Responding to People with Mental Ill Health or Disability

(POLICY & PROCEDURE)

OFFICIAL

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Policy

National Context

Authorised Professional Practice (APP) is produced by the College of Policing as the official source of professional practice on policing. All officers and staff are expected to have regard to APP in discharging their responsibilities. Essentially, our "policy" is to comply with APP as it develops to cover all areas of policing.

Where content exists within APP, we should not be reproducing it locally but instead signposting the on-line version. Similarly, we should not retain or develop any local policy documents if the subject matter is covered by APP. We may have some relatively low volume procedural documents but only if they are deemed necessary to supplement the content of APP.

Statement

Leadership & Me framework and the Just Principles

As an organisation, through our policies and Leadership & Me framework, we will ensure we create a consistently great place to work were, as Healthy People:

- You take responsibility for how you behave.
- You are inclusive and any exclusion is addressed.
- You have a safe space to speak, and things are talked out.
- You can focus on doing your own job well.
- You are trusted and empowered to make decisions and do the right thing.
- We are all One Team - inquisitive and open to new ways of doing things better together.

The Leadership & Me framework means we have a consistent approach to our behaviours across the organisation, and therefore consistent approach through our policies, which is necessary to deliver against our One Team ethos. The Leadership & Me framework is underpinned by our Just Principles:

JUST LISTEN	ACTIVE LISTENING | CARE & RESPECT | EMOTIONAL INTELLIGENCE
JUST LEAD	PRIDE & DIRECTION | RESPONSIBILITY | TRUST – HONESTY & HUMILITY | DELIVERY
JUST THINK	MAKING DECISIONS | CONTINUOUS IMPROVEMENT | ADAPTING PLANS | CHANGE
JUST TALK	TEAMWORK | COURAGE-SPEAKING UP | PERFORMANCE FEEDBACK | RELATIONSHIPS

Nationally, the police service is committed to improving the service it provides to people experiencing mental ill health or who have learning disabilities. Merseyside Police Force will make every effort to deliver this commitment at a local level by working effectively with all relevant partner agencies. These include organisations across the public, private and voluntary sectors.

We recognise that the police service is often the first port of call for many people experiencing, or being exposed to mental ill health, so will work closely with mental health practitioners to successfully resolve all such situations.

Aims

The aim of this policy is to ensure Merseyside Police's response to dealing with people who may have mental health needs or learning disabilities are appropriate, proportionate and in line with College of Policing Approved Professional Practice and locally agreed multi-agency protocols.

Objectives

The overriding objective is to ensure that vulnerable people in our community are dealt with in a way that is non-discriminatory, proportionate, fair, and accountable.

Associated objectives are:

a) Ensure our service is provided in a way that is non-discriminatory, proportionate, fair, and accountable.
b) Provide clarity and consistency on the legal powers and responsibilities of the police when operating under the Mental Health Act 1983.
c) Ensure a consistent response when dealing with individuals who have mental health needs or learning disabilities.
d) Ensure individuals the police encounter are referred to appropriate agencies.
e) To work in partnership with external agencies in line with locally agreed protocols to ensure the right outcome and support for the individual.

Application and Scope

All police officers and police staff, including the extended police family and those working voluntarily or under contract to Merseyside Police must be aware of, and are required to comply with, all relevant policy and associated procedures.

This policy document sets out principles to help guide decision making and is in some parts prescriptive. However, it is vital that officers and staff have the freedom to innovate, exercise discretion and take risk-based decisions, centred on the needs of the individual and the merits of each case. There may be occasions when

a member of staff is considered to have acted outside of policy but if they have done so with honesty, integrity, and professionalism, to make the best decision for the community we serve, they will be trusted and supported. On occasions when this is the case, the rationale for it must be properly recorded.

Outcome Evaluation

Outcomes should reflect the specific objectives and progress measured against each of the objectives on a routine basis. In general terms desired outcomes are:

a) Develop relevant Continuous Professional Development and ensure this communicated and delivered to relevant Merseyside Police staff.

b) The Policing Mental health Triage Team will monitor the use of S135 & S136 Mental Health Act and ensure compliance with recording processes.

c) Ensure a consistent response when dealing with individuals who have mental health needs or learning disabilities.

d) Ensure officers are aware of the remit and responsibilities of the Mental Health Triage Car and that are using the service appropriately.

e) Ensure multi-agency protocols are developed and regularly reviewed including that all agencies comply with them.

f) Ensure Merseyside Police are represented at strategic multi-agency meetings.

Procedure

Version History

Version Number	***Date***	***Detailed rational behind amending/updating policy or procedure.***	***Policy Owner Details***	***Policy Author Details***
v1.1	09.03.2015	Miscellaneous amendments made to Section 10 to reflect updated definitions re "Missing" & "Absent". These now reconcile with similar references in the Missing Person Policy.	D/Ch Supt Inv	PVP
v1.2	27.12.2018	Updates in relation to legislative amendments to MHA under PACA. Added a chapter relating to Triage car.	D/Ch Supt Inv	PVP
v1.3	08.02.2019	Updates as a result of internal and external consultation, miscellaneous relating to typos, grammar and policy statement relating to officers discretion.	D/Ch Supt Inv	PVP
v1.4	11.04.2019	Version history added and formatting amendments.	D/Ch Supt Inv	PVP
V1.5	09.04.2024	Policy revisions following consultation replies and phased implementation of Right Care Right Person.	Supt R&R	Insp Steve Fenna & Hayley Sherwen

1. Introduction and Definitions

Police Officers and Police Staff deal with people experiencing mental ill health, learning disability and mental health crisis in a number of different circumstances. This policy outlines the guidance for officers and staff (some of which have been agreed with partner agencies) when they encounter individuals who are experiencing mental ill health or who have a learning disability. There are numerous terms to describe people experiencing mental ill health and learning disability which varies across legislation and different agencies. Throughout this document the term 'mental health condition' is used. For the purpose of this document this will refer to mental illness, personality disorder, learning disability and autistic spectrum condition.

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

1.1 Concern For Welfare

Some requests for police assistance are categorised as Concern for Welfare (welfare checks, concern for safety, safe and well checks). Guidance for which requests police will service can be found in the Right Care Right Person policy.

1.2 Mental Disorder

(1) The provisions of the Mental Health Act 1983 shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.

(2) In this Act:

- "mental disorder" means any disorder or disability of the mind, and
- "mentally disordered" shall be construed accordingly, and other expressions shall have the meanings assigned to them in section 145 below.

(2a) But a person with learning disability shall not be considered by reason of that disability to be:

(a) Suffering from mental disorder for the purposes of the provisions mentioned in subsection (2b) below; or

(b) Requiring treatment in hospital for mental disorder for the purposes of Sections 17E and 50 to 53 below unless that disability is

associated with abnormally aggressive or seriously irresponsible conduct on their part.

(2b) The provisions are:

(a) Sections 3, 7, 17A, 20 and 20A below.

(b) Sections 35 to 38, 45A, 47, 48 and 51 below; and

(c) Section 72(1)(b) and (c) and (4) below.

(3) Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above.

(4) In subsection (2a) above, "learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.

The term mental disorder will only be used when operating under the Mental Health Act (MHA) 1983.

1.3 Mental Health Incident

The definition of a mental health incident is:

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

Supporting guidance to that definition is:

Mental health – anything which a police officer could consider as the basis for the appearance of a 'mental disorder' if they were considering use of Section 136 of the Mental Health Act 1983 (S136 MHA)– this could include mental illnesses such as schizophrenia or bipolar disorder, personality disorders as well as learning disabilities, autism, brain injury, etc.. There is no requirement for diagnosis of any kind or for the officer to be precise about the condition they think someone may have. e.g. Use of S135, S136 MHA or a missing patient who is AWOL under MHA.

Additionally or differently – any incident, including crimes, where officers are professionally obliged to do something which they would not have done if that same person did not have that mental Health problem. e.g. A victim of crime requiring ABE processes because of their learning disability; a suspect in custody requiring MHA assessment; a missing person who needs returning to hospital because they are AWOL from the Mental Health

Act; an encounter which necessitates safeguarding considerations because of vulnerability related to mental health.

1.4 Learning Disability

Section 1(4) of the MHA defines a learning disability as:

"A state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning."

A learning disability may be mild, moderate, or severe and affects the way a person learns and communicates. It may result in a reduced ability to learn new skills, adapt to and cope with everyday demands, understand complex information or, in some cases, to live independently. Those with mild learning disabilities may not receive any formal support and their needs and disability may not be obvious. They may not have had their disability identified before contact with the police. Other people have profound and multiple learning disabilities, and their needs may be considerable. Some people may have physical characteristics that may help identify a learning disability, for example, people with Down's syndrome (which is classed as a learning disability).

1.5 Learning Difficulties and Neuro-Disabilities

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

- Intellectual disabilities.
- Specific learning difficulties.
- Communication disorder.
- Attention Deficit Hyperactivity Disorder.
- Autism spectrum disorders.
- Traumatic brain injury.
- Epilepsy.

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

to engage effectively in their judicial proceedings or to benefit from traditional forms of rehabilitation. Common symptoms include:

- Communication difficulties.
- Cognitive delays.
- Specific learning difficulties.
- Emotional and behavioural problems.
- A lack of inhibition regarding inappropriate behaviour.
- Muscle weakness.

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

1.6 Autism

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

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

1.7 Drugs and Alcohol

Medical classification includes “acute alcohol or drug intoxication” as a recognised condition, in addition to many other alcohol or drug dependence disorders. This definition should be applied to alcohol or drug related incidents **only** where there is an additional or underlying mental health problem. e.g. Someone under the influence of alcohol who is threatening suicide on a bridge and requires police intervention such as detention under S136 MHA or any police response required for a frequent caller, under the influence threatening harm to themselves.

1.8 Terms that describe people

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

1.9 Patient

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

1.10 Mental Health professional

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

1.11 Approved Mental Health Professional (AMHP)

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

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

1.12 Responsible Clinician (RC)

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

1.13 Recording a Mental Health Incident

An incident is NOT 'mental health related' purely because someone involved in it as a mental health condition, diagnosed or undiagnosed.

The key question is whether someone's mental health has:

- Caused the need for the policing incident, or
- Meant that the police have had to do something differently, because of it.

If a policing incident meets the definition of a mental health incident; When resulting the incident on Storm, staff from the control room should add the mental health qualifier to the Storm log.

2. Roles and Responsibilities

2.1 Strategic and Tactical Lead for Mental Health in Policing

The Strategic and Tactical Lead for Mental Health in Policing will ensure:

- A consistent and appropriate police response to all incidents involving mental health and/or learning disability.
- All officers and staff fulfil their responsibilities set out within this document.
- Relevant data is gathered.
- Relevant partner agency contact is maintained within each Hub.

2.2 Mental Health Liaison Officer (MHLO)

The MHLO role is responsible for:

- Building and maintaining effective working relationships at a strategic level with partner agencies.

- Developing and delivering the Force Mental Health strategic plan, the national strategy on policing and mental health within Merseyside and associated policy and procedures.
- Providing advice and guidance as a subject matter expert for mental health and policing within Merseyside Police.
- Develop and maintain mental health and policing policy and procedures, ensuring that any change to relevant legislation, College of Policing APP and recommendations from national reports are incorporated that they are communicated effectively.
- Maintain links on behalf of Merseyside police with regional and national police colleagues and to stay appraised of initiatives that could be implemented in Merseyside.

2.3 Mental Health Operational Liaison Officer (MHOLO)

The MHOLO role is responsible for:

- Providing an operational liaison function for Mersey Care NHS Foundation Trust First Response/Urgent Care services.
- Building and Maintaining effective working relationships at an operational level.
- Providing guidance within Merseyside Police at an operational level in relation to legislation and the effective management of incidents involving individuals who are suffering with their mental health.
- Assist with the delivery of training in both police and NHS settings, to assist in the raising of awareness of legislation and processes relating to Mental Health and Policing.
- Attending necessary multi-agency meetings including High Demand Action Plan (HDAP) meetings.
- Working in partnership adopting a problem-solving approach to towards high intensity users of police and health resources, taking responsibility for case managing individuals who are part of the High Demand Action Plan (HDAP) process.
- Work closely with the following from Merseyside Police; Mental Health Liaison Officer (MHLO), Mental Health Investigators (MHI) and the Mental Health Triage Car Team.
- Provide specialist advice and support to Mersey Care NHS Foundation Trust in association with the Mental Health Police Liaison Officer.

2.4 Mental Health Investigator (MHI)

Numerous Mental Health Hospitals/Units within Merseyside have appointed a dedicated Mental Health Investigator (MHI). The MHI roles are part of and can be contacted via the PVP Policy & Strategy Unit, however the officers are predominantly based within their respective hospital or unit. Primarily the MHI investigates all offences which occur within the unit and works pro-actively to reduce crime. Key Responsibilities are to:

- Function as a SPOC between the mental health hospital/unit and Merseyside Police.
- Ensure consistent and appropriate police responses to both crimes and incidents involving mental health.
- Proactively investigate offences which occur within the hospital/unit.
- Maintain a visible presence on all wards within the hospital/unit.
- Provide specialist advice and support to the NHS Trust in conjunction with the MHLO.
- Facilitate and support victims, including those with a mental health condition during criminal proceedings, ensuring agreed procedures and legislation are followed.
- In instances whereby a patient is a victim of crime, ensure relevant safeguarding issues are highlighted.
- Ensure multi-agency links are developed at a management and staff level to assist effective working practices (including Mental Health staff, Local Authority, Criminal Justice Liaison and Diversion Team).

2.5 Mental Health Triage Car Officer

The Mental Health Triage officer role is NOT merely to drive the mental health practitioner to police incidents requiring the Triage Car. Key responsibilities are:

- Share relevant details from the logs where Triage Car have been asked to assist and consider sharing any information relating to the individuals or previous calls relating to the individual with the practitioner to enable them to conduct searches on their own care notes systems.
- Ensure that every incident referred to the triage car is recorded on the Triage Car database.
- Adopt a problem-solving approach to policing incidents with a mental health component.

- Consider any appropriate policing response that compliments or is an alternative to the mental health practitioner response and advise officers in attendance at the incident accordingly.
- Ensure that they are aware of any individuals subject to a Triage Car Action Plan (TCAP) or High Demand Action Plan (HDAP) and ensure that the information on the plans is communicated to officers dealing those individuals.
- Identify and refer any individuals suitable for consideration of Triage Car Action Plan (TCAP) or High Demand Action Plan (HDAP)
- Appraising themselves of any missing patients from the inpatient units within the relevant mental health trust. If circumstances allow, triage car staff should consider if they can add further relevant information or assist with the recovery of missing patients.

3. Operational Responses to Victims and Witnesses with a Mental Health Condition

People with mental health issues and learning disabilities, because of their conditions, may be at greater risk of becoming victims of crime, especially those with severe mental illnesses.

The Victim will be treated in line with the Code of Practice for Victims of Crime Code of Practice for Victims of Crime in England and Wales (Victims' Code) - GOV.UK (www.gov.uk) - see Special Measures below.

A victim or witness with mental ill health or learning disabilities should have equal access to justice and be treated with respect and dignity. Their ability to report crime and have that investigation conducted fully must not be prejudiced by their additional needs. Officers and staff should not assume that mental ill health in any way equates to the potential unreliability of that person as a victim or witness.

All victims and witnesses to crime, including those with a mental health condition or learning disability are entitled to an equitable quality of service. This includes:

- A full explanation of what is happening.
- Information about court hearing dates.
- The outcome of pre-trial hearings, the verdict, and the sentence.

To ensure that responsibilities to such victims and witnesses are met, the service provided should be tailored to fit their individual requirements. Officers should consider (at the earliest opportunity) a victim or witness's

suitability to give evidence on a case-by-case basis, as with any other potential witness, both in terms of the potential quality of the evidence and the impact on their ongoing health.

3.1 Victims of Crime on Basis of Disability (Hate Crime)

When investigating reports of crime against people who are mentally vulnerable, officers should consider the possibility that people have been targeted because of their vulnerability. Where officers suspect this, they should manage the incident according Merseyside Police Hate Crime Policy for investigating and prosecuting disability hate crime (mental health problems are recognised as a disability). The impact of offences and a victim's perception of their experiences should also be reflected in a victim impact statement.

If an officer deals with a victim or witness who they suspect may have a mental health condition and is vulnerable or not receiving any health or social care support, an E-VPRF should be completed.

3.2 Special Measures

(see also Merseyside Police – Child Abuse Policy & Working Together to Safeguard Children 2023)
If a victim or witness is identified as vulnerable or intimidated, an explanation of the special measures that can be made available to make giving evidence less stressful should be provided to the individual concerned. The need for special measures, in and around a person's court appearance where there is significant risk that the quality of his or her evidence may be diminished as a result of having to appear in court, should be considered at the earliest opportunity.

Under the provisions of S16 and S17 of the Youth Justice and Criminal Evidence Act 1999, special measures apply to all vulnerable witnesses under S23 to S30 of the Act to be utilised at Crown Court.

S28 of the 1999 Act allows for a vulnerable/intimidated witness to pre-record their cross-examination before the trial and for this to be shown as evidence at trial. The aim is to:

- Facilitate improvement in the experience of witnesses by enabling them to give evidence at an earlier stage in proceedings when their recollection of events is likely to be fresher.
- Maximise the potential for earlier resolution of hearings as cross-examination might strengthen the prosecution case, thus

encouraging the entering of a guilty plea, or it may result in the conclusion that there is no longer a realistic prospect of conviction.

Special measures apply to both prosecution and defence witnesses but not to the defendant.

Vulnerable witnesses are at a disadvantage when providing information or evidence, as they may have special needs. Special measures are designed to put these witnesses on the same footing as witnesses who are not vulnerable by ensuring that they receive the necessary support and assistance from all agencies. The measures available include:

- Screening the witness from the accused.
- Evidence by means of a live TV link.
- Evidence given in private in cases involving sex/intimidation offences.
- Removal of wigs and gowns.
- Video recorded evidence in chief.
- Aids to communication (signers, interpreters, pictorial techniques etc).
- Use of intermediaries.
- Pre-recorded cross examination (see 3.3).

The MG2 form is used by the CPS to apply for special measures. It is imperative that this is accurately completed and submitted at the earliest opportunity.

3.3 Pre-Recorded Cross Examination

Full Guidance can be found in the Section 28 YJCE Act – Pre-Recorded Cross Examination.

This measure currently only applies to cases which fit all of the following criteria:

- Where a witness who is required to give live evidence is under the age of 16 (not 18 for the purposes of the pilot) at the time of the special measures hearing or suffers from a mental disorder within the meaning of the MHA or has a significant impairment of intelligence and social functioning, or has a physical disability or a

physical disorder, and the quality of their evidence is likely to be diminished as a consequence.

- Where the witness's evidence in chief is video recorded in accordance with the principles of Achieving Best Evidence Guidelines with a view to it being used as the witness's evidence in chief.
- Where the case is one that will be tried at Crown Court.

3.4 Intermediaries

All witnesses who are considered vulnerable can get help from an intermediary. The main function of an intermediary is to communicate:

- To the witness, questions put to the witness.
- To any person asking questions, the answers given by the witness in reply to them, and to explain such questions or answers as far as is necessary to enable them to be understood by the witness or person in question.

As well as improving access to justice for vulnerable people, intermediaries also help criminal justice practitioners. Intermediaries can:

- Improve decision making by providing practical information about a witness's needs.
- Make investigative interviews and court testimony more productive.
- Improve the prospect that a case will have a positive outcome in court.

In summary, an Intermediary:

- Helps vulnerable witnesses and criminal justice practitioners at every stage of criminal proceedings from investigation to trial.
- Conducts initial assessment of witness's communication needs.
- Provides advice (including a written report) to help achieve a more productive interview or get best evidence at trial.
- Directly assists in the communication process.
- Assists with pre-trial preparation.

Intermediaries come from a range of professional backgrounds, including speech and language therapy, occupational therapy, psychology, education, and social work. When an intermediary is requested, the Intermediary Matching Service will match the skills of an intermediary with the needs of the vulnerable witness, usually within 24 hours.

If the investigating officer considers that the victim/witness would benefit from the allocation of an intermediary, they should follow Merseyside Police Intermediaries Guidance.

3.5 Taking a Witness Statement (MG11)

Communication styles and general interviewing techniques may need to be adjusted when dealing with individuals with a mental health condition.

When considering taking a witness statement from either a victim of or witness to a crime, the police should establish:

- Whether there are any indicators of a mental health condition.
- Whether the witness needs additional support.

Prior to writing the statement itself, officers should complete the witness details on the MG11 W (2) form, as this will help them consider the needs of the individual and enable early identification of any issues. This includes seeking the views of the individual about any special measures they may require at court. In the event that a person is deemed to have a mental disorder then officers should request the presence of an appropriate adult to assist in the statement taking process. Upon completing the MG11, the appropriate adult should be asked to countersign where appropriate.

Further to the completion of a witness statement, victims of crime can choose to make a Victim Personal Statement (VPS). Such a statement gives the victim (or their families) the chance to explain the effect the crime has had on them physically, emotionally, or financially. To provide such a statement is the choice of the victim, and its function and possible contents must be explained to the victim in order that they can make an informed decision. The VPS must be in the victims own words and may contain information such as:

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

More detailed guidance on taking statements from vulnerable adults is available Merseyside Police – Adults at Risk Policy and Achieving Best Evidence Guidelines.

3.6 Interviewing Victims or Witnesses

When interviewing vulnerable victims or witnesses, this should always be done with due regard to the guidance document Achieving Best Evidence Guidelines. This document offers advice on:

- Preparing and planning for interviews with vulnerable and intimidated witnesses.
- Decisions about whether or not to conduct an interview.
- Decisions about whether the interview should be digitally recorded or whether it would be more appropriate for a written statement to be taken.

Before contacting the victim, early consideration should be given to Special Measures.

More detailed guidance on interviewing vulnerable adults is available in the Force Merseyside Police – Adults at Risk Policy.

3.7 Victims or Witnesses Unable to Give Evidence

Where a victim or witness cannot give evidence even with special measures in place, evidence should still be gathered to allow the prosecution to consider continuing with the case if appropriate.

Officers should consider seeking evidence from other agencies such as the NHS and documents such as care plans, visitor records, medication records and previously reported incidents involving the same victim or suspect.

4. Operational Responses to Suspects and Offenders

This chapter should be read in conjunction with Merseyside and Cheshire Joint Agency Standard Operating Procedures Local Response to Mental Health and Learning Disability Inpatient Setting.

4.1 Incidents of Crime involving Suspects with a Mental Health Condition

The relationship between mental health and criminal offending is complex. A mental disorder may directly cause someone to offend or play no significant part in their offending behaviour. The presence of a mental health condition and/or legal status under MHA of a suspect, should not preclude the pursuance of an appropriate legal sanction against them. This includes inpatients on a mental health unit (Para 4.5 refers).

Investigating officers should recognise that the law presumes all suspects to be sane and to be legally accountable for their actions unless the contrary is proved in court. This is an underlying principle of the criminal justice system (as outlined in the M'Naghten rules on insanity).

Where an offence is involved, this should be the basis of the intervention, unless:

- The offence is minor.
- The crime is victimless.
- The victim does not want to report the crime but is seeking help for someone in distress.
- The behaviour is directly linked to the individual's mental health condition.

The most important consideration for the police, when dealing with a suspect with a mental health condition is whether the situation requires:

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

Crimes should be recorded in accordance with National Crime Recording Standards (NCRS). This should be regardless of the setting (i.e. mental health establishment or in the community).

All evidential opportunities should be explored, rather than adopt an assumption that No Further Action will be taken as a result of their mental health condition/legal status under MHA.

There should not be a presumption either for or against prosecution. Each case should be considered on its individual circumstances. All decisions involving such individuals require a balance between the rights of the suspect, the victim, and the protection of the public.

If an individual is not deemed fit for detention/interview, a prosecution should still be considered, particularly in relation to protecting the public.

Where possible, decisions should be made in collaboration with partner agencies. At scene, consideration should also be given to all other sources of information regarding the individual's mental health condition e.g. family, friends, documentation etc.

4.2 Reasons to Prosecute

Dealing effectively with offenders who have a mental health condition is essential for the following reasons:

- A prosecution may be appropriate in order for an individual to accept responsibility for his or her actions and ultimately have an effect on challenging behaviour.
- Prosecutions build upon an individual's psychiatric forensic picture which informs the risk assessment and risk management, enabling appropriate care pathways. (An apparently minor offence may form part of an escalating pattern of behaviour.)
- Certain powers and protections under MHA can only be instigated by criminal courts.
- It supports victims including mental health staff and other vulnerable patients.
- MHA tribunal hearings take more cognisance of convictions rather than unsubstantiated allegations, when deciding whether the legal criteria for detention are still met.
- Without sanction the individual may continue to offend.

4.3 Insanity and Fitness to Plead

Prosecution may be necessary for more serious offences, even where vulnerable suspects are potentially unwell. A suspect may be likely to succeed in putting forward a defence of insanity or be found unfit to plead. If the offence is one that would require the public to be protected from a serious risk posed by the defendant, however, then the investigating officer should consider the evidence and benefits of a prosecution.

A defendant will be considered unfit if they cannot:

- Understand legal proceedings.
- Instruct their legal representatives.
- Challenge a jury.

A finding of unfitness can then lead to a so-called 'trial of the facts' under the Criminal Procedure (Insanity & Unfitness to Plead) Act 1991. The defendant can be found legally insane if they demonstrate to the court that they did not know what they were doing or did not know what they were doing was wrong. If a court is satisfied that a defendant did the acts or

omissions they are accused of, then they have powers to impose a (restricted) hospital order, a supervision order, or an absolute discharge.

As part of a community sentence, courts may also impose a Mental Health Treatment Requirement. A Mental Health Treatment Requirement is one of three possible treatment requirements which may be made part of a Community Order. It is sometimes given to offenders where the crime they are convicted for is below the threshold for a custodial sentence. The offender will also have a mental health problem that does not require secure inpatient treatment.

This is a decision made by the courts with supportive evidence.

4.4 Liaison and Diversion Team (Criminal Justice MH Liaison Teams)

Liaison and Diversion is a process whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible as they pass through the youth and criminal justice systems. In Merseyside, these teams are known as **The Liaison and Diversion Team** and are based within the custody suites seven days a week.

The aim of this team is to improve the health and criminal justice outcomes for adults and children who come into contact with the criminal justice system (CJS) and will provide advice and guidance relating to individuals who appear to have a mental health condition who come into contact with the police.

The Liaison and Diversion Team can also assist officers in making an informed decision regarding prosecution, provide advice and guidance in relation to the individual when processing them through the criminal justice system which includes assessing the individual whilst in custody to support diversion of individuals, where appropriate, out of the CJS into health or other supportive services or diversion within the CJS into an appropriate pathway.

The team can be contacted on the following numbers:

- St Anne Street Custody Suite – 0151 777 4857
- Copy Lane Custody Suite – 0151 777 3132
- Wirral Custody Suite – 0151 777 2783
- South Sefton Magistrates Court – 0151 478 6550
- Liverpool Combined Courts – 0151 478 6599

Or via email to the secure email address: mcn-tr.Criminal-Justice@nhs.net

4.5 Crimes committed at Mental Health Inpatient Units

Where the suspect is a patient in a mental health unit, the offence must still be recorded and investigated with a view towards achieving a positive outcome. It is anticipated that most crimes occurring in such locations can be dealt with via a coordinated approach by means of an interview under caution at the unit.. Assaults or other offences against patients or staff and the misuse of drugs at inpatient units can seriously affect the care environment.

Any decision to investigate crime where the suspect is an inpatient should be taken in conjunction with health staff, and in particular, the responsible doctor for the patient concerned (psychiatrist).

The majority of mental health units within Merseyside are covered by a Mental Health Investigator (dedicated detective). These officers will deal with the majority of crimes reported at that location. However, in cases where officers are deployed to the units, the attending officer would be expected to crime the incident and collect as much evidential material as possible including witness statements from staff adhering to golden hour principles.

Where arrest is deemed not necessary:

- The officer should obtain, from the Responsible Clinician (psychiatrist), written confirmation of the suspect's suitability for interview. (NOTE – The majority of inpatient units have agreed pro forma). This should be scanned onto Niche and will form part of the investigation file. This document must be obtained prior to interview of the suspect.
- The incident should be recorded appropriately i.e. Niche/Storm.
- The officer should ascertain whether the inpatient unit has a dedicated Mental Health Investigator, who will subsequently take over the investigation.
- If the unit does not have a dedicated Mental Health Investigator, the crime will be allocated in accordance with crime allocation.
- Best practice would dictate that if a suspect interview under caution is required, this should be conducted within the Mental Health Unit itself as a Voluntary Interview and recorded on Niche.

Where arrest is deemed necessary:

- It is imperative that the suspect is not removed from the inpatient unit without confirmation (preferably written) of their suitability for

detention and interview. (NOTE – The majority of inpatient units have agreed pro forma). The Responsible Clinician (psychiatrist) can provide this. This document should accompany the suspect to custody and be scanned onto Niche and will form part of the investigation file.

- When considering disposal from police custody, where appropriate and in agreement with the Mental Health providers, the individual can be returned to the same mental health unit. It is not appropriate for mental health providers to discharge patients immediately after arrest unless discussion has taken place with arresting officers.

4.6 Illicit Substances and Weapons Found Within a Mental Health Unit

Each incident will be dealt with depending on the circumstances in which they are found.

Mental Health Units should have their own arrangements for disposal of small amounts of illicit substances that cannot be attributed to any individual or subject to investigation.

All crimes should be recorded in accordance with the Home Office Counting Rules.

4.7 Care within the Custody Environment

For full guidance see Detention and Custody Approved Professional Practice.

If there is concern regarding a detainee's mental health condition or a question regarding the detainee's fitness for detention or interview whilst in police custody, it is the responsibility of the Custody Officer to ensure appropriate assessment and/or treatment is sought (this would include Criminal Justice Liaison and Diversion Team).

4.8 Appropriate Adults

In accordance with PACE Code C, if a custody officer suspects or has been informed that a detainee may be mentally disordered or otherwise mentally vulnerable, an appropriate adult must be requested. This can be someone who knows the detainee (e.g. their carer or relative) but it is good practice to use an independent, trained appropriate adult.

4.9 Pre-Charge Bail & Released Under Investigation (RUI)

For some suspects who have been diverted to hospital for assessment under MHA, it may be appropriate to Release Under Investigation (RUI) or consider releasing on police bail, until the investigating officer is able to access all available information that might support a decision to charge the suspect.

When more information becomes available, bail may then be cancelled for those suspects. This approach means that a charge and prosecution for the offence can be progressed if appropriate (for example, if it later emerges that the suspect's condition was not relevant because the behaviour was solely due to substance abuse).

This approach serves to prevent a situation in which a suspect who has been diverted to a hospital and assessed while detained under S2 or S3 MHA is then released without a criminal justice sanction despite health staff concluding that they do not have a mental health disorder that prevents the criminal justice system holding them to account.

4.10 Disposals

A mental health condition does not negate the use of any type of disposal.

In relation to minor offences, it is important to consider whether the offence forms part of an emerging pattern of behaviour that is escalating and therefore, may point in favour of sanction. A sanction may also be appropriate for a patient to accept responsibility for their actions e.g. financial penalty or to ensure the patient is compliant with treatment or Community Order with condition of treatment.

4.11 Crime Outcome Type 12

Crime Outcome Type 12: The Named Suspect is Too Mentally or Physically Ill to Give Evidence and Unlikely to Recover National Crime Recording Standard Home Office Counting Rules.

A case may be finalised as Type 12 provided:

- A notifiable crime has been committed and recorded.
- There is credible evidence linking the offender to the crime.
- The victim has been informed of the outcome.
- The outcome has been authorised.

- The nature of the illness is set out in a report which is attached to the case file.
- A report from a suitably qualified medical examiner, which states why the offender cannot testify, is attached to the case file.

4.12 Administrative Requirements

All of the matters set out above must be recorded in a clear and auditable form.

The fact that an offender is ill and unlikely to recover or lacks capacity or too mentally disturbed for proceedings to be taken, must be verified by a suitably qualified medical practitioner and be auditable, e.g. by documenting the contact details of that practitioner. A medical certificate is not mandatory.

5. Mental Health Triage Car

5.1 Triage Car Model

The Merseyside Police Mental Health Triage Car (MHTC) is collaborative model provided by Merseyside Police and both mental health trusts in Merseyside and provides support and advice to officers when dealing with individuals who have contact with, or who contact the police and have a mental health component to their presentation.

Hours of operation vary across each of the three cars.

5.2 Triage Car Remit

All three cars operate the same remit, however HQ97 and HQ99 operate an all ages provision, and HQ98 provides for individuals aged 16 years and above.

The following triage car remit has been agreed by all agencies involved.

The Mental Health Triage staff can be requested to assist with any policing incident with a mental health component. The mental health component can be a piece of information that leads an officer or member of police staff to suspect that an individual may have mental health issues. The Mental Health Practitioner alongside the triage officer is there to support Merseyside Police by triaging any police incidents that are identified in order to support officers in making decisions about people with all vulnerabilities.

Many health needs and vulnerabilities are interrelated and codependent. The Mental Health Triage model is a process where people with mental health problems, learning disabilities, substance misuse issues and other vulnerabilities, who come into contact with the police may be identified as requiring assessment at the earliest opportunity.

The triage car should be reactive, proactive, and preventative.

5.3 Triage Car Deployment

The triage car will only respond to incidents where there is a police Storm log/NICHE occurrence or Compact missing person investigation in existence.

Officers considering detaining an individual under S136 MHA must always, where circumstances allow, contact the triage car, prior to any detention.

Even where officers are not considering detention under S136, the Triage Car can be contacted for information, guidance or deployment to any officers dealing with individuals with a mental health component. For incidents relating to patients from Mersey Care NHS Foundation Trust or individuals with the geography of the Mersey Care NHS Foundation Trust boundaries there is a dedicated professionals telephone number which can be contacted to seek advice.

5.4 Triage Car Officer Role

The police officer's role is NOT merely to drive the mental health practitioner to police incidents requiring the triage car.

The triage officer will receive details of any logs for consideration of deployment by Triage Car from the Force Contact Centre.

The Triage Car Officers will share relevant details of the logs and consider sharing any information relating to the individuals or previous calls relating to the individual with the practitioner to enable them to conduct searches on their own care notes systems.

The Triage Car Officer should appraise themselves of any missing patients from the inpatient units within the relevant mental health trust. If circumstances allow, triage car staff should consider if they can add further relevant information or assist with the recovery of missing patients. The triage officer must ensure they update Compact with any actions taken.

The Triage Car Officer will ensure that every incident referred to the triage car will be recorded via the triage car data entry sheet, regardless of

deployment or method of triage intervention i.e. phone contact, face to face contact, update log only.

The Triage Car Officer will adopt a problem-solving approach to policing incidents with a mental health component. Consideration should also be given to future opportunities to prevent unnecessary calls to the police.

The Triage Car officer will consider any appropriate policing response that compliments or is an alternative to the mental health practitioner response and advise officers in attendance at the incident accordingly.

The Triage Car officer will ensure that they are aware of any individuals subject to a Triage care Action Plan (TCAP) or High Demand Action Plan (HDAP) and ensure that the information on the plans is communicated to officers dealing those individuals.

The Triage Car officer will consider if any individuals they encounter are suitable for a TCAP and refer this information via the relevant permanent Triage Officer.

The TCAP Manager for each car will be responsible for creating and managing TCAPs including relevant markers and the Niche occurrence.

5.5 Mental Health Triage Car Joint Problem-Solving Approach

This chapter should be read injunction with Triage Car Action Plan & High Demand Action Plan Procedure and Merseyside & Cheshire Mental Health Triage Car Information Sharing Agreement.

MHTC operates a joint problem-solving approach in relation to individuals who are high demand generators to the police. There are two levels of action plans which are designed for partner agencies to work together in order to improve outcomes for the individual and to reduce unnecessary demand for each partner agency.

5.6 Triage Car Action Plan (TCAP)

There are a number of individuals who call or come into contact with the police frequently or excessively. The content/frequency of the calls or the presentation of the individual concerned can indicate a mental health issue or other vulnerability.

TCAP is a simply an agreement between the relevant Merseyside Police Triage Team and NHS Police Triage Team to adopt a problem-solving approach to the individual identified ensuring the individual is in contact with the correct support services, and signposted or referred appropriately. The

aim being to have a positive effect on the number of calls and resulting in the individual only contacting the police appropriately.

Criteria for TCAP – Triage Car Action Plans (TCAPs) are part of a range of options used by the Police Triage Car staff, which can support individuals who have regular/increasing contact with Merseyside Police. The police will investigate their systems to support if and how they are high demand.

An individual referred for consideration of a TCAP and the associated data will be discussed at the TCAP/HDAP meeting.

A combination of factors & associated information will be considered at the meeting as follows:

Demand for the Police – When considering demand for Merseyside Police in association with a TCAP referral, this will usually be a high volume of calls from the individual themselves (often from their home address). Mostly they will not require any policing intervention/deployment. If the calls are not from the individual, however, this does not preclude a discussion around the benefits of a TCAP.

Known to Mental Health Trust – An individual referred for consideration of a TCAP does not have to be an existing service user of the Mental Health Trusts.

Risk – Often, an individual referred for a TCAP can be assessed as 'low risk.' A TCAP enables the team to consider all the factors around the individual's health (both mental and physical), and social circumstances. This can lead to a more accurate assessment of risk. An example would be an individual who has recently started to make frequent calls to the police, who may be the start of a deteriorating health and social care picture.

Complexity of Presentation – Individuals referred for TCAP do not always have complexity of presentation, but a TCAP does allow for a thorough consideration of the individual's vulnerabilities and social circumstances. If upon knowing further information, or the individual's presentation changes, consideration can be given for an HDAP (for organisations who have agreed the HDAP process).

5.7 High Demand Action Plan (HDAP)

Some individuals who have complex needs or behaviours may not call the police frequently themselves, but their actions result in a third party contacting the police. The agencies working in partnership may benefit from managing the individual via a joint agency High Demand Action Plan (HDAP).

The HDAP is jointly agreed between the individual subject to the plan, their psychiatrist, mental health team and Merseyside Police. Other organisations/agencies involved with the individual should be invited to the initial meeting to discuss the plan e.g. North West Ambulance (NWAS), supported living accommodation.

5.8 Criteria for HDAP

High Demand Action Plans (HDAPs) are part of a range of options in the Police Triage Car protocol which can support individuals who have regular/increasing contact with Merseyside Police. The police will interrogate their systems to support if and how they are high demand.

An individual referred for consideration of a HDAP will be discussed at the TCAP/HDAP review meeting. Both NHS Triage Car manager and Merseyside Police will be present at this meeting.

A combination of factors & associated information will be considered at the meeting as follows:-

Demand for the Police – The demand for Merseyside Police in association with an HDAP referral, is less likely to be volume of calls from the individual themselves, but more likely that the individual has presented in a way that elicits a response from Merseyside Police. This is often with a view to being taken to hospital or to gain admission e.g. presenting at bridges, waterfront, being detained under S136 of the Mental Health Act or committing offences. Consideration is given to alternative options i.e. positive action.

Known to NHS Mental Health Trust – The individual needs to be under the care of the relevant NHS Mental Health Trust and has care provided under the Care Programme Approach with a Registered Clinician (RC) and Care Co-ordinator (CC). Should a referral be received that does not meet these criteria then a dialogue should take place with the team to consider a CPA review and consider care co-ordination.

Escalation of Risk – The individual can be considered a risk to themselves or to others. There may be a pattern of escalation that could be considered in terms of nature of risk, imminence, likelihood, severity, and frequency.

Complexity of Presentation – Complexity can be considered in terms of a range of vulnerabilities or mental disorders. This could include multiple conditions, including physical health issues combined with social factors and behaviours which can be care seeking and/or demanding.

If an individual is thought suitable then further discussion will be held with the RC and CC to discuss consensus for the HDAP and to ensure that the care team leads on the plan. If suitable then there will also be discussion with the individual and consent to the HDAP will be considered.

For role responsibilities, referral and monitoring please see Triage Car Action Plan & High Demand Action Plan Procedure above.

6. Section 136 Mental Health Act 1983

All S136 MHA detentions will be recorded on Niche. For more information please consider. S136 Niche Templates 7at7 v4.pptx (sharepoint.com)

The decision to exercise the power under S136 MHA is a police decision and should be based on all available information and intelligence, risk, and threat assessment. Officers should always consider de-escalation and act in the least restrictive way to protect the safety and welfare of the individual, public and professionals concerned. Advice from Mental Health Triage Car (MHTC) should always be sought initially where possible prior to making any decisions.

If an individual is willing to attend hospital voluntarily, they should be encouraged to make their own transport arrangements. However, if officers convey the individual to hospital, they should complete the Voluntary Attendance Handover Form via the handheld device which will generate an e-mail to the AED reception staff.

There are occasions when A&E staff contact the police with concerns about an individual who has attended voluntarily (without the police). It should be established what is required of the police, and consideration should be given to the fact that A&E staff have no autonomous powers under the MHA.

NPCC guidance states that officers should use Body Worn Video (BWV) when attending reports of a mental health incident – see NPCC Body-Worn Video Guidance (npcc.police.uk).

6.1 Legislation – Section 136 Mental Health Act 1983

S136 If a constable encounters a person who appears to be suffering from mental disorder and to be in immediate need of care or control, they can, if necessary to do so in the interests of that person or for the protection of other persons:

- Remove the person to a place of safety within the meaning of S135, or

- If the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

The power may be exercised where the mentally disordered person is at any place, other than:

- Any house, flat or room where that person, or any person, is living, or
- Any yard, garden, garage, or outhouse that is used in connection with the house, flat or room, (other than one that is also connected with one or more other houses, flats, or rooms).

6.2 Power of Entry

S136(1b) – For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, by force if necessary.

6.3 Legal Requirement to Consult

S136(1C) – Where the use of the Mental Health Act S136 is considered, it is a legal requirement to consult with a healthcare professional (where practicable), prior to detaining someone. The law allows consultation with several types of professionals.

The purpose of the consultation is to provide officers with the necessary information and advice prior to detaining S136, so that an officer can make a more informed decision as to their course of action that is in the best interests of the person concerned.

In Merseyside, the contact numbers for consultation have been jointly agreed as follows:

Area	Contact
Wirral	01244 397 202 (Adults and Children)
Liverpool and Sefton	0151 330 7215 (Adults)
Liverpool and Sefton	0151 293 3577 (Children)
Knowsley & St Helens	0151 330 7215 (Adults and Children)

If the Triage Car is in attendance and S136 MHA is advocated, Triage staff will make the call to the relevant number.

The details of the consultation must be recorded in the S136 Occurrence (including who was consulted, what information was relayed, advice provided & rationale for the decision).

Ultimately the decision to detain S136 remains with a police officer having careful consideration for any professional advice that has been given to them.

If it is not practicable to consult before invoking S136 MHA, the police officer will record the reason on the Niche OEL. However, the police officer should still ring the relevant number above to be directed to a relevant place of safety.

If consultation has taken place prior to detention, the professional consulted with will identify and inform relevant place of safety.

6.4 Removal to a Place of Safety

The 2017 Mental Health Act 1983 (Place of Safety) Regulations make it unlawful to detain a child at a police station under S136. The Regulations also state that an adult may only be detained at a police station under S136 if the behaviour of the individual poses an imminent risk of serious injury or death to themselves or another person. The removal to or detention at a police station can only be authorised by an officer of the rank of Inspector or above.

In Merseyside, the following are designated places of safety for purpose of detention under S136 MHA.

Place of Safety	Remarks
A&E Arrowe Park Hospital, Wirral CH49 5PE	
A&E Southport General Hospital, Southport PR8 6PN	
A&E Royal Liverpool University Hospital, Liverpool L7 8YE	
A&E Aintree Hospital, Fazakerley. L9 7AL	
Prenton 136 Suite, Clock View Hospital, Walton L9 1EP	To be used if there are no physical health requirements.
Mere 136 Suite, Hartley Hospital, PR8 6PL	To be used if there are no physical health requirements.
Resource & Recovery Unit, Whiston Hospital L35 5DR	To be used if there are no physical health requirements.
A&E Whiston Hospital. Prescot L35 5DR	Only to be used instead of Resource & Recovery, if a physical health check or treatment for and injury/overdose is required.

Place of Safety locations for children detained under S136 MHA are:

Place of Safety	Remarks
A&E Arrowe Park Hospital Wirral CH49 5PE	
A&E Alder Hey Hospital Liverpool L14 5AB	
A&E Whiston Hospital Prescot L35 5DR	
A&E Ormskirk General Hospital Ormskirk L39 2AZ	For children detained in the Sefton area

6.5 Transport of Individuals Detained Under S136 MHA

See also Chapter 8 – Transporting and Conveying People with a Mental Health Condition.

The preferred method of transport should be an ambulance, with the detaining officer(s) travelling in the vehicle with the detained individual.
Force Contact Centre (FCC) will always contact NWAS when an individual has been detained under S136 MHA, to register the need for an ambulance.

Decisions to use police vehicles can be made if all the prevailing factors suggest this is more appropriate and will resolve unnecessary delays i.e. in cases of extreme urgency, risk, or excessive delays with NWAS (The decision should be made by a supervisory officer).

6.6 Detention at the Place of Safety

S136(2) MHA – A person removed to, or kept at, a place of safety (PoS) under this section may be detained there for a period not exceeding the permitted period of detention for the purpose of enabling them to be examined by a registered medical practitioner and to be interviewed by an AMHP and of making any necessary arrangements for their treatment or care.

The permitted period of detention is 24 hours (starting from when the individual is **accepted** at the PoS).

The period of detention can be extended from 24 hours to 36 hours by the registered medical practitioner responsible for the examination of an individual under S136 MHA.

The period can only be extended if the registered medical practitioner (psychiatrist) considers that the extension is necessary because of the condition of the person detained is such, that it would not be practical for the assessment to be conducted before the end of the 24 hours. The period must not be extended due to a lack of resources e.g. a bed not being available.

The powers conferred by S136(2) MHA are not conferred expressly on the police but are given to any person who is party to the detention of the disordered person once he/she is brought to a PoS. Therefore, staff at the PoS (or anyone directed by them) can lawfully detain the individual whilst waiting for an assessment.

6.7 Arrival at the Place of Safety

The individual should be booked in at the reception of the PoS.

The detaining officer should complete the relevant part of the S136 Monitoring Form (forms held at PoS).

6.8 Police Remaining with the Individual at the Place of Safety

The risk assessment conducted by the place-based Inspector to determine if and how long police officers will remain at the place of safety and the process of a lawful handover when they leave is outlined in Appendix 2 Police Remaining with the Individual at the PoS.

NOTE – This risk assessment does not apply to children (Anyone under 18 years). Officers will remain with children at the PoS safety until the S136 MHA assessment has been completed.

Officers are also required to record an individual's detention under S136 MHA on Niche.

6.9 Detained Person's Rights at the Place of Safety

It is the responsibility of the staff at the PoS (under S132 MHA) to inform the individual detained under S136 MHA of their rights; this includes assessing their ability to understand them and providing an information leaflet containing details of their rights.

6.10 Protective Search Power

S136C (3) MHA – allows a police officer to search a person subject to S135, S136(2) MHA – detained in a PoS, or S136(4) MHA – being transferred to another place of safety if the officer has reasonable grounds to believe that the person may be a danger to themselves or others AND is concealing something on them which could be used to physically injure themselves or others. The power continues for the length of detention as long as the grounds exist at that point.

NOTE – This only applies once the individual is at a PoS. Any initial searches must be justified under S32 PACE.

6.11 Transfers Between Places of Safety

S136(3) MHA & S136(4) MHA, provide a legal framework for patients detained under S136 MHA to be transferred from one PoS to another, it is

the responsibility of the AMHP, doctor or other healthcare professional to coordinate the transfer.

As with all conveyance under the MHA, the preferred mode of transport is an ambulance.

NOTE – The transfer will be recorded on the hospital S136 form and on the relevant Niche occurrence. The original S136 MHA paperwork must be taken with the patient to the new PoS so that the record of assessment may continue.

6.12 Patients who Abscond En Route to or from a Place of Safety

S138(3) MHA provides a power to retake a patient who has absconded from S135(1) or S136 MHA. The power is available before the assessment has been started or once the assessment has been completed.

If the individual absconds prior to their arrival at the PoS, the 24 hours begins from the time of the abscondence.

If the individual absconds from the PoS, the 24 hours begins at the time of the individual's arrival at the PoS.

An extension to the detention period applied prior to the abscondence also extends the time period that the individual subject to the detention can be retaken.

S138 MHA does not provide authority for force to be used to enter premises where the patient is believed to be. In such circumstances, an application to a Magistrate under S135 MHA should be made.

Discharge After S136 MHA – Responsibilities

The power under S136 MHA ends when:

- The 24 hrs expires (or 36 hours if extended).
- An AMHP has made the necessary arrangements for that person's treatment or care e.g. detention in hospital, informal admission or community mental health follow up or G.P.
- Discharge no follow up.

NOTE – Informal Admission – MHA Codes of Practice (MHA CoP) states 'once assessment has been completed and suitable arrangements have been made,' the person is deemed able to agree to the admission to hospital on a voluntary basis. Therefore, the assessing team should discharge the S136 MHA, as they are in effect an informal patient awaiting admission.

All parties involved who are present at the time should discuss arrangements on how the individual is returned to their home.

6.13 Escort of Dangerous or Violent Inpatients

In exceptional circumstances, the risks of a particular situation justify police assistance, i.e. where the movement of a dangerous patient presents risks to the community and that there has been insufficient time to appropriately plan for the transfer.

The request for police assistance should not be based upon a lack of health or ambulance resources.
If a joint risk assessment between the relevant place-based Inspector and the nurse in charge of the unit concludes that police assistance is necessary, police vehicles will not be used to transport the patient.

A member of hospital staff should always be with the patient throughout the journey.

The hospital staff have responsibility for transporting the patient. Police officers are present to prevent escape and deal with any BOP. The Storm log should be fully updated with the reasons for police resources being used.

Sedated patients should not require any involvement from the police.

6.14 Transport of an Individual to an Inpatient Unit following S136 MHA

Refer to Chapter 8 – Transporting and Conveying People with a Mental Health Condition and North West Regional Policy & Guidance for Transporting Mental Health Patients

6.15 Offences Disclosed in Relation to an Individual Detained Under S136 MHA.

Where an offence has been committed and the decision is made to detain under S136 MHA, officers should always record the crime and consideration should always be given on a case by case basis in relation to investigating the crime (especially if the individual is discharged from the S136 MHA detention without being admitted or any mental health follow up).

6.16 S136 MHA Data Collection and Quality Assurance

MHTC supervision is responsible for quality assuring S136 MHA data and identifying individuals frequently detained under S136.

6.17 Managerial Escalation Regarding Delays with S136 MHA Procedures

The following, jointly agreed, escalation processes should be implemented when there is a delay. Please refer to adult S136 Escalation Process (Appendix 4) and Child S136 Escalation Process (Appendix 5).

7. Mental Health Crisis in a Dwelling, MHA Assessments & Warrants Under S135 MHA

There are occasions when AMHPs, doctors and Mental Health Practitioners request police assistance in circumstances where a person is already being assessed, needs to be assessed under MHA, or where a warrant has been obtained under S135(1) MHA.

Police involvement with incidents on private premises is normally required where someone's mental health has deteriorated to the extent that they are in crisis and are a risk to themselves or others, or their behaviour has become unmanageable for the professionals at scene. Incidents of this nature can also involve the police due to the need to gain entry using a warrant.

These incidents fall into three categories:

- Pre-Planned:
  - Where an AMHP contacts the police in advance requesting police assistance with an MHA assessment (usually at the individual's home address)
- Pre-Planned:
  - Where an AMHP contacts the police with a view to executing a warrant under S135(1) MHA, or
  - Where an AMHP or Mental Health Practitioner contacts the police regarding a patient who is liable to be detained or absent without leave under MHA and entry is required to a premises under S135(2) MHA.
- Spontaneous incidents notified to the police by the individual themselves, a member of the public, a mental health professional or where police officers attend a person's address for another reason when it becomes apparent that the person is in crisis with their mental health.

7.1 Support to Mental Health Professionals

RAVE is a mnemonic to assist in establishing whether a non-criminal incident, involving the administration of health and/or social care processes should involve the police and/or inform a joint risk assessment.

It relates to the heightened potential for risks which are legitimately beyond the ability of NHS or local authority staff to manage after employing their normal procedures.

- **R**ESISTANCE (e.g. history of non-compliance, not aware they are ill, therefore likely to resist).
- **A**GGRESSION (e.g. history of threatening, abusive or hostile behaviour).
- **V**IOLENCE (e.g. history of assaultive behaviour, access to weapons).
- **E**SCAPE (e.g. history of attempts to abscond).

Where there is information to justify one or more sections of the mnemonic, these are the grounds upon which it could be agreed that the police should be involved supporting MHA Assessments.

By law, some incidents must involve the police e.g. executing S135 MHA warrants, however, the RAVE mnemonic will be used to provide background and risk information when AMHPs are requesting police to support executing a warrant.

7.2 Dealing with Pre-Planned MHA Assessments in a Dwelling

All requests for police assistance at MHA assessments on private premises will be made via email to the FCC. Unless there is an urgent nature to the request, the AMHP will complete the agreed form (See Appendix 1 – Request for Police Assistance Form) at the earliest opportunity and email it to COMMCEN@merseyside.police.uk and cc. Mental.Health.Triage@merseyside.police.uk.

FCC will create a Storm log within an hour of receipt and reply to the informant informing them of the log number. FCC will communicate with the informant to discuss the feasibility of deployment at a time suitable for all professionals involved.

Basic checks on Force systems (PNC/STORM/NICHE) should be completed to ascertain is there any additional information that the attending officers need to know.

The AMHP has overall responsibility for co-ordinating the assessment and is responsible for completing the application for compulsory admission to hospital under the MHA, this includes transport arrangements to hospital (not the PoS). NWAS do not offer a facility to pre-book transport, therefore police deployment should not be deferred due to lack of ambulance.

Where the police are supporting an assessment, it is essential that there is clarity between all agencies involved and that the police role is to prevent a Breach of the Peace (BOP) and to protect the public i.e., partner agency staff.

At the very minimum, this planning process should involve a joint discussion. The following points should be considered:

- Access to premises can be affected lawfully. The Police will only enter and remain on the premises if they are satisfied that they are doing so with consent, until the AMHP has completed the admission papers, and the person is deemed to be in legal custody.

- Each participant is fully aware of the plan for conducting the assessment, including dealing with contingencies e.g., if the person leaves the premises before the completion of the assessment, or consent is refused or withdrawn at any stage.

7.3 Entering Private Premises

When it is necessary to enter premises where there is a concern for an individual's mental wellbeing, police officers can enter only if:

- Consent to enter a premises has been given by the individual about whom there are concerns about or a co-occupier. Consent can be withdrawn at any time, in which case the AMHP and other professionals should leave, unless the application for compulsory admission to hospital under MHA have been completed.

- The officer has reasonable grounds to suspect that the person on the premises is about to commit serious harm to themselves or others, entry can be gained, using the power under S17 PACE in order to save life and limb.

- A warrant under S135(1) MHA has been granted (see below) to enable an application under MHA to be made in order to detain the individual under S2 or S3 the MHA.

- A warrant under S135(2) MHA has been granted. This authorises a police officer to enter premises, by force if necessary, in order to search for and retake an individual who is liable to be detained under the MHA and who is Absent Without Leave (AWOL).

7.4 Dealing with Pre-Planned S135 MHA Warrants

Legislation – Power to Enter, Search Premises and Remove Persons Under MHA.

S135(1) MHA – If it appears to a justice of the peace, on information on oath laid by an AMHP, that there is reasonable cause to suspect, that a person believed to be suffering from mental disorder:

a) Has been, or is being, ill-treated, neglected, or kept otherwise than under proper control, or

b) Being unable to care for himself, is living alone in any such place.

The justice of the peace may issue a warrant, authorising a police officer to enter, if need be by force, any premises specified in the warrant, in which that person is believed to be, and, if thought fit, to remove them to a place of safety with a view to making an application under part II of the Act (compulsory admission to hospital or guardianship in S2 to S34), or other arrangements for their treatment or care.

S135(1A) MHA – If the premises specified in the warrant are a PoS, the constable executing the warrant may, instead of removing the person to another place of safety, keep the person at those premises.

S135(2) MHA – If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act to take a patient to any place, or to take into custody or retake a patient who is liable under this Act.

a) There is reasonable cause to believe that a patient is to be found on premises within the jurisdiction of the justice, and.
b) That admission to the premises has been refused or that a refusal of such admission is apprehended.

The justice may issue a warrant authorising any constable, to enter the premises, by force if necessary and remove the patient.

S135(3) MHA – A patient who is removed to a PoS in the execution of a warrant issued under this section (or kept at the premises specified in the

warrant under subsection 1A) may be detained there for a period not exceeding the permitted period of detention.

In subsection (3), "the permitted period of detention" means:

a) The period of 24 hours beginning with:

   i) in a case where the person is removed to a place of safety, the time when the person arrives at that place.

   ii) in a case where the person is kept at the premises specified in the warrant, the time when the constable first entered the premises to execute the warrant, or

b) Where an authorisation is given in relation to the person under S136B (extension of detention), that period of 24 hours and such further period as is specified in the authorisation.

7.5 S135(1) MHA Warrant Procedures

All S135(1) MHA Warrants will be recorded on Niche

S 135 Niche Templates 7@7

All requests for police to attend and execute S135 MHA warrants will be made via email to the FCC. The AMHP/Mental Health Practitioner will complete the agreed form (Appendix 1 – Request for Police Assistance Form) and email it to COMMCEN@merseyside.police.uk and cc. Mental.Health.Triage@merseyside.police.uk.

FCC will create a Storm log within an hour of receipt and reply to the informant informing them of the log number. FCC will communicate with the informant to discuss the feasibility of deployment at a time suitable for all professionals involved.

Force systems should be interrogated for any information that will inform the attending officers of any likely risks.

The warrant authorises any constable to enter (accompanied by the AMHP and a registered medical practitioner), if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety (for a period not exceeding 24 hours) to allow an assessment under the Act to take place.

The role of the constable is to gain entry to the premises and to ensure the safety of the doctor and the AMHP, whose joint role is to assess whether the person should be removed to the place of safety for further assessment. The AMHP will show the warrant to the officer prior to entry.

There should be a joint discussion prior to entry which includes contingencies e.g. if the person leaves the premises before the completion of the assessment, or consent is refused or withdrawn at any stage.

If the premises specified in the warrant are a PoS (as per S135(1A) MHA), the constable executing the warrant may, instead of removing the person to another place of safety, keep the person at those premises for the purpose of assessment (for a period not exceeding 24 hours, which will begin when the officer enters the property).

If premises named on the warrant is to be used as the PoS, both the person named on the warrant & any other occupier need to agree the premises being used as a PoS.

The doctor and the AMHP will assist the police officer in deciding whether it is 'fit' to take the person concerned to a place of safety. It is the responsibility of the officer to arrange transport if the individual is removed to a PoS. As with all conveyance under MHA, where possible this should be via ambulance accompanied by the officer.

(For further detail on Transport Powers & Conveyance see Chapter 8)

7.6 Police Remaining with the Individual at the Place of Safety

The risk assessment conducted by the place-based Inspector to determine if and how long police officers will remain at the place of safety and the process of a lawful handover when they leave is outlined in Appendix 2 Police Remaining with the Individual at the Place of Safety

NOTE – This risk assessment does not apply to children (anyone under 18 years). Officers will remain with children at the place of safety until the S135 MHA assessment has been completed.

7.7 Points of Note

- The warrant will authorise an entry on one occasion only (unless specified otherwise).
- Any search that takes place will only be to the extent required for the purpose of the warrant i.e., finding the person not property.
- The warrant only authorises police officers to search for the person named on the warrant.
- The existence of a warrant does not mean it has to be executed (this is the decision of the constable).

- If entry is without a warrant, police will only enter and remain on the premises if they are satisfied that they are doing so with consent, until the AMHP has completed the admission papers, and the person is deemed to be in legal custody.
- Access to the premises can be effected lawfully if a co-owner or co-occupier gives permission. (As long as that owner/occupant has the right to exclude others or deny access to anybody to that particular room).
- The AMHP will leave a copy of the warrant with the occupier or at the premises.
- Entry must be within 3 months from the date of issue.
- The individual is not further legally detained under a S2 or S3 MHA until the name of the hospital (where the bed is) is legally endorsed (by the AMHP) on the application part of the MHA papers.

7.8 Securing Premises

S47 Care Act 2014 places the responsibility for securing a property following removal of a person (to hospital) on the relevant local authority (AMHP). It is therefore, the AMHP's responsibility to ensure that the premises are re-secured (if this is likely to cause an excessive delay, police boarding up arrangements can be implemented).

7.9 Hotel rooms

R v Rosso the court determined that in relation to if a warrant is required or not, it must be established whether the person has 'an exclusive right to occupy a room,' by asking the following questions –

a) Does the occupant have a right to exclude others from the room?

b) Does the occupant have the right to deny access?

If the answer to both questions is no, the individual does not have an exclusive right to occupy a room.

Where doubt exists, a warrant should be sought and the application for the warrant should clearly set out the access and consent issues in relation to the premises, leaving the court to decide.

7.10 Patients Who Refuse to go to Hospital Once Detention is Authorised

MHA CoP 17.13 states 'If the patient is likely to be unwilling to be moved, the applicant (AMHP) will need to provide the people who are to transport

the patient (including any ambulance staff or police officers involved) with authority to transport the patient. This will give them the legal power to transport patients against their will, using reasonable force if necessary, and to prevent them absconding en route.'

The AMHP themselves and/or any police officer or member of health and social care staff so authorised by them may move the individual using reasonable force, where proportionate and necessary.

The power under S135(1) MHA ends when:

- When the 24 hrs expires (or 36 hours if extended).
- An AMHP has made the necessary arrangements for that person's treatment or care e.g. detention in hospital, informal admission or community mental health follow up or G.P.
- Discharge no follow up.

NOTE – Informal Admission: MHA CoP states 'once assessment has been completed and suitable arrangements have been made,' the person is deemed able agree to the admission to hospital on a voluntary basis. Therefore, the assessing team should discharge the S135 MHA, as they are in effect an informal patient awaiting admission.

7.11 Responsibilities During Absence

The police will investigate cases falling within the definition of 'missing' in accordance with Force Policy and National Guidance on Missing Persons. When completing the missing report, the officer should document the agreed action in relation to the management and return of the patient once they are located.

Health care, social care, and support staff (involved with the individual or employed at the establishment from which they are missing) will be expected to make reasonable enquiries both before and after a report is made to the police and to work co-operatively with the police during any enquiry. Even after reporting a person missing, staff should recognise that they continue to be responsible for people in their care at all times and this responsibility is not absolved when they have reported a person as missing to the police.

Unless the patient is witnessed leaving the hospital or other mental healthcare setting, and every attempt has been made by staff at that location to stop the patient from doing so, staff should make every effort to search their own premises and to make contact with the patient to establish their whereabouts prior to contacting the police.

Discharge during absence – it is not good practice for mental health inpatient staff to report a patient missing and then immediately discharge them in their absence from the ward. If discharge becomes absolutely necessary, the police may decide to close the missing person investigation, this will be communicated to the hospital. If the missing person investigation remains live, it is expected that the mental health trust responsible for the patient (be that inpatient or community staff), will remain involved and continue to assist the police with their enquiries.

7.12 S135(2) MHA – Patients (Absent Without Leave) or Liable to be Detained and Refusing Entry

In Merseyside, officers are not expected to swear out these warrants, depending on the local arrangements, it is the responsibility of the Mental Health Trust or local authority.

NOTE – S135(2) MHA Warrants will NOT be recorded on Niche.

As per the legislation, a Magistrate may issue a warrant authorising a Constable to enter the premises, if needs be by force, and remove the patient. The warrant authorises the removal of a patient (who is already liable to be detained or Absent Without Leave) to the place where they are required to be e.g., the ward from which they have absconded, the ward where they are liable to be detained etc.

When making enquiries to locate an individual who is liable to be detained under MHA (i.e., the relevant recommendation and paperwork for detention under the MHA has been completed) and they are suspected to be at premises and are refusing access, a warrant under S135(2) MHA should be considered.

All requests for police to attend and execute S135(2) MHA warrants will be made via email to the FCC. The AMHP/Mental Health Practitioner will complete the agreed form (Appendix 1 – Request for Police Assistance Form) and email it to COMMCEN@merseyside.police.uk and cc. Mental.Health.Triage@merseyside.police.uk.

When executing a warrant under S135(2), it is good practice (but not mandatory) for the police officer to be accompanied by a health/social care professional. However, the feasibility of coordinating this with patrol availability may prove difficult and therefore it may be operationally more efficient for the police execute the warrant without support.

A copy of the warrant should be left with the occupier or at the premises.

Any search that takes place will only be to the extent required for the purpose of the warrant.

The officer should endorse the warrant stating whether the person sought was found.

7.13 Dealing with Spontaneous Mental Health Incidents in a dwelling

Police can be called to incidents in a dwelling that involve a person who appears to in mental health crisis and action, or assistance is required. i.e. where in a location where S136 MHA cannot be invoked. e.g.

a) An individual in mental health crisis contacts the police for assistance.
b) Whilst in a dwelling dealing with another issue, it becomes apparent that a person is in crisis with their mental health/learning disability.
c) A Mental Health Practitioner visiting an individual in the community contacts the police as the person has become violent.

As such incidents are not pre-planned, a warrant will not exist, and due to the lack of powers available in this situation, these can potentially be extremely demanding situations to deal with.

It is not appropriate in such circumstances to persuade the individual to leave the premises, in order to detain them under S136 MHA.

Any risk posed by the individual to themselves, or others should form part of the decision making. The following options should also be considered:

a) Contact the mental health triage car (see also Chapter 5 – Mental Health Triage Car).
b) Contact 24/7 Crisis Line/Professionals line for advice and their assistance in contacting any other relevant professionals.
c) If the individual lacks capacity and it is necessary to provide life sustaining treatment or to do a vital act necessary to prevent a deterioration in their health, consider the Mental Capacity Act (MCA) 2005 . (See also Chapter 9 – Mental Capacity Act 2005).
d) If the individual is prepared to go to Accident and Emergency Department (AED), an ambulance should be called. Officers should also consider the risks of leaving the individual alone at AED e.g., risk of the individual walking out of AED and harming themselves, or the risk to AED staff. The Voluntary Attendance Handover Form should always be completed via the handheld device which will generate an e-mail to the AED reception staff.

e) Contacting the relevant local authority to make an urgent referral for an MHA Assessment (however, this should be a consideration for staff on the 24/7 Crisis Line/Professionals line).

f) Considering any offences disclosed.

g) If there is no risk posed, consider the support of friends or family, and complete the mental health page on the eVPRF.

Entry to premises in these instances can only be with consent, unless entry is justified under PACE or BOP etc.

Where the circumstances are not as serious or critical and entry to the premises cannot be justified as lawful, the options are:

a) Contacting the mental health triage car (see also Chapter 5 – Mental Health Triage Car).

b) Contact 24/7 Crisis Line/Professionals line for advice and their assistance in contacting any other relevant professionals.

c) Complete eVPRF.

8. Transporting and Conveying People with a Mental Health Condition

8.1 Mental Health Act 1983 (including Codes of Practice)

The MHA Codes of Practice advocates the use of an ambulance to transport any patient detained under MHA and also:

- Indicates that the police may be involved in moving the patient to suitable healthcare facilities if they are likely to be 'violent or dangerous.'
- Where police are asked to assist in conveying, an ambulance should still be the preferred mode of transport with a police escort or, an officer(s) travelling with the individual in the ambulance vehicle.
- Where it is necessary to use a police vehicle, it is appropriate for the highest qualified member of an ambulance crew to accompany the patient. In such cases the ambulance should follow directly behind the police vehicle.

The below protocol outlines arrangements for all North West forces and NWAS in relation to transporting patients detained under the MHA.

North West Regional Policy & Guidance for Transporting Mental Health Patients

8.2 Standards for Police Involvement in Mental Health Act Conveyance.

In line with the above, this chapter should be read on the assumption that:

- The police should only be asked to assist with conveying a patient when the patient is violent or dangerous.
- Every effort will be made to secure an ambulance to convey, regardless of NWAS deployment times or ability to deploy, NWAS will always be contacted to register the need for an ambulance.
- However, decisions to use police vehicles can be made if all the prevailing factors suggest that it is more appropriate and will resolve unnecessary delays, i.e. in cases of extreme urgency, risk, or excessive delays with NWAS.
- **A supervisory officer should make this decision.**
- The relevant STORM log will be endorsed as to the decision made and the reasons why.

S137 MHA provides that:

S137(1) Any person required or authorised by or by virtue of this Act to be conveyed to any place, or to be kept in custody, or detained in a PoS, or at any place to which he is taken under S42(6) (below) shall, while being so conveyed, detained or kept, as the case may be, be deemed to be in legal custody.

S137(2) A constable or any other person required or authorised by or by virtue of this Act to take any person into custody, or to convey or detain any person shall, for the purposes of taking him into custody or conveying or detaining him, have all the powers, authorities, protection, and privileges which a constable has within the area for which he acts as constable.

S137(3) In this section “convey” includes any other expression denoting removal from one place to another.

S42(6) The Secretary of State may, if satisfied that the attendance at any place in Great Britain of a patient who is subject to a restriction order is desirable in the interests of justice or for the purposes of any public enquiry, direct him to be taken to that place; and where a patient is directed under this subsection to be taken to any place, he shall unless the Secretary of State otherwise directs, be kept in custody while being so taken, while at that place and while being taken back to the hospital in which he is liable to be detained.

An individual who escapes from legal custody under this Act can be retaken under S138 MHA (see also Chapter 10 – Missing Patients with a Mental Health Condition).

The powers within S137 MHA do not include the power to force entry to premises (see also Chapter 6 – Section 136 Mental Health Act 1983).

Some situations allow for the use of S18 MHA to provide the power to take an individual into 'custody' and return the patient to hospital.

8.3 Role of the AMHP and Conveyance Under MHA

Under the MHA, if an AMHP is involved, (e.g., following an MHA assessment a patient is liable to be detained under S2 or S3 MHA) the role of an AMHP is to take the lead in coordinating and risk assessing the most appropriate mode of conveyance.

Once an AMHP has made an application for admission, S6 MHA provides the authority for them to detain and convey the patient to hospital. The AMHP may delegate their authority under S6 to others. This then provides the power to detain & convey to hospital.

The patient at this point is liable to be detained and then, by virtue of S137 MHA, is in the AMHPs legal custody or whomever the authority is delegated to e.g., the police.

S135 & S136 MHA provide powers to remove to a PoS. A person who is being conveyed to a PoS is deemed to be in lawful custody (S137 MHA).

8.4 Transfers between Places of Safety

When a patient detained under S135/S136 MHA is to be transferred from one PoS to another, it is the responsibility of the AMHP, doctor or other healthcare professional to coordinate the transfer.

8.5 Transport of Inpatients to Other Hospitals

Where an inpatient i.e. a patient who is already admitted to a mental health unit, requires transport between hospitals, it is the responsibility of the hospital managers to have suitable transport arrangements in place.

8.6 Transport of Recalled Community Treatment Order Patients

See also Chapter 11– Community Treatment Orders (S17(E) MHA)

A notice of recall under a Community Treatment Order (CTO) properly completed by the Responsible Clinician and served on the patient in accordance with the Act, provides the authority to transport a patient subject to a CTO to hospital compulsorily, if necessary.

Staff of the hospital, any police officer or any other person authorised in writing by the Responsible Clinician or the managers of the hospital, to which the patient is recalled, can convey a recalled CTO patient.

It is the responsibility of the Responsible Clinician or staff acting upon their behalf to determine the most appropriate way to transport the individual back to hospital by way of a risk assessment (RAVE see Appendix 3 Recalled Community Treatment Order (CTO) Police Assistance Request). Risks must be justified to request the police to assist in returning the individual to hospital.

On the occasions that the police do assist, it should be to assist a mental health professional in returning the patient to a predetermined ward and hospital.

8.7 Transport of Individuals Detained under MHA to a Hospital Outside of Merseyside

All requests for the police to assist with conveying an individual detained under MHA to a bed outside Merseyside, should be referred to the place-based Inspector who should ensure that other alternatives such as specialist private companies have been considered.

If the place-based Inspector is left with no other option, a joint risk assessment should be conducted with the AMHP in relation to the journey and provision of suitable trained staff to accompany the patient.

The rationale should be recorded on the relevant STORM log.

8.8 Responsibilities for Returning/Transporting Missing Detained Patients Back to Hospital

See also Chapter 10 – Missing Patients with a Mental Health Condition & North West Regional Policy & Guidance for Transporting Mental Health Patients.

Police assistance in returning a patient to hospital should not be considered a matter of routine. MHA Codes of Practice (MHA CoP) are clear that this function lies with the hospital.

Where a patient who is absent without leave from a hospital, is taken into custody by someone working for another organisation, the managers of the hospital from which the patient is absent are responsible for making sure that necessary transport arrangements are put in place for the patient's return. (MHA CoP 17.30).

When arranging for the return of patients temporarily held in police custody, hospital managers should bear in mind that police transport to return them to hospital will not normally be appropriate. (MHA CoP 17.32)

If there are likely to be delays in arranging the above, MHA CoP 17.31 states: "The organisation, which temporarily has custody of the patient, is responsible for them in the interim and should, therefore, assist in ensuring that the patient is returned in a timely and safe manner."

If an officer locates a patient who is AWOL under MHA and invokes their powers under S18 MHA, the mode of conveyance to return them to the hospital should be in line the above standards for conveyance.

The relevant STORM log should be endorsed as to the decision made and rationale.

8.9 Patients Found in Merseyside who are Absent Without Leave from a Hospital Outside Merseyside

The MHA CoP are clear that this function lies with the hospital from which the patient is missing.

The police should not be asked to assist in the absence of other transport being available or due to another agency's unwillingness to undertake the journey.

All requests made for the police to assist with returning an individual detained under MHA to a mental health unit outside of Merseyside, should be referred to the place-based Inspector. They in turn should contact the most senior 'duty manager' for the mental health trust that has responsibility for the unit from which the patient is missing.

The place-based Inspector should ensure that the following has been considered:

- Have NWAS been contacted?
- Has the Trust who has responsibility for the patient contacted local Merseyside Trusts to see if a bed can be arranged in the interim whilst suitable arrangements can be made?

- Do the Trust have their own transport or have the Trust contacted any private transport companies?
- What is the availability of suitably trained staff to accompany the patient?

If the place-based Inspector is left with no other option, a joint risk assessment should be conducted with a manager from the detaining trust in relation to the journey.

8.10 Missing Detained Patients from Merseyside Found Outside Merseyside

Merseyside Police are not involved with returning detained patients who have gone missing from a mental health unit in Merseyside who have been found outside of the Merseyside area.

The responsibility for arranging return lies with the hospital managers of the mental unit from where the patient is missing.

8.11 Transport of Patients to and from Court

Transport of In-patients from Hospital to Court

MHA CoP 22.36 outlines the responsibilities of hospitals in respect of conveying detained patients who have been admitted on remand or who are subject to an interim hospital order under MHA.

Responsibilities include escorting the patient to and from court. The hospital will also be responsible for providing a suitable escort for the patient when travelling from the hospital to the court and should plan for the provision of necessary staff to do this.

The assistance of the police may be requested if the patient is violent or dangerous that cannot be managed with pre-planning and suitably trained staff (this should not be due to lack of health resources). In such circumstances the police may escort the patient by riding in the ambulance or hospital transport and/or follow in a police vehicle. Medical or nursing staff should remain with the patient on court premises, even though legal accountability while the patient is detained for hearings remains with the court.

Transport of In-patients from Court to Hospital

MHA CoP 22.35 provides guidance in respect of conveying detained patients from court to hospital.

Some mentally disordered offenders are diverted to hospital from court. There will not normally be an AMHP involved in such cases to decide on the most appropriate method of transport. Therefore, the court will make this decision. The court may contact the ambulance service or have access to other transport arrangements (this may include the police).

For patients remanded to hospital under S35 or S36 MHA, or subject to S37 or S38 MHA, the court has the responsibility and the power to direct who is to be responsible for conveying the defendant from court to the hospital (this may include the police).

It is the responsibility of the hospital receiving the person to make suitable arrangements for the conveying and transfer of those detained under the above orders back to court.

8.12 Transportation of Individuals Detained under Mental Capacity Act

See also Chapter 9 – Mental Capacity Act 2005 & North West Regional Mental Capacity Act Joint Protocol

S5 MCA and Chapter 6 MCA (Codes of Practice) operate together and provide a legal basis to control, restrain, and remove people who lack capacity to hospital in certain circumstances.

The preferred method of transport under MCA is an ambulance. Police vehicles should not be used to transport individuals under MCA.

9. Mental Capacity Act 2005

9.1 Legislation

The Mental Capacity Act 2005 (MCA) provides a statutory framework for acting and making decisions on behalf of individuals (aged 16 years or over) who lack capacity, or who are reasonably believed to lack mental capacity to act or make decisions for themselves and to restrain them if necessary for their self-protection.

The ethos of the Act is that people who lack mental capacity must be treated in their best interests. Whilst the Act is primarily aimed at health professionals and carers when making decisions about a person's welfare, it will in some circumstances be applicable to police officers when dealing with members of the public.

Some people will experience fluctuating capacity. A person can lack capacity to make a decision at the time it needs to be made, even if the loss of capacity is partial, the loss of capacity is temporary or their capacity

changes over time. It also covers temporary incapacity due to drug or alcohol abuse, physical pain or injury and mental ill health.

Mental Capacity is decision and time specific: 'Can the person make THIS decision at THIS time?'

9.2 Five Key Principles of the Mental Capacity Act 2005

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity at that time.
2. Take all practical steps possible to help someone make an informed decision.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision, as an apparently irrational or wrong decision does not by itself provide evidence of lack of capacity.
4. If you are making a decision for or about someone lacking capacity, always act in their best interest.
5. In making the best interest decision, seek the least restrictive option that will meet the person's needs.

9.3 Section 5 MCA and Chapter 6 MCA Codes of Practice

Section 5 MCA and Chapter 6 MCA CoP operate together and give the police and other agencies a legal framework to detain, restrain and remove people to hospital.

This is to ensure that someone who is at risk of serious harm and lacks the mental capacity to make decisions about their own healthcare needs is conveyed to an Accident and Emergency Department.

Reasonable force may be used to protect and control someone who does not have the mental capacity to take action to protect themself. The officer must reasonably believe that it is necessary to use restraint or other force in order to prevent the subject being harmed or harming themself.

The degree of force used must be proportionate to:

- The likelihood of that person suffering harm, and.
- The seriousness of that harm.

Any authority to restrain a person as a result of the MCA does not interfere with any existing powers of arrest for criminal offences, or under S136 MHA.

9.4 Points to Note

The MCA applies to public and private locations.

If a person does have capacity, under this legislation there is no power to treat them without their consent.

Every effort should be made, to encourage and enable the person who lacks capacity to take part in making decisions that concern them.

Officers should always weigh up the risks of forcing help on an unwilling person against the benefits it may offer.

9.5 Police Use of Mental Capacity Act 2005

Police officers may need to make immediate decisions that relate to containing, controlling, and potentially restraining an individual who lacks the capacity to make the decision in question for themselves, while awaiting further input or direction from a heath or social care professional.

MCA is most likely to be necessary in emergency situations, when officers are faced with someone lacking mental capacity and whose life may be at risk or, who may suffer harm if action is not taken. For example:

- People attempting and threatening suicide.
- Victims of serious assaults.
- Casualties of major incidents.
- Individuals with serious injuries who decline medical aid.

Where the police are the only service on scene and the severity or urgency of the situation dictates, it may be necessary to make an assessment and act accordingly before other services arrive. Where health or social care professionals are on scene, police will defer to their expertise on capacity and provide support as appropriate.

9.6 Decision Making

Step 1 – Determining Someone's Mental Capacity.

Everyone is presumed to have capacity, unless there is evidence that they cannot make a decision because of an impairment or disturbance in the functioning of their mind or brain. E.g. because of:

a) Significant learning disabilities.
b) Mental illness.

c) Dementia.

d) Brain damage.

e) Physical or mental conditions that cause confusion, drowsiness, or loss of consciousness.

f) Delirium.

g) Concussion following a head injury.

h) The symptoms of alcohol or drug use.

A person may be deemed unable to make a decision when they cannot do any one of the following:

a) Understand information about the decision to be made.

b) Retain that information in their mind.

c) Use or weigh that information as part of the decision making process.

d) Communicate their decision.

An apparently irrational or wrong decision does not, by itself, provide evidence of lack of capacity.

NOTE – Where a person who is threatening suicide appears to know exactly what they are doing and why, others may be reluctant to conclude they lack capacity – basing this judgement on principle 3 of the MCA (namely a person is not to be treated as unable to make a decision merely because he makes an unwise decision).

It is not the decision to take their own life that necessarily shows lack of mental capacity, however, but rather their inability to consider or fully think through alternative options such as counselling, medical assistance or help from statutory or voluntary agencies (weighing that information as part of the process of making the decision).

The mnemonic 'ID A CURE' will assist officers in remembering the test to determine if an individual lacks capacity:

- **Impairment** – (temporary or permanent) which prevents the person from being able to 'CURE,' as below, or
- **Disturbance** – (temporary or permanent) which prevents the person from being able to 'CURE,' as below.

AND the person cannot do any one of the following:

- **Communicate.**
- **Understand.**

- **Retain.**
- **Employ.**

Officers should take all reasonable and practical steps, to explain the risks and benefits and foreseeable consequences of making the decision (e.g. refusing medical help for serious injury).

Questioning such as "Do you realise you have an injury?" or "Do you realise how serious it is?" Asking questions and noting responses will help the officer decide if the person has capacity to make decisions, about their own emergency needs at that time.

A person may give replies to the questions shown above that indicate they do not understand the risks to their health if they do not receive emergency treatment. This, in itself could strongly suggest their incapacity because they appear unable to comprehend the risks involved.

Asking people to recall what you have just said, may also help to provide evidence that they are unable to retain information. Whenever possible and practicable, officers should consult friends, partners, relatives, or anyone the person wants contacted.

Step 2 – Determining What is in Someone's Best Interests.

Deciding what is in the person's best interests, will be relatively uncomplicated for the emergency situations faced by police.

The MCA CoP states that: 'In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay.'

NOTE – This only applies where the person is reasonably believed to lack capacity, and that the risks of having to use force to enable treatment to be given must be taken into account.

Step 3 – Consider Using Restraint.

Reasonable force may be used to protect and control someone who does not have the mental capacity to take action to protect themself. The officer must reasonably believe that it is necessary to use restraint or other force in order to prevent the subject being harmed or harming themself.

The degree of force used must be proportionate to:

- The likelihood of that person suffering harm, and.
- The seriousness of that harm.

The power to restrain a person under the MCA does not interfere with existing powers of arrest for criminal offences or detention under S136 MHA.

Step 4 – Record Your Decisions and Actions.

Having assessed an individual as not having mental capacity and then acted in their best interest, the officer must record their decisions/actions and rationale on their electronic pocket notebook (PRONTO).

The electronic pocket notebook entry should include:

a) The information/behaviour/actions used to decide the individual lacked capacity.
b) Why was action necessary e.g. life threatening injury requiring immediate treatment.
c) What other options were considered.
d) Any other individuals consulted e.g. family/health care professional.
e) What action was taken.
f) If applicable, how the individual was restrained and for how long.
g) The effect of the action taken.

When police officers are requested to assist the ambulance service with a person lacking capacity, officers should record the following in their pocket notebook:

a) The name of the ambulance staff member who has assessed under MCA.
b) Their contact details.
c) Ambulance incident number.

9.7 Ambulance Staff request Police Attendance

Ambulance staff are trained to assess and record mental capacity in line with the requirements of the MCA.

Ambulance staff can also remove an individual to an AED under the MCA. Ambulance staff may contact police for assistance:

- When a patient they have identified as ‘lacking capacity’ is in need of emergency treatment and requires restraint due to their threatening or violent behaviour.

- The patient is refusing emergency treatment and/or transport in their best interests.
- Patients who are at risk of causing further harm to themselves or others.

In such circumstances, the officer's role, is to provide assistance with restraint and/or to deal with violent or absconding behaviour, or to deal with other exacerbating factors, such as violent/obstructive family members etc.

9.8 Transport

See also Chapter 8 – Transporting & Conveying People with a Mental Health Condition & North West Regional Mental Capacity Act Joint Protocol.

The patient should be transported in an ambulance with appropriate police support where justified.

Police vehicles should not be used to transport individuals under MCA.

If an ambulance is not already at scene, unless circumstances at the time clearly dictate otherwise, the FCC will always contact NWAS when an individual has been detained under MCA, to register the need for an ambulance.

9.9 Arrival at Hospital

Upon arrival at the hospital, the officer should make clear who has detained the individual under MCA, i.e. if ambulance staff have requested police assistance to convey, it is the ambulance staff who have conducted the mental capacity assessment and removed the individual under the MCA.

Officers will not be obliged to remain with the person unless they are concerned that the individual poses a risk to themselves or others by way of violence.

Currently there is no agreed form across Merseyside in relation to removal of an individual under MCA. Therefore, an electronic pocket notebook entry detailing why the police were requested and including ambulance staff details and log number should be recorded.

9.10 Mental Health Act 1983 Versus Mental Capacity Act 2005

The MCA should not be used as a way to circumnavigate the requirements of a detention under S136 MHA i.e. because the person is in a dwelling.

It is unlawful to remove an individual from a dwelling under the MCA to another place in order to detain them under S136 MHA.

Powers to remove under the MCA require that an officer must suspect the individual lacks capacity. There is no such requirement under MHA.

If the criteria for S136 MHA exists, then it must be used. The MHA will always have primacy over the provisions of the MCA.

9.11 Criminal Offences under MCA

S44 MCA introduced two new criminal offences, ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions. The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family, carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home.
- An attorney appointed under a Lasting Power or Enduring Power of Attorney.
- A deputy appointed for the person by the court.

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine, to a sentence of imprisonment of up to five years or both.

Ill-treatment and neglect are separate offences. For a person to be found guilty of ill treatment they must either:

- Have deliberately ill-treated the person, or
- Be reckless in the way they were ill-treating the person or not.

The meaning of 'wilful neglect' varies, depending on the circumstances. It would usually mean that a person has deliberately, failed to conduct an act they knew they had a duty to do.

10. Missing Patients with a Mental Health Condition

10.1 Missing Persons Policy

Merseyside Police – Missing Persons Policy should complied with for all individuals who have a mental health condition and who are deemed to be missing or having absconded or absented themselves under MHA 1983.

10.2 Definitions

NPCC Definition Missing:

"Anyone whose whereabouts cannot be established will be considered as missing until located, and their wellbeing or otherwise confirmed."

All reports of missing people sit within a continuum of risk from no apparent risk (absent) through to high risk cases that require immediate, intensive action.

Absent Without Leave:

The definition of when a patient is AWOL is contained in the MHA 1983 under S18(1) MHA 1983. 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 MHA 1983 S135(2).

Section 18(1) states that a patient becomes AWOL if they:

- Absent themself from the hospital without leave granted under S17 MHA 1983.
- Fail to return to the hospital at the expiration of any period of leave or on being recalled from leave.
- Absent themself without permission from any place where they are required to reside in accordance with conditions imposed on any grant of leave.

The term can also be applied to community treatment order (CTO) patients who have failed to return to hospital when recalled, or who subsequently abscond from hospital. In the context of a CTO, recall occurs when the patient's responsible clinician requires the patient to return to hospital.

Patients subject to Guardianship under the MHA 1983 are considered to be AWOL when they are absent without permission from the place they are required to live by their guardian.

Liable to be Detained:

Where an MHA assessment has occurred and an application has been made (there are two medical recommendations from Doctors and the Hospital (bed) has been named on the Application part of the papers), patients are then "liable to be detained." If the patient chooses to leave the

location where the assessment is taking place there are legal powers to intervene under the MHA.

Absconding (from legal custody under MHA 1983):

Patients are deemed to have absconded from legal custody under MHA 1983 if:

a) A patient who is liable to be detained (i.e., they have been assessed under the MHA, two medical recommendations have been completed and the Application is complete, including naming the hospital where the patient is to be detained) and they have absented themselves prior to arriving at hospital.
b) Where an individual has been detained for removal to a Place of Safety under S 136 (1) MHA 1983 or S 135 (1) MHA 1983 who has absconded before or after their arrival at the Place of Safety.

Hospitals:

In this chapter the term 'hospital' also covers other mental healthcare settings and includes Places of Safety for detentions under S135 and S136 MHA.

10.3 Categories

There are two categories of missing mental health patient:

a) Those who are detained under a section of the MHA (in hospital or the community).
b) Those who are informally (sometimes called voluntary patient) admitted for treatment (in hospital).

It is important to establish the distinction between the two, as it will potentially impact upon the policing response, most notably the powers to detain and return the patient.

10.4 When Should the Police be Contacted/Deploy?

The MHA 1983 Code of Practice (para 28.15) indicates that there are three situations that should always and immediately be reported to the police by healthcare services:

1. Patients subject to MHA Part III – this means patients connected to criminal proceedings, either before or after trial or conviction.

2. Patients who are dangerous.
3. Patients who are particularly vulnerable.

There is no obligation in law for hospital staff to report any other relevant matters immediately or at all. However, as the police have a role in searching for missing people, some AWOL patients outside of the above three situations may be classed as a missing person.

The above outline the circumstances when the police should be notified that a patient is being reported as AWOL by the Mental Health Trust.

This is not the same threshold by which a patrol should be deployed.

Where it is reported that there is an immediate risk to life or risk of serious harm (Article 2&3 ECHR) or that there is a present and continuing risk to any other person, other than the patient, there is a statutory obligation on the police to deploy a patrol. The Contact Resolution Officer should reclassify this incident as a '345 – Concern for Welfare and follow the *Right Care Right Person'* call-script.

FCC Staff will be expected to conduct checks on Force Systems, such as Niche, Storm and PNC in order inform their decision-making, especially when there is information which suggests the patient is at risk of criminal or sexual exploitation.

In the absence of an immediate risk to life, serious harm and there is no present and continuing risk to any person, other than the patient, the responsibility to make enquiries to locate and return the patient remains with the Mental Health Trust.

The Mental Health Trust will be responsible for conducting enquiries to locate and return the patient, including making telephone calls to the patient, any known friends or family or NOK.

The Mental Health Trust will be responsible for conducting physical address checks on the patients address or other known addresses, including NOK. Full details including time and date of these address checks should be provided to the police if the patient is being reported as missing.

In instances whereby the police do not assume responsibility for locating and returning the patient and that duty remains with the Mental Health Trust then a 'locate info' marker will be added to PNC by the FCC Staff to ensure that the patient's status could be determined should they have a chance encounter with the police.

10.5 Information Required by the Police

See Appendix 6 – Information Required by the Police

When a patient from a hospital or other mental healthcare setting meets the criteria of a missing person, it is vital to have access to all necessary information to provide an effective policing response.

Any information obtained should be recorded on Compact. Whilst the decision to share information remains with the health professionals, health professionals should provide and/or police should ask for, all of the available information documented within Appendix 6 – Information required by the police.

10.6 Missing Patients who are Detained Under MHA

If a patient detained under MHA absents themselves, depending on which section of the MHA they are subject to, they are deemed to be Absent Without Leave (AWOL) under MHA they have absconded from Legal Custody.

Under the MHA, patients are considered to be AWOL when they:

a) Have left the hospital in which they are detained without their absence being agreed (under S17 MHA) by the responsible clinician.

b) Have failed to return to the hospital at the time required to do so by the conditions of leave under S17 MHA.

c) Have failed to return to the hospital when their leave under S17 MHA has been revoked.

d) Are patients subject to a CTO who have failed to attend hospital when recalled.

e) Are CTO patients who have absconded from hospital after being recalled there.

f) Are conditionally discharged restricted patients whom the Secretary of State for Justice has recalled to hospital; or

g) Are guardianship patients who are absent without permission from the place where they are required to live by their guardian.

h) Are patients who left the hospital after being detained under S5(2) MHA by a Doctor (They should be detained within 72 hours).

10.7 Legislation and Associated Powers

Absconding & Absent (Under MHA)

Absent Without Leave – A person who is AWOL can cover a range of scenarios:

a) An individual detained in hospital as an in-patient under S2, S3, S4, S5(2) or S5(4) MHA or guardianship (S7 MHA) and has left without permission.

b) An individual granted S17 MHA leave and has failed to return on time.

c) An individual subject to a Community Treatment Order (CTO) who has been recalled.

d) An individual detained in hospital under S37, S37/41.

For an individual who is AWOL, providing the authority to detain for that section is still within the time limit, an officer (or anyone authorised by the hospital managers) can detain and return the individual using S18 MHA.

For instances whereby the location of the patient is known and they are refusing to return with the Mental Health Trust personnel, the police can be deployed to assist the Mental Health Trust in returning the patient.

For instances whereby the location of the patient is known and they are refusing to return, or refusing access to a property, the Mental Health Trust will be expected to apply for a S135 (2) MHA Warrant and to contact the police. (See 7.5)

S18 MHA provides powers for returning patients to hospital who are absent without leave.

A patient who is absent without leave may be taken into custody by:

a) Any officer on the staff of the local Social Services Authority.

b) A Police Officer, or

c) Any person authorised in writing by the guardian or local social services authority.

S18 MHA does not provide a power to enter premises by force (See S135(2) MHA above).

S18 MHA does not give the power to hold people at a police station or to remove them to a police station but purely to return them to the hospital from which they went missing.

Absconding from Legal Custody – A person who has absconded from legal custody under MHA can cover a range of scenarios:

a) An individual in the community who has been sectioned (S2, S3 or S4 MHA) who has gone missing before arriving at hospital.
b) An individual who has been detained for removal to a place of safety (S135, 136 MHA) and has gone missing either before or after their arrival at the place of safety.
c) An individual who has been remanded to hospital (S35, S36, S38 MHA) and has absconded from hospital.

For an individual who has absconded from legal custody, providing the authority to detain for that section is still within the time limit, an officer or an AMHP can detain and return an individual for the scenarios outlined in a) and b) above.

For an individual who has absconded from legal custody, providing the authority to detain for that section is still within the time limit, only an officer can detain and return an individual for the scenarios outlined in c) above.

The specific section providing the power to detain depends on the Section they were placed under.

For individuals fitting the criteria outlined in points a) & b) above, the power to detain and return is provided by S138 MHA (see below).

For individuals fitting the criteria outlined in point c) above, the power to detain and return is provided by those specific sections:

- Section 35 MHA power to retake provided by S35(10) MHA.
- Section 36 MHA power to retake provided by S36(8) MHA.
- Section 38 MHA power to retake provided by S38(7) MHA.

Patients who have absconded from S35, S36 or S38 MHA must be returned to the court that remanded them.

S138 MHA – states:

(1) If any person who is in legal custody by virtue of Section 137 above escapes, he may, subject to the provisions of this section, be retaken:

(a) in any case, by the person who had his custody immediately before the escape, or by any constable or approved mental health professional.

(b) if at the time of the escape he was liable to be detained in a hospital within the meaning of Part II of this Act, or subject to guardianship under this Act, or a community patient who was recalled to hospital under Section 17E MHA, by any other person who could take him into custody under Section 18 MHA if he had absented himself without leave.

(2) A person to whom paragraph (b) of subsection (1) above applies shall not be retaken under this section after the expiration of the period within which he could be retaken under section 18 above if he had absented himself without leave on the day of his escape unless he is subject to a restriction order under Part III of this Act or an order or direction having the same effect as such an order; and subsection (4) of the said section 18 shall apply with the necessary modifications accordingly.

(3) A person who escapes while being taken to or detained in a place of safety under Section 135 or 136 above shall not be retaken under this section:

(a) In a case where the person escapes while being removed to a place of safety in the execution of a warrant under Section 135(1) or under Section 136(1), after the end of the period of 24 hours beginning with the escape.

(b) In a case where the person escapes after the beginning of the period that is the permitted period of detention in relation to the person under Section 135(3ZA) or 136(2A), after the end of that period (taking into account any authorisation under Section 136B(1) that was given before the person escaped).

(4) This section, as far as it relates to the escape of a person liable to be detained in a hospital within the meaning of part II of this Act, shall apply in relation to a person who escapes:

(a) While being taken to or from such a hospital in pursuance of regulations under Section 19 above, or of any order, direction, or authorisation under Part III or VI of this Act (other than under S35, S36, S38, S53, S83 or S85), or

(b) While being taken to or detained in a place of safety in pursuance of an order under Part III of this Act (other than under S35, S36 or S38 above) pending his admission to such a hospital,

As if he were liable to be detained in that hospital and, if he had not previously been received in that hospital, as if he had been so received.

10.8 Powers of Entry

When making enquiries to locate an individual who is liable to be detained under MHA and you suspect them to be at a premises, but are refusing access, a warrant under S135 (2) MHA should be considered. (See Chapter 7 – Mental Health Crisis in a Dwelling, MHA Assessments & Warrants Under S135 MHA for further detail)

In Merseyside, it is expected that the mental health unit from which the patient went missing (provided that unit is within Merseyside) will arrange to swear out the warrant. Therefore, discussion should take place with the relevant unit manager.

10.9 Missing Community Treatment Order Patients who have been Recalled

See also Chapter 11 – Community Treatment Orders (S17E MHA)

Once a patient on a CTO has been served with a recall notice in accordance with MHA. If the patient has failed to attend the ward by the specified time, the patient can then be considered to be Absent Without Leave (AWOL).

If all attempts to locate the patient have failed and their whereabouts are unknown, the care team will contact the police to conduct a missing person enquiry.

If the patient's whereabouts are known but the patient is refusing to comply AND RAVE indicators are present, the care team can consider requesting the assistance of the police to retake the patient, by completing the relevant form (see Appendix 3 Recalled Community Treatment Order (CTO) Police Assistance Request).

The Recalled CTO patient can only be brought or returned to hospital during the period before:

(a) The CTO expires; or

(b) The end of the six-month period starting with the first day of the absence without leave if that is the latter.

10.10 Missing Patients detained under S41 MHA

S41 MHA (often referred to as a Restriction Order) can be added by a Crown Court if an individual is considered to be a risk to the public.

S41 MHA can be used by the Courts to restrict the discharge of people committed by the Courts to hospital for treatment under S 37 MHA. The restriction means that an individual can only be discharged from hospital if the Secretary of State for Justice agrees.

Where a patient subject to S 41 MHA restriction order goes missing this must be treated as a missing person presenting risk to self, and/or others. The Responsible Clinician (the psychiatrist) responsible for the individual's care must also inform the Ministry of Justice.

As patients subject to S41 MHA have or are likely to pose a risk of harm, the Place-Based Inspector should consider any Threat Harm Risk posed by the patient whilst the patient is missing.

10.11 Patients who are AWOL and found outside England, Wales & Northern Ireland

Patients who are AWOL may be taken into custody in England, Wales, or Northern Ireland. Contact must be made with the hospital's Mental Health Act Office in order to establish arrangements for return of a detained patient from Scotland, the Isle of Man, or the Channel Islands. Arrangements for the retaking of AWOL patients who have absconded to or from these locations are set out in regulations made under the Act.

10.12 Missing Informal Patients (NOT detained under MHA)

An informal patient is a patient who is not subject to any compulsory measure under MHA.

If an informal patient is expressing a desire to leave the ward (this does not include AED) and there are concerns regarding this individual's mental health, a qualified mental health nurse and psychiatrists have authority under the MHA (S5 MHA) to detain informal patients on the ward in certain circumstances outlined by the Act. However, once a patient has crossed the threshold and left the immediate hospital grounds, these authorities cease to apply.

If the information disclosed to the police does not constitute an immediate risk to life, or risk of serious harm or there is a present and continuing risk to any other persons, other than the patient then there is no statutory legal obligation on the police.

However, if the Mental Health Trust have completed all necessary enquiries, including physical address checks to known locations of the patient, NOK or known friends or family, then the police may record the patient as a missing person and will grade the risk according to the circumstances.

10.13 Responsibility for Returning & Transport

(For further detail on Transport Powers & Conveyance see Chapter 8)

Police assistance in returning a patient to hospital should not be considered a matter of routine.

Transport involving the police should only occur where the patient is violent or dangerous and all other avenues have been explored.

Mental Health Trusts should have appropriate transport arrangements in place to comply with their responsibilities under the MHA Codes of Practice, this could include access to secure transport, or contracts with specialist private transport companies including appropriately trained staff (with knowledge of their powers under MHA and trained to respond to violent or difficult to manage patients).

According to the MHA Codes of Practice (17.30), responsibility for the return transport arrangements rests with the hospital as set in the following paragraphs:

Where a patient who is AWOL under the MHA is taken into custody by police, the managers of the mental health establishment from where the patient is missing are responsible for making sure that any necessary transport arrangements are put in place for the patients return. (MHA CoP Para 17.30)

When making arrangements for the return of patients temporarily held in police custody, hospital managers should bear in mind that police transport to return them is not appropriate. Decisions about the kind of transport used should be taken in the same way as for patients being taken to hospital for the first time. (MHA CoP Para 17.32)

The police should be asked to assist in returning a patient to hospital only if necessary. If the patient's location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital. (MHA CoP Para 28.14)

See Chapter 8 For further detail on transport including responsibilities for transport, duties of the hospital managers and transportation of Patients who are found in Merseyside but are Absent Without Leave from a Hospital outside of the Force area.

10.14 Detaining/Retaking Patients who are Liable to be Detained or AWOL

Once a patient who is subject to MHA has been located, the powers used to detain the individual depend on:

- The section of the MHA they are subject to.
- The expiry date of the period they are liable to be detained (which varies dependent on the section and if they have gone missing from the hospital they are detained to or prior to arriving at the hospital they are detained to).

Should the time limit have expired a discussion should take place with the ward from which they are missing. If the circumstances fit the appropriate criteria, consideration may be given to reverting to powers under S136 of the MHA.

S128 MHA – It is an offence under S128 MHA (1) to induce or knowingly assist a detained person to go AWOL. It is also an offence under S128 (3) to knowingly harbour a patient who is AWOL or hinder his/her return to hospital.

10.15 Returning Informal Patients

There is no power to apprehend a service user who is not detained under the Mental Health Act, i.e. an informal patient who is reported as missing. Action by the Police will therefore be confined to use of S136 MHA (where appropriate).

Once located, the hospital staff should be informed of the service user/patient's whereabouts and how they appear to be from a mental health perspective. Hospital staff should consider further appropriate action e.g. Mental Health Community team could visit the patient or informing their GP.

10.16 Patients Who Return of Their Own Accord

If a staff member from a mental health inpatient unit informs the police that a patient who has been reported missing has returned to the ward of their own accord, the staff member's details and contact number should be recorded on any existing Storm log and Compact.

The Compact found report and associate procedures will then be completed as per the Merseyside Police Missing Persons Policy.

If the patent is found in any other place other than; any house, flat or room where that person, or any person, is living, or any yard, garden, garage or outhouse that is used in connection with the house, flat or room, (other than one that is also connected with one or more other houses, flats or rooms) and appears to be suffering from a mental disorder and is in immediate need of care and control, the implementation of S136 MHA may be considered.

If the service user is found within a dwelling (or part thereof) and there are concerns for the individual's mental state, guidance should be sought from the hospital from which they are missing, options include:

a) Considering returning the individual to the ward with their consent.

b) Contacting the ward from which they are missing and request them to deploy a community/crisis team worker to the address.

c) Contacting the relevant Local Authority (Duty Approved Mental Health Professional) to arrange an urgent MHA assessment.

d) Contacting the individual's G.P to arrange an urgent home visit.

The person will no longer be regarded as missing once the hospital has been notified.

11. Community Treatment Orders (S17 MHA)

This chapter relates to requests for police assistance in returning an individual who is subject to a Community Treatment Order (CTO) under the Mental Health Act 1983 who has been recalled back to hospital.

11.1 Supervised Community Treatment

The Supervised Community Treatment (SCT) provisions allows some patients with a mental disorder to live in the community whilst still being subject to powers under MHA 83. The patients are still under the care of a 'Responsible Clinician' (Doctor). The order under the MHA 83 releasing them from hospital and placing them in the community is known as a Community Treatment Order (CTO). Certain conditions set out by the patient's 'Responsible Clinician' will be attached to the CTO upon release, e.g. to reside at a certain address, to comply with treatment regime and attend outpatient appointments.

11.2 Recall of Patient Subject to a Community Treatment Order

If the patient is not compliant with the CTO, breaches the conditions of the CTO or there is evidence of a relapse or high-risk behaviour relating to the patient's mental health, the 'Responsible Clinician' may recall the patient to hospital under S17E MHA.

Essentially, the responsibility for the return of a recalled CTO patient rests with health care agencies and police should only be asked to assist where:

a) There is a suggestion that Resistance, Aggression, Violence or Escape (RAVE Indicators) will be a factor.

b) Entry to premises is required under MHA warrant or there are risks justifying urgent entry to premises under Section 17 Police and Criminal Evidence Act 1984.

c) All attempts to locate the patient have failed and their whereabouts are unknown, therefore the police are required to conduct a missing person enquiry.

The recall notice will contain a time and a place (a hospital) when the patient is expected to attend hospital by.

The recall notice can be served:

a) By hand to the patient, in which case it is deemed effective immediately.

b) By 1st Class post to the patient's usual or last known address, in which case it is deemed effective on the second business day after posting.

c) By hand to the patient's usual or last known address, in which case it is effective on the day after being delivered i.e. after midnight on the day it was delivered.

Once the recall notice has been formally served in accordance with the above, and the patient has failed to attend the ward by the specified time, the patient is now considered to be Absent Without Leave (AWOL), therefore S18 MHA provides the power to retake the individual to hospital (using force if necessary).

This power can be invoked by any AMHP, officer on the staff of the hospital, by any Constable, or by any person authorised in writing by the managers of the hospital.

This power can be invoked in any public or private place, as long as lawfully on the premises.

11.3 Police Involvement

Following the recall notice being served, if the patient's whereabouts are unknown, the care team can consider reporting them missing to the police.

Following the recall notice being served, if the patient's whereabouts are known but the patient is refusing to comply AND RAVE indicators are present, the care team can consider requesting the assistance of the police to retake the patient, by completing the relevant form (see Appendix 3 Recalled Community Treatment Order (CTO) Police Assistance Request).

NOTE – Where police are asked to assist, before deployment, checks should be made with the relevant hospital managers to confirm the hospital named on the recall notice is still available to accept the patient. If it is not available, the hospital managers must confirm the plan before police are deployed.

11.4 Police Responsibilities

On the occasions that the police do assist, it should be to assist a mental health professional in returning the patient to a predetermined ward and hospital.

If there is evidence to suggest the patient subject to recall is inside a premises, but refusing entry, a S135(2) warrant may be required to gain access to premises in order to return the patient to hospital. The responsibility for obtaining the warrant should sit with the patient's care team.

Once the police receive the Request for Police Assistance with Recalled CTO form via COMMCEN, a Storm log will be created and graded in line with Force Policy.

11.5 Transportation for Recalled CTO Patients

(See also Chapter 7 North West Regional Policy & Guidance for transporting Mental Health Patients)

Where a patient is subject to a CTO and has been recalled, the Responsible Clinician or other care team staff acting upon their behalf, will need to decide the most appropriate method of conveying the individual back to hospital and should coordinate this with NWAS (or other suitable MH transport) and the police if necessary.

Any police officer or the staff of the hospital or any other person authorised in writing by the 'Responsible Clinician' or the Managers of the hospital, to which the patient is recalled, can convey a CTO patient.

The most appropriate person to convey the patient will depend on the individual circumstances but a police vehicle should only be used if a risk assessment deems it to be necessary. The use of police transport should be avoided and should only be considered when the patient is violent or dangerous or it is a matter of extreme urgency.

The police may escort the patient by travelling in the ambulance and/or following in a police vehicle.

12. Responding to Incidents at a Mental Health/Learning Disability Setting (MHLDS)

Guidance on responding to such incidents, including roles and responsibilities of health care staff is outlined in the multi-agency protocol below:

Cheshire & Merseyside - Local Response to Mental Health & Learning Disability Inpatient Settings

12.1 Emergency Responses to Mental Health/Learning Disability Settings

Ordinarily, the police should not need to be called to assist healthcare staff in responding to a patient who is presenting management problems. Employers have legal obligations to ensure that sufficient numbers of trained staff are available.

Police officers may be called to a hospital inpatient ward (or other location for detained and voluntary patients) in connection with one or more of the following requests:

- To restore control to a situation on the ward which has become dangerous for staff or patients.
- To assist staff in restraining patients for various purposes under MHA.
- To record and investigate allegations of crime.

Where police are asked to respond the guidance and process in the above multi-agency should be followed, including:

- Step 1 – Decide RVP (rendezvous point/meeting point).

- Step 2 – Incident explained: police and health staff meet at the RVP.
- Step 3 – Police/health roles established & use of body worn video (in line with Use of Force Act 2018).
- Step 4 – Police handover.
- Step 5 – Determine need for criminal investigation.

13. Risk Management and Public Protection

Statistically, individuals with a mental health condition are not dangerous and do not pose a risk to the public.

The risk of harm in the context of mental health is complex. This is partly due to the multiple factors underlying a person's behaviour and the way these interrelate.

Risk assessment and management is a core responsibility of mental health services and is an integral part of the assessment and care planning process.

Where possible, decisions in relation to individuals with a mental health condition who may pose a risk to themselves, or others should be made in collaboration with relevant partner agencies.

From a police perspective it is important that decisions in relation to prosecution regarding an offender with a mental health condition include consideration of risk and how a criminal justice disposal may assist in risk managing that individual.

13.1 Multi Agency Public Protection Arrangements (MAPPA)

(See Merseyside Police Policy – Managing Sexual Offenders, Violent Offenders and Other Potentially Dangerous Persons)

S325 to 327B of the Criminal Justice Act 2003 (CJA) established multi-agency public protection arrangements (MAPPA) in each of the forty-two criminal justice areas of England and Wales. These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent offenders.

All force custody suites have access to a Criminal Justice Mental Health Liaison and Diversion Team (CJLDT) who provide support & advice, including informed decision making in relation to charging & prosecution, risk assessments and court decisions.

Even if an individual is not deemed fit for detention/interview a prosecution should still be considered, particularly in relation to protecting the public. Although an incident may be minor, it is important to establish whether it is the latest in a developing pattern of dangerous behaviour. The need to protect the public may indicate that formal action is needed. Therefore it is crucial that decisions relating to the risk of harm should be made with other agencies wherever possible.

There should not be a presumption either for or against prosecution, each case should be considered on its individual circumstances. All decisions involving such individuals require a balance between the rights of the suspect, the victim, **and** the protection of the public.

The circumstances around some individuals with a mental health condition may prompt the need for a strategy/professionals meeting, these can be chaired and organised by any agency, however if the individual is open to mental health services it would be appropriate for them to be the coordinating agency.

13.2 Risk Management Meetings

Mental health services are responsible for risk assessment as part of delivering care. As well as being part of the MAPPA framework, each Mental Health Trust will have their own policy providing governance to this aspect of their service delivery. This can include a more enhanced layer of risk management. The meetings can be called (depending on the organisation) Risk Assessment Management Meeting (RAMM) or Health Risk Assessment Management Meeting (HRAMM).

These meetings provide a system for the sharing of confidential information across agencies, within existing policies and protocols.

Merseyside Police will be invited to these meetings. Officers attending should prepare appropriate information from police systems to share at the meeting and ensure any actions from the meeting are duly completed.

14. Appendices

14.1 Appendix 1 – Request for Police Assistance Form

Police Assistance Requests for
Section 135 MHA, MHA Assessments & Guardianship

R.A.V.E. (Resistance, Aggression, Violence, Escape)
Assessment Form

PLEASE READ ATTACHED GUIDANCE NOTES BEFORE COMPLETING THIS FORM

Once fully completed send this form to COMMCEN@merseyside.pnn.police.uk and Mental.Health.Triage@merseyside.police.uk you will receive a confirmation email. Merseyside Police will then make contact with you.

Person requesting Police Assistance

NAME	Click here to enter text.	UNIT/DEPT	Click here to enter text.
ROLE	Click here to enter text.	WORK TEL	Click here to enter text.
MOBILE	Click here to enter text.	E-MAIL	Click here to enter text.

Reason for requesting assistance (tick as appropriate)

☒ TO EXECUTE S135 MHA WARRANT (Only Police Officer can execute). You must indicate the intended Place of Safety: e.g. Address on Warrant / Name of Place of Safety (PoS). If location is not the address upon the warrant, confirm PoS has been informed.	Click here to enter text.
☐ TO SUPPORT MHA ASSESSMENT (Justified by R.A.V.E. below).	Click here to enter text.
☐ TO SUPPORT MH PROFESSIONAL WITH AN INDIVIDUAL SUBJECT TO MHA GUARDIANSHIP (either AWOL or transfer from one Guardian to another justified by R.A.V.E. below).	Click here to enter text.

Location Police Requested to Attend

ADDRESS	Click here to enter text.	POST CODE	Click here to enter text.

Patient Details

SURNAME	Click here to enter text.	FORENAME	Click here to enter text.
DOB	Click here to enter a date.	GENDER	**Male**

When is Police assistance required?

14.2 Appendix 2 – Police Remaining with the Individual at the Place of Safety (S135 & S136 MHA)

THIS RISK ASSESSMENT WITHIN THIS SECTION WILL NOT APPLY TO CHILDREN (Anyone under 18 years). **OFFICERS WILL REMAIN WITH CHILDREN AT THE PLACE OF SAFETY UNTIL THE MHA ASSESSMENT HAS BEEN COMPLETED AND ARRANGEMENTS MADE.**

S136 (1) MHA: Allows a Constable to remove the individual to a place of safety, however the powers of detention given by S136(2) MHA are not conferred expressly on the police but are given to any person who is party to the detention of the disordered person once he has been brought to the place of safety.

S135(3) MHA: Provides the power to detain an individual at a PoS. This power is not just for officers, the power is given to 'any person who is party to the detention' i.e. PoS staff.

Lawful Handover: Where officers have detained someone under the MHA, they remain responsible for that person's detention and their health & safety, until they hand responsibility for ongoing detention as well as health & safety to a **willing, competent authority** who is properly briefed on the relevant background and risks.

It is the responsibility of the Place-based Inspector in conjunction with the Nurse in Charge at the Place of Safety to decide if officers will remain with the individual removed to a Place of Safety under S135 or S136 MHA.

The Place-based Inspector should be contacted by the detaining officer who will outline the circumstances of the detention and the demeanour of the detained individual.

Upon arrival at the place of safety, the detaining officer should request any relevant information from staff at the place of safety regarding the individual that will inform the Place-Based Inspector's decision. This information along with information from police systems will be considered using the table below to inform the decision.

Low (not requiring police presence) – upon arrival after completion of 135/136 form and the officer and Nurse in charge agree that there is no requirement for the police to remain with the individual.

Medium (requiring police presence) -- the police will initially remain with the individual whilst enquiries are made by Health to secure observational support. Emphasis should be on allowing the police to leave as soon as

possible, once the lawful handover can be completed to a willing competent Authority.

High (requiring police presence) – Police MUST remain with the individual for the duration of their assessment or until their risk status determines that the police can leave.

NOTE – Once the decision has been made for officers to remain with the patient. Responsibility for managing the officers remaining with the patient and any issues that may arise will fall to Place-Based Inspector.

Section 135/136 Mental Health Act – Risk Assessment Tool

Section 135/136 Mental Health Act – Risk Assessment Tool for determining the need for continued Police Support within the Place of Safety

Low Risk	Medium Risk	High Risk
To be managed within hospital or health based Place of Safety – Continued Police support is NOT necessary.	To be managed within the hospital or health based Place of Safety – Continued Police support MAY be required.	To be managed within the hospital or health based Place of Safety with CONTINUED Police support
Current/Recent Indicators of Risk	Current/Recent Indicators of Risk	Current/Recent Indicators of Risk
No current or historic behavioural, criminal, or medical indications (other than mild alcohol or substance use) that the individual is violent OR poses a risk of absconding OR is an imminent threat to their own or anyone else's safety. OR	Some currently presented or recent behavioural indication which is more than just verbally abusive. AND/OR Some recent criminal /medical indications that the individual may be violent or poses a risk of absconding or is a threat to their own or anyone else's safety. BUT	Currently presented or recent history of behavioural, medical, or criminal indications (including significant substance intoxication) that an individual is violent and/or poses a high risk of absconding or is an imminent threat to their own or anyone else's safety. OR
Previous Indicators	Previous Indicators	Previous Indicators
Which are few in number and historic or irrelevant: BUT Excluding violence graver than ABH and not involving weapons, sexual violence or violence towards NHS staff or vulnerable people.	Limited in number or historic or irrelevant: including violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people. OR LOW RISK persons who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged.	Include violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people. OR LOW or MEDIUM risk persons who have disengaged from treatment and where there are HIGH RISK threats when disengaged.

The level of risk and the reasons for determining that level should be fully documented on the relevant Niche Template.

The nurse in charge at the place of safety should be informed of the decision. **Details of the nurse informed, their response, and the time the police leave, must be documented on the Niche Template.**

Low (not requiring police presence):

(a) Following the jointly agreed decision, the nurse in charge must be informed when the police are leaving.

(b) The officers at the Place of Safety should complete the **Niche Departure Template (including details of the nurse in charge accepting responsibility)**.

Medium (requiring police presence):

(a) Following the jointly agreed decision, the nurse in charge must be informed that the police will initially remain with the individual whilst enquiries are made by Health to secure observational support to allow the police to leave as soon as possible.

(b) After two hours – An update should be requested from the nurse in charge as to what preparations are in place for handing over the responsibility of the patient to staff at the Place of Safety.

(c) After four hours – The Place-Based Inspector should make enquiries with the Nurse in charge/Shift Lead to ascertain when observational support is likely to be available. The outcome should be recorded on the Storm log.

(d) The decision and rationale of Place-Based Inspector should be documented on the relevant Niche Template.

(e) If an individual is still presenting as Medium risk a discussion must take place with the Nurse in Charge regarding the formal handover of responsibility for the patient.

(f) The relevant Storm log number should be provided to the nurse in charge who must be willing to accept responsibility for the patient.

(g) The officers at the Place of Safety should complete the Niche Departure Template (including details of the nurse in charge accepting responsibility).

High (requiring police presence) – Police must remain with the individual for the duration of their time at the place of safety or until their risk status determines the police can leave.

Lengthy delays regarding assessment or once assessment completed, locating a bed, should be escalated via jointly agreed S135/136 escalation process (see appendix 4 and appendix 5).

Disputes Regarding Level of Risk/Officers Remaining with the Individual

In the event of a disagreement regarding the determined risk level and officers remaining in attendance, the following apply:

- Attempts should be made to resolve the dispute at a local level by those present at the assessment.
- If a dispute cannot be resolved at this level, then it should be referred to the relevant FIM and the Duty Manager for the POS.

14.3 Appendix 3 – Recalled Community Treatment Order (CTO) Police Assistance Request

Recalled Community Treatment Order (CTO) Police Assistance Request Form

MERSEYSIDE POLICE

Recalled Community Treatment Order (CTO) Police Assistance Request

PLEASE READ ATTACHED GUIDANCE NOTES BEFORE COMPLETING THIS FORM

Once fully completed send this form to COMMCEN@merseyside.police.uk and you will receive a confirmation email. Merseyside Police will then make contact with you.

Person requesting Police Assistance

NAME	Click here to enter text.	UNIT/DEPT	Click here to enter text.
ROLE	Click here to enter text.	WORK TEL	Click here to enter text.
MOBILE	Click here to enter text.	E-MAIL	Click here to enter text.

Location Police Requested to Attend (to carry out recall)

ADDRESS	Click here to enter text.	POST CODE	Click here to enter text.

Patient Details

SURNAME	Click here to enter text.	FORENAME	Click here to enter text.
DOB	Click here to enter a date.	GENDER	Choose an item.

Method of Issuing Notice of Recall (tick as appropriate)

Please tick the method the Recall was served and confirm the Time & Date it is effective: ***NOTE: ONLY CONTACT POLICE WHEN RECALL IS EFFECTIVE***	TIME & DATE EFFECTIVE:
☐ By hand to the patient, in which case it is deemed effective immediately.	Click here to enter text.
☐ By 1st Class post to the patient's usual or last known address, in which case it is deemed effective on the second business day after posting.	Click here to enter text.
☐ By hand to the patient's usual or last known address, in which case it is effective on the day after being delivered i.e. after midnight on the day it was delivered.	Click here to enter text.

Reason for Requesting Police Assistance (MUST BE JUSTIFIED BY R.A.V.E)

Appendix 4 – Adult S136 Escalation Process

Adult S136 Escalation Process

Adult S136
Escalation Process.p

14.4 Appendix 5 – Child S136 Escalation Process

Child S136 Escalation Process

Child S136
Escalation Process.p

14.5 Appendix 6 – Missing Patient Checklist

Missing Patient Checklist

Initial Actions Checklist.docx