Mental vulnerability and illness

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Early police recognition of the possible mental health problems, learning disabilities or suicidal intent of people they come into contact with is crucial to ensuring an appropriate and effective response. This is true whether the matter requires a criminal justice response, a social or healthcare response or a combined response. This section of guidance examines the process of identifying and assessing the vulnerability of an individual who has come to police attention.

Decision making

All police decision making on the most appropriate course of action under any circumstances should be guided and structured using the **national decision model (NDM).**

Decision making concerning health care matters should be made by clinically trained professionals and not police officers. When police officers are called to respond to a situation involving a mentally vulnerable person, it is important that they have access to relevant information that may inform risk management. They should seek guidance from healthcare professionals where appropriate. Police actions and interventions should be proportionate to the requirement, using the least restrictive means to protect the safety of the individual, the public and themselves, and to prevent crime.

Officers should also consider the possible explanations for an individual's behaviour, including physical illness, injury or neuro-disability, mental ill health, a learning disability and intoxication (caused by medication, illicit drugs or alcohol). Mental health problems and illness exist along a continuum of severity and even those with severe and enduring mental illness may have episodes of functioning very well and may have episodes of crisis.

Gather information and intelligence

The first stage of the NDM requires that officers and staff consider all available information and intelligence that is available to them before deciding on a course of action.

The quantity of available information concerning the risks and medical considerations that relate to any individual is likely to vary depending on the circumstances of each incident. It is appropriate and helpful for officers to be provided with all potentially relevant information by force call handling operators before they arrive at an incident or as soon as possible on arrival.

Force control or contact room supervisors should have knowledge of the **Data Protection Act 1998**, and be confident in applying this knowledge so that they can access and provide relevant information to response officers. This is particularly relevant when officers require medical information about a subject, and it is necessary for operators (or officers) to seek this information from NHS partners (see Medical records). Officers may also be able to gather crucial information from the subject, other professionals and members of the public at the scene.

Sources of information

Useful information may be available or sought from:

- the subject (the individual may be the best source of relevant information concerning their health, medical needs, and established support network – see The individual as an information source)
- the person who reported the incident
- any medical professionals on scene (or associated with the individual)
- next of kin, family, friends and known associates – see Information from parents, carers, family and associates
- local street triage/community or mental health nurse/crisis services for the area
- the local mental health trust unit/GP/relevant local clinic (if known)
- NHS medical record database (RIO) via approved mental health professional (AMHP)/community nurse/mental health unit/hospital
- children and adult social care services
- appropriate adult services
- liaison and diversion unit
- police information systems, including:
  - PNC (Police National Computer)
  - PVP (Police Vulnerable Person database – if available)
  - PND (Police National Database)

- ViSOR (Violent and Sex Offender Register – also known as the Dangerous Persons Database)
- local information or intelligence databases (consider that the individual may have also provided an advance statement)

- CCTV

For further information, see the national framework and principles for managing information for policing purposes which is set out in the **authorised professional practice (APP) on Information Management**.

The individual as an information source

People experiencing mental ill health or other vulnerable people who may not understand or correctly interpret police efforts to communicate are at increased risk of not having their immediate needs adequately met.

When the police are in contact with people who are mentally vulnerable, have mental ill health or learning disabilities, the most important source of information will be the individuals themselves, some of whom will carry information about their circumstances and needs. In many instances, the individual may be able to provide the name and details of those who should be contacted if they need assistance.

Crisis or medical information cards and services

‘Crisis cards’ or other information cards are sometimes carried by people who have communication difficulties or who may find it difficult to communicate when in a crisis. The cards provide a range of information, from personal details of the individual and those of a trusted person to be contacted in a crisis or emergency, to advice on how to respond to and communicate with the individual (for example, details of approaches a person finds helpful to alleviate distress).

In some areas, the distribution of information cards has been a police-led initiative. These schemes have clear advantages for the police (for example, reducing the time needed to deal with a particular situation, and providing the most appropriate support for vulnerable individuals in the community). Officers and staff should be aware of any local use of crisis cards. Where this work is being led by partner agencies, it may be beneficial for forces to be involved in their design and

management so that the information remains up to date and can be as useful as possible to all parties.

A number of police forces currently use other types of communication aids, including:

- Picture Exchange Communication System (PECS) – (for communicating with children with autism spectrum disorders)
- Autism Attention Card Scheme (for example, Autism Cymru in partnership with each of the four police forces in Wales)
- Keep Safe cards (for example, Leicester Learning Disability Partnership Board)
- Head/Brain Injury card (for example, Headway Brain Injury card scheme)

A list of force's vulnerability identification schemes is provided by that **National Appropriate Adult Network**. The absence of such a card does not mean that the individual does not have a particular disability or support need.

Equally, police officers and staff should recognise that individuals may not know that they have a disability or support need. Some individuals will be reluctant to volunteer information or will actively try to hide their disability or support need for a range of reasons – see Behaviour.

Research suggests that respectful communication and active listening techniques are some of the most effective ways of interacting with mentally vulnerable people.

Active listening skills

The use of 'active listening skills' refers to officers paying careful attention to the intent and content of an individual's communications through use of a range of techniques (such as mirroring, paraphrasing, emotion labelling and use of open-ended questions) to demonstrate an understanding of their needs.

Research has indicated that these skills may be useful for interactions involving individuals in mental health crisis (Castellano-Hoyt 2003) and those with suicidal intent, for example, suicide by cop incidents (Sarno and Van Hasselt 2014).

Further research by Castellano-Hoyt (2003) and Ireland (2011) has also suggested that adopting a slow pace of conversation, asking simple questions and giving the person sufficient time to respond

may be useful for interacting with individuals with depression, autism or learning disabilities. Another research study by Lipson and others (2010) reports that telling a delusional person that, although sceptical, you want to listen to their accounts and understand how their beliefs may justify their actions, may help de-escalate such situations.

Go to **Communication**.

Supporting interactions with people with learning disabilities

The Foundation for People with Learning Disabilities has produced a range of guides to support frontline staff working within criminal justice roles. They are:

- **how to spot signs that a person has a learning disability**
- **finding out about other services that may help**
- **communication**
- **making information easier to read**
- **making appointments**
- **making decisions**
- **useful information and resources**

See further information from the **Foundation for People with Learning Disabilities**.

Information from parents, carers, family and associates

Parents, carers, family or others who know the individual experiencing mental ill health or with learning disabilities can be an important source of information and support in a range of situations, for example:

- where the police are trying to identify the person's needs
- where an individual is in crisis or otherwise has difficulties communicating
- when the police are planning action involving the individual, for example, assisting healthcare professionals by using police powers under the **Mental Health Act 1983 (MHA 1983) s 136**

Consulting people who know the individual well, and asking them about things such as the best way to approach the person, their habits, or the layout of their home, is likely to help the police deal with the situation in a way that causes as little added distress as possible. An attitude that is empathetic and considerate is likely to gain the person's trust and cooperation and achieve a better outcome.

Where possible, the police should seek the views and consent of the individual in question to interact with their parents, carers, family and associates. Police officers and contact management staff should be aware that the people providing information may also require support and advice about what is happening and why, and what they can expect from the whole process.

It is also important to be honest, factual and not to make promises when communicating so as not to set unrealistic expectations. For example, saying ‘we will take you to hospital where you will get help’ may lead to people feeling rejected when they are assessed at hospital and then discharged. A more factual explanation might be, ’we will take you to hospital to be seen by a mental health professional and you can talk to them about what support you need’.

Consent

Before seeking information from other people, the police should, wherever possible, obtain the subject’s consent. There may be various reasons why someone would rather certain people were not involved. A case of domestic abuse, for example, where the parent or carer is suspected of being the offender, may make it inappropriate to contact that person. Even with consent, the police should take care with what they reveal about the person to others.

In exceptional circumstances, the police do not have to obtain an individual’s consent for obtaining or sharing information. These circumstances might include:

- fulfilling statutory duties relating to protecting the individual and others
- if, through seeking consent, the police would hamper the prevention or investigation of a serious crime
- if seeking consent would put a child at risk of significant harm or an adult at risk of serious harm (Go to **Common law**)

Police information systems

Where appropriate, officers and staff should check national and local information systems for information on individuals with, or thought to have, mental health problems or learning disabilities. These include the local police incident management system, PNC, PVP databases, PND and ViSOR. Searches should be in accordance with the **APP on Information management**.

Warning and information markers should be kept up to date as far as possible, and should be reviewed and amended whenever new information comes to light. For example, this could be following assessment of an individual while in police detention or via an information submission from a partner agency.

Other agencies

Many people with mental ill health or learning disabilities will be known to statutory health and social care agencies and/or voluntary agencies dealing with mental health problems. These agencies are a useful source of information for police officers fulfilling any statutory function.

Mental health carers and support workers in the community (for example, those working for Mind) may also be able to advise. They may be able to provide insight if the subject is not able to articulate their needs and there are no family or other close associates available.

While many people will be known to services, there are many who will not be known. Not being known to services does not mean that an individual does not have a disability or support need.

For information on multi-agency information sharing agreements go to **Multi-agency working**.

Medical and social care records

Medical and social care records may be an appropriate source of information. Officers and staff may request relevant information where the requirement is proportionate to the prevailing risks and necessary to enable an appropriate response to the individual's needs (go to **'Need to know' information**).

Officers may be able to access useful information relating to existing health and social care arrangements. Information may be available via existing street triage or crisis response team mechanisms locally, via liaison and diversion teams, or directly from the local mental health unit, GP surgery facilities and social care teams.

When dealing with an individual who is suicidal or someone who lacks the capacity to make a decision in their own best interests, the nationally agreed **Consensus statement on information sharing (2014)** provides a basis for healthcare professionals to share relevant information with the police (and others) when it is in the subject's best interests. This statement has been developed so that clinical confidentiality is not a barrier to effective assessment and communication between

public bodies.

Contact information

Police forces should identify relevant local multi-agency services to facilitate appropriate signposting and referrals and ensure that officers and staff have access to adequate and up-to-date information. This includes contact information for key agencies, such as appropriate adult providers, managers of community mental health teams, managers of community learning disability teams, mental health units and places of safety.

Options include working with local partner agencies to produce an electronic contact directory of the relevant agencies available to provide support and services to people with mental health issues or learning disabilities in a particular force area. Where possible, this should include the contact details of individual practitioners. Such a resource may already exist, for instance, in the local witness care unit, liaison and diversion teams or in force control rooms.

Communication

The police should consider how their presence, attitude and demeanour may influence a person's reaction when approaching a member of the public for any reason. This reaction will have an impact on subsequent risks to officers, suspects and the public.

Any contact with members of the public requires good communication techniques. These may need to be adjusted when dealing with people experiencing mental health problems or who have learning disabilities. In particular, police officers and staff should be aware that difficulty with communication is a defining feature of having a learning disability.

Guidance on foreign language and cultural requirements are available in **Equality and individual needs**.

Help in facilitating communication may sometimes be necessary. Officers and staff can seek assistance from:

- parents, family and carers
- an intermediary (for a witness)
- an appropriate adult (for a suspect)
- a mental health professional, learning disability nurse or other relevant professional

- someone who knows the person well
- a specialist adviser (as in a hostage or firearms situation)
- a specialist voluntary agency

Officers should, however, be mindful of not excluding the subject from conversation or decision making in favour of a carer, intermediary or advocate unless their needs demonstrate that this requirement exists – see **Mental capacity**.

The **Bradley Report (2009)** and the **Independent Commission on Mental Health and Policing (2013**) reports into mental ill health and policing recognise that there have been recurrent failings in the level and style of communication between police officers and people with mental ill health and vulnerabilities. The reports suggest that this may have led to the disproportionate use of force and traumatic experiences for these people.

Attitude, patience and empathy

Effective communication can increase the availability of information from the individual (concerning their illness or disability and the rationale for their behaviour) and improve risk management by enabling informed decision making. This is valuable information if an individual intends to self-harm or take their own life, or if there are immediate safety concerns for the public.

How can communication style be improved?

Research has indicated that police officers who participate in training programmes that emphasise verbal (for example, word choice, tone of voice) and non-verbal (for example, facial/body language, demeanour) de-escalation skills felt these were worth implementing in their daily work (Hanafi 2008). The officers believed that these skills would help them put individuals in mental health crises at ease and reduce the risk of injury to both parties (Silverstone and others 2013).

Qualitative and survey research has identified the following communication techniques as being potentially effective during interactions between police officers and people with mental health conditions:

Less coercive forms of communication

Livingston and others (2014a) found that people who perceived the police as being less coercive when communicating with them were typically more satisfied with their interactions and more likely to think they had been treated fairly and with respect.

Practitioner experience suggests that compliance is negatively affected and risk levels may increase when the communication style becomes negative or patronising.

Compassion

Research by Watson and others (2008) found that people with various mental health conditions were more likely to be satisfied with their police interactions when officers were compassionate and respectful, taking extra time to show concern, check their welfare and talk to them, putting them at ease. Additionally, people believed officers should demonstrate these skills more when interacting with them (Livingston and others 2014b).

Active participation

People were more likely to be satisfied when officers directly communicated with and involved them in the interaction, allowing them to ‘have a voice’ to explain their version of events (Watson and others 2008; Gregory and Thompson 2013).

Patience

People recommended that officers should interact with them in a patient and calm manner to show they are there to help (Watson and others 2008).

Why is this important?

The research on police communication with people with mental ill health is consistent with wider evidence on ‘procedural justice’, which emphasises the importance of the police making fair decisions and treating people with respect. (Mazerolle et al 2014; Sunshine and Tyler 2003; Tyler 2003).

There is a substantial body of research to suggest that fair decision making and respectful treatment of the public by the police helps foster police legitimacy. This increases people’s willingness to cooperate with the police and to not break the law. By using the approach outlined

below, officers may encourage people experiencing mental ill health to follow their requests and reduce the requirement for more potentially coercive measures.

The procedural justice approach

1. Voice – officers seek and actively listen to the opinions of those they interact with, so the person feels they have had the opportunity to influence decisions that affect them.
2. Neutrality – officers make impartial decisions based on the facts, and explain their decisions and actions to the person affected.
3. Trustworthiness – officers are open and honest in their communication so the person feels the officers' motives are good and in their best interests.
4. Respect – officers treat the people with whom they interact with dignity.

De-escalation

De-escalation is an approach and range of tactics that may be used by the police or other professionals to calm an agitated individual to reduce or prevent the use of force or restraint.

Verbal de-escalation and containing a disturbed or confused and vulnerable person in a calm, ideally familiar, and closed environment may be safer and less traumatic for the individual. It may reduce the need for physical restraint and sectioning.

Practitioner experience suggests that, where possible, officers and professionals should maximise the time and space provided so that an individual is offered every opportunity to calm down.

Failure to listen and actively engage in dialogue to draw out an explanation for apparently aggressive or odd behaviour represents a missed opportunity to de-escalate and resolve a situation informally before arrest and restraint may be necessary. An individual who is frightened, confused or injured may appear to be experiencing mental illness, but this should not be assumed before the subject has had a good opportunity to explain what is going on.

De-escalation and communication training

The use of force (including restraint tactics) is only legal and appropriate when it is absolutely necessary in the circumstances and proportionate to the threat and risks posed to the safety of all concerned. Police Mental Health training and Personal safety training includes emphasis on

communicating effectively and using de-escalation tactics.

Research into using a US crisis intervention team (CIT) training programme found that officers felt it was important to communicate with people who appear to be experiencing mental health crisis in a patient and empathetic manner. They also felt it important to use verbal and non-verbal de-escalation techniques in order to put people at ease (Hanafi 2008). Another study found that US officers who received CIT training perceived non-physical actions (for example, issuing verbal commands, negotiating with a suspect) as more effective than physical force, especially in response to an escalating mental health crisis scenario (Compton and others 2011).

Police mental health training resources, the personal safety manual and associated personal safety training resources are available via **College Learn**.

Providing reassurance

When interacting with people with communication difficulties, the police should provide reassurance and information about what is happening and why. They should also provide clear information about the person's rights in the particular situation (for example 'easy read' rights and entitlements documentation). This may help to alleviate some of the concerns and anxiety people often feel, whether as a victim, a suspect or someone detained under the MHA 1983 **s 135** or **s 136**.

Asking the right questions and terminology

Unfortunately, mental ill health and disabilities often carry an associated stigma. This may present a barrier to effective communication and cause people to feel less able to provide information to the police or others about their health needs.

Officers and staff should be careful in choosing the terminology they use to describe mental ill health or learning disabilities to avoid causing offence and distress. They should be willing to take advice from other agencies on this matter.

The National Autistic Society proposes that officers ask questions such as, 'Do you have any difficulties that I may not be aware of?' if an officer 'has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally vulnerable' ('mentally disordered' is defined in the Police and Criminal Evidence Act 1984 Code C (1) (1.4).)

People with mental ill health or vulnerabilities should not be referred to using their illness as a label. For example, referring to someone as a ‘schizophrenic’ instead of a person first is negative and dehumanising.

Officers and staff should also understand that misinterpretation can cause anxiety and mistrust that increases risk. For example, some people with autism might take certain common sayings literally. Saying ‘it will only take a minute’, when in reality a process may take longer to complete, might cause additional anxiety (National Autism Programme Board 2014). Officers and staff should use clear and unambiguous language and regularly check understanding.

Autism

The national autism strategy for England, **Think Autism**, sets out how public authorities are required to recognise and support people with autism. Although this strategy is primarily directed towards local authorities and NHS organisations, there may be times when it is relevant to the police response to people with autism.

The legal framework for this strategy is set out in the **Autism Act 2009**, and the National Autistic Society has developed **statutory guidance**.

The National Autistic Society has also produced a **guide for all criminal justice professionals** who may come into contact with people on the autism spectrum as victims, witnesses, suspects or offenders. It is based on the experiences of people with autism and those who work with them, and contains real-life examples and personal accounts by professionals.

Officers and staff may need to interview children with autism or other speech and language difficulties. Autism falls in a spectrum of severity and type of impact. Some special schools have worked together to develop a resource kit for anyone who may need to interview children with autism or other speech and language difficulties. You can access the materials on the following **website** or you may be referred to them by a parent, carer or school so that you have relevant information to assist you in your investigation. The materials are owned and maintained by the organisations, not the College.

For further information see:

- **Students with Autism**
- **Autism Resource Center**

Learning disabilities

If an officer or member of staff believes that an individual may have some form of learning disability or communication difficulty, the following tips may help to improve communication (adapted from the Foundation for People with Learning Disabilities **Communication factsheet**).

- Use short sentences using simple language and avoid jargon.
- Break information into smaller chunks so that one idea or concept is explained at a time – for example, if arrested, explain one at a time who can be considered as an appropriate adult rather than read out the list.
- Pause frequently, so as not to overload the person with words.
- Allow time to make sure that the person has understood, and recheck the person understands you – for example, 'Can you tell me what I have just said so I know I have explained it properly?'. (Be aware that learning disabled people may have stronger receptive (understanding) communication skills than expressive skills, and a person's expressive speech may sometimes give an impression of better comprehension than is actually the case, so check their understanding.)
- If it is a busy environment with many distractions, consider moving to a quieter location as some people may find it hard to concentrate in such a busy place.
- When trying to explain something, such as the advantages and disadvantages of an intervention, using visual aids can be effective – it may also help to offer a photo or drawing to support understanding. (For more information on this see the Foundation for People with Learning Disabilities **'Making information easier to read'** fact sheet).

Language

Using interpreters must be seen as an integral part of the service the police provide. Using interpreters to facilitate communication may not be an easy task when people are unwell and where English is not their first language.

Providing communications support to people with mental ill health or learning disabilities is a legal requirement. Legislation such as the **Equality Act 2010** and the **Human Rights Act 1998** require public organisations to provide language and other communications support to individuals requiring help. See **Equality**.

Forces should ensure they have a list of professional interpreters who might be used, and should be careful to only use interpreters who are competent. Voluntary sector organisations represent a

range of communities, and provide a potential source of interpreters. Where such local services are not available, police officers and health care practitioners should consider using Language Line or a similar telephone interpreting service.

For further information, see **National Agreement on Arrangements for the Use of Interpreters, Translators and Language Service Professionals in Investigations and Proceedings within the Arrangements for the Attendance of Interpreters in Investigations and Proceedings within the Criminal Justice System, as revised 2007**.

Language Line can be contacted on 0800 169 2879.

For further information on the use of interpreters, see **Using interpreters during interviews**.

Assess threat and risk, and develop a working strategy

The second stage of the NDM is ‘assess threat and risk, and develop a working strategy’. Police officers and staff are not medical professionals and are not expected to hold or maintain any level of clinical knowledge or understanding. In order to respond effectively to risk and protect the safety and welfare of the public, however, it is reasonable to expect police officers and operational staff to recognise the potential medical significance of symptoms and behaviours associated with mental vulnerability. It is also important that they are able to record, act on and communicate this information to medical professionals in a meaningful and structured way.

The Vulnerability Assessment Framework

The Vulnerability Assessment Framework (VAF) was originally developed by Dr Karen Wright and Ivan McGlen at the University of Central Lancashire and may be used and integrated into the **NDM** at the stage of gathering information and intelligence.

The VAF is a simple tool to prompt identifying vulnerability in all circumstances where the police have contact with victims, suspects and witnesses. It enables officers to build a more detailed record of the circumstances and information that led them to identify someone as vulnerable and in need of assistance, arrest or referral.

Officers trained in using this tool are expected to recognise signs of vulnerability. They should record and relay this information effectively using each letter (ABCDE – see the bullet list below) and related elements as a cue or framework for their report. Officers can provide this report to medical staff (ambulance crew, hospital medics and mental health nurses) verbally or in writing via a formally recorded risk assessment or statement.

The ABCDE system is as follows.

- Appearance and atmosphere – what you see first, including physical problems such as bleeding.
- Behaviour – what individuals are doing, and if this is appropriate behaviour given the situation.
- Communication – what individuals say and how they say it.
- Danger – whether individuals are in danger and whether their actions put other people in danger.
- Environment – where they are situated, whether anyone else is there and what impact the wider circumstances may have on the individual's health and safety.

Information concerning the individual's vulnerability at the point of arrest or detention under the MHA 1983 s 136 may prove valuable for medical diagnoses and risk management. Where possible, officers should convey this information to ambulance staff, healthcare professionals and/or police custody staff without delay.

For further information see **Wright K and McGlen I (2012)**.

Behaviour

Assessing an individual's level of illness, disability and vulnerability is complex because of the multiple factors underlying a person's behaviour and the way these may interrelate. A person may be vulnerable for a wide range of social, emotional, behavioural and cognitive reasons.

Some behaviour may appear to indicate that a person has mental ill health or learning disabilities but could actually be the result of:

- physical illness (for example, diabetes, epilepsy, urinary tract infection, encephalitis or sickle cell disease)
- physical injury (for example, head injury)
- physical disability (for example, deafness or the effects of a stroke)
- drug or alcohol misuse

- frustration due to not being listened to

Given that many types of mental ill health are not permanent, an individual's vulnerability may also vary according to their condition on a particular occasion.

Some people may be unaware that they have mental ill health or a learning disability. For this reason, where the police suspect that the person is displaying signs indicating that extra support is required, they should use sensitivity and discretion in all their interactions, see **Asking the right questions and terminology**.

The impact and effects of mental ill health or learning disabilities can be diverse. For example, the risk of violence can depend on a medical diagnosis, the nature and severity of symptoms, whether the person has been receiving treatment and/or care and whether there is a history of violence. Aggression can also be associated with the side effects of medication. It is crucial, therefore, that decisions relating to the risk of harm to an individual and the public should be made with other agencies and professionals wherever possible.

There are a number of potentially relevant issues that the police need to be aware of.

When mental vulnerability is masked behind other problems

Officers and staff may easily overlook mental ill health or learning disabilities when an individual has a more immediately recognisable need such as a physical illness, injury, and/or drug or alcohol misuse. Officers and staff should always consider the possibility of less obvious conditions. Some mental health conditions and learning disabilities are not readily identifiable. Signs of impairment can often be obscured by expressions of distress, anxiety, aggression or anger, the effects of drugs or alcohol, or co-existing social or behavioural problems.

Reluctance to report

People who experience mental ill health or have learning disabilities or other difficulties might find it difficult to approach the police for help because they:

- do not know how to complain
- are afraid they will not be believed
- will be perceived to be a nuisance
- have difficulty in communicating

- have low self-esteem
- are unaware of their rights
- are afraid of having to cope with a stressful environment or situation

In cases of abuse, it may be because they are dependent on the person who is abusing them.

Reluctance to disclose

Due to perceived stigma, personal embarrassment or previous negative experiences, some individuals may be reluctant to self-identify their mental ill health or learning disabilities. They may make efforts to ensure that these remain undetected or are actively concealed. This may be because they are afraid or self-conscious, or do not wish to be labelled in a particular way or treated differently from others.

Cultural differences

Some behaviour may be a common occurrence in one culture but appear odd in another. For example, in some religions a prayer must be spoken out loud, but this can give the impression of someone talking to themselves. Practitioners must take care not to make assumptions about a person's cultural background, language and beliefs. Instead, they should ask individuals directly and sensitively about their cultural and religious needs and how these should be met.

The need for appropriate adjustments to support communication and understanding

Officers and staff may need to give the notice of **rights and entitlements** in different ways which are more easily understood by individuals with particular needs. Not everyone communicates using speech. For example, some use British Sign Language, Makaton (a language programme using signs and symbols), communication boards and pictures to support text and other messages. Officers and staff should seek advice if they are not familiar with the individual's preferred method of communication. This is particularly important for people with a known or suspected learning disability, as communication difficulties are a defining feature of those conditions.

Avoid making assumptions

Officers and staff should not assume that if people are unable to communicate effectively they cannot understand what is being said, and do not mind their personal details being discussed. It is important that officers and staff display sensitivity and discretion in all their interactions with people

with mental ill health and vulnerabilities.

A person's ability to understand information and make decisions may also fluctuate. For example, the difficulties exhibited by an individual during a period of mental ill health may be entirely absent when in good mental health.

For further information see **Mental capacity**.

Sometimes more than one of these factors will be relevant.

Signs of mental ill health or learning disabilities

Although police officers and staff are not expected to be able to identify the specific symptoms of mental ill health or learning disabilities or attempt to diagnose illness, it is important that their training enables them to recognise indicators of mental health problems so that these can be taken into consideration. This recognition can occur at any point in their interaction with people.

The APP on Detention and custody provides additional guidance on the role and responsibilities of the custody officer, **risk assessment** in police custody and **fitness for detention**.

Indicators of general concern

Practitioner experience suggests that the following list of things may be perceived as indicators of general concern. This list is not exhaustive and may simply be used as a general guide. These indicators may alert officers and staff to the possibility that the person is either experiencing mental ill health, learning disabilities, or is otherwise vulnerable.

Appearance and behavioural indicators	Aspects of communication

• irrational conversation or behaviour • inappropriate or bizarre behaviour • talking about seeing things or hearing voices which cannot be seen or heard by others • removing clothing for no apparent reason • confusion and disorientation • paranoid beliefs or delusions • self-neglect • hopelessness • impulsiveness • obsessional thoughts or compulsive behaviour	• inappropriate responses to questioning • apparent suggestibility • poor understanding of simple questions • confused response to questions • speech difficulties (for example, poor enunciation, slurring words or difficulty with pronunciation) • difficulty reading or writing • unclear concepts of times and places • problems remembering personal details or events • poor ability to cope with interruptions • poor handwriting that is difficult for others to read • difficulty with filling out forms • inability to take down correct information or follow instructions correctly • talking continuously, or slowly and ponderously • repeating themself

Practitioners should be aware that the above indicators are seldom definitive proof of mental ill health or learning disabilities. There may be other explanations for such behaviour, such as:

- physical illness – a person’s behaviour and mental health may be affected by a physical medical condition such as a head injury, infection or diabetes
- medication – for example, someone slurring their words might indicate that they are using anti-psychotic medication that affects speech
- other intoxication – the person may be intoxicated by alcohol, drugs or so called ‘legal highs’
- false behaviours – officers and staff should treat all indications that a person is experiencing mental ill health, is vulnerable or has a learning disability as genuine. While a person may seek to mislead the police or other services, when in doubt, officers should consider all available

information and consult with mental health professionals. In this situation, officers should record their observations, responses and actions alongside any additional available information and must be guided by the **NDM**

Risk indicators

Behaviour which may raise concern about people's risk of harm to themselves or to others includes:

- putting themselves in danger (for example, walking into the path of moving traffic or on railway lines
- asking for help with their mental health
- engaging in threatening behaviour towards others for no obvious reason
- threatening or engaging in self-harm
- attempting or threatening suicide (for example, expressing ideas, intentions or plans relating to suicide)
- a high level of volatility
- being unresponsive to others or withdrawn
- a tendency to trip, fall over or bump into things
- hyperventilating (over-breathing)
- showing physical signs of severe malnourishment and self-neglect

This list is not exhaustive.

Recognising mental vulnerability in children and young people

Mental health problems affect young people as well as the adult population. In children and adolescents, however, mental health conditions often emerge in ways that are less easily defined. For example, this can be through (Youth Justice Board 2016):

- behavioural problems
- emotional difficulties
- substance misuse
- self-harm

Mental health professionals may also be reluctant or unable to provide a clear diagnosis, as the adolescent brain is still evolving. For further information, see **The Early Intervention Foundation**.

Police officers must be able to identify when mental illness may be an underlying cause of a young person's behaviour. This ensures that young people can access effective referral pathways for assessment, treatment and support.

If children and young people's mental health needs are addressed at the earliest opportunity, it may help reduce the likelihood of these problems escalating, improve life chances and prevent crime.

For further information, see **Children and the use of Section 136 of the Mental Health Act 1983**.

Recognising mental vulnerability, learning disabilities and other needs

All officers should receive appropriate training and have a basic understanding of the range of possible issues listed above when dealing with individuals in the criminal justice system who have mental ill health or learning disabilities.

In some cases, a mentally vulnerable person may choose not to disclose their needs to the police, and officers may not be presented with any reason to believe that they have additional requirements.

Risk assessment for people detained by the police under the Mental Health Act 1983 and suspects of crime

The risk assessment process for the management and care of detainees should be guided by guidance in the **Risk Assessment APP** (from the APP on **Detention and Custody**).

Medical emergency

In a physical medical emergency, the police should take the individual experiencing mental ill health immediately to an emergency department (ED). In such circumstances, treating the person's physical needs takes priority over mental healthcare. Where appropriate and necessary, a mental health assessment will be arranged once the individual's condition has stabilised. This could occur in ED, following transfer to another **place of safety** for those detained under the MHA 1983, or in police custody, for those who have been arrested.

Some ambulance service areas have access to pre-hospital doctors who can provide medical intervention at the scene and on the journey to hospital. If they are available, officers and staff should seek the assistance of pre-hospital doctors in instances where the paramedics or police officers believe the patient's condition or behaviour requires a higher level of medical oversight than

they can provide themselves.

Conditions which should indicate to the police that ED is appropriate as the first place of safety include physical injury, physical illness, attempted self-harm or an acute psychiatric crisis, for example, **Acute Behavioural Disturbance (ABD)**.

Alcohol and drug intoxication

Differing levels of drunkenness pose different risks to the individual. Their level of vulnerability may be affected by other factors such as the environment or other injury or illness. Intoxication alone or behaving in an unusual way is not sufficient to satisfy the **MHA 1983 s 136** and is not a reason for the police to interfere with people's freedom to go about their lawful business in a public place. As well as potentially being lethally toxic in itself, however, alcohol consumption may also mask the effects of head injury or drug intake, which could have lethal consequences.

The most serious risk is posed by a person who is **drunk and incapable**, namely, highly intoxicated. Drunk and incapable individuals are in need of hospital assistance and officers should call an ambulance. If a person is both physically unwell through intoxication as well as mentally unwell, then their physical health needs must be addressed first.

For further information, see the APP on **Detention and custody: Alcohol and drugs**.

Acute behavioural disturbance

Guidance on acute behavioural disturbance (ABD)

Information on the recognition and management of ABD (also known as acute behavioural disorder) is available from:

- **Acute behavioural disturbance** (in the APP on Detention and custody)
- The Personal Safety Manual (Module 4 Medical Implications, available via **College Learn**)
- **Faculty of Forensic and Legal Medicine (FFLM) guidance on managing ABD in custody**

If there is any concern that a person is displaying symptoms that may indicate the onset of ABD, officers and staff on the scene should treat the situation as a medical emergency and summon an ambulance to take the person to an ED without delay (regardless of local place of safety arrangements).

The police and the NHS both have legal obligations that affect managing vulnerable detained patients when they are in police custody. The management of this issue should be specifically addressed in local protocols.

Multi-agency protocols for response to acute behavioural disturbance and other potentially violent individuals

Additional guidance on developing joint protocols for managing ABD between services can be found in the **Home Office Circular (17/2004) General principles to inform local protocols between the police and health services on handling potentially violent individuals**.

Referral and risk management

Multi-agency care and treatment of people experiencing mental ill health should, wherever possible, take place within the **Care Programme Approach (CPA)**. The CPA involves risk assessment and allows for a multi-agency approach which includes involving criminal justice agencies where appropriate. In some cases, the risk posed by the individual requires police action in addition to that of other agencies.

There are a number of risk management and referral mechanisms and pathways to care for people with mental ill health and vulnerabilities who come into contact with the police service. These are the subject of local force arrangements and should be included explicitly in local multi-agency protocols. Some existing mechanisms include referral to support services via:

- **local safeguarding children boards**
- **safeguarding adults boards**
- **multi-agency safeguarding hubs (MASH)**
- **multi-agency risk assessment conferences (MARAC)** (in some forces the scope of MARAC conferences has been extended to include all vulnerable adult safeguarding matters)
- **multi-agency public protection arrangements (MAPPA)** (specifically for managing sexual and violent offenders)

Referral of offenders within the criminal justice system

Health and social care referral should not routinely be viewed by police officers as an alternative to charging and prosecuting offenders. Offenders who are vulnerable and/or experiencing mental ill

health should be able to access care and treatment through the criminal justice system via liaison and diversion services.

Where suspects or offenders are known or believed to be experiencing mental ill health, officers should contact health, adult and children's social care services to ensure coordinated action.

The management of serious or violent offenders (MOSOVO) should be guided by:

- **Management of offenders: Offenders with mental health issues APP**
- **the management of risk and suicide prevention for detainees that are perpetrators of Child Sexual Exploitation (CSE)**

Referral for assessment of needs under the Care Act 2014

The **Care Act 2014** provides a method by which the police are able to refer and direct an individual towards services provided by the relevant local authority.

If an individual comes to the attention of the police because they are in need of care or in a caring role (for example, because they may be suicidal or vulnerable in other ways), officers may submit a referral request for assessment of needs to their local authority.

The local authority then has a duty under the **Care Act s 9** to carry out a needs assessment of the welfare needs of that individual against national **eligibility criteria** and, where appropriate, provide them with a care and support plan.

The following are examples of what may be provided (via local authority services) to meet needs under the Care Act 2014 **ss 18-20**.

- accommodation in a care home or in premises of some other type
- care and support at home or in the community
- counselling and other types of social work
- goods and facilities
- information, advice and advocacy

Further information

Web resources:

- **MHA 1983**
- **Mental Capacity Act 2005**
- **Care Act 2014**
- **Mind website**
- **APP on investigative interviewing**
- **APP on detention and custody**
- **Mental Health Cop blog**
- **Prison Reform Trust: Mental Health, Autism & Learning Disabilities in the Criminal Courts: Information for magistrates, district judges and court staff.**

Relevant publications:

- **HM Government (2014) Mental Health Crisis Care Concordat**
- **Ministry of Justice (2022) Achieving Best Evidence in Criminal Proceedings**
- **The Bradley Report (2009**)
- **Mind and Victim Support report: At risk, yet dismissed (2013**)
- **Independent Commission on Mental Health and Policing Report (2013**)
- **Criminal Justice Joint Inspection: A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system: Phase 1 from arrest to sentence (2014)**
- **The Welfare of Vulnerable People in Custody (2015**)
- Equality and Human Rights Commission (2015) **Preventing Deaths in Detention of Adults with Mental Health Conditions**

Academic publications

- Castellano-Hoyt DW. (2003). Enhancing Police Response to Persons in Mental Health Crisis: Providing Strategies, Communication Techniques, and Crisis Intervention Preparation in Overcoming Institutional Challenges. Springfield: Charles C Thomas Publisher, LTD.
- Compton MT and others. (2011). Use of force preferences and perceived effectiveness of actions among crisis intervention team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia. Schizophrenia Bulletin 37 pp 737-745. Oxford: Oxford University Press.
- Gregory MJ and Thompson A. (2013). From here to recovery: One service user's journey through a mental health crisis: Some reflections on experience, policy and practice. Journal of Social Work

Practice 27 pp 455-470. Abingdon-on-Thames: Taylor & Francis.

- Hanafi S and others. (2008). Incorporating crisis intervention team (CIT) knowledge and skills into the daily work of police officers: A focus group study. Community Mental Health Journal 44 pp 427-432. Berlin: Springer.
- Ireland CA, Fisher MJ and Vecchi GM. (2011). Conflict and Crisis Communication: Principles and Practices. Abingdon-on-Thames: Routledge.
- Lipson GS, Turner JT and Kasper R. (2010). A strategic approach to police interactions involving persons with mental illness. Journal of Police Crisis Negotiations 10 pp 30-38. Abingdon-on-Thames: Taylor & Francis.
- Livingston JD and others. (2014a). Perceptions and experiences of people with mental illness regarding their interactions with police. International Journal of Law and Psychiatry 37 pp 334-340. Amsterdam: Elsevier.
- Livingston JD and others. (2014b). What influences perceptions of procedural justice among people with mental illness regarding their interactions with the police? Community Mental Health Journal 50 pp 281-287. Berlin: Springer.
- Mazerolle L and others. (2014). Procedural justice and legitimacy in policing. Berlin: Springer.
- Sarno M and Van Hasselt VB. (2014). Suicide by cop: implications for crisis (hostage) negotiations. Journal of Criminal Psychology 4 pp 143-154. Bingley: Emerald Group Publishing.
- Sunshine J and Tyler TR. (2003). The role of Procedural Justice and Legitimacy in shaping public support for policing. Law and Society Review 37(3) pp 513-548. Hoboken: Wiley-Blackwell.
- Tyler T. (2003). Procedural Justice, Legitimacy and the Effective Rule of Law. Crime and Justice: Review of Research 30 pp 283-357. Chicago: University of Chicago Press.
- Watson AC and others. (2008). Defying negative expectations: Dimensions of fair and respectful treatment by police officers as perceived by people with mental illness. Administration and Policy in Mental Health and Mental Health Services Research 35 pp 449-457. Berlin: Springer.
- Wright K and McGlen I. (2012). Mental health emergencies: using a structured assessment framework. Emergency Nurse 19(10) pp 28-35. London: Royal College of Nursing.

Tags

Mental health