here, she said you better get somebody here now, but she's got mental health problems… and she [is] known [to be] suicidal because she's tried before"*.

The call handler did not ask any further questions, and did not complete a THRIVE (threat, harm, risk, investigation, vulnerability and engagement) assessment. This was also not in line with the force's policy at the time.

During the investigation, the call handler noted she did not believe the incident demonstrated a *'real and substantial risk to life'*. The call remained uncategorised by the call handler and no response time was allocated.

The investigation found the call handler did not complete any intelligence checks during the call. If the call handler had checked force systems, she would have identified self-harm warning markers for the caller's daughter and numerous recent records of police and ambulance attendance to incidents involving the caller's daughter for incidents relating to mental health.

College of Policing Mental Health Authorised Professional Practice: Mental vulnerability and illness

Where appropriate, officers and staff should check national and local information systems for information on individuals with, or thought to have, mental health problems or learning disabilities.

More information
www.college.police.uk/app/mental-health/mental-vulnerability-and-illness

The call handler advised the woman to call 999 again and ask for the ambulance service. The call handler did not create an incident log for the call, which lasted around two minutes. The decision not to create an incident log was also not in line with the force's policy at the time.

The woman called the ambulance service again. She told them she was still unable to contact her daughter. The ambulance service asked if she thought this was a suicide attempt. The woman said *"I think so… the last word she said to me [was], mum I can't do this anymore"*.

An ambulance was dispatched and arrived at the daughter's home 15 minutes later. This was around two and a half hours after the woman's initial 999 call.

The ambulance was unable to gain entry to the daughter's home. They requested assistance from the police and fire service to gain entry. Both services arrived a few minutes later and the fire service forced entry. The woman had taken her own life.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How does your guidance and training support staff to understand when and how to complete THRIVE assessments?
- How do you make sure that staff make use of information available on force systems to identify relevant risk information?
- How do you support control room staff to make decisions about when there is a policing duty to respond to an incident?
- How do your policies, guidance and training help staff to identify incidents which demonstrate a real and immediate risk to life or serious harm?
- What processes do you have in place to regularly review your policies and practices to make sure they are in line with national guidance?
- What quality checks do you have in place to make sure incident logs are completed following calls?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What questions could you ask to make sure you understand the level of risk associated with a mental health call?
- What information sources can you use to inform your understanding of risk related to a call?
- How can your force's local partnership agreement help you make an assessment about if the police are the right agency to attend an incident?

ACTION TAKEN BY THE FORCE

- Following this incident, the force reviewed their welfare check policy and information available on their force intranet about welfare calls and will continue to audit this area. Their THRIVE assessment protocol was refined so that call handling staff can make a better assessment about risk, and relevant staff will complete refresher training.
- The force also introduced a new customer records management system to make sure all calls are logged and recorded accurately. They developed a policy to provide greater accountability to staff when making decisions and completing risk assessments. The policy advises staff to record rationale when logging a call and signposting to another agency, before closing the log.

OUTCOMES FOR THE OFFICERS AND STAFF

- The call handler did not have a case to answer for misconduct and did not face disciplinary proceedings. She received a negative entry in her personal development record, along with individual feedback to improve her understanding of control room policies and processes.
- There was no indication that any other person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

HAMPSHIRE & ISLE OF WIGHT
CONSTABULARY

Sending the right agency – Hampshire and Isle of Wight Constabulary

Peter Hunt describes Hampshire and Isle of Wight Constabulary's journey to improve their response to vulnerable people in crisis.

More than ten years ago, Hampshire and Isle of Wight Constabulary identified that vulnerable members of their community were not receiving the care they needed from the right agency.

Ahead of the national rollout of Right Care, Right Person (RCRP), we began our own journey to identify how to support our officers and staff to make the right decisions about police attendance at mental health incidents, prioritising the right care for people in need.

Welfare checks

In 2013, we established that completing welfare checks on behalf of the public and other agencies was not always the right thing to do. We recognised that often, by sending police officers, who are not mental health professionals, to people in crisis, we were increasing the level of risk to vulnerable members of our community.

To make a change, we recognised the importance of our control room staff being equipped with sufficient information and understanding to make effective decisions about which incidents officers should be sent to.

Call handlers attended a whole day training on how and why to safely decline incidents. The training equipped call handlers to explain their rationale to callers when a decision was made to not send officers, and importantly, how to proactively signpost callers to other agencies so no-one was left without the help they needed.

While our internal training was effective, there are things we would do differently. I encourage other forces who may be at the start of their journey to change their approach to welfare checks, perhaps because of RCRP, to reflect on two lessons we learnt:

1) The importance of early engagement with partners. We sustained good relations with our partners after we had made the change, and we maintain good relations now. But by not engaging with partners early, we put that at risk. We would lead with engagement first if we could start again.

2) Having a solution in place prior to implementation to continue to identify and share risk information. Our process was completely geared around officers physically attending incidents, but we continued to receive risk information from initial calls about incidents we decided not to attend. We found we were holding this information which would usually be shared with partners via the Multi Agency Safeguarding Hub (MASH), which brings together different agencies to enable fast information sharing to safeguard vulnerable people. We needed to develop our process to share risk information via MASH without attending.

Secure transport

The Mental Health Crisis Care Concordat was launched in 2014 - a national agreement which sets out how organisations will work together to make sure people in crisis get the right help.

An early action arising from the Concordat for us was to look afresh at the *Mental Health Act* Section 136 pathway, considering the *Mental Health Act* Codes of Practice and the then new 'Guidance for commissioners: service provision for Section 136 of the *Mental Health Act (1983)*'. The guidance recommended police should be able to handover a person in crisis to the care of mental healthcare professionals and leave within 30 minutes.

The NHS Clinical Commissioning Group (now the Integrated Care System) contracted a company to send a secure ambulance to incidents when requested by officers, with a service level of attendance in one hour. This service is managed and paid for by our local NHS Integrated Care System (ICS) – a partnership of organisations that come together to plan and deliver joined up health and care services.

In 2014 as little as 25% of Section 136 detentions across Hampshire and Isle of Wight were 'converted' into further detentions. The remaining 75% were discharged. A fair challenge to us from healthcare services before commissioning a service to convey Section 136 patients was how we could reduce the number of Section 136 detentions being made.

Pre-Section 136 and crisis alternatives

We had introduced a street triage service on the Isle of Wight in 2012, made up of a mental health nurse and a police officer in a single vehicle. But after a review of incidents the car had attended, we discovered that at no time had the officer used their policing powers.

This made us reflect - did having an officer present criminalise people unduly? Were people with mental ill health receiving the right standard of care?

We moved to a control room triage scheme in 2015, comprising of a mental health nurse in the control room. Call handlers could transfer calls from members of the public and police officers could request pre-Section 136 advice. The service was in high demand, and we began receiving calls from ambulance crews too. To address this, the service was extended to 24/7, and moved out of the force control room into our local 111 centre. A direct dial-in service was also established for healthcare professionals to receive prompt advice.

This service was expanded again in 2019 with the addition of three mental health rapid response vehicles across our force area. These vehicles are funded by health services and include a paramedic and a mental health nurse. They have space in the rear for privacy, de-escalation, and can transport people to hospital or a safe place.

The future

The Office of the Police and Crime Commissioner (OPCC) has recently funded a new role in our area. This is split between the ambulance and police control rooms, and the 111 mental health triage team. The role will monitor incoming call logs and custody whiteboards. It will signpost support, de-conflict deployment decisions, and make sure mental health rapid response vehicles are used to their potential.

2024 will also bring us interoperability of systems, with a single platform being accessible to each partner in the Section 136 pathway – from booking a secure ambulance through to assessment. This will bring greater efficiency and patient safety. ■

My thanks go to:

Sonya Mclean, ICS Senior Programme Manager, for her innovative commissioning. Sonya is instrumental in keeping the partnership team close with a common goal.

Inspector Huw Griffiths (retired), my predecessor who started the work ten years ago, which is now a core part of what we know as RCRP.

The Office of the Police and Crime Commissioner and Police and Crime Comissioner Donna Jones – for funding the new mental health deployment coordinator roles.

Peter Hunt is the mental health lead at Hampshire and Isle of Wight Constabulary

More than crisis intervention: a vision for police response to mental health

Ben Rowe and **Tony Jarred** discuss the impact of the National Police Chiefs' Council's Mental Health Strategy in re-shaping the police response.

In November 2022, the National Police Chiefs' Council (NPCC) lead for mental health, Chief Constable Rachel Bacon, launched the Mental Health Strategy (2022-2025). It aims to make clear what the role of policing is when responding to mental health incidents.

At the time of its publication, the country was emerging from a global pandemic. There were concerns about the impact of exponential rises in mental health demand on existing services already under pressure. In addition, Chief Constables and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services were voicing concerns about the impact of mental health on the delivery of core police duties.

The previous strategy had encouraged the development of systems that supported people experiencing acute mental health crisis. Initiatives that followed were generally based around localised joint working practices on issues such as call handling, training, or joint triage arrangements. These approaches were widely accepted as supportive, caring and compassionate. However, limited evaluation of them and concerns about policing becoming entrenched in treatment pathways created inconsistency in approaches across the country.

The latest strategy seeks to address this, to ensure the policing approach to mental health has a wider focus than just crisis intervention. Now, at the midway point of the strategy, we have an opportunity to reflect on the progress made.

The announcement of the 'National Partnership Agreement' and publication of Right Care, Right Person (RCRP) national guidance in 2023 represent a change in approach driven by the strategy. The Policing Productivity Review recently published a report on how public trust and confidence can be improved by making the best use of police resources. RCRP has the potential to save one million officer hours by making sure the most appropriate service responds to mental health related incidents - which is often not the police. The Review's recommendations also align with the strategy by supporting the call for better data capture and routine recording of mental health interventions. The use of analytics by forces in understanding their mental health demand has started to inform partnership engagement, and forces are being encouraged to develop systems to allow for automated capture of this demand.

The NPCC mental health portfolio have also invested time supporting the reforms detailed within the Mental Health Bill (2022). It was therefore disappointing to learn that the agreed amendments to the *Mental Health Act (1983)* would not be progressed. Despite this, we will make sure improvements are made to case management decision-making where mental health is a factor, and we will support the development of alternative disposal pathways to divert people away from the criminal justice system when appropriate. The Portfolio is also actively supporting the recommendations made within the Police Race Action Plan, to understand the drivers of disproportionality in mental health.

The challenge for us is to make sure continued political interest remains in this area and public debate and partnership discussions remain active. With the strategy remaining in place until 2025, and as forces start to implement RCRP, the objectives contained within the strategy can continue to be used as a framework to maintain the momentum for change.

You can read the strategy here: www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/2022/npcc-mental-health-strategy.pdf ■

Detective Inspector Ben Rowe is the Staff Officer for the NPCC Mental Health portfolio
Tony Jarred is the Mental Health Coordinator for the College of Policing

Oscar Kilo: supporting mental wellbeing

Jenna Flanagan describes how Oscar Kilo is at the forefront of a cultural shift in policing - one which focuses on the mental and physical wellbeing of police officers and staff.

Oscar Kilo, the National Police Wellbeing Service (NPWS), provides support and guidance for police forces across England and Wales. It addresses a crucial internal issue: the wellbeing and mental health of our officers and staff.

The NPWS was developed by and for policing. It recognises the significant strategic issues posed by stress, anxiety and trauma within policing. These factors are often increased by demanding working conditions and hierarchical structures.

The NPWS run an annual wellbeing survey to better understand these issues. Our 2023 survey had its highest response rate yet of more than 42,000 officers, staff and volunteers. It revealed that addressing wellbeing issues is now, more than ever, a necessity.

The NPWS, which sits within the College of Policing and works with the National Police Chiefs' Council and the Home Office, leads the way in improving organisational wellbeing. Our ambition is for everyone who works in policing to understand how to build personal resilience, feel confident to speak up when things are not going well, and to get the best personalised support possible when they do.

> **"By providing support, encouraging resilience, and fostering a culture of open dialogue, we are enhancing the lives of everyone who works in policing"**

Our approach is multifaceted: from the Blue Light Wellbeing Framework, which allows forces to assess and monitor wellbeing provision, to the facilitation of national practitioner networks that encourage best practice and learning to be shared.

The annual Oscar Kilo awards recognise excellence in wellbeing provision across police forces, celebrating achievements and inspiring continued commitment.

The NPWS is also a pivotal delivery partner of the Police Covenant. The Police Covenant is a pledge to do more as a nation to help those who serve this country and to recognise the bravery, commitment and sacrifices of people in policing.

Central to our mission is to both support and guide police forces, and to offer a range of resources and support mechanisms directly for officers and staff. These include access to training, online learning materials, webinars, toolkits, and collaborations with experts to provide current and reliable resources. Specific areas of support encompass mental health, sleep and fatigue recovery, physical fitness and nutrition.

We also extend our support to the families of officers and those who leave the service, acknowledging the comprehensive impact of policing on personal lives.

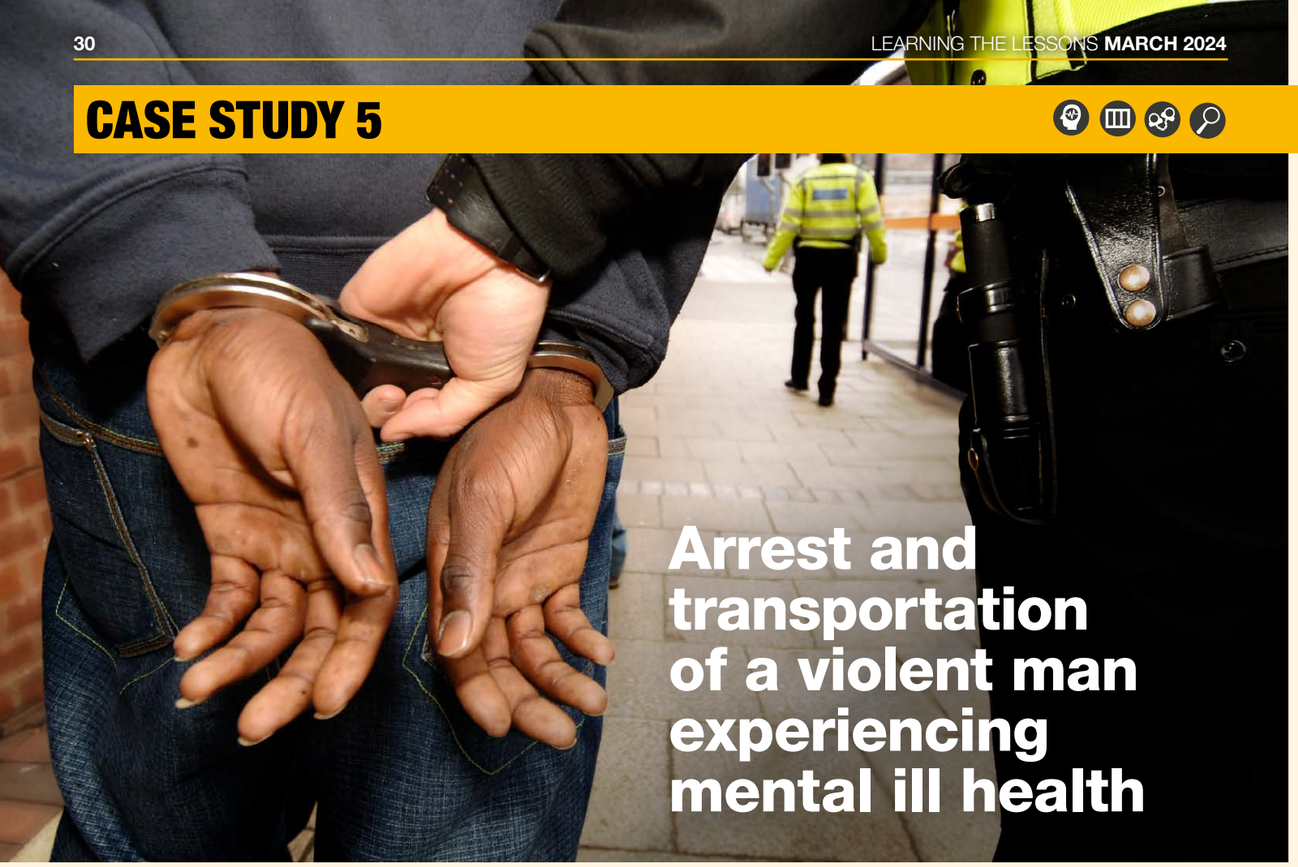
A key development is the upcoming launch of a mental health crisis line for policing, an initiative inspired by successful models in the fire and rescue and ambulance services. This line will provide immediate, confidential assistance, ensuring that help is just a phone call away for those in crisis.

The NPWS is at the forefront of a cultural shift in policing. By providing support, encouraging resilience, and fostering a culture of open dialogue, we are enhancing the lives of everyone who works in policing, and improving the quality of service they provide to the public. The wellbeing of our officers is a cornerstone of effective and compassionate policing.

Visit www.oscarkilo.org.uk for more information. Resources are available for police officers and staff, and their families. ■

Jenna Flanagan is the Strategic Communications Lead for Oscar Kilo

CASE STUDY 5



Arrest and transportation of a violent man experiencing mental ill health

This case was independently investigated by the IOPC.

A woman called 999 to report an incident involving her son. The call handler could hear a man shouting aggressively in the background. The call was categorised as a domestic incident.

Four officers arrived at the address ten minutes later and spoke with the woman. She said her son had *"spat on her face and grabbed her hair"*.

Officers also spoke with the woman's son. During this conversation, he said he had *"mental health problems"* and bipolar disorder. The officers also noticed he appeared to be *"under the influence of drugs and alcohol"*.

The man was placed under arrest for assault and put in handcuffs.

The man resisted as officers escorted him outside. He was placed on the floor following a struggle. He said: "if you don't let me go, I will bang my head on the floor". The man then banged his head. Officers tried to stop him by placing their hands and legs under his head. During the struggle, the man shouted *"I want to go to hospital. I need mental health"*.

The man was placed on the floor in the cage of a police van wearing handcuffs and leg restraints.

He continued to bang his head against the ground and cage during the five-minute journey to custody. The officer in the back of the van observing the man believed he was doing this *"in an attempt to be taken to hospital"*. The officer rationalised the man would be assessed at custody in minutes.

During the IOPC investigation, this officer said: *"I have been asked if there is any form of head protection to place on a detained person's head if they are being erratic, and while they are being transported in a police van, and there is nothing that I am aware of"*. The investigation also found the use of head protection might have reduced the possibility of further injury but noted the officers had taken reasonable steps to try to prevent this.

G College of Policing Detention and Custody Approved Professional Practice (APP): Moving and transporting detainees

Every detainee must be properly supervised and monitored at all times during transport. Officers and staff should take particular care with individuals who have been subject to force upon arrest, particularly where they are restrained with handcuffs or leg restraints, as this can increase the risk of injury.

More information
www.college.police.uk/app/detention-and-custody/moving-and-transporting-detainees

The custody sergeant met the van at arrival to custody. Officers told the sergeant the man had repeatedly hit his head. A bruise was visible on the man's forehead.

The sergeant assessed the man *"needed to be taken straight to a cell… I did not believe [he] was compliant enough to follow my requests and instructions"*. The leg restraints were removed. Officers escorted the man to a cell where he continued to struggle, shout and express his desire for medical help.

G College of Policing Detention and Custody APP: Alcohol and drugs

Differing levels of drunkenness pose different risks to the detainee. Not only can alcohol be lethally toxic in itself, but it can also mask the effects of head injury, drug abuse or physical and mental ill health, which could have lethal consequences.

More information
www.college.police.uk/app/detention-and-custody/detainee-care/alcohol-and-drugs

Officers placed the man in safety clothing once he was in a cell, used when someone is believed to be at risk of suicide or self-harm. The man continued to act violently, shout and request medical help. An officer said: *"he made some attempt to bite his wrists… he was definitely under the influence of some kind of drugs and alcohol"*.

During the investigation, the sergeant noted he did consider if the man needed to go to hospital. However, in his experience, it was not possible due to the risk the man would pose to others. The investigation found this decision was in line with the force's policy at the time.

The man was left alone in his cell. The sergeant completed a care plan and risk assessment. The man was placed on level one observations with rousing checks every 30 minutes.

Shortly after, the sergeant noticed on CCTV the man was banging his head on the cell wall. The health care practitioner (HCP) was notified, who was not prepared to visit the cell due to the man's behaviour. However, based on CCTV observations, she agreed the man did not need to go to hospital.

The next HCP came on duty several hours later. The man's behaviour had de-escalated at this stage, so she was able to assess him. She sent the man to hospital. It was identified the man had a bleed on the brain, likely from banging his head. He later recovered. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What guidance do you provide to officers on transporting someone who is trying to self-harm?
- What provisions do you have in place to reduce the risk of people self-harming in police vehicles?
- How do you train custody officers and staff to respond to a person trying to self-harm in a cell?
- What does your policy say about how healthcare assessments should be completed when a person is violent?
- What arrangements do you have with local health boards to manage patients who are violent or under the influence?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- What tactics would you consider to reduce the risk of someone hurting themselves during an arrest?
- What steps can you take to gather information about a person's vulnerabilities at the point of arrest or at custody?
- How would you manage the risk of someone arriving in custody suspected to be under the influence of alcohol and drugs with a head injury, in line with national guidance?

ACTION TAKEN BY THE FORCE

- Following this incident, the force reminded all officers of the appropriate steps that should be taken to ensure the safe transport of people to custody. This included a reference to transporting people who caused a risk to themselves. The reminder also asked officers to make sure that any harm caused on the way to custody should be reported to the custody sergeant immediately to ensure appropriate medical interventions.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Charity partnership supports mental health in custody

Richard Scullion introduces a partnership between City of London Police and Samaritans to look after the mental wellbeing of people and staff in custody.

In 2021, City of London Police and the Samaritans charity joined together to try to improve the support available for people in police custody. This took shape as a face-to-face listening service available to people in custody, as well as police officers and staff. The listening service allows people to have confidential conversations with trained Samaritans volunteers to help look after their mental wellbeing. This collaboration has gone from strength to strength and is gaining interest from police forces across the UK.

We spoke with Richard Scullion to find out more.

Why is it important to have mental health support available in custody?

Many people who pass through custody present a range of vulnerabilities. It is only right that when we take away a person's liberty, we fulfil our duty of care in the hope that, where possible, they leave having received the right care relevant to their needs.

All people arriving in custody will experience a range of emotions, and being in a cell can be a lonely place. Having a confidential conversation with a Samaritan can make a huge difference by helping to reduce stress, and help people to cope with the situation they are in.

But our Samaritans volunteers do not just work with people taken into custody. They are available to police officers and staff too. Samaritans recognised officers and staff in custody perform difficult and stressful jobs, and can also benefit from a confidential, supportive conversation with a Samaritan listener. Officers and staff can approach Samaritans volunteers directly and in confidence for a conversation.

What impact has this partnership made in your force?

We have seen a notable difference in the mental wellbeing of people in custody following interactions with Samaritans. Typically, a person arriving in custody would be booked in, and their next conversation would be in a more formal environment with a solicitor or in an interview with an officer. Now, people in custody can have a conversation with a Samaritan listener and talk about anything they want. Samaritans have built up a fantastic reputation supporting people in crisis and there was no better partnership suited to deliver this.

Samaritans have also extended their support by becoming a regular presence in our welfare hubs, positioned in public and designed for members of the public to speak with the police and obtain safety information. Samaritans also join officers on patrol to better understand the work police do, and to help officers to understand the work of Samaritans and the support that is available.

Samaritans' volunteers cannot be present in custody 24/7. However, their regular presence reminds custody staff that they can signpost people in custody to Samaritans on their release, or by making a third-party referral for someone to receive a call while in their cell.

Samaritans have also provided listening skills workshops for City of London Police officers and staff. More than 10% of our work force have completed Samaritans training. Although there is a cost, 100% of the money goes back into supporting the Samaritans charity and our force wellbeing network kindly funded the training, recognising the benefits it brings. Feedback from the course has been fantastic, and I have made use of the skills myself in my role. Our ambition is to see all officers and staff trained.

> **"We have seen a notable difference in the mental wellbeing of people in custody following interactions with Samaritans"**

We are also proud to say that two of our volunteer Samaritans have received Commissioner's Commendations for their work in setting up the scheme.

Have there been any challenges?

It has been extremely rewarding to launch this scheme in the City of London, which incidentally is where Samaritans started 70 years ago in a church close to the police station. But introducing a new procedure into an already busy custody suite can be difficult.

It was important to us early on that Samaritans were familiar with the practices and challenges of working in custody. To help with this, we designed an induction training package to familiarise Samaritans volunteers with the custody environment and their role in keeping custody a safe place for all. We also trained Samaritans volunteers on non-contact conflict resolution to make sure they are self-sufficient while working in custody.

How could other police services develop a partnership with Samaritans?

As one of the first forces to run this scheme, a lot of groundwork has been completed already. We have created standing operating procedures and a memorandum of understanding, as well as risk assessments and training material. We are happy to share this material with other police services for them to re-brand to fit their own Samaritan partnerships.

The Samaritans lead for this work and I have already spoken to a number of other forces and Samaritan branches who have enquired about setting up a similar scheme, including in the Republic of Ireland. If you are interested in finding out more about our approach, you can contact learning@policeconduct.gov.uk who will pass your enquiry to me.

What three tips would you give forces looking to take a similar approach?

1. There is no need to reinvent the wheel. Make sure to discuss the work with Samaritans and police already involved in a similar partnership to find out how it could work in your area. We are keen to support other police services and recognise that one size does not fit all.
2. Keep it simple and trust the experts. Samaritans have so much experience and the ability to adapt to working in custody, making use of resources already available including risk assessments, procedures, and training materials.
3. Remember that Samaritans are volunteers. They provide this service willingly in addition to their responsibilities in their local branch. Our volunteers value invitations to relevant CPD training opportunities we run in custody which helps their own personal development. And remembering to say 'thank you' is always appreciated. ■

Richard Scullion is a Police Sergeant at City of London police

CASE STUDY 6

Decision making during a mental health incident

Photo: Alamy

This case was locally investigated by the force. The IOPC reviewed the investigation to decide whether there was an indication that a person serving with the police may have committed a criminal offence or behaved in a manner which would justify disciplinary proceedings.

A man was arrested for malicious communications, public order and assault on police.

While in custody, he repeatedly threatened to harm himself once released. The custody mental health team could not speak with the man because he was aggressive and verbally abusive, however the psychiatric nurse declared him *"fit to be interviewed expressing no concerns around his capacity"*.

A risk assessment was completed later that evening. It noted the man had previously been detained under the *Mental Health Act*. The man was released on bail and officers escorted him home.

The following day the man rang the police to ask for an update. During this call, the man said *"if nothing gets sorted out within the next couple of days… I am actually going to kill myself"*. He then said he had started stabbing himself and intended to take all his medication.

Police systems identified the man had called from home. The call handler graded the incident as an emergency and requested an ambulance.

Three officers were sent to the man's home due to the immediate risk to life. While officers were on their way, the man told the call handler he had a personality disorder and said *"I hate myself, I have nothing to live for"*.

> **"A risk assessment was completed later that evening. It noted the man had previously been detained under the *Mental Health Act*"**

The officers requested background information from the force's mental health service, designed to help in incidents involving an immediate mental health crisis.

The mental health service told the officers about the recent assessment in custody and noted the man *"has mental and behavioural [issues] due to drug use"*. The assessment also stated the man had a history of threatening self-harm. The service also told officers *"his medication is placebo, so he is unable to overdose on it"*.

Officers arrived at the man's home 15 minutes later. The man told them he was going to take his own life. He picked up a handful of tablets to put in his mouth. An officer grabbed his hand to stop him. The man then asked the officers to *"section"* him. An officer told him they did not have the powers to do so but encouraged the man to voluntarily go to hospital. They offered to transport him, but the man did not wish to go voluntarily.

The man then attempted to walk outside. He believed this would allow officers to detain him. The officers recognised they could not use Section 136 powers because the man was at home.

College of Policing Mental Health Authorised Professional Practice (APP): Mental health – detention

Section 136 allows this power to be exercised in any public or private place other than:

- a house
- flat or room where that person, or another person lives
- any yard
- garden, garage or outhouse that is used in connection with the house, flat or room, other than one used in connection with one or more houses, flats or rooms.

More information
www.college.police.uk/app/mental-health/mental-health-detention

The man then ran into the kitchen and cut himself. Officers updated the force control room that *"[the man] had a minor superficial cut to his chest... [he] has been advised to see a doctor or nurse should he require any further medical assistance"*. Officers asked that the ambulance requested earlier was cancelled.

Before leaving, officers confirmed with the man that he did not wish to voluntarily go to hospital. The officers then left the man with *"no immediate concerns that he would attempt to take his life"* and asked him to contact the mental health crisis team or Samaritans if he needed support. The man stated *"so you're going to leave me where I want to kill myself. Are you stupid?"*

The force's own investigation found their mental health policies and procedures did not guide officers about what they should do when they could not use Section 136 powers, including considering requesting a referral to an Approved Mental Health Professional (AMHP) by the mental health service.

The man's sister called the police shortly after. The man had called her and said he had taken tablets to end his life. She advised he was vulnerable, had mental health issues and had tried to take his own life before. The police requested an ambulance who told the police there were 40 minute delays. Officers were not sent back to the man's home.

The ambulance service contacted the police half an hour later. The man was found with life-threatening self-harm injuries and was suspected to have overdosed. He later recovered in hospital. ■

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How does your force work with partner agencies to make sure local partnership agreements reflect the nature of local provision and support available to people experiencing a mental health crisis?
- How do you support officers to understand options if they are with a person in a mental health crisis, but use of Section 136 powers is not appropriate?
- How do your make sure your policies reflect current national guidance around police involvement in mental health incidents?
- How do you support officers and staff to understand when there is a policing duty to respond to an incident?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How can you develop your awareness and understanding of police powers under the *Mental Health Act*?
- Would you know who to ask for advice before leaving a person alone who has told you they want to take their own life?

LEARNING RECOMMENDATIONS AND ACTION TAKEN BY THE FORCE

- The IOPC issued one learning recommendation to the force. It asked them to bring their mental health policy and procedures in line with APP, to encourage considerations by officers in situations where a mental health assessment may be required. This included adding information around consultation with AMHPs and the use of Section 135 powers.
- The force amended their procedure. They are now considering changes to future requests for service for mental health incidents.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.
- The attending officers were de-briefed to discuss learning opportunities.

Safeguarding the *Mental Health Act*: professionals and policing

Christina Cheney and **Robert Lewis** answer our questions about their work as Approved Mental Health Professionals.

What is the role of Approved Mental Health Professionals (AMHPs)?

AMHPs represent a fundamental legal safeguard under the *Mental Health Act (1983)* for people at risk of compulsory hospital admission or controls in the community that impact their human rights. AMHPs have the ultimate power to decide whether a person is taken to hospital, or such controls are put in place. This work takes place 365 days a year.

AMHPs receive specialist training to carry out a range of statutory duties in relation to the *Mental Health Act*. They are approved by local authorities but act independently. Their decisions cannot be directed or influenced by others, nor appealed or overturned.

AMHPs respond to requests under the *Mental Health Act* where a person is in a mental health crisis and presenting risks to themselves and/or others in a way that appears they cannot be supported in the community. The role of AMHPs is to consider the case, explore alternatives to detention under the *Mental Health Act*, and make sure the least restrictive options are explored so independence is maximised.

What misconceptions are held about AMHPs?

There are three common ones:

1. That AMHPs must 'section' someone when a doctor or other person requests them to do so. AMHPs do not have to agree with doctors and can go against their recommendations and formulate alternative plans and approaches.
2. That AMHPs can find hospital beds. AMHPs do not have responsibility or control over medical resources including beds, doctors and ambulances.
3. That AMHPs take over caring responsibilities for an individual in distress who has been referred to them. This is a common misconception in policing and among health professionals. The AMHP's role is to consider alternatives to the use of the *Mental Health Act*, or assess whether the criteria for detention is met where necessary.

When do AMHPs and the police work together?

We work together in a number of ways, for example when executing a warrant under Section 135 of the *Mental Health Act*. Section 135 warrants are obtained from court by an AMHP but must be executed by a police officer, AMHP and a doctor. Only when all three roles are present can the warrant be executed, and a person be taken from a dwelling to a place of safety for assessment. This process can be frustrated by a lack of resources and police colleagues may find themselves booked in multiple times for the same assessment.

We also work together when a police officer has made an arrest under Section 136 of the *Mental Health Act* and takes a person to a place of safety for an assessment by an AMHP and a doctor.

AMHPs also work in the community, and it may be necessary to obtain police support when conducting an assessment under the *Mental Health Act* in a person's property. Some visits can only be managed safely with the assistance of the police, for example when a person is violent, known to have weapons, or where environmental factors present a significant risk.

We may also be asked by the police to go to custody to assess someone whose mental health cannot be managed within the resources available in custody or in the community.

It is important that AMHPs and the police recognise and respect each other's roles and limitations and feel able to call on each other for support and advice.

What is your perspective on Right Care, Right Person?

We work across all areas of mental health crisis care and have knowledge and awareness of all parts of the systems in contact with people in crisis. This includes in the community, hospital, police custody and prisons. We also have detailed knowledge of the wide range of legislative frameworks relating to mental health.

So, when it comes to Right Care, Right Person, we are sympathetic to the challenges faced by officers and broadly support the aims of the initiative. However, it is critical police colleagues understand their ongoing statutory responsibilities under the *Mental Health Act*, for example, executing Section 135 warrants and the use of Section 136. We call on leaders and policy writers in policing to support officers and staff to confidently understand their ongoing responsibilities alongside the scope of Right Care, Right Person.

Why do *Mental Health Act* assessments take so long?

Once a referral has been made for an AMHP to consider admitting a person under the *Mental Health Act,* they are duty bound to consider the person's history, social situation, family, views, engagement with mental health services, human rights and – where assessment is needed – to secure the necessary support of other agencies. A high proportion of requests for assessment will not proceed beyond this first stage.

If an assessment is deemed appropriate, AMHPs will often arrange for two doctors to attend and must make sure they interview the person in an appropriate manner. AMHPs rely on local agreement and availability of doctors. This stage of the process can take hours and even carry to the next day.

If a hospital bed is required, an AMHP application cannot be completed unless a bed has been identified and a hospital named. It is common for beds to not be available for hours or days. If the original AMHP is no longer available to proceed with the application, a re-assessment is required from a new AMHP.

AMHPs must then arrange appropriate transport to hospital once an application for a hospital bed is completed. This relies on multiple partner agencies, and the need for an out of area placement, restraint-trained crews or other specialist provision can all increase delays.

What resources are available to improve understanding of the role of AMHPs?

We encourage people who work in or design training for officers and staff in response and custody roles to make use of a free 30 minute e-learning session designed to support better understanding of the AMHP role: www.e-lfh.org.uk/programmes/approved-mental-health-professional/.

Police services are also encouraged to establish links with their local AMHP service, and to consider opportunities for sharing learning and training. We also encourage people working in policing to ask questions when engaging with AMHPs through the course of their duties to find out more. ■

Christina Cheney and **Robert Lewis** are Approved Mental Health Professionals (AMHPs) and co-chairs of the AMHP Leads Network

CASE STUDY 7

Absent without leave from a mental health hospital

This case was independently investigated by the IOPC.

Day one

A nurse at a mental health hospital called the police one evening. The nurse said an inpatient had not returned to hospital after 30 minutes of authorised unaccompanied leave several hours ago in the afternoon.

The nurse told the call handler the man had been detained under the *Mental Health Act*. The nurse also said the man had paranoid schizophrenia and an alcohol misuse problem, and that it *"could well be possible that he's at home drinking"*. He emphasised he did not know this for certain.

The nurse said the hospital had not completed any checks to try to establish the man's whereabouts or welfare since he failed to return to hospital several hours earlier.

The call handler notified the force control room inspector. The inspector believed the incident was low-risk and the man was not *"likely to be lost, have taken ill, presenting a self-harm concern, or any significant risk to the public"*.

> **"The incident log was updated to note the man would not be treated as missing as the man's neighbour had seen him"**

College of Policing Mental Health Authorised Professional Practice (APP): Absent without leave (AWOL) patients

The definition of when a patient is AWOL is contained in the *Mental Health Act Section 18*. This definition is key to understanding when police powers to re-detain an AWOL patient apply, and the circumstances in which a warrant may be required under the *Mental Health Act* Section 135.

More information

www.college.police.uk/app/mental-health/awol-patients

The call handler informed the nurse that the man would not be considered a missing person because hospital staff suspected the man was at home. The nurse was asked to contact a neighbouring police service to request a welfare check as the man's home address fell under their jurisdiction. The call handler also advised the nurse to consider obtaining a warrant under Section 135 of the *Mental Health Act* as this would provide a legal basis for the man to be detained and returned to hospital once found. The call handler then closed the incident log.

The inspector reviewed the incident log a couple of hours later. They requested it to be re-opened until an update had been obtained from the neighbouring force.

Day two

A control room operator contacted the hospital for an update the next morning. The nurse advised they had not yet requested a welfare check with the neighbouring force and had not completed any checks to try to establish the man's welfare.

Following this call, a second force control room inspector requested a welfare check be completed. The inspector advised they did this to avoid more delays. The purpose of this check was to decide if the man should be treated as a missing person.

The man's mother contacted the police before this had happened. She said the man was vulnerable and had suffered from falls in the past which required hospital treatment.

Two officers arrived at the man's home several hours later. The man did not answer his door or phone. A neighbour reported seeing the man *"come and go"* the previous day. The neighbour said the man had left his flat that morning but had not returned. The neighbour also noted the man had been making *"strange noises"* in the early hours of the morning.

The incident log was shared with the neighbouring force for awareness.

Day three

The control room called the hospital the following day for an update. The hospital said the warrant had still not been obtained.

The inspector advised it was now a matter for the hospital to obtain a warrant and engage with the neighbouring force. The incident log was updated to note the man would not be treated as missing as the man's neighbour had seen him. The incident log was closed.

Later that day, the hospital called the neighbouring force to ask them to assist in carrying out the warrant they had obtained. The hospital told the neighbouring force about the man's *"serious self-neglect"* and *"excessive alcohol use"*. The call was graded as a medium-level priority, and the police informed the hospital that they did not currently have resources available to support.

Day four

Officers from the neighbouring force contacted the hospital the following day to advise they could go to the man's home in the next 15 minutes to help carry out the warrant. The hospital advised they had also been liaising with the ambulance service. The ambulance service said they would not go to the man's home until police were present. This meant the officers could be waiting up to four hours for the ambulance to join them because of the projected delay.

A police sergeant advised the officers to prioritise other jobs instead due to the projected delay.

Day five

Five days after the initial call to police, the neighbouring force went to the man's home with hospital staff. Officers forced entry before the ambulance arrived due to a number of empty alcohol bottles visible from the window. The man had died at home due to an existing condition relating to alcohol misuse.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- How do your local partnerships support understanding of the responsibilities of the police and other agencies to complete checks to establish a person's whereabouts and welfare?
- How do you help officers and staff to understand your local partnership agreements?
- What does your policy say about what to do when the police have attempted to check on a person's whereabouts and welfare, but have not physically seen the person they were looking for?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- Are you aware of what your force's local partnership agreements say about the steps other agencies should take to establish a person's whereabouts and welfare when they are absent without leave from a mental health setting?
- How can your force's local partnership agreements help make sure people in need receive care from the agency best placed to respond?

ACTION TAKEN BY THE FORCE

- Following this incident, the neighbouring force reviewed their policy and procedures on welfare checks and carrying out Section 135 warrants.

OUTCOMES FOR THE OFFICERS AND STAFF

- There was no indication that any person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Association of Police and Crime Commissioners

Choosing the right course of care for the most vulnerable

Lisa Townsend sets out her view on Right Care, Right Person, describing the importance of public accountability and returning the police to their core duties.

As the Association of Police and Crime Commissioner's (APCC) lead for mental health and custody, and Surrey's Police and Crime Commissioner (PCC), it is crucial that I believe Right Care, Right Person (RCRP) is the right course of action for society's most vulnerable people.

Many of us know the pressure police are under from incidents relating to mental health. In Surrey alone, the hours officers have committed to supporting people with mental ill health has dramatically increased. In August 2023, officers in Surrey spent more than 700 hours with people in mental health crisis – the highest number ever recorded in this county. For comparison, in 2017, the highest number of hours recorded in a single month was 183.

Fewer than one in five calls to Surrey Police's contact centre are related to crime. The greatest proportion – 38% – are marked as 'public safety/welfare'.

There will always be a role for policing where there is a threat to a person's safety. We have a duty to protect our communities, and we will never fail to respond where we are needed. However, most contact with forces around the country are no longer related to this concern. It is here we must draw a line.

> **"There will always be a role for policing where there is a threat to a person's safety"**

This is not a new problem. His Majesty's Inspectorate of Constabulary and Fire and Rescue Services produced their 'Policing and mental health: Picking up the pieces' report back in 2017, highlighting significant concerns in this area.

Few people honestly believe the best outcome for a person in mental health crisis is to be in a police car or a cell because they have nowhere else to go. That is why I am a long-term advocate of RCRP.

The initiative can sound frightening to the public, who have over time come to see the police as the only emergency service able to deal with any societal issues.

However, its success is based on a set of simple steps that create tangible, measurable improvements to the lives of those with mental health issues. We can so clearly see this in Humberside where the initiative was first developed.

While the results are ground-breaking from a policing point of view, the changes that are needed simply return care for people in crisis from the police to medical professionals.

It is important for all PCCs to believe RCRP is the way forward. PCCs are elected representatives who are, unlike chief constables, directly answerable to the public.

In supporting this initiative, I am publicly committing the police to attending more offences and improving the service residents receive. Residents can also contact their PCC to discuss policing in their community. PCCs carry out regular meetings with their residents and can be contacted by phone or email.

Through direct engagement, PCCs are directly accountable as individuals. For me, that is why it is vital that I genuinely believe in two things: that RCRP is the right course of action for the most vulnerable, and that it will help police return to the job only they can do – protecting the public and solving crime. ■

Lisa Townsend is the lead for mental health and custody at the Association of Police and Crime Commissioners, and Surrey's Police and Crime Commissioner

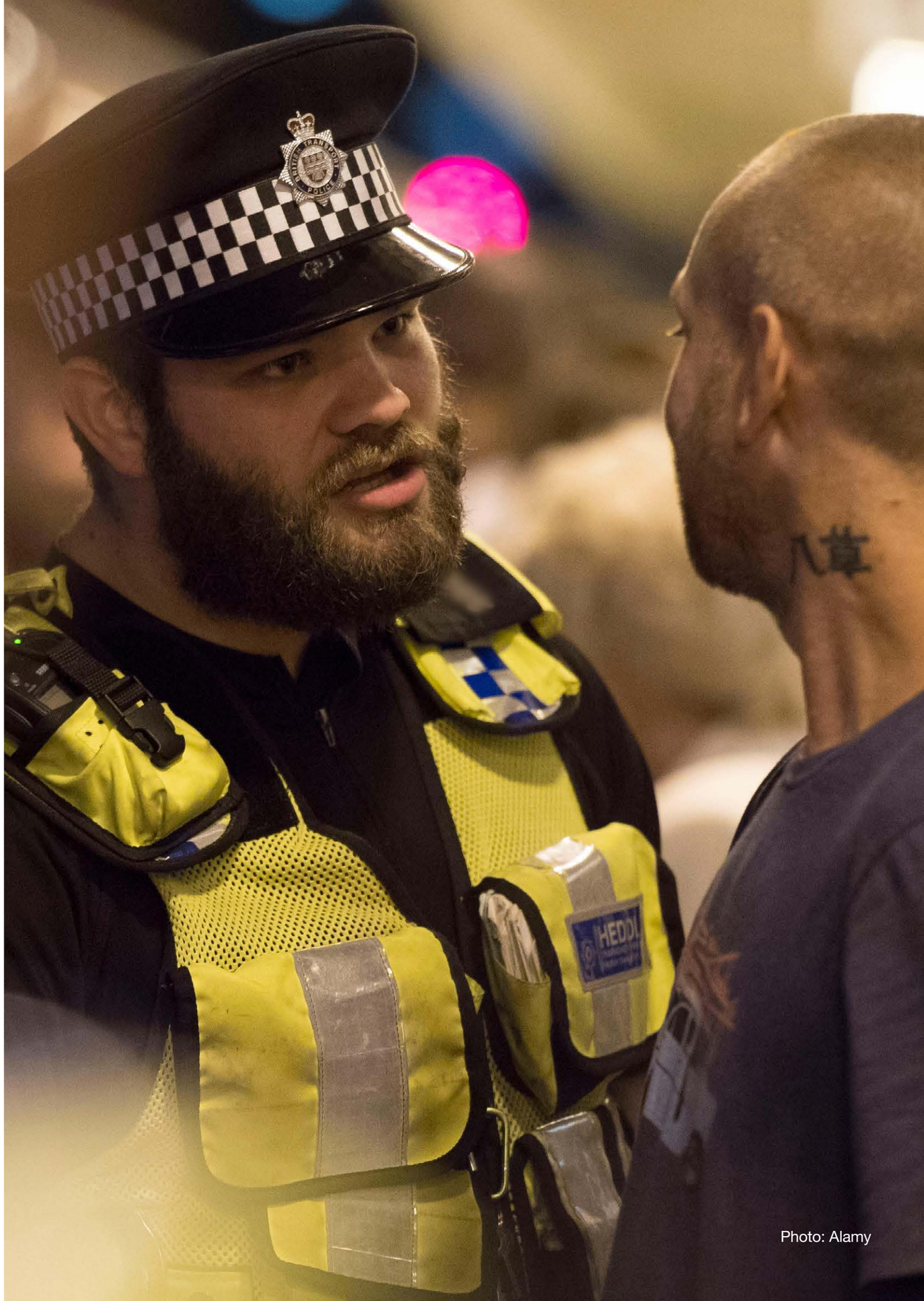


Photo: Alamy

CASE STUDY 8

Changing priority level for a young person at risk of harm

This case was independently investigated by the IOPC.

A 17-year-old called the police but quickly ended the call. A call handler listened to a playback. The young person could be heard saying *"can you send someone to pick me up, I'm about to kill myself"*.

The call handler traced the call to a large park using a database containing geographic locations. The exact location of the young person within the park could not be identified.

The call handler called the young person back twice, but they hung up both times. The call handler escalated the call to her team leader. The team leader also rang the young person and asked for their location. They replied, *"I don't know"* and *"what do you mean, help me?"* before hanging up.

The team leader updated the incident log. The call was graded as requiring an immediate response due to the immediate risk to life and transferred to dispatch.

The main dispatcher downgraded the call priority from 'immediate' to 'high' shortly after receiving the details.

The dispatcher was new in post and had a coach to support her decision-making while learning the role. The dispatcher told the IOPC that her coach told her to downgrade the call because there was no physical description of the young person, and the park was a large area. The dispatcher said she trusted the advice and did not feel she had the power to override it.

The downgrade in priority meant it was less likely officers would be sent to the area, because less resources were available for incidents not graded as requiring an immediate response. The IOPC investigation found it was likely there would have been officers available to go to a call requiring an immediate response at the time.

> **"The dispatcher's coach told the IOPC there was not enough information to send officers. He said the incident log only included the coordinates of the park."**

The dispatcher's coach told the IOPC there was not enough information to send officers. He said the incident log only included the coordinates of the park.

The coach explained that he had questioned the team leader about the rationale for grading the incident as requiring an immediate response at the time. The team leader explained this was in line with their force policy at the time, as there was an immediate risk to life. Despite this, the force control room supervisor agreed with the coach that the call should be downgraded, based on the limited information available on the incident log.

The force control room supervisor added rationale for downgrading the call. He noted the recommended action was to continue to try to contact the young person by phone.

Another dispatcher requested another call be made to the young person's phone. Following this request, the force incident manager asked if any officers were available to be dispatched. He also requested a check to see if ambulance services had received any calls from the young person.

The call to the young person went unanswered. There were no records of them calling ambulance services.

Another unsuccessful call attempt was made over two hours after the young person's initial call to the police. A dispatcher sent a text message asking the young person to call the police a further two hours later.

During the investigation, this dispatcher said they sent a text message as no one else had done this. There was no existing practice in place at the time for concern for safety text messages to be sent to someone that had disclosed a suicide risk.

No officers were sent to the park despite the request from the force incident manager. The main dispatcher explained to the IOPC the continued decision not to send officers was due to the wide search area and lack of available patrols.

The young person was found by a member of the public in the park seven hours after their initial call to the police. The young person had taken their own life. ■

You can call Papyrus for free on 0800 068 4141 or visit www.papyrus-uk.org/ if you have been affected by this case and would like support.

KEY QUESTIONS FOR MANAGERS, POLICY MAKERS AND TRAINERS

- What resources do you have to narrow search areas when tracing calls?
- What steps do you take to make sure sufficient detail is captured on call logs to aid dispatch teams?
- What resources do you have available to try to identify unknown callers?
- How do you promote understanding through policies, guidance and training of what constitutes a real and immediate risk to life or serious harm?
- How does your force use text messages to help reach people at risk?

KEY QUESTIONS FOR POLICE OFFICERS AND STAFF

- How do you make sure vulnerability linked to a person's age, when known, is considered as part of your risk assessment?
- How do you make sure all relevant information is recorded on a call log to assist decisions about deployment?

LEARNING RECOMMENDATIONS AND ACTION TAKEN BY THE FORCE

- The IOPC issued six learning recommendations to the force. They asked them to update their policies, guidance and training about grading and dispatch in incidents relating to immediate risk to life. The force was also asked to include guidance for call handlers and dispatchers to text a person at risk of taking their own life when they do not answer their phone.
- The force updated their guidance about 'threat to life' calls to ensure 'immediate' grade incidents are not downgraded because there is no location to deploy to, or no patrols to attend. Staff were briefed that a dispatcher who considers an incident has been incorrectly graded must inform a force control room supervisor as soon as possible. Only the supervisor can downgrade the incident. The force also updated their guidance for dispatchers to consider sending a text message if a caller is a suicide risk. The text signposts contact information for mental health charities.

OUTCOMES FOR THE OFFICERS AND STAFF

- The coach, force control room supervisor, force incident manager, and two of the dispatchers involved did not have a case to answer for misconduct and did not face disciplinary proceedings.
- The coach, force control room supervisor and force incident manager were referred to the reflective practice review process to learn from the incident.
- There was no indication that any other person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.

Support and information

Mental health

Samaritans
www.samaritans.org
Every ten seconds, Samaritans respond to a call for help. No judgement. No pressure. Samaritans are here for anyone who needs someone. Whatever you're going through, you can call any time, from any phone for free.
Tel: 116 123
Email: jo@samaritans.org

Mind (also Mind Cymru)
www.mind.org.uk
A national mental health charity providing advice and support to empower anyone experiencing a mental health problem. Mind campaign to improve services, raise awareness and promote understanding.
Tel: 0300 123 3393 (9am – 6pm)
Email: info@mind.org.uk

Rethink Mental Illness
www.rethink.org
Rethink Mental Illness is the charity for people severely affected by mental illness. They provide expert information and services, and campaign to improve the lives of people living with mental illness, their families, friends and carers.

Oscar Kilo
www.oscarkilo.org.uk
Oscar Kilo is the National Police Wellbeing Service, providing support and guidance for police forces across England and Wales to improve and build organisational wellbeing. It provides resources and support developed specifically for policing, by policing, and designed to meet the unique needs of officers and staff, their families and those who leave the service.

Zero Suicide Alliance
www.zerosuicidealliance.com
The Zero Suicide Alliance offer free online suicide awareness and prevention training and resources. Their online courses teach people the skills and confidence to have a potentially life-saving conversation with someone who may be struggling with suicidal thoughts.

The Jordan Legacy
www.thejordanlegacy.com
The Jordan Legacy's mission is to help move towards a 'zero suicide society'; a society that is willing to do all it can to prevent all preventable suicides.

With You
www.wearewithyou.org.uk
With You is a charity providing free, confidential support to people experiencing issues with drugs, alcohol or mental health.

Shout
www.giveusashout.org
Shout is the UK's first and only, free, confidential, 24/7 text messaging support service for anyone who is struggling to cope.
Text: 'SHOUT' to 85258

Survivors of Bereavement by Suicide
www.uksobs.org
Survivors of Bereavement by Suicide are the only organisation offering peer-to-peer support for all those over the age of 18, impacted by suicide loss in the UK. They offer peer-led support groups, online virtual support groups, a national telephone helpline, online community forum and email support.

Children and young people

Childline
www.childline.org.uk
Childline is here to help anyone under 19 in the UK with any issue they're going through. Childline is free, confidential and available any time, day or night. You can talk to Childline by phone, email or through 1-2-1 counsellor chat.
Tel: 0800 1111

Papyrus
www.papyrus-uk.org
Confidential support and advice for young people struggling with thoughts of suicide and anyone worried about a young person. Papyrus' helpline also offers a debrief service for professionals who have had an experience with suicide and would like to talk it through with a trained professional.
Tel: 0800 068 41 41
Email: pat@papyrus-uk.org

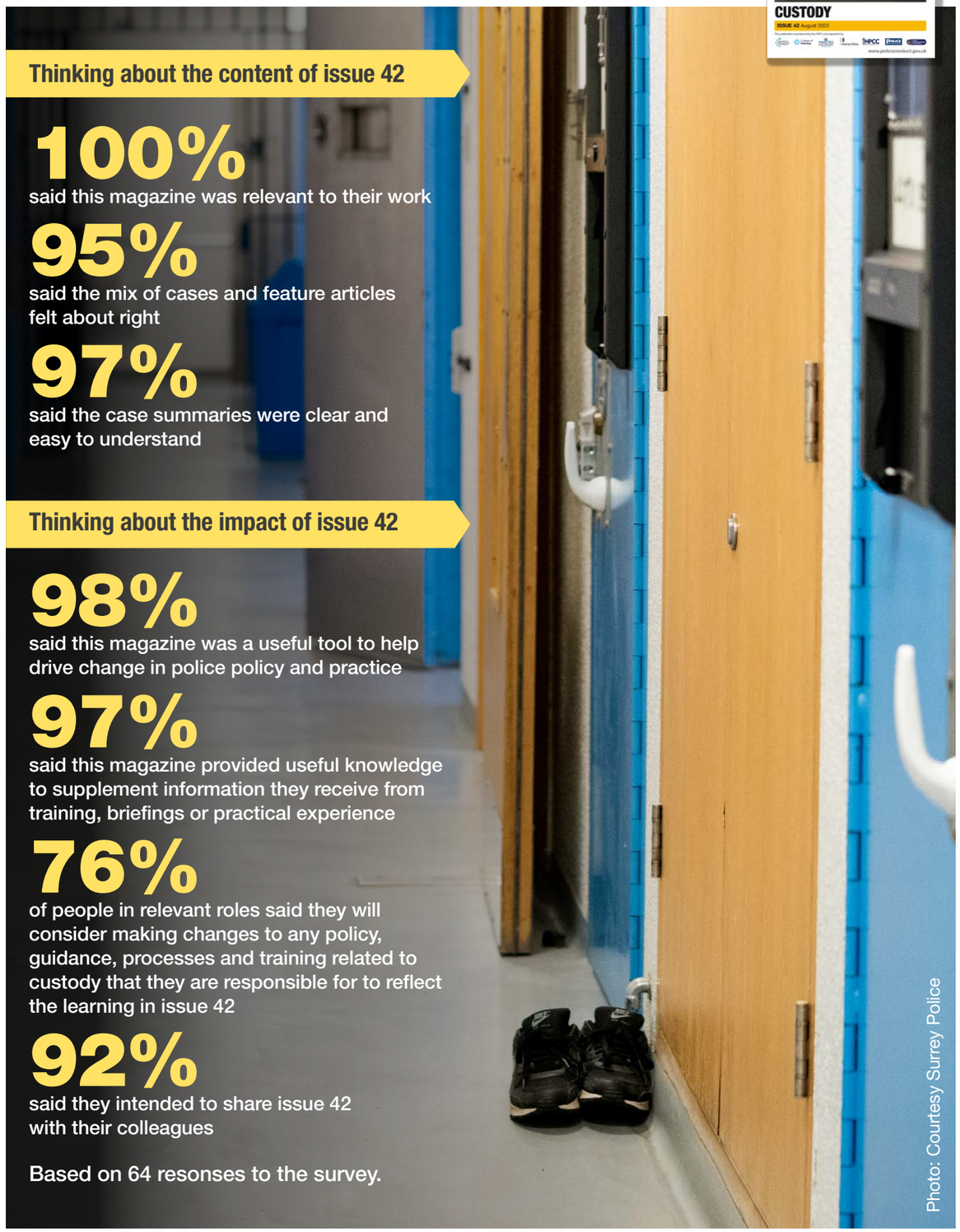
Missing people

Missing People
www.missingpeople.org.uk
Offers support to people affected by a disappearance via a free, confidential helpline. Missing People also run TextSafe; a way to reach out to a vulnerable missing child or adult to let them know that the confidential helpline services are available to them.
Tel: 116 000

YOUR FEEDBACK ON

ISSUE 42: Custody

(August 2023)



Thinking about the content of issue 42

100%
said this magazine was relevant to their work

95%
said the mix of cases and feature articles felt about right

97%
said the case summaries were clear and easy to understand

Thinking about the impact of issue 42

98%
said this magazine was a useful tool to help drive change in police policy and practice

97%
said this magazine provided useful knowledge to supplement information they receive from training, briefings or practical experience

76%
of people in relevant roles said they will consider making changes to any policy, guidance, processes and training related to custody that they are responsible for to reflect the learning in issue 42

92%
said they intended to share issue 42 with their colleagues

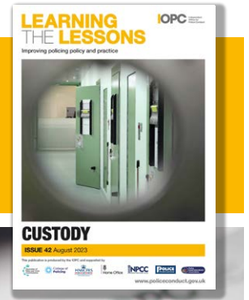
Based on 64 resonses to the survey.

Photo: Courtesy Surrey Police

YOUR FEEDBACK ON

ISSUE 42: Custody

(August 2023)



HUMBERSIDE POLICE

Inspector Dave Dosdale shares the impact issue 42 had at Humberside Police.

Feedback spotlight

I received *Learning the Lessons* 42 on the theme of custody by email from the IOPC. It is standard practice for me to make use of the learning in new issues of the magazine as Humberside Police's Organisational Learning Inspector in the Professional Standards Department (PSD), and to embed that learning force-wide.

After studying the nine case studies in issue 42 in detail, I gave a summarised briefing about the contents of the magazine to our Custody Operational Management Group, and Force Custody Board. I sit on both groups to provide PSD representation. I used these groups to help disseminate the magazine to officers and staff across our two force custody suites in Hull and Grimsby.

The case studies gave us the opportunity as a force to check our current practices and procedures within the custody environment, and to make sure we adhere to College of Policing Authorised Professional Practice. I set a task for custody inspectors and trainers to answer the 33 'key questions' included throughout the magazine targeted at managers, policy makers and trainers.

I tracked responses from our custody leads via a spreadsheet over several weeks. We used responses through engagement with the Custody Board to make sure our policies, procedures and training were compliant with the recommendations made, or we were working towards them. I am pleased to say that we are now compliant with all the recommendations set out in the key questions magazine, and I shared our spreadsheet and findings with the IOPC.

We will continue to routinely use issues of *Learning the Lessons* to benchmark our processes and performance, and to track improvement work which arises from them.

Inspector Dave Dosdale works in the Professional Standards Department at Humberside Police

YOUR FEEDBACK NEEDED

What do you think about the latest issue?

How useful did you find the case studies and articles?

Do you have ideas about topics you would like to see covered in future issues?

Please complete our two-minute feedback survey at **www.smartsurvey.co.uk/s/LearningtheLessons43**

The survey is open until **24 April 2024**.

Interested in receiving new issues of Learning the Lessons?

The magazine is available to everyone. Email **learning@policeconduct.gov.uk** and we will let you know when a new issue is published.

Want to get involved in the development of Learning the Lessons?

We have created a virtual panel, bringing together stakeholders from the police, community and voluntary sectors, and academia, to support the development of future issues of Learning the Lessons.

Email **learning@policeconduct.gov.uk** if you are interested in joining the panel. Panel members are invited to review and provide feedback on drafts six to eight weeks before publication.