National Strategy on Policing and Mental Health
Many police officers have heroically saved the lives of some of society’s most vulnerable people through their actions at critical incidents, acting with a humanity and compassion which is a credit to them and to the police service as a whole. The challenge to operational police officers in responding well to mental health related demand cannot be under-estimated. An effective response to a vulnerable person in crisis may mean simultaneously taking account of complex medical issues which would challenge experienced healthcare professionals, the distress of a vulnerable person feeling frightened and perhaps criminalised, as well as the interface all of this has with mental health and criminal law. Quite often, this must all happen in a tight timescale without access to all of the information which would ideally be to hand.

The police service’s response to some mental health related demand has also included some of the most controversial and high-profile incidents in the history of policing in the United Kingdom. Deaths in police custody and following police contact involve a disproportionate number of those of us who live with mental health problems; over-reliance upon the use of police custody as a Place of Safety has proved controversial even where such tragedies have not occurred and it has been argued the police service has failed to react to the emergence of mental health as a major thematic area as it has previously done with domestic abuse, hate crime or terrorism. One potential reason is because mental health cuts across all areas and issues in policing and is so heavily dependent upon partnerships with health care organisations.

“There are frequent calls for better training on mental health issues to be given to police officers. While training is of course necessary, equally important is the ability for officers to access and work alongside expert health and social care professionals to support people experiencing mental health crisis. We are pleased that the NHS Long Term Plan (2019) acknowledges the gaps in crisis provision. Such gaps have led to the police on occasions having to provide a ‘first response’ service to mental health related incidents when it would have been more appropriate for NHS or local authority services to respond instead of or alongside the police. We therefore welcome the investment set out in the NHS plan that commits every part of the country to having more accessible, 24/7 NHS mental health crisis services, as well as more voluntary sector ‘alternative’ crisis services such as crisis cafes and safe havens. At a national level, the NPCC and College of Policing will continue to work alongside NHS England to ensure these commitments are delivered.

This strategy sets out the importance of ensuring that we minimise those occasions where police officers provide responses purely because of capacity issues or other difficulties in

health care agencies - we know from understanding those tragic incidents gone awry that police officers are not a substitute for professional mental health care, even where officers are acting with compassion and attempting to ensure the dignity and safety of those detained. We recognise the role of the police service as one of society’s ‘safety-nets’ but remind everyone that this has natural limitations. It also seeks to ensure that police forces attend to their responsibilities to prevent and detect crime; and to protect the public where this is necessary in cases involving people with mental health problems.

A great many reviews and reports have touched upon this in recent years, including the Crisis Care Concordat2 (England, 2014; Wales, 2015) and the Independent Review in to Policing and Mental Health3 (2013). Most recently, Her Majesty’s Chief Inspector of Constabulary warned4 (2018) that over-reliance upon the police had become a “national crisis” because of a “broken mental health system”. Even those reports which were commissioned to focus completely upon policing have been unable to avoid the conclusion that police demand connected to mental health can only be addressed in partnership with other organisations and communities, hence their recommendations for improvement have always been a blend of suggestions for the police service and for health or social care services. In that regard, this strategy aims to support and compliment the Long Term Plan and to build on the findings of the Care Quality Commission report Right Here, Right Now5 (2015) on crisis care, which found that police officer attitudes towards those in crisis are amongst the best found in our system of emergency mental health care and support.

The purpose of this strategy document, is to set out the challenges, principles and objectives for the police service in England and Wales, in accordance with the Policing Vision 20256 - responding to those who live with mental health problems. It touches upon issues which are known to affect most police services internationally and is developed in light of initiatives and research undertaken in those countries as well as within the UK. It has been approved by the National Mental Health Forum (NMHF) following consultation with the public and partners and it will be subject to annual review as a living document, via the NMHF.

Mark Collins QPM
Chief Constable Dyfed-Powys Police
NPCC Lead on Mental Health

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5 Right Here, Right Now, Care Quality Commission, 2015.
Strategic Principles

The strategic intent of the National Police Chief’s Council is achieved by adherence to these nine core principles -

• Those living with mental health problems know most and know best what helps whilst they are in crisis and those views should be paramount in everything the service does.
• Respect for human autonomy, equality and dignity is enshrined in law and should be the cornerstone of all policies and procedures developed by the police service.
• The service should ensure that ‘parity of esteem’ is reflected in how we operate and how we seek to build partnerships with the public and healthcare providers.
• The police service has a role to play in ensuring the safety of those of us experiencing mental health problems - a part of the “core business of the police”.
• Police officers have a finite capacity and capability and should be considered a best response to a healthcare situation only where there are additional factors which necessitate their involvement, such as an immediate threat to life or public safety.
• Policing inherently brings an implied use of force but officers should always seek to use the least restrictive method possible. The importance of de-escalation and containment are always preferable to restraint which should only be relied upon only where it is necessary, proportionate and justified.
• The police alone cannot ensure effective responses to, or prevention of, mental health crisis incidents - officers and forces must be supported by health and social care organisations.
• The risk of over-policing is as serious as the risk of under-caring: leaders must ensure effective policies, partnership protocols and training to consistently strike this balance.
• The most important partnership the police must develop and maintain is with the public they exist to serve. The police are there to provide support when it is required.

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8 IPCC Use of Force Report.pdf, IOPC.
Strategic Objectives

• The police service should work to completely eliminate reliance upon the use of police custody as a Place of Safety under the Mental Health Act 1983 - this has already been achieved in some police force areas like West Midlands and Merseyside. It is also a recommendation in the Mental Health Act Review.

• All forces should have policies, partnership protocols and training programmes in accordance with College of Policing standards, to ensure that frontline police officers, force mental health leads and senior leaders are equipped to understand the implications of this strategy.

• It should not be easier to access unscheduled mental health care via the police or criminal justice system than through existing provisions.

• Forces should develop a more sophisticated understanding of mental health related demands, including relevant data on the use of legal powers, individuals linked to repeat presentations, victims and suspects in criminal investigations - this should drive demand and risk reduction across policing and mental health.

• In line with recent Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) recommendations, forces should regularly review their mental health training programmes aligned with this strategy as well as considerations from The Independent Office for Police Conduct (IOPC) cases, coroner’s recommendations and future HMICFRS inspections. Whenever possible it is important to seek the views of those with lived experience of mental ill health when carrying out such reviews.\footnote{Police cannot fix a broken mental health system, HMICFRS, 2017.}
Crisis Care

The operation of the Mental Health and Mental Capacity Acts

Existing legislation on mental health and capacity is complicated, made all the more so by the comparative lack of attention that this legislation has received in police (and other agency) training. The College of Policing APP's summarises the most important aspects of this legislation and this needs to be reflected in the operating policies and protocols which exist between police forces and healthcare providers. It is vital to the success of operational policing that frontline officers and supervisors have the legal knowledge they require to protect the rights and dignity of vulnerable people in the context of how they want to be helped, wherever possible. Changes will occur as part of the Mental Capacity (Amendment) Act 2019 and these will be provided once the legislation is ratified.

Where police officers provide an initial response to a mental health crisis incident, they should seek to act in the least restrictive way and take advantage as far as they can, of any information which may be available from healthcare sources to improve the nature and quality of their response. They should listen to patients and act in accordance with what they say will help, as far as they can do so, consistent with advice from mental health professionals, context and safety. In recent years we have seen the spread of various partnership initiatives under the banner of ‘street triage’ and whilst operating models and hours vary, they are consistently flagged as providing fast access to background information that may not be available via police information systems, allowing from improved and collaborative decision-making.

As the law stands, the police service in England and Wales have no powers under the Mental Health Act 1983 in private dwellings and this is the deliberate will of Parliament following the 2014 review of police powers under the Act. It is therefore vital that officers have the ability to contact crisis care services, out of hours GPs or Approved Mental Health Professionals where necessary. Street triage tells us that most mental health crisis calls to the police relate to incidents in private dwellings and we know coronial inquiries have focussed upon how officers have discharged their responsibilities in these circumstances. It is also imperative that the emergency healthcare system, including the ambulance service and Emergency Departments of acute hospital Trusts understand the implications of national guidance to the police service and the health service which have a bearing upon emergency responses to mental health crisis incidents.

Authorised Professional Practice, Mental Health, College of Policing, 2016.
Repeat demand

Many of the vulnerable people encountered by the police are known to local services. In some force’s dip-samples, two-thirds of those detained under s136 MHA were existing Trust patients; and in some ‘street triage’ schemes, 88% of the people at the centre of the call were current or previous patients of the local trust. The numbers will under-estimate the true figure because the police service do not only encounter people in the Trust area where they may be known to services. We also know that most areas experience repeat demand connected to a small number of individuals, often who are presenting to different agencies across the public sector.

It is vital that police forces ensure they have relevant partnership structures to jointly review demand and look at reasons why individuals present to the police or repeatedly to the emergency system as a whole, that this may be prevented by targeted interventions by health care organisations or, if necessary, criminal justice interventions. We know there are complex reasons why some patients disengage with health services and this can simply be the exercise of personal autonomy, however unwise it may be considered by some. The police service must recognise that not everyone’s experience of mental health care is a positive one and there may be many reasons, valid to individuals, as to why they do not wish to engage with services or have not done so previously. No assumptions should be made by the police service about what is best for patients: that is something deeply personal for individuals. The role of the service is to understand how they can best help someone in a given situation.

Complex cases should be subject to multi-agency decision-making where possible but the police role is to aim to support individuals in taking their own decisions, in the context of their legal rights and responsibilities. We also know there is a complex relationship between mental health and criminal justice and these two systems must be capable of working alongside each other and integrating where necessary to meet the needs of some whose requirements and lives are complex, whilst also affecting others in society.
**Conveyance**

Chapter 17 of the Code of Practice to the Mental Health Act 1983 (in both England and Wales) relates to conveyance and states that the transfer of anyone detained under the Act should not be done in a police vehicle, unless particular circumstances demand it. Police services should ensure they understand how conveyance occurs in their areas and work with commissioners of ambulance and mental health services to ensure dignified patient transfers where they are required. We welcome the proposals within the NHS long-term plan to fund designated mental health ambulances which will be accessible to forces and is planned for 2021.

It must also be acknowledged that where emergency situations present themselves to police officers who believe someone may have a mental health condition, the officer’s skill base is limited. A wide range of presentations which might prompt consideration of mental ill-health could be attributable to other medical conditions which require expert care from paramedics or emergency departments, in addition to or instead of mental health services. It is also widely accepted that those of us living with mental health problems are likely to have poorer than average physical health and that such problems may exist co-morbidly with a mental health condition.
Mental Health establishments

Justice does not stop at the hospital gate: the police service can have a role to play within care facilities for patients detained under mental health law. In recent years, two mental health professionals have lost their lives after being attacked whilst at work and the NHS reports that two-thirds of all violence towards NHS staff occurred within the mental health sector. It is therefore only proper the police service recognises its role to ensure safety where it has been seriously compromised and to objectively investigate allegations of crime which are reported to them (see Suspects, below).

The role of the police service in attending mental health units to assist in managing safety should be minimised, if not eliminated, through the approach of healthcare organisations to their health and safety as well as their human rights obligations. On occasions where safety has nonetheless been compromised and the police are called to assist, local policies should ensure concordance with the national Memorandum of Understanding. This will allow for a balance to be struck between the roles of police officers and healthcare professionals whilst ensuring safety and effective communication is at the forefront.

In light of the Mental Health Units (Use of Force) Act 2018, it is recommended that when available and it is reasonably practical to do so, officers should activate their body worn cameras when called to mental health settings. The availability of recorded footage when investigating serious or sensitive complaints, or where there has been a death or serious injury, provides valuable evidence in the investigation of such incidents.

12 The Police Use of Restraint in Mental Health or Learning Disability Settings, College of Policing, 2017.  
13 mentalhealthunitsuseofforce/documents.html
Welfare Checks

The police service is often asked to attend private premises to check on the welfare of vulnerable people. Where this is connected to concerns about someone’s mental health, there are particular difficulties to be borne in mind. Police officers, of course, do have some statutory powers which could greatly assist in a situation where concerns do exist, no least from their power to force entry to private premises where life and limb is at risk. However, police officers are not best placed to assess non-obvious risks around the potential that someone may harm themselves at a future point.

Police officers have no legal powers in someone’s private premises unless they believe there is a crime or a breach of the peace occurring. This means they may be quite unable to safeguard someone who is believed to be at risk and the unannounced visit of uniformed officers may well be something that adds anxiety and distress to a situation for that person.

Local policies should ensure that police control rooms, healthcare partners and others understand what is and what is not possible where police officers are requested to check on someone’s welfare. Where such welfare checks are considered necessary, there should be clear channels of support for the officers in the event that they are unsatisfied that someone is safe and where they are unable to act to keep that person safe.
Crime

Victims

Following the publication in 2014 of the Victim Support report ‘At Risk, Yet Dismissed’ we know that victims with mental health problems face considerable difficulties in achieving access to justice. Adults with mental health problems are three times as likely to be a victim of crime as adults without mental health problems; adult women with mental health issues are ten times as likely as the general population to be the victim of a violent crime. Despite these difficulties, vulnerable people are more likely to find their case does not progress beyond the police to a trial in court and it is less likely for defendants in their case to be found guilty at court when compared to similar cases involving those of us who do not live with mental health problems.

Parity of esteem therefore also has a part in the criminal justice process - victims who are vulnerable for any reason are entitled to consideration of special measures and even where mental illness manifests itself in behaviour or belief that might appear to contradict or undermine an account of an event, it doesn’t automatically mean that someone’s recollection of an incident is unreliable or could not be corroborated by other evidence.
Suspects

Work undertaken by professionals “at the interface of the mental health and criminal justice systems is amongst the most complicated by any in those professions”, wrote Professor Jill Peay. It remains a difficult matter of public policy to contemplate when it is appropriate for the police to arrest a vulnerable person for an offence following behaviour which might be regarded as a consequence of a mental health condition, but which would ordinarily be regarded as criminal conduct. Home Office circulars 66/90 and 12/95 outline public policy on the prosecution of ‘mentally disordered offenders’ and in addition to the Code for Crown Prosecutors, the Crown Prosecution Service publishes guidelines on this matter. That said, the question of prosecution remains affected by myths and folklore about prosecution, which are especially relevant when officers are required to investigate allegations against patients who are accused of offending whilst detained in hospital under the Mental Health Act or having been assessed in police custody as requiring admission under the Act.

- Where someone with a mental health problem offends, it is not usually the case that they have done so directly because of their mental illness.
- It is both possible and necessary to prosecute some suspects for offences committed whilst mentally ill - this remains true where a person is so unwell that they are detained under the Act.
- Whether someone should be prosecuted is a different matter - all cases should be assessed on their individual merits.
- ‘Capacity’ is not the legal issue to be determined during criminal investigation: some offenders who ‘lack capacity’ and insight are nonetheless prosecuted, where this is appropriate.
- Mental illness may or may not affect the mens rea (the guilty mind) element of criminal conduct - all cases should be taken on their individual merits and the various forms of mens rea borne in mind.
- The NICE Guidelines on Violence (2015) outline that only 8% of people who offend whilst mentally ill lack all insight in to their actions.
- Prosecution should not occur purely for the purposes of accessing relevant kinds of mental health care - for example, medium or high secure care. It should be necessary on its own terms as a criminal justice intervention.
- Only the criminal courts in England and Wales have powers under Part III of the MHA and they can only make use of those opportunities (remands for assessment, psychiatric reports, etc.) if someone is charged before the court.

In weighing up whether or not criminal charges are required in a given circumstance, generally the more serious the alleged offence, the less relevant someone’s mental health problems to the police or CPS decision to prosecute but decisions should reflect the full set of evidential and public interest test requirements in the Code for Crown Prosecutors.

The investigative starting point is one of neutrality - all cases turn on their individual merits.

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19 Legal Guidance on the Prosecution of Mentally Disordered Offenders, CPS, London (downloaded, 10th January 2019). This guidance is due to be updated in late 2019.
Police custody is potentially the most challenging environment of all in which to manage mental health related demand. The reduction in recent years in reliance upon police custody as a Place of Safety under the MHA is extremely welcome and forces have worked hard to achieve this. Use of custody for this purpose has reduced to just 136 in 2018/19\textsuperscript{21} and in keeping with the NPCC Custody Strategy\textsuperscript{22} the service should be working towards complete elimination of the use of custody for this purpose.

What this progress does not affect is the number of individuals who are brought in to police custody under other legislation, usually criminal or common law. We know from ‘street triage’ programmes that most mental health crisis encounters are in private premises where MHA powers cannot be relied upon. We continue to see individuals arrested for their own safety and brought to custody unless officers can secure timely support to mental health crisis at the scene of incidents, often in people’s own homes.

It is vital that where someone is arrested, custody managers ensure effective identification of vulnerabilities and safe care whilst those with mental health problems remain detained; but it is equally important that all vulnerable people are properly safeguarded and not just those in dire need of psychiatric care. Reports sent to forces following Her Majesty’s Inspectorate of Prisons (HMIP) / HMICFRS joint inspections specifically focus of mental health to ensure that detainees are treated with dignity and that their diverse needs are met. These are then shared as part of a systematic review of learning.

It is also true to acknowledge we sometimes see the use of s136 MHA after the commission of criminal offences where the appropriate response should be investigation with a view to determining which cases should be brought to justice notwithstanding someone’s vulnerability.

Focus in recent years has improved the ‘clinical’ attention that is given to those detained under s136, with routine consideration of calling ambulances to aid early clinical assessment and early liaison with mental health professionals or even Emergency Departments. It should be born in mind that extant clinical risks are not reduced merely because a police officer has taken a legal decision to arrest someone rather than detain them under s136 MHA. Parity of esteem would demand that health needs are still identified and met, notwithstanding that someone has been brought within the scope of the criminal justice system. The importance of pre-release risk assessments is a lesson well-learned from investigations in to suicide following release and forces should ensure they understand support mechanisms for vulnerable people who are released from detention.

Currently the biggest challenge is the difficulty in ensuring the timely hospital admission of those patients assessed in custody as requiring to be detained under the MHA. Several high-profile incidents have outlined how delays in accessing beds can take several days

and this amounts to a very real legal problem for the police and for NHS partners alike. We welcome that NHS England and the Royal College of Psychiatrists have acknowledged the need to urgently address the issue of mental health bed availability, backed by new investment through the NHS long-term plan. Work will continue by the NPCC lead to address this issue through national partnership structures in addition to supporting forces to work with their local partners to ensure this problem is eliminated.

The landmark ruling in *MS v UK* (2012) reminds us all about the very real problems in relying upon police custody for those “in dire need of psychiatric care” and is a cornerstone in consideration of when custody may be used for those of us who are acutely ill and in need of urgent admission. This was an incident relating back to 2004 when a man was arrested and detained under s136 MHA and taken to a police station as a Place of Safety. It was acknowledged by the Judge that due to a lack of NHS facilities this was the only option available. He was subsequently admitted to a regional medium secure unit after more than three days in a police cell. Over eight years later in 2012, he won his claim that his detention and lack of care amounted to inhumane and degrading treatment - a contravention of his European Convention Rights (Article 3). It was the need for such medical treatment, the inability to render it and the subsequently ongoing degradation which amounted to inhumane and degrading care.

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23 *MS v The United Kingdom (2012) ECHR 804.*
Deaths in Police Custody

Over the last two decades, a number of high-profile untoward events have occurred which have brought difficult questions for the police service and individual officers following deaths in custody and other legal challenges. The Angiolini Report (2017) was published after a review into all deaths in police custody and within which mental health was a major theme. The charity Inquest, whose chief executive acted as a special advisor to that review, has commented repeatedly in specific cases, that the lessons learned from cases twenty years ago, such as the death of Roger Sylvester are not dissimilar to learning which appears necessary from more recent tragedies.

Historically, health and social care organisations have not been privy to the lessons learned that arise from inquiries by the IOPC or coronial inquests. This has then presented challenges in fulfilling recommendations in the likes of the Adebowale and Angiolini Reports. It is however recognised that as police forces obviously need to improve and learn from such incidents, so to do partners from across the criminal justice and healthcare sectors. On-going work with the Ministerial Board on Deaths in Custody and the NPCC is ensuring that there is a wider and more effective embedding of this learning.

Effective practice to minimise the likelihood of deaths in police custody will come from forces ensuring tight adherence to the objectives listed in the Appendix to this national strategy and from the oversight of national bodies such as the IOPC and HMICFRS to ensure compliance and driving forward national partnerships on behalf of the service.
Demand, Research & Evaluation

In recent years, the two main partnership initiatives through which progress has been forged are Street Triage and Liaison and Diversion in police custody. At this time, evaluation of both has been partial and this reflects the understanding the service has of mental health related demands. Whilst the use of s136 MHA has always been subject to annual data, other powers under the MHA are less well understood. Reliance upon the Mental Capacity Act is little examined and the cross over with criminal investigation is ripe for further research. A key objective in coming years will be to achieve greater understanding of the detailed operation of mental health and capacity law in frontline policing and in how criminal justice processes fit in to police responses to crisis incidents. This will require analytical resources and improved data capture at all levels.
Street Triage / Mental Health Triage

It must be a key objective to further understand the multitude of initiatives which are collectively known as a ‘street triage’. These initiatives have been hailed at the highest levels as demonstrating the potential of effective collaboration between police and mental health services and are often cited by operational police officers as the most important operational development in that officer’s service. The positive impact in some areas cannot be under-estimated and many forces are rightly proud of the impact these schemes have had on the use of police powers and police custody as a Place of Safety. Street triage is responsible for building trust and effective relationships between the police and healthcare partners where it may not have existed before.

Accepting those points, it remains true that these schemes are relatively unevaluated. We have seen the University College London evaluation24 of the original ‘pilot’ schemes; we have seen other evaluations in to individual schemes in some force areas.25 Only three evaluations of street triage were considered adequate to be included by NICE during their production of their Guidelines into the Mental Health of Adults in the Criminal Justice system and all were rated ‘low’ or ‘very low’ quality. Most evaluations focus on the use of s136 and reliance upon custody despite the fact that most encounters by ‘street triage’ schemes do not occur in the street and could not lawfully lead to the use of this power. The discussion around street triage also omits the fact that several forces have attempted at various times to implement models of triage and then withdrawn them. We urgently need to understand much more of the detail behind the successes and the failures, in order to distil that which is good from that which has proved problematic.

Given the high-profile nature of such initiatives, a key action from this strategy for NPCC will be to undertake the work necessary to improve our understanding of the dynamics at play. Recommendation 3 in the HMICFRS ‘Picking up the Pieces’ report advised all forces to evaluate their mental health triage service - the College of Policing is working to develop a set of guidance principles and framework.

It seems to be an unavoidable conclusion that regardless of the format, coverage or structure of street triage, what seems most vital is the ability of police officers and mental health professionals to have a real-time conversation, sharing information and discussing the best approach.

Liaison and Diversion

At the point of publication, approximately 82% of the population of England reside in an area which has a Liaison and Diversion scheme and work will continue until 2021 to roll out complete coverage across the country. This is the idea of placing mental health nurses in police custody areas to help identify and manage those vulnerable people who are arrested and brought into custody. It is believed that better identification of vulnerable people in particular, by virtue of mental health, drug or alcohol misuse issues at the point of arrest, will ensure that information can be shared which would aide more appropriate decisions in custody and influence criminal justice decisions. Referrals can also be made for unmet health and social needs to help address potential underlying drivers of offending behaviour.

Again, hailed as one of the flagship partnership initiatives in policing and mental health and called for in the Bradley Report (2009), there are certain challenges to be faced in how we understand and develop Liaison and Diversion and ensure the development of local practice and policy with the police at a force level -

• How liaison and diversion can support pre-arrest decision-making?
• Voluntary interviews for suspects who are not arrested during criminal investigations.
• The evidence base for Liaison and Diversion in improving criminal justice outcomes.
• The lack of an equivalent national Liaison and Diversion programme for Wales.

NPCC is represented on NHS England’s Liaison and Diversion Programme Board and will continue to work with them at a national and regional level to ensure people are identified and supported as soon as possible following detention. We also seek to continue the partnership and support of both Police and Crime Commissioners as well as those Commissioners working in Local Authorities to continue progressing this area.

Learning Lessons

It has been a criticism of policing that hard lessons learned in one police service do not always translate to lessons learned in all areas of the country. A key feature of this strategy is a commitment by NPCC, the College of Policing, HMICFRS and the IOPC to develop communications and media on policing and mental health, to maximise the potential for learning.

This will be done via the NMHF, the National Conference on Policing and Mental Health as well as via regular communications, formal and informal, including key messages from inquests and other inquiries.
Mental Health Act Review

This strategy is published after the publication of an independent review of the Mental Health Act 1983, led by Professor Sir Simon Wessely on behalf of the Prime Minister. The National Police Chiefs Council sat on the Advisory Board to the Review where various strategic objectives and problems mentioned within this strategy were raised. This document will be kept under review and updated as necessary via the NMHF, chaired by the NPCC lead, in light of the Government’s response to Sir Simon’s proposals.

The most direct implication of the review is a proposal, already accepted by the Government, to introduce a complete ban on the use of police custody as a Place of Safety under the Mental Health Act 1983. This will require primary legislation and it is unlikely to occur until 2023/24 at the earliest. The more general recommendations about the Mental Health Act as a whole, would have various indirect effects on policing but it is not specifically possible to predict what they would be until a new Bill is introduced to Parliament with specific proposals.

The review also commented on the fact that ‘equality issues, particularly police interactions with people from ethnic minority communities under the MHA, should be monitored and addressed’. It is appreciated that there is an over representation of BAME people, most notably black people, who are diagnosed with serious mental health concerns and this has implications for policing.

This will be kept under review by the College of Policing and NPCC.
People with mental health concerns and police complaints

In November 2018, the IOPC published research in relation to people with mental health concerns making a complaint about policing. The research was conducted by the Institute of Mental Health and highlighted that people with mental health concerns considered there to be a number of barriers to using the police complaints system - with many unaware of how to complain, or that they had a right to do so.

Those aware of the complaints system listed a number of reasons why they would not make a complaint, including fear of harassment, a belief they would be treated unfairly, or their condition handled insensitively and concern that the process would be so stressful it would make their condition worse. It is essential that people with mental health concerns have both access to the complaints system and confidence that it will deal with their concerns in a fair and thorough manner.
Appendix: Delivering the strategy -

To below points should be seen as a guide for forces to ensure implementation of this strategy. It will be reviewed and updated as appropriate.

1. Ensure development of an effective force mental health policy, taking account of relevant legislation, Codes of Practice and College of Policing APP.

2. Implementing the HMICFRS ‘Picking up the Pieces’ report which highlighted 4 key recommendations to assist forces in identifying and understanding their demand:

   • Recommendation 1 - The NPCC lead and College of Policing should agree a new national definition of mental ill-health for all forces to adopt

     “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.”

     Launched on 1 April 2019

   • Recommendation 2 - All forces should carry out a ‘snapshot’ exercise to assess their mental health-related demand.

     A 24 hr national snapshot of demand across all forces in England and Wales was carried out on 12 November 2019. Analysis from the data will be shared in due course.

   • Recommendation 3 - All forces should evaluate their mental health triage services.

     The College of Policing is to provide a framework to assist forces and their partners to evaluate a criteria and need for a street triage model. It is recommended that Experts by Experience are consulted as part of this process.

   • Recommendation 4 - All forces should review their mental health training programmes.

     The College of Policing has provided an APP to assist forces in the delivery of mental health related training.

3. Ensure joint operating protocols with relevant health & social care partners for topics where policies are required by the Code of Practice to the MHA:
- S136 MHA and Places of Safety.
- Mental Health Act assessments on private premises and s135 MHA.
- Absent without leave and absconded MHA patients.
- Conveyance of patients detained under the MHA.

4. Ensure local policy or protocols on topics which are subject to national Memorandums of Understanding or other Codes of Practice:
   - The Investigation and Prosecution of Offenders, including psychiatric inpatients.
   - Police Responses to Requests for Restraint on Inpatient Wards.
   - The operation of the Mental Capacity Act 2005.

5. Ensure meeting structures at both force and partnership level to oversee development of the force’s approach to mental health under the leadership of a Chief Officer.

6. Ensure processes develop an understanding of demand in policing, related to mental health to understand how partner pathways and policing relate.

7. Ensure the availability of training and refresher training for all operational police officers, using College of Policing modules as a common minimum standard.

8. Ensure the development of joint-training and other CPD for those officers and staff who have enhanced or additional responsibilities, including force mental health leads.

9. Ensure that partnership activity and mental health training is evaluated so that force leaders can be confident they are delivering a quality product - both to the public and to their workforce.

10. Ensuring that the IOPC and HMICFRS are routinely invited to the appropriate national forums where their attendance would help achieve a culture of learning from mistakes. This will allow the development of mechanisms where learning is shared more systematically across and between relevant bodies, including learning from inquests and coroner’s recommendations.