NHS England

Guidance on implementing the National Partnership Agreement: Right Care, Right Person

Avoiding unwarranted police involvement in mental health care by improving access to personalised mental health support

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To help you navigate this document please find some links below to key sections

- Introduction - This guidance aims to support the implementation of the NPA:RCRP and covers principles for implementation, multi-agency working, and the four phases of RCRP implementation.
- Guiding principles for implementation - This section outlines the importance of working in partnership, personalisation, least restriction, addressing health inequalities, and using local intelligence to ensure successful implementation of RCRP
- Effective multi-agency working - This section provides guidance on establishing effective multi-agency governance and delivery structures, and on the cross-cutting areas that partners will need to work together on for enable effective implementation of the NPA:RCRP.
- Implementing the Right Care Right Person Partnership - This section provides practical support on how to respond to welfare calls (phase 1), support for people who leave acute hospitals before completing treatment (phase 2a), and people who absent from inpatient services (phase 2b). It also sets practical support on conveyance of people with mental health needs (phase 3), and timely handovers to healthcare following use of Section 136 (phase 4).

Lived experience foreword

This foreword has been written by 2 members of an Advisory Network that provides advice and direction to NHS England's Mental Health Programme. While independent of NHS England, members of the Advisory Network seek to shape NHS England's work on mental health, drawing on their diverse experiences of a range of mental health needs, social determinants of health and mental health services. Within this foreword, the Advisory Network members do not claim to speak for all lived experiences and/or perspectives but seek to reflect the pain that some of their community feels about police involvement in mental health care.

People with mental health needs have a range of reactions when the police attend during mental health crisis. It can be reassuring or helpful but, for many, it is uncomfortable and can sometimes cause long-term trauma and physical harm. Here is an example of a carer describing what went wrong when the police were involved in responding to her husband who was in mental health crisis:

> "He [husband] has dementia, he's in his 70s, he didn't know what was happening but still the officers shoved him to the ground and cuffed him. He was shouting, he was confused, and they wouldn't let me help." – White carer in her early 80s

People with mental health needs, particularly those who also have a learning disability or are autistic, are not always treated with respect, compassion or dignity when they come into contact with the police. Furthermore, certain groups of people, including Black men and people from other ethnic minorities, experience particularly poor experiences in their interactions with the police and criminal justice system. They frequently express feeling dehumanised and that their mental health crisis is being criminalised. Here is an example of a Black man describing his cousin's experience when things have gone wrong:

> "My cousin has paranoia, schizophrenia and other health issues. In the past, he was known to possess firearms, which means whenever the police respond when he's in crisis, they send the firearms squad. They never consider the fact he is no longer a threat and what he needs is mental health support. It's so distressing to watch him experience this unacceptable treatment." – Black man in his 30s

Right Care, Right Person (RCRP) is a crucial step towards reducing unwarranted police involvement in mental health care – something people with lived experience have fought for, for decades. This is an opportunity to influence both **when** the police engage in mental health care and **how**. In doing this we urge systems to keep in mind that people with mental

health needs are members of the communities the police serve – and we are more likely to be the victims than the perpetrators of crime. Where police do need to be involved in the care process, the reasons for this need to be explained to the person and efforts should be made to include the person in decision-making. This quote demonstrates why this approach is required:

> "When I was experiencing crisis, I had sensory overload, being autistic I was struggling with communication and emotional dysregulation. The police wouldn't listen to me, they just threatened me with arrest." – South Asian teen.

Working with those with lived experience needs to be central to health systems' implementation of RCRP. Partnering with a range of organisations and communities, RCRP must take a human rights-based approach to mental health care - creating safe and respectful services that offer compassionate support, promote shared decision-making and tailor care to people's individual needs. It cannot be emphasised enough how essential collaboration with individuals receiving services, their families and carers, and other grassroots organisations is in working towards this goal.

This guidance is the beginning of a commitment to change practice, and to do so in a way that reduces the harms that people with mental health needs can currently experience. Services must listen and learn from past experiences, such as those highlighted by the STOPSIM campaign, about how to create an appropriate role for the police in mental health care, and empower health staff to deliver person-centred and trauma-informed care. Above all, services must continue to learn lessons and build on the changes outlined in the Mental Health Units (Use of Force) Act, so that tragic cases, such as those of Olaseni (Seni) Lewis and Colin Holt in 2010, do not occur again.

We would like to express our gratitude to our policing, health, social care and voluntary, community, faith and social enterprise (VCFSE) colleagues for their collaborative efforts in developing this guidance. Their open and supportive approach has facilitated the creation of this guidance, which will help ensure that people with mental health needs receive compassionate and supportive care from the right service.

Written by 2 lived experience advisors who provide independent advice and direction to NHS England's Mental Health Programme

Contents

1. Introduction

Across the NHS, there is agreement that people of all ages with mental health needs require timely access to mental health support that is compassionate, personalised and meets their needs. The NHS Long Term Plan has transformed community mental health services, helping more people to live well in their communities, and has expanded the availability of varied models of mental health crisis care, including support offered by VCFSE organisations. We are proud of this improvement across mental health services in England but know there is still much more to do to ensure that people are less likely to reach crisis and, when they do, that they can access the right support.

In improving the quality of mental health support, it is important that the right agency responds to and supports people - when someone needs mental health care, it is not right that they only receive a police response. While police involvement in the response may be warranted in some situations, police officers generally do not have specialist mental health training or skills; and their involvement can be distressing to the person and potentially result in the increased use of force and the criminalisation of mental health problems. We know, for example, that police involvement can have harmful consequences for people from racialised and ethnically diverse communities, particularly Black people, and autistic people (Baker et al. 2019; National Police Chiefs' Council (NPCC) and College of Policing, 2022; Collins et al. 2022).

To ensure that people are receiving timely access to a mental health specialist, and that the police are only involved where this is appropriate, the National Partnership Agreement (NPA): Right Care, Right Person (RCRP) was published in July 2023, signed by NHS England, the Department of Health and Social Care (DHSC), the Home Office, and national policing organisations. This NPA:RCRP is an all-age agreement for England that commits to reducing the unwarranted involvement of police in supporting people with mental health needs.

This does not mean total withdrawal of police support. The police still have responsibilities to protect and serve everyone in the community, including people with mental health needs, who are more likely to be the victim than the perpetrator of crimes. The police will continue to respond where their involvement is warranted; that is, where the threshold for a police response to a mental health-related incident is met, as set out in the NPA:RCRP (see section 1.2). The police will also continue to fulfil their existing legal and statutory duties, including in relation to the Mental Health Act and safeguarding children and adults (see section 2).

We know implementing the NPA:RCRP is the right thing to do to improve the experiences and outcomes for people requiring mental health support; there is broad agreement about this from people with lived experience of mental health problems as well as those who work in the NHS. It is however a major change for health services, including mental health services, which are already under significant pressure and experiencing a rise in the number and complexity of mental health presentations.

For this reason, NHS England has been clear that implementation of the NPA:RCRP needs to put people's wellbeing and safety first, ensuring they do not fall through the gaps between services. We recognise that no additional funding has been provided for RCRP delivery, yet it involves the health service taking on significant additional activity. Therefore, it is critical that the timelines for each phase of delivery are agreed on the basis that there is a safe pathway in place, and if this is not the case, we support local systems seeking to agree slow timelines for delivery. It is also vital that RCRP implementation is underpinned by strong partnership working across agencies – health, children's and adults' social care, VCFSE organisations, and the police. Importantly, it cannot be delivered without involving people with lived experience in co-producing changes to these services. This includes the involvement of people from racialised and ethnically diverse backgrounds, as set out in NHS England's Patient and Carer Race Equality Framework (PCREF).

1.1 Purpose and scope of this guidance

This guidance aims to support the implementation of the NPA:RCRP and covers guiding principles for implementation (section 2), multi-agency working (section 3), and the four phases of RCRP implementation (section 4). It is aimed at integrated care boards (ICBs) and providers of mental health services, ambulance services and acute services across England that deliver support to people of all ages with mental health needs. It will also support others involved in the local implementation of the NPA:RCRP, including commissioners and providers of primary care services, children's and adults' social care services, VCFSE organisations delivering mental health support and police forces.

This guidance should be read alongside the NPA:RCRP, which sets out the RCRP approach, including the threshold for a police response and what local cross-agency partnerships should seek to achieve for people with mental health needs through its implementation. The NPA:RCRP focused on mental health, and that is why the scope of this guidance is limited to mental health. Where the RCRP approach is being applied beyond mental health, local partners will need to agree their approach to deliver this.

This guidance should also be read with reference to separate, but jointly informed guidance from DHSC, which will be published shortly and is primarily aimed at social care

professionals, and the police toolkit produced by the NPCC and College of Policing, which is available via the College of Policing webpage. One of the modules of the toolkit, which was developed in consultation with the Association of Directors of Children's Services and the Local Government Association, covers principles for applying RCRP to children under 18. Across England, most police forces are including children and young people as part of their implementation of RCRP, which is why this NHS England guidance covers all age groups.

This guidance has been produced by NHS England's Mental Health team, working with an expert reference group that included people with lived experience, people working in health services (mental health – inpatient, crisis and community, acute hospitals, ambulance services, learning disability and autism services, primary care), police forces, Approved Mental Health Professional (AMHP) services, children's and adults' social care services and VCFSE organisations. This group also included people with expertise in relation to service provision for children, young people, adults and older adults (see Section 5 for acknowledgements).

Learning from each other is a critical part of implementing the NPA:RCRP. Alongside this guidance our FutureNHS space provides webinar recordings and resources from other systems, and we would encourage you to look at these. If you have any additional resources to share, please send them to england.adultmh@nhs.net.

1.2 Definitions of terminology used in this guidance

People and communities

- We refer to **a person** or to **people** with mental health needs, rather than to patients or service users, to focus on the person as an individual. Our references to 'a person' or to 'people' include children, young people, adults, and older adults.
- Where we refer to **people with mental health needs**, this includes people who require mental health support (including urgent mental health support) due to a suspected or diagnosed mental health condition. It includes people with a learning disability and autistic people, people with dementia, and people with drug or alcohol problems, where they also have a mental health need.
- We refer to **family and carers** to mean the family members, partners, friends, neighbours or other members of a person's social network who provide support to a person with mental health needs. This also includes those acting as a person's attorney or as a deputy appointed by the Court of Protection, as set out in the Mental Capacity Act and corresponding Code of Practice. For children and young people, the term family and carers should always include those with parental responsibility, which for most children and young people will be their parent or

guardian. Where the child or young person is looked after by the local authority, the local authority should be contacted to clarify who holds parental responsibility and to arrange their involvement in discussions about the care of the child or young person. Foster carers and residential staff will not hold parental responsibility, but they should be involved in discussions, unless there are exceptional reasons not to do so.

- We use the term **racialised and ethnically diverse communities** to refer to ethnic, racial and cultural communities who are minoritised populations in England and who experience marginalisation as a result of their heritage. Where relevant, more specific terminology, for example, 'Black communities', is used. This follows the approach in NHS England's PCREF.

Threshold for a police response

Where we refer to the **threshold for a police response**, this is the threshold for a police response to a mental health-related incident as set out in the NPA:RCRP. This is where there is a need:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm. (This person could be the person with mental health needs, a family member or carer, a mental health worker or other member of the public.)

Reference should be made to the full NPA:RCRP for the context to this threshold. Further information can also be found in the College of Policing Legal Overview for RCRP, which explains how the police have determined the threshold, based on Article 2 and Article 3 of the Human Rights Act.

Risk assessment

Where we refer to **risk assessment**, this means a health-based approach that involves weighing up the factors that protect a person or others from harm and those that increase the likelihood of harm (including the likely severity, imminence, frequency and duration of harm) to determine next steps that maximise therapeutic benefit and minimise any potential harm. This approach, rather than those based on stratifying risk into categories such as 'low', 'medium' and 'high' is in line with National Institute for Health and Care Excellence (NICE) guidance on self-harm.

Risk stratification can be harmful and misleading, particularly where it limits the access that people deemed as lower risk have to mental health support, or where it results in missed

opportunities to take steps to meet a person's needs and promote safety. However, we recognise that police forces may use different terminology for, and approaches to, assessing risk. Therefore, when communicating with the police, it may be necessary to state a risk level to demonstrate how the NPA:RCRP threshold (see section 1.2) of 'serious harm' is met, but this should always be done in conjunction with a clear articulation of the situation that is occurring and the reasons for contacting the police, including the potential harms that may occur.

We also recognise that risk factors are often dynamic, and it is therefore important that risk assessments are carried out as part of an ongoing process, to respond to any changes in risk factors in a timely and proactive manner.

2. Guiding principles for implementation

This guidance is underpinned by 5 principles, which should inform all aspects of how local areas implement the NPA:RCRP.

In addition to the principles that follow, local implementation, including any policies and protocols developed, must comply with legislation, along with relevant statutory guidance. This includes the:

- Mental Health Act 1983 (MHA) and its Code of Practice
- Mental Health Units (Use of Force) Act 2018
- Mental Capacity Act 2005 (MCA) and its Code of Practice
- Care Act 2014
- Health and Care Act 2022
- Equality Act 2010
- Human Rights Act 1998 (HRA)
- Data Protection Act 2018 (DPA)

It is also vital that policies and implementation comply with legal safeguarding obligations – these are not superseded by the NPA:RCRP. This includes statutory safeguarding partners (ICBs, the police, local authorities) complying with children's safeguarding duties set out in the Children Act 1989, the Children Act 2004, the Children and Social Work Act 2017, and the statutory guidance, Working Together to Safeguard Children and Care and Support. Further information is provided in the NHS Safeguarding Accountability and Assurance Framework and via the NHS Safeguarding App and FutureNHS Safeguarding workspace.

2.1 Working in partnership

Where RCRP has been implemented successfully, effective multi-agency partnership working has been key. The NPA:RCRP approach should be developed, implemented, monitored and adapted in the spirit of partnership and coproduction, with people who have lived experience and their family and carers, along with health services, the police, children's and adults' social care, and VCFSE organisations that offer support to people with mental health needs (including ethnic-led VCFSE organisations and those offering support with housing, homelessness and co-existing alcohol and substance use problems). It is vital that delivery is coordinated across agencies, with ICBs playing a key role, so that people with urgent mental health needs are not left without the support they need.

2.2 Personalisation

People with mental health needs should be treated with empathy, compassion, respect and understanding. All support should be delivered in a way that promotes positive experiences

of the urgent mental health pathway by enabling shared decision-making, supporting individual recovery outcomes, protecting each person from harm and taking into account people's individual needs, wishes and preferences. These may be expressed at the time by the person or their family and carers, or in crisis or advance care plans, and may require providing culturally appropriate care, care that is adapted to the needs of people who are LGBT+, and making reasonable adjustments, including for people with cognitive difficulties, dementia or a learning disability, and autistic people.

2.3 Least restriction

Implementation of the NPA:RCRP should focus on minimising the use of restrictive interventions, adhering to the requirements and guiding principles of the MHA Code of Practice in all relevant circumstances and of the Mental Health Units (Use of Force) Act in inpatient settings. Least restrictive alternatives should be explored and put into place when initially responding to someone with urgent mental health needs, during conveyance and throughout each person's care in a community or hospital setting. It is essential that use of restrictive interventions is documented, including the factors that contributed to their use, to inform positive changes to practice. This is especially important for communities that can experience higher levels of restrictive interventions, such as Black people, autistic people and people with a learning disability.

2.4 Addressing health inequalities

Implementation must be designed to meet the needs of the local population, including proactively recognising and tackling the differential experiences and outcomes of certain groups of people within the urgent mental health pathway. Action should be taken with people from groups who experience health inequalities and those with protected characteristics, with a focus on addressing the disproportionate levels of restriction and criminalisation experienced by certain groups, including autistic people and people from racialised and ethnically diverse communities, particularly Black people. Adopting the actions set out in NHS England's Advancing Mental Health Equalities Strategy and the PCREF, which include better use of data and workforce development, will help to achieve this.

2.5 Using local intelligence to monitor and adapt implementation

The approach to implementation should be informed by data – both operational data and feedback from people with lived experience, their family and carers, and people from across agencies involved in implementation. The collected data should cover access to care and treatment, the experiences and outcomes of people accessing support for an urgent mental health need, use of restrictive interventions, and information relating to serious incidents and escalations. Partners should work collaboratively to collate, analyse, share and review

relevant data – including any differential impact on any group of people – and use it to inform joint decisions about the ongoing approach to implementation. All data sharing must comply with data protection legislation and confidentiality duties (see section 3.7).

3. Effective multi-agency working to enable implementation

This section provides guidance on establishing effective multi-agency governance and delivery structures, and on the cross-cutting areas that partners will need to work together on for enable effective implementation of the NPA:RCRP.

3.1 Establishing multi-agency governance and delivery structures

The NPA:RCRP states that the services working together in each area to implement the RCRP approach should agree joint multi-agency governance structures for the planning, delivery and monitoring of the RCRP approach locally. Partners will need to consider what works for their locality; in some localities it will make sense to build on existing joint working arrangements, such as crisis care concordats, while in London a regional approach is appropriate given the geographical area of the Metropolitan Police. In general, we recommend that:

- ICBs hold overall accountability for leading and coordinating the implementation of the NPA:RCRP from a health perspective. A Senior Responsible Officer should be identified within the ICB, alongside leads in local police forces and local authorities. In some areas, the geographical boundaries for ICBs, local authorities and police forces may not overlap. In such cases, it may be possible to identify a lead ICB for a particular police force area, or it may be necessary for 2 or more ICBs to jointly lead implementation.
- Areas set up a multi-agency Implementation Board (or use appropriate existing local structures) to develop an agreed strategy and plan for delivering the NPA:RCRP locally (including setting out key milestones for each phase of RCRP implementation; see section 4); oversee delivery; and manage risks and escalations (see section 3.4). The Implementation Board should consist of senior leads from each agency, so that there is buy-in for the delivery approach and collective decisions can be made. Any local protocols/agreements should be jointly signed off by the Implementation Board.
- Areas should also set up working groups to focus on the delivery of the different phases of implementation and the actions set out in the NPA:RCRP (for example, data capture, impact assessments, multi-agency training). Each working group should have a clear workplan (including details of the protocols or other products they will develop) and report into the Implementation Board (or appropriate existing local structure).
- Stakeholder analysis is undertaken to identify who should be members of the Implementation Board and working groups. This needs to consider representation from the following:

  - Health – including all-age mental health services (community, crisis and inpatient and NHS-employed AMHPs), ambulance services, acute providers and primary care.
  - Police and probation services.
  - Local authorities – including AMHP services, children's and adults' social care, drug and alcohol services, and homelessness and housing services.
  - Organisations with responsibilities for safeguarding or with relevant statutory duties, including Safeguarding Adults Boards and Safeguarding Children's Partnerships.
  - VCFSE organisations that support people with mental health needs – including ethnic-led VCFSE organisations and those that support people with housing, homelessness, and co-existing alcohol and substance use problems.
  - People with lived experience of the urgent mental health pathway and of police involvement in mental health support, either directly or as a family member or carer, including people from racialised and ethnically diverse communities.
  - Education services, including schools, colleges and universities and wider services for children and young people.
  - Fire and rescue services.

- Both the Implementation Board and working groups meet regularly to promote partnership working, enable open communication between partners, review progress against agreed objectives, and discuss and resolve any challenges.

3.2 Building a shared understanding of the threshold for police response and multi-agency roles and responsibilities

The NPA:RCRP states that multi-agency partners should reach a shared understanding of the aims of implementing RCRP locally and the roles and responsibilities of each agency in responding to people with mental health needs. To support this, we recommend that multi-agency partners:

- Discuss their understanding of the RCRP approach, the outcomes that each agency is seeking to achieve through implementation, and any concerns about implementation.
- Share relevant information relating to mental health demand and the (anonymised or pseudonymised) experiences of people with mental health needs under current ways of working.
- Reach a shared understanding of the threshold for police response (see section 1.2), including how different agencies assess and view risk, and how certain legal

duties, for example in relation to the MHA, are distinct from the threshold (as set out in the NPA:RCRP).

- Review local examples of recent mental health-related cases, including complex cases and those where health and children's and adults' social care services requested police support, to determine which cases were suitable for a police response, and in which cases an alternative course of action would have been more appropriate.
- Reach a shared understanding of the local approach to applying the NPA:RCRP to children and young people, paying due regard to the need for statutory safeguarding partners (ICBs, the police, local authorities) to do this in a way that complies with legal safeguarding duties for children and young people (see section 2). For further information, see the NPCC and College of Policing's shared set of principles for applying RCRP to children aged under 18.
- Identify the lead agency for response in a range of situations and the role of other agencies (this may be developed within phase-specific working groups), including situations where it is not initially clear whether there is a health emergency or mental health concern at play. Based on this, we recommend developing a responsibility matrix that identifies who the agreed lead and supporting agencies for given situations, as well as those where further work is required to clarify who is expected to respond. An example responsibility matrix can be found on our FutureNHS space.

3.3 Undertaking an impact assessment, including of the equality and health inequality impacts of implementation

Based on the shared understanding of roles and responsibilities, areas should undertake an impact assessment to identify how different agencies and services will be impacted by the changes agreed, and how any negative impact will be mitigated. This should include an assessment of the resource impact to identify where any required additional resources (including funding) will come from, and any training or commissioning requirements. This assessment will likely need to be informed by and reviewed in light of the work undertaken by the phase-specific working groups.

Partners should ensure their impact assessment covers the equality and health inequality impacts of implementation, and that it is developed with people with lived experience and their family and carers. This will support the guiding principle of this guidance to address health inequalities (see section 2.4), and the need to implement with due regard to the public sector equality duty and NHS England's PCREF.

Areas should use their impact assessment to inform their approach to implementation, including what data to capture (see section 3.8), and development of policies and procedures. It should also be used as a dynamic tool to review progress with implementation, including to identify whether implementation has any differential impact on people from racialised and ethnically diverse communities, autistic people, or any other group, and to take action to address any negative impact.

3.4 Developing escalation processes

As set out in the NPA:RCRP, areas should develop robust escalation processes for when agreement cannot be reached on the appropriate agency to respond in certain situations, resulting in a possible delay or gap in service provision, and for when any other concerns are raised about implementation. Concerns may be flagged through data monitoring (see section 3.8) or raised by multi-agency partners, the wider workforce, or members of the public, including people with mental health needs and their family and carers.

An escalation protocol should be developed and agreed by the Implementation Board (or equivalent group), and shared with all relevant stakeholders, including those working in the VCFSE sector. The protocol should clearly set out how and to whom concerns should be escalated within each agency, and distinguish between:

- Real time escalation – escalation routes where there is uncertainty or disagreement between multi-agency partners about how to respond to a live situation. The protocol should set out that the overriding priority when handling real time escalations is that one agency agrees to respond (usually the agency initially contacted), so that there is no delay in a person receiving support, with retrospective escalation routes used for discussions and decision-making about who should respond to similar situations in the future.
- Retrospective escalation – used to regularly review situations that have occurred and been escalated to learn lessons and agree changes that are needed in terms of how similar situations will be handled in future. We recommend that escalations are reviewed at the Implementation Board to clarify roles and responsibilities, refine processes and practice, and inform updates to policies and procedures. All agreed changes should be communicated to the workforce and reinforced through leadership.

3.5 Stakeholder communications

Successful implementation of the NPA:RCRP requires good communication with stakeholders, both internally and externally. A stakeholder communications plan should be developed (based on a stakeholder analysis) that sets out which messages need to be

received by whom, by when, as well as which communications route will be most effective for sharing messages about implementation, including local protocols/arrangements.

Local areas should look to develop 2 specific aspects within their communications planning:

- A protocol (compliant with data protection legislation and confidentiality duties – see section 3.7) that assists healthcare staff to communicate definitively with the police about the situation that is occurring, the potential for harm, and the reasons police attendance is required (where applicable). This will support cross-agency communication and help police working in control rooms to make decisions about the deployment of officers. When developing this protocol, it should be noted that the threshold (see section 1.2) is for control room staff to use to determine whether to deploy officers; it is not for use by other agencies or members of the public to determine whether they should contact the police. Often contacting the police can be useful to make them aware of situations that may unfold, rather than because an immediate police response is needed.
- Local communications for people with mental health needs, family members and carers, and other members of the public to inform them who they should contact if they or someone they know requires support with their mental health, including urgent mental health needs. Consideration should also be given to providing police forces with information about when it is appropriate to refer callers to alternative sources of support, including NHS111. The NHS111 'select mental health option' soft launch communications toolkit can be found on this FutureNHS page.

3.6 Health-led multi-agency triage models

The NPA:RCRP sets out that areas should embed multi-agency ways of working that support decision-making about the most appropriate service or services to respond to a call to the emergency services (for example, whether it should be a police, ambulance or mental health response, or a joint agency response). Where there is joint working between agencies, information sharing agreements need to be in place between agencies, which protect confidentiality and comply with data protection legislation (see section 3.7).

An example of multi-agency working is Bristol, North Somerset and South Gloucestershire (BNSSG)'s Integrated Access Partnership model of joint working between the local ambulance service, integrated urgent care provider, mental health trust, police force, fire service and VCFSE organisations. The model has a police link worker embedded alongside ambulance and mental health staff in the ambulance emergency operations centre, to determine the right responder(s) to 999 calls. This has resulted in a 50% reduction in ambulance dispatch to 999 calls and a 32% reduction in police dispatch, with people with

mental health needs instead receiving timely access to more appropriate mental health care. Further information about the model, including a webinar, can be found on this FutureNHS page.

Other examples of joint working between mental health and ambulance services to improve the ambulance service response to people with urgent mental health needs have been shared in this webinar.

3.7 Information sharing

Partners should have agreements for cross-agency information sharing and ensure that all data sharing complies with the DPA and the Common Law Duty of Confidentiality. Information shared for the purpose of informing implementation planning and delivery should be anonymised or pseudonymised. Confidential information about a person should only be shared with family and carers or other agencies, including the police, where the person has consented to this, the disclosure is in the best interests of a person who lacks capacity to consent, or there is an overriding public interest to make the disclosure (for example, to protect others from serious harm).

Partners should establish clear thresholds and protocols for cases where information sharing without consent is lawful. Note that in cases where consent is not granted to share information, family and carers can be asked their views about the person's care and what might help them, provided confidential information is not shared with them.

Further information can be found on the NHS England Consent and Confidential Patient Information webpage, as well as the Caldicott principles from the National Data Guardian.

Capacity and consent in relation to children and young people under 18

A child or young person aged 12 or over is generally presumed to have the competence to give or withhold agreement to the sharing of their information. However, each case must be judged on its own merits.

Where a child or young person under the age of 16 lacks competence, those with parental responsibility can give or withhold agreement to the sharing of information on their behalf. For a young person aged 16 or 17 who lacks capacity under the MCA, information can be shared if this is determined to be in their best interests under the MCA.

The principles of capacity and consent also apply to decisions about healthcare treatment. For young people aged 16 or 17, as with adults, the MCA applies, and if they have capacity they can give or withhold consent to treatment. If they do not, they may be treated in their

best interests under the MCA (as long as this does not involve a deprivation of liberty, as this statutory scheme does not apply to under 18s).

For a child or young person under 16, the principle of Gillick competency applies. If they do not have Gillick competency (based on an individual assessment of their maturity, understanding and ability to appreciate the consequences of their decision), they cannot give or withhold consent to treatment, and those with parental responsibility need to make a decision on their behalf (unless it is an emergency situation). If they do have Gillick competency, then the child or young person can accept or refuse treatment, and those with parental responsibility cannot override this. However, it is good practice to encourage children and young people to involve those with parental responsibility in care decisions, unless it would not be in their interests to do so.

Further information can be found in the Care Quality Commission (CQC) guide on capacity and competency to consent in under 18s.

3.8 Data collection and use to inform implementation and delivery

As well as the guiding principle to use local intelligence to monitor and adapt implementation (see section 2.5), the NPA:RCRP includes an action for local systems to establish effective mechanisms to support data collection and sharing across agencies, to inform the planning and delivery of the RCRP approach locally. This should include measures of the impact of implementation on health, children's and adults' social care and police services, and on the experiences and outcomes of people requiring care, including those to capture impact on access to care and treatment, use of restrictive interventions, and any differential impact by protected characteristic.

Multi-agency partners, working with people with lived experience and their family and carers, should identify useful measures that can be captured locally. We suggest metrics for each of the phases of implementation in section 4. In addition, we recommend that data is captured on:

- The details of any escalations, for example, situations where healthcare staff feel the threshold for a police response is met (see section 1.2) but the police do not respond or provide a delayed response, and any impact of these escalations, including in terms of the safety and wellbeing of people with mental health needs, family and carers, staff, or other members of the public.
- The number of occasions where ambulance and NHS111 services signpost people to contact the police, and the police signpost people to contact health services, to understand shifting demand.

Partners should collaborate to identify mechanisms for the collection, storage and sharing of agreed data, using automated processes wherever possible. These should be underpinned by data sharing agreements and be legally compliant (see section 3.7). Areas will also need to set up processes for analysing data (including establishing accurate baselines of agreed metrics), regularly reviewing it and using the data to inform joint decisions about the ongoing approach to implementation. We expect that from a health perspective, ICBs will play a crucial role in facilitating processes for the collection and use of data.

3.9 Multi-agency training

The NPA:RCRP states that local areas should develop multi-agency training to support decision-making and understanding of roles and responsibilities in relation to RCRP, as well as the MHA. Areas should agree what training is required and how best to deliver it, ensuring that it is a rolling programme to onboard new starters. In some areas, training involves opportunities to shadow different disciplines (for example, mental health staff spending time in police controls rooms, or police shadowing intensive home treatment/crisis resolution home treatment teams; CRHTTs). Others have commissioned training such as Respond, which brings together multi-agency staff to discuss real-life scenarios relating to the urgent mental health pathway.

As well as supporting specific training needs in relation to RCRP, areas should ensure that staff supporting those with mental health needs understand how to apply relevant legislation (see section 2) and how to deliver care that is trauma-informed, promotes shared decision-making and is personalised to people's individual needs, including by providing care that is culturally competent, age-appropriate and meets the needs of people who are LGBT+, have a learning disability or are autistic.

Section navigation

This next section of the guidance sets out the different stages of implementation. Local areas are best placed to consider the sequencing of implementation please simply refer to the relevant stage below.

- Phase one: Responding to mental health related concerns for welfare - This section sets out that local areas should reach agreement on what is a MH related concern for welfare, which service is responsible for responding, what actions should be taken, and how progress should be monitored.
- Phase 2a: People with mental health needs who leave acute hospital before treatment is complete - This section covers the measures local areas should put in place in acute hospitals to improve experience and support people to remain in hospital, where appropriate.
- Phase 2b: People who absent themselves from inpatient mental health services - This section focuses on what mental health services need to put in place to locate and return people to hospital. Including when the person; is detained under the Mental Health Act, was admitted under the Mental Capacity Act, or in hospital voluntarily.
- Phase 3: Conveyance of people with mental health needs - This section suggests how partnerships can end the use of police vehicles for the conveyance of people with MH needs. It also suggests improvements to deliver the best possible experience for individuals in distress.
- Phase 4: Timely handovers to healthcare following the use of section 136 - This section provides information on reducing handover times and improving the experience for people who are held under Section 136. It also outlines how services and police can work together to reduce the use of Section 136.

4. Phases of Right Care, Right Person implementation

The 4 phases described in this section broadly match those used in Humberside to implement RCRP, where delivery took place over 3 years. Humber Teaching NHS Foundation Trust's implementation resources can be accessed on their website.

The phases are:

- Responding to mental health-related concerns for welfare (Phase 1).
- Responding to cases where people with mental health needs leave acute hospitals before assessment or treatment is complete (Phase 2a) and where people leave inpatient mental health services or do not return from leave when expected (including where people are detained under the MHA) (Phase 2b).
- Conveyance of people with mental health needs (Phase 3).
- Timely handovers to healthcare following use of Section 136 of the MHA (Phase 4).

Local areas will need to consider whether these phases suit their local context or they need to have different phases or require different sequencing.

4.1 Phase 1: Responding to mental health-related concerns for welfare

Concerns about the welfare of a person with mental health needs may be reported by a member of the public (such as a family member, carer or neighbour), or by health, children's or adults' social care or other services. When these concerns are about the person's safety or wellbeing, proportionate action needs to be taken to check on their wellbeing and that of any dependents, including children and young people. This will include attempts to contact the person and, if there is no response, may involve a visit to the person's home address or other place they are known to be or likely to be.

Although the police in some areas have previously responded to mental health-related concerns for welfare, including conducting in-person checks, it is generally best for mental health services to lead the response where there is good evidence that a concern relates to a person's mental health. This is because:

- Mental health staff have the appropriate training or expertise to undertake clinical assessments and establish an appropriate course of action if welfare concerns are identified. In some cases, they will already have a relationship with the individual.
- People generally have a right to a private life (under Article 8 of the HRA) and to choose not to accept treatment or support. Police-led responses to concerns for welfare risk implying that choosing to withdraw from treatment is unlawful.

- People who have had poor experiences with criminal justice services, particularly refugees, those who have experienced persecution or torture, people from Black and other racialised and ethnically diverse communities, people from the LGBT+ community (particularly trans people) and other people who are disproportionately affected by the use of police powers, are more likely to find the presence of police officers aversive and potentially re-traumatising. This can be harmful in itself, and may also further weaken trust and engagement with health services.

4.1.1 Aim of this section

The section will support multi-agency partners to implement a health-led approach to responding to mental health-related concerns for welfare. As a result of this section, local areas should reach agreement on:

- What is and is not a mental health-related concern for welfare.
- Which services/agencies are responsible for responding to mental health-related concerns for welfare in a range of scenarios, including those where police involvement is required.
- What actions should be taken in response to a mental health-related concern for welfare, including initial enquiries and in-person checks.
- How progress with implementation should be monitored and reviewed, including to ensure that there is no inequitable impact on those with any protected characteristic.

4.1.2 Defining mental health-related concerns for welfare

We use the term ‘mental health-related concerns for welfare’ to mean concerns for which there is good evidence that they relate to a person’s mental health (and not that there is concern about a person with mental health needs). Concerns for welfare that do not meet this definition (that is, are not mental health-related) are not covered in this section, but where local areas are applying RCRP more broadly than mental health, multi-agency partners will need to agree their approach to responding to these concerns.

Partners need to work through a range of scenarios to clarify what is and is not a mental health-related concern for welfare, and the resulting responsibilities. It is important to note that implementation of the NPA:RCRP does not supersede legal safeguarding duties (see section 2) and statutory safeguarding partners (ICBs, the police, local authorities) will need to continue to fulfil those duties. This includes in situations where a concern for welfare is raised about an adult and there is a child or young person with them, for example, in their household, which may require a safeguarding response.

4.1.3 Determining responsibility for responding to mental health-related concerns for welfare

Local partners will need to agree the right agency to respond to mental health-related concern for welfare in different scenarios. They will also need to agree how these concerns, which may be received through a number of routes (for example, 999, 101, crisis lines/NHS111 'select mental health option' or directly from healthcare professionals), will be communicated to the right agency or agencies in a timely way that complies with data protection legislation and confidentiality duties (see section 3.7), and with sufficient detail for the right response to be provided.

While responsibilities need to be determined locally, we anticipate that the following approach will be broadly followed for mental health-related concerns for welfare (as defined above):

- For emergency situations: the ambulance service will lead the response if there is an emergency health concern (including an emergency physical health concern alongside a mental health need). The police may also provide an emergency response, where the threshold for their involvement is met (see section 1.2) and/or there is a legal or statutory duty for the police to act.
- For non-emergency situations where a person is currently receiving support from a community mental health service: their usual mental health care service will normally lead the response. However, if the person's usual care team is unable to respond with sufficient urgency (including out of hours), then the CRHTT/intensive home treatment team will lead.
- For non-emergency situations where a person is not known to services or they are receiving support from a talking therapies service (that is, are not on the caseload of a secondary mental health service), but there is good evidence that the concern relates to the person's mental health: intensive home treatment/CRHTT will lead.

The lead agency may be supported in its response by other services; for example, primary care (which can be a useful source of information and advice), children's or adults' social care, housing or VCFSE organisations, or mental health and ambulance services where they are not already the lead agency. This will depend on the person's individual needs and the nature of the situation, including the urgency of the concern. Where the threshold for a police response is met (see section 1.2) and/or the police have a legal or statutory duty to act, a joint approach with police services will be appropriate. As with other elements of RCRP the threshold for a police response (see section 1.2) needs to be considered both in terms of the concerns raised about the individual and the potential risks to staff, for example in

undertaking a check at the person's home address, or to others, for example children present in the home.

Mental health services are likely to already have protocols in place to respond to mental health-related concerns for welfare, and these should be reviewed (or, if required, created) with multi-agency partners and people with lived experience in light of the NPA:RCRP. The local protocol should identify the lead and supporting agencies for a range of scenarios, ensuring clarity on which service should respond across the local system's geography. It should also align with existing local response standards, for example the mental health clinically-led review of standards.

As set out above, during local working hours and in non-emergency situations, it will usually be appropriate for the response to a welfare concern involving a person currently receiving support from community mental health services to be from their usual mental health service. This service has an existing relationship with the person, knows the person's history and care plan and will therefore be able to make the most informed decisions about the right next steps following the check. Additionally, it will be able to provide age-appropriate care and be aware of any reasonable adjustments required to respond to the concern (such as communication adaptations for people with dementia, a learning disability, or who are autistic). In situations where the service responding to the concern for welfare does not have ongoing responsibility for the person's care, there should be a clear protocol in place for the handover of information to the service that does, including information on the action needed to support the person. Where a person is located outside their usual care pathway and an in-person check is required, mental health services within the area that the person is located are expected to take reasonable steps to support this check.

Some mental health staff may think that they cannot conduct an in-person check without the person's consent. Although staff cannot enter a property without the occupant's permission, they can still attend and request to speak to an individual, to check on their wellbeing. If there are significant concerns about a person and staff cannot gain entry on arrival, then further action should be considered, for example whether it would be appropriate to apply for a warrant under Section 135 of the MHA. Alternatively, in an emergency situation, the police or fire and rescue service may need to be contacted (as set out in locally agreed protocols), as they have powers of entry in certain situations. For example, under Section 17 of the Police and Criminal Evidence Act, the police can force entry for the purpose of 'saving life or limb'.

ICBs should work with health providers (including ambulance and mental health providers) to assess whether additional staffing or resource is required to respond to concerns for welfare,

and how these requirements will be met. Agreement should also be reached with partners about the timeline for implementing the agreed response to mental health-related concerns for welfare. If there is any potential gap in the availability of suitably skilled mental health staff members to respond to such concerns, in any part of a system's geography and at any time, this should be reflected in system risk registers, with suitable mitigation in place. If a gap has arisen because of incomplete implementation of systemwide 24/7 age-appropriate mental health crisis services, or the Community Mental Health Framework for adults and older adults, expediting expansion of these services should form part of the system's plan to address the risk.

4.1.4 When police assistance is required to respond to mental health-related concerns for welfare

The police may support the response to a mental health-related concern for welfare where the threshold for a police response is met (see section 1.2) and/or when they have a legal or statutory duty to act. The decision about whether health services involve them should generally be made after initial enquiries to better understand the welfare concern.

There will be circumstances where it is hard to judge whether police involvement is warranted in the response to a concern for welfare, and partners should work together to test different scenarios and ensure joint understanding, which should be reflected in local policies and protocols. Protocols should also be clear about how healthcare staff request police support with concerns for welfare.

As referenced above, some people will find it distressing or traumatic to interact with the police, and if the police assist with in-person checks, the person may respond both to the police and other services involved with distrust. This could lead to misinterpretation of risk and unwarranted use of force. Where there may occur, it is important to consider whether additional trusted support can be provided, for example by drawing on the person's family and carers or the support of VCFSE organisations that serve a particular community.

4.1.5 Actions in response to a mental health-related concern for welfare

Local protocols should set out the responsibilities of and expected steps that services will take in response to a mental health-related concern for welfare, depending on the level of urgency (where it is an emergency situation, existing emergency service protocols should be followed).

Initial enquiries

For non-emergency concerns, the following steps should usually be taken first (where a more urgent response is required, the above steps and an in-person check may be carried out in parallel):

- Review the person's Summary Care Record and electronic record (including recent engagement, care plans, crisis/safety plans and any known welfare or safeguarding concerns).
- Make attempts to contact the person and the family and carers via text, phone or email.
- Check with other people involved in the individual's care about recent contact – these may include representatives from other health services (including GPs), children's or adults' social care, housing, education, and VCFSE organisations. The extent of this engagement will depend on the urgency of the situation.

Before gathering information, staff should consider their confidentiality duties (see section 3.7) and any potential harm from making enquiries.

If it is possible to contact the person or their family and carers via phone or email and assure their wellbeing, this should be recorded in their electronic record. Consideration should still be given to whether the person requires any additional support, building on their care plan.

If it is not possible to contact the person and/or assure their wellbeing, this should be recorded in their electronic record, and consideration given to conducting an in-person check at the person's home address and/or other location where they are likely to be.

In-person checks

There should always be a clear purpose or reason for carrying out an in-person check, and the decision to do one should be informed by legal frameworks. These include risk to life under Article 2 of the HRA and risk of serious harm or abuse under Article 3, as well as a person's right to a private life under Article 8 and the principles of the MCA, which state that people over the age of 16 can make their own decisions, even if unwise, unless they are assessed as lacking capacity to make these decisions. For children and young people under 16, the principle of Gillick competency should be considered, alongside the duty to safeguard children from harm, which may mean sharing information with the adult with parental responsibility for the child or young person, if this is in their best interests.

It is important that in-person checks meet the needs of the individual concerned. Local areas should work with people with lived experience, including people from racialised and

ethnically diverse communities, to agree the best approach to carrying out in-person checks. Suggestions include:

- Ensuring that before carrying out an in-person check, initial enquiries have provided a sufficient understanding of the person's circumstances and needs. For example, it will be important to understand if a person with dementia or a learning disability, or who is autistic, has any communication or sensory needs, so that reasonable adjustments can be made.
- Carefully considering who should attend in-person checks. This may include multi-agency staff (health, children's social care, adults' social care, housing, police, or education for children and young people), family and carers, or other individuals who the person trusts, for example peer support workers or people working in VCFSE organisations. Particular consideration should be given to planning how to undertake in-person checks in a culturally appropriate and trauma-informed way for people from Black and other racialised and ethnically diverse communities and those who have experienced persecution or trauma.
- Ensuring that those undertaking the check understand its purpose before it is conducted, including that the police (where they are assisting) understand their role and the joint approach being taken.
- Informing the person of the in-person check in advance wherever possible, using the method of communication that the person is most likely to access (text, phone call, email).
- Explaining clearly to the person at the start of the check why it is being undertaken, and by who, and seeking to understand how to make the person feel safe and comfortable during the check. For example, this could include offering to meet outside the person's home address or property they are in, where this is practicable.
- Discussing the person's holistic needs with them during the check and working collaboratively to agree immediate next steps. Follow-up discussions may be needed to update the person's ongoing care plan, and to agree the steps that should be taken if the person withdraws from the support of services in the future, or if there is a concern for their welfare. These discussions should include the person, relevant multi-agency services, and the family and carers that the person has consented to involve in their care (see section 3.7).
- Ensuring that there is no implication during the check that if the person does not adhere to certain conditions, then they will be sanctioned, for example detained under the MHA, or that the police will carry out a follow up check.
- Ensuring all mental health staff involved in welfare checks are suitably trained and competent. This includes having skills in providing personalised, collaborative,

trauma-informed, culturally appropriate care; carrying out personalised risk management and safety planning (based on the risk assessment principles outlined in section 1.2); and an understanding of how to apply the MHA and MCA in the context of welfare checks.
- Uploading a record of the in-person check to the electronic record system of the lead agency, including details of the actions agreed during the check.
- Following lone working policies in all instances. This is to ensure not only the safety of the person whose welfare is a matter of concern but also that of the staff undertaking the check.
- Ensuring that where mental health services have not located a person through in-person checks and critical concerns remain about their safety, this is referred to the police, who can assess against local missing persons policies.

Services should also seek to understand the reasons that mental health-related concerns for welfare are reported and identify if any changes are needed to service delivery. For example, ensuring everyone on mental health services' caseloads has a crisis/safety plan in place, or working with people with lived experience to identify how best to support people to stay engaged with services.

4.1.6 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform implementation:

- Number of mental-health related concerns for welfare reported, who reported the concern, which service/agency the concern was reported to, and brief details of the concern.
- Number of mental health-related concerns for welfare responded to, number involving an in-person check, which services/agencies were involved in in-person checks, and brief details of the outcome of the response.
- Number of mental health-related concerns for welfare where police assistance was requested and by who, the percentage of requests accepted and police were deployed, the reasons why the police attended or declined to attend, and brief details of the outcome of the response (both where the police were and were not part of the response).

Each agreed metric should be broken down by protected characteristics, including race, age and whether someone has a co-existing physical health problem or disability, a learning disability or autism. Where there is unwarranted variation, particularly in relation to police

involvement in undertaking in-person checks, actions should be taken to address this, working in partnership with people with lived experience from relevant groups.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to mental health-related concerns for welfare, the working group should discuss these and if they cannot be resolve an issue, it should be escalated, following locally agreed escalation processes (see section 3.4).

4.2 Phase 2a: People with mental health needs who leave acute hospitals before assessment or treatment is complete

Acute hospitals, particularly emergency departments (EDs), are not always the best place for people presenting for support with a mental health need. EDs can be busy and pressured environments, and staff in acute hospitals are generally not mental health specialists (apart from those working in psychiatric liaison teams). This is why the NHS Long Term Plan has helped systems to establish a range of community-based mental health support options for people with urgent mental health needs. However, some people will continue to seek support for a mental health need by presenting at ED (including those who also have an urgent physical health condition that requires assessment or treatment), and some people admitted to acute hospitals for physical health treatment will have a significant mental health need.

While the proportion of people presenting at EDs with a mental health need is small (internal NHS data indicates around 3%), wait times are a key reason why people may decide to leave an ED before they have been formally assessed, received an intervention or completed treatment. People may also decide to leave acute hospitals because they are not clearly told about next steps in their care, because of being subject to ongoing supervision by police or hospital security, and because they are experiencing symptoms such as paranoia, delusions or suicidal thoughts, or withdrawal from nicotine or other substances.

The NPA:RCRP sets the objective that the police should only be involved when a person with mental health needs leaves an acute hospital if the threshold for a police response is met (see section 1.2) and/or legal or statutory duties apply. Alongside continued work to develop and promote community-based services where people can access support for urgent mental health needs, achieving this objective will involve ensuring that acute settings have effective provision in place to support people to remain in treatment. It will also involve strong partnership working between agencies to agree and put in place clear response protocols for when a person leaves hospital.

4.2.1 Aim and scope of this section

The guidance for this phase focuses on people whose primary reason (or a significant reason) for attendance at ED is a mental health need (who may also require assessment or treatment of a physical health need, for example, due to self-harm); and people with a significant mental health need who are admitted to an acute hospital for assessment or treatment of a physical health problem (including people transferred to an acute hospital from a mental health inpatient service). These people may have attended hospital voluntarily, have been assessed as lacking capacity under the MCA if over 16 years old or be detained or held under the MHA.

The section covers:

- Measures that should be in place in acute hospitals to improve experience and support people to remain in hospital, where appropriate.
- Procedures that should be in place to respond where a person indicates that they intend to leave, or have left, an acute hospital, including an ED.

It should be read alongside the following documents, to inform local approaches to delivery:

- 'The Patient Who Absconds', produced by the Royal College of Emergency Medicine. This provides detail on legal powers and practical considerations in relation to people leaving EDs.
- The multi-agency response for adults missing from health and care settings: A national framework for England – produced by the NPCC, Home Office and the charity Missing People, supported by health, social care and other partners.
- Statutory guidance on children who run away or go missing from home or care – produced by the Department for Education, and the accompanying flowchart showing roles and responsibilities when a child goes missing from care.

Note that cases where a person leaves a hospital or other health setting are separate to missing persons cases. Health services should first take reasonable steps to try and locate a person (in relation to acute hospitals, see section 4.2.5). Where services are unable to locate a person and critical concerns remain about the person's safety or wellbeing and/or the person is detained under the MHA, this should be referred to the police, who will assess against local missing persons policies (which are not impacted by the NPA:RCRP). Health services should also continue to follow best practice for missing persons, including the creation and use of Herbert Protocols.

4.2.2 Measures to support people to remain in acute hospital settings for assessment or treatment

While the NPA:RCRP does not directly introduce changes around the quality of care that people presenting with mental health needs receive in acute hospitals, by improving people's experience, it is more likely that they will stay in hospital for the assessment or treatment they require. Improving quality and experience of care for people with mental health needs presenting in acute hospitals is also the right thing to do.

Local implementation should therefore involve acute hospitals coming together with all-age mental health services (psychiatric liaison, community, crisis, inpatient), AMHP services and people with lived experience from diverse backgrounds to understand current challenges, including the reasons that people leave hospital before assessment or treatment is complete, and to identify how to strengthen the care pathway. This should be informed by existing standards and guidelines, including:

- NHS England, the National Collaborating Centre for Mental Health, and NICE guidance on mental health liaison services for adults and older adults.
- The Royal College of Psychiatry Psychiatric Liaison Accreditation Network standards, which cover children, young people and adults.
- The Royal College of Emergency Medicine Mental Health in Emergency Departments toolkit.
- NHS England guidance on supporting children and young people with mental health needs in acute paediatric settings.
- The Royal College of Paediatrics and Child Health Facing the Future - standards for children and young people in emergency care settings, which include standards for mental health.

Suggestions in relation to the care of individuals include:

- Supporting the person to contact their family or carers, if they have not already done so, to see if they can come to hospital to contribute to decisions about the person's care and provide support (for example bringing a phone charger, change of clothes or other items that help the person feel more comfortable while in hospital). For children and young people under 18, it is vital that their family and carers are contacted, as well as their social worker, if they have one.
- Ensuring there is clear and frequent communication with the person and their family and carers (where consent for this has been given – see section 3.7) about the next steps in the person's care and when the person is likely to be seen by a clinician for

assessment or treatment. If an interpreter is required, this should be promptly arranged.

- Reviewing a person's existing mental health care plan (where applicable) and speaking to the person and their family and carers (where consent has been given – see section 3.7), to identify any reasonable adjustments that need to be met and to tailor support to meet the person's needs and preferences, for example in terms of age, cultural background or whether a person is LGBT+. This will depend on what is feasible in an acute hospital or ED environment.
- Making sure the hospital environment is as safe and quiet as possible. Outside spaces should be accessible, dependent on local policies and an individual assessment of the benefits and risks to the person of going outside.
- Asking at the initial assessment whether the person smokes or uses e-cigarettes and, wherever possible, offer nicotine replacement therapy. Similarly, there should be active management of any alcohol or drug withdrawal symptoms to support continued engagement with hospital care.
- Ensuring people's physical and mental health needs are met in parallel and kept under regular review. For example, while someone receives mental health assessment or treatment, their wound dressings should be regularly changed, and they should be provided with any medication they need for physical and mental health needs.

Suggestions to consider at a service or system level include:

- Working to improve access to and the quality of the community-based mental health crisis pathway, including crisis alternatives such as crisis cafes, sanctuaries and crisis houses, which enable people to access care in settings other than the ED. Some EDs employ community navigators to help people attending the ED to access these alternatives. Other areas have set up crisis assessment centres, which offer an alternative to the ED for urgent same-day crisis care; further information is available on this FutureNHS page.
- Putting processes in place to enable timely triage, initial assessment, and referral of people requiring mental health support to psychiatric liaison teams. The mental health clinically-led review of standards indicates that for people in EDs with mental health needs, the psychiatric liaison team should aim to start a face-to-face assessment within one hour of referral. To achieve this, psychiatric liaison teams will need sufficient capacity to respond to local patterns of demand.

- Putting additional support in place from peer support workers, a VCFSE service or healthcare assistants, to give people someone to talk to, who will respond with empathy and compassion while they are in hospital.
- Working towards ending the use of security staff to undertake observations. Every hospital should have provision, or develop plans for, in-house observation by appropriately skilled and trained staff (in conjunction with security staff where there is risk of violence). All staff who undertake observations (including security staff), and where possible wider staff in acute hospitals, should be trained in providing supportive care to people presenting with mental health needs, least restrictive practice and de-escalation techniques. The NHS England South West regional team has compiled these mental health training resources for ED staff. Training for acute hospital staff working with children and young people with mental health needs, can be accessed via NHS England's e-learning platform.
- Working with local police forces to agree the types of situations in which it is warranted for the police to remain in attendance to support the management of a person presenting with mental health needs, and when it is appropriate for them to handover care (in line with the MHA and threshold for police response, see section 1.2).
- Reviewing all-age pathways for onward care from an acute setting (for example, for MHA assessments, community-based mental health crisis care, mental health inpatient care, and drug and alcohol support), identifying the causes of any delays and actions to address these, as well as ensuring effective escalation processes are in place.
- Ensuring there are urgent action and escalation protocols for when transition delays occur (for example, waits of more than 12 hours in the ED), and that these are followed. Protocols should cover both the action to secure onward care as quickly as possible, and how the person can be supported and made as comfortable as possible while they wait. For example, they will need regular meals and any required medication prescribed; support could also include arranging for the person's named key worker or other trusted professional to visit the person in hospital. The protocol used in London, the East of England and the South East is the Mental Health Compact.

Where identified service or system level changes have resource implications, changes should be planned with the relevant ICB and the funding implications assessed. Any staffing requirements (for example, to undertake observations) should be considered as part of bi-annual establishment reviews, with any new roles having a quality impact assessment, including to set out the scope of the roles and the training and supervision requirements.

It is also vital that NPA:RCRP implementation does not increase the use of restrictive interventions to prevent people from leaving hospital (monitoring should take place as set out in section 4.2.7). There must be a legal justification for use of restrictive interventions, and any use must be proportionate, for the minimum time necessary, as a last resort after de-escalation techniques have been attempted, and documented in clinical records. There should also be written agreement with hospital security services regarding the training they require to apply restrictive interventions (for example, training in least restriction and de-escalation), the circumstances in which they can be applied (including the importance of doing so under the guidance of clinical staff), how to apply them in different circumstances, and when police support may need to be requested (with reference to the threshold for police response, see section 1.2).

4.2.3 Procedures when a person indicates that they intend to leave, or have left, an acute hospital before assessment or treatment is complete

With NPA:RCRP implementation, it is expected that healthcare staff will take reasonable steps to locate people for whom a mental health need is a significant part of their presentation and seek to return them to hospital (if required) before contacting the police, apart from where the threshold for a police response is met (see section 1.2), and/or legal or statutory duties apply. This will be a change in practice from immediately calling the police for some services.

To support this change, acute hospital providers and mental health services, working with other relevant partners such as ambulance providers, should develop or review their existing protocols for how to respond when a person leaves an acute hospital before assessment or treatment is complete. Section 4.2.4 onwards sets out guidance on how local areas may decide to approach this. To inform these protocols, health partners should review examples of recent cases with police colleagues, including complex and all-age examples, to reach clarity and agreement among partners about when the response should be health-led and when the threshold for a police response is met (see section 1.2) and/or the police have a legal or statutory duty to act. The protocol should document the agreed actions that the police are expected to take, recognising that where the police are involved in responding, health services are still expected to work with the police to locate the person, as part of their ongoing duty of care. Note that the police generally only have the power to return someone to an acute hospital against their wishes if they are under arrest, detained or subject to police holding powers under the MHA.

Protocols will need to take account of a person's age, legal status (for example, voluntary attendance, assessed as lacking mental capacity under the MCA, detained under MHA, awaiting MHA assessment, recommended for detention, or liable for detention but awaiting admission), whether they are known to mental health services or not, whether they have a

physical health need that needs to be addressed in parallel, and their stage of care, for example, whether they have already been seen by the psychiatric liaison team. Where a hospital is located on the boundary of different police force areas, elements of the protocol relating to the police response will also need to be agreed with neighbouring forces.

Below are suggestions for what should be covered in these protocols, though roles and responsibilities should be agreed locally, dependent on local service models. For the protocols to be effective, acute staff need to have been trained in the application of legal frameworks (particularly how to assess mental capacity to make a specific decision under the MCA, and how to weigh up the hospital's duty to protect life under Article 2 of the HRA against the duty under Article 5 to not restrict liberty disproportionately).

4.2.4 Actions before a person leaves or attempts to leave hospital

Acute staff should ensure at the initial assessment in the ED or on admission to an acute hospital:

- The contact details of the person and one of their family members or carers are documented (where the person is willing and able to provide them). For a child or young person under 18, the contact details of those with parental responsibility should be recorded.
- A physical description of the person is recorded to assist if there is a future need to locate the individual.
- The person is advised about the plan for assessing and/or treating them and when they are likely to be seen by a clinician, with regular updates provided. Their family and carers should also be informed (where the person has consented to this – see section 3.7).
- The risks of leaving hospital before assessment or treatment is complete are explained to the person, and they, and their family and carers (provided consent has been given – see section 3.7) are given details of who to contact if certain side effects or symptoms occur.
- The person's mental capacity under the MCA is considered (for those aged 16 and older), and if there is any reason to doubt capacity, a formal assessment is made and documented in relation to the plan for their assessment and/or treatment. For children and young people under 16, Gillick competency should be considered, and involvement of those with parental responsibility, where required.

Acute staff should also assess the factors that might contribute to the person leaving hospital before assessment or treatment is complete (such as likely waiting time, types of symptoms), and what concerns would arise for the person's safety (or that of others) and wellbeing if

they were to do so. This assessment should follow the principles set out in NICE guidance on self-harm; that is, it should focus on how to support the person's immediate and longer-term psychological and physical safety, and should not involve using risk assessment tools or risk stratification to predict future suicide or self-harm. See also the risk assessment definition in section 1.2.

Where assessment indicates substantial concerns for a person's safety or wellbeing (or that of others) were they to leave hospital before assessment or treatment is complete, acute staff should ensure that the person is:

- Prioritised for a mental health assessment by the psychiatric liaison team and the person is supported to stay in hospital – see section 4.2.2.
- Observed (this may be enhanced observation if the person is at very high risk of leaving), either with the person's consent or within an appropriate legal framework (this should be documented in clinical record systems).

If a person expresses the wish to leave hospital, a senior decision-maker, ideally from the psychiatric liaison team (especially where the person is due to be admitted to an inpatient mental health service) or jointly with acute care staff (particularly where the person also has a significant physical health need), should assess if leaving is in the person's best interests. If from weighing up the likelihood of harm and protective factors it is judged that:

- The person does not need to be in an acute hospital, then this should be documented in the person's clinical record and they can be discharged.
- It is in the person's best interests to remain in hospital:
    - The reasons for this should be explained to the person, and attempts made to understand why they want to leave and address their concerns. At the same time, a clinician trained in assessing mental capacity under the MCA (or Gillick competency for under 16s) should assess their capacity to make the decision to leave hospital.
    - If the person cannot be persuaded to remain in hospital and there is no legal justification for preventing them from leaving, they must be allowed to leave.
    - If the assessing clinician believes there is a legal justification to prevent the person from leaving, then steps must be taken to prevent them from leaving, ensuring compliance with the identified legal framework. Where the position is unclear, legal advice should be sought.
    - Where a restrictive intervention is used to prevent a person from leaving, this should be proportionate, used for the minimum time necessary and as a last

resort after de-escalation techniques have been attempted. It should also be recorded as an incident in clinical record systems, with the legal justification. Any restraint applied by hospital security should be under the direction of clinical staff, and carried out by hospital security who have been trained in least restrictive practice and de-escalation.

4.2.5 Actions when a person has left hospital without notifying or agreeing this with the inpatient team

- Acute staff should attempt to contact the person, using the contact details given during the initial assessment, or held in clinical record systems.
- If it is not possible to speak to the person or ascertain their safety, acute staff should make rapid contact with the psychiatric liaison team to determine next steps, based on an assessment of the person's physical health, mental health and any known risks to self or others (based on the risk assessment principles outlined in section 1.2). The mental health assessment should draw on information from the psychiatric liaison assessment (if completed) and relevant information in a person's clinical record (if known to mental health services). If the psychiatric liaison team had not yet assessed the person before they left hospital, acute hospital staff will need to share as much information as possible about the person's presentation from triage and the initial assessment to inform the decision.
- The different outcomes of this process are:
  a) No further action is required (based on the assessment of protective factors and likelihood of harm) and because the person is not subject to detention under the MHA. Note that if the person is a child or young person under 18, a safeguarding referral should be made.
  b) A non-urgent follow-up (i.e. beyond 24 hours) is required by the community mental health service already overseeing the person's care. If a person is not already on the caseload of a community mental health service, the psychiatric liaison team should refer for assessment by the most appropriate service locally. For children and young people under 18, a safeguarding referral should also be made.
  c) A follow-up, either urgent (within 24 hours) or very urgent (within 4 hours), is required by the local intensive home treatment/CRHTT. The psychiatric liaison team should make this referral to the intensive home treatment/CRHTT that operates in the person's most likely location. A referral may also need to be made to local AMHP service for an MHA assessment, where this is required.
  d) The threshold for a police response is met see (see section 1.2) and emergency action by the police is needed to locate the person, liaising closely

with the acute hospital or crisis mental health services, as required. Ambulance services may also be involved in the response once the person's location is known and they are identified as having an emergency health need that the ambulance service can support with. If there are any differences in opinion between agencies about how to respond to a particular situation, local escalation processes (see section 3.4) should be followed.

- If the person's situation is judged to be urgent, very urgent or an emergency, in parallel with contacting the relevant services:
    - Hospital security staff should rapidly search the hospital and grounds, making use of CCTV footage.
    - Acute staff should continue to try and contact the person, as well as their family and carers, using contact details supplied at the initial assessment or held in clinical record systems (where consent for sharing information with family and carers has been given – see section 3.7).
    - A safeguarding referral should be made if the person is under 18, or there are concerns an adult is at risk of abuse or neglect.
- If the police are contacted for emergency support to locate a person, the acute hospital should have a proforma outlining the information staff should share with the police. This should include the person's name and a description of them, when and which department they left from, the actions that the hospital has already taken to locate them, a clear articulation of the potential for harm to self or others (that is, why police involvement is needed), and the recommended actions if the person is located. Where confidential information about a person is disclosed to the police, this must be in line with data protection legislation and confidentiality duties (see section 3.7).
- If the ambulance service is involved in the response (once a person's location is known), then the acute hospital should similarly communicate information about the person's presentation and the intended plan, for example what assessments will be needed and whether or not it is likely that the person will need to return to hospital.

4.2.6 Actions when a person is followed-up or located

The response may be led by mental health services (in non-urgent, urgent or very urgent cases), the police (emergency action to locate the person, where the threshold for a police response is met, see section 1.2), or the ambulance service (once the person's location is known and there is an emergency health need that the ambulance can support with). Regardless of the responder, it is important that the person is treated with compassion and understanding when they are located or followed up, and not made to feel judged or that they will be punished.

When the response is led by mental health services:

- The person's mental health needs should be assessed:
  - If this assessment indicates that the person requires urgent mental health support, then this should be arranged. This could involve support from an intensive support team/CRHTT, other community-based crisis support or – after sufficient consideration of less restrictive alternatives – an inpatient admission (with an MHA assessment arranged where required).
  - Where urgent mental health support is not required, mental health staff should still ask the person why they went to hospital, and discuss any support they would find helpful at this time (for example, through talking therapies, community mental health or VCFSE services).
- Their physical health needs should be assessed, as required:
  - If they have physical health needs that require emergency attention, for example due to serious self-harm or a suicide attempt, an ambulance should be called. Paramedics may be able to treat the person at the scene or need to convey the person to hospital.
  - If they have non-emergency physical health needs, the person should be encouraged to seek appropriate medical attention from an urgent treatment centre (for example, to treat cuts), through their GP, pharmacy or NHS111.
- Following any immediate action required, the person's crisis/safety plan should be reviewed (or developed if they do not have a plan), to identify the specific support they can access if in crisis again; for example, through contacting local crisis lines/NHS111 'select mental health option', and crisis alternatives like crisis cafes, sanctuaries and/or crisis houses. It is also important that the person's clinical record is updated so that information on relapse signs and what action can help is easily accessible in any future crisis.

If mental health services are unsuccessful in contacting or locating the person after multiple attempts, and critical concerns remain about their safety or wellbeing and/or they are detained under the MHA, the person's case should be referred to the police. The police can then assess against local missing persons policies.

Where the response is led by police and/or ambulance services in emergency situations:

- There should be ongoing communication with the acute hospital and/or mental health services to share relevant information and inform next steps.
- Health services should assess the person's physical and mental health needs, as appropriate, once the person is located. Based on this assessment and information

shared, health services should decide whether return to an acute hospital is required.

- If it is required, an assessment should be made of how to carry this out, including who should lead and whether there are any legal powers that could be used to return the person if they will not return voluntarily. Note that if the person is not subject to powers under the MHA and they have mental capacity under the MCA, generally there is no power under which they can be made to return. If it is deemed that an MHA assessment is required, then this should be arranged.
- If the person is returned to hospital, hospital staff should clarify their legal status, (for example, detained under the MHA, subject to Section 135 or 136 police holding powers, brought in under the MCA, or voluntary attendance), and agree handover processes.
- The person should be considered higher risk for leaving hospital again, and hospital staff should review their management plan to reflect this.

4.2.7 Reviewing progress with implementation

To understand what leads people to leave hospital, as well as the impact of changes introduced by the NPA:RCRP where people leave acute hospitals before assessment or treatment is complete, we suggest that ICBs facilitate the collection and analysis of the following measures:

- Number and proportion of mental health attendances where the person spends over 12 hours in the ED. This information can be accessed via the Urgent and Emergency Mental Health Dashboard. Where possible, this data should also be broken down by protected characteristics including race, age, and whether someone has a co-existing physical health problem or disability, including a learning disability or autism to determine if there is unwarranted variation.
- Number and proportion of mental health attendances in the ED where the person requires 1:1 observation, and whether this is undertaken by healthcare assistants, nurses, hospital security or police officers.
- Number and proportion of people for whom a mental health need is the primary (or a significant) reason for their presentation who have left an acute hospital. This data should be broken down by protected characteristics and legal status – for example, whether the person was in hospital voluntarily, under the MCA, recommended or liable for detention under the MHA, detained under the MHA (including which section they were detained under) or subject to police holding powers (for example, Section 136).
- Number and proportion of cases where a person has left an acute hospital and a) did not require follow-up, b) required follow-up and referral to mental health

services, c) required follow-up and a call to the ambulance service, d) required follow-up and a call to the police.

    - Where a report is made to the police, brief details of why a report was made should be recorded and the number and proportion of these cases that were accepted for police response. This should inform joint learning about when it is warranted for the police to respond.

- Number of people brought to the ED by the police voluntarily or under the MCA for whom a mental health need is the primary (or a significant) reason for attendance, and the proportion of these cases in which restraints (such as handcuffs or leg cuffs) are used. This needs to be monitored to ensure that an increase in inappropriate use of restraint or legal powers is not an unintended consequence of NPA:RCRP implementation.
- Number of uses of restrictive interventions in acute hospitals (including the ED) on people for whom a mental health need is the primary (or a significant) part of their presentation. This should be recorded as an incident on clinical record systems, analysed by protected characteristic and monitored during implementation to ensure that the use of restrictive interventions does not increase with NPA:RCRP implementation.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to how cases where people leave an acute hospital are managed, the phase-specific working groups should discuss these, and if they cannot resolve a concern, then this should be escalated following locally agreed escalation processes (see section 3.4).

4.3 Phase 2b: People who absent themselves from inpatient mental health services or do not return from leave when expected

A person may choose to leave an inpatient mental health service without informing or agreeing this with the inpatient team, or may not return to hospital following a period of agreed leave because, for example, they are very unwell, feel their needs are not being supported in hospital, or dislike the restrictions to everyday freedoms in inpatient settings, such as how frequently they can see loved ones. Some people with lived experience have also reported that feeling unsafe and experiencing racism, homophobia, transphobia and assault in inpatient settings contributed to their decision.

That a person chooses to leave or not return to hospital when expected may be a real concern for their family and carers, and hospital staff, who may fear for the person's health

and wellbeing when they are no longer receiving support and treatment from an inpatient service.

4.3.1 Aim and scope of this section

With implementation of the NPA:RCRP, the police may only respond to situations where a person leaves an inpatient mental health service, or does not return from a period of leave when expected, if the threshold for a police response is met (see section 1.2), and/or the police have a legal or statutory duty to act. This aligns with the MHA Code of Practice, which states that the police should only be asked to assist in returning a person who is detained to hospital if necessary, and that where a person's location is known, the police's role should, wherever possible, only be to assist a mental health professional to return a person to hospital (28.14).

This section focuses on what mental health services, including NHS inpatient mental health providers and NHS commissioned independent providers, need to put in place to enable health-led responses to locate and return people to hospital.

We cover situations where the absent person:

- Is detained under the MHA.
- Was admitted under the MCA (if aged over 16) as the person was assessed as lacking capacity to consent to admission and assessment or treatment and does not fall within the scope of the MHA.
- Was receiving assessment or treatment in hospital voluntarily.

It is important that with regards to people detained under the MHA, this section is read alongside Section 18 of the MHA and Chapter 28 of the MHA Code of Practice.

While the MHA refers to people who are 'Absent Without Leave (AWOL)', we generally avoid both the terms 'Absent Without Leave/AWOL' and 'absconded' because they assign a label or judgement and because this guidance also covers people who are not detained under the MHA. Instead, we refer to a person having 'absented themselves'.

The term 'Absent Without Leave' refers to a number of situations involving people who are detained under the MHA (for example, people placed on a community treatment order under Section 17A of the MHA not returning to hospital when recalled). In this section, we focus on 2 situations where someone may be classified as 'Absent Without Leave': people leaving hospital without informing or agreeing this with the inpatient team, and people not returning from a period of leave at the expected time. These are the situations that the police report most frequent contact about. However, the principles in this section may inform local

approaches to responding to other situations involving people classified as 'Absent Without Leave'.

Note that cases where a person leaves a hospital or other health setting are separate to missing persons cases (see section 4.2.1).

4.3.2 Addressing the reasons why people absent themselves from inpatient mental health services or do not return from leave when expected

Mental health providers should carry out a multi-disciplinary review of the care received for each person who has absented themselves to understand how and why they chose to do so, including discussing the reasons with the person. Using this information, organisations should work with people with lived experience to identify steps that could prevent people absenting themselves. These will likely focus on improving the quality of inpatient care, for example by: making sure that people have supportive and collaborative relationships with staff in inpatient services; care is therapeutic, trauma-informed, culturally and developmentally appropriate, and adjusted to individual needs; and that shared decision-making is promoted. It is also crucial that as a response to NPA:RCRP implementation, inpatient services do not increase the use of restrictive interventions – inpatient services should continue to work towards minimising the use of restraint in line with the Mental Health Units (Use of Force) Act.

Further information on good practice is provided in the NHS England guidance on acute inpatient mental health care for adults and older adults and through guidance on the Quality Transformation programme webpage.

Inpatient providers should also ensure that the steps that will be taken if a person leaves hospital or has not returned from leave are individually planned, particularly for people detained under Part III of the MHA. Individual planning may be informed by learning from any previous occasions where a person has absented themselves, for example, the location they went to.

4.3.3 Determining when and how to report cases to the police where people absent themselves from inpatient mental health services or do not return from leave when expected

Currently, if a person absents themselves, it is common for inpatient mental health services to report this to the police. Following the NPA:RCRP, it is expected that mental health services will take reasonable steps to locate and return a person, before contacting the police, apart from where the threshold for a police response is met (see section 1.2), recognising that risk factors may change as the situation unfolds, and/or the police have a legal or statutory duty to act.

Multi-agency partners should work through scenarios to reach a shared understanding about when the threshold for a police response is met (see section 1.2) in relation to people who absent themselves, including how the threshold applies to children and young people, ensuring there is compliance with legal safeguarding duties (see section 2). They should also take into account that the MHA Code of Practice states that where a detained person is particularly vulnerable, dangerous and/or subject to restrictions under Part III of the MHA, the police should be immediately informed (28.15). If a multi-agency public protection arrangement (MAPPA) is in place, then the MAPPA coordinator should be informed.

Based on these discussions, partners should develop a written protocol outlining the circumstances in which the police should be informed, by whom and at what point, and ensure it complies with data protection legislation and confidentiality duties (see section 3.7). As part of the MHA Code of Practice (28.11), hospitals should already have written policies in place, agreed with multi-agency partners, including the police and ambulance, about the actions that should be taken when a detained person absents themselves, which all relevant staff should be familiar with. 28.12 of the MHA Code of Practice sets out what should be included in these policies. Multi-agency partners should review and update these policies in light of the changes introduced under the NPA:RCRP – including with information on when the police should be informed. Where these policies do not cover people who are not detained under the MHA, this information should be added or a separate policy developed for this group.

When reports are made to the police, the situation should be explained in a way that is specific and unambiguous, and with explicit reference to why police assistance is required, so that the right decisions are made about next steps. To support communication, we recommend that inpatient mental health services and the police jointly develop a proforma outlining the information that should be shared (compliant with data protection legislation and confidentiality duties, see section 3.7). This should include sharing information on what has occurred, the potential for harm to self or others, actions that the health provider has already taken and what support the health service is seeking from the police. If police involvement has distressed the person in the past, this should also be conveyed to the police to inform their response, with the aim of reducing distress.

4.3.4 Actions to locate a person who has absented themselves or not returned from leave

People may absent themselves by leaving hospital buildings or grounds, leaving an escort while on escorted leave, or not returning from unescorted leave at the agreed time. The actions that health services take to locate them will depend on the situation and whether the person is detained under the MHA, and will need to be informed by a risk assessment,

(based on the risk assessment principles outlined in section 1.2). Even where a report has been made to the police, mental health services will be expected to try and locate the person as part of their ongoing duty of care, working with the police to do so.

Depending on the circumstances, mental health services may try and locate a person who has absented themselves by:

- Conducting a search of the hospital grounds and places in the vicinity, if appropriate, and the person is believed to be nearby. When doing this there should be an ongoing risk assessment (based on the risk assessment principles outlined in section 1.2), adequate staff deployed to the search to ensure staff safety and wellbeing, and clear communication with the inpatient team about the unfolding situation, including if further assistance is required. Wherever possible, staff looking for the person should know the person and have formed a trusted relationship with them, to support their return to hospital.
- Phoning or texting the person.
- Contacting other services and agencies that support the person, as well as the person's family and carers to find out if they have seen or heard from the person (where consent to share information with these agencies and family and carers has been given – see section 3.7).
- Visiting the person's home address and other locations in the local area where there is a reasonable likelihood they may be, for example, where a person has been found when they have previously absented themselves. This will need to be informed by a risk assessment (based on the risk assessment principles outlined in section 1.2), and undertaken in line with lone working policies. As above, staff known to the person and with whom they have a positive relationship with should do these visits.

Hospitals should ensure that their written policies concerning people who absent themselves are updated in relation to the actions that mental health services will take to locate them. Policies should cover people who were in hospital voluntarily, people who were detained under the MHA, and people aged over 16 who were admitted under the MCA, as they lacked capacity to consent to admission and assessment or treatment and fall outside the scope of the MHA. These policies should set out the role of the police in assisting with locating people where the threshold for a police response is met (see section 1.2) and/or there is a legal or statutory duty for the police to act, ensuring there is clarity between partners about the actions that the police will take to help locate people in a range of circumstances. Where a hospital is located on the boundary of different police force areas, the policy will need to be agreed with neighbouring forces.

Staff should be trained in the locally agreed policy, including how to respond when someone leaves an inpatient mental health service unexpectedly. Training, guidance and support should be provided on:

- How to conduct a risk assessment, in line with the risk assessment principles outlined in section 1.2, to inform decision-making about appropriate and proportionate next steps when someone has absented themselves. For example, a person may be slightly late to return from unescorted leave because of transport difficulties, and this situation will likely require a different response from when a person has left a hospital building.
- Who should be informed and how urgently when a person has absented themselves, and what information needs to be communicated. The person in charge of the inpatient service and the staff member in charge of the person's care (the responsible clinician for people detained under the MHA) should be informed and other agencies, such as the local authority and the person's family and carers may also be informed (where the person has consented to the sharing of information with these agencies and family and carers, see section 3.7). Guidance should also be provided on what action to take if there is good reason to think someone could be harmed as a result of the person absenting themselves.
- The situations in which the police should be informed, in a way that complies with data protection legislation and confidentiality duties (see section 3.7), and the actions that the police can be expected to take.
- The circumstances in which the hospital grounds and local vicinity should be searched, and how mental health staff should undertake this search (including the role of hospital security, where applicable).
- The circumstances in which the person's home address and any other locations should be visited, and how to arrange this (see paragraph below on local arrangements in relation to this).
- How to apply relevant parts of the MHA in relation to people who are detained, namely Section 18 and Chapter 28 of the Code of Practice.

Services will need to consider the availability of inpatient staff to support with locating people who are absent. Agreement will also need to be reached locally about who is responsible for conducting visits to the person's home address and any other locations in the local area. For example, it may be agreed locally that this is the responsibility of community or crisis mental health services. Services should review data on the number of people who absent themselves to determine what additional resource may be needed, with the funding implications of this assessed by ICBs, and plans put in place about how any additional resource requirements will be met. Where someone has been admitted to a hospital outside

their home address area, we expect that mental health services operating locally to the person's home address will help in undertaking visits.

4.3.5 Actions when a person is located

Under the NPA:RCRP, mental health services will be expected to play a role in responding when a person is located, including returning them to hospital, where required. For people who are detained, this is in line with the MHA Code of Practice (28.14), which states that the police should only be asked to assist in returning a person who is detained to hospital if necessary, and that where a person's location is known, the police's role should, wherever possible, only be to assist a mental health professional to return a person to hospital.

Hospitals should work with partners to review and update their written policies on the actions that mental health services will take when a person who has absented themselves is located and when they are not found. The policies should also set out the role of the police in assisting with returning people to hospital, where the threshold for a police response is met (see section 1.2), and/or where there is a legal or statutory duty for the police to act, ensuring there is clarity between partners about the actions that the police will take to support a person's return. Where a hospital is located on the boundary of different police force areas, the policy will need to be agreed with neighbouring forces.

Policies will need to set out the actions where people are willing and unwilling to return to hospital, for people who are detained under the MHA, people admitted under the MCA (those aged over 16) as they lacked capacity to consent to admission and assessment or treatment and fell outside the scope of the MHA and people who were in hospital voluntarily.

In all cases, when a person is found they need to be treated with compassion and understanding, and not made to feel judged or that they will be punished. It is also important that, as soon as practicable, there is a collaborative conversation with the person to understand why they left hospital or did not return as agreed, to inform next steps in their care, including any changes to improve their inpatient experience, and to identify any wider learning. This conversation should involve the person's family and carers, where consent for involving them is given (see section 3.7).

For people who were in hospital voluntarily and are unwilling to return, healthcare staff should listen to and understand why they do not want to return. Consideration should be given to whether they need to return, or whether a community service, such as an intensive home treatment/CRHTT could support them. If it is judged that the person needs to return, then healthcare staff should seek to explain to the person why it would be beneficial to do so, and to discuss what changes could be made to their care in hospital to better support their

needs. This could include consideration of admission to an alternative inpatient service or hospital. Where possible, this conversation should involve the community mental health service with ongoing responsibility for the person's care, any other key services that support the person, and the person's family and carers (where consent has been given to involve them – see section 3.7). If the person remains unwilling to return to hospital, their decision should be respected unless there are concerns about potential harm to self or others; if there are, consideration should be given to contacting the local AMHP service to determine whether an MHA assessment is needed.

Healthcare staff should also listen to people detained under the MHA who are unwilling to return to understand why, and seek to encourage a voluntary return by explaining the benefits and any changes that could be made to their care in hospital to better support their needs. In many cases, this is successful. Where the person remains unwilling to return to hospital, returning the person without their consent, under Section 18 of the MHA will need to be considered. This section states that a person can be returned to hospital by an AMHP, hospital staff member, a police officer or any other person authorised in writing by the responsible clinician or hospital managers. If healthcare staff believe that they cannot safely return the person to hospital without police involvement, then the police should be contacted for assistance, with a clear explanation as to why their help is required. If a person is in a private dwelling and will not grant entry, an application may need to be made to court for a warrant under Section 135(2) to gain entry. Local processes should be in place for staff to make these applications; where they are not, advice may be sought from AMHP services, who may support using their knowledge of the Section 135(1) process.

Hospital providers should ensure that relevant staff have received training, guidance and support on the actions they should take when they locate someone who has absented themselves, in line with the locally agreed policy. This should cover:

- Roles and responsibilities of different services when a person who has absented themselves is located, including how to apply relevant parts of the MHA to people who are detained, namely Section 18, and Chapter 28 of the Code of Practice.
- Steps to return people who are and are not detained under the MHA.
- How to respond to people when they are located with compassion and understanding, in a way that meets their individual needs and seeks to understand why they absented themselves.
- How to use verbal persuasion to encourage people to return to hospital.
- Techniques to prevent and manage aggression, with a clear focus on ensuring that practice is least restrictive. Restrictive interventions should only be used to protect the person's or someone else's safety and wellbeing and use the least restrictive

means available, for the minimum time possible, as per inpatient service guidelines.
- When the police should be contacted to support the return of people to hospital.

Systems will need to consider the availability of mental health staff to support when people are located and with returning them to hospital, informed by data about the frequency of these situations. Local agreement should be reached on the circumstances in which it is the responsibility of inpatient services to respond, and when it is the responsibility of community or crisis mental health services. Where it is determined that additional staffing resource is required, ICBs should assess the funding implications and put plans in place to meet any additional resource requirements.

4.3.6 Actions when a person cannot be located

Where mental health services have exhausted all reasonable efforts to locate a person (see section 4.3.4), and critical concerns remain about the person's safety or wellbeing, or the person is detained under the MHA, the case should be referred to the police who can assess against local missing persons policies (which are not impacted by the NPA:RCRP).

Further information on missing persons procedures can be found in following guidance:

- The multi-agency response for adults missing from health and care settings: A national framework for England – produced by the NPCC, Home Office and the charity Missing People, supported by health, adults' social care and other partners.
- Statutory guidance on children who run away or go missing from home or care – produced by the Department for Education, and the accompanying flowchart showing roles and responsibilities when a child goes missing from care.

4.3.7 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform the approach to NPA:RCRP implementation:

- Number of people who have absented themselves from inpatient mental health services – broken down by whether the person was or was not detained under the MHA and whether they a) left from hospital buildings or grounds b) left while on escorted leave c) did not return from unescorted leave at the agreed time. This data should also be analysed by protected characteristics, including race, age, and whether someone has a co-existing physical health problem or disability, including a learning disability or autism.

- Details of how a person absented themselves (for example, how a person was able to leave hospital buildings or grounds), the reasons that people give for having left or not returned to hospital as agreed, and the suggestions they make for improving their inpatient mental health experience. This information should also be reviewed by multi-disciplinary members of the inpatient mental health provider, who should have a debrief after each case of a person absenting themselves.
- Number and proportion of people who have absented themselves who are reported to the police (broken down by protected characteristics), brief details of why each case was reported to the police, and the number and proportion of these cases that are accepted by the police - to inform joint learning about where it is warranted for the police to respond.
- How people are returned to hospital (via police or others), broken down by protected characteristics. If there is unwarranted variation in police involvement in returning people with particular protected characteristics, action should be taken to address this, working in partnership with people with lived experience from relevant groups.
- Use of restrictive interventions in inpatient mental health services, broken down by protected characteristics – to ensure that use does not increase to prevent people absenting themselves. Further information on recording restrictive interventions can be found in Section 6 of the statutory guidance on the Mental Health Units (Use of Force) Act.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to people who absent themselves are managed, the working group should discuss these and if they cannot resolve an issue, then it should be escalated following locally agreed escalation processes (see section 3.4).

4.4 Phase 3: Conveyance of people with mental health needs

People with mental health needs are regularly conveyed or transported between different settings, for example, from private addresses and public places to a health-based place of safety (HBPoS), from mental health hospitals to acute hospitals, and between mental health hospitals. We know that experiences of conveyance can be confusing, distressing and potentially traumatic, especially where restraint is used, as illustrated by these quotes from people with lived experience and staff (taken from the Ambulance Mental Health Commissioning Guide):

> “Need to remember that conveyance in itself is an extremely scary and anxiety-inducing experience.”

> "Sometimes patients are driven around for hours on end without being informed what was going on and with no toilet breaks, drinks or food provided."
>
> "Being cuffed in an ambulance is a painful and uncomfortable experience."

Use of police vehicles can further escalate people's distress and fear of what is going to happen to them, increasing the potential for harm and likelihood restriction or force will be used. We also know that there are inequalities in the use of police vehicles for conveyance that need to be addressed. For example, internal NHS England data indicates that in some regions Black people are more likely to be transported to an HBPoS in a police car.

The NPA:RCRP sets an expectation that all local areas will work towards ending the use of police vehicles for conveyance, aligning with Chapter 17 of the MHA Code of Practice, which states that when someone is transported to hospital, ambulance vehicles or similar should be used wherever practicable, with police officers supporting where required (17.14), and that transporting people in police vehicles should only happen in exceptional circumstances (17.15). A commitment was also made in the NHS Long Term Plan to introduce new mental health response vehicles (MHRVs) to improve the timeliness, quality, and experience of conveyance and reduce the use of police vehicles for conveyance. Up to 90 MHRVs will be in use by the end of 2024/25.

4.4.1 Aim of this section

This section suggests how local partnerships can work towards ending the use of police vehicles for the conveyance of people with mental health needs, recognising that Home Office data indicates that in 2021/22 nearly 50% of people held under a Section 136 were transported to a first place of safety in a police vehicle. It also suggests how conveyancing arrangements can be improved to deliver the best possible experience for individuals in distress, including through acting on inequalities.

4.4.2 Developing the right local model of health-based conveyance

Vehicle provision

A major part of delivering Phase 3 will be identifying the right model of vehicle model provision to meet people's needs and putting in place the required provision locally to enable timely access to health-based transport. To plan and deliver this provision, local areas will need to involve people with lived experience; AMHPs - given their central role in arranging and coordinating transport in relation to the MHA; commissioned ambulance providers (including local ambulance mental health leads); mental health providers; acute hospital providers; ICBs and the police.

Areas should begin by gaining a thorough understanding of the current vehicle provision used to convey people with mental health needs, including the reasons why police vehicles are used, and conduct demand and capacity modelling. Suggested areas to consider as part of demand and capacity modelling include:

- Types of health-based transport that are available locally to support conveyance of people with mental health needs (including ambulances, MHRVs and privately commissioned secure transport), their capacity to transport people, and whether this varies by time of day, day of week, or other factors.
- How frequently people with mental health needs require transport, and whether demand varies according to the time of day, day of the week or other factors.
- Frequency with which transport is required for individuals with additional needs, such as a physical disability, frailty, a learning disability or autism, or for those who have urgent physical health needs requiring medical attention.
- Circumstances in which transport is required and which vehicles are used in different circumstances, including:
    - Transporting people to hospital who have been assessed as requiring detention under the MHA; are going to hospital voluntarily for assessment and treatment; or will be admitted under the MCA (for those aged over 16) because they lack capacity to consent to admission and assessment or treatment and fall outside the scope of the MHA.
    - Transferring of people between hospitals – those detained under the MHA admitted under the MCA, or receiving assessment or treatment voluntarily. Transfers include situations where someone requires transport from an out of area hospital to a hospital closer to their normal residence.
    - Returning people to hospital who have absented themselves or not returned from leave when expected.
    - Taking people on a community treatment order or who have been conditionally discharged to hospital on recall.
    - Returning people who are subject to guardianship to the place their guardian requires them to live.
    - Taking people to and between HBPoS.
    - Taking people to and from court.
- The frequency with which, and the reasons why, police vehicles are used for conveyance, and the frequency and reasons for requiring police assistance where people are conveyed in health-based vehicles.
- Vehicle response times, including whether these vary by time of day, day of week or other factors, and whether they differ according to circumstances, such as providing transport to or from an out of area location.

Based on this modelling, local agreement should be reached about the right model of health-based vehicle provision needed locally to meet demand and offer good experiences to people requiring conveyance, drawing on the expertise of people with lived experience. This should include agreement on which health-based transport option is most appropriate in different circumstances (noting the concerns discussed below about some secure transport providers). It will also involve consideration of the response times in different circumstances.

For example, where a person is subject to police powers under Section 136 of the MHA ambulances aim to achieve an average response time of 30 minutes.

Any gaps identified between the current provision of health-based transport and the agreed model should inform commissioning decisions (for example, whether more MHRVs need to be commissioned) and any other actions required. ICBs should assess the funding implications and, if additional resource is required, plans put in place to meet these requirements.

Using privately commissioned secure transport services

In some areas of England, the commissioning of secure transport services has improved the timeliness of conveyance and reduced police involvement in the provision of transport. The CQC has however raised concerns about secure transport services, including that some lack knowledge about people's rights when detained, inappropriately use restraint and routinely transport people in safe spaces ('vehicle cages') without conducting a risk assessment of whether this is required. Further information can be found in the Ambulance Mental Health Commissioning Guide (Annex A).

If ICBs or mental health providers commission secure transport, due diligence is vital in managing the contract. In line with the NHS Standard Contract, all NHS commissioned services must be quality assured to ensure that subcontracting arrangements adhere to all national and any locally agreed standards. This includes ensuring that all uses of restrictive interventions are recorded and monitored. It is also good practice to involve local AMHP services, health providers (mental health, ambulance and acute) and people with lived experience in the tendering and contracting process and reviews of provision.

Secure transport providers that operate vehicles with safe spaces ('vehicle cages') need to register with the CQC, whereas those that do not have safe spaces are not necessarily required to be registered. Therefore, it should not be assumed that it is best to commission a registered provider, as safe spaces are highly restrictive and better alternatives are available, such as vehicles that separate the driver and other staff from a person who is highly distressed.

NHS England's Reducing Restrictive Practice Oversight Group (part of the Quality Transformation Programme) has recently commissioned the Restraint Reduction Network (RRN) to raise awareness of the experiences of people in inpatient settings who have been conveyed using secure transport, and how providers and commissioners can build on examples of good practice to improve care.

Workforce

Based on local demand and capacity modelling, areas will need to consider the staffing levels and mix (including in terms of male-to-female staff ratio) required to put in place the agreed conveyance model, with ICBs assessing the funding implications. Any gaps in the staffing required for the model to work effectively should be recorded, and actions identified to address them.

It is also crucial that all staff involved in the conveyance of people with mental health needs, whether working for an NHS service or a commissioned service, have the right skills to support people who may be experiencing significant distress. Without such skills, situations can escalate, resulting in avoidable restraint or police involvement. Services should work to ensure that staff have received training and are competent in the following areas, as well as those outlined in section 3.9:

- Understanding what drives mental distress and underlies mental health presentations, including where people are reluctant to be conveyed and appear distrustful, violent or aggressive.
- How to engage with people experiencing mental distress, quickly establish therapeutic rapport, offer choice and provide person-centred care, including where individuals have a learning disability, cognitive difficulties or are autistic.
- De-escalation and restraint reduction techniques to manage situations without use of restraint. This training should adhere to RRN standards, which include specific guidelines for the conveyance of people with mental health needs who may also have a learning disability or be autistic (see Appendix 24 of the standards).
- Appropriate use of restraint to manage violence and aggression, proportionate to the situation, as a last resort and for the minimum time necessary, in line with RRN standards. In particular, staff should understand that handcuffs (including 'soft cuffs') should not be used unless there is a legal justification for doing so, and their use needs to be reasonable, necessary and proportionate to the circumstances, including for the shortest time possible.
- Conducting live risk assessments (based on the risk assessment principles outlined in section 1.2), and putting in place contingency plans for the management of an escalation or incident during conveyance.
- Understanding roles and responsibilities under the MHA in relation to conveyance.
- Providing basic life support (at a minimum), but ideally intermediate life support, as this is recommended where staff may be involved in delivering rapid tranquilisation or using restraint.

The requirements for staff working for a commissioned secure transport service should be set out in the service contract and reviewed as part of quality assurance processes.

The NHS Learning Hub Mental Health Ambulance Service Education is an online repository of mental health training resources relevant to supporting people with urgent mental health needs.

4.4.3 Ensuring clarity about roles and responsibilities

Clarity is needed around the roles and responsibilities of different agencies for the locally agreed model to work. This is in line with the MHA Code of Practice (17.26), which states that local multi-agency agreements should be in place in relation to transporting people and these should set out the roles of each agency in relation to conveyance.

In implementing the NPA:RCRP, local agreements will need to be reviewed, with reference to Chapter 17 of the MHA Code of Practice and agreement reached on the limited circumstances in which the police should assist conveyance in ambulances or other health-based transport, and the exceptional circumstances in which police vehicles will be used to transport people; that is, where there is no viable alternative that is in the best interests of the person. For example, situations where remaining in the same location, such as by a motorway or bridge, could result in harm to them or others. The agreement on situations where police involvement in conveyance is warranted should be reached following a review of recent local cases where the police were involved.

When reviewing and updating local agreements, note that:

- The police have a legal power to take people held under Section 135 and 136 of the MHA to an HBPoS. As set out above, however, in most cases an ambulance or other health-based transport service should be used.
- For Section 136, the police officer who has exercised the holding power should arrange the health-based transport and escort the person to the HBPoS to facilitate the handover to healthcare staff (MHA Code of Practice, 16.41).
- For Section 135, the police may need to remain in attendance and support conveyance to an HBPoS, where it is agreed that police assistance is required, for example, to manage potential harm to the person or others

It is also important that the local agreement sets out:

- Communication channels between services involved in conveyance, including for requesting police assistance.
- Who is responsible for arranging and ordering transport across the range of circumstances in which transport can be needed, including who holds the budget and cost code for ordering privately commissioned secure transport, where this is used.
- How all staff, including frontline staff, can escalate concerns around how local arrangements are working, following locally agreed escalation processes (see section 3.4).

The updated local agreement should be communicated to all staff across agencies that have a role in the conveyance of people with mental health needs and reinforced by service leads and those in senior leadership roles.

4.4.4 Improving experience of conveyance

A person's needs for transportation will often be at a time when they are experiencing substantial distress. While the NPA:RCRP does not change the way conveyance is undertaken, beyond the aim of working towards ending the use of police vehicles, it presents an opportunity to improve the quality and experience of conveyance by making sure it is least restrictive, meets people's individual needs, and makes people feel safe, supported and treated with kindness and empathy. It also involves identifying any inequalities in the way that people are conveyed, including the potential role of discrimination and racism, and taking steps to address these inequalities.

Local areas should work with people with lived experience, including people from racialised and ethnically diverse communities, to determine what actions can be taken locally to improve experiences of conveyance. Information to support this process can be found in Chapter 17 of the MHA Code of Practice and NHS England's Ambulance Mental Health Commissioning Guide; and the suggestions here:

- Identify what could help the person to feel more comfortable during conveyance, through reviewing their electronic record (including any advance choices recorded) and speaking to them and their family and carers (where the person has consented to involving them in their care, see section 3.7). The person's individual mental and physical health, sensory, cultural and communication needs (such as whether someone is a non-English speaker or non-verbal) and any needs related to the person's age should be considered, as well as understanding what worked well and less well during any previous conveyance.
- Enable a person's family member or carer to travel with them to provide reassurance and support and to help communicate the person's needs and preferences. In addition, it can be helpful to have a family member or carer meet the person at the destination. Where there is a specific reason why a person's family member or carer cannot travel with the person (for example, a safeguarding concern, individual preference), a mental health staff member, who is not the driver, should travel with the person to provide support and reassurance.
- Explain to the person in a way they can understand, where they are going, why and what will happen on arrival, and continue to communicate with them about how the journey is going and how long it will take to reach the destination. It may help some people to track the journey themselves on an electronic device (for example, a mobile with GPS).
- Plan what to do if the person needs to use the toilet or requires a comfort break during the journey, particularly on longer journeys and/or if the person has a physical health need or disability.
- Ensure that adequate water or other refreshments are available, particularly for longer journeys.
- Give the person the option to play sound during the journey (for example, music, a podcast or an audiobook), or to have a quiet environment. Autistic people or those who have other sensory needs may want to wear ear defenders to block out sound, including vehicle sirens.

- Allow people to bring possessions with them that they find calming and help to meet sensory needs, and anything else they would find useful or need in hospital, including glasses or hearing aids.
- Ensure that where a person has been sedated or received rapid tranquilisation before conveyance, they are accompanied by a healthcare professional who can identify and respond to any physical distress or complications and has access to the necessary emergency equipment to do so (usually requiring conveyance in an ambulance). If a person has other physical health needs, steps should be taken to provide the appropriate physical health support.
- Ensure that healthcare staff meet the person on arrival at their destination and that there is a process in place for the prompt handover of information about their care, so that the person can move from the vehicle into the onward care setting without delay. The information handed over should include the reasons for/circumstances around conveyance, information from the person's care plan (including any immediate potential harms), information about dose and timing of any medication, and information on any restrictive intervention used as part of conveyance, which may affect the person's care needs.

4.4.5 Reviewing progress with implementation

We recommend that the following measures are collected, analysed and used to inform the approach to NPA:RCRP implementation:

- People's experience of health-based conveyance, by vehicle type – to understand whether people feel that conveyance is done in a therapeutic, supportive, least restrictive and safe way, and what could improve the experience. These measures should be collected after people have had a chance to settle and can reflect on their experience (that is, not when they are highly distressed or unwell) and there should be a particular focus on collecting information from groups who face inequalities in the urgent mental health pathway. Data should also be collected on people's experience of conveyance in commissioned secure transport, and this should be reviewed as part of contract management.
- Number of times people with mental health needs are conveyed, where conveyance is to and from, the vehicle type used (including police vehicle) and vehicle response time. This should be broken down by protected characteristics, such as race, age, and whether someone has a co-existing physical health problem disability, such as a learning disability or autism, and any other relevant inequalities.
- Reasons why police vehicles were used for conveyance, the proportion of such conveyances where the ambulance service was contacted before the police undertook the conveyance, and if not, the reasons for this.
- Use of restraint during conveyance, broken down by type of restraint (including mechanical restraint using handcuffs or 'soft cuffs') and by protected characteristics. The reporting of this data should be a requirement of the contract of commissioned secure transport services, and it should be reviewed as part of contract management.

In particular, cases where police vehicles are used for conveyance should be regularly reviewed to inform ongoing work to reduce its frequency. Action should also be taken to

identify and address any unwarranted variation in the use of police vehicles in relation to any protected characteristic, working in partnership with people with lived experience from relevant groups.

Where data monitoring indicates any issues with the approach to implementation or other concerns arise in relation to conveyance, the working group should discuss these and if they cannot resolve an issue, then it should be escalated following locally agreed escalation processes (see section 3.4).

4.5 Phase 4: Timely handovers to healthcare following use of Section 136

Section 136 of the MHA gives police the power to remove a person from a public place to a place of safety (or to keep them in a place of safety if they are already at one) for up to 24 hours, or 36 hours with an extension, for the purpose of completing an MHA assessment and making any necessary arrangements for the person's treatment or care. This power, which does not require a warrant, can be used if the person is in any place other than the house, flat or room where they live, appears to have a "mental disorder" and be "in need of immediate care or control", and the police think it necessary to exercise the power in the interests of that person or for the protection of others. Before using this power, where practical to do so, police officers are required to consult a registered medical practitioner, a registered nurse, an AMHP, occupational therapist or paramedic. Chapter 16 of the MHA Code of Practice provides further details on police powers and places of safety.

Although the NPA:RCRP sets the threshold for the police response to mental health cases (see section 1.2), this does not affect the threshold for decision-making in the application of Section 136. Police officers in control rooms use the NPA:RCRP threshold to decide whether the police are the right agency to respond at the point the public or other professionals contact them, while it is for police officers at the scene to decide whether to use Section 136.

The NPA:RCRP sets an ambition for health systems to work towards enabling the police to complete handovers of care within 1 hour of arrival at a place of safety, unless mutually agreed otherwise on a case-by-case basis. Currently police officers can spend significant time waiting to handover care – The Policing Productivity Review estimated this to be around 800,000 hours annually – and often during this time people with mental health needs will not be receiving specialist care. In most circumstances, police should seek to handover care at a HBPoS; a definition of which is provided in section 4.5.2 rather than at an ED or other place of safety.

While it is best for a person in mental distress to start receiving care from a health professional as soon as possible, achieving prompt handovers should not be put ahead of

providing compassionate treatment and ensuring the safety and wellbeing of the person, staff, or other members of the public.

4.5.1 Aim of this section

This section provides information on what health systems can do to reduce handover times and improve the experience of handover for people who are held under Section 136.

While we use the term ‘handover’, people with lived experience and their carers can find it dehumanising. It is important that the transfer of care and support between agencies is done in a caring and humane way, with the needs of the person given priority over the completion of paperwork. Wherever possible, handovers should be done in an environment that is designed for people in crisis, and not one that is busy or noisy. This is particularly important for people with sensory needs, including autistic people and people with dementia.

This section also outlines how healthcare services can support the police in reducing the use of Section 136, including by supporting officers’ decision-making about when to use Section 136 powers and providing advice on alternative care pathways. Reducing the use of Section 136 will likely improve handover times due to creating increased capacity within the system, as well as improving people’s experiences of care.

Section 136 is the MHA power that the police use most frequently and one that can result in long handover times between the police and health services, and as such is the focus of this section. However, many of the recommendations are also applicable to Section 135. Section 135 allows the police, once they have obtained a warrant, to enter a person’s home and take them to a place of safety (or keep them at a place of safety if they are already in one) so that an MHA application can be made, or other arrangements made for their treatment.

4.5.2 Health-Based Places of Safety (HBPoS)

MHA legislation sets out the locations that can be used as a place of safety. This allows for local flexibility to respond to different situations and to identify the place of safety that best meets the needs of the person in crisis. However, DHSC and Home Office guidance is clear that, with limited exceptions, the most appropriate place to take the person to is a dedicated, mental health-based HBPoS. Where available, HBPoS generally provide a more therapeutic environment for people in crisis, better access to suitably trained mental health professionals and handover times from the police to healthcare services are typically quicker. One important exception is that people with an urgent physical health need should be brought to an ED.

Increasing numbers of people held under Section 136 are being brought to EDs, even when they do not have an urgent physical health need; increasing to almost 40% over the past 5

years according to Home Office data (with HBPoS used in 58% of cases). This is often because HBPoS are at capacity. Adequate HBPoS capacity is vital in all areas as this makes a crucial difference to how long police officers spend with a person before their care and support is handed over to health services, and reduces pressure on EDs. Good access to community-based crisis care and inpatient mental health services is equally important, so that following assessment at the HBPoS, the person can be swiftly transferred to onward care. ICBs should assess the funding implications and if additional resource is required, determine how this will be met.

4.5.3 Development of local handover protocol

Local areas should develop or review their Section 136 handover protocol in light of the NPA:RCRP, in partnership with local health services, police forces and social care partners. Consideration should be given to:

- Compliance with the ruling on Webley v St George's Hospital NHS Trust (2014). This sets out good practice principles for safe and effective handovers from the police to health services. This includes that police officers have a duty to:
  - Take reasonable steps to ensure that the person does not come to physical harm while in their custody.
  - Take reasonable care only to release the person into a safe environment.
  - Provide relevant information to those into whose care the person is transferred, including the circumstances for holding someone under Section 136.
- How HBPoS and ED staff should confirm to the police that they are willing and capable of accepting the person. The police should remain with the person until HBPoS or ED staff have accepted responsibility for their care. The protocol should set out the actions that should be taken where the police would like to handover care, but HBPoS or ED staff do not feel this is safe, including using local escalation processes (see section 3.4) to swiftly resolve any differences of opinion.
- The types of circumstances in which the police may be required to remain in attendance beyond 1 hour. In an HBPoS, unless staff request this due to the individual circumstances of a case, the police are not expected to remain once the handover is completed. In EDs, which are generally less secure environments, the ED should determine if it is safe for the person and healthcare staff to accept legal responsibility for the individual or if police officers may be required to continue to provide support.
- Escalation where there is an unwarranted or exceptional delay in handovers from the police to health services. Processes should be in place to review handover times and address any challenges to timely handovers.
- Steps to ensure timely handovers from other providers involved in the transportation of people held under Section 136. For example, the NHS Standard Contract (Annex A – National Quality Requirements Ref E.B.S.7) sets out quality standards for handovers between ambulance and ED. The aim is for handovers to be completed within 15 minutes (100% within 60 minutes, 95% within 30 minutes and 65% within 15 minutes).

4.5.4 Supporting a reduction in use of Section 136, where appropriate

There will continue to be cases where it is appropriate for police officers to use Section 136 powers and their use should not be avoided altogether. However, apart from 2022/23 when there was a 3% decrease, Home Office data shows that there has been a sustained year-on-year increase in use of Section 136 powers. It is important that there is continued growth in community-based crisis support, which can support people in crisis without police involvement, therefore helping to reduce the number of Section 136s. In turn, with fewer Section 136s issued, this can help to improve handover times.

Considerations for enabling an appropriate reduction in the use of Section 136 include:

- Embedding joint working models that reduce unwarranted use of police powers and enable timely access to appropriate support when powers are used. Review existing models of partnership working between the police, health and social care services in relation to responding to people with urgent mental health needs and consider how they can be strengthened. For example, the Bristol, North Somerset and South Gloucestershire (BNSSG), Mental Health Integrated Access Partnership has helped reduce police deployments and use of Section 136 as well as ensure that people only need to tell their story once when accessing physical and mental health services.
- Supporting police access to specialist mental health advice about use of Section 136. As set out in Section 136, where practical to do so, police officers are required to consult with a registered doctor, nurse, AMHP, occupational therapist or paramedic, before keeping someone in, or taking someone to, a place of safety. This function is often achieved through professional advice lines, which police officers call for information about alternative sources of mental health support, such as crisis cafes, sanctuaries and crisis houses, and, for people known to services, guidance about how best to support the person, based on their care record, including information from their crisis/safety plan. The partnerships set up to implement the NPA:RCRP should review data on uptake of this advice before holding people under Section 136, and address any issues with police accessing this support or using the information in their decision-making.
- Reviewing cases of people held under Section 136 to improve crisis pathways. For people already known to mental health services, who experience a crisis that leads to police involvement, systems should seek to understand whether they should have received earlier intervention, and whether any additional provision is needed within the local care pathway to support people to stay well and not reach the point of crisis. For example, all areas should ensure that their community-based mental health care and crisis care is accessible via the NHS111 ‘select mental health option’ and sufficiently responsive.
- Understanding variation in the use of Section 136 by analysing data by protected characteristics, and taking steps to address any unwarranted variation. For example, at a national level, we know Black people are disproportionately likely to be held under Section 136 (see Home Office data). The cultural appropriateness of the community mental health may need to be improved through working with VCFSE organisations that are ethnic-led and/or support ethnic minority

communities. This is in line with the PCREF, implementation of which is mandatory for all mental health trusts by the end of 2024/25.

4.5.5 Managing demand for and capacity of HBPoS

Effectively managing the demand for, capacity of and onward flow from HBPoS will enable timely police handovers. Demand may depend on time of day, day of week and other factors.

Some suggested actions in relation to this include:

- Analysing data to understand the HBPoS capacity required to meet demand, requirements for 24/7 staffing, and the reasons why HBPoS reach full capacity (for example, waits for inpatient admissions). Data should also be analysed to identify how frequently people require urgent assessment or treatment of physical health needs alongside mental health support – these people will need to go to the ED as an HBPoS would not be appropriate. Additionally, an assessment should be made of how often children and young people require an HBPoS. Any gaps identified between the current provision of HBPoS and the agreed model should inform commissioning decisions and any other actions required. ICBs should assess the funding implications and if additional resource is required, consider how this can be met.
- Developing arrangements to coordinate the use of HBPoS. Local areas should have systems in place to advise police officers of the closest HBPoS that has capacity to receive someone. This could be achieved through police contacting the HBPoS duty nursing officers or professional advice lines (described above). To work effectively, HBPoS coordinators will need access to real-time HBPoS capacity. Systems may also wish to explore local agreements for neighbouring HBPoS to share capacity, particularly at times of peak demand, noting that where such agreement exists, the police should only take a person to a HBPoS in a different locality if a healthcare professional agrees this is in the person's best interests.
- Improving the timeliness of MHA assessments to reduce the time an individual spends in an HBPoS by:
    - Analysing data to understand frequency and patterns of demand for MHA assessments across the ICB and using this to plan Section 12 doctor and AMHPs staffing. Good practice suggestions in relation to Section 12 doctor availability can be found via this FutureNHS link.
    - Ensuring HBPoS staff notify the local AMHP service of the need for an MHA assessment as soon as clerking and an initial check of the person's needs (which may show there are reasons to delay the assessment, for example, the person being intoxicated or having urgent physical health needs) is completed. The HBPoS should also give the AMHP service a named contact who can provide further information, if required.
    - Developing cross-border agreements to clarify responsibilities between neighbouring areas, to avoid situations where there can be a difference of opinion about who should conduct an MHA assessment when a person is taken to an HBPoS outside the area they live.
- Using data to identify how often and in what types of cases handovers from the police to health services cannot be completed within 1 hour (ensuring data is

pseudonymised/anonymised). This can pinpoint the challenges in staffing and demand that need to be addressed and inform discussions with the police about the types of situations in which it is appropriate for them to remain in attendance.

- Commissioning services to support the running of HBPoS. For example, Hampshire and the Isle of Wight ICB delegates the coordination of their HBPoS to its commissioned secure transport provider, which works in partnership with the mental health trust to manage HBPoS occupancy and provide support within it. Police officers contact the secure transport provider directly to arrange conveyance and handover of the person to the HBPoS. In other areas, VCFSE or peer support services provide a dedicated support worker who can sit with the person while they wait for assessment or onward care.

4.5.6 Improving experiences of HBPoS and EDs for people held under Section 136

Implementation of the NPA:RCRP presents an opportunity to consider what improvements can be made to improve the experiences of people when they are held under Section 136. We recommend that services work with people with lived experience to do this. Below are suggested areas to consider; see also the CQC A Safer Place to Be report:

- Reviewing the environment to identify improvements that can be made to help people feel as safe and comfortable as possible within it, including providing facilities that are age appropriate (for example, chairs that are not too low for an older person) and meeting the needs of people with a range of mental health, physical health, sensory and communication needs.
- Ensuring staff working with people held under Section 136 have the right skills and access to relevant support and training – with training ideally co-delivered by people with lived experience. People working in HBPoS should be trained and competent in:
  - Supporting people who are in acute mental health crisis, in a way that is trauma-informed, compassionate and person-centred.
  - Using de-escalation and restraint reduction techniques to manage situations without the use of restrictive interventions. This training should adhere to RRN standards, which include specific guidelines for people with mental health needs who may also have a learning disability or be autistic (see Appendix 24 of the standards).
  - Providing age-appropriate care to children, adults and older adults. HBPoS staff are often adult mental health practitioners and it is particularly important that they are able to apply contextual safeguarding principles and understand the role of the network around a child or young person. MHA assessments should also be conducted by clinicians who specialise in working with children and young people.
  - Providing culturally appropriate care to people from racialised and ethnically diverse communities who are in crisis, for example, understanding different cultural descriptions or interpretations of symptoms and enabling access to interpreters.
  - Recognising the needs of people with a learning disability and autistic people and how to adjust care to meet these needs. At a minimum, mandatory Oliver McGowan training must be completed.

    - Providing appropriate care to people from the LGBT+ community, including using inclusive language.
    - Supporting people who are intoxicated with drugs or alcohol, and recognising when people have acute physical health needs that require medical attention. To support this, staff should have completed basic life support training and have access to emergency first aid equipment.
- Ensuring HBPoS staff have access to health records to understand the needs of people brought to the service and to record information about the diagnosis, treatment and care of individuals. Where possible this should include access to both primary and secondary care records. Having this information will help staff to put the right support in place as quickly as possible to minimise a person's distress and can also facilitate faster handover of care from the police.
- Ensuring the person's needs and preferences shape decisions about their care. Staff should discuss care needs and preferences with the person and the family and carers that they have consented to involve in their care (see section 3.7). Care notes should also be reviewed, including the content of any crisis/safety plans and advanced directives, which should be followed as far as possible.

4.5.7 Additional considerations when EDs are used as a place of safety

Many of the above points are as applicable to EDs as to HBPoS. However, EDs are generally a less therapeutic environment in which to receive people, and when used as a place of safety, there are additional considerations to ensure people receive the best possible care. Good practice suggestions include:

- Ensuring a senior ED doctor, the nurse in charge and, if possible, a member of the psychiatric liaison team meets with the police to obtain information about the circumstances of the individual's detention, presenting risks and any physical health needs. The handover from police to health services should be completed in line with the local handover protocol (see section 4.5.3) and all legal duties. Should a member of the psychiatric liaison team not be present at the initial handover (and this team are part of the local Section 136 pathway), ED staff should facilitate the subsequent handover to this team by giving them the information obtained from the police along with that from the initial ED assessment.
- Ensuring that as soon as the person arrives in the ED, a referral is made to the local AMHP service for an MHA assessment (unless there are factors such as urgent physical health needs or intoxication, which means that it is best to delay assessment). The ED should provide a named contact, who the AMHP service can liaise with for further formation, if required, and communicate the information provided by the police officer to this service.
- Ensuring that an urgent joint review takes place between emergency medicine and the psychiatric liaison team if police officers have applied mechanical restraint (such as handcuffs or leg restraints), to determine whether the mechanical restraint can be ended immediately. If it is not safe to do so, procedures set out in Chapter 26 of the MHA Code of Practice should be followed.
- Using de-escalation strategies if a person's agitation or aggression is such that the police cannot safely handover and leave, with restrictive intervention (including rapid tranquilisation) only used as a last resort to protect a person's safety or wellbeing,

after other strategies have not worked. If restrictive intervention is used, the person will need to be monitored, and its use documented.
- Ensuring the psychiatric liaison team liaise with ED staff to decide whether it is in the person's best interests to be transferred to an HBPoS once capacity becomes available and/or after physical health treatment has been provided.
- Minimising the use of hospital security for undertaking observations. As set out in section 4.2.2, every hospital should have provision or develop plans for in-house observation by appropriately skilled and trained staff (in conjunction with hospital security where there is risk of violence), with systems working towards ending the use of hospital security for observations.

Services can use the Royal College of Emergency Medicine guide to Section 136 for EDs to develop and improve their processes for handling Section 136 cases in the ED. See also section 4.2.2 of this guidance for information on providing good care to people with mental health needs in EDs.

An initiative being trialled in West Sussex is to situate AMHPs in the ED to conduct MHA assessments following referral, working in partnership with the psychiatric liaison team. This is reducing waiting times and enabling earlier handovers from the police.

4.5.8 Reviewing progress with implementation and responding to escalations

We recommend that the following measures are collected, analysed and used to inform NPA:RCRP implementation, with each broken down by protected characteristics (such as race, age and whether someone has a co-existing physical health problem disability, a learning disability, or is autistic), and any other relevant inequalities:

- Number of uses of Section 136 and the proportion involving people already receiving support from mental health services.
- Number and percentage of cases where police sought advice from a mental health professional before holding a person under Section 136.
  - If advice was sought, the number and percentage of cases where the outcome was and was not use of Section 136.
  - If advice was not sought, the reasons it was not practical to do so.
- Length of time that a person is held under Section 136, handover time from police to health services, and the reasons for any handover times being longer than 1 hour.
- Utilisation levels of each HBPoS, including whether the people taken to an ED required treatment for an urgent physical health need or not.
- Number and percentage of people held under a Section 136 who following an MHA assessment go on to:
  - Be detained in hospital, and where they are not, the reasons for this.
  - Receive community-based crisis care.
- Time to allocate a mental health inpatient bed, where an MHA assessment following Section 136 indicates that this is required.

Agreement will need to be reached between the police, AMHP and health services on who is best placed to collect which metrics and how data will be shared across agencies in a way that complies with data protection legislation and confidentiality duties (see section 3.7).

Multi-agency partners should monitor these measures and review any escalated cases, with a view to informing continuous learning and improvement on the use of police powers, including reducing any unwarranted variation by any protected characteristic; improving people's experience of handovers; and reducing handover times.

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