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**METROPOLITAN
POLICE**

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REVIEW OF ASSESSMENTS ON PRIVATE PREMISES

REPORT AND RECOMMENDATIONS, JUNE 2005

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Summary

- **The pan-London standard for Assessments on Private Premises has been inconsistently implemented across London, and there are substantial variations in practice within agencies**
- **the flowchart and guidance notes need to be revised on a small scale in order to provide more clarity on certain issues, and need to be better communicated and disseminated**
- **the police service, and those engaged in assessments, are best protected by the existence of a S135 warrant when attending assessments on private premises. However, the general consensus is that the grounds referred to in current legislation do not cover all the circumstances in which police attendance is needed**
- **there would be great benefit for all agencies from working closely with the Department of Health to ensure that new legislation is very clear on this issue**
- **data on police attendance at assessments and use of warrants is not routinely collected by police or social services**

Section 1: Background

1.1 History of development of pan-London standards

A framework for protocols for use in situations where statutory organisations have to work together to provide the best care for people with mental health problems has been in development as a result of recommendations in the Dixon Inquiry, published in 1999. With the objective of achieving consistency across London, the London Development Centre for Mental Health, overseen by the London Mental Health Partnership Group, developed standards for local multi-agency protocols in three areas:

- when service users are missing from hospital or healthcare premises;
- use of Section 136 of the Mental Health Act 1983, and
- Mental Health Act assessments on private premises.

Each standard consisted of a single page flowchart and a set of general guidance notes. The intention was that these two documents would then be supplemented by a third document, developed locally for individual London boroughs, which covered local policies and procedures and practical information, such as telephone numbers and hours of availability.

The standards were developed with the input of service users, carers, and frontline staff from all the relevant agencies and piloted in several areas in London during 2003.

Following the evaluation of the pilots, concerns remained about the issues involved in police attendance at Mental Health Act assessments on private premises, specifically the grounds on which a S135 warrant could be applied for. A separate piece of work, reviewing the literature and legalities relating to S135 was commissioned by the London Development Centre in late 2003 and completed by Nick Purchase, an independent consultant, in February 2004.

Using the results of Nick Purchase's work, and the evaluation of the pilot sites, refinements were made to the standards documentation, and implementation groups in each London borough, comprising representatives from the Metropolitan Police, Social Services, the London Ambulance Service, and the local Mental Health Trust, were asked to develop or modify existing protocols in each area in line with the standards set, by summer 2004.

Implementation of the standards was audited by asking each implementation team to report their own progress to the London Development Centre.

1.2 Scope of this project

This project was commissioned following concerns raised about the consistency of implementation of the Assessment on Private Premises standard, and a letter issued by the Metropolitan Police in December 2004, directing police officers not to attend assessments unless a warrant had already been obtained. In response, serious concerns were raised by representatives of the London Development Centre for Mental Health and the Association of Directors of Social Services. In conjunction with the Metropolitan Police to Service, they agreed to commission further work to review the implementation of the pan-London standards, devise an appropriate monitoring framework and produce, if necessary, revised standards.

The specific objectives for this piece of work were:

- to ensure that locally-developed protocols remain consistent across London;
- to resolve any outstanding problems with implementation of the pan-London standards;
- to share examples of good practice;
- to establish a system for monitoring, across London, the use of local protocols and their outcomes.

Although it was not a specific objective, there was a great deal of interest in the practicalities of implementing a warrant-only approach.

The project took into account, but did not revisit, the conclusions reached by Nick Purchase in his review of the legal framework, undertaken less than a year ago, as these had already been considered and agreed by the Mental Health Partnership Group.

The project team's approach was to focus on what was actually happening in different parts of London, and consider practical solutions to problems faced by frontline staff in the different agencies involved.

1.3 Specific constraints

This work has not benefited from the input of the London Court Service at either a central or local level. We have found it extremely difficult to talk to people who might give us some insight into how Magistrates make decisions on whether to issue S135 (1) warrants, although we have received substantial anecdotal feedback about the inconsistencies of this process from Approved Social Workers. This represents a significant gap in this piece of work, and must be kept in mind while considering our findings and recommendations.

Section 2: Methodology

The project team talked to stakeholders from the following groups:

- mental health professionals
- police officers
- ambulance crews staff
- mental health service users
- carers

in 11 London boroughs, representing a cross section of inner and outer London and a wide variation in local practices. The boroughs visited were:

- Barnet
- Bexley
- Brent
- Croydon
- Hackney
- Haringey
- Hillingdon
- Redbridge
- Kingston
- Southwark
- Westminster.

We asked about current processes used, perceived problem areas, multi-agency practices of which they were proud, and any changes they would like to see in the way they worked.

There was some variation in the way the meetings were conducted – some with individuals, some with specific professional groups, and some with small mixed professional groups. We collected copies of protocols, risk assessment forms and other documents from the areas we visited, and also received copies of forms used in other parts of London.

The Metropolitan Police held a multi-agency workshop at the beginning of May to explore a number of issues in relation to mental health, and assessments on private premises were discussed in some detail.

We also undertook a data collection exercise in order to find out how often police assist with assessments on private premises and the proportion of these assessments for which a S135(1) warrant is obtained.

Section 3: Review of current practice

3.1 Data collection

We asked each borough in London to provide us with information, for the period April 2003 – March 2004, about

- the number of Mental Health Act assessments carried out on private premises
- the number of assessments on private premises the police attended
- the number of assessments on private premises using a S135(1) warrant

Unfortunately, we discovered that very few areas collected such statistics, and those which did warned us that they were not reliable. The data we did gather is displayed below, and the full results, with detailed notes about where the figures came from, is in Appendix 1. The figures are displayed as percentages for ease of reference.

Borough	% of assessments on private premises attended by police	% of assessments on private premises attended by police which have s135(1) warrant in place
Barnet	28	18
Bexley	34	13
Brent	44	36
Camden	14	43
Hammersmith & Fulham	75	29
Harrow	39	17
Havering	39	23
Redbridge	52	32
Richmond upon Thames	65	9
Southwark	58	28
Tower Hamlets	18	44
Waltham Forest	47	58
Average	43%	29%

Although there are only figures for 12 boroughs, and these are not directly comparable, they demonstrate that

- there is a great deal of variation in policy and practice across London
- generally, police are being asked to attend fewer than half the assessments carried out
- warrants are being sought in a minority of cases.

3.2 Common difficulties

This section has been written in response to our interviews with professionals from all organisations who take part in, or supervise those who take part in, Mental Health Act assessments on private premises. We have highlighted issues which arose in several areas, not where they seemed to be specific to one borough. Nor should they be interpreted as applying to all boroughs. The most common issues raised were:

3.2.1 Lack of understanding of the roles and responsibilities of professionals from other organisations

Individuals did not understand fully the legal constraints under which other professional groups worked, nor were they generally aware of the processes for allocating resources in other organisations. This generally led to frustration about decision-making processes taking place in other organisations.

Police officers were not familiar with the grounds on which ASWs could obtain a s135(1) warrant; ASWs were not generally aware that, without a warrant, police officers have to leave private premises when asked. There were also a number of points made about the problems which arise for mental health professionals when emergency service staff are diverted from attending a Mental Health Act assessment to a more urgent incident.

3.2.2 Lack of local contact points

In a number of areas we discovered that managers were not aware of who their opposite numbers were in other organisations, or how to contact them. In particular, links with local London Ambulance Service managers were poor. Without these links, problems, disagreements and disputes remain at the level of frontline practitioners and officers and unresolved in the long term.

Difficulties resulting from an over-reliance on specific individuals were also identified as an issue. There is a frequent turnover in the people who hold the role of borough mental health liaison officer, with little continuity or succession planning. Each postholder appears to develop their own contacts and ways of doing things.

3.2.3 Inconsistent “gate keeping” by the police in response to requests for attendance

We found a huge variety in the ways in which police borough command units accepted and responded to requests for assistance at assessments. In different places, requests were sent, usually by fax, to CAD rooms, operations offices, events offices or directly to the Mental Health Liaison Officer.

In a number of places, there were different processes in place for requesting assistance out of normal office hours, or in urgent circumstances. This had an impact on the urgency with which the request was dealt with and on the quality of assistance provided.

The clear perception of ASWs was that when those receiving the request were familiar with mental health issues, they received what they felt was a more appropriate and timely response. ASWs also commented that when the same team of officers attended assessments on a regular basis, they built up expertise and a relationship with service users.

3.2.4 Difficulties in ensuring that all those attending the assessment have appropriate knowledge

Again, there was substantial variation in how risk assessment or other information was shared with the professionals who were present at the scene. In some instances, this was directly linked to the way in which local police allocated officers to attend the assessments. Where response teams were used to assist ASWs, they were less likely to have been passed on information, and relied on a briefing at the scene. Ambulance crews never have access to detailed information in advance and always rely on a handover from the ASW or the police on arrival.

3.2.5 Lack of debrief, reflection and learning

It seemed that there were rarely opportunities – at either an operational or strategic level – to discuss how Mental Health Act assessments had been carried out, what the outcomes were for service users, family and professionals, and what could be learned from both what had gone well, and what had not. Without occasions on which to reflect, however briefly after the assessment, difficulties do not get resolved, attitudes became entrenched and hostility between agencies is allowed to build up.

3.3 Examples of good practice

It needs to be emphasised that there is a great deal of good practice in different parts of London, and these are just a couple of specific examples

3.3.1 Dedicated teams

In each of the boroughs of Hackney, Haringey, Camden, the Metropolitan Police have set up specific teams to deal with various issues relating to mental health. In two of these boroughs, there are also dedicated ASW teams who link closely with the police. This approach has resulted in the development of close working links between the two organisations, a significant level of trust amongst individual members of staff, and the development of expertise in mental health for the police officers.

3.3.2 Mental health training for probationer police officers

Mental health teams in Southwark provide 2 days of experience in mental health services for every probationer police officer. There are other boroughs where mental health services offer training opportunities to both new and experienced police officers. This builds up the officers' knowledge and confidence in dealing with mental health situations and reduces the stigma attached to mental health issues.

Section 4: Discussion of specific issues

There are three particular areas – (1) the use of S135(1) warrants, (2) dealing with service users who passively resist removal to hospital and (3) the most appropriate vehicle in which to take a service user to hospital – which tend to spark theoretical disagreements between agencies. It should be pointed out that:

- whilst these areas are of concern to both those in senior positions and to people on the front line, detailed discussion do not undermine work undertaken on a daily basis
- occasions on which there are genuine disagreements amongst frontline staff about how best to handle a specific situation are very infrequent
- legislation does not provide a basis on which to develop or enforce definitive guidance in these areas.

For the sake of completeness of this report, we have set out the standard arguments below, but they are well-rehearsed and will be familiar to all. The only conclusions we can draw are:

- the welfare and safety of the service user and their family and carers, as well as that of all those involved in the assessment, is paramount;
- professionals from different agencies should always aim to work as one team, with the objective of the best possible outcome for the service user in the safest possible environment;
- there should be arrangements in place to escalate problems to a management level if frontline staff are unable to agree on a course of action;
- after such situations occur, there should always be a debrief and discussion about what could be learned for the future.

4.1 Use of warrants

4.1.1 Legal context

The purpose of this review was not to go over once again the issues of legal grounds for obtaining a warrant – these were covered in substantial detail in the work done by Nick Purchase, who also carried out a review of the literature and case law – but to look at how these are applied in practice.

The Mental Health Act (1983) s.135(1) states:

“If it appears to a justice of the peace, on information on oath laid by an ASW, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder:

a) has been, or is being ill treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or ,

b) being unable to care for himself, is living alone in any such place, the justice may issue a warrant authorising any constable...to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.”

Neither the Act itself, nor the Code of Practice, provides greater clarity about the circumstances in which a warrant might be sought, or the grounds on which it might be issued.

The consensus amongst Approved Social Workers, who cover this area in some detail during their professional training, is that a warrant should be obtained if they anticipate, on the basis of evidence, being unable to gain entry to a property to carry out an assessment or being unable to remain on the property to complete an assessment, and should be an option of last resort. We found no resistance from ASWs to completing paperwork, contacting the Magistrate's Court and obtaining a warrant if the grounds to do so exist.

For them, decisions on whether to obtain a warrant are based on the issue of entry to the property for the purpose of carrying out an assessment. Difficulties in gaining entry or in being able to stay on the property for the assessment are one of the circumstances in which ASWs will request police assistance, but there are other scenarios, for example, a risk of the service user resisting being taken to hospital, where although entry to the property is not anticipated to be a problem, there is an identified need for police officers to attend.

For police officers, the difficulty exists that if they are on premises without a warrant and are asked to leave, they must do so, unless the ASW has completed the Mental Health Act paperwork. If such a situation occurs, then grounds clearly exist for a warrant to be sought for a return visit. However, justifiable concerns are raised about the best use of resources in such situations.

4.1.2 Evidence from areas which have used or are using a warrant-only policy

We visited and talked to key professionals in two boroughs in London, one of which is currently operating a policy where police officers will only attend assessments when a warrant is in place, and another where that same policy had been instigated but subsequently withdrawn to find out about their experiences.

We heard evidence from ASWs in both boroughs about the impact of such a policy on their practice. In both areas, the existence of the policy had resulted in:

- mental health professionals taking unnecessary risks in carrying out assessments without police support, as the grounds for obtaining a warrant did not exist;
- mental health professionals having to allow service users' health to deteriorate until it was likely that grounds for warrant did exist and they could obtain police support
- greater risks for service users, their families and the community, when service users could not be assessed at the earliest opportunity.

The project team felt very strongly that the result of a warrant only policy would be an increase in risk for all those involved with the service user. This applies equally to the police who are likely to face a much riskier situation when an assessment is postponed until the grounds for a warrant exist.

4.2 Dealing with service users who passively resist being taken to hospital

These situations are rare, and the pan-London guidance notes say on the issue of passive resistance:

“Planning in advance for the possibility of passive resistance is very important, as current legislation does not identify any one of the disciplines who are likely to be present during a mental health assessment profession (the police, ASWs or ambulance crew) as having a duty to remove a person physically from a private household, when they have been assessed by mental health professionals as needing to be detained in hospital under the Mental Health Act. When dealing with passive resistance, this role could be taken on by any of the disciplines present, or a combination of all, depending on the situation.”

There is very little that we can add to this. Each situation has to be assessed on its own merits, and the best that we can do is to state clearly each professional's skills and responsibilities in this area, whilst remembering that it is the outcome for the service user, alongside the safety of those involved, which is paramount:

- the ASW, having completed the section papers, is responsible for the service user's admission to hospital, and can delegate authority to convey the individual
- police officers have a duty to prevent a breach of the peace
- ambulance crews have particular skills in lifting people gently and therapeutically.

4.3 Conveyance to hospital

London Ambulance Service and the Metropolitan Police Service have been working to develop a joint policy for some years. However, the policy is not yet complete, and we can only restate what is currently in the pan-London standard:

“a service user will be transported to hospital in an ambulance unless he or she is so violent that a police van is required.”

Section 5: Performance framework

5.1 Success criteria

From our conversations with stakeholders, including service users and carers, we have developed a set of success criteria for individuals and organisations involved in Mental Health Act assessments on private premises:

<p>SERVICE USER</p> <ul style="list-style-type: none"> - assessment carried out, and removal to hospital, with least stigma - rapid access to assessment and appropriate care - least possible use of force or restraint - understanding of illness and situation from all professionals involved - maintenance of confidentiality - clarity about individual rights 	<p>CARER / FAMILY MEMBERS</p> <ul style="list-style-type: none"> - access to appropriate support from relevant professionals before and after assessment - assessment takes place quickly in response to request - assessment carried out, and removal to hospital, with least stigma - service user, self and family kept safe - kept in touch with any changes to plan for assessment
<p>APPROVED SOCIAL WORKER</p> <ul style="list-style-type: none"> - making most appropriate decision about the care and treatment for the service user - straightforward to organise all parties - least possible delays imposed externally - opportunity to discuss roles in advance - police support when needed even if grounds for warrant do not exist - appropriate and proportional support in violent or resistant situation - access to relevant information held by police - police and ambulance crew have knowledge of mental health - minimal wait for transport after assessment complete - opportunity to reflect / feed back with other professionals 	<p>POLICE OFFICERS</p> <ul style="list-style-type: none"> - access to relevant information held by mental health services to inform decision about attendance and potential action - opportunity to discuss situation in advance - rapid access to Level 2 officers or TSG if needed - feel attendance / involvement important and useful - security of access through warrant when grounds exist; clarity of reason for attendance when no grounds for warrant - minimal wait for alternative transport
<p>AMBULANCE CREW</p> <ul style="list-style-type: none"> - appropriate notice of being required - access to relevant information about service user and situation - appropriate support (ASW / police officer) during conveyance - clear guidance about dealing with passive resistance 	<p>MEDICAL STAFF</p> <ul style="list-style-type: none"> - opportunity for multi-agency discussion in advance - most appropriate decision for care and treatment of service user - properly briefed before assessment
<p>HEALTH / SOCIAL CARE MANAGEMENT</p> <ul style="list-style-type: none"> - alerted to problems / delays - staff safety 	<p>POLICE MANAGEMENT</p> <ul style="list-style-type: none"> - awareness of mental health workload - officer safety - public safety - positive community relations

Some, as one might expect, are contradictory, and a balance has to be sought on the basis of individual circumstances. We have taken these criteria into account in considering potential changes to the pan-London standard.

5.2 Monitoring

Although the pan-London standard was designed to improve consistency across London, a lack of capacity to monitor its implementation has resulted in a wide range of protocol development, and in one or two areas, no work at all.

If consistency in the provision of safe, secure and supportive services for mental health service users, their carers and members of the community remains the objective, then a method of centrally monitoring the development and use of local protocols must be put in place.

We believe that the approach of standard documentation across London, with the opportunity for limited local adaptation, as taken by the Mental Health Partnership Group is correct. We have suggested some very small amendments to the existing flowchart and guidance notes for Assessments on Private Premises, but these should remain the basis for multi-agency working.

However, we suggest that the flowcharts and guidance notes are reissued, and that the London Development Centre takes on the responsibility for collecting and reviewing local protocols to ensure that they meet the pan-London standard.

We also suggest that a system of central data collection about multi-agency working in London is developed and implemented so that variations between boroughs can be identified and investigated. We recommend that three specific sets of data are collected on a regular basis by each agency:

- the number of Mental Health Act assessments carried out on private premises
- the number of assessments on private premises the police attended
- the number of assessments on private premises using a S135(1) warrant.

Section 6: Recommendations for change and implications for resources

6.1 Practical, short-term recommendations

These recommendations are intended to be practical and relatively easy to implement. They are divided into 4 areas:

- A Infrastructure which supports local partnership working
- B Internal policies
- C Procedures for carrying out assessments on private premises
- D Documentation and data collection

We have identified some milestone dates:

December 2005 – agencies to have considered recommendations and how to implement them

March 2006 – infrastructure changes to be in place, and plans for full implementation in next financial year

The column on implementation levels refers, for ease, to senior managers, middle managers and frontline practitioners. These terms should be interpreted as:

	Social Services and Mental Health Trusts	London Ambulance Service	Metropolitan Police
Senior managers	Directors of Social Services, Borough Directors, Trust Chief Executives, Service Directors	HQ based managers	Borough commanders
Middle managers	Assistant Directors, Lead Social Workers, Service Managers	Ambulance Operations Managers (AOMs), Duty Station Officers	Borough mental health liaison officers
Frontline staff	ASWs, community mental health nurses	Ambulance crews, control room staff	Police officers, control room staff

	Headline recommendation	Details	Lead agency	Resource implications	Implementation level	Deadline / timescale	Performance measurement
A1	Each borough to hold regular, structured, multi-agency meetings (to include police, social services, local Trust and LAS) where multi-agency strategy and operational procedures can be discussed. This group should also be linked to the local court user group, and consideration should be given to how best to link to local user and carer groups.	This group does not need to be separate from other groups already in existence, eg local LITs, as long as existing groups include representation from all key agencies. This group should have responsibility for local protocols and for reporting on progress to the MHPG.	All	Limited, if structures are already in place. Current structures, membership and terms of reference will need to be reviewed.	Middle managers – Assistant Directors, lead ASWs, operational managers, AOMs, BMHLOs, Service managers.		Group to be identified in local protocol, and noted by LDC.
A2	Each agency to identify a role which takes the lead on multi-agency liaison in mental health. There should be arrangements for deputising and for succession planning for the role, and frontline staff should be aware of the role and contact details for the individual	We suggest a “middle management” level, eg BMHLO, AOM, Lead ASW, but it is up to individual organisations to make a final decision.	All.	Some, in terms of giving individuals appropriate level of protected time in which to carry out the role.	Discussion between senior and middle management.	Role to be identified by December 2005	Common list to be held at LDC for communication and information.
A3	Structured, joint training should be commissioned and delivered for all professionals involved in APPs. Frontline staff should have access to an annual learning opportunity involving staff from other agencies.	The form of learning can be flexible and designed locally; it is the contact between agencies which is important.	All.	Training budgets will need to be reviewed and perhaps reallocated; releasing staff to attend will take more resources and organisation.	Needs approval by senior managers; design and delivery by middle managers.	Should begin early in 2006/07 financial year.	Organisations should provide an annual report to MHPG.

Headline recommendation		Details	Lead agency	Resource implications	Implementation level	Deadline / timescale	Performance measurement
A4	Each borough to have written, joint protocol in accordance with pan-London standard	LDC to update current flowchart and guidance notes and recirculate.	All	Each borough will need to review its current documentation. Implications are insignificant for those areas which put protocols in place last year.	Varied		Submission of completed documentation to LDC by December 2005.
A5	MHPG should find constructive way to engage with London Court Service	Need to find out how LCS is structured and invite suitable representative to join MHPG	LDC	None	LDC	ASAP	
B6	The Metropolitan Police should <u>not</u> adopt a “warrant-only” approach to assisting at Mental Health Act assessments, and should ensure that local boroughs retain flexibility.	The police Mental Disorder Project Team should take steps to withdraw the original letter and ensure all senior managers are aware of agreed policy.	MPS	Specific work may need to be done with any borough currently working with warrant-only policy	Senior management	ASAP	Report to MHPG
B7	The profile of mental health should be raised within control room environments	Likely to take form of awareness training.	LAS and MPS	Development of standard training packages (which could be shared) and release of staff to attend training.	Senior management	During financial year 2006/07	Organisations should report to MHPG on % staff attendance.

Headline recommendation		Details	Lead agency	Resource implications	Implementation level	Deadline / timescale	Performance measurement
B8	The police should review their internal procedures relating to decision-making, related risk assessments and deployment to APPs and make recommendations for consistent practice.	Aim is to have same process within each police borough	MPS	Significant project management resource – 2 months to analyse & recommend; longer to implement	Borough Commanders	Review by December 2005; implement by March 2006	To be monitored by MPS; progress reported to MHPG.
B9	London Ambulance Service should agree a corporate policy for its crews' involvement in APPs, and review internal procedures to ensure that crew attending APP has access to risk assessment document in advance.	Disagreement about whether ambulance should be available before assessment or after decision to admit needs to be resolved and be consistent across organisation.	LAS		HQ management	Decision asap	Report to MHPG; ensure way of working built into local protocols.
B10	London Court Service should issue clear guidance about the grounds on which warrants will be issued and ensure that a consistent approach to decision-making about warrants is applied		LCS	Project management and communications and training resources needed	LCS	URGENT - by December 2005	
C11	Wherever possible, carers should be fully involved in the assessment process		Social Services	None	ASW	Ongoing	Review locally with carers' groups
C12	ASW should ensure a briefing for key people involved in the assessment is held beforehand and a debriefing at the conclusion of each and every assessment	Time and location of briefing should be flexible, depending on level of risk identified.	Social Services	Short time	ASW	By December 2005	Part of local protocols

	Headline recommendation	Details	Lead agency	Resource implications	Implementation level	Deadline / timescale	Performance measurement
D13	Any separate risk assessment made by the police should be shared with mental health and LAS professionals.	All information relating to assessment process should be shared with those going to be present and those involved in planning process.	All		Practitioners		To be part of local protocols
D14	There should be a standard risk assessment form used by ASWs when making a request for police (and LAS) assistance across London. It should be a single document, jointly owned, shared and understood between agencies.	Draft provided in Appendix	All	Needs consultation and communication	All agencies, London-wide	In place by March 2006	To be reviewed by LDC as part of local protocols
D15	There should be a standard and explicit procedure for how data is recorded and stored (ie secondary uses of the information) within each agency after the assessment in accordance with DPA	Suggest guidance is attached to risk assessment document	All	None	Middle management	As part of RA development	
D16	The use of a secure website for structured risk assessment documentation should be considered, rather than relying on faxing, telephone or personal contact.	Faxing is most secure method of communication currently used; does not allow document to be updated and added to by other parties.	LDC to commission feasibility study	Will need to purchase appropriate software – could be up to £20,000 plus maintenance costs	London-wide	Feasibility study by March 2006	MHPG to make decision

	Headline recommendation	Details	Lead agency	Resource implications	Implementation level	Deadline / timescale	Performance measurement
D17	Data collation across London should be put in place by MHPG	Need to know what actually happens in terms of police attendance and use of warrants, rather than relying on anecdotal evidence.	LDC	Significant – need to put process in place, monitor and chase submission of data on regular basis.	Senior management	Suggest “dry run” Jan-Mar 2006; quarterly collection thereafter.	Receipt of accurate data
D18	A standard form should be used for data collection, and responsibility for its completion should lie with the ASW.	Suggest becomes part of MHA papers	LDC	Needs consultation and implementation	ASW	March 2006	

6.2 Wider and longer-term recommendations

These recommendations are based on some of the good practice examples we saw, but involve substantial resource implications, or organisational changes, or come from our thinking about what an ideal situation for all agencies and service users would look like.

We suggest that they be considered as part of planning for the implementation of the new Mental Health Bill, or as opportunities arise through other wide scale changes:

- consider setting up dedicated police and ASW teams in each borough to deal with Mental Health Act assessments, working closely together
- influence Mental Health bill work to ensure that wording in Bill and in Code of Practice is as clear as possible on the purpose, grounds and process of obtaining warrants
- consider piloting a specialist mental health “conveyance” team in one part of London
- consider reviewing local Mental Health Act reporting arrangements and making consistent across London.

Kirsty Jarvie
London Development Centre for Mental Health

Paul Bather
Metropolitan Police Service

Patrick O’Dwyer
London Development Centre for Mental health

The project team were also assisted by Ralph Gilman Social Workers Development manager from Redbridge Borough and Margaret Anderson Head of Social care (Bexley) from Oxleas NHS Trust.

GLOSSARY AND EXPLANATION OF TERMINOLOGY

Service user	We have used the term service user throughout the document to refer to people cared for by specialist mental health services.
s135 warrant	Refers to section 135 of the Mental Health Act 1983 (see section 4.1.1, page 10 of the report for what the law says).
AOM	Ambulance Operations Manager
APPs	Assessment on private premises
ASW	Approved Social Worker
BMHLO	Borough Mental Health Liaison Officers (police)
CAC	Central Ambulance Control
CAD	Computer & Dispatch (police)
DPA	Data Protection Act 1998
LAS	London Ambulance Service NHS Trust
LCS	London Court Service
LDC	London Development Centre for Mental Health
MHPG	Mental Health Partnership Group
MPS	Metropolitan Police Service
RA	Risk assessment
SCP	Single Contact Point
SHA	Strategic Health Authority
TSG	Territorial Support Group (police)

Summary of information gathered from Social Services departments across London

Key

MHAA = Mental Health Act assessment
 APP = assessments on private premises
 DNG = data not gathered by SSD

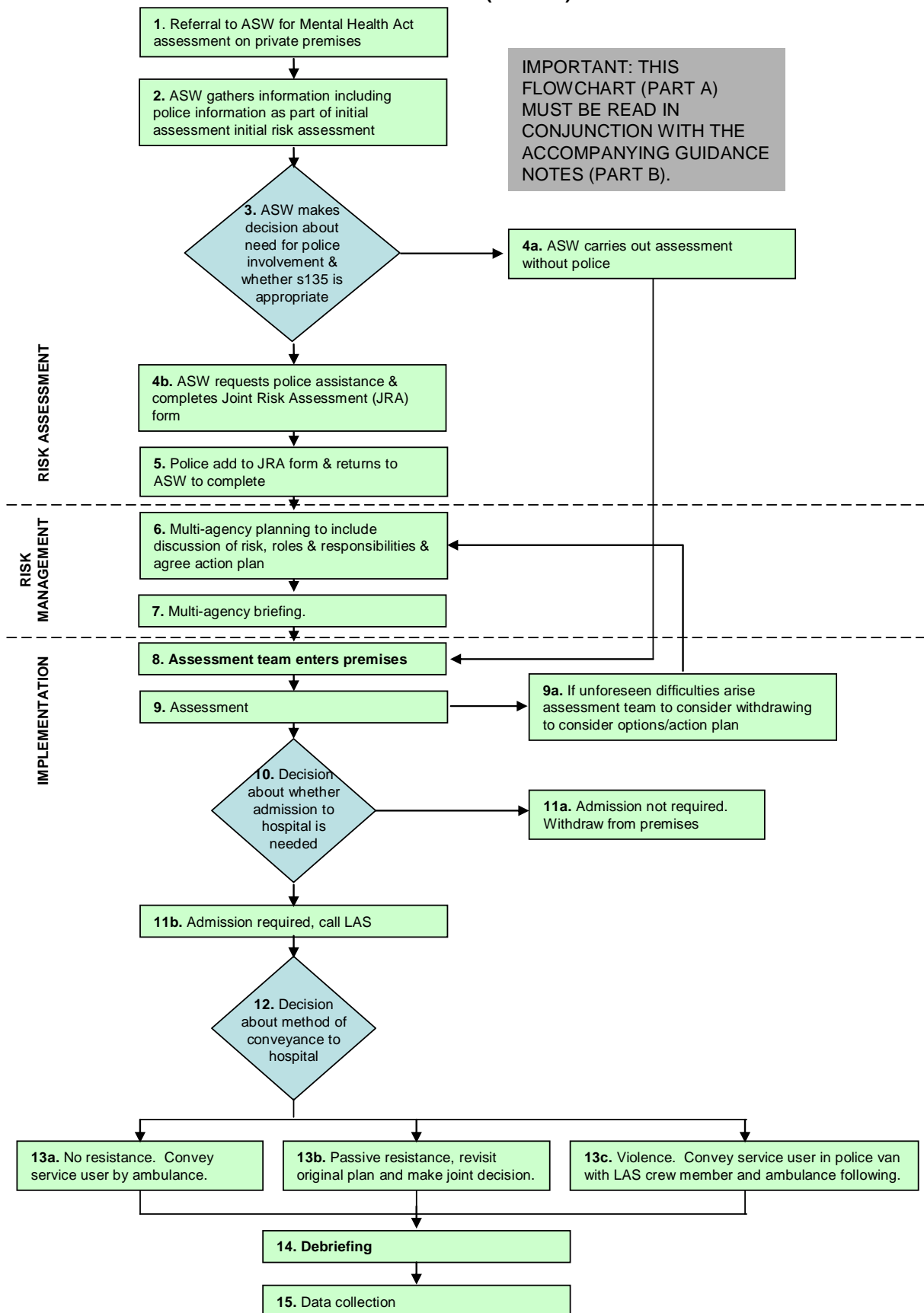
Borough	No. of APPs	No. with Police	No. of s135s	Explanatory notes
Barking & Dagenham				No response to requests for information.
Barnet	101	28	5	
Bexley	140	47	6	Not clear from information provided whether 140 was total MHAAs or figure for APPs.
Brent	308	134	48	These are the best figures from a variety of sources – routine data collection is not accurate. Work in is progress to improve data collection.
Bromley	82	DNG	4	The figure of 82 is approximate as 13 assessments were carried out and location was not stated.
Camden	DNG	150	65	Figures for 2 nd & 3 rd column gathered from the Borough Mental Health Liaison Officer.
City of London	7	DNG	2	Data covers the period 2004/05.
Croydon	DNG	DNG	0/81	Info for the period covering Oct to Dec 2004. Source – Mental; Health Trust quarterly Report; did not receive any information direct from the Social Services department.

Borough	No. of APPs	No. with Police	No. of s135s	Explanatory notes
Ealing				No response to requests for information.
Enfield				No response to requests for information.
Greenwich	DNG	DNG	6	Figures given for 2004/05. They are reviewing their data collection in relation to this area.
Hackney				No response to requests for information.
Hammersmith & Fulham	147	110*	32	Figures for 1 year period extrapolated from figures for period Jan to April 2005. * This information not routinely collected. Would estimate the 75% of MHAAs in the community involve the Police.
Haringey	DNG	DNG	DNG	MHAA data is not collated centrally.
Harrow	76	30	5	Data covering period April 2004 to March 2005.
Havering	67	26	6	
Hillingdon				No response to requests for information.
Hounslow				No response to requests for information.
Islington	291	100	21	Data covering 2004/05. Figures in first two columns are approximate.
Kensington & Chelsea	91	DNG	9	In the process of reviewing the assessment / monitoring forms and will be making changes to the forms and databases to be able to record this information.
Kingston	52	74	10	These are approximate figures for the borough covering the period March 2004 to February 2005; work is in progress to improve data collection.

Borough	No. of APPs	No. with Police	No. of s135s	Explanatory notes
Lambeth	DNG	DNG	6	Info for the period covering Oct to Dec 2004. Source – Mental; Health Trust quarterly Report; did not receive any information direct from the Social Services department.
Lewisham	225	DNG	35	These are approximate figures; work in progress on improving data collection.
Merton				No response to requests for information.
Newham	DNG	DNG	20	Source: Mental Health Act Commission form on use of s135 & s136. This data is not routinely collected.
Redbridge	159	82	26	Data covering Jan 2004 to Dec 2004.
Richmond upon Thames	68	44	4	Data covering Jan 2004 to Dec 2005.
Southwark	125	72	20	
Sutton				No response to requests for information.
Tower Hamlets	142	25	11	These are approximate figures.
Waltham Forest	150	71	41	
Wandsworth	450	DNG	40	These are approximate figures for the borough; work is in progress to improve data collection.
Westminster	DNG	DNG	DNG	

**PAN-LONDON FLOWCHART FOR LOCAL PROTOCOLS:
MHA ASSESSMENTS ON PRIVATE PREMISES (PART A)**

APPENDIX 2



**PAN-LONDON GUIDANCE NOTES FOR LOCAL PROTOCOLS:
MENTAL HEALTH ACT ASSESSMENTS ON PRIVATE PREMISES (PART B)**

**IMPORTANT: THESE GUIDANCE NOTES (PART B) MUST BE READ IN
CONJUNCTION WITH THE ACCOMPANYING FLOWCHART (PART A).**

The objective of the attached flowchart (part A) and this guidance document (part B) is to ensure consistency across London in the provision of a safe, secure and supportive service to service users, carers and members of the community, along with the creation of a local implementation document (part C). The complete protocol for Assessment on Private Premises consists of these three documents, which should be used together.

Any action taken by agencies, either unilaterally or jointly, must be:

- Proportionate.
- Legal.
- Accountable.
- Necessary.
- Based on the best available information.

and in accordance with the Human Rights Act and other legislation (see appendix).

These documents provide a framework of minimum standards around which local partner agencies are able to ensure clear arrangements are in place for the planning and implementation of local Mental Health Act assessments. It is recognised that many such arrangements already exist, and that these documents provide an opportunity to review, consolidate and build upon good practice.

It is essential that all such local arrangements are documented and publicised to all staff, and are readily available for reference.

PAN-LONDON GUIDANCE NOTES FOR LOCAL PROTOCOLS: MENTAL HEALTH ACT ASSESSMENTS ON PRIVATE PREMISES (PART B)

Each numbered section refers to the numbered boxes in the flowchart (Part A).

1. Referral to ASW for Mental Health Act assessment on private premises

Referrals can arrive from a number of different sources including public, private and professional organisations and individuals. Information may vary in quantity, quality and reliability, and all cases need to be considered on their individual merits.

2. ASW information-gathering and initial risk assessment

The ASW should carry out a documented risk assessment using the best information available, including information from other sources, such as the Police, Housing, Health, Social Services, Probation Service and carers, family, friends and neighbours.

Arrangements for an ASW to obtain information should be in place and should cover:

- how police-held information can be accessed on a 24 hour basis
- access to information held by local Multi Agency Public Protection Panel
- reference to any existing borough information sharing protocols, e.g. under Crime and Disorder Act
- an agreement for information-sharing between police and ASWs for the purpose of Mental Health Act assessments
- the ownership of data
- what should be done with the information once it has been used for the assessment.

The ASW may want to consider a pre-visit to the premises, possibly with another health professional, if they consider it safe to do so.

3. Decision about police involvement in Mental Health Act assessment

The ASW's decision to involve the police in Mental Health Act assessments should involve a risk assessment of what could happen. Identified risks which might lead to police involvement include:

- Violence
- Self-harm
- Resistance to entry
- resistance to the assessment process
- Resistance to removal to hospital, including passive resistance
- Absconding

Local organisations should consider developing a joint (Social Services / police / LAS) risk assessment and management model and ensure common understanding of, and joint training in, such a model.

4a. ASW carries out assessment without police

If the risk assessment indicates that a Mental Health Act assessment can be carried out without police involvement, the ASW should still consider in advance:

- what action they will take if they are met at the scene by violence or resistance
- what action they will take if the service user passively resists once the papers are completed (see Passive Resistance in para 6).

4b. Request for police assistance

- There should be a robust process in place by which an ASW can enlist the help of the police, eg through the borough control room or operations or events office. Arrangements for out-of-hours requests should also be in place.
- There should also be a robust process for the police to respond to such requests.

5. Multi-Agency Risk Assessment

- Key partners, including the ASW and the police, must conduct a joint risk assessment to ensure that all the available relevant information is shared and considered.
- A policy should be in place to cover how and where this risk assessment will take place.
- A lead agency should be identified at this stage.

Good practice: identifying a lead agency

If there is a clear history of a risk of violence, either in accessing a property or removing a person to hospital, the police should manage the overall process of entering and securing the premises. This will allow the Mental Health Act assessment to take place and the safe removal of the service user – if the assessment indicates – by the police, using police transport if necessary.

6. Multi-agency planning

- A robust planning process must take place to ensure that all identified risks (refer to paragraph 3 above) are considered and managed safely.
- This process should consider all the further steps in the flowchart, from 8-15.
- Local organisations should have a policy in place which covers:
 - which organisations will be involved in the planning process
 - how and where planning will be carried out
 - how to deal with a situation where one of the key players (eg a doctor or an LAS representative) is unable to participate in the planning process
 - where the resulting documentation will be stored
 - arrangements for escalation of problems to a management level if frontline staff are unable to agree a course of action

- Determining the method of entry is an essential part of the planning process. When police accompany an ASW into private premises, their entry can be either under the authority of a warrant issued by a Magistrates' court under Section 135(1) of the Mental Health Act or with the consent of a person capable of providing that consent. All agencies should understand who can grant consent to entry, and in what circumstances.

Section 135 warrants

Despite the ASW having lead responsibility for making an application to the courts consideration of the need for a s135 warrant should also be part of the multi-agency planning discussions.

A warrant is usually applied for by the ASW if s/he anticipates, on the basis of evidence, being unable to gain entry to a property to carry out an assessment or being unable to remain on the property in order to complete an assessment.

There may be circumstances where it is clear that it would not be appropriate or necessary to obtain a s135 warrant for police to enter premises, and where consent to entry is anticipated. However, it must be clearly understood that where consent is withdrawn prior to the relevant Mental Health Act paperwork being completed all agencies will need to withdraw immediately from the premises, as their presence would constitute trespass. For police officers, the difficulty exists that if they are on premises without a warrant and are asked to leave, they must do so. There should be a clear and explicit plan to deal with these occasions. If such a situation occurs, then grounds clearly exist for a warrant application.

- An agreed procedure for obtaining warrants, both during and outside court hours, should be in place.

Good practice – information for Magistrates

It is good practice for magistrates to ask the ASW why they are applying for a s135 warrant and to provide documented evidence for doing so. Magistrates practice on this issue was reported to vary across London. Ideally, an agreement on standards of information to be supplied in support of a s135(1) warrant should be reached between local Magistrates' courts and social services.

Dealing with passive resistance

Planning in advance for the possibility of passive resistance is very important and should involve the ASW, police, doctors and ambulance staff. Current legislation does not identify who has a duty to physically remove a person from the assessment location, when they have been placed under section of the Mental Health Act. When dealing with passive resistance, this role could be taken on by any of the disciplines present, or a combination of all, depending on the situation.

The safest method of removing the subject must be considered and a decision made as to who will have responsibility for lifting the person into the ambulance. LAS crew staff can assist in the safe removal of the subject, as may other health care professionals present. Police will intervene and assist more fully if a violent struggle or breach of the peace occurs or if greater force is required during the process. Local organisations should consider the need for further training for staff across agencies on this issue.

- The nature of the police response in each situation will be at the discretion of the police and will depend on the information available at the time, and in discussion with the ASW.

7. Multi-agency briefing

- All personnel involved must be briefed on the perceived risks, measures to minimise or eliminate those risks, and the roles of individual professionals and agencies during the assessment.
- Arrangements should be in place to agree the location of where the briefing will take place, taking into account the possibility that some professionals may be unable to attend the main briefing.
- If doctors, ambulance crews or other individuals are unable to attend the multi-agency briefing, arrangements must be made to inform them, before they enter the premises, about their safety and theirs' and others' roles in the assessment process.

Good practice – involvement of ambulance service

Ideally the London Ambulance Service (LAS) should be involved early in the multi-agency planning and risk assessment process. However, as it is never known in advance which ambulance crew will be attending the call, this may be difficult to achieve. There may be a way for a member of the local station management team to participate in the process, and to pass the information to the ambulance crew, but this will take further work to develop.

As a minimum, the LAS must be briefed at the time of the call about any immediately relevant information (e.g. whether to enter the premises or wait outside). On arrival, the crew must be given both a clinical handover and a briefing on any risk information,

8. Entry to premises

- Where it has been considered unnecessary to obtain a warrant under s135(1), and where consent to entry has been given, it must be clearly understood that if consent is withdrawn prior to papers being completed, all mental health professionals and the police (if present) will need to withdraw immediately. Failure to do so would constitute trespass and would infringe the individual's human rights. Generally, a s135(1) warrant would then need to be applied for, unless there were serious risks to "life or limb" or serious damage to property and immediate police action would be justified under S17 of PACE and under common-law.
- A warrant – under s135(1) of the Mental Health Act - gives powers, but does not compel the police to force entry or to convey the service user to hospital, if the service user is complying with the assessment. Individual police constables should use their judgment and discretion depending on the circumstances of the situation. However, the police should remain in attendance as the person being assessed may change their minds at any point during the course of assessment and police assistance may then be required.
- Sections 15 and 16 of the Police and Criminal Evidence Act (PACE) state that a warrant shall authorise entry on one occasion only, within one month of its issue. It should be acknowledged that Section 17 of PACE should only be used where it is necessary and proportionate, and not as a convenient alternative to obtaining a warrant.
- If the occupier of the premises is present at the time when the police officer seeks to execute the warrant, the police officer shall:

- identify himself / herself to the occupier;
 - produce the warrant for the occupier, and supply him / her with a copy;
 - if the occupier is not present and entry has been executed, a copy of the warrant must be left on the premises.
- The action which will be required if consent to entry is withdrawn before the assessment is completed, must be considered in advance.

9. Assessment

- The responsibility of each agency at the scene should be clear in advance.
- Those who will be present should also consider in advance who has control at the scene, both generally and in specific scenarios.

9a. Unforeseen difficulties

- If unforeseen difficulties occur during the assessment the team should consider withdrawing from the assessment (ensuring the service user's safety) to discuss their options and agree an action plan.
- If frontline staff are unable to agree a course of action they will need to refer the issue/s to a senior manager. There should be a local process in place to facilitate such action.

10. Decision about admission to hospital

- Powers to remove the individual to hospital only come into effect once the relevant Mental Health Act section papers have been completed.

11a. Withdrawal

- If detention under the Mental Health Act is not necessary consideration should be given to the actions, if any, that each agency needs to take.

11b - 13c Transportation to hospital

- An ambulance should only be called if and when papers for admission to a named hospital have been completed.
- On arrival, the ambulance crew must be given both a clinical handover and a briefing on any risk information, by those personnel carrying out the assessment. It is the ASWs responsibility to ensure that this happens.

Work underway – transportation policy

Currently, a service user will be transported to hospital in an ambulance unless he or she is so violent that a police van is required. An agreement is currently being developed between the Metropolitan Police and the London Ambulance Service on transportation of patients to hospital

Guidance currently available

A booklet, entitled 'Admitting Mentally Ill Patients to Hospital', produced jointly by the London Ambulance Service and the Metropolitan Police, contains some good practice guidance. While the whole issue is under review, this document may well prove helpful in addressing the issues of conveyancing. Copies of this booklet will be made available to implementation groups on request.

- Powers under section 3 of Criminal Law Act (1967) (Use of Reasonable Force) must be understood by all parties.

Good practice – dealing with violence

If there is a clear indication of a risk of violence, in removing a detained person to hospital, the police should manage the overall process. This will allow safe removal of the service user by the police, using police transport if necessary, with the ASW and/or member of the ambulance staff accompanying in the police van, with the ambulance following behind.

- When, following the completion of section papers under the Act, the service user declines to be conveyed to hospital, it is essential that the means of ensuring compliance is legal, proportionate and necessary. The ASW has the ultimate responsibility to ensure that the service user is conveyed in a lawful and humane manner and should give guidance to those asked to assist.
- A plan will need to be agreed by the agencies and professionals present, according to the level of urgency and the circumstances, about who actually first lifts a service user and what other assistance and resources might be required. This could be any, or a combination of professionals depending on the situation. Alternatively, the ASW may need to consider arranging other staff to assist in the removal. The police should remain in attendance until the person has been removed from the premises and taken into the ambulance. The ASW or delegated other, should accompany the patient and the police will follow in case the situation changes and their assistance is required.

14. De-brief

- At the conclusion of a Mental Health Act assessment, a de-brief should take place. It may not be practical for all parties involved to take part in an immediate de-brief, but as a minimum requirement there should be a multi-agency forum at which assessments are reviewed.

15. Data Collection

- Each local authority social services department should routinely collect a minimum set of data in relation to assessments on private premises. It is recommended that for a given period the following data should be collected:
 - the total number of assessments carried out on private premises
 - the number of assessments on private premises which involved police assistance, and
 - how many of these assessments took place using s135 (1) of the Mental Health Act.

APPENDIX: SUMMARY OF RELEVANT LEGISLATION

Human Rights Act

Section 6(1) of the Human Rights Act 1998 makes it unlawful for a public authority to act in a way which is incompatible with right under the European Convention for the Protection of Human Rights and Fundamental Freedoms. It is essential that any proposed course of action be:

- Proportionate.
- Legal.
- Accountable.
- Necessary.
- Based on the best available information.

Health and Safety Legislation

Participating agencies are subject to the requirements of The Health & Safety at Work Act 1974 and all other relevant statutory provisions and recognised codes of practice. They also accept their responsibility for the health and safety of other people who may be affected by their activities.

All pre-planned operations must be risk assessed and risk managed and this requires high quality information.

The Race Relations Act 1976 as amended by the Race Relations (Amendment) Act 2000, and the Code of Practice on the Duty to Promote Race Equality

All public authorities have a general duty to:

- Eliminate unlawful racial discrimination.
- Promote equal opportunities.
- Promote good relations between people from different racial groups.

Mental Health Act Code of Practice

All service users will 'be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any of these characteristics'.

Disability Discrimination Act 1995

It is unlawful for service providers to treat disabled people less favourably for a reason related to their disability.

Data Protection Act 1998

Anyone processing personal data must comply with the eight enforceable principles of good practice. They say that data must be:

- fairly and lawfully processed;
- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate;
- not kept longer than necessary;
- processed in accordance with the data subject's rights;
- secure;
- not transferred to countries without adequate protection.

Request for police assistance for community mental health assessment – Joint Risk Assessment Form

1. Introduction

In accordance with recommendation D14 of the report the project team developed this draft Joint Risk Assessment Form and guidance notes to be used by ASWs and police when planning Mental Health Act assessments in the community. It was compiled in consultation with ASWs, police and LAS and used a sample of similar forms currently in use in six London boroughs.

Ideally the London Ambulance Service (LAS) should be involved early in the multi-agency planning and risk assessment process. However, as it is never known in advance which ambulance crew will be attending the call, this may be difficult to achieve. There may be a way for a member of the local station management team to participate in the process, and to pass the information to the ambulance crew, but this will take further work to develop.

In addition, the information held by the LAS on its 'risk address' register is already shared with the police, so LAS involvement in the process would mainly be as a recipient of information, rather than a contributor.

As a minimum, the LAS must be briefed at the time of the call about any immediately relevant information (e.g. whether to enter the premises or wait outside). On arrival, the crew must be given both a clinical handover and a briefing on any risk information, by those personnel carrying out the assessment.

This form was developed in accordance with the following guiding principles:

- acting in the best interests of the service user, their carer/s &/or dependents
- minimum necessary information provided with the purpose of protecting the health and safety of all those involved in the process
- maintaining professional confidentiality
- compliant with relevant legislation and guidance
- accessible to the different professional groups involved in the process, i.e. minimal use of jargon
- ease of completion.

It is recommended that this form is initially piloted and the final version of this form should be made available to staff in both paper and electronic formats.

2. General guidance notes for ASWs and police on using this form

2.1 ASW

Prior to completing the form the ASW must first make telephone contact with the relevant police station and have a discussion about the request. Ask the police to provide a CAD reference number for your call and note this in part 1 of the form. The ASW (or a colleague) should then complete parts 1 – 7 of the form and fax it to the relevant police station. If a colleague is completing the form on behalf of the ASW the ASW must check the form before faxing it to the police.

When completing the form do not leave questions unanswered. If there is no information available, or you are unable to obtain information relating to any question or the question is

not relevant to the service user's circumstances, please just state as much in the space provided.

2.2 Police

On receiving the form the police must log the receipt and complete part 8 of the form. Once a decision about providing assistance has been made the completed part 8 must be faxed back to the ASW's office. Please follow this up with a telephone conversation with the ASW, at which point final arrangements for carrying out the assessment can be agreed.

3. Guidance on secondary uses of information

3.1 What mental health services may do with information obtained from police

Mental health and social care service staff may:

- record the information in the service user's health or social care record (which may be either a paper or an electronic record). The information should be clearly identified as having been obtained from police.
- share the information with relevant members of the multi-disciplinary team.
- share the information with the service user, if appropriate and if authorised by the originator.

Mental health and social care service staff may not:

- pass on information beyond existing policies and practices.
- store information in a manner not in accordance with organisational policy and guidelines.

3.2 What police may do with information obtained from mental health services

Staff working for the Metropolitan Police may:

- use the information in relation to the incident/assessment for which it was requested; they may record in any records created in relation to that incident/assessment (e.g. in CAD, decision logs or incident report books) the receipt and contents of the information provided by mental health services.

Staff working for the Metropolitan Police may not:

- transfer information as a block onto other databases, including CRIMINT and the Police National Computer.
- retain any information without allocating a handling code of 5 "No further dissemination: refer to originator" according to the National Intelligence Model. The details (name and contact details) of the originator must be stored with the information for future reference.

Mental Health Act assessment, section 3 (admission for purpose of treatment; 6 months max; 2 doctors required)	
Mental Health Act assessment, section 4 (emergency admission for purpose of treatment; 72 hours max; doctors required)	
Mental Health Act, section 135 (1) Has application for section 135 warrant been considered in this case? If not, why not?	
Other assessment in the community (please specify)	

3.3 Timing & location

Proposed/preferred time & date:

Address of assessment if different from service user's home address:

Final agreed time & date (to be completed after decision by police):

Part 4 Current circumstances & risks

Are family member/s &/or carer/s aware of the proposed assessment? (yes or no)

If yes, do they agree with your actions? If no, please give details?

Is there evidence of self-neglect? If yes, please briefly specify.

Is the person threatening self-harm? If yes, please briefly specify.

Does the person have any physical health problems which the assessment team need to be aware of? If yes, please specify.

Is there anything about the person's current mental state/crisis which indicates that they may become agitated, aggressive and/or violent during the assessment? If yes, please specify and include suggestions for managing such behaviour.

Have you any reason to believe that the person might use a weapon during the assessment? If yes, please be specific about likely weapon.

Are you aware of any other aggravating factors that might impact on the assessment (e.g. current alcohol/drug use, difficult relationships with family member, neighbour, etc)

Has the person been involved in any recent incidents which have given you cause for concern?

Please include any other information you think is relevant?

Part 5 History of previous assessments & admissions

Has the service user been aggressive or violent in the past, either in the context of a Mental Health Act assessment or at other times? If yes, please give details.

Have police assisted with previous assessments or transporting to hospital? If yes, please give details?

Are you aware of any aggravating factors which may have led to aggression or violence in the past? If yes, please give details?

Has the person a history of using weapons?

Has the person a history of self-harm?

Are you aware of any incidents of resistance during previous assessments (include refusal to be taken to hospital)?

Is there any history of the person attempting to abscond during previous Mental Health Act assessments? If yes, briefly describe.

Please give any other information about the person's history you think may be relevant?

Part 6 Relevant safety issues for this assessment

Who else (apart from professionals) is likely to be present during assessment?

Who are you expecting to give you entry to the premises? Are you expecting any problem with gaining entry? If yes, please specify.

How is access to the property gained, e.g. block of flats, floor level, stairs, lift, etc?

Please give a detailed description of the layout of the property (note, no. of floors, no. /type of rooms, the number/location of exits and any physical barriers, e.g. grilles, etc)

Are you aware of any other hazards on the premises, e.g. hoarded materials blocking passages?

Are you aware of any strong reactions (either positive or negative) of the person towards any of the following?

- uniformed staff (please specify)
- any particular family members; partners; friends, etc.
- a particular racial or religious group
- a specific gender
- other

If yes, please give details.

Are there any children or other vulnerable adults residing at the address? If yes, please give details (indicate (i) whether Children & Families services have been informed, and (ii) whether they will be in attendance at the assessment).

Who owns the property where the assessment is taking place? (service user, private rented, council accommodation, housing association, supported accommodation)

Are you aware of any animals living at the premises?

Please outline any issues which you think may be relevant to immediate neighbours and/or local community?

Part 7 Post-assessment considerations

Following completion of the assessment will any of the following need to be addressed?

- childcare
 - pet care
 - securing property
 - looking after keys to the property
-

Please fax this to (*insert name and fax number of local police station*)

Part 8 FOR POLICE USE ONLY

Fax received (date & time):

Acknowledged:

Assistance to be given (*Yes, No or More info / discussion needed*). If 'No' or 'more info / discussion needed' please say why and any actions to be taken.

CHECKS COMPLETED

PNC:

CRIMINT:

CRIS:

Other:

Police resources to be deployed: Numbers:

Level:

Notified ASW (time /date):

Duty officer / other informed:

Date and time agreed with ASW:

Closing CRIMINT log no.

Please fax this page only to the ASW at (*insert name and fax no. of mental health team*)
