Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation

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Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation

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Contents

1. Purpose of this guidance

1.1 This guidance is aimed at providers of NHS-commissioned mental health services and contains information applicable to mental health professionals who work within them. It is designed to support providers and staff to exercise their statutory and professional duties to safeguard vulnerable children, young people and adults at risk of radicalisation.

1.2 It sets out expectations and considerations that providers and professionals should take into account when exercising these duties, and is structured into four key components:

- **Prevent responsibilities of mental health providers** – outlining the safeguarding pathways that should be in place, the roles and responsibilities of key staff and training requirements for mental health professionals.

- **Prevent referrals from mental health providers** – outlining the processes for referring to Prevent, making a referral including consent considerations, and working in partnership with police.

- **Role of mental health providers in the Prevent process –** outlining expectations for mental health representation at Channel Panels, information sharing and considerations relating to detention under the Mental Health Act.

- **Referrals into mental health services from Prevent** – outlining expectations to ensure timely access to services to those at risk of radicalisation with mental health needs and considerations for the prioritisation of cases.

1.3 Examples based on real cases and flowchart diagrams have been developed for this guidance to illustrate Prevent in a mental health context.

1.4 This guidance builds on a range of existing guidance and advice on safeguarding and information sharing in the health sector, as well as guidance on the Prevent Duty and Channel programme. Key publications are signposted at the end of this document.

2. Mental ill health and radicalisation

2.1 Research on individuals who have engaged in terrorist activity demonstrates that there is no single socio-demographic profile or pathway that leads an individual to become involved in terrorism, making involvement in terrorist activity inherently difficult to predict. Vulnerability to radicalisation depends on complex interactions between different risk factors. These can include involvement in criminality, family influence, failure to integrate, or a sense of grievance or injustice.

2.2 Presence of these and other risk factors does not make radicalisation inevitable or predictable. The vast majority of people exposed to risk factors do not go on to engage in terrorist activity. This might be due to the presence of protective factors, such as having a strong family life that provides a sense of belonging, self-esteem and purpose, friendships that would be jeopardised by involvement in terrorism, or being open to challenge from other perspectives.

2.3 There is a need for further research on links between terrorism and mental health. The data available on the mental health of terrorists is limited given the small number of terrorists relevant to the population. Existing evidence suggests that while there is no link between mental disorder and group-based terrorism, terrorists who act alone may be more likely to have a background that includes mental ill health.

2.4 There should be no conflation of mental ill health and terrorism. There should be no assumption that an individual who carries out a terrorist attack is suffering from mental ill health, nor that someone with poor mental health is likely to carry out a terrorist act.

2.5 However, mental ill health may contribute to the risk of making an individual susceptible to adverse influences and exploitation. Timely access to mental health treatment might reduce the overall risk. This is part of the everyday work of mental health professionals, and part of their professional and statutory duties.

3. Prevent as part of safeguarding

3.1 Prevent is a key part of the Government's counter-terrorist strategy, CONTEST.[2] The purpose of Prevent is to safeguard people from becoming terrorists or supporting terrorism, by engaging with all people who are vulnerable to radicalisation – including children and young people - and

protecting those who are being targeted by terrorist recruiters.

3.2 It aims to do so by tackling:

- the influences of radicalisation and respond to the ideological challenge of terrorism, working through partnerships;
- safeguarding and supporting those most at risk of radicalisation by identifying them and offering support; and
- Enabling those already engaged in terrorism to disengage and rehabilitate.

3.3 The Prevent statutory duty, introduced through the Counter-Terrorism and Security Act 2015, requires local authorities, schools, colleges, universities, health bodies, prisons and probation, and police to have '*due regard to the need to prevent people from being drawn into terrorism*'. The duty helps ensure that individuals who might be at risk of radicalisation are supported as they would be under other safeguarding processes.[3]

3.4 In the course of this duty, specified authorities will share relevant information about those individuals they consider to be at risk of radicalisation through dedicated safeguarding pathways. Concerns are then considered by police for deconfliction - the process where the police check with partner organisations and agencies whether any other concerns have been raised about an individual which would prevent a referral from being taken forward. Police will then determine the validity of the referral which was made, if there is a genuine vulnerability to radicalisation, and ensure that there is no imminent threat to the public. Referrals operate in the non-criminal space and therefore do not result in a criminal record or criminal investigation.

3.5 The Channel programme is a multi-agency approach to provide support for people identified as being vulnerable to being drawn into terrorism. Following police deconfliction, a multi-agency Channel panel, chaired by the local authority, will meet to discuss the referral, assess the extent of the vulnerability and decide on a package of support to be offered on a voluntary basis to the individual.

3.6 As vulnerability to radicalisation depends on complex interactions between different risk factors, the Channel programme brings together statutory partners to design and deliver a package of diverse and tailored support which may include education, vocational, mental health and theological support.

3.7 People who do not consent to receive support through Channel, or who decide to leave the programme before the Channel panel decides they are

ready, may be offered alternative forms of support by the local authority or other providers.

4. Prevent in mental health provider organisations

4.1 In the health sector, the Prevent duty sits alongside long-established duties on all NHS organisations and health professionals to work with local authorities, police and other partners to safeguard people from harm or exploitation.

4.2 As with all safeguarding duties, mental health provider organisations must ensure that sufficient capacity is in place to fulfil their statutory and professional duties for Prevent. This includes ensuring that:

- Prevent pathways are in place to facilitate referrals to and from Prevent;
- key Prevent roles are established and supported within the organisation; and
- frontline staff are trained to recognise potential risk of radicalisation.

Prevent safeguarding pathways

4.3 The Prevent referral process and Channel programme present an opportunity to obtain a wide range of relevant support from a range of services for people receiving care from mental health services who may be at risk of radicalisation.

4.4 It also provides a mechanism to identify and address the unmet mental health needs of vulnerable people at risk of radicalisation, who may not otherwise have come into contact with mental health services.

4.5 Two key Prevent pathways should be established in all mental health provider organisations, and providers should ensure effective leadership and management of these processes.

- Pathway to refer people in the care of mental health services who may be at risk of radicalisation, to police to access multi-agency Channel support (Chapter 5).
- Pathway to ensure timely access to mental health assessment and support for referrals received by mental health providers from Channel panels where an individual at risk of radicalisation has mental health needs (Chapter 7).

4.6 The following chapters of this guidance provide further detail on each of these pathways, including flowchart diagrams and considerations that should be exercised at each stage of the process.

Key roles and responsibilities

4.7 Mental health providers should assign staff to hold three specific Prevent roles within their organisations:

- Board level accountable clinician
- Senior clinical lead
- Prevent lead

4.8 **Board level accountability** and mechanisms should be in place to provide assurance on the discharge of an organisation's Prevent duties. In many cases this is likely to be the person who has board-level responsibility for safeguarding, and would usually be a senior clinician such as the Director of Nursing or Medical Director. The responsibilities for this role include:

- Providing leadership and taking responsibility for compliant delivery of the Prevent duty, and its integration within safeguarding procedures
- Monitoring Prevent delivery, including referrals made and received and their outcomes, reporting to the board and providing assurance on Prevent delivery
- Ensuring appropriate Prevent training is undertaken by all staff and adherence to information governance protocols and reporting

4.9 **Senior clinical oversight** is important given the complexity of safeguarding risk assessments, particularly in mental health where they will often involve people with multiple and complex needs. The senior clinician undertaking this role must have undertaken Prevent training such as the Workshop to Raise Awareness of Prevent (WRAP) (see section 4.14). The responsibilities of this role include:

- Supporting the Prevent lead by advising on potential referrals as necessary
- Reviewing referrals and providing clinical assurance on appropriateness, as would be expected for all safeguarding referral processes
- Supporting the Prevent Lead to ensure that mental health referrals from Prevent are appropriately prioritised for triage and assessment

4.10 **Prevent lead delivery** will be undertaken by a named lead who should be in place in every NHS Trust, preferably in the safeguarding team. Prevent leads ensure that statutory Prevent duties are exercised appropriately and

proportionately. The appointed person must have undertaken Prevent training. The responsibilities of this role include:

- Acting as a single point of contact for staff, police and Channel Panels
- Facilitating referrals, information requests and feedback to and from Prevent
- Advising staff on Prevent, such as concerns, referrals and processes
- Linking with appropriate adult and children safeguarding and protection processes
- Delivering training on Prevent within the organisation as appropriate
- Ensuring authorised information sharing agreements are applicable to Prevent
- Overseeing collection of Prevent data for NHS England and commissioners
- Working closely with NHS England's Regional Prevent Coordinators
- Attending regularly quarterly regional Prevent forums
- Engaging and representing the trust at local Prevent and safeguarding groups
- Ensuring mental health provider representation at Channel panels and monitoring and triaging mental health referrals from Channel panels (see section 6.6 and 7.4).

4.11 In order to ensure that referrals are made appropriately, Prevent Leads and the senior responsible clinicians overseeing the Prevent duty should have a strong understanding of the process and have completed the relevant training. They should also have experience of handling Prevent safeguarding referrals, and working with police and channel panels. On the occasions where it is not clear if a referral should be made, Prevent Leads should seek to discuss and agree with the clinicians involved, including explaining why referrals may not be appropriate. However, if the responsible clinicians still disagree, their judgement should take priority. This is because clinicians are likely to be closer to understanding the individual in question and will also remain accountable for the patient's care. The senior responsible clinician will hold an overall responsibility for ensuring that Prevent safeguarding referrals are clinically appropriate. However, this does not mean they will be expected to review every referral.

4.12 There is also **Regional Coordination** of delivery by 7 Health Regional Prevent Coordinators (RPCs), situated across the country in NHS England teams and funded by the Home Office. The RPC network supports local delivery of Prevent within NHS Trusts and Foundation Trusts, this includes:

- Supporting and facilitating Trusts to provide training for their staff'

- Facilitate regional forums to cascade information and support to Prevent leads in delivering Prevent compliance
- Identifying areas of concern that require escalation to NHS England Regional Safeguarding Leads
- Providing ad hoc support on complex cases, linking together when necessary multi-agency partners
- Providing expert guidance to senior management teams in Trusts and Foundation Trusts in the delivery of Prevent for frontline services

Training of mental health professionals

4.13 A core element of the Prevent Duty in mental health provider organisations is ensuring that mental health professionals are appropriately trained to correctly recognise the signs that someone is at risk of radicalisation, which may increase their risk of engagement with terrorism. Professionals should be aware of, and be able to locate available support, including the Channel Programme where necessary.

4.14 Mental health providers should ensure that mental health staff are trained to:

- Correctly recognise exploitation of vulnerable individuals who have been or are at risk of being radicalised
- Understand the organisational policies, escalation procedures and processes in place through which they can raise concerns and share information, and who to contact
- Balance patient confidentiality with their professional duty to safeguard against the risk of radicalisation
- Regularly refresh their Prevent knowledge and understanding.

4.15 NHS England's Prevent Training and Competencies Framework[4] has been developed to provide a proportionate approach to raising awareness of Prevent as part of the wider safeguarding agenda. It provides clarity on the level of Prevent training required for healthcare workers by identifying staff groups that require basic Prevent awareness and those that would require a more detailed understanding of the Prevent duty and processes. As a minimum, all staff must undertake basic Prevent awareness training as part of a mandatory e-learning or safeguarding training.

- **Basic Prevent Awareness (levels 1 and 2)**
  This often delivered as part of the wider safeguarding training that takes place when a person joins a Trust, and could take the form of a small number of slides on Prevent within a wider safeguarding e-Learning package.

- **Prevent Awareness Training (levels 3, 4 and 5)**
  This requires attendance at a Workshop to Raise Awareness of Prevent, which is delivered face to face and utilises training materials produced by the Home Office.

4.16 A full list of Prevent training products is available online[5] which mental health providers may wish to consider incorporating into their established safeguarding training programmes.

5. Prevent referrals from mental health provider organisations

5.1 A process should be in place in all mental health provider organisations to ensure that professionals are able to refer concerns about patients who may be at risk of radicalisation to Prevent, via their organisation's Prevent Lead. **Figure 1** sets out this referral pathway in practice.

Making a Prevent referral

5.2 There is no single way of identifying who is likely to be vulnerable to being drawn into terrorism. Recognising that someone is at risk of radicalisation is complex and sensitive and in any scenario the circumstances and vulnerabilities will be as unique as the individual themselves. The decision as to whether to make a referral is no different to other safeguarding concerns, and professionals should exercise their judgement on a case-by-case basis and liaise with their line manager and/or organisation's Prevent Lead.

5.3 Often the factors that have a bearing on someone becoming vulnerable to radicalisation are similar to other safeguarding vulnerabilities, which may include: peer pressure, influence from other people or via the internet, bullying, crime against the person or involvement in crime, anti-social behaviour, family tensions, race/hate crime, lack of self-esteem or identify and personal or political grievances. Considering the possibility of radicalisation as an early intervention safeguarding consideration could serve to ensure that the individual is offered the support they require.

5.4 Prevent training, outlined in Chapter 4, supports professionals in identifying signs that may indicate someone is at risk of radicalisation and suitable for the Channel programme. Vulnerability to radicalisation is assessed by Channel Panels on the basis of engagement with an extremist group, cause, or ideology, intent to cause harm, carry out violence or other illegal acts and capability of causing harm or contributing directly or indirectly[6].

5.5 Professional judgement will always need to be exercised in assessing a person's vulnerability to becoming radicalised. To support this, the following indicators, which are based on interviews with individuals convicted of terrorist offences, are aimed to support professionals to identify those who are at risk of radicalisation. These factors may include, but are not limited to, the following:

- Behaviour becoming increasingly centred an extremist ideology, group or cause.
- Loss of interest in other friends and activities not associated with an extremist ideology, group or cause.
- Identifying another group as threatening what they stand for and blaming that group for all social or political ills.
- Expressing attitudes that justify offending on behalf of the ground, cause or ideology.
- Condoning or supporting violence or harm towards others.

5.6 These indicators are not exhaustive and vulnerability may manifest in other ways. As there is no single route to terrorism, any attempt to derive a 'profile' can be misleading. It must not be assumed that any set of characteristics or experiences will necessarily lead to individuals become terrorists, or that these indicators are the only source of information required to make an appropriate assessment about vulnerability.

5.7 As radicalisation depends on complex interactions between different risk factors, treating the presenting mental illness alone may not be enough to safeguard an individual from the risk of radicalisation. Mental health professionals are routinely required to work with partner agencies to support patients in their care. The Prevent process can further support this by facilitating access to a number of partner agencies, such as education, housing, social care and police, providing wider contextual information and access to support for about an individual that mental health services may not otherwise be able to access.

5.8 Channel Panels are also able to facilitate a tailored and multi-agency package of support for a person who may be at risk of being radicalised, to access wider support than that available through mental health services. Importantly, a referral to Prevent does not constitute a referral out of mental health services, and any mental health support being provided to an individual referred to Prevent should form an important part of any package of support the Prevent process may provide.

5.9 Given this, it is important that mental health professionals and Prevent partners ensure continued engagement with each other following referrals into Prevent. At a minimum, this will include regular working between NHS Prevent Leads and police, as well as involvement in Channel Panels (see sections 6.2-6.8). When sharing information with each other, local agencies must follow existing duties and guidance around patient confidentiality (see sections 6.9-6.13).

5.10 Some people who are acutely unwell may be difficult to engage in mental health services. People in the care of mental health services can often experience extreme emotional distress, high levels of anxiety, disinhibition, thoughts of self-harm or suicide. Some people experience unsettling deviations from reality such as hallucinations or hearing voices, which may be unpleasant and can evoke fear and paranoia. As with all safeguarding decisions, mental health professionals will need to consider whether a referral could escalate an individual's condition or risk disengagement from mental health services altogether. Balancing considerations about patients with complex needs, alongside potential safeguarding concerns will not always be straightforward. Mental health clinicians will need to exercise their professional judgement, seeking the advice of the organisation's senior clinical lead, Prevent lead and others as necessary.

5.11 Professionals should also have due regard to the Public Sector Equality Duty and be sensitive in their considerations. Outward expressions of faith or an interest in global or political events, or opinions that may seem unpleasant, in the absence of any other indicator of vulnerability or risk, are not reasons to make a referral to Channel.

5.12 Referral to Prevent is not an appropriate next step when professionals have concerns that a patient may be at risk of carrying out an imminent terrorist act or other act that would put themselves or others at risk. In these instances, urgent 999 contact with the Police should be made and where there is a mental health need, consideration should be given to an urgent assessment under the Mental Health Act. Sections 6.14 and 6.15 provide further detail on information sharing between NHS and Prevent for people detained under the Mental Health Act.

Example 1 – Prevent referral from a clinical psychologist

Eric had been providing cognitive behavioural therapy (CBT) to twenty-four year old Kelvin for six weeks after being referred by his GP with anxiety and difficulty controlling his anger. Kelvin had visited his GP following the death of his father and his subsequent difficulty sleeping, during which he reported symptoms of constant restlessness, feeling on edge and distress.

As a child Kelvin suffered physical and emotional abuse from his father and as an adult he was burdened by his father's hatred of his partner's ethnicity. After the breakdown of his relationship with his girlfriend, Kelvin became withdrawn and stopped working or visiting friends. Kelvin became convinced that the system rigged against him when he lost his job and failed to gain custody of his daughter, and turned to online groups to share his grievances.

Eric became concerned about Kelvin when he began recount conversations with groups online about the need for a new world order and blame minority ethnic groups for the problems he saw in Britain. When Kelvin severed his relationship with his daughter as a result of her mixed ethnicity and mentioned his interest in joining a neo-Nazi activist group, Eric raised concerns with the Prevent Lead in his trust.

The Prevent Lead facilitated a referral to Police who were able to access information about Kelvin from a range of wider partners unavailable to Eric and the Trust. Kelvin's case was determined suitable for the Channel Programme, through which Kelvin agreed to access a range of support alongside his ongoing CBT and decided not to join the activist group he was considering. This included:

- support through the local authority to access relevant training and help into a new job;
- a key support worker to facilitate access to his daughter to rebuild their relationship; and
- access to a local project aimed at breaking down barriers between different ethnic groups.

Obtaining consent

5.13 Guidance from the General Medical Council (GMC)[7] states that information sharing procedures for *Prevent* should be no different to any other safeguarding referral. Where clinicians have a safeguarding concern, they would ordinarily explore this with the person (or for minors under the age of 16, if appropriate, the person with parental responsibility)[8], explaining that their primary concern is the patient's welfare, and that by preventing them from the risk of committing a criminal or harmful act, it is intended to help them.

5.14 When making a Prevent referral professionals should ordinarily aim to seek consent from the individual or where the person is under 16, if appropriate, the person with parental responsibility, before sharing their personal information with another agency. When seeking consent professionals should provide information about the Prevent process, informing them that it is a voluntary and non-criminal process and making them aware of the beneficial support they may be eligible to receive. A patient information leaflet is available to support clinicians in discussions with patients about Prevent.[9]

5.15 Clinicians may need to explain that they have obligations to protect others and the public, and they reserve the right to make a safeguarding referral should the person's behaviour and risk escalate to a level that can no longer be managed in a clinical setting alone.

5.16 As in other safeguarding scenarios, there may be times where consent is not provided but a referral is made as the individual's or public safety outweighs the duty of patient confidentiality. In these instances professionals should usually inform the patient that their information has been shared and the reasons for this.

5.17 There may be exceptional instances where consent is not sought to make a referral or when a clinician does not inform an individual that their information has been shared. This may, for instance, be where there would be a consequent risk to the safety of the professional or public.

5.18 Balancing legal duties around patient confidentiality may not always be straightforward and requires professionals to exercise their judgement. Where professionals are uncertain, they should seek advice of the organisation's Prevent lead and senior clinician. Other staff in the organisation's safeguarding or information governance teams may also be able to provide assistance. In all instances, the reasons for making a referral and the consent obtained (or not obtained) should be clearly documented in the patient's care record, as well as the issues considered and the advice sought. Further guidance has been developed on information sharing for healthcare professionals, with a specific focus on exercising their duties relating to Prevent.[10]

Working in partnership

5.19 Prevent referrals are made from health organisations to their relevant local authority or police depending on local procedures. Police partners will continue to review referrals for deconfliction, in which they carry out preliminary checks to assess the risk of radicalisation and ensure there is no immediate risk to the public, drawing on contextual information unavailable to mental health services. The referral will then be managed by the local authority or police; this may vary by area as administrative changes to the Channel programme are underway so that local authorities manage the Prevent process. If the police decide that a referral is not suitable for the Channel Programme they may signpost to or draw upon other local services such as social services or substance misuse services, to meet an individual's needs.

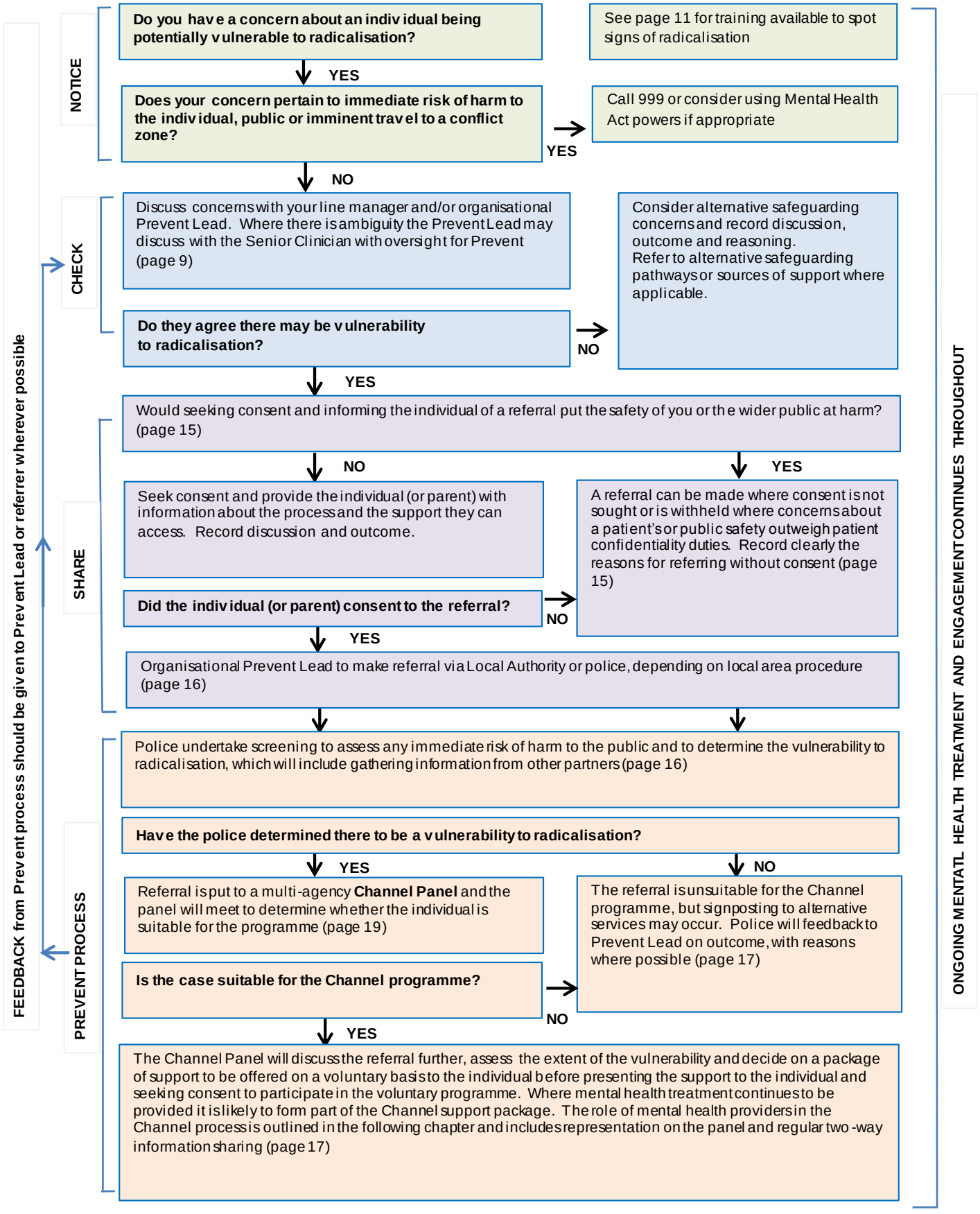
5.20 In these instances, the Prevent referral is closed. Though details of the referral will remain on the police database for seven years as a closed referral, the person's details would not appear in any criminal record or disclosure and barring service checks.

5.21 Police and mental health providers should co-operate and work together closely when individuals are referred into the Prevent process. Prevent Leads in each mental health provider are expected to build a close working relationship with police.

5.22 Mental health providers should seek to maintain the person's engagement in mental health services following a referral to police as they will retain clinical responsibility for people who have been referred in to safeguarding processes. As such police should provide timely feedback about the decisions they have made, including whether the referral will proceed to a Channel Panel, the reason for cases not being referred to Channel, and any relevant details of discussions with the individual or any alternative support that has been offered.

5.23 In some exceptional circumstances police will be unable to provide feedback on a referral. There are a number of reasons why this may be the case, and when possible police will explain the reasons behind this. NCTPHQ are working to ensure that all referrals which are received are acknowledged by the police.

Figure 1: Prevent referral pathway in mental health providers



6. Role of mental health providers in *Prevent* process

6.1 Effective joint working between all partners in the Prevent process is crucial to successfully safeguarding individuals from risk, whether a referral originates from a mental health provider or an alternative source. It is the responsibility of mental health providers, police and other partners forming Channel panels to establish effective working relationships, ensure appropriate representation at Channel panels and facilitate the sharing of information.

Representation at Channel Panels

6.2 Channel panels meet on a monthly basis to discuss new cases received and the progress of ongoing cases. During these meetings they will:

- identify individuals at risk of radicalisation
- assess the extent and nature of that risk; and
- develop appropriate support plans for the individuals concerned; and
- review on a monthly basis whether the risk has been successfully managed.

6.3 Channel partners will develop, deliver and monitor a package of diverse and tailored support, which focuses on early intervention to protect people from the risk of radicalisation. This may, for instance, include facilitating access to statutory support through education, social care and mental health services, as well as the provision of additional support such as vocational and theological support.

6.4 Panels are made up of multi-agency partners and chaired by the local authority. They are attended by the police and include representation from a range of other sectors depending on the referral. This will usually include representation from children and adults' social care, the NHS, as well as education, housing, immigration and probation services.

6.5 Channel panels should have senior clinical representation from local mental health providers. Given the varying footprints of local authorities, police forces and mental health providers, there is not a uniform way that this should happen. Mental health providers should work with their local Channel panels to agree and provide suitable representation based on local geographical footprints, and driven by the number of referrals where mental ill health is thought to be a factor.

6.6 There are two roles for mental health representatives on Channel panels:

- **Standing advisory role** undertaken by an experienced clinician attending in an independent capacity to provide professional mental health expertise. This role includes sharing understanding of the local system and scope of services, providing clinical advice about need, urgency and risk based on referral notes, and facilitating access to services. Provider Prevent leads should be responsible for ensuring representation from the mental health provider at Channel panels as necessary. In practice, it is likely to be the provider's senior clinical lead who attends in this capacity.

- **Case advisory role** drawn upon when a referral originates from a mental health provider. The referring or responsible clinician is expected to be present to discuss the individual referred and feedback relevant outcomes to their trust. This is in line with usual practice for any safeguarding referral.

6.7 Coordination of individual Channel cases, and overall responsibility for delivery and monitoring of support packages, is the responsibility of the Channel Chair from the local authority. However, each partner remains responsible for the relevant part of the support package that their agency has been charged to deliver.

6.8 In practice, it may be appropriate that coordination of a particular individual's support package is undertaken by the professional who has the closest relationship with them. Where mental health support is the main element of support in the package, it may be appropriate for a mental health clinician to lead the Channel support package, drawing on other services as relevant.

Example 2 – Multi-agency support provided by a Channel Panel

Rashmi had been Gary's community psychiatric nurse for three years since his diagnosis of paranoid schizophrenia. Gary was twenty years old, had a history of drink and drug abuse which aggravated his condition and a criminal record for aggravated burglary.

Gary had continued to take his prescribed medication but its side effects, including excessive dribbling, had caused him to become increasingly isolated. He converted to Islam after befriending a group of older men he met with to smoke cannabis after they explained that in heaven he would be free from the stigma of his condition. Gary became increasingly interested in Jihad due to the videos and websites on the subject his new friends had shared.

In his meetings with Rashmi, Gary became preoccupied with the idea that his condition was as a result of his past sins and that he needed to make amend.

Rashmi became concerned when Gary mentioned that martyrdom would cure his condition and learned that he had moved in with a group of older men who had suggested he no longer needed to continue to meet with her.

Rashmi spoke to her line manager who supported her in discussing her concerns with the Trust's safeguarding lead with responsibility for Prevent. Agreeing that Gary may be at risk of becoming radicalised a referral was made to Police who referred the case to Channel.

Gary's case was determined suitable for the Channel programme and Rashmi was able to persuade Gary of the benefits the range of Channel support could provide him alongside his continued mental health treatment. This support included:

- sessions with an Imam registered as a Channel intervention provider to help him reassess the version of Islam he had come to know;
- support through the local authority to move into alternative housing in a safer environment with increased assistance; and
- A key support worker who assisted the rebuilding of his relationship with his mother when he expressed a desire to see her again.

Information sharing

6.9 When police receive referrals they may request relevant information from a range of statutory partners to further assess an individual's vulnerability to radicalisation. Where a referral has not originated from a mental health provider, the Police may make a request to local mental health providers about whether the person in question is known to them.

6.10 Any information sharing requests made by police or Channel panels to mental health providers should be managed via the organisation's Prevent lead. The decision on what information to share should be treated in the same way as other safeguarding enquiries made by the Police, in line with Caldicott principles. NHS organisations and local partners are expected to have information sharing agreements in place for safeguarding and Prevent enquiries should form part of that agreement.

6.11 In line with this, only information that is relevant to the enquiry should be shared, and this is unlikely to require the sharing of an individual's full case history. For example, if a person was known to services more than five years ago with no safeguarding or radicalisation concerns, it is unlikely that the information in the case history would be relevant to the enquiry.

6.12 When sharing information about a patient, a mental health provider should ordinarily seek the patient's consent (or parental consent as appropriate) prior to sharing. If consent is not provided, but the mental health provider deems it necessary to share information for safeguarding purposes, the

person should be informed of the nature of the information that has been shared.

6.13 There may exceptional instances where it is not appropriate to seek consent or inform the person. Judgements that balance patient consent with considerations about risk to public or personal safety should be made on a case-by-case basis, and advice should be sought as necessary where professionals are not certain. Where consent is either not provided or not sought, but information is shared nonetheless, the decision-making process should be documented in the patient's care record.

Detention under the Mental Health Act

6.14 When a person identified at risk of radicalisation is detained in hospital under the Mental Health Act, consideration must be given to whether the Channel case should remain open. In conjunction with the Channel panel, professionals may judge that intensive health input in an inpatient mental health setting may mitigate the person's risk or vulnerability to radicalisation. If this is the case, and no further Channel interventions would be appropriate upon release, the Prevent case should be closed by the Channel Panel and the sharing of patient information should cease.

6.15 However, an individual's vulnerability to radicalisation may equally remain while detained in hospital, with the risk managed only by the physical security of the hospital. In this instance, or where it is suspected that the individual may still benefit from intervention and support from the Channel Panel upon their release, the case should remain open and information should continue to be chaired with the Channel panel.

6.16 Where a Channel case remains open when an individual is detained in hospital, mental health providers, working with police and Channel panels should consider a number of options to ensure appropriate information sharing, all of which will be subject to usual information sharing protocols. This is likely to include:

- **Putting information sharing protocols in place at the point of admission**. This should include agreeing from the outset what information will be shared to and from Prevent and what the criteria for sharing it are. Any protocol should be in line with standard practice for information sharing, including seeking of consent.

- **Agreeing timescales for regular review**. This may include the mental health provider reporting to the Channel panel and/or police contacting

the mental health provider for updates about the person's vulnerability to radicalisation.

- **Undertaking joint assessments where appropriate**. Partners may decide that it would be beneficial for police to work jointly with the treating clinical team and undertake joint assessments while the individual is detained in hospital.

- **Ensuring records are kept** and that vulnerability to radicalisation is recorded as part of assessments and care planning under the Care Programme Approach (CPA) during and following discharge from hospital, and reviewed every year under CPA and/or subsequent risk assessments during the care planning process.

- **Closing a Channel case if risk becomes addressed by detention**. If it is determined that the risk of radicalisation is wholly addressed by detention and treatment in hospital, a Channel case should be closed and sharing of patient information stopped.

7. Referrals into mental health services from Prevent

7.1 Most referrals into the process originate from other sources, some of which cite a suspected mental health need as a factor contributing to an individual's vulnerability to radicalisation. These referrals present a potential opportunity to address the unmet mental health needs of people who may not otherwise come into contact with services. In such instances, it is key that timely access to mental health assessment, and support as appropriate, is facilitated by mental health providers. **Figure 2** sets out the referral pathway in practice.

Timely Referral

7.2 Within **one week** of receiving a mental health referral for an individual identified as at risk of radicalisation by the Prevent process, mental health providers should:

- undertake rapid screening and triage of the referral to determine whether there appears to be a mental health need, and level of urgency based on the information available in the referral;
- where there appears to be a mental health need, make contact with the individual and make the offer of a mental health assessment;
- schedule a mental health assessment in line with urgency of clinical need and any relevant access and waiting time standards;

- use clinical expertise to encourage take up of an assessment where an individual may be reluctant; and
- provide feedback to Channel panel partners on suitability of referral and actions undertaken.

7.3 Referrals into mental health providers from Channel Panels will be made via a Trust's Prevent Lead, who should provide oversight of these referrals through the pathway to ensure appropriate prioritisation and responsiveness and provision of appropriate feedback.

Rapid screening and triage

7.4 As for all incoming referrals, processes should be in place to allow for rapid triage to assess the level of urgency, based on the information available in the referral. The Trust Prevent Lead should monitor all incoming referrals from the Channel Panel and ensure that initial triage of the referral is undertaken by an experienced clinician within 1-2 days of the referral having been received, or sooner if the need appears to be urgent.

7.5 The Prevent Lead may draw on support of the Senior Clinician with prevent oversight throughout the process to assist in prioritisation of screening and triage of referrals from Prevent.

7.6 Where a referral appears to have been made inappropriately as a mental health need is not perceived by the mental health provider, the Prevent Lead should provide feedback to the Channel Panel as soon as possible with reasoning and include signposting to suitable local services that may reduce vulnerability.

Contact and offer of assessment

7.7 Where any mental health need is suspected, the Prevent Lead should facilitate and oversee contact with the individual to offer a mental health assessment within one week. This may involve working with Channel Panel partners to identify the most appropriate professional to make contact and offer a mental health assessment. This may be particularly beneficial where another professional has an existing relationship with the individual who has been referred.

7.8 There is no obligation for an individual to take up the offer of a mental health assessment, unless they are compelled to do so under the Mental Health Act. However, clinicians should use their skills to encourage take up of assessments and outline the benefits of accessing mental health care. This may include drawing on support from other professionals who have a

relationship with the individual.

7.9 When making an offer of a mental health assessment, the mental health provider should ensure that the individual's GP and the Channel Panel are informed and kept up to date of outcome.

Scheduling of an assessment

7.10 An assessment should be scheduled and undertaken according to existing access and waiting time standards. The level of clinical need will dictate whether emergency, urgent or routine pathways are appropriate.

7.11 **Urgent and emergency care:**

- If it appears from the information in the referral that the individual is very acutely unwell, the triaging clinician may decide that the person should be routed via the urgent or emergency mental health pathway. This may include escalating the referral to a crisis resolution team, or arranging an assessment under the Mental Health Act if there appears to be an immediate risk of harm to self or others as a result of mental illness.

- In these cases, the provider will make proactive efforts to engage the individual (e.g. home visit from crisis resolution team or children and young people's mental health team) and conduct an assessment within 24 hours if the referral appears to be urgent, or within 4 hours if there appears to be an immediate emergency.

- Following urgent or emergency assessment, the person may need to enter the acute mental health care pathway, for example by referral to inpatient admission or for an episode of intensive home-based treatment. Alternatively, if the mental health crisis has resolved, the person may be referred for support by community mental health services or signposted to other community or primary care services.

7.12 **Routine secondary mental health care:**

- If the level of mental health need does not indicate routing via the urgent and emergency pathway and the case is triaged as requiring routine secondary mental health care, the individual should be contacted within one week and offered an assessment in line with local and national access standards.

- The offer should include a date and time of assessment to be agreed with the person, and should be prioritised in accordance with existing

standards based on the level of clinical need identified from information in the referral notes.

- Appropriate activity, in accordance with local procedures, should be undertaken to ensure individuals take up an assessment once scheduled.

Treatment and further support

7.13 If the assessed mental health need meets clinical thresholds for secondary mental health care, a referred individual will be accepted on to the caseload of the community mental health service to commence treatment.

7.14 The wait from referral to treatment should be in line with local and national access standards where these are in place. For example if the person is triaged and assessed as potentially experiencing a first episode of psychosis, their treatment should commence within a maximum of 2 weeks of the referral having been received.

7.15 Where secondary mental health care is not appropriate for the level of need identified, other routes to support may be engaged:

- **Referral to primary care:** where an assessment determines that the individual's mental health needs do not meet the threshold for secondary mental health care, the person should be referred to their GP with a recommendation (e.g. with a recommendation of referral to the local primary care psychological therapy (IAPT) service or children and young people's mental health service if under 18).

- **Signposting to alternative services:** where an assessment suggests that the person does not require mental health treatment, the mental health provider should signpost and encourage access to other relevant services that may reduce vulnerability and provide benefit. This may include substance misuse, housing, employment or voluntary sector support.

7.16 The mental health provider should provide regular updates to the Channel Panel as to action undertaken and relevant progress on open Channel cases. The Channel Panel should also provide updates to the provider as to relevant progress with any other support an individual receiving mental health care is receiving.

Example 3 – Mental health support for an individual at risk of radicalisation

Mariam was a 15 year old girl studying at secondary school when a teacher became concerned that she had demonstrated happiness in class over recent Islamic terrorist attacks. Further exploration by the teacher determined that Mariam had also expressed a desire to travel to Syria to one of her friends.

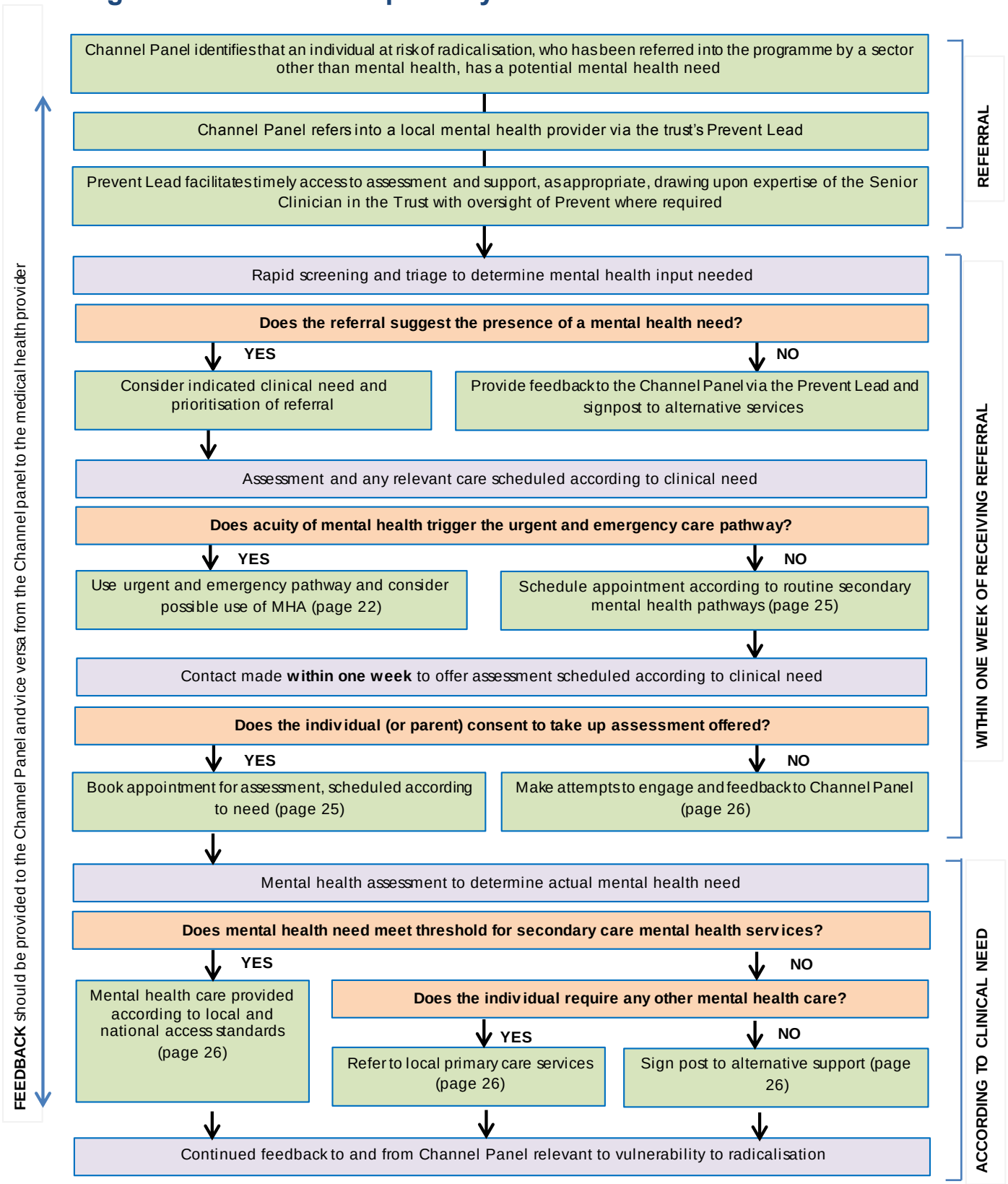
The teacher liaised with the school's designated safeguarding lead about his concerns and made a referral to Prevent, which was subsequently considered at a Channel panel. The panel was presented with further information gathered from other teachers which suggested that Mariam had become increasingly isolated and withdrawn in recent months, and that she had often demonstrated disorganised speech and behaviours. The mental health clinician providing advice to the Channel panel recognised that Mariam may have a possible undiagnosed mental health condition. Following this, the school's dedicated safeguarding lead, who already had a good relationship with the family, approached her parents, and facilitated a discussion about what could happen next. Mariam's parents agreed for her to be accepted onto Channel.

The panel referred Mariam's case to the Prevent Lead in the local mental health Trust, who facilitated screening of the information received and triaged through the routine secondary mental health pathway. The Trust made contact with Mariam and her parents to offer and schedule a mental health appointment within 5 days according to the clinical need demonstrated in the information provided to the Trust. They offered her an assessment of her mental health needs later that month.

At this assessment, it was established that Mariam may have been suffering from an episode of psychosis, and a referral was made to the local Early Intervention in Psychosis (EIP) service. In line with national access standards, Mariam commenced a NICE-recommended package of care within two weeks which prevented her condition escalating, and supported her recovery.

Alongside mental health treatment, the Channel panel offered a support programme including one-to-one theological mentoring sessions which allowed Mariam to explore her faith in a safe way, and increase her knowledge of Islam with the support of a theological expert. She was also provided with education and careers advice. This support package was provided with the consent of Mariam's parents until the Channel Panel no longer assessed there was any risk of radicalisation. Mariam exited the process with no further concerns and is now continuing with her education.

Figure 2: Mental health pathway for referrals from Prevent



8. Further information

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