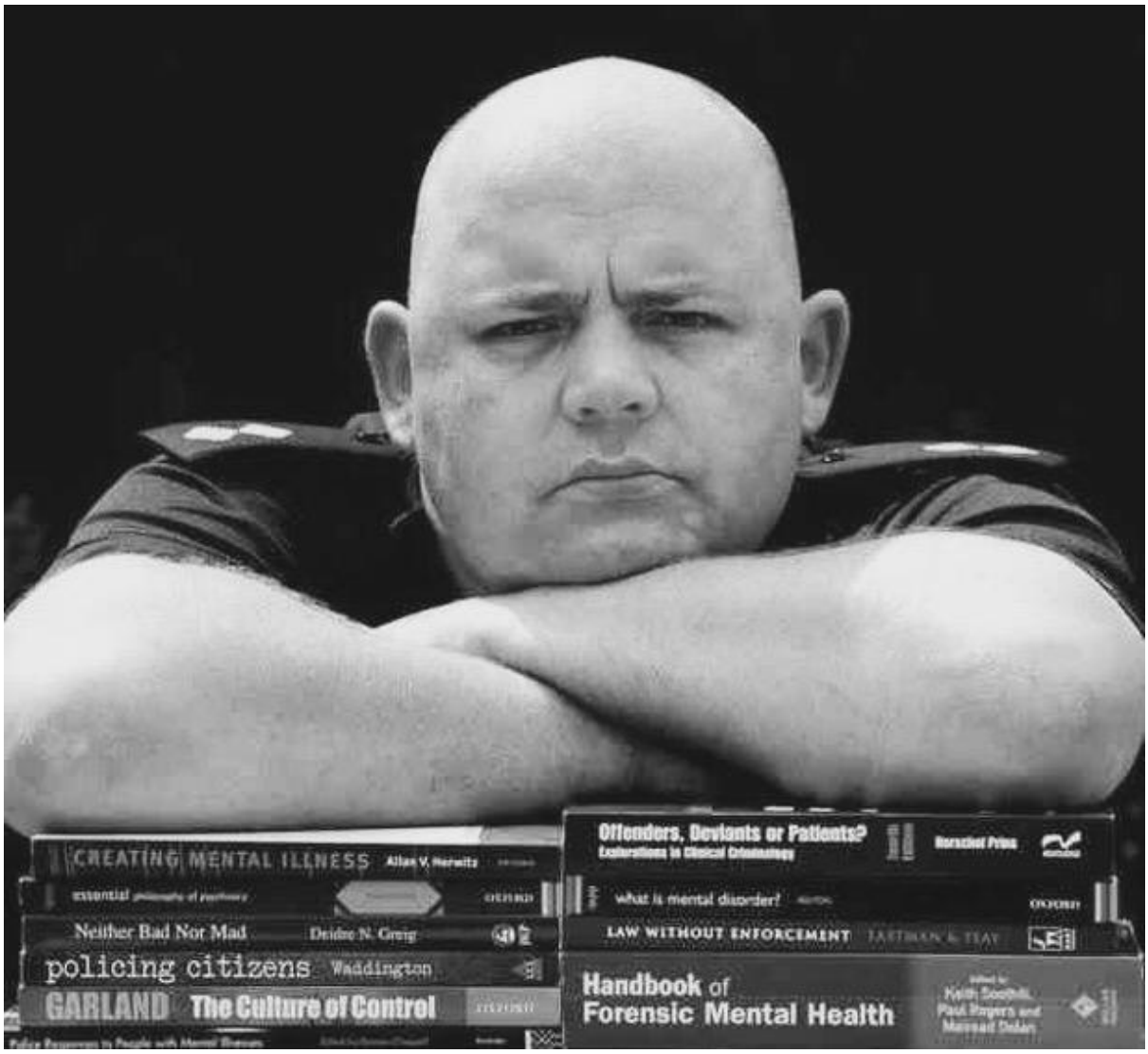
MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

Volume Three – 2013

*Winner of the **President's Medal** from* the Royal College of Psychiatrists.

*Winner of the **Mind Digital Media Award**.*



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JANUARY 2013

01st January 2013

The World of Mentalists: We Won!! –

What a way to start 2013! – it took eleven and a half months to win an award in 2012, but only eleven and a half hours for the blog to win its first award this year – a #TWIMAward from The World of Mentalists.

This blog provides overviews and insights into the whole range of mental health issues and runs the #TWIMAwards at the end of each year. The MentalHealthCop blog has won in the "Not Otherwise Specified" category – fair comment, given how difficult it is to file mental health within policing and vice versa!

If you have not read this blog before, you should check out the results page for this year's awards. All the winning and short-listed blogs are there, with hyperlinks, and it represents the best in social media on mental health across the spectrum of condtions and professions associated with it.

I am grateful to the judges for the #TWIMAwards, many of them excellent tweeters and bloggers in their own right and / or who do great work on mental health as professionals for various organisations. That they consider my blog to be 'up there' is a real honour.

Best Mood Disorder Blog

Purple Persuasion

Best Psychosis Blog

A Path With Heart

Best Eating Disorder Blog

Giant Fossilized Armadillo

Best Personality Disorder Blog

Beauty From Pain Blog

Best Anxiety, Stress or Trauma Blog

Conversations With My Head

Best Autistic Spectrum Disorder Blog

Aspergers & the Alien

Best Psychiatry, Psychology or Psychotherapy

Mind Hacks

Best Nursing, Social Work or Professions Allied to Medicine Blog

The Masked AMHP

Best Student or Academic Blog

World of Oid

Wildcard

Chaos and Control

2nd January 2013

Cognitive Dissonance –

Two things happened to me recently to cause my head a brief period of cognitive dissonance as I unwound from my LATE shift last night. I recently went to work to find a person in the cells who had not long been arrested under section 136 of the Mental Health Act. I noticed when I got home from work yesterday, a Twitter remark from an A&E Consultant questioning why he and his staff should have to put with aggressive behaviour from the public and being shouted at?

These two things got me thinking –

EMERGENCY MENTAL HEALTH CARE

The person detained under s136 had been removed to the cells because the Place of Safety in the area concerned had been telephoned by the police control room after arrest to notify them that officers would be heading towards them with a detainee and were asked, "Have they been violent?" In fairness, the person concerned had displayed some agitated behaviour. Actually, they were screaming very loudly in distress and had been doing so before the police arrived – that's the reason the police were called in the first place: members of the public concerned about the individual and their behaviour in a public place.

When detained by the officers, the person had been resistant – frankly, very frightened by what was going on – and had been handcuffed by the officers in order to maintain the safety of the person. There is one other dimension to the incident I'm afraid I can't recount as it would potentially be an identifiable factor, but I'd ask you to just believe that it would be something causing additional distress and the officers had to manage that too.

The phone call lead to the receiving nurse saying that because violence was an exclusion criteria, the person could not be taken to the place of safety and would need to be removed to the cells. Paragraph 10.22 MHA CoP anyone? *(This is now paragrah 16.38 under the new Code of Practice – see below).*

EMERGENCY PHYSICAL HEALTH CARE

Meanwhile, in Accident & Emergency in another part of the UK, our Consultant colleague is being shouted at by aggressive patients and their family members whilst attempting to deliver healthcare. Why should they have to put up with that? Why, indeed, DO they put with that?!

So, I asked him! Various responses to his question "Why do we put up with it?" came back with clinical reasons and an underlying fear of rare events leading to professional misconduct allegations, etc.. Maybe the aggression was attributable to underlying organic disease and premature dismissal of the patient for their opprobrious behaviour could lead to undiagnosed disaster? Even though this is a rare possibility, it *is* a possibility and goes a long way to explaining why A&E staff suck up a level of personal abuse and threats that most of us wouldn't stand for: even in the face of threats to their safety, they are attempting to assess their potential and their professional need to *care*. Perhaps they'll have A&E security standing nearby and sometimes they will call the police and staff will continue to treat people even after assaults have occurred – believe it or not.

If you want to see this for real, look at the case of Christopher ALDER in Humberside. The events leading to the police arresting Mr ALDER who subsequently died in the police station, was that A&E dismissed him without adequately evaluating a head injury that had been sustained when he was assaulted.

COGNITIVE DISSONANCE

So here's my question for place of safety services who decline to accept patients following a third-party telephone triage because of violence that they haven't seen:

How much violence is too much violence, where's the evidence base for that line being drawn and how do you know whether or not the violence is clinically attributable? Where is the level of anxiety about undiagnosed, unidentified threats leading to professional disaster that appears to exist in A&E? How do you tell all of this when you're not actually seeing the patient but are speaking to a police control room operator who isn't with the patient either? **Are we ever going to get that right, except by chance?!**

Actually, one of my main objections is that it wasn't violence at all, it was resistance predicated upon very real fear and a case of being very, very "shouty". The fear in this person was no less real for the fact that it was all clinically attributable to psychosis – in the opinion of the s12 Doctor who

saw the person in custody. All were agreed: **police custody was making things worse** but because we still have a level of "Doctor knows best" respect for our NHS, the officers concerned had removed that person to the cells.

My questions when I took over as duty inspector included –

- Was the person transferred from arrest to custody by ambulance? – if not, why not?! See Chapters 10 and 11 of the MHA Code of Practice.
- Has anyone asked the question about "RED FLAGS"?
- If the detainee has not been *seen* by any healthcare professional, can we be sure they are safe in custody? – if so, how?! Remember: almost half of all deaths in custody involve people with mental health problems, often complicated by drugs and / or alcohol.
- Unless the FME is getting out of their car in the police station car park, should we not think about transferring the person to hospital?

As it happened, the FME was nearby and the first thing he said after examining the person was "being here is making it worse". There were reports of psychosis, hallucinations and paranoia – fear that officers were going to inflict injury or death, a total lack of communication with *anyone* in custody. I mean that literally. There were suggestions that sedation may be required.

The first thing I did, was send two officers to custody and tell the custody sergeant to ring the relevant area's place of safety to inform them that the doctor had authorised a transfer to them because the person was **not** violent and was being made worse and being made to suffer in custody. Within a couple of hours of being detained, they were in that area's PoS facility and any ongoing concerns for staff safety arising from the patient's presentation would be mitigated by officers remaining at the PoS to support NHS staff.

Of course, we'd also "breached the protocol" by transferring someone to a PoS in another area – the person's home area. Normally, everything happens in the local authority area where the police detention occurred. Oops! – but of course, no laws were broken in doing so, everyone agreed it was right and it expedited the persons MHA assessment.

Incidentally, I got shouted at and very personally abused last night by a young man who took a dim view of police actions at a job, but then we are trained and empowered to deal with this in a variety of ways. I couldn't manage to get myself into the position the young man had suggested whilst wearing a protective vest so I just ignored him and cracked on … but our colleagues in the NHS don't have that luxury.

So the cognitive dissonance is at the organisational level of the NHS: how can we think it is simultaneously OK to dismiss some patients to police cells for resistant or aggressive behaviour that has not gone anywhere near a healthcare professional AND think it acceptable that NHS staff continue to suffer abuse and assaults because of fears that such obnoxious conduct may have an underlying clinical cause?

Leave it with you …

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

7th January 2013

Failure Demand –

I want to share with you some thoughts about the concept of 'Failure Demand', as it relates to policing and mental health. For those who have not previously heard of this term or are unfamiliar with the work of organisational psychologist Professor John Seddon and Vanguard, let me explain what this is by giving you John's own definition:

"Demand generated from a failure to do something or a failure to do something right (for the customer)."

I have spent much of the last year reading about Vanguard's work and considering it as it applies to policing and mental health – actually in relation to policing generally – and it has really caused me to pause for thought and start all over again. I'd encourage you to read **Systems Thinking in the Public Sector** (2008) as well as some other stuff I'll mention as I go through.

In a previous blog called 'Signals from Noise', I outlined some considerations that should be occurring to multi-agency groups who oversee 'Place of Safety' (Mental Health Act) operations. These would include asking questions about 'repeats' as well as about all detentions which occur in relation to any person who is already known to mental health services.

Before I write anything else in this piece, I need to be crystal clear about one point: **not all mental health related demand for the police is 'failure demand'; and not all of the 'failure demand' that I am referring to here is predictable and avoidable.** *<< Please keep this at the forefront of your mind!*

Somethings go awry despite everyone's best efforts and for a wide variety of reasons. But some things that go wrong are as predictable in general terms as night following day and we have far more capacity to address this by looking at the system within which certain decisions work.

PREDICTABLE FAILURE DEMAND

How much of the demand that we face is demand which is 'failure demand'? And how much of that 'failure demand' is predictable?

We probably don't know, if the truth be known: we are not counting the things that would be relevant to our understanding of it. We often find that public sector organisations are counting quite arbitary things, convinced that they related to the public's empirical understanding of how services work. What we can say, by way of example, is this: in one mental health trust –

- 50% of s136 detentions are known MH patients
- 30% of s136 detentions are people resident out-of-area, of which we know some will be MH patients in their home area's mental health trust – shall we estimate this figure 33%?
- 10% of people detained under s136 have been repeatedly detained.
- Of course, not all of these detentions occur for predictable reasons. But some do, and I'm not sure we know how many.
- Of the 66% of 136 detentions, are we saying that all them were unavoidable?

Do these newly discovered numbers cause the system to be reviewed and revised to mitigate against the generation of such demands? If we reviewed these s136 detentions by the police OR if we reviewed offences committed by suspects with mental health problems who are known to the MH trusts, what would we learn about care planning? Would we learn that there were certainly predictable features – like failure to keep care community appointments, disengagement from medication, etc.? **Almost certainly**.

Policing exists in many respects to be able to provide a remedial, potentially crude intervention after other social structures have tried or failed to ensure the 'right' outcomes. This could be connected to failures in personal responsibility; in parental responsibility or in relation to other organisations' capacity or capability to respond to demands which, ideally, would sit with them. So it is no surprise that some failure demand – predictable or otherwise – gravitates to the police. Some of it also gravitates to the ambulance service, Accident & Emergency and out of hours GPs. Do the dynamics and implications of all this? I'm not sure we do.

To make another important point: not all mental health-related police demand is 'failure demand'. Recently, my area dealt with a lady under section 136 of the Mental Health Act who was very unwell and all information suggests she is someone who simply has never, ever come to police or mental health services' attention before. So the 'demand' is not a result of any failure of any kind, but the 'system' is about having a 'clean'

flow of work from the officers who came across her to the health and social services who will be key to ensuring she gets the right support in terms of unmet needs. But a 'clean flow' is what we often do not have, following the use of s136 and this lack of flow often means that the professionals who are seeking to survive in a system will improvise within the rules. Most of the blog posts I have written on s136 MHA are a testimony to the problems around the flow of cases not being 'clean' or straightforward.

MENTAL HEALTH PROVISION – AS A SYSTEM

To summarise Seddon's work: you build an effective 'system' to manage demands by ensuring that the necessary expertise and capacity is within your 'system' at the point where the customer touches it. That way, the right professionals with the right skills, are available at the right time to respond to demand. It is through this simple-enough approach that the right expertise is on-hand to ensure that the work then flows cleanly through the system.

You can already see what's happening can't you? Mental health demands for the NHS or social care system can and do manifest themselves twenty-four hours a day and more than occasionally, issue manifest themselves amidst a cloud of drug or alcohol abuse. We know that it is not necessarily possible to access mental health care twenty-four hours a day, especially if you are intoxicated. << *There is your first problem.*

Your second and subsequent problems can often relate to actions which occur as result of the first problem. The person or relative who sought support from a crisis team with insufficient capacity to respond to predictable demand who is then told, "Ring the police." or "Go to A&E". << *Failure demand.* I have sometimes looked at some of the more controversial issues in policing involving the use of force or even deaths in custody and thought, "Failure demand."

Sometimes, these demands arise because of system capacity; other times because of exclusion or access criteria. Our 999 services and A&E can then be sucked into the vacuum because the demand is still there, notwithstanding that the system isn't. Arising from all of this work doesn't flow cleanly, causing 'failure demand' of various kinds because we have the wrong people dealing with issues, or at the wrong time or in the wrong place.

There is a lifetime's work there for someone who wants to research this, but we know that in public services generally – including the police – failure demand is very high. Perhaps as high as 80% in some police forces, according to Professor Seddon. I am really interested in failure demand across these agencies involved in this venn diagram of work and it is not

just one-way traffic. Inappropriate police responses to incidents can cause "failure demands" for the NHS, which is why better training of officers and responsive mental health services are important. One of the repeat "s136 detentions" referred to above occured because the police were persisting with s136 when they should have been arresting and prosecuting someone. *<< Failure demand for the NHS.*

Now – start this post over again whilst thinking about AWOL patients, criminal suspects with mental health problems and inpatient violence both *by* and *against* NHS staff: and remember to think of the whole NHS-police-Local Authority interface as **one system**. You wouldn't design it like that if you were starting from scratch, would you?! *<< Therein lies the problem.*

It might just be cheaper to do it properly …

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8th January 2013

Information Sharing –

This post should have been written far, far earlier as it covers a subject issue that runs through everything I've written on this blog. Information sharing is one of the most difficult subjects for many people as there are perceived conflicts left, right and centre: between legal restrictions on information sharing, professional guidelines about information sharing. Do they conflict, what if they do? One reason they may conflict, is because some confidentiality guidelines about the police are just plain wrong. See the links at the bottom of the page.

This post will focus on tactical, or job-specific, information sharing. There is more to be said about more wholesale organisational information sharing to build better joint responses which cross agencies. That will be for another day.

I have written a couple of information sharing protocols in the last ten years and read countless more of them. Broadly, they all say the same things and at the end of writing the main one that I did, I wondered about the point of it all. The document ended of with the following outline structure, just like all the other protocols I'd read:

- Introductory remarks of broad principles and commitments of working together, etc., etc..
- Excerpts from legislation and professional guidelines, including the Data Protection Act 1998 (DPA), the Human Rights Act 1998 (HRA) and the GMC / BMA / NMC guidelines.
- Details on the administrative mechanisms by which the relevant organisations had agreed to share information – the design or agreement of a few forms or (secure) email arrangements.
- Review processes for governance of the protocol's operation
- A list of contacts in each organisation for getting beyond barriers created by bureaucracy.

Meetings and training about information sharing were always interesting. Professionals are well aware that their positive decision to disclose information must be defendable against the frameworks that govern them and this gets you straight into the medical confidentiality discussion. Of course, the police are also privy to a host of confidential information – no less confidential than medical information. You have as much right to

expect police officers to keep your previous convictions secret than your doctor to keep your medical history, but I came away with a perception that none of us understand the legal frameworks appropriately.

Of relevance to the NHS is the Caldicott Report. This report lead to the establishment in every NHS trust of a Caldicott Guardian to oversee issues about the sharing of "patient identifiable information" in the various ways that it flows between NHS organisations and between the NHS and non-NHS organisations. *<;;<;; Please remember that "the NHS" is not one organisation.*

DATA PROTECTION ACT 1998

Ultimately, this piece of legislation is the Information Sharing Protocol for the nation. Regardless of what your protocol says, you can, ultimately, be criminally prosecuted under the DPA for breaches of your duty around keeping certain information confidential. Interestingly, you can't be prosecuted for failing to share information that could have been shared and that is perhaps why a senior police officer I know once wondered aloud how different the world would be if we had called this the "Data Sharing Act 1998". Obviously the emphasis is "you can't share unless you can justify it" rather than "here's when and how you should share."

This is of relevance because in many mental health homicide reviews, under-sharing of information has been criticised. Most notably for my own force following the killing of DC Mick Swindells in 2004, criticism of how quickly the NHS were able to access and then share mental health related risk information on a particular man, was held to have been especially problematic. It was also found that there were other, missed information-sharing opportunities before the critical events of that day. We know from other reviews that under-sharing of information has been the target of recommendations for review. I can't find the example of where over-sharing of information was criticised. Certainly, if you review the enforcement website of the Information Commissioner, there have been no prosecutions of police or NHS professionals for over-sharing information to manage risks.

So actually, the DPA sets out an agenda where information can be shared. It divides all confidential information, or data, into two types: personal data and sensitive personal data.

- **Personal data** is defined in s1(1)(e) of the DPA – "data which relate to a living individual who can be identified from those data, or from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller."

- **Sensitive personal data** is defined in section 2 – "personal data consisting of information as to:

  (a) the racial or ethnic origin of the data subject,
  (b) his political opinions,
  (c) his religious beliefs or other beliefs of a similar nature,
  (d) whether he is a member of a trade union,
  (e) his physical or mental health or condition,
  (f) his sexual life,
  (g) the commission or alleged commission by him of any offence, or
  (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings.

The Act sets out in various schedules, information which all professionals reading this blog should know:

- Principles which govern data sharing – see Part I of Schedule I.
- Interpretation of those principles – see Part II of Schedule I.
- 'Conditions' relevant to the first principle of data sharing for **personal information** – see Schedule II.
- 'Conditions' relevant to the first principle for **sensitive personal information** – see Schedule III.

NB: When 'processing' sensitive personal data, there must a justification from both schedule 2 and from schedule 3.

EXAMPLES

So organisations may share information where this is necessary to the statutory functions of other agencies. I always like to raise "Risk Assessment" as the example here. The police and the NHS often have to formally or dynamically risk assess situations to determine their responses and risk assessment is a *statutory* responsibility – under the Health & Safety At Work Act 1974. Information held by the police which is relevant to risk assessment being undertaken by the NHS is able to be shared, so that the NHS can make appropriate decisions about keeping the public and their staff safe. And vice versa: so! –

- If the police detain someone under s136 MHA and we know from police intelligence or from convictions that the person has a particular history of violence in attacking NHS staff, that can be shared because it would be relevant to how NHS staff manage that the person within an NHS place of safety and keep staff safe.
- In this situation I have previously said, "If you would be telling the custody sergeant something which is relevant to keeping that person

or custody staff safe, you should be telling the PoS nurse the same thing for the same reasons."

- If the NHS want the police to enter a premises under a s135(1) warrant to detain someone for Mental Health Act assessment, the police have to decide whether to send a couple of 'normal' police officers or whether we will send extra officers and whether any of them may have specialist training or equipment. This could include Tasers, dog handlers, officers in protective equipment.
- The information in each scenario needs to be detailed enough to be meaningful: saying, "He plays up a bit" could mean any number of things. Specifying verbal aggression that has never translated up into physical violence indicates different kinds of risk. Even physical aggression varies: was in ABH or GBH … did it involve weapons or not?

All of this is relevant to the sergeant or inspector who is determine number and nature of resources or the PoS nurse who has to ensure a safe, appropriate environment for a 136 assessment and unless we've properly shared relevant information, how are we going to get this right, except by chance? Well, we actually know that this has been wrong in the past and it has been at a cost in terms of lives and injuries.

CRIMINAL INVESTIGATION EXEMPTION

There is also a particular provision of the Data Protection Act which is relevant when the police are undertaking a criminal investigation. Section 29(1) DPA provides an exemption for information which is shared for "the prevention or detection of crime [or] the apprehension or prosecution of offenders". This is where it can often get interesting!

I have written before about when, where and how to share information which could be relevant to a criminal investigation of someone suffering a mental health problem. Exchange of information to the police can be crucial to statutory decisions which we make around this. By way of example, an MHA assessment recently took place in police custody in my force area where the custody officer quite properly asked for various bits of information from the assessing professionals. They wanted to take a decision to admit the patient to hospital under the MHA, but the custody officer was considering asking the CPS to prosecute the individual regardless. This was because the offence was far from trivial, someone had been seriously hurt and it may well have been in the public interest to prosecute dependent upon the individual's previous history and an assessment of the risk that this may present for absconding or further offences. It is, ultimately, a decision for the police and CPS about whether offenders are prosecuted or diverted from justice.

There was a **total** lack of information sharing, despite a DPA 'notice' being handed over – signed up by an inspector, as it must be – because of confidentiality. And yet, this confidential information – otherwise known for DPA purposes as 'sensitive personal data' – can be shared according to schedule 3 if it "is necessary for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings)".

The final thing to say on information sharing, is that where it occurs in the context of established arrangements to manage risk on a multi-agency basis, the law around Data Protection and confidentiality still apply. this would cover MAPPA arrangements which are statutory provisions for public protection with regard to violent and sexual offenders, and would also extend to MARAC (domestic abuse) and Safer Estates arrangements. Occasionally, professionals have assumed that because of a formalised agenda and structure being implemented to jointly manage certain things, that it can be a free forum to talk openly. This is true only to an extent – the law still applies.

USEFUL LINKS

I'll issue a warning about some of these links, because the content of some of it is just plain wrong! Be aware of this when making decisions.

1. GMC confidentiality webpages.
2. BMA confidentiality webpages.
3. NMC confidentiality webpages.
4. Information Commissioner's Office.

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10th January 2013

Section 136 on the Railways –

I subscribe to a couple of different online groups for people interested in mental health issues. In a couple of them today, discussion has been had about the use of s136 of the Mental Health Act in connection with our railway network.

A couple of facts about the railways –

- They railways are privately owned property, the network itself being owned and run by Network Rail.
- They are mostly policed by a unique police service – **British Transport Police**, who cover the railways as well as other travel networks like the London Underground and the Birmingham to Wolverhampton metro line.
- The Police Service of Northern Ireland are responsible for the policing of their rail networks. The suicide rate in Northern Ireland has been rising in recent years, so this is a challenge for PSNI too in an area of the UK where suicide rates are higher than the average.

- **To conceive the extent of the problem**: British Transport Police operate in two different legal jurisdictions with their own laws (England / Wales and Scotland)
- They cover three different health systems (England, Wales and Scotland) including over 150 Primary Care Trusts; 58 Mental Health Trusts and 11 Ambulance Services – in addition to A&E Trusts, local authorities, etc., etc..
- PSNI are slightly better off in that regard – having just one health and legal system.
- All three legal systems contain laws specific to railways, with unique criminal offences that can only be committed on the railway network, such as trespass on a railway line and endangering rail users.
- The relationship between BTP and the geographical police forces in the rest of the UK is good, in my experience – for example, BTP and West Midlands Police work together, literally, in the Safer Travel Team which looks to reduce crime and disorder across the whole public transport network in my region.

We work very closely together: for example, during football matches BTP will have public order (riot) trained officers deployed to major railways

stations like Birmingham New Street or Euston and they travel on the rail network. That said, because they cover such an area as vast as the whole UK, they are not always proximate to offences that need an immediate response and my officers and I have often found ourselves on railway lines taking initial action to events and handed it over to BTP as soon as they are able to take it.

Imagine being the British Transport Police officer asked to "sort out" mental health or s136 for BTP?! I've met him and he drinks a lot of coffee. But where to start?! How to you give guidance to nearly 3,000 police officers about how to 'do' section 136 properly when you have to work alongside over 50 different ways of doing it? Are they ever going to get this right about exclusion criteria, remaining in support of the NHS or making decisions around children – when they may not know local procedure? How would you like to have 50 different ways of doing your job and never be sure which rules apply today?! **Remember** – an officer who lives and starts work in Birmingham could make an arrest anywhere in the Midlands, Wales or South West of England and s136 detentions tend to occur unpredictably.

MENTAL HEALTH ISSUES ON THE RAILWAYS

Mental health issues are a significant issue for British Transport Police. Suicide on the rail network is not an infrequent event and the impact upon the network and the economy as a whole as well as upon the family concerned, is absolutely immense. There are few years in the last decade or more where the number of suicides on the rail network has numbered below 200. That's 4 a week, at least.

A suicide on a commuter line into central London, for example, can cost tens of millions to the economy and whilst we may ask "at what cost a human life?", we can also ask other questions that may assist in reducing the occurence or the impact when these tragedies do occur. Methods by which suicide may be prevented or discouraged are of great interest to Network Rail and British Transport Police because they are also legally charged with protecting life and property, as well with ensuring a safe and efficient railway that doesn't negatively impact upon and inconvenience millions of people, literally. Of course, it is also important that fatalities on the network are effectively investigated so that Coroners are in possession of the fullest possible information during Inquests and families can obtain answers.

I would add a final, quick word about the impact upon railway drivers and emergency services: suicide on the railways has all the potential to impact massively upon them. Who is protecting the protectors? … and also in this example, the drivers? It is important.

Of course, section 136 of the Mental Health Act could be of use here or a130 of the Mental Health (Northern Ireland) Order 1986 or s297 of the Scottish Mental Health (Care and Treatment) Act 2003. After all, they are legal mechanisms by which any police officer may potentially intervene before such events. Where someone is standing on a bridge above a railway line or is present on a railway platform, this presents no problem. Each of these places is a "place to which the public have access" and s136 MHA or a129 may be used as with anywhere else.

TRESPASSING ON THE RAILWAY LINE

What about the example where officers turn up to find someone already trespassing on the railway line itself? If you remember the bullet points from above, they are trespassing on private property and it is in no way "a place to which the public have access". Not for a moment. Of course, it is easy enough to physically access a railway line if you really want to, but you always find clear signage telling you that you are not allowed to do so – except for accessing railways stations and railways crossings. Enter a crossing and then walk up the track and you've started committed a criminal offence.

Officers could, of course, arrest the person for trespassing on the railway line or endangering the safety of rail users but this then leads to police cells after arrest for an offence. What if the principle concern during the incident is the mental welfare of the person brought to police attention? This is not dissimilar to other possible-136 scenarios in non-railway situations where people may be committing minor public order offences, assault or damage offences, but where the principle concern is about mental ill-health.

So this is what the debate has been about: British Transport Police do use s136 in these circumstances. It immediately begs the question – how can they do this, if the person is trespassing on private property?! Surely that is like arresting people in their own front garden? … to use just one comparison made.

No – here is a legal argument and it is more than mere 'technicality'.

- Officers have a common law power to use force to evict trespassers.
- Officers also have a legal right to use force to prevent crime – s3 CLA 67.
- It is a crime to trespass on the railway line so we can safely say that if an officer turns up to a job where they find someone on a railway line, they can either evict them (under one of two grounds); or arrest them for the offence.
- **If they arrest** – they can remove the person to custody and handle any MH issues there. You may have a view about whether this is ideal

or not, but for example ensures that people are supported if the MH issues come to light after arrest.
- But the police do not HAVE to arrest for the offence – they can exercise discretion.
- They could equally well take the view that they will evict the person.
- They can rely upon s3 of the Criminal Law Act 1967 to prevent crime (trespass / endangerment) OR use Common Law powers because they know that Network Rail want trespassers evicted – they always do, for the safety of the network.

Now this is where the legal lesson gets interesting for me, and this is precisely where the debate focussed! >;>;

- Having evicted a trespasser to the nearest public place, the police may then regard that person has having been 'found' there.
- This was shown in **Winzar v Chief Constable of Kent (1983)**

In Winzar, a man was taken to hospital whilst drunk by his friend because of concerns for his health. After the medical assessment, the hospital concluded he was 'just' drunk and told him to leave. Instead, he slumped in the hospital corridor. The police turned up and evicted him from the hospital and having done so, arrested him for being 'found' drunk in a public place and he was convicted. He appealed against this conviction and lost.

How could he be 'found' there if the police had forced him there?! The essence of the court case, and that of another drunk and incapable appeal from the 1950s (whose name I admit I can't remember!) was that you are considered 'found' there if you were previously evicted from a place you had no right to be.

SEAL v CHIEF CONSTABLE OF SOUTH WALES POLICE

In the case of 'Seal', a man in his own home was arrested to prevent a breach of the peace, arising from an incident where his mental health was a major concern. Having removed the man outside the premises under the Breach of the Peace provisions, he was then arrested under s136 MHA. The legal case was not principally about this illegal arrest, it focussed on other matters. But in ruling upon them, the court did make mention of the issues which arise from the practice of detaining for something in the dwelling where s136 cannot be exercised and then detaining s136 outside the address. **It is illegal** – precisely because the person was not 'found' in the place where they were subsequently detained under the MHA.

But the difference between Seal and the Winzar case is that question of whether the person was entitled to be where they were originally encountered by the officers. Seal was; Winzar was not. I am arguing here,

that where officers have lawfully used powers to evict someone (from a railway line or ANY other place where they are found as a trespasser) they may then be regarded as 'found' for the purposes of other legislation. So they may detained for drunkenness offences (as in Winzar) and under the Mental Health Act. No-one will have artificially created a condition where use of s136 then 'appears' warranted.

West Midlands Police officers have twice recently removed someone from the railway network and then detained them under s136 Mental Health Act. My former boss, Chief Superintendent NICHOLSON who is now the police commander for Coventry, recently commended two of his officers for precisely this. Some of the arguments I have heard today suggest he should instead have disciplined them for illegally arresting people. This doesn't survive contact with common sense experts and probably not with the individual's family.

It's all nonsense – they quite probably saved this person's life and they did it lawfully. Don't worry about the wording of the news article, either – the journalist isn't mental health lawyer.

OTHER LINKS

UK Human Rights Blog – Seal v UK –

Coventry Evening Telegraph

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

12th January 2013

A "Quick Little Job" –

Our controllers asked last month if some officers could do a "quick little job". It amused me how much head scratching this subsequently caused between the controllers and the sergeants when I got involved in making sure it was done correctly and carefully –

Before our team commenced duty that day, an AMHP and two DRs had attended an address to 'section' a patient. He quickly ran off from them and was reported missing to the police amidst some confusion in communication about whether he had actually been 'sectioned' at the point where he absconded. A short while later, but after office hours had finished and before we had actually managed to take a full missing person's report, the CrisisTeam indicated that the patient was believed to have returned home. Were we able to go and get him? Why they couldn't also help by going to get him, given that they have the same legal powers as us, I'm not quite sure.

It sounded like a straight-forward enough conveyance request – go to this address, remove this man to hospital. Simple enough and we nearly did, too – until I heard discussion about the job in the sergeants' office.

STOP – no!

We don't casually nip to address to "blast him up the hospital." Two officers in Kent did that in 2010 and they will be standing trial in April this year. We've seen other such instances where the police have been FAR too casual about such matters and people have died. We have a legal duty to risk assess this, even if that does happen quite dynamically.

Anyway, just tell me again: is he "sectioned" or do they just "want to section him?" We need to be certain – the first means there could be some legal powers to play with, the second means we've got no powers whatsoever. Has the previous AMHP actually made a written application to the managers of a hospital for this person's admission? – and can we have sight of those papers to prove it?! Without sight of the papers, we are not prepared to regard him as sectioned. << *That's known as experience.*

Yes – he's been sectioned, we've seen the papers.

Right – he's in his house and last time you went there he ran off. Do we anticipate he'll actually open the door given we know he is now resistant to admission or will he actually run off again even with the police there? We can handle the running off bit (assuming we don't send one of our larger units who is better at kicking doors off than running after people, but we've got a couple of runners on the team too). If this guy just sits in the house with the door shut waving at us, we'll just end up waving back before returning to the station for more coffee and doughnuts.

And – if we get there and he *does* open the door, are we sure of our powers given that he is not AWOL? He has absconded from legal custody and is liable to detention – he may be retaken by the police under s138 MHA. And we're not doing it at all unless an ambulance is conveying him with us supporting that process to keep him legally detained. We don't want dead patients in police vehicles do we, like Dorset had in 2009?

Incidentally, in the Kent and Dorset cases, amongst the first questions to be asked was, "Why wasn't an ambulance called earlier?" << *Chapter 11 of the Code of Practice to the MHA – is law!*

THE LEGAL LESSON

This "Quick Little Job" has got quite a lot going on – it is almost very interesting indeed!

- The man never made it as far as hospital so when he ran off having been made subject to an application under the MHA, he was not AWOL because he was never an inpatient.
- Legally, the main person with a detaining authority over him in at this point is the AMHP from whose legal custody he escaped.
- The AMHP, a police officer or anyone from the hospital in which he is liable to be detained may detain him and convey him to the hospital in which he should be.
- So the power of detention for the police is not under s18 for him being AWOL, he is not; but it is under s138 MHA.
- If the man had made it back to his own house and lawful access may be gained, then s138 may still be used but there is no right to detain him at all or force entry to secure his detention – **except** with a warrant under s135(2).
- I have often described s135(2) warrants as relating to AWOL patients and they do – this example serves to remind us that they also relate to patients "liable under this Act to be taken or retaken". This covers AWOL patients and this man's situation of having absconded.
- Both the police and an AMHP can apply for a s135(2) warrant but guidance is that the police should be accompanied by a mental health professional. As such, it would be my view that the AMHP is better

placed to obtain the warrant, not least because we know some Magistrates misunderstand the ability to grant warrants to applicant police officers under this sub-section.
- If in this scenario were repeated and the man had not yet been 'sectioned', had access been refused they would have needed a s135(1) warrant – which only the AMHP can obtain.

ELEMENTARY ERRORS

This job had all the potential to go awry and at risk of invoking melodrama, is precisely the kind of potential casualness which can get officers into trouble and get people killed, however unintentionally – we police according to laws for a reason.

The pedantry I am outlining above ensures that ambulances are called; that officers ensure that what they are told by other professionals is checked where this is relevant to establishing the potential lawfulness of their own subsequent actions; that respect is afforded for the decisions of the courts and the rights of patients. Notwithstanding that he is unwell and "liable under this Act to be taken", the man has a right not to have his house illegally invaded by the police, as in the D'Souza v DPP case (1993).

We all need to know **more** mental health law so that we don't put our arm in the mangle! This is the lesson of many mental health related police tragedies in recent years. And as I was told by an inspector when I was two days into my police career: "Knowledge brings confidence; and confidence brings authority."

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13th January 2013

The Nearest Relative –

This post is not substantively about the police but it relates to something that has come up in queries to me as a result of running this site. Also, there is one particular police situation I came across as a custody sergeant where a "Nearest Relative" emerged from the mist of a difficult investigation and caused a real procedural difficulty for the police management of an offender.

Your Nearest Relative is determined by section 26 of the Mental Health Act 1983 and they have various important roles to play with regard to MHA process. Chapter 33 of the Reference Guide to The Mental Health Act 1983 goes into detail about this. However, for extremely simplistic purposes regarding situations facing police officers, the Nearest Relative of anyone potentially subject to the Mental Health Act has certain roles and rights to play, with regard to admission or care. A Nearest Relative may –

- Apply for admission to hospital under the Mental Health Act, or for guardianship
- Object to an AMHPs application for admission or guardianship
- To discharge patients from hospital (with certain exceptions)
- Expect to receive certain information with regard to a patient.

The NR role is fulfilled by the first person from this list –

- Husband, wife or civil partner;
- Son or daughter;
- Father or mother;
- Brother or sister;
- Grandparent;
- Grandchild;
- Uncle or aunt;
- Nephew or niece.

But! –

- If more than one person occupies the same 'rank' in the list, the eldest takes precedence.

- Relatives have to be at least 18 years of age – unless they are a parent, husband, wife, civil partner, or living with the patient for at least 6 months as the husband, wife or civil partner.
- Adopted children count as natural children.
- Half brothers / sisters count as any other brothers / sisters.
- Illegitimate children are always treated as if they are the legitimate child of their mother; and of their father only if he has parental responsibility for them, as defined in section 3 of the Children Act 1989.
- A "whole-blood relation" will take precedence over a "half-blood relation".

And –

- A relative who lives with, or cares for, the patient, takes precedence over other relatives.
- If you are married or in a civil partnership, but separated or abandoned by your partner, then that person cannot count as your nearest relative.
- If a relative permanently lives abroad, then they don't count.
- If you do not have a nearest relative on that list, but have lived with someone else other than as a husband, wife, or same-sex partner, then they would count.

Some situations are very easy to work with. I am my wife's Nearest Relative and she is mine. Others are far more complicated and AMHPs can have great fun trying to establish it all. It has been known that AMHPs proceed with legal proceedings under the MHA in the belief that a particular relative fulfils this role, only to learn of new information later that establishes otherwise. As the requirement upon AMHPs is that they take reasonable steps and act "to the best of their knowledge of belief", it doesn't necessarily invalidate decisions or legal applications.

NEAREST RELATIVE IN POLICE CUSTODY

When I was a custody sergeant, my team arrested a young man for an offence. It became obvious in the police station that he was quite unwell. As it turned out, he was well known to mental health services and after a Mental Health Act assessment in custody, the AMHP had indicated that they wished to apply for admission to hospital under s3. As part of the requirements of an assessment for admission under s3, the AMHP must, under s13, take steps to consult with the Nearest Relative and in this particular case, it was the young man's grandfather. His father and various siblings of greater 'rank' existed, in terms of the list outlined above, but as

the man lived with his grandfather on a permanent basis, this trumped everything else for the AMHPs purposes. However, his grandfather was either unwilling or unable to come to the police station to act as the man's appropriate adult, so his brother had turned up to do this. (There is no such requirement to consult the NR for admission under s2 MHA.)

When the AMHP contacted the man, the grandfather objected to hospital admission causing the brother some upset as he agreed with the need for admission and was relieved that his brother would not be prosecuted. I distinctly remember the AMHP and a the CPN approaching the custody desk and informing me. "The grandfather is his nearest relative and he has objected to the man's admission, so there's nothing more we can do to admit him." I will confess: I was **absolutely stunned**.

Here we had three experienced mental health professionals saying that the man required inpatient treatment and care for serious mental illness and the grandfather's objection trumped it. When I started thinking that the offence involved was a violent one – not the most serious things you've ever heard of, but certainly not trivial and involving a substantive victim – I wondered what on earth we do next.

The man had been assessed by the police surgeon in custody as unfit to be interviewed because of his illness and now he couldn't be admitted to hospital. **So what on earth do we do now?!** Do we just release him into the street knowing he is seriously mentally ill?!!

CONTINGENCY PLANS

Of course, the AMHP didn't just walk out! There was a detailed conversation about what they could arrange in terms of follow-up if the man ended up progressing into the criminal justice system and what could happen if he did not. There were 'bailed' and 'remanded' versions of the contingency "plan B" for both the police station and the courts, dependent upon what we did next.

Although we never seriously considered interviewing the man, we asked the force surgeon to advise again, in light of the MHAA and subsequent developments, whether an interview for assault with an appropriate adult and solicitor would be possible. He advised it would not – even if officers just provided an opportunity to the suspect to explain what happened without specifically questioning him, there was far too much scope for suggestibility and / or for false confessions, as well as for a serious impact upon his already fragile mental health. This is what we thought he would say, but we wanted to be able to tell the CPS that we had asked for this view, as we were going to have to seek his prosecution. << This is awful, isn't it? Let me explain –

The first duty of the police service is to prevent crime; its second duty is to bring offenders to justice. We have a duty to protect life / property and maintain the Queen's Peace. It was considered by all of us involved, that in the absence of an application for admission to hospital, these objectives were at risk. As we considered that there was sufficient evidence to charge the suspect with offences – because of multiple witnesses, including the initial police officers to arrive – we took the view that to prevent further offences and to safeguard the suspect himself, we should seek prosecution.

If you are wondering how such a potentially heartless decision could be reached, don't forget that this was another example of the least worst option in practice. No-one wanted to do this, but on balance it was better than the one other available alternative – letting him walk out of the police station. At least we were taking a kind of positive action, keeping him and others immediately safe and presenting certain options to the court to further manage this. Bail after charge is usually denied because of further criminal risks of offending or failing to turn up at court or interfering with justice or witnesses – it may be also be denied to keep a suspect safe, either from themselves or others.

The AMHP had indicated earlier that he intended to initiate the process to "displace" the grandfather as Nearest Relative. This can be done via the County Court under s29 MHA but it is not something that can be done at a weekend in the timescales which apply to a police investigation in custody.

I admit to being surprised that the CPS authorised the man to be charged with assault and possession of a weapon but having heard the circumstances, they agreed on how important it was to prevent further risks and safeguard the man. Having been charged and remanded in police custody for court, he appeared before the Magistrates and for a want of other responsible and legal options, he was assessed and supported by the court diversion nurse. He was, unfortunately remanded to prison initially, but was subsequently moved to the hospital estate and the CPS decided to discontinue the prosecution. I will have to assume that the AMHP either succeeded in displacing the grandfather as Nearest Relative or that they had managed to persuade him that inpatient treatment was in his grandson's interests.

I pick this anecdote about Nearest Relatives, frankly, because it is my only one that has police relevance! Conscious that it could be perceived as a negative portrayal of this important legal function, it is right that I end by reminding you that the role of the NR can also be a very positive and important thing under the MHA, both in terms of NRs safeguarding, advocating and agitating for our relative's rights and wellbeing or in making objections – perhaps validly – about what they may perceive as unnecessary admission or enforced treatment.

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14th January 2013

The Adebowale Commission -

Today, the Independent Commission on Policing and Mental Health established by the Metropolitan Police Commissioner has launched a website. The Commission, chaired by Lord Adebowale and involving ACPO Lead on Mental Health, Chief Constable Simon Cole, will ultimately publish their report in **March 2013** on this website so it is worth book-marking, but they have also established a survey that seeks the viewpoints of any and all people connected to the issues.

The deadline for the survey to be completed is 11th February 2013. You should also note that the Commission are doing a specific survey within the Metropolitan Police for officers and staff.

I want to devote this post to explaining why as many people as possible who are around these issues in London should ensure that their opinions are known. It is my strong personal view that the interface between policing, mental health and criminal justice often invokes emotionally skewed views because of people's perspective. This is not a criticism: it is natural and to be expected and **I absolutely include myself in this remark**.

But only if we ensure a broad cross-section of responses from the police, other professionals and **far more importantly** from the public we serve, can Lord Adebowale and his team stand a chance of blending this into sensible recommendations which we can all use to make the world a better place.

Please take 15 minutes (max) to complete the survey.

THE INDEPENDENT COMMISSION

The remit of Lord Adebowale's Commission is around the Metropolitan Police and the first question of the survey seeks to understand the perspective from which respondents are commenting. You will notice that police responses are **not** restricted to Metropolitan Police officers (but if you are from the Met, bear in mind the internal survey which is different) and in addition to various categories of individual who will have had

personal or professional contact with the Met, there is a section for "other" respondents.

Anyone can fill this in, but just remember the Commission are focussing upon the Metropolitan Police.

Please make your view known because we police by consent in this country and we, the police and our partner agencies, need to know what we could do better and differently to get this right, amidst the varying views that will exist.

When I respond to the Commission later this week, I will be covering various things that I've mentioned on this blog in what is very nearly 250 articles on the "natural venn diagram" I am interested in. This is a snapshot:

- **Provision of s136 Places of Safety** – thinking outside the box about where these could be and how we structure integrated health and police services to manage the most challenge cases which prompt the commissions inquiry. These include cases like Sean Rigg, Olaseni Lewis, Michael Powell and Kingsley Burrell.
- **Deaths in Custody** – various points to make about the criminalisation of medical issues and the medicalisation of crime issues: as well as about the "duality" of the most high-profile matters that have led to tragedies in police stations and vans around the UK. There are answers to this, but they are at the strategic if not political levels.
- **Training of Police Officers** – why does 17% of all police demand get training measured in hours or, at most, days when other police training spends weeks ensuring the understanding of complex legal and procedural frameworks? And could we not train and then use officers in a different way to ensure better knowledge and experience is deployed?
- **Diversion of Offenders** – do we know what this means in the real world to custody sergeants who have to make incredibly tough calls and do the necessary services in exist in a responsive way to ensure it is influenced by the right information and done well? Not currently, in my view.
- **Senior Leadership on Mental Health** – there is a survey to complete because the Metropolitan Police Commissioner has shown leadership in establishing the commission. We also need leadership at the very local level and I have no reason to suppose that the Metropolitan Police Boroughs and their health counter-parts are different to anywhere else where there is a different amount of focus and priority afforded to these issues. As it is key to public confidence in policing, we need informed senior and middle leaders on the case.

- **Joint Inspection** – we absolutely know for a fact, that many procedures and processes for application of arrangements around the policing mental health interface are in breach of laws, codes of practice or jointly agreed guidelines and procedures. Who is policing this and requiring improvement in those arrangements?
- **Research** – we need to know more about this stuff. We don't even know how many section 136 cases there have been, never mind 135s or AWOL patients from hospitals. How can we then possibly say we understand the issues arising.

"The police are the public and the public are the police", said Robert Peel, so let's do this together and make it right by telling the Commission what we think.

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17th January 2013

Paramilitary "Nursing" –

In the general debates about policing, we hear a lot about the importance of policing by consent and those who have read into the history of policing will know that the service was founded by Sir Robert Peel who set down nine principles of policing. These principles, in the opinion of many officers including me who have them postered or framed on their office walls, have stood the test of two hundred years of policing as we've moved from industrial, nineteenth century Britain to the current time.

I would like you to read these principles and think about what you want your police service to be – it won't take long:

PEEL'S PRINCIPLES OF POLICING

1. To prevent crime and disorder, as an alternative to their repression by military force and severity of legal punishment.

2. To recognise always that the power of the police to fulfil their functions and duties is dependent on public approval of their existence, actions and behaviour and on their ability to secure and maintain public respect.

3. To recognise always that to secure and maintain the respect and approval of the public means also the securing of the willing co-operation of the public in the task of securing observance of laws.

4. To recognise always that the extent to which the co-operation of the public can be secured diminishes proportionately the necessity of the use of physical force and compulsion for achieving police objectives.

5. To seek and preserve public favour, not by pandering to public opinion; but by constantly demonstrating absolutely impartial service to law, in complete independence of policy, and without regard to the justice or injustice of the substance of individual laws, by ready offering of individual service and friendship to all members of the public without regard to their wealth or social standing, by ready exercise of courtesy and friendly good humour; and by ready offering of individual sacrifice in protecting and preserving life.

6. To use physical force only when the exercise of persuasion, advice and warning is found to be insufficient to obtain public co-operation to an extent necessary to secure observance of law or to restore order, and to use only the minimum degree of physical force which is necessary on any particular occasion for achieving a police objective.

7. To maintain at all times a relationship with the public that gives reality to the historic tradition that the police are the public and that the public are the police, the police being only members of the public who are paid to give full-time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.

8. To recognise always the need for strict adherence to police-executive functions, and to refrain from even seeming to usurp the powers of the judiciary of avenging individuals or the State, and of authoritatively judging guilt and punishing the guilty.

9. To recognise always that the test of police efficiency is the absence of crime and disorder, and not the visible evidence of police action in dealing with them.

THE BROADER MENTAL HEALTH SYSTEM

I have had concerns about the emerging role of our police service in the broader mental health system for some years, precisely because we implicitly attempt to undermine these general principles. Other posts I have written highlight in particular how we expect more and more that the police will be the agents of the use of force in administering the Mental Health Act, despite the fact that Parliament intended this to be far from a frequent occurrence. Perhaps in community setting where there is limited circumstances where there is an urgency and broader risks to the public we can understand that it has legitimacy and utility, but I never forget the incidents where the police are calmly requested to attend mental health wards to restrain patients for medication, almost on a pre-planned basis. "You've got to be kidding? You knew this patient would need medication at 8pm and yet you haven't planned to have sufficient staff or sufficient trained staff for that time?! Are you aware that some barristers argue that this is not legal on a few different grounds?"

The above picture is of officers detaining someone in a non-mental health context: it was during public order disturbances around St Paul's Cathedral, London in 2008. One of the main objections of the public when they see this, is the number of officers involved. And yet guidelines for the NHS in undertaking restraint is to have one professional per limb, one ensuring safety of the head and airway and one taking an overall view. Just count the number of officers, above bearing in mind they are also applying

handcuffs to a resistant adult man … now imagine again that this was on a mental health ward somewhere near your house.

And this is not just a debate about resources, either:

- We know that NHS organisations have difficulties in staffing health based places of safety, in accordance with Royal College of Psychiatry Standards – in other words, being able to receive patients without the need for ongoing police support "even where patients are disturbed" (p8).
- We also know that many AWOL protocols fail to acknowledge in reality para 22.13 of the Code of Practice to the MHA, despite it being fairly unequivocal.
- We know that where force is deemed necessary after a patient is subject to compulsory admission under the Act from a community location, AMHPs do not believe it is their role to use force (training, lone working, etc.) and they are not at liberty to call upon other, trained mental health professionals in order to coerce those patients whose resistance or aggression is consistent with non-police professional management.

It may be that some people would read the above and think that there are good reasons to prefer the police service to undertake these functions. Perhaps it's an argument about their training and availability; perhaps it is about something else and you are entitled to your view. I've got two things to say on this –

- **It's not what Parliament intended** – our laws, our codes of practice were put together after exhaustive democratic processes. Even where we are referring to non-statutory guidance like Royal College standards: they are documents agreed between organisations like ACPO, BASW, etc., but to what point if they're ignored?
- **Is anyone asking service users about this?** I know from what little mental health training I have received and from some experience picked up along the way, that cognitive issues around policing can be serious problems for patients. Whether manifested in delusions or paranoia or some kind of less-acute anxiety about whether it will be a humane, sensitive and patient police officer who arrives – such feelings can be aggravating factors for people in crisis.

Of course, if the police also subsequently struggle to access other services quickly and efficiently: all of this can aggravate the impact upon someone's clinical condition. Only last week a police surgeon, section 12 qualified, stood in my area's custody office and said, "Being *here* is making it worse – we need to get her to a hospital." But the clinical features in play were

not 'RED FLAGS' – no-one wanted to deal and this was making the patient worse. So which hospital?!

Are we not at risk of developing a paramilitary style of something well-short of nursing and creating a situation where the only role that policing plays in the broader mental health system is coercion? Is that not **precisely** what Peel said policing should NOT be about; and precisely what our mental health system should NOT be about?

If the last resort – policing, police stations and "paramilitary nursing" – is often also the first thought, where does this leave our principle of 'least restriction' in social care? And if I'm wrong that it all too often is the first thought, why do we still have areas of the UK with no NHS place of safety where the expectation still remains that police officers will potentially breach laws because we can't get our commissioning together? Where are the community deployable nurses or nursing assistants who can use low levels of proportionate and therapeutically appropriate force on nervous, frightened and / or confused patients without the need for uniformed stab-vests and tasers implying "or else" somewhere in the background?

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18th January 2013

Absconding or Absent? –

Do you know the difference between someone who has absconded or someone who is absent under the Mental Health Act? There are two different conditions of "not being where you are supposed to be" under the Act: you are either **absent without leave** or you have **absconded from lawful custody** and there is an implication for police powers to return patients to where they were supposed to be.

This post is intended to provoke thought as to the distinction between the circumstances and to invite you to question what the police can do with regard to either situation because in some situations the police power to detain persists until the patient is found, on other occasions it runs out within days or months. That's why we must question the precise legalities of what is being reported to us.

Firstly, however, I want to make it clear what this post is **not** about: informal patients who have left hospital without permission. By all means, the police can look for them if reported missing; what we cannot do, is legally return them; unless they happen to be chanced upon in a public place and section 136 is of application to the situation. (It won't always be, despite the fact that they have been an informal inpatient.) When such patients are found, it is a matter of referring the location back to the relevant authorities to deal, perhaps by turning up to assess for admission under the Act or by getting a s135(1) warrant – but that is up to them.

Quick legal reminder – relevant to explaining my following summary:

- Detention under Part II of the Act is admission to hospital under sections 2, 3 or 4; or guardianship under s7.
- Detention under Part III of the Act is a remand to hospital under sections 35 (for reports) or 36 (for treatment); or a hospital order under s37 or an interim hospital order under s38.
- Hospital orders under s37 can be granted with or without a restriction order under s41.

All clear?! … excellent! You were obviously reading carefully on previous blogs.

ABSCONDING OR ABSENT?

- **Absence** (without leave)
- Sometimes referred to as AWOL and covers a range of scenarios –
- Detained in hospital as an inpatient (under Part II of the Act) or under guardianship and has left without permission.
- Granted s17 leave from hospital and has failed to return on time.
- Community Treatment Order (CTO) patient who has been recalled from it, but failed to turn up at hospital as directed.
- **NB:** someone who was detained in hospital under s37 MHA or s37/41 will be treated "as if" they had been admitted under Part II. This is made clear in s40 MHA.
- **Legal Powers –**
- With all of these different sections and scenarios: an AMHP, a constable or anyone authorised by the managers of the hospital, may act under s18 MHA to detain the person.

- **Absconding** (from legal custody).
- Someone who has been 'sectioned' in the community under Part II of the Mental Health Act (ss2, 3 or 4) and has run off before arriving at hospital.
- Someone who has been remanded to hospital under Part III of the Mental Health Act (ss 35, 36, 38) and has absconded from hospital.
- Detained for removal to a place of safety under s135 or 136 and run off either before or after their arrival at the PoS.
- **NB:** you will notice that s37 or s37/41 patients are not mentioned in this section – by virtue of s40, they will be treated "as if" they had been admitted to hospital under Part II of the Act, even though they weren't! << I didn't write this stuff, I'm just trying to explain it!
- **Legal Powers –**
- Where someone has absconded after being detained for admission, but before being received at the hospital or into guardianship, they may be retaken by the person who had immediate prior custody, a police officer or an AMHP. This is under s138 MHA.
- Where someone had been remanded under sections 35, 36, or 38 and has absconded, they may be retaken **only by a constable** under specific provisions within those sections – they are s35(10), s36(8) and s38(7) respectively.
- Patients who have absconded from s35, 36 or 38 detention **must** then be returned to the court who remanded them, not to the hospital from which they absconded.
- Where someone absconded whilst on their way to, or after arrival at, a PoS, they may be retaken for up to 72hrs by a constable.
- The 72 hrs is calculated either from a) the time they run off if they had not yet arrived at a PoS; or b) the time they run off if that had arrived and were pending assessment or admission.

Powers of entry – should entry need to be forced to a premises in order to detain someone, a warrant under s135(2) must be obtained whether they are **absent** or have **absconded** unless entry may be justified under s17 PACE to "protect life or limb"

TIMESCALES

The timescales which apply to these different authorities vary – make sure you ask nursing staff to specify when the authority runs out. They have a duty to provide this information (para 22.15 of the Code of Practice to the Act.)

- Some of the absconding powers' timescales are covered, above.
- People who absconded from sections 35, 36 or 38 may be retaken without time limit because these are patients concerned in criminal proceedings.
- Patients who absconded after application to detain them under Part II of the Act, may be retaken under the timescales which would have applied if they'd made it hospital and gone AWOL.
- Detaining patients who are **absent** (without leave) has timelimits connected to the length of the section: it will usually be that they can be detained for up to six months, but the specific answer is the later of two dates:
- Six months after they first go missing; OR
- The end of the period for which they are detained or subject to guardianship.
- **Except!** – that those who went absent having been detained under the following sections may only be retaken during the period that the section would have run:
- **Section 2** – 28 days from being detained MHA
- **Section 4** – 72hrs from being detaine
- **Section 5(2)** – within 6hrs of having been detained by a nurse.
- **Section 5(4)** – within 72hrs of having been detained by a doctor.

Example 1 – a section 2 patient admitted MHA on 01/01/13 who becomes AWOL on 11/01/13 may be detained for up 28 days from 01/01/13. **Example 2** – a section 3 patient admitted MHA on 01/01/13 who becomes AWOL on 11/01/13 may be detained for up to six months after 11/01/13. **Example 3** – A section 37/41 patient – detained without limit of time – who was admitted on 01/01/13 who goes AWOL on 11/01/13 may be detained at anytime because the MHA section never runs out.

Nursing staff have obligations under the CoP MHA to specify these dates to the police when reporting patients missing, so if in doubt, ask them. **Then check the answer!**

Rather than provide hyperlinks to all the different sections on my favourite mental health law resource, I will just flag the index to the Mental Health Act and you can look up any of these sections for yourselves, if you need to.

You should also remember, it is **a common law offence** to escape from lawful custody and anyone in any circumstances where they are deemed to be in lawful custody, may be arrested for that offence and investigated. Of course, each case will turn on its merits and it would usually be preferable to utilise the MHA powers mentioned here and take any decision about prosecution in conjunction with mental health professionals involved after the patient has been safely returned. However, as escaping from lawful custody is a "recordable offence" should we be recording as crimes each instance of patients running off from mental health authorities?!

The Home Office Counting Rules would say so … I'll leave that thought with you.

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

24th January 2013

The Man in the Arena* –

Here is a profoundly important example in practice of some of the decisions facing operational, front-line cops about their duties and obligations with regard to mental health patients once they have had contact.

Nicola Edgington is currently standing trial for murder. It is relevant to point out that she had previously been tried for the murder of her mother in 2006 and was found guilty of manslaughter on the grounds of diminished responsibility. Having then been detained in a secure unit under a restricted hospital order, she was discharged from detention under s42 of the Mental Health Act into forensic community care. She was living in supported accommodation in Greenwich, London when the latest incident occurred in November 2011.

Last year I wrote a post about how the decision would be taken on whether or not to release a convicted killer back into a community model of care, when rumours floated about PC Nina MACKAY's assailant being considered for release. The same legal and risk assessment process would have applied in the build up to Nicola Edgington's release in 2009. I am interested in this post in neither the conclusion of the current trial nor in the whether the release decision in 2009 may or may not have been premature.

JUDGEMENT CALL

Prior to the attack, Nicola Edgington is known to have approached a taxi rank in Bexleyheath, south London and asked to be taken to the Queen Elizabeth Hospital. When it emerged she didn't have the money to pay the fare, the taxi driver called the police and there have been various reports. They include that she was "pleading with the police to section her" and that she "begged him [a police officer] for help to get sectioned". << *Of course, there is a distinct difference between the two things.*

The police have a power under s136 of the Mental Health Act and I'll come on in a moment to whether it could or should have been used; but asking for help to "get sectioned" is different and does not necessarily mean via section 136 MHA. There are other routes to getting sectioned and in this

particular example, the two officers took the lady to the Accident & Emergency Department of the QEH, without legally detaining her.

- **Could they** have detained her under s136 of the Mental Health Act 1983? – very probably; almost certainly.
- **Should they** have detained her under s136? – it is very far from clear.

Remember the grounds for detention? –

- A constable finds in a place to which the public have access – **check.**
- A person who appears to be suffering from mental disorder – **check.**
- And who is in immediate need of care or control – **check.**
- The constable may, if he thinks it *necessary* – **hang on a minute**
- In her own interests or for the protection of others – **STOP RIGHT THERE!**

Nicola Edgington wanted help, the police were willing to take her to a 24/7 medical facility with liaison psychiatric services who can call upon MH professionals to provide whatever assessment and admission she needs. So if she is willing to undertake the journey and engage with staff, is legally detaining her "necessary"? Strictly speaking, perhaps not. Why coerce someone through a process with which they are apparently willing to engage?

But doesn't it depends what you mean by "necessary"? Although not necessary to detain her at the taxi rank in order to secure her attendance at a medical facility for assessment, was it 'necessary' to ensure that a patient who can now be seen as erratic and in crisis, remained engaged in that process? Earlier in the month, I wrote up a report after investigating a complaint against an officer where he was accused by a patient of failing to detain him MHA when at the time of this officer's alleged neglect, the patient was busy getting into an ambulance to go willingly to A&E.

- So why would the officer arrest you, in order to force you to do what you're already doing very willingly?!
- Should the police act to ensure that no matter what happens in the subsequent hours, the person remains to be assessed?
- If the officers don't arrest now, could they arrest later? Yes – s136 may be exercised in Accident & Emergency if it becomes necessary to do so and the patient decides to leave.

SHOULD I STAY OR SHOULD I GO?

So what I am interested in is the debate about "should I stay or should I go?" Having arrived in Accident & Emergency with a patient who is not

under arrest or in any condition of legal custody, the officers would have to think about whether they remain with the patient after arrival. On the face of it, there is no legal obligation to remain. Officers have exercised a duty of care in immediately removing the patient to hospital, but nothing explicitly demands their continued attendance.

Does it matter that the patient concerned was previously convicted of homicide – the manslaughter of her mother, committed whilst mentally ill? Some may well argue that it does. Certainly John COOPER QC put it to the police witnesses that they should have stayed there with the patient until she was assessed and he pressed them quite keenly about why no background check was done to establish previous risks. It also emerged during his questioning of the officers that at one particular point they began to leave and Nicola followed them claiming that she did not want to wait on her own. After sitting with her for a while further, the officers claimed to be satisfied that she would remain there and left.

Within a few hours she had been seen and arrangements were being made to admit her as a voluntary patient to a nearby mental health ward – so the officers were not the only people convinced that she was a willing participant in a process to arrange her admission. It has emerged during the trial on 24th January that whilst waiting for those arrangements to come into effect, she rang 999 and informed operators that she felt as she did prior to killing her mother. She subsequently left the unit and bought a knife, attacking the first victim who managed to resist and fight back, disarming her. She then stole a knife from a butcher's shop and killed her second victim. To describe this as a tragedy for all involved, is to understate the matter enormously.

TWENTY TWENTY HINDSIGHT

This is exactly the kind of debate that gets police officers going. My sergeants and I recently discussed this at length having had three such cases on our team in the last week. "Did we PNC and FLINTS check any of them?" Apparently we did – all three. "Did we remain at A&E after arrival?" No, not in any case. What would have happened if any of those people had then committed a serious offence? Our approach would have been questioned, no doubt.

- Are we saying that all people removed to A&E by the police should be PNC checked? … or just the mentally ill?
- Are we saying that we should stay with all patients in A&E until the MH assessment process is completed?
- Do we do this every time – and even where this risks criminalising an 80yr old dementia patient?

- What are the dynamics here? – we wouldn't do this with physical or medically unwell patients so is this a further example of stigma, discrimination and presumptions of violence in mental health care?
- If we are saying, "No, you don't have to stay with all mental health patients", how are defining the divide? Which ones are we staying with?
- Is it just those with a homicide conviction, or would GBH convictions also count towards attracting a police chaperone?
- What about violence to property or are we only interested in violence against people?

This situation is a tough judgement call. Once you hear that Nicola Edgington is a mental health patient with a previous homicide conviction, it is hard to countenance why the police would even think about leaving her unaccompanied. But at that time, she was engaging in something and not just because of the police being present. The officers formed a view and made a decision that they could leave and she remained there for a couple of hours. When she was formally assessed under the MHA, the AMHP and Doctors could have sectioned her and caused her detention to be framed by law. They did not.

Not only with police powers of arrest, but also with medical applications of the Mental Health Act, the law requires professionals to operate against 'necessity criteria', 'least restrictive' principles and the way in which these principles are explained and framed by guidance (usually in Codes of Practice – are not black and white. They are endless shades of grey.

So if we are going to trace history backwards to look for intervention opportunities ahead of this second serious offence, why go back to the officers at the taxi rank and not to the AMHP and Doctors who assessed her after the police had left and / or to the psychiatrists and officials from the Ministry of Justice who released her in 2009? Just asking.

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* ***The Man in the Arena*** is the title given to an excerpt of a speech by President Theodore Roosevelt (a former Police Commissioner of the New York Police Department). The speech was made in the Sorbornne, University of Paris, in April 1910.

The Man in the Arena

It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.

Theodore Roosevelt, Paris, 1910

27th January 2013

Section 139 Mental Health Act –

When I wrote our force policy on mental health in 2005/6, I put an excerpt from s139 of the Mental Health Act on the front of the documents. This section states –

"No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VII of this Act, unless the act was done in bad faith or without reasonable care." **– section 139(1)**.

It goes on to add –

"No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought against any person in any court in respect of any such act except by or with the consent of the Director of Public Prosecutions." **– section 139(2)**.

Isn't legal language great?! – it means that if someone does something which is said to be done under the Mental Health Act 1983, they will not be liable in civil or criminal proceedings for that action unless it can be shown that it was done in bad faith or without reasonable care. AND – before someone can sue that person or organisation in the civil courts they need the authority of the High Court; before a person may be criminally prosecuted for an offence under the Mental Health Act, the prosecuting authority must have permission of the Director of Public Prosecutions.

WHY DOES THIS MATTER?

In 1997, South Wales Police were called to an address in Merthyr Tydfil by Robert Seal, over a traffic obstruction. When they arrived at his mother's house, they ended up arresting him to prevent a breach of the peace and having arrested him and removed him outside, the officers formed a view that he may be suffering from a mental disorder and detained him under

s136 of the Mental Health Act. He subsequently initiated legal proceedings against the Chief Constable for unlawful arrest – he wasn't 'found' in a place to which the public have access – and this challenge was thrown out because he had failed to secure the permission of the High Court ahead of his action.

Seal v Chief Constable of South Wales Police (2005) proceeded through the various appeal courts and eventually to the European Court in Seal v UK (2010) basically because the claimant argued that section 139 denied him access to justice:

"The section is intended to strike a balance between the legitimate interests of the applicant to seek the adjudication of the courts … and the equally legitimate interests of the respondent to not to be subjected to the undoubted exceptional risk of being harassed by baseless claims". *Winch v Jones* (1986).

He lost his case because section 139 requires High Court permission before the case is commenced and this is unambiguous. (There was a little bit more to Mr Seal's claim: that the original arrest to prevent a breach of the peace was unlawful and therefore that he was assaulted and falsely imprisoned. There is no particularly reason why his civil action for these non-Mental Health Act elements could not have proceeded. For reasons of his choosing, he proceeded with no claim at all.)

THE PURPOSE OF SECTION 139

The point is to ensure that those people who exercise sensitive powers under the Mental Health Act are given an additional layer of legal protection from litigation for their acts. Such additional protections are not unique to potential claims or allegations from patients with a mental disorder: the United Kingdom and many other countries provide similar protections against claims which could be made by children or even people who have been declared bankrupt.

So it ensures that if you wish to argue that a police officer has illegally arrested you or that an AMHP has failed to take reasonable steps to consult with your Nearest Relative before 'sectioning' you, you must first convince the High Court that the police officer or the AMHP acted in bad faith. Equally, if you wish to allege that a psychiatrist has criminally neglect a patient, the DPP must give permission for the prosecution. Again, this is not specific to victims with mental disorders: many crimes require DPP consent before they may be prosecuted – such as the offence of inciting racial hatred.

UNEXACTING

In 2006 Mr David JOHNSTON was detained under the Mental Health Act by Merseyside Police after a third party called the ambulance service claiming that Mr JOHNSTON was acting violently. When the police arrived Mr JOHNSTON ran off and an officer pursued him, using CS spray to detain him under the Act. In 2009, Mr JOHNSTON applied to the High Court under s139 to seek leave to commence a civil action against the Chief Constable. This was granted and in 2010 Mr JOHNSTON won his claim of assault for excessive force used. It is clear from the "s139 application" that the court assessed the potential evidence against the standards outlined above, before deciding that the application was not "frivolous, vexatious or an abuse of process", but that it had "a real prospect of success."

I wondered at first what the point of section 139 was: it appeared to me to just make it harder for vulnerable people to assert their rights in the courts against powerful state institutions like the police or the NHS. However, as Lord Bingham stated in the original Seal case, "the threshold for obtaining leave under section 139(2) has been set at a very unexacting level … an applicant with an arguable case will be granted leave" and this has been shown. There was evidence in JOHNSTON which directly contradicted his claim but the courts took the view that it should be tested because it was not "frivolous, vexatious or an abuse of process."

But section 139 does make sure that those who take difficult decisions in this challenging area of business are just slightly more protected than they otherwise would be from various types of legal claim – and for good reason.

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

27th January 2013

Prison Transfers –

We've discussed the issue of 'diversion' (whatever that means) on this blog many times. It is often conceived as being something that happens before, at or just after the point of arrest and before people enter the justice system proper by facing criminal charges. In reality, 'diversion' can occur at four different stages; each representing a part of the criminal justice system. This post focusses upon diversion from prison.

I want to highlight how prison transfers work in order to assist an understanding about why some people with a mental health problem are sent to prison in the first place; the role of criminal justice system as a causation of mental ill-health; and how transfers to prison work whether illness develops or is exacerbated by incarceration in gaol.

Firstly, there are four sections of the Mental Health Act I want to highlight, as well as an informal term –

- **Section 47** – **The transfer of convicted prisoners**. People who are sentenced by a court to imprisonment after conviction may be assessed by a psychiatrist in prison if it is thought that their mental disorder is of a nature or degree that requires treatment in hospital. The prison and health services then apply to the Ministry of Justice to transfer the patient to a suitable hospital.

- **Section 48** – **The transfer of remand and other prisoners**. Remand prisoners refers to people who have been charged with a criminal offence by the police and then remanded to (prison) custody by the courts, pending trial. The same process would occur if a transfer to hospital was being considered under s47, but this section also relates to other categories of 'prisoner' like those detained under immigration or extradition legislation, pending removal from the country.

- **Section 49** – **The restriction direction for transferred prisoners**. Where it is felt that prisoners represent "a serious risk of harm to the public", the Ministry of Justice may impose a restriction order upon the transfer. Like a restricted hospital order under s37/41, this restriction prevents the Responsible Clinician from doing the same three things: discharging the patient from care;

transferring the patient to another kind of psychiatric unit or granting the patient leave from hospital – unless agreed by the MoJ.

- **Section 50** – **The remittance of transferred prisoners back to prison**. Where a patient's mental condition has improved sufficiently for it to be no longer necessary that they receive inpatient care, the individual may be remitted back to prison under this section. This can only occur in the case of convicted prisoners where their sentence has not yet expired. In the case of remand or other prisoners, where they have not yet stood trial but it is still intended that they do.In some instances, patients pending trial will have their cases discontinued because their transfer to hospital causes reflection upon the public interest in proceeding with a case. For example, if a serial shoplifter was on remand pending trial and then transferred under s48, it may be decided to discontinue the case if the Responsible Clinician predicts a protracted period in hospital for treatment, perhaps six months or more.

- **"Notional s37"** – **I also want to briefly explain what this phrase means**: I have previously written a full post on it, but for here, I'll just summarise that it refers to someone who was transferred to prison under either s47 or s48:

1. If a s47 patient's sentence ran out whilst they were in hospital, subsequent to a transfer direction; they would continue to be detained "as if" they had been sentenced to a hospital order under s37 but any restriction direction under s49 would cease at the point where sentence ended.
2. If the grounds for a s48 patient's remand or detention came to and end whilst they were in hospital subsequent to a transfer direction under s48, they would continue to be detained "as if" they had been admitted under a s37 hospital order. Any restriction direction under s49 would cease at the point where detention in prison would have ended.

All clear?! … I might write a blog at some stage which amounts to a test! *<< Only half-joking!*

The Bradley Review highlighted that there are problems in bringing about such transfers in a timely manner and recommended that the Government work towards ensuring that all such transfers can occur within 14 days. It is currently **much longer** than that – frequently three or four times that of Bradley's aspiration, often measured in months. To achieve the criteria for a transfer, the prisoner being assessed but be deemed by two psychiatrists to be suffering from a mental disorder, "of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment."

PRISONS AS MODERN ASYLUMS

We know that the prevalence of mental disorder amongst the prison population is high. Depending on your choice of statistics, you can estimate as high as 80% or even 90%. Even internationally, this remains true – one often sees on Twitter the statistic that the largest provider of mental health care in the US states of New York or California are prisons – each catering for thousands of convicted prisoners with diagnosed mental health disorders.

It is appalling isn't it? I want to put an argument that it is both appalling, inevitable and something we will have to get better at managing. For three main reasons:

- **Firstly** – we have an exceptionally reactive mental health system, once people have become entangled in the criminal justice system it can be appreciably harder to ensure a (proper) reaction from mental health services. If you want to see this in action, ask why some psychiatric liaison services in A&E and acute trusts will see anyone in contact with those services *unless* they are in contact with the police. Ask yourself why most police liaison and diversion services are not twenty-four hour a day operations … or even sixteen-eighteen hours a day.

- **Secondly** – the criminal justice system is a known to be a causal factor in some cases. We know that many people struggle to come to terms with the stresses of prosecution and / or imprisonment, including for example, when it wasn't justified in the first place and where there are miscarriages of justice. For some, prosecution and prison will exacerbate pre-dispositions to mental ill-health and we know for example, that the rates of self-harm in some women's prisons can be exceptionally high.

- **Thirdly** – we talk about equality of access to healthcare when making representations that those suffering from mental health problems are treated differently. For those who consent to treatment of their mental disorder, by whatever means, there could be good reasons for ensuring that this is provided in prison by in-reach teams. Not all prisoners' physical healthcare requirements need treatment in hospital; just like not all mental health problems are "of a nature or degree that requires treatment in hospital."

Now, none of those three remarks mean that I think we've got the balance correct – very far from it! We know that rates of psychosis in prisoners are very high and that potentially far more prisoners could or should be transferred to hospital. I don't under-estimate the challenge this

represents to government or the services involved given that secure mental health care can cost, per patient, four or five times as much as imprisonment. Some very crude mathematics for you: if 1 in 7 of our prison population suffers from psychosis and we assume that most of those that is well over 10,000 people who would represent an additional cost per person of over £200,000 per year for inpatient treatment. That bill does not take account of capital costs of building new psychiatric facilities that would surely be necessary if we did wish to see this catchment of offender removed from prison. This is roughly the extent to which we've criminalised people and a complex social problem.

But what I am suggesting, is that the prevalence of mental disorder in society, along with our social and political tendency to criminalise mental illness and those who suffer from it, as well as the pathologising impact upon our criminal justice system means it is inevitable that someone people in prison will suffer from mental disorder. Our prisons represent an exaggeration of the extremes that our population present and this includes mental ill-health. But there is plenty of work to be done to make things better.

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28th January 2013

Interim Hospital Orders and Unusual Places of Safety –

You will remember very vividly because of the attention you paid what a hospital order is, under s37 of the Mental Health Act. You'll also remember how the Crown Court can 'restrict' a hospital order under s41 MHA. If you can't and you want to refresh your memory, you can read my original post on Restricted Hospital Orders – I won't tell anyone that you needed to but beware the test at the end of term!

Something open to a court which is considering a hospital order is to give it a "test drive" as a potential way forward and impose an "interim hospital order" under s38 MHA. This interim order can be imposed by the courts initially for a period of 12 weeks and it may then be renewed for 28 days periods up to a maximum of twelve months. If whilst a patient is detained under s38 the court is provided with information which leads it to conclude that a full hospital order under s37 is required, they can make it a substantive order without the patient having to be brought back before a court.

The criteria for making an interim order are that "the offender is suffering from mental disorder and that there is reason to suppose that the mental disorder from which the offender is suffering is such that it may be appropriate for a hospital order to be made in his case." So I would like to put forward a inexact comparison with section 2 and section 3 MHA:

- Sections 2 and 38 allows for detention because of mental disorder in order to establish a full diagnosis and treatment plan.*
- Sections 3 and 37 allow for detention because of mental disorder in order to provide treatment for a confirmed and established diagnosis.** I am aware that is a very *generalised* comparison! – intended for colleagues in the police.

UNUSUAL PLACES OF SAFETY

Where are court is exercising a power under either s37 or s38, it may be the case that the hospital bed to which the patient is to be admitted is not immediately available. In such circumstances the court has powers – under

37(4) and s38(4) – to remand the patient to a place of safety for up to 14 days. In this legal context, the PoS definition applies to adults only and is:

"Any police station, prison or remand centre, or any hospital the managers of which are willing temporarily to receive him."

When we think about a "Place of Safety" we normally think about police powers under s136 and s135(1) and we think about the definition in s135(6) of "residential accommodation provided by the local social services authority, a hospital, a police station or anywhere else temporarily willing to receive the person."

Well, this is only one of two definitions of a place of safety under the Mental Health Act. That definition relates to those police powers under Part X of the Act; but there is another definition in s55 MHA and it relates to a PoS after the exercise of a Court's powers in Part III of the Act – the part concerned with patients in connection with criminal proceedings.

Did you spot the bombshell for custody sergeants?! – yes(!) there are, in theory, just some circumstances in which a judge could direct the police to detain a patient in custody for up to 14 days! I have never heard of this occurring but I did recently hear of a prison being used as a s38(4) PoS which is what prompted this blog.

ABSCONDED FROM s38

Finally, **only** a police officer may re-detain someone who has absconded from a s38 MHA order and they **must** then return the person to the custody of the court; **not** return them to the hospital. The court may then decide how to sentence or handle the situation which could include remand to prison; return to hospital under s38 or proceed to full sentencing of whatever kind the court thinks is appropriate.

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31st January 2013

The Strategic Command Course –

The Strategic Command Course is the months-long training and assessment to which superintendents and chief superintendents must subject themsleves if they dream of leading the police service. Promotion to the rank of Assistant Chief Constable and above – known as ACPO ranks – is contingent upon successful completion of this course and you cannot get on to it without active support from your own Chief Constable AND without passing a selection process. (ACPO is the Association of Chief Police Officers). The below picture is Henry VIIIs Manor House which is the centre-piece of Bramshill.

Amongst other things, the candidates are set projects and assessments by existing chief officers around current policing issues and this year, the ACPO lead on policing and mental health, Chief Constable Simon COLE, has set the syndicates a challenge! Chief Superintendent Gavin Stephens from Surrey Police is on the #SCC13 and has blogged on the challenge, to solicit ideas and feedback.

Firstly, I will list the challenge and invite you to respond to his blog with your ideas. Secondly, I will provide my own response!

THE CHALLENGE

"The long term reduction in spending on policing is already raising questions about how far the police role stretches beyond narrowly cutting crime. Using the particular challenges of police involvement in mental health cases, outline how forces should reconcile what has been the wider mission of policing over recent years with changed economic conditions while staying faithful to core values?"

Chief Supt Stephens highlightes how his group have held three meetings already, identifying these **key issues**:

- **Local practices that really work:** identifying evidence based local practices that should be replicated nationally

- **Partnerships that make a difference:** Identifying the components of successful mental health partnerships from national and international experience.

- **Future challenges:** forecasting ahead to identify opportunities to intervene and influence earlier.

- **Culture:** Identifying cultural barriers and enablers – what will really make our fail or succeed?

There it is – if you would like to directly influence this group of aspiring chief officers, click here for the original blog and leave a comment. If you want to leave a comment below, either in addition or instead, I will make sure they see them before the deadline for their project work.

I would just like to say – I think this is great! One of my complaints as a frontline cop is that too few senior officers are genuinely interested in this stuff and it's often in the "too difficult" basket. Having the focus of future Chief Constables and Deputy Chief Constables of UK policing, as well as some international candidates – I know of one French senior officer attending the course – is potentially very significant. That they will emerge from their training and assessment, particularly sighted upon the fact that over 15% of ALL POLICING DEMAND is connected to mental health issues, bodes well for us all. We just need to help them hang their hats on the right pegs when addressing the issues.

Michael./

MY RESPONSE

I want to argue that there are three things we need to get right, from which everything else, including the above four agenda can flow as the natural consequence of getting basics right and the service focussing correctly:

SENIOR MANAGERS:

We know that there are areas where BCU commanders have not ensured that they have proper joint protocols with mental health and broader health services, which are written in accordance with Codes of Practice and other relevant standards like RCPsych guidelines and NPIA Guidelines for policing (which are badged by the Department of Health). We also know that some

senior officers take little active interest in this area and this could be for a range of reasons. *<< There: I've said it.*

What is needed to succed in basic terms isn't that difficult to conceptualise – see the Senior Officers Checklist, which I wrote several years ago and which was circulated last year by the Superintendents' Association to all of its members – but it will take a strategic leader to carve up what is best done at Force or Regional level, from what is best done locally and ensuring police commanders account for progress.
And this will take difficult conversations: too often, we know that some mental health services will unilaterally say, "Sorry we can't accept intoxicated detainees in our Place of Safety, they must go to the cells." or "Your officers must stay here through all of the 136 assessment" and this will take many hours in some places. There are arguments to move on these issues, within my blog.

Making progress in these areas may involve some very difficult conversations and potentially having to deal with other agencies' difficulties in prioritising their own budgets. We need to convince our partners that proper MHA arrangements are not optional extras and "nice to do", but legal requirements which can no longer be allowed to impact catastrophically upon the public and upon policing because we kept trying to do "the wrong thing righter" in handling "failure demand".

One major problem is that an interface between policing and mental health does not necessarily naturally occur within the previous frameworks for inter-agency partnership working. Crime and Reduction Disorder Partnerships, Child and Adult Safeguarding structures; MAPPA and MARAC arrangements: each of these will see the interface in part, but none of them is not looking at it from an overarching strategic point of view.

Health and Wellbeing Boards could in future provide this, but one problem with them is that they are not exclusively focussing upon mental health and the interface with criminal justice: nor are police services a compulsory member of them. A second problem, is that forces often struggle to situate mental health as a policy area in their headquarters and subsequently struggle to brigade BCUs and HQ departments into a cohesive whole. This is why leadership on the issue is crucial – in my view and why senior officers may need to forge a path where none naturally exists.

MENTAL HEALTH TRAINING

This week, I have had two days away from my main role to undertake my annual "personal safety training" refresher. In April, I will have three days away to undertake my annual "public order" refresher. This is a full working week to re-do training that I have done as an inspector **ten times**. The

first time I did it as an inspector, I had already done it five times as a PC and a Sergeant and it wasn't massively different wearing two pips to three stripes. Don't get me wrong: this is important training, but I would like to make a comparison with mental health training – of which I have had two hours in the last fifteen years.

The publicly debated controversies around the 2011 riots were not the personal conduct of police officers with calls for better training for them – it was, amongst other things, about how quickly senior officers ramped up the response and whether sufficient numbers of officers were trained to be deployed. Controversies around restraint and personal safety tactics are not necessarily about whether officers need better training: it is usually about whether they put that training into practice or why they did not also recognise the potential medical impacts of restraint.

So my question and challenge to the #SCC13 to address their overarching is "Why do police officers, including senior officers, get far, far less training in mental health issues than they do in public order or personal safety – or for that matter fire marshalling and diversity – given the strategic threat this business represents to the UK police service? And when we get training, why is more of it given over to identification and diversity, than to legal powers and procedures and the initial management of clinical risks?"

We know that almost **half** of deaths in custody are connected to mental health issues; we know that some of the most high profile criticisms of we have ever seen in policing – Sean Rigg, most recently – are about how the service handled emergency mental health responses and the ability of such incidents to massively impact upon public confidence in ALL policing is obvious. We know that (at least) 17% of police demand is connected to mental health issues. We also know that the legislative framework within which our frontline officers must operate is complex: it is at least as complex as PACE or RIPA and yet we give custody sergeants a one week course purely focussing on custody law; another one week course focussing upon first aid and Safer Detention and custody sergeants have had to pass a detailed law examination just to get promoted to that rank.

Why do we think we can expect officers of any rank to survive contact with all the different situations they can encounter unpredictably on the front line of policing; or within the partnership structures that we will need to invent to make this work, with 4-6hrs of training, alot of which is often given over to identification of mental illness and diversity? What about understanding these legal topics in terms of what officers can and cannot; and should and should not do:

1. Section 136
2. Section 135(1)
3. AWOL patients

4. Prosecution / diversion of offenders
5. Mental Capacity Act

Obviously, this blog lists hundreds of posts on other topics where we need to know that officers can either recall or research a range of topics quickly and they need to do this in an environment where the protocols and guidelines put together at National level, like the NPIA and RCPsych guidelines – will match the locally devised protocols put together at BCU level and that all of this amounts to the same thing as the law of England.

VISION AND VALUES

I want to put an argument that policing involvement in mental health related cases should be predicated upon the legal responsibilities of the Office of Constable, which we all swore when were were attested:

1. Prevent Crime
2. Bring Offenders to Justice
3. Protect life
4. Protect property
5. Maintain the Queen's Peace.

I would like to suggest that this approach will also position the service far more subtley than one which looks simplistically at pure legal obligations. These five principles are guidelines to senior officers in agreement of strategic and operational protocols: how does the police service agreeing to move patients from "this" mental health unit to "that" mental health unit, contribute to these five things if a patient has become violent and threatened staff safety? Well, once the police have immediately mitigated that risk by attending and possibly by restraining or detaining, it doesn't – and our involvement should then be scaled back and the situation returned to being a medical issue. But for frontline officers to do this, they will need good training and leadership at both tactical, operational and strategic levels because it is way outside the expectations of the NHS, currently.

NOTEWORTHY PRACTICE:

In my experience nowhere has got this nailed. There are individual areas of noteworthy practice in certain aspects of MH – for example, I'd put in a shout for West Midlands on s136 and PoS services where over 97% of detainees **don't** go to the cells. Other forces are good on Liaison and Diversion or reducing missing people volumes.

But few forces have a proper lead on MH issues at inspector (-ish) level, and some don't have an identified ACPO lead as suggested in the NPIA

Guidelines (2010) in the way that we have such leads at those levels for Domestic Violence, Child Protection, Firearms or Public Order. Where forces do have such leads, they themselves have to pick it up (or make it up?) as they go along because there is no training to access. We need to normalise our understanding that mental health issues are core police business across our functional and geographical areas and lead our people to give them every chance of success.

You need an ACPO lead in each area driving this; you need an HQ department driving it as a "business as usual" and you need people at HQ who can work through the bringing the organisation together across the disciplines that are all affected by this. You need training on **law** first, as well as awareness issues and you need to think about whether deploying every officer with minimal training is the right way to do things.

WEST MIDLANDS POLICE PILOT

In a few months, West Midlands Police will start a pilot in some BCUs where we train four or five people per response team with far better MH knowledge and awareness, especially on law and risk management and we deploy them more constructively to the right jobs to manage the risk. This way, we are investing better in a smaller group of people and then using them more creatively for better impact. This is precisely what the service already does in CID, Firearms, PPU work – we need to do this in MH work and understand how this is just keeping step with international developments. In the US, Canada and Australia and elsewhere Crisis Intervention Training (CIT) is a developing phenomenum – along with using these trained officers to undertake joint patrols with either mental health social workers, psychiatric nurses or in some cases psychiatrists. I have been pushing for this approach to be tested in the UK for seven years and if we agree that increased knowledge brings confidence to do the right thing, this has to be worth testing.

There is much to do – **GOOD LUCK!**

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

FEBRUARY 2013

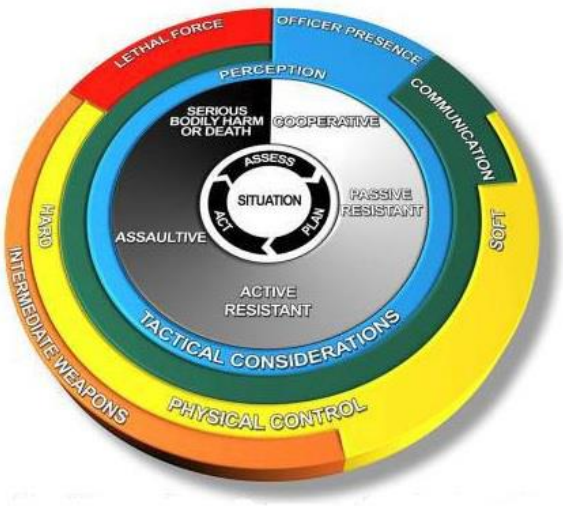
1st February 2013

The Use of Force: Part 1 –

This post should summarise, inexpertly, the police approach to **the use of force**. I am writing this because it has become obvious to me over the years, especially during debates about requests for police officers to use force on mental health patients in certain predictable situations, that we are not clear what is being implicitly requested when we ask officers to move people to hospital when they are 'sectioned' or return them to hospital when they have been found after becoming AWOL, for example. I am currently doing my police personal safety refresher so it seems apposite to run this particular post now.

I first want to put up large and clear, a diagrammatic example of the use of force and explain the three central, constant aspects of it – you might refer back to it these as I explain:

- **The white-grey-black section in the middle:** this represents the threats a police officer may be dealing with. It covers everything from people who are cooperative with the police, through to people posing a risk of causing serious injury or death and everything in between. The difference between "passively resistant" and "actively resistant" is important for policing and mental health, for reasons I'll explain shortly.
- **The blue section is a constant:** officers in all situations where they are present are assessing the situation *from their* perspective and considering their 'tactical options' – what am I actually going to do? This should be *ongoing* assessment – risks at jobs go up and down over time, sometimes changing quickly. Police actions need to reflect this realty, whether risks suddenly rise or fall.
- **Green is a constant –** officers should be constantly trying to communicate. Even when we see or hear of armed officers pointing firearms at people and considering whether to shoot someone, you will notice officers shouting "Armed police, put the weapon down" or similar instructions. Even when an officer is pointing a taser or a CS-type incapacitant at you, they will be trying to avoid using it. << *Yes, really!*



BASIC CONTROL SKILLS

Physical control – officers are taught a range of physical control skills. We teach officers about wrist locks, arms locks and about pressure points – most techniques are designed to inflict non-injurous pain, arising from which people will be inclined to move as the officer is directing them to for the legal reasons which the officer will have in mind. For example, when making a straight forward arrest, an officer will often take hold of someone's arm, perhaps one hand to the wrist of the suspect and the other hand around the elbow. This type of loose hold can be turned into a more forceful grip quite quickly which can then be turned into a wrist-lock if people attempt to run free or push away. These are sometimes known as 'primary control skills'. Using your hands to restrict and control other people's movement – *of course* whilst continuing to communicate where practicable.

We do actually teach police officers to punch, kick and push people. Obviously, use of such techniques would have to amount to reasonable force in the circumstances if they were used. Some are surprised by this: I have several times been asked by over enthusiastic young kids, curious about the police "Are you allowed to punch people?!" When you say, "Occasionally, yes." they are often surprised but you then invite them to think about whether it would be reasonable to punch someone in the chest or face if that person was trying to stab you with a knife that had been suddenly produced and it was the only realistic way to stop them hurting you? "Oh, yeah, I guess." **Context is everything; abstraction is meaningless.**

LEVELS OF RESISTANCE

Passive resistance – this is where someone is, for example, sitting in a road protesting. It may well be a peaceful protest, but it may well also be an offence of obstructing the highway. Sometimes, the police facilitate lawful protest and this law is not enforced. On other occasions, officers decide that they must make the person move, possibly for their own safety if nothing else. Assuming you've done as much persuading and encouraging, directing and ordering as you can reasonably be expected to undertake and you've reached the point of thinking, "Nothing I can reasonably do or say is going to make this person move" … how do you now move someone against their will?

Officers would consider, perhaps in pairs, taking hold of someone who for example, is sitting on the floor on in a chair and either first trying a loose arm hold and asking them to move or using pressure point techniques or arm / wrist locks to induce non-injurous pain and whilst encouraging the person to move. Of course, if the person's reaction to this is to resist further, either by pushing, hitting or kicking it may have escalated to active resistance.

Active resistance – this where people are making concerted efforts to resist the police by pushing, punching, kicking, spitting, etc.. Officers may still think that physical tactics are appropriate. They may still think they can apply a wrist lock or arm lock. They may consider what the Home Office text-book calls "a distraction strike". This could involve a strike with a fist or knee to a large muscle area which very briefly renders the suspect disoriented or unable to totally control their movements and which gives the officer a brief time in which to properly secure their wrist lock or their handcuffs. There are certain techniques for managing active resistance when an officer has just one handcuff applied to a wrist. This can involve taking a person to the floor, where officers know how to apply further types of wrist locks which can be used to ensure a persons compliance, for example until the second handcuff is securely applied and locked on.

Of course, which of these may be reasonable would depend on context. Would a distraction strike be appropriate on an elderly mental health patient? Far less likely to be than upon a strong, adult man in his late 20s who is more over-powering to the officer themselves. **Context is everything; abstraction is meaningless.**

Serious aggravated resistance – when things have reached this level and people are attempting to deliberate and seriously hurt others, police officers will not be thinking about anything other than using their equipment unless the threat occurs so suddenly that they are unable to access it in time: that is when officers may consider pushing people away, or if in close

proximity to serious danger from the suspect, punching or kicking their way to safety before drawing their equipment to deal with the threat. The escalating order that they should consider use of equipment, sometimes known as 'secondary control skills' is:

- handcuffs
- CS
- police baton
- taser
- firearms – the last two only being issued to certain officers.

A debate on taser has included people questioning whether it is in fact a more serious option than a baton. Batons can break bones and cause serious injury and whilst there is a debate about the controversy that taser represents, some argue it is safer and less likely to be injurous. Could you justify tasering a dementia patient? – well if he was a tall, strong adult man in his fifties who you'd already tried to handle with verbal and then physical control skills and failed, who had then thrown your only colleague across the room, hitting them off a wall, maybe it could be justified in law, however regrettable it may be morally. **Contact is everything; abstraction is meaningless.**

Deadly force – this is where any officer is going to want taser or more probably firearms officers to take the lead. Those of us who have had guns waved at us and knives drawn in close proximity whilst armed with an aluminium tube and a small tin of pepper know why. Even at this stage, officers having to manage the threat would still be thinking tactical options and just because guns may be justified, doesn't mean that's how things will be managed. I would advise you to read a previous blog about how I watched a firearms sergeant tackle an armed man with a police baton because he trusted his colleague to keep the situation 'covered' with a firearm whilst he de-armed the man without a shot being fired or any significant injury being caused to anyone.

I hope this explains the approach that the police take to how they should use force. Part 2 – *coming soon!* – will explain the translation of these ideas to mental health situations.

4th February 2013

Taser: Buckingham Palace –

The last few months saw various debates about Taser and I wrote a post about it just before Christmas. Today we saw events outside Buckingham Palace in which a man who has been reported to have "mental health issues" was tasered by a police officer as he brandished two knives, holding one of them to his neck.

Talhat Rehman, 54 from Harrow has been charged with possessing a bladed article and affray and will appear before Westminster Magistrates. I was keen to learn the outcome of this man's arrest and to learn more about whether the comments about mental health issues are vindicated. It has since emerged that he was previously arrested near Westminster Abbey in possession of a weapon and then diverted from justice under the Mental Health Act. Of course, irrespective of whether that was known, it may just have been officers' initial perception of him that he was mentally unwell and a proper assessment will have occurred in police custody after he was arrested for affray – an offence concerned with threatening behaviour in circumstances where bystanders could be caused to fear violence. At that stage, proper enquiries would have revealed the Westminster Abbey incident from September 2012 and this background may well have influenced the decision to charge him for the Buckingham Palace incident.

Is it interesting that he was arrested for affray and that he was not detained s136 MHA? Maybe – officers may have suspected MH issues only *after* the arrest; or they may have weighed up whether to arrest for s136 or an offence and "affray" was their judgement. Again – all reflective of real decisions facing police officers every day but even if he does have mental health issues, the evidence suggests he will still bear criminal liability.

In the broader debate about the coercion by the police, taser remains controversial – see the comments on my recent post on the Use of Force for examples of that. I would argue that the incident which you can see for yourself illustrates why taser can **not** be ruled out as an option – we see for ourselves that as soon as the man realised he was being approached by the police officer he turned towards him and had all the appearance of intending to lunge towards him with his very large knife as the effects of the taser took hold when he was struck by a second officer.

Why not watch it for yourself? –

Had the police officers approached that situation without a taser there are only two things that would have happened:

- **Approach him using CS, baton and handcuffs** – the close proximity in which the officer would have had to place himself would have rendered that extremely dangerous and we have seen what can occur. Even if the officers had navigated the incident unscathed, the CS may or may not have worked – it doesn't work on everyone – and batons are only ever likely to cause injury, sometimes seriously.

- **Approach him using firearms** – you can see on the video that many of the Metropolitan Police officers present were armed. This is routine near Buckingham Palace. This could only have led to a prolonged stand-off, which may not have been viable in such a congested, densely population tourist area OR to the use of firearms. Taser avoids the need for a firearms conclusion.

Whilst I don't like the idea that anyone with a mental health problem is tasered, I look at this video and wonder whether what we have seen is the least worst option in the circumstances? All use of force options in this situation would carry risks, including the "do nothing" option. The particular tactical choices made here brought this incident to a conclusion very quickly and very safely without significant risk to the subject but the officers still put themselves in harm's way because the Taser is not guaranteed to work either. I kep noticing how the man was wearing a fairly thick outer garment and quite probably lower layers of clothing. This can lead to problems in the taser barbs connecting to form a circuit so the officers approach here was not without its own risks.

Something to think about – recognising that the debate goes on.

Talhat REHMAN from Harrow pleaded guilty at Southwark Crown Court to two counts of possession a knife in a public place. He was sentenced to a mental health treatment requirement as part of a community sentence.

5th February 2013

Possession of Items for Self-Harm –

I was recently asked on Twitter about the law around people possessing items like blades or scissors, purely for use in self-harm and whether or not they can be arrested / prosecuted? It was quite hard to explain in 140 characters so to avoid creating confusion or the wrong impression, I offerred to do this blog.

Firstly, a disclaimer! – *nothing* that appears in the following explanation means that a person MUST be prosecuted for offences where they are being committed or that I think they should be arrested and prosecuted. All situations will turn on their particular circumstances. As I've explained elsewhere, it may not necessarily be in the public interest to prosecute someone for the commission of an offence – officers may decide to approach the situation using the Mental Health Act or by not detaining at all. This post merely seeks to explain the offences that *may* have been committed, rather than the complex decision about *whether* that offence should be prosecuted.

The examples given to me in the questions on Twitter have included someone possessing either a pair of scissors or a razor blade for use in self-harm only – is the act of possessing these items an offence? Well, there are two offences to think about and neither of them can be committed in a private place – most people have all manner of knives, scissors, screwdrivers and razor blades in their house, and obviously the law frames simple possession of these things as an offence *only* in a public place:

- Possession of an "**offensive weapon**" – contrary to s1 of the Prevention of Crime Act 1953.
- These include items which are "made, intended or adapted for causing harm to the person." So for example, a "knuckle-duster" is made *purely* for the purpose of causing harm – it is an offensive weapon *per se*. A baseball bat is not an offensive weapon *per se* and if taken from your house to the park to play baseball you would not be committing an offence. If having played your game and you were walking home, you decided to use the baseball bat to rob the newsagents, it would "become" an offensive weapon by virtue of your changing the use to which you are putting it – in legal words it would have become "intended" for use as an offensive weapon.

- **Knives, razor blades and scissors are not offensive weapons per se, either –**
- They obviously have a function, primarily around cutting vegetables, shaving faces and cutting paper, etc.. It became clear that it was becoming too difficult to prosecute people found in possession of knives because you had to prove that additional element that the article was "intended" for use in causing harm. The Government of the day decided to update the legislation to make it harder to legally possess a knife, a blade or a "sharply pointed article" like a screwdriver.

- Possession of a "**bladed or sharply pointed article**" – contrary to s139 of the Criminal Justice Act 1988.
- Very similar offences, but modernising and extending the offensive weapons legislation. It is an offence to possess "any article which has a blade or is sharply pointed except a folding pocketknife." The folding pocket knife is only permitted to have a blade up to 3 inches long.
- You have a legal defence if you can show that you had "good reason or lawful authority for having the article" or that you had it "for use at work; for religious reasons; or as part of any national costume."

DEFENCES

Investigations into these offences often include some general or specific sense that people have possessed them for "self-defence". This is not an arguable defence for either of the above – even where it can be shown that there was indeed a threat to be feared or faced.

The defences for example cover people who have bought these items and are taking them home; people who used tools as part of their job like builders; or parents who have confiscated them from a child. A member of the public who had picked up a knife at an incident, to keep it safe and from being used or reused until the police get there would not be guilty of possessing a bladed article even though they clearly were possessing it! They would have a "good reason" for doing so.

SELF-HARM

Possession of items in a public place intended for use purely in self-harm situations would also not be a defence. You'll notice if you read this, however, that there is not a total ban upon possessing things to self-harm – it is a partial ban, not to possess offensive weapons or bladed / pointed articles except for folding pocket knives. Also, I remind you that these offences are committed **only in a public place.**

So if you are caught with a pair of scissors in a public place whilst attempting to self-harm with them, the officers could either respond to the offence or, if they thought it appropriate, detain under the Mental Health Act. If you were caught with scissors having just bought them at the shop and you were taking them home, officers would look upon that you having "a good reason". Of course, usually, people with freshly purchased sharply-pointed or bladed articles will have them in a bag, possibly with a receipt and will know where they bought them, etc.. All questions that officers may ask if there is doubt as to whether the items were possessed "for good reason".

Obviously I want to suggest, that if you are feeling the need to self-harm and you feel you may put yourself at risk, you should seek *urgent* help:

999 is always available to access the police or ambulance services in addition to your normal NHS resources like your GP, NHS Direct or Accident & Emergency.

Also bear in mind the Samaritans 24hr phone line:

08457 909090 – talk to someone if you need help.

I want to repeat my point: none of the above means officers can't assess the full circumstances and act with discretion. They could confiscate an item and detain under the Mental Health Act, for example. (It would be lawful to seize something in circumstances where it were an offence, even if the criminal invesgation route were not being taken and discretion were being exercised to seek alternative approaches.)

TRUE STORY

I hope you can tolerate a little true story which, although not connected to mental health or self-harm issues, shows the extent to which these laws are misunderstood. It occurred when I was a PC after we arrested a man from the A&E department who had been very threatening towards staff and when we searched him after arrest, we found a VERY sharp craft knife blade in the lining of his jacket. He was further arrested for possessing a bladed article. When we checked out his background, we discovered he was "wanted" for a serious robbery where a samurai sword had been used to threaten to execute a man's wife unless he opened a safe in his house and thousand of pounds worth of cash and jewellery had been stolen. His previous convictions suggested that the threat would not have been idle: he subsequently received **ten years** in custody for this offence.

They decided to run a trial in the Magistrates Court for the craft blade and I turned up to give my evidence. Upon arrival, both prosecution and defence solicitors were arguing about it all and when I went into the court room before the Magistrates entered to tell the usher I had arrived, the defence very arrogantly shouted across to me, "I don't know why you people don't measure the size of these things – it's not even three inches." I immediately said, "It's also not a folding pocket knife so I'm not really concerned how large it is – it's bloody dangerous in the hands of man like that."

Out came the law books and I was sent out of court only to be beckoned in again and told the case was being dropped because "it's not an offensive weapon *per se*." I protested that I knew this which is precisely why we hadn't charged him with possessing an offensive weapon. All too late … the case had been dropped.

When the formal aspects had been finished, the stipendiary Magistrate came back into court to chat with the defence solicitor – I think they knew each other. He overheard me and the CPS falling out over the whole affair and unhelpfully added, "If he'd been waving it about, intending to use it, it would have been different."

I just looked at him and asked, "Sir, can I have your permission to return this item to the man in the cells below, bearing in mind he's on remand for armed robbery having threatened to decapitate someone with a samurai sword. He's a very violent criminal but this is his craft blade and the view has been taken that possession of it is not an offence."

He said, "No! – of course you can't. That would be incredibly dangerous!!" Exactly ……

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here and the full document is here. The Code of Practice (Wales) remains unchanged.*

7th February 2013

No Beds: part 2 –

Almost a year ago, I ventured into a legal argument about admissions under the Mental Health Act in circumstances where finding a bed is proving difficult. In particular, I was interested in those situations where the want of a bed means that police officers are being implicitly requested to do things which could be *illegal*, however moral it may be thought they are.

The situation was this: someone is arrested for a not-incredibly-serious crime and after MHA assessment they need admission to hospital under either s2 or s3 of the Act. It having then been decided that a criminal prosecution will not (yet?) occur because of the obvious need to divert from justice and prioritise healthcare, finding an inpatient bed is proving problematic.

Obviously, the law allows only a certain amount of time for a solution to be found before it starts to become illegal to continue to detain the person.

- The Police and Criminal Evidence Act 1984 allow the police 24hrs in which to investigate and question a suspect. After this limit is reached, the person must be charged with the offence or released.
- Where someone is subject to an application for admission to hospital under the MHA, they enter into the legal detention of the AMHP and the police may continue to detain the person on their behalf, pending conveyance to the hospital specified by the AMHP on the application.

- **So what happens if the AMHP will not or cannot make the application, because no hospital is stating that they have a bed for the application to be made?**

We can only suppose that one year on from the original post, that finding a bed can be even more difficult: in some areas, the number of places available in psychiatric units has reduced by a third – **TWICE**. That's more than 50% in total.

MOVING ON

Since my last post a relevant legal judgement has occurred, actually from my force area, which reinforces some of the points I made last year. In May, the European Court of Human Rights ruled in MS v UK that certain prolonged detentions in police stations amounted in inhumane and degrading treatment where the health of the patient was put at risk by refusal to identify a bed for onward admission in a reasonable timeframe. The judgement alludes to the "criminalisation contingency" about which I have also written – medium secure services declining or resisting admission directly from the police station on grounds that were not really clinical grounds.

I think it is now worth quoting directly, the words of the former Mental Health Act Commission. To explain, the MHAC was an NHS Special Health Authority, charged with statutory oversight of how the Mental Health Act was used. During its time in existence, it published a Biennial Report on the use (and abuse) of the MHA, highlighting usage, problems, solutions. The MHAC's legal responsibilities were absorbed by the Care Quality Commission upon its creation – but I can find no record of the MHAC or the CQC withdrawing, amending or qualifying the following advice:

In the 08th Biennial and the 09th Biennial, the MHAC addressed the subject of applications being required in circumstances where there are no obvious beds available; and said –

Para 4.45 of the 08th Biennial Report –

- "The Commission advises the [AMHPs] have a duty to carry out their functions as prescribed in the Act, and that the responsibility for finding a bed is clearly laid on health care providers whose **duty it is to admit the patient.** If the patient cannot be admitted for want of a bed, the relevant social services authority, health authority and police authority **will be liable** if one of more of them fail to perform for the patient those functions which the law **requires** them to discharge.
- In practice terms, this means that **in an emergency the [AMHP] should complete the applications**, making it out to a hospital specified by the relevant health authority in the notice required to be given under Section 140 of the Act, **and convey the patient** to that hospital. The [AMHP] should inform the hospital that he or she will remain with the patient while a bed is organised, but that **it is the hospital managers' responsibility to admit the patient**; the patient is per se not fit to be in the community."

Para 2.49 of the 09th Biennial Report –

- "The common problem of [AMHPs] finding no beds available when conveying a patient to a hospital for urgent compulsory admission was raised in our Eighth Biennial report.
- We advised that the [AMHP] should remain with the patient while a bed is organised, taking the view that, where the hospital has been identified by a Health Authority as a place that will admit patients in emergencies, it is reasonable to expect the hospital to find a bed for the patient, even though Section 140 does not place a legal duty on it to do so."
- **For clarity** – all bold emphasis above is mine, not that of the MHAC.

I have always acknowledged: this advice is dated by nearly fifteen years. It has also, as far as I can tell, not been rendered defunct by any further publication from eithe the MHAC or the CQC.

So let me be bold enough to suggest what is going on in these situations and I'll stand the criticism:

- **PCTs in England are routinely failing to specify** to Local Social Services Authorities those hospitals in their areas designated "for the reception of patients in cases of special urgency" under section 140 – otherwise, why do most PCTs not answer their Freedom of Information requests asking to see this list, except the one who proceeded to list every single hospital in the region whilst acknowledging that they did not understand the question?
- **Received wisdom has taken hold within networks of AMHPs** – that the criteria which must be satisfied to make an application valid and appropriate include criteria which are not actually in the Act. We see this elsewhere, both in policing and in mental health, where people fall into the "policy as law fallacy" and engage in various other acts of folklore. I don't doubt the disruption, tension and conflict that this approach can bring: but so does leaving vulnerable undetained in the community or illegally languishing in police cells.
- I'm more than happy to learn that I'm wrong about this – just tell me *why* without effectively saying "because you are."

I repeat another point I've made several times: I can name AMHPs who share this view, that *in utter extremis*, you can do this and force the issue. Whether you regard this as brinksmanship or something else, I don't mind. All I know is that when these debates have come "on top" in an operational situation and police forces like Greater Manchester have served legal papers upon the AMHP / NHS to take them to court for breaches of law, there has been no example of AMHPs and the NHS standing their ground to defend leaving vulnerable people in police custody illegally.

SAYING THE SAME THING AGAIN

I write this additional post, essentially just repeating and amplifying the first because the debate has occurred again on social media. I made the point previously and I do again now, that if someone can explain to me why I have misinterpreted the law, the MHAC guidance or anything else that is relevant, I'm all ears. In particular, I had the objection today that "it hasn't been tested in the courts" – with any indication by the courts in either direction.

I submit that in the absence of a test-case our presumption should be in favour of following the advice of the the statutory authority on the implementation and use of the Mental Health Act. Otherwise, what is the point of them issuing it and on what basis to we ignore it?

13th February 2013

Twenty Percent –

How much of policing is connected to mental health issues? – obviously you could play all day with the definitions that would have to apply to any proper analysis of that question – what do you mean by "connected"; what do you mean by "mental health issues". And yet the question remains important even if we haven't got time to do a quick stroll through the philosophy of mental illness and the history of semantics to agree upon some kind of standard as to what we mean … what, precisely, do you mean by "illness" and "semantics"?!

As this is a policeman's blog – I've never pretended to be an academic – so I've given my gut instinct in the title – **twenty percent**.

One in five, of **all** demands in policing is 'connected' to 'mental health issues' … we knew that we could pull-off a claim about fifteen percent, because the Centre for Mental Health claimed this several years ago on the basis of some decent research.

I'm also happy to admit that twenty percent is very probably an *under*estimate of prevalence but there are various reasons why we don't want pitch the claim any higher.

WHAT I AM COUNTING

I keep coming up with this number when I do little spot samples of different things. At work I sometimes keep a little count of calls to which my officers are sent in an hour; the number of persons in custody at any given time; the number of people who are reported missing at any given time; the crime investigations for which my team take initial action – which may include arresting an identified offender or not – I look at the totals for these things and the number of those events which are obviously connected to mental health issues.

At least **twenty percent** – it keeps coming up over and over again.

Remember I talked about "failure demand"? – I try to keep a track of that too. What proportion of these incidents become demand for the police

because of other failures or inabilities in our broader "mental health system". I include failures or inabilities in policing as well as in health or mental health related services. Failure demand in mental health jobs for the police often runs at **fifty percent**. This means demand that was only created because previous interventions did not occur or did not occur correctly.

These are *not* scientific samples: I am obviously not always in a position to be tracking this stuff for a whole shift when I am busy in my own right. I'm also certainly not attempting to track all of these things at the same time, even for just one hour. It's during slightly quieter times that I can choose to monitor something for an hour or do a snapshot. I have to check the number of missing persons every day – there were five on the system yesterday and two had mental health issues. There are six on today and two have mental health issues. (Not the same two).

More than **twenty percent**.

WHAT I AM NOT COUNTING

Definitions are important, of course. What I don't count in these things are straight-forward drug / alcohol addictions without additional mental health problems. So the prisoner who is a known alcoholic who becomes abusive in an off-licence and is arrested for being drunk & disorderly – I don't include him in my "mental health" snapshot. The heroin addict who is arrested for burglary because they need to secure items to sell to buy drugs – I don't include him in my snapshot.

Why not? – because whilst addictions are broadly regarded as mental health disorders, I want to be able to distinguish in my head between "functional" or "organic" mental health disorders and those broader disorders connected to and arising from behaviours – again, I accept this is a further definitional nightmare. I also want to be able to give the figure which emerges if I do include those broader addictions so we can compare and contrast: **Forty percent**.

Again, this figure can represent an under-estimate. During a previous shift I looked at the custody system which lists all currently detained people in the cells. When one looked at mental health disorders as well as alcohol or drug addicted people in custody, there were twelve in and six of them hit one of those two criteria. This is not untypical.

CAUSAL OR COINCIDENTAL?

One big question in all of this, of course, is whether a mental health disorder or a drug / alcohol addiction is "*causal or coincidental*" to the events being

policed. For example, if an officer had exercised a detention under s136 MHA, it would be *causal* to the officers actions: the police are policing *because* of a mental health problem (manifested in someone needing immediate care or control, for example.)

In some of the cases which fit into the dip-samples, I've mentioned, the presence of a mental health disorder is co-incidental to the events in hand. For example, I recall a missing person recently, who had a formal diagnosis of Alzheimer's, but it was in its earliest stages, diagnosed only recently and it most certainly was not the reason *why* he absented himself from his life. On another occasion, a well-known heroin addict and prolific burglar was arrested for assault during a family argument. This argument was nothing to do with his heroin addiction or his burglary habits: both were *coincidental* to the events in hand.

SO WHAT?

Well, this gives rise to various questions, not least the question of why a thematic contributor to demand is not better reflected in the resources devoted to ensuring proper responses at all levels of the police. Imagine, for example, if the police put 20% of their resources into this area; or 20% of their training time? It sounds ridiculous doesn't it?! I'm actually wondering what 20% of us would do all day, if some hypothetical Chief Constable were so bold. But we can at least say that it is worth investing in a member of staff in every local policing area as well as some at headquarters to ensure our policies, procedures and partnerships are correct.

And of course: **nothing** in this blog means that none of this 20% is not perfectly legitimate police business, even if it is failure demand arising from issues outside of policing. Policing exists to handle society's "failure demand" and therefore it would be discriminatory to assume that we should exclude patients, their families and mental health issues from that.

If you are a police officer, please test the theory and let me know your percentage figure. Do several little snapshots – logs in an hour or persons in custody; crime reports generated in a day or an assessment of the jobs you are sent to in a day – just whatever your job allows you to survey. It gets interesting after a while!

15th February 2013

ZH v Commissioner of Police for the Metropolis –

The Court of Appeal delivered a significant judgement yesterday regarding the police, the Mental Capacity Act and autism. Many have argued that it is an appeal case that should never have been brought at all given the clarity of the judgement in the initial County Court hearing.

THE INCIDENT

In 2008 a young man known throughout as 'ZH' was on a trip to a local swimming pool from his specialist school in West London. As the school party prepared to leave he became fixated by the water and stood fully clothed at the side of the pool, staring at the surface. None of this is unusual for people with severe autism and learning disabilities and he was accompanied by specialist school staff and of course, the pool was staffed by trained lifeguards.

After a period of time, the pool manager called the police, concerned that ZH may enter the pool in face of danger and that he was in contravention of rules regarding poolside access. The Metropolitan Police despatched several officers – the pool's manager having contrived to state, inaccurately, that the young man was violent.

When the police arrived, they took control of the situation without much consultation with school staff and when one officer touched ZH on the back, he began to move with momentum towards the water. The officer and another tried to grab his arms in fear of him entering the water but he jumped in.

Lifeguards entered the water and formed something of a cordon, encouraging him to move to the shallow end. Once within reach, police officers pulled him out and then restrained him on his back with handcuffs and leg restraints before moving him to a police van. He remained there for a short while before being released and he left in the care of his teachers.

ZH claimed to have suffered a range of medical and psychological problems as a result of the events and action was brought against the Commissioner.

COURT PROCEEDINGS

In March 2012, ZH won his claim for assault, battery, false imprisonment and claims under the Human Rights and Disability Discrimination Acts. He was awarded over £28,000 in damages. The Metropolitan Police Commissioner Bernard Hogan-Howe was quick to announce that they would appeal the judgement.

In February 2013, the Court of Appeal unanimously dismissed the Commissioner's points, specifically rejecting that the judgement would adversely affect the general ability of the police to respond to such incidents. The Commissioner has already indicated that he will not appeal further.

When I first read the original judgement it made complete sense to me. The explanation given of officers having acted under the Mental Capacity Act 2005 was unconvincing and almost completely in tune with abuse in another Metropolitan Police case, 'Sessey'. I predicted that the Appeal would fail and am sorry to have been proved correct. It is sad to see it, especially when the particular officers involved were acknowledged to be trying hard to do the right thing. Unfortunately, they were hasty and misguided in their application of the law.

I don't think we should under-estimate the damage that was done by appealing the original finding either. Rather than pay the damages awarded, the appeal has also been seen by others, including ZH's father, as more public money defending the indefensible. This claim can now be made substantively, the police having lost and I'm not sure that the Metropolitan Police press release will help dispel that perception given it conspicuously fails to apologise, express regret or mention the young man involved or the impact upon him.

SO WHAT CAN BE DONE?

The likelihood of police officers being called to exactly similar circumstances where the verdict in this appeal can be directly implemented is small. But we have to take on board the lessons to be learned and turn this into advice for officers.

So what are the main messages? –

1. The Mental Capacity Act is not the right legislation for the police to use in non-urgent circumstances – it is best reserved for situations in which there is a genuine need to intervene in a life-threatening situation. This was not and it links to my next point:

2. The formation of sound judgement about risks and threats needs to improve and be accurate – of course it was a risk to ZH that he may have gone into the pool and officers would be wrong to ignore this. Had he done so, he was going into a pool which had numerous fully trained life-guards immediately on hand. It is not as if this was occurring at a canal side where the officers were the only people present – context is everything.

3. Even if action were immediately required because of some development in the situation not precipitated by the police, it could easily be argued that s136 of the Mental Health Act were more appropriate – although terminology is argued over, autism and learning disabilities are 'mental disorders' for the purposes of s1(1) MHA and the pool a place to which the public have access: once you have 'immediate need of care or control' you have a lawful basis for acting.

4. But by far the most important lesson in this situation is the recognition of a fallacy – this incident was a classic example of "something must be done, this is something so we'll do this." I also don't doubt that it was done for the best of reasons but the broader context was that ZH was accompanied by specialist teachers and there were pool staff present. The police, in the court's opinion, were too hasty in their approach and perhaps should have focused upon encouraging the staff to stop eating crisps and work with each other in leading resolution. We put our arm in the mangle, again, when best advice would have been to recognise that things not having reached a point of emergency, others were better placed to act.

DAMNED IF YOU DO, DAMNED IF YOU DON'T?

I'm not at all certain that I share the view expressed on Twitter that the police are damned either way. It was quite disappointing to see views basically saying, "We'll next time we just won't go" – sorry, you don't get out of it just because it's complex!

The National Decision-Making Model is quite handy here – think about risks / threats; think about laws / powers; take a judgement call in light of them all and crack on. It's easy to conceive a response which is patient, tolerant and led by the most appropriate people and supported by the police in the background.

I am pleased, in a way, that this judgment has ended up being made. It reinforces important legal obligations on the police around equality,

discrimination and human rights. I do think it also re-raises the debate about training:

The National Autistic Society straight away called for autism training for all police officers and managed to omit the courts remarks that the officers were, in ther court's view, acting to safeguard ZH, however misguidedly. My previous blog on policing and autism agreed with the need for training but this is a challenge that has to be seen against the background of calls by other interest groups for other types of mental health disorders for similar priority: dementia training, personality disorder training, bipolar training and many others. I don't wonder whether what we really need is better legal training?

We have been found wanting and now it's time to recognise that and raise our game. Policing mental health demands is **core police business**, accounting for twenty percent and more of our workload and so we need to get better at it.

20th February 2013

Creating 'Patients' –

It occurred to me recently that the actions of the police can have the effect of appearing to create a mental health patient where none really exists. This can become a self-fulfilling prophecy of repeated interventions which creates a lot of failure demand, for both policing and health services. Let me explain! –

EVER DECREASING CIRCLES

Once upon a time, the police detained a man who was on the wrong side of a road bridge, expressing suicidal ideas and threatening to jump. The road has been closed, officers starting to try and persuade the man not to jump and a negotiator was called. After a protracted discussion to persuade and influence this guy back over the railing, he was detained under s136 MHA – because suicidal ideas, hanging off a bridge may indicate the presence of mental disorder, right? And the interaction with officers may lead to further suspicion that the man was mentally ill. Following assessment at the "136 suite" the man was neither admitted to hospital under the Mental Health Act nor referred for mental health care or support to anyone. << I have known this outcome from such incidents many times in my fifteen years' service. The person then having been released from section 136, the police resume and the person goes about their life.

What happens if we attend a similar job in the future? – maybe a different bridge in a different area and almost certainly different police officers; but background circumstances broadly the same. Did the MH assessment first time around get it wrong; do the officers even know that outcome or are they simply aware from intelligence systems that the person was previously detained by the police under the MHA? Maybe they are aware of nothing at all and simply start from the basis that the first officers did … suicidal ideas, bridge, communications and perceptions so there is a mental disorder and when they person is persuaded back over the rail, they will be detained under s136 MHA for assessment at the PoS and an outcome. Guess what it is? Not "sectionable" so no admission and maybe a referral to GP or CMHT; or maybe not – all depending on circumstances.

REVOLVING DOORS

We can see where this is going can't we? My police area are currently attempting to manage two people who fit this category and on a recent early shift one the men rang the police from his flat at 9am having been drinking heavily and as part of our response to what an officer described as "that regular mental health patient who is constantly ringing" I rang the Crisis Team to find out more about him. Their answer motivates this blog because it suddenly occurred that we – the police – have "created" this mental health patient.

The Crisis Team had assessed this man for the first time about two years previously and had assessed him several times over that two-year period. Every single time they assessed him, it was following a police intervention: either detaining him under s136, including whilst hanging off bridges expressing suicidal ideas; but also following him being arrested for minor offences. They always, always found him to lack any obvious mental disorder and either released him from s136 or advised us to do what we wanted with any criminal allegation against him. Yet look up this guy and several like him on PNC and police intel systems and you couldn't fail to think he had a mental health history.

It becomes the "obvious" to do – to attempt to involve mental health services in the police response and think about diversion from justice and so on. But he's not mentally ill, except to the extent that we regard anyone who drinks a lot to be mentally ill. He has been repeatedly offered support for alcohol related issues by both the police and the health system and declined to take up those offers.

CRIMINALISATION

The first time I came across a similar case, was about seven years ago: a female drug user who often brought the M5 to a standstill (at massive economic cost, I might add) because of her obsession with a certain bridge and the adverse of its parapet. Repeated s136 interventions led to some frustration being expressed by the mental health trust that the police kept perpetuating this revolving door when a better approach may not involve s136 being used at all. When we asked what they thought would be better they emphatically said, "Prosecution!" Simple when you know how, isn't it?!

And so we did.

Few people realise that it is an offence under s22A of the Road Traffic Act to place something (including yourself) "on or over a road" in circumstances where it causes a danger to road users. Obviously, someone falling from an M5 motorway bridge onto a 70mph triple carriageway would be horrendously dangerous. So after something like five s136 interventions

in a short period of time – all by different officers acting in good faith – we made it more widely known that s22A was the way to go, secure MH assessment in police custody as part of the investigation if that were thought to be necessary and take a broader view than whether it is a "health or justice" issue. It could well be both.

In these cases, criminal sanction for behaviour has been shown to be effective – at least in terms of a short-term solution. All the mental health assessments and the criminal investigation considered the issue of drug use for the woman mentioned and alcohol support for the man. The female drug user was prosecuted, remanded to prison (because of various other criminal justice antecedents) and subsequently found guilty. It brought an immediate end to incidents on the bridge. Maybe she found another bridge, some may ask how effective this strategy was in the longer-term. All fair points, but not issues that prevent us prosecuting those who commit street robbery where we think they'll take the consequences and just commit more robbery elsewhere on different victims.

21st February 2013

"Mentally Ill Migrant Criminals" –

How much stigmatisation can you take in one go?

Try this article: it has criminals, immigrants and mental health patients all rolled together into one problem – mental health bed blocking. All of this arises from the case of Imtiaz Ahmed, who was convicted of manslaughter on the grounds of diminished responsibility and sentenced to prison. He was subsequently transferred to hospital under the Mental Health Act and remains there because the hospital argue they cannot release him knowing he is not entitled – as an illegal foreign national convicted of an offence – to aftercare and community support.

The article is talking about a lot of law that we've covered together on this blog – I have this idea in my head that your journey in understanding it is associated with my efforts to research and present it. This current appeal case brings a lot of it together. But more importantly, I'm going to suggest that the doctor in this matter was wrong – after advice from Amanda Weston who has commented below.

PRISON TRANSFERS

Two quick reminders for you to recall –

- If a person is convicted of an offence and known to have a mental disorder of a nature or degree that it would be appropriate for them to be detained in hospital, the court can impose a hospital order under s37 of the Mental Health Act – discharge from s37 is at the discretion of the Responsible Clinician in charge of the patient's care. If the person is deemed to pose a serious risk of harm to the public, the s37 order can be 'restricted' under s41. This ensures that the Ministry of Justice must sanction release, not the Responsible Clinician.

- If an imprisoned criminal becomes in need of hospital treatment for mental disorder whilst serving their sentence, they can be transferred under s47 of the Mental Health Act to hospital – if the prison sentence expires whilst the person is detained under s47 MHA, they continue

to be detained in hospital *as if* they had been subject to a hospital order upon conviction.

So, if a non UK citizen is convicted of an offence and suffering from a mental disorder is either given a s37 hospital order or transferred under s47 MHA, they will occupy a bed in our secure mental health system.

Normally, when such a patient is considered fit for discharge from hospital, their mental health care will not simply be terminated: they will come under the auspices of a community based mental health team, often the community forensic team. This ensures that recovery and rehabilitation through the period of re-adjustment to semi-independent or independent living is properly supported. It also ensures for restricted patients, that if recovery and rehabilitation are not progressing well, the community mental health team can instruct the Ministry of Justice accordingly and they can, if necessary, recall the patient to hospital under s42 MHA.

So why is there a problem? – well, it was suggested during the Ahmed Appeal that non-UK citizens don't qualify for the community support that is alluded to, known in law as "s117 aftercare". As such, Doctors would consider themselves to be discharging patients into a vacuum of care or support. The risks around this would be significant given that the individuals concerned have been convicted of offences and / or assessed as posing a "significant risk of harm to the public". There are also challenges around how the NHS tie up their decisions with the United Kingdom Borders Agency who are responsible for removing from the UK those who should be deported after conviction. There are additional considerations for UKBA where the person to be removed is also mentally ill – questions arise about their ability to secure treatment / care in the country to which they would be deported and whether deportation takes account of human rights considerations that we often hear about.

SO WHAT?

Where a Doctor is not convinced that releasing a 'restricted patient' into the community without the necessary support, they are keeping them detained to protect the public. This gives rise to the supposed "bed blocking" argument to which the Court of Appeal has said the authorities should give 'speedy attention'. Let's hope they do, as the occupancy of a medium secure bed is said to cost more than £200,000 per annum!

The problem is that the claims made in the article may well in fact be wrong: section 117 aftercare applies to any patient who is discharged from hospital after that have been detained there under ss3, 37, 45A, 47 or 48. This entitlement to aftercare is not contingent upon immigration status and there are various mental health trust policies available on the internet

which show this reflected in practice. It is schedule 3 of the National Immigration and Asylum Act 2002 which details which public services can be withdrawn or withheld from non-UK citizens on the basis of immigration issues and s117 aftercare is not listed upon them. See also chapter 27 of the Code of Practice to the MHA which makes no mention of immigration matters.

But as the article attracted my attention for completely different reasons – it was around the potential for the piece to be full of stigmatising attitudes as soon as I read the headline "mentally ill migrant criminals" – I am even more persuaded that this was behind the piece now that I have learned that the claims within it may not even be correct. All I can conclude is that we're appear to be detaining certain patients indefinitely despite their entitlement to statutory aftercare and without limit of time … potentially because of politics around the deportation of those patients who were detained originally for serious offences and whom UKBA would prefer to deport once issues around mental ill-health mean that they can.

23rd February 2013

An Garda Síochána –

I have noticed recently that the number of times my blog has been read in the Republic of Ireland has markedly increased. Our colleagues in the Garda Síochána are serving in the country of our nearest neighbours and I have recently become curious about the similarities or differences between policing and mental health both in our two countries.

GENERAL

The Republic of Ireland last updated their legislation in the Mental Health Act 2001. This formalised certain roles for the Garda in the detention, conveyance and recovery of certain people or patients and additional details can be found in various Codes of Practice to the 2001 Act. A useful document in understanding how this new legislation operates can be found in the report of a joint working group on Mental Health Services and the Police (2009).

This identifies many issues that will be familiar to readers in the United Kingdom as well as in other areas where this blog is read like Canada, Australia and New Zealand: there are issues around the capacity of health and / or social care services to respond to situations out of hours which creates a vacuum into which the Garda are drawn; there are issues around the training given to Garda trainees in the identification of people who may potentially be experienced a mental disorder and the nature of what an appropriate response to that may be. Like most countries, the nature of police responses has been questioned in response to deaths in Garda custody because of the prevalence of vulnerable people experiencing mental ill-health issues and drug or alcohol problems.

Arising from recommendations in the 2009 report, the Health Service Executive of Ireland and and published a memorandum of understanding (2010) to bring detail to joint working agreements. There was a review of the Mental Health Act (RoI) in 2012.

EMERGENCY INTERVENTION

I want to concentrate minds on the difference between legal authorities in the UK and the RoI on the ability to apply an emergency intervention. It is these powers I am contrasting across the countries concerned:

- Section 136 Mental Health Act 1983 – England / Wales.
- Section 297 Mental Health (Care and Treatment) Act 2005 – Scotland.
- Article 130 Mental Health Order 1986 – Northern Ireland.

- Section 12 Mental Health Act 2001 – Republic of Ireland.

In the United Kingdom, none of the three pieces of legislation cited allow UK police officers to detain anyone in a private place and therefore do not offer a power of entry, by force if required, in order to do so. The Republic of Ireland does –

"Where a member of the Garda Síochána has reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons, the member may either alone or with any other members of the Garda Síochána –

- Take the person into custody; and
- Enter, if need be by force any dwelling or other premises or any place, if he or she has reasonable grounds for believing that the person is to be found there."

It is not only the public / private and "power of entry" issues that are different: s12 MHA (RoI) requires a higher assessment of risks than in the UK legislation. You will recall that British MHAs call for "immediate need of care or control, in that person's interests or for the protection of others." Quite clearly this can include situations of "immediate and serious harm" as per Irish law, but it includes other, lower levels risks where purely on the basis of a perceived need for care, the police may intervene if that need is immediate despite it not necessarily being likely to lead to "serious harm".

CLARITY

This allows An Garda Síochána a clear operational advantage over UK police services responding to mental health crisis situations in private dwellings. The ability to remove someone to a safe place for assessment by a doctor where there are immediate fears around serious risks, whether apprehended in a public or private space, removes the possibility of the "999 What's Your Emergency" type incidents. Ireland are not unique in this

regard – most states of Australia and Canada are the same, as well as South Africa.

Irish law provides further clarity around situations which are routinely frustrating in the UK and British officers reading this may not enjoy this next point! – where a patient in Ireland has been "sectioned", the applicant for the patient's admission to hospital may request An Garda Síochána to assist them secure safe admission if they are unable to do it themselves and the Garda *must* assist.

There are so many advantages to such clarity – whether or not you agree with individual points – that just a cursory reading of Irish Law reinforces how many grey areas of debate British law currently creates. It is Irish Mental Health Law that I cite when trying to highlight how we leave so much unspecified and how we've managed to make it so complicated.

I'm confident from reading the 2009 report and the 2010 MoU that there are still problems in operationalising effective joint working practices as Ireland continues to move to a full model of community mental health care – but to have to attempt it against a background of modern mental health legislation whose attraction is in its simplicity must be a real advantage.

25th February 2013

Training Day –

On 17th February this year, the Observer published an article in the wake of the failed "Commissioner v ZH" appeal in which it was reported that "Hundreds of thousands of pounds of public money used by the commissioner to fight this case [could have] been used to train police officers to humanely treat people with disabilities. The Association of Chief Police Officers has categorically refused to provide such training."

On 24th February the Observer printed only part of a letter which was sent in response by the ACPO Lead on Mental Health & Disability, Chief Constable Simon Cole. The full press release has been published by ACPO:

"It is not correct to say that 'the Association of Chief Police Officers has categorically refused' to provide training on dealing with people with disabilities (Trauma of autistic boy shackled by police, Observer, 17 February). Dealing with vulnerable people and those with disabilities or mental health issues is embedded in officer training across the service. Restraining vulnerable people appropriately is also a central part of officers' initial training and it is revisited throughout their career. All of this training and guidance has been reviewed and updated with the input of outside expertise from the health and charity sector in the last five years."

I know that this is true because I wrote some of it and it has been made mandatory in many forces across the UK and embedded within other training programmes like personal safety, public order, custody, etc., etc.. **Is it enough?** – not in my view, but you've got to put my perspective into perspective, as it were.

POLICE TRAINING

More generally than the "ZH" case and the issues arising from it: we can always have a debate about whether some training is enough training, whether it is then used correctly and how we could make things even better – but it must be borne in mind that some of the implications of courts' verdicts in this country are in stark contrast to medical opinion in some quarters. Only recently, the IPCC issued a formal recommendation to police forces following one of their investigations which is now causing

review of whether procedures and partnerships are correct in order to respond to "excited delirium". And yet if you try to have a discussion about excited delirium with some doctors you'll find that the very existence of this concept as a disease-condition or syndrome is in question – some pathologists and psychiatrists going far enough to suggest that the term "excited delirium" is language which attempts to medicalise the use of excessive force by police officers.

You also have to remember that the law of the United Kingdom does not always allow a police-led response to certain situations which usually attract police attention. After I published a blog last week on "An Garda Síochána" I went to work where one of the first things my officers had to do was deal with a call from the ambulance service to "do something" about a young woman in her own dwelling who was mentally ill. She wasn't committing an offence, she wasn't breaching the peace – actually, she wanted to go to bed by the time the police arrived – but the paramedics' (perfectly valid) assessment of mental ill-health led to a call for the police. Why not call the CrisisTeam or the duty AMHP? We all too often want to criminalize people experiencing mental health disorders but at least if the event had happened in Ireland, the Garda would have had at least some legal basis for doing something if the threshold for intervention were met because Irish law directly allows the police to act in private premises.

Therein lie the problems: we have mid-twentieth century laws from an era of mass institutionalisation to deal with a no-longer-newly deinstitutionalised model of mental health care which has decided, without design, to rely upon the police for certain responses and certain supports that are not necessarily possible and are often not desirable.

I was pretty appalled by the "ZH" case, if you're interested – and I predicted on this blog and twitter that the appeal would fail. But we need more than a debate about training – we need debate about the role of the police in our broader mental health system with clearer mandates for both the police and the health / social care organisations. **We also need to consider the legal framework we're still operating from a time when people carried ration books.**

27th February 2013

Para 10.22 to the Code of Practice –

The College of Emergency medicine today published a mental health toolkit, to assist acute trusts' Emergency Departments in understanding the overlaps with mental health and improving liaison psychiatry services for the benefit of us all. A comparatively short document in an accessible format, I opened it up and searched for the phrase "place of safety" which I couldn't find. I then searched for the word "police" and it brought me directly to section 11: which also includes a link to Royal College of Psychiatry Standards on s136:

"All areas in England will have a multi-agency policy for section 136 patients. There should be an appendix relating to the use of emergency departments. It is prudent to ensure that this is appropriate for your local service, and that the ED is only used for 136 patients who have an acute healthcare need. Otherwise mental health services should provide an assessment suite, or where necessary the patient should be taken into police custody. The policy should also include a strategy to ensure that acceptable time frames for a mental health act (MHA) assessment are established, with provision for police to remain with the patient if they are managed in the ED. The police should stay until a MHA assessment has been completed."

Based upon that, I want to talk about para 10.21 and 10.22 to the Code of Practice to the Mental Health Act.

- **Para 10.21** – A police station should be used as a place of safety only on an exceptional basis. It may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting. It is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided (subject, of course, to any urgent physical healthcare needs they may have).
- **Para 10.22** – A police station **should not be assumed to be the automatic second choice** if the first choice place of safety is not immediately available. Other available options, such as a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily, should also be considered. (My emphasis.)

And let's not revisit the nonsense that A&E is not a place of safety. Of course it is: whenever they agree to temporarily receive a patient and by virtue of them being hospitals. And we understand that A&E can be a distressing environment that can exacerbate symptoms. What do we think happens in police custody when the masturbating drunks are singing songs and we're dragging in the offenders who are screaming obscenities at the custody officer, wishing cancer upon their families? Not a great place to be if you're mentally unwell. Has anyone asked patients where they would rather be if it came to a choice – it often does: the CEM document does talk about service-user engagement, after all.

THE BROADER PICTURE

Emergency Departments remain entitled to decline to provide healthcare to patients on an individual basis, if they wish. It is also true to say that police officers are under a *duty* to ensure that their management decisions of people they detain, survive contact with all legal realities – including human rights realities. Nothing in UK law prevents police officers asking ED to provide assessment and care for people detained if the officer believes that would be appropriate, or potentially just less inappropriate than the other options. Let's remember: policing mental health events amidst a health service whose over-funcationalisation is as severe as is represented in this CEM document, it is often a matter of choosing the least-worst option. It's also relevant to add, that if you detain an elderly person under s136 – perhaps a dementia patient – and remove her to A&E explaining that the cells are rammed full of screaming drunks, A&E usually makes itself available – the very practice of our NHS in this area doesn't live up to the statements of the kind we see here.

I know that this sounds exceptionally subversive: encouraging officers to go against what a place of safety protocol may say; against what an eminent body like the Royal College of Psychiatrists might have in their s136 standards or the CEM in their mental health toolkit. It is really not intended to be: but it is intended to ensure that English and Welsh police officers (different CoP in Scotland / Northern Ireland) are aware that they are not bound by this, despite the phrasing in the document above and there are some – not all, just some – situations in which the law will require them to know this and act upon their legal responsibilities. It is in our oath of office that a police officer's first duty is to the law.

This blog has listed several instances of individual police officers falling foul of laws where they have acquiesced to broadly preferred policy positions like this one. "Do as you're told and don't be awkward" appears to me to be the implication. That's fine as long as it works, but such generalised statements of the kind we've found here and in some areas' "Place of Safety" policies mean **nothing** when the impact of particular cases is being

assessed by the IPCC and the courts after untoward events. We have seen before police officers criminally prosecuted for "doing as they're told" by NHS organisations and for not agitating to access needed supports like ED or the Ambulance Service. We've seen other legal challenges brought and adverse inquest verdicts – not least in the case of Sean Rigg. From the Metropolitan Police's point of view, the operational 'answer' to the detention of Sean Rigg, was to undertake the restraint differently and for a shorter period of time; to get an ambulance to him as soon as possible and get him to A&E. Whether or not A&E would agree with this, either in principle or in practice …

Finally, the last time I had doubt about whether it was appropriate to remain in the Emergency Department with a s136 case, it involved a patient who was also physically injured and had been sedated by ED doctors in order to stablise his position to give appropriate care. Staff were demanding police officers remain there – as suggested by this document – but I was managing TWO simultaneous firearms incidents in the middle of the night and we had officers elsewhere involved in responding to a serious sexual offence. I *ordered* the officers at ED to leave – I don't often have to "order" anything, but the officers needed the ability to tell NHS staff that they were being directed by a more senior officer and were obliged to comply.

I actually did think about our "national decision-making model" and my own force's statement of values to guide this decision and of all the things I would be prepared to justify to my Chief Constable if things went awry in any of my legal duties in those four significant policing events, it was the decision to leave a sedated patient in the care of medical staff who have security nearby whilst we cordoned three large areas to protect the public from firearms threats and preserved the scene of a serious crime.

28th February 2013

What If Richard Bentall Is Right? –

As I've journeyed through understanding just some of the issues around mental ill-health, various kind health and social care professionals have pointed me towards various books to increase my understanding. As a young PC I really didn't think very hard about the "validity" or the efficacy of mental health treatments and interventions. One assumes that whilst there are constant debates about funding and equity, we nevertheless have a developed mental health system which is underpinned by universities engaged in research and that many of them are acknowledged to be at the forefront of international research in mental illness. My *alma mater*, Cardiff University undertake pioneering work in the Neuroscience and Mental Health Research Institute around bipolar disorder and dementia, amongst other things. Their patron is Stephen Fry, also an honorary fellow of the university, and there are various lectures and resources on the website that you will find extremely interesting.

And then someone told me about Professor Richard BENTALL: professor of psychology at the University of Liverpool. I sent off for two of his books – Madness Explained and Doctoring the Mind – and over the course of a few weeks, I ploughed through them. They very accessible books given that they come loaded with explanations about scientific research methods, genetics and psychology and I stopped studying science at 16. When I got to the end of them, I just started over and read them again before wondering, "Bloody hell – what if he's right?!"

BENTALL makes a various claims, but a few I found utterly astounding, hence I had to read it more than once:

- That recovery from major mental health disorders may well be better in developing countries without the trappings of a developed mental health system;
- That the science upon which major claims are made about the efficacy of various treatments including anti-psychotics, anti-depressants and electro-convulsive therapies is often quite poor;
- That psychiatric treatment through drugs brings no long term benefits to patients and that short-term benefits can often be outweighed by side-effects.

He has also written the occasional article for the Guardian, most recently arguing that there is too much coercion in mental health care and he debated the validity and relevance of psychiatric classifications with Professor Nick CRADDOCK from Cardiff University following controversy about the soon-to-be-published DSM-5 – this is the Diagnostic and Statistical Manual from the American Psychiatric Association.

Here's an obvious point: I haven't got a barking clue whether Richard BENTALL is right or wrong; my GCSEs in maths, chemistry and biology do not take me far enough. But what I do know, is that the claims he's making in his book could be tested – the data upon on which he makes them are available, the sources clearly referenced. When I read or listen to accounts predicated by psychiatrists of the 'medical model' of mental illness, I am usually left with more questions than I started with and I'm often left with the quandary that we take for granted the existence of distinct disease concepts based not upon an understanding of causes but by symptoms that we've grouped together and we go from there.

So I would like you to imagine I'm an eight year old and tell me: why is Richard BENTALL wrong? For that matter, why are the other authors and academics who've argued against psychiatric taxonomy wrong, like Allan HORWITZ who wrote "Creating Mental Illness"?

I'd love to learn more about this and the reason I'm interested, is that it strikes me as fundamentally linked to how our society responds to mental ill-health where overlaps occur with the criminal justice system – remember what Professor Jill PEAY said in Mental Health and Crime (2010) … professional work at the interface of mental health and criminal justice is amongst the most difficult that either set of professionals will do:

The arguments that BENTALL and several others put forward are challenging for the criminal justice system. We have a political preference and a social inclination to divert from justice offenders experiencing mental ill-health where this is not inconsistent with the protection of the public and based on assumptions about diagnosis, treatment and recovery. So what does it say about efficacy if the science that underpins this assumption is as poorly conceived as BENTALL claims; and what about equity to other offenders who were prosecuted for their actions because no medical model of social / legal deviance has translated them from the criminal justice paradigm to any other metaphysical sphere?

Just thinking out loud … and I'm not trying to focus on Professor BENTALL specifically: but to use him and his writings as a metaphor for the whole non-medical model argument. If someone thinks they've got it all wrong, please let me know why because with all the books thrown at me so far, it seems BENTALL's argument about actually listening to people living with

problems in the real world whilst rejecting much, but not everything, about the medical seems more sensible than anything else I've read.

MARCH 2013

5th March 2013

Elephants In The Room –

I predict that in a decade or more, we will still know Nicola's Edgington's name. I really fear, as with many of these cases, that the public will have forgotten Sally Hodkin's name and that it will be her family who keep her memory alive, forever consumed with regret that it was their wife, their mother and their grandmother who had to be the one who was attacked – forever wondering whether two massive organs of the state, the police and mental health services, could have prevented it? I also predict no-one will remember Kerry Clark, who was fortunate not to die during that incident and who will forever live with the impact that event has had upon her and who has had to watch the trial unfold the background of the woman who attacked her.

The hopeless tragedy of this case is beyond measure. We will be hearing about it for years to come because there will yet be a criminal appeal against conviction and sentence, there may well be an Inquest, there will – eventually – be reports from within the NHS about the treatment and care of Nicola Edgington and Sally Hodkin's family have stated through their solicitor, that there could be civil action against the NHS and / or the police.

I want to provoke a thought in you to consider as you read this blog about the Metropolitan police response on 10th October 2011:

Do we think that the judgement of the court today reflects a message from the criminal justice system to the mental health system that attempts to say, "You've had your chance to handle this case: now we're ensuring beyond doubt, the public's ongoing protection."

Discuss.

BACKGROUND

I am not going to rehearse all of the ins and outs of the events leading up to and including the 10th October. If you are not entirely familiar with the case, you should read the report from the IPCC into the matter or the BBC News website. (It is paragraph 47 on page 12 of the report that is concerned with the substantive events of 10th October). Alternatively, pick

up a more respectable newspaper but I will tell you upfront that none of them – none – have summarised this case correctly and I've spent the afternoon and evening reading them all having read the IPCC report cover to cover – twice.

Finally, by way of introduction(!) – there are two things here that I am not commenting about:

- The validity of the original decision in 2009 to release Nicola Edgington from secure mental health care; OR,
- The judgement reached by the Crown Court, in terms of whether I think it was right or wrong. There is now an appeal pending.

On the first issue, we don't have published reports about how that decision was reached; on the second, there is a criminal appeal pending where the debate about liability for murder versus manslaughter on the grounds of diminished responsibility will be aired, along with an appeal against the sentence imposed which a life sentence with a minimum tariff of 37 years.

I am interested in the policing-related decisions.

THE TENTH OF OCTOBER

The police were called at around 4am to a taxi rank in Greenwich to a report of a female who was asking for help to get "sectioned". When officers arrived, they found Nicola in the private area of the taxi firm's offices. She was asking for help and willing to receive it, albeit that she did not want to be conveyed by the London Ambulance Service. She was removed to A&E by the two officers in police car.

- They arrived there just before 4:30am and having booked her in and her being in a queue for triage, made to leave A&E at 04:31am.
- Nicola followed them out, indicating she didn't want to wait on her own.
- At 04:34am, the officers returned her into the waiting area – she is shown on CCTV to be agitated.
- At 04:37am, the officers left the department and Nicola followed them again, claiming she just wanted a cigarette and she then re-entered the hospital.
- Keep reading the IPCC report from paragraph 72 on page 16 if you want more detail after that point – for my purposes on this blog, that is all I want you to focus upon.

The Independent Police Complaints Commission report highlights two particular points of contention for the police.

- **Firstly** – that officers did not undertake a PNC check at any stage prior to leaving at 04:37am – it is suggested that had they done so, it would have confirmed Nicola Edgington to have been previously convicted of a homicide offence which may have influenced police decisions (around the second criticism) or medical decisions, in terms of the priority afforded to her as a patient.

- **Secondly** – officer missed an opportunity to detain Nicola under s136 MHA at the point where she first attempted to follow them out of the hospital at 04:31am – it is held that if they had detained her, the assessment of her, especially one informed of the homicide conviction from the PNC check that never happened – may have reached a different decision about her risk and therefore may have taken different decisions.

The PNC Check – I've worried about this observation whilst acknowledging that PNC checks take just a couple of minutes and can be done by an officer in any location over their radio. I've worried about it not because I would have questioned a check being done – certainly not. I worry about it because we're seeing this through the prism of a murder trial, knowing Nicola's previous history. The two officers on 10th October went to a taxi rank and met someone who, at that stage, wasn't committing an offence, or resisting the care pathway the officers were offering her. She was described in the report as "agitated" but essential capacitous and willing to engage.

So I ask this: are we now expecting a PNC check on *every* person we meet in a non-arrest situation where we are any part of offering a pathway to care in connection with mental health issue? And if we're doing this for people with a mental health presentation are we also doing this for other, potentially risk-related presentations where we are not detaining or arresting people – like drugs and alcohol?

Section 136 – It is beyond doubt that the officers *could* have detained Nicola at 04:34am under s136. I have hinted before that for me, this decision rests on how you interpret the word "necessary" in the definition of s136(1) MHA. Officers may detain "if it is necessary" … if by that you mean, "making sure she is enters a process she is not willing to enter" then you may take the view it was not "necessary". If you mean "making sure she remains detained in a process that she is currently engaging with but from which we worry she may withdraw", then that is a different approach. We just need to be clear about which approach we're telling people to take. Of relevance to the decision is a whole background of principles to the application of mental health law on vulnerable people

which talks of "the least restrictive principle" and the "necessity test" for arresting people under any legal provision.

Whatever position you take on the issues in this case, one thing is beyond doubt: **Nicola Edgington remained at that hospital** until *after* she was assessed by mental health services who offered her admission to hospital and walked her over to the mental health ward with a security guard. By this time, because of access those mental health staff would have had to their own medical records, her previous history would have been established and the IPCC note that mental health staff did not legally detain her either. If the police *had* detained her under s136 MHA and even if they had then remained involved in the assessment process to ensure she continued to be detained, the officers would have disengaged as soon as Nicola was safely escorted onto the ward. This is standard procedure across the UK for the police because from that point, hosptial staff are responsible and have their own legal powers to detain, if the need arises.

She was taken from A&E at 06:25am on the 10 minute walk. **She left the mental health ward at 07:19am.** The police would almost certainly have been gone by then anyway.

HOLDING POWERS

In my experience, mental health staff don't take patients into the wards unless they are being admitted – so whilst the IPCC report doesn't specify that she was formally admitted as an inpatient, I will infer this was the case from the circumstances until I'm told otherwise. So she was a voluntary inpatient from around 06:40am and she left at 07:19am – at a time when doctors or nurses may have applied their holding powers to her under s5(2) MHA or 5(4) MHA, respectively, to keep her detained. << *This is the first elephant in the room, for me.*

When the NHS report into her treatment and care is eventually commissioned and published, I want to know whether my inference about admission is correct and, if so, why holding powers were not applied to stop her leaving or why the physical security of the ward does not prevent this. There is just as much ground to question this as to question the non-use of s136. Of course, the IPCC don't question this, because their remit is not the health staff decisions – we're yet to publicly learn those because the NHS investigation isn't public.

Either way, had the police exercised a detention under s136 at around 04:34am, it is my speculation that when she was moved to the ward for admission, there is no way they would have remained there for half an hour or more. They would have left and the "absconding situation" would very probably have been the same as it was in this case – in my view.

It is worth bearing in mind – that by the time Nicola Edgington absconded, the Trust would have known her previous history because mental health staff have access to their trusts records on which her status as a s42 conditionally discharged restricted patient would have been recorded. **It is also worth noting** – that two nurses involved in this case have been sacked.

CONDITIONAL DISCHARGE AND MAPPA

And why is no-one taking about conditional discharge?! << *This is the second elephant in the room for me*, along with her status as a MAPPA eligible offender.

Nicola was previously a patient detained after the manslaughter conviction under s37/41 of the Mental Health Act. This means that if discharge from hospital is considered appropriate, it's not a wholesale relaxation of all laws governing her treatment or care. Nicola was "conditionally discharged" under s42 of the Mental Health Act and this ensures that whilst she is in receipt of community care, in Greenwich, there is a named psychiatrist in a multi-agency team including social workers and psychiatric nurses who are responsible for ensuring her care.

We know that Nicola had conditions to her release: drug / alcohol testing, residence, exclusion from a defined geographical area and compliance with certain outpatient health regimes.

If those professionals develop concerns on any level that a conditionally discharged patient is relapsing and beginning to pose a risk to themselves or others – or merely if they are not abiding by the imposed conditions – then they may ask the Ministry of Justice to issue a warrant for her recall to hospital. The MoJ can be contacted 24hrs a day to do this, if need be.

We know from the trial that Nicola had stopped taking medication and was making crisis calls to the police – albeit a police service who did not know she was MAPPA eligible because, in breach of legal requirements on others, they hadn't been told. I want to read something in an NHS document in the next few years that talks about the 72hrs prior to 10th October and which gives a general impression of how conditionally discharged community care was working – or not.

And what we know about MAPPA offenders, is that where the police are told of them being in their area, the local MAPPA meeting may well have devised a "trigger-plan" – a list of what to do, in the event of a relapse situation involving the patient. This may well have involved contacting the psychiatrist on-call and / or the MoJ and / or any number of other things depending on the nature of the event that triggered. Not done of course,

because Greenwich MAPPA were not told of Nicola's release, thus breaching various laws.

BLAME GAME

We saw the media launch into the blame game, both feet first earlier today. I was utterly amazed by the media reaction to police failures: many of them reporting the issues incorrectly.

The truth of this case is you could point to about seven or eight different things done or not done by the professionals involved and put an argument that this alone caused the outcome. The reality is, that it was a mixture of all of those things and more besides that conspired to create the conditions in which it occured. The prevention of that conspiracy is precisely why we have complex offender management arrangements in the form of MAPPA. This is the vehicle through which all risks and intelligence should have been brigaded, shared and understood in order to prevent all of the professional groups involved in this case from attempting to distance themselves from the events. It is human nature to point to the other features of "failure".

It is perfectly valid for mental health services to point out how comparatively rare mental health related homicide is, especially stranger attacks like this one; they also tend to emphasise "you can't keep all people detained forever" and that discharge, conditional or otherwise, is a normal part of rehabilitation and recovery that has to be attempted at some stage for most patients in these legal cirumstances. << *This is not the same as saying that this particular decision was appropriate.*

Sally Hodkin died and Kerry Clark was extremely lucky not to. We owe it to both of them to reflect as individuals on our professional practice and our multi-agency procedures but we also owe it to the professionals involved not to get our analysis wrong. Everything is connected to everything else and we do confuse cause with effect and vice versa on occasions. Whatever you think of the content of this post, it is only PART of the debate because we don't know enough about the role of the mental health trust and that's why we need to know the outcome of an NHS inquiry into the health service decision-making: argubaly we need this all brought together with the IPCC report and I personally would like to see this all explored at the Inquest.

MEDIA

For what they are worth – media coverage from the main broadsheets. Should be read in conjunction with the IPCC report and the Metropolitan Police press release.

- The Guardian
- The Telegraph
- The Independent
- The Times (£)

10th March 2013

So What Happens Now? –

UPDATE 12/03 *– West Midlands Police have been given the authority to charge Phillip SIMELANE with murder.*

The tragic events of this Thursday have reverberated around the country: a young woman with her life ahead of her, killed in an apparently random attack on a city bus in the early morning build up to rush hour. No-one could fail to be moved by the impact this will have on those who knew and loved Christina Edkins and I want to add my condolences to those expressed by West Midlands Police and thousands of others. There are no words.

On Friday evening, the police announced that the suspect who was arrested just over 24hrs before had been sectioned under the Mental Health Act. This has prompted various reactions in the press and on social media – not all of them in light of what is actually occurring here. So this post seeks to explain how and why such decisions are reached when any investigation involves suspects who may be suffering from mental health problems; and it seeks to explain the implications of someone being sectioned and what may happen next.

Before I do so, I want to point out that I am not involved in this investigation and have no more access to information concerning it than anyone who has followed the details released to the media. This outline is not specific to the particular case: it hopes to outline how custody officers and investigating officers approach the decisions that the law requires them to take.

POLICE CUSTODY PROCEDURES

The police must always attempt to establish whether anyone in custody may have a history of mental or other health problems and whether this has any bearing on their detention in custody or upon the investigation – this is a legal requirement. If need be, a police surgeon can call upon trained mental health professionals from the NHS to advise further and this includes whether or not it may be appropriate for the suspect to be detained in hospital for assessment or treatment under the Mental Health Act 1983.

If someone is arrested for any offence, their mental health is directly relevant to the potential for them to be held responsible for their actions – which means we have understand their mental health issues to properly investigate.

Whilst assessments in custody are undertaken to reach these decisions, the person being detained will be deemed unfit for interview – this is really important to how legal decisions are made. People suffering from mental health issues are known to be especially 'suggestible" – this means prone to making false confessions or false denials when being questioned by experienced detectives. Police interviews can also seriously impact upon an individual's health and make issues worse: both could have profound legal implications should the investigation lead to a trial at a later time. There are various safeguards in place for people in custody who are deemed 'vulnerable' and someone with mental health problems is covered by these.

So in some investigations where a suspect needs admission to hospital under the Mental Health Act, the lack of being able to question them means there is insufficient evidence to charge them with an offence. Even if there is enough evidence, it can still be necessary to delay any charge decision to establish whether or not it "is in the public interest" and to ensure the courts can take their decisions in light of any health issues.

MENTAL HEALTH AND CRIMINAL JUSTICE

"Diversion" is the word used when a person in contact with the criminal justice system is brought into contact with the mental health system. It does not always mean someone is moved *from* the criminal justice system *to* the mental health system. It means the two systems start to operate alongside each other and this is done for several reasons –

- With more minor offences, it may be that the whole response to someone's minor offending is best addressed by just ensuring they receive appropriate health care.
- With more serious offences, it will be important to fully understand the nature and extent of someone's mental health problems, because it will be relevant later if that person is charged with any offence.
- Someone's mental ill-health can affect how a trial is conducted and will be relevant to sentencing if the person is found guilty – any court will need to make decisions about "fitness to plead" or "fitness to stand trial" and psychiatric assessment is key to this.
- Any jury that may be involved in a trial may have to reach decisions about "insanity" or "diminished responsibility" and psychiatric assessment will be key to this, too.

So where any offender is 'sectioned' under the Mental Health Act and admitted to hospital, there are various things to say –

- **Someone being 'sectioned' means one of two things** – either, the person requires assessment and treatment for suspected mental disorder; OR they need treatment for known mental disorder.
- **This does NOT mean that the investigation is over** – West Midlands Police policy states that where suspects are diverted, the investigating officers will not end a criminal investigation until after the hospital have assessed the patient and the officers have liaised with them to understand the legal implications of that assessment.
- **This does not mean the suspect has a known mental health history** – the fact that someone was 'sectioned' does not mean that they are previously known to mental health services OR that they have previously been 'sectioned' before.

WHAT HAPPENS NOW

Whilst there are cases every year where suspects who have been 'sectioned' after arrest do not face formal prosecution, this is always for comparatively minor offences like shoplifting, criminal damage or assault. Where more serious offences have been alleged suspects who are 'sectioned' are assessed and treated in hospital until they can later be questioned by the police. After questioning, and dependent upon the evidence in the case supplemented by the medical information, the police and the Crown Prosecution Service can then take their normal decision about whether to prosecute the person concerned.

This is crucial – this is no different than for any other suspect who is ill or seriously ill when arrested by the police. If someone had a serious heart problem or a broken leg that required an operation, the criminal justice system would take a slight pause to ensure that treatment and care, before then proceeding as normal based upon the evidence. The process is no different where offenders are suspected to have mental health problems, which can be equally serious.

And where things happen in this order, it has various *advantages* for the justice process:

- If a person had appeared in court whilst still 'unfit', they would not be able to enter a plea and the trial would have been delayed anyway – remember the case of Nicola Edgington who was sentenced last week? This trial was delayed for many months because she was unfit to appear before the court.
- After someone's first appearance, a court has no power to remand a person directly to hospital for treatment and assessment, so

understanding the nature of someone's ill-health and ensuring proper treatment would be delayed compared to the approach of 'diversion' before charge.

- By the time of any appearance in court, much more is known about the offender's mental health history and this allows the court process to proceed far more efficiently, if after assessment and treatment the evidence is there to support charges being brought.

PUBLIC OPINION

Various reactions to the news that the suspect had been 'sectioned' were understandable – this incident has shocked many of us who have understood the details of it. Obviously a key role for the police is to bring to justice those who commit offences and temporarily diverting an offender for a serious offence so that the investigators can better understand the impact of someone's mental health on the incident, is a part of this investigation process – it may also mean that if a suspect is eventually questioned once 'fit', more evidence is secured for any trial that may occur.

To those who have argued in response to the decision that it appears to be all about safeguarding a suspect and not prioritising the victim, I would say this: let the police gather as much evidence and information as they can to take the best decision possible. That will help ensure that justice is done.

12th March 2013

Infanticide and the Criminalisation Contingency –

Do you remember what I mean by "the criminalisation contingency"? – the process whereby access to certain types of healthcare are made dependent upon the legal framework wrapped around the patient? If not, I wrote about it last year and you can take a look at that before reading on, if you wish.

But try to imagine if your access to healthcare were made conditional upon certain police decisions about legal issues? What if this happened in other areas of health? – "I know you have diabetes, but you'll have just keep seeing your GP about it even though you need a specialist diabetic consultant, unless the police prosecute you for some offence arising from your diabetes." Replace the word diabetes with "cancer" or "a broken leg" if you want. It all adds up to the same thing.

Well, we saw yesterday how this has occured again in 2010 following the tragedy of an infanticide offence. Infanticide is the killing of a child under the age of one by its mother in circumstances where "the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child". Although such cases are rare, they inherently give rise to mental health considerations admidst legal recognition in the Infanticide Act 1938 that this is always connected to mental ill-health.

In the particular case of Ms X, who suffered from severe depression, it was alleged that she had smothered her ten-day old son Leo, with a pillow having received inadequate mental health care both before and after giving birth. As required following any homicide, an independent report has been published regarding her treatment and care by various healthcare providers and it revealed inadequacies in care planning, risk assessments, and informtion sharing as well as a failure to listen to her to family.

When I read the report, one thing struck me beyond the obvious tragedy that this obviously is for everyone involved: there was a clear example of the criminalisation contingency. Let me remind you of the main parts:

- Ms X was assessed in police custody after arrest as being in need of admission under the MHA.

- Despite the criteria for an admission under part II MHA being satisified, a deliberate decision was taken NOT to apply for her admission to hospital under either s2 or s3 MHA.
- Instead, the prosecution of Ms X was sought so that she "could be admitted to hospital under s48 MHA".
- This was so should could access a secure service.
- If someone needs a secure service, why can't they just access one? – we know that some people do, so why some and not others?
- The man arrested and sectioned after the killing of Christina Edkins accessed a secure service without having (yet) been charged, so why didn't Ms X?

Can you see the similiarities in criteria for direct admission to hospital under s3 MHA and transfer from prison under s48 MHA?

- **Section 3** – "Suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and appropriate medical treatment is available."
- **Section 48** – "Suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and he is in urgent need of such treatment; and appropriate medical treatment is available."

I submit it amounts to the same thing, for Ms X's purposes but what the report doesn't make clear, is what is actually involved in getting there. Having been denied an application to hospital for section 3 admission because of the preference for immediate prosecution, she was placed before a Magistrate's court who has no power whatsoever to remand her to hospital for the treatment and care which had been identified as necessary in the police station. This means the court only has two options: to remand her to prison pending transfer under s48 MHA; OR to release her from court on bail, which then means amidst a suggestion of serious mental health problems and a criminal prosecution for a homicide offence, she is at liberty whilst, one presumes a potential suicide risk, if nothing else.

Of course, some reading this will say, "But she had killed her child!" Well, there are two things to say – firstly, innocent until proven guilty and even if guilty we now know this was partly due to poor healthcare and a failure to mitigate known risks at least partly beyond her own control; but secondly, admission to hospital under Part II does not preclude a prosecution occuring. It potentially makes it easier to manage all of the mental health implications of preparing for a criminal trial where mental ill-

health will feature large. This is what I outlined recently in the case of the man arrested following the death in Christina Edkins.

And of course, transferring any prisoner under s47 or s48 from prison to hospital can take weeks, if not months. Whilst waiting for that transfer to occur, you have a person in prison, suffering from serious mental health problems who is at best, receiving some input on the prison hospital wing where the opportunities or benefits of treatment under the Mental Health Act cannot touch her at all. Far from satisfactory.

Here we have the criminalisation contingency writ large: a woman who this independent reports had already been failed by the healthcare system on several levels, is then prosecuted for an offence amidst suggestions that she needed immediate treatment and care and then put through a period of imprisonment during which she could not fully receive it, pending the bureaucratic wheels of transfer turning, to arrange her removal to a hospital.

Here's my question – why not, just divert her to the appropriate secure hospital from the police station, prioritise her treamtent and wellbeing and once that is in hand, prosecute for the offence because of its serious nature and allow the court process to take its course? Dignified, humane and a proper balance of ensuring treatment for a vulnerable person whilst ensuring a proper legal hearing of the relevant issues.

Ms X pleaded guilty to infanticide and was given a hospital order (without restrictions) in what is one of the saddest cases I have ever read about.

13th March 2013

Doing Other Stuff –

This post has been a while coming: I'm going to make a deliberate decision to blog less often so that I can do various other things: in life as much as in my "natural venn diagram!"

I hate to think how many hours of my personal life have gone in to all of this – the vast majority of it was done in time off at home and in addition to my 'day job' – but that was all time not spent being a husband, a father or a dog-walker. It was time not spent playing music and squash. In particular, I need to sort the garage out!

I started this off so I could put a load of information in the public domain, available to police officers and others about laws, clinical threats and risks so they could police more effectively or work with the police. Along the way, I've written dozens of pieces that some refer to as "polemic": my views on how some of this stuff could be done far better. As I approached a hundred posts I started to think I was running out of issues to cover and various things prompted yet more posts as weird and wonderful situations led to officers asking questions and requesting other issues to be explained or made accessible in a different way. It's been apparent to me for a while, that I'm now repeating myself, possibly to exemplify newsworthy events, but also for its own sake.

I've also written some posts like the recent "PARAMEDIC SERIES" which simply restate what is already there, albeit pitched to a different audience with another perspective and that's fine too if it helps a different professional group. I'm half thinking about a psych-nurse series, for example. But essentially, I'm sort of done here. I have about twenty draft blogs in the pipeline and these will be the basis to continue from time to time, but I'm going to start thinking about other things, in life and mental health.

A few measurements of impact for you (I don't do targets) –

- Last weekend, the blog was used over 10,000 times in single day;
- Last week, it was used over 25,000 times
- It has been used more than a quarter of a million times in the eighteen months since it all started and has been read in almost 150 countries around the world.
- It is regularly and seriously used across Europe, the Commonwealth and the United States.

Not bad outcomes arising from a frontline policeman just banging on about laws, guidelines and Codes of Practice. All very turgid stuff, potentially.

THE FUTURE

I am determined to keep chipping away in this arena of policing and working as hard as I can to influence it from wherever I am posted to work, I'm just going to do this less by blogging.

- I am determined to get around to doing a few vlogs – video blogs, because I've had various requests to explain some of this material in short video clips that could then be used by others in various ways.
- I will continue with those draft pieces, but I'll be devoting only a certain amount of time per week to finishing them and they'll come out as and when.
- I may think about doing a monthly round-up of news, other people's blogs and some other short-thoughts
- I may do the odd one-off post about especially newsworthy or unusual events.
- I will think about how the blog can be used to support the inputs I now regularly do at a few universities, like the MSc course in Forensic Mental Health at the University of Birmingham – I've been a visiting lecturer there for a few years.

- The blog will shortly have material published on it to support a pilot training programme we are going to do in the West Midlands.

You might see one or two posts a month from me, at the most, unless something specific pops up as suggested in the bullet points above … maybe a guest post here and there from others. But I just want to be clear: I'm won't entirely stop blogging and I'm not back away from this agenda of police work. It's just time for a refreshed strategy!

And meanwhile, in the immortal words of Tom Petty:

21st March 2013

Deflecting Demand: Safe and Well Checks –

A person with mental health problems who may have taken an overdose walks out of A&E before conclusion of an MHA assessment and before the results of blood tests are fully known. What do we **always** call for? – a safe and well check by the police, right?! Yes. But it's **pointless**; and here's why –

Nathan CONSTABLE writes much that is moving and insightful about mental health and policing – if you're reading this because you're interested in what I write, you should also check out his blog. We don't always precisely agree on things and that's a plus for me, because he really keeps challenging my thinking which I find a very healthy thing. His latest blog entitled "Crisis? What Crisis?!" gets the mind moving – about what the police are FOR, and what the police can DO: where does the role start and stop? It also hints at it issues about how the NHS are handling austerity. And I don't entirely agree with him in this blog, although we're roughly on the same page!

I have had two mental health professionals tell me this month alone how some of their managers are deliberately cutting or restricting services and making 'policy' decisions that the NHS will purposefully deflect demand for health services to the police. << **You read that correctly**: where the NHS cannot or have chosen not to provide a service for health issues because they have begun to argue they are not commissioned or obliged to do so, they will *deliberately* direct that demand to the police. Criminalisation of vulnerable people, mostly.

Now, I've always said that there is **no** dividing line between crime and health – much though many would like that to be so – and that mental health issues are core police business. So just as I agree with Nathan's assessments in the examples he cites, we will all agree that where anyone else is threatening other people with knives, there is going to be a role for the police. But if that incident comes around because of a thirteen-year old with established or even just strongly suspected medical or mental health problems, there has to be a **pathway to care** available to the officers who had to front up the knife.

We also had a very similar job to Nathan's just this week, it's just that ours involved a ten-year old throwing objects at his physically disabled

parents. The NHS response in our case was, "Can't you arrest him?" Well of course we *could* he's assaulting his parents; whether we *should* is a quite different assessment. Do we really want a ten-year old with established medical problems under a CAMHS specialist in the cells? I admit I'm not a fan of the idea, so let's try EVERYTHING ELSE, first.

SAFE AND WELL CHECKS

Police officers cannot do safe and well checks on medically vulnerable people. **We just can't** – because we're not trained or equipped to do so, no matter how much we might want to help or how urgent the issue is. I've written about this before in a productive debate with ambulance blogger Ella SHAW. Her view on all this was a guest post on my blog last year. << Crucially, this **does not mean** that we should not or will not be involved in trying to locate people at risk or in managing safeguarding risks arising from medical vulnerabilities of all kinds.

It merely a remark about limits.

Our basic first-aid at work certificates, the legal limits on the circumstances in which we should assess capacity and an inability to stare at someone and tell what unknown or unquantified substances may be doing to their vital organs prevent this. We can "safe and well check" a child who may at risk from forms of abuse – because we are trained to assess the backgrounds of adults they are with; whether they have physical injuries; we are trained to speak to them and to question the adults they are with about concerns in a way that allows us to highlight potential safeguarding issues. We also have legal authorities under the Children's Act 1989 to take kids into "police protection." It's what Parliament intended to happen.

It is probably from this that we assume the police can "safe and well" someone who has walked out of A&E against advice. But of course, I can't! – I can tell you whether he's where you think he's gone; whether he's alive; whether he's breathing and conscious but absolutely **none of that amounts** to guarantees on a short or long-term basis to whether he is "safe and well." And even if it were obvious that he's **not** safe and well – let's say because we find him self-harming and at risk, there are limits on police officers' legal powers in his home address. We have none, unless he is committing an offence – so what do you want us to do? If you don't have an answer for that, you're passing the buck, I'm afraid.

He may or may not look "fine" to me, even to you – but here are two facts:

- A healthcare professional doing a visual examination, or asking clinical questions will get nearer to the truth of somebody's safety

and wellbeing that anything I can do – I can only advise the person to seek help ASAP.

- It is health and social care professionals, not police officers, who have the legal ability to arrange the coercion of someone from their own dwelling if that is felt to be necessary – so please have a plan around what this looks like if it turns out to be needed.

RETHINKING THINGS

So here is what I hope >> that all police forces will consider reviewing their approach to "safe and well checks" for any kind of *medically* vulnerable person by asking just one question: "**Once we find them alive, breathing and conscious – who do you want us to tell? Because we could not, even if we wanted to, establish whether they are safe and well, medically speaking.**"

We want a **detailed** brief based upon the risks that person faced when they walked from A&E or declined treatment to their CMHT for the potential overdose they've taken as to whether we –

1. Call an urgent ambulance and consider Mental Capacity issues;
2. Call the CMHT and request arrangement of an urgent MHA assessment;
3. Refer them to A&E on a voluntary basis or to their GP for follow-up.

And of course, **you can't tell this either** because in the hours they were missing or absent, they could have done any number of things that would alter an assessment of their safety and wellbeing. They could have deteriorated to a certain degree, their capacity will have fluctuated to some extent or they may have consumed alcohol or (more) drugs – you're going to have to come with us and help if you want it done properly or react in support of us once we find them. If you don't or if you won't, you may find your refusal to arrange (mental) health assessment in situ recorded by the police, in defence of officers legal inability to act or tell.

The police can't do safe and well checks on medically vulnerable people – we only ever establish where they are and whether they are Alive – Breathing – Conscious. The ABC of "Safe and Well Checks". So if you're a cop, don't over-reach yourself by pretending you can doing anything other than a) find them; and b) call for medical assessment of people who are found ABC.

Update on 01st April 2015 – *since writing this article, a new Code of Practice has come into effect in England. It doesn't substantially alter the post but certain reference numbers have changed. My summary post about the new Code of Practice (2015) is here, the new Reference Guide is here*

and the full document is here. The Code of Practice (Wales) remains unchanged.

25th March 2013

March Newsletter –

Since deciding to blog a bit less often, it has caused me to think about how I can develop this resource differently and I've decided to instigate something of a monthly 'newsletter' – which to give me a memorable deadline, I'll publish on the 25th of the month. The aim here, is to refer to a few news articles, reports or other little ideas or incidents, without detail. As previously indicated, I've covered most of the detail in the posts already written, to which I might refer people through the newsletters.

The remaining ideas I have for new posts will be published one at a time on the 10th of the month. I will do additional posts only if they are specifically indicated for particular reasons.

POLICE POWERS IN A PRIVATE PREMISES

On 10th April 2010 two detained patients on a mental health ward in east London were involved in a violent episode during which Mr C killed Mr E. An independent report has recently been published on the care and treatment received by each man, as is required by the Department of Health following a homicide incident.

The panel involved in the preparation of this report included a retired Detective Chief Inspector from the Metropolitan Police, alongside a senior psychiatrist, nurse and social worker. It emerges in the report that on the 01st April, the police and ambulance service were called to Mr Cs home address to a report of him behaving violently. Unfortunately for a clear understanding of what occured, the nature of the violence is not specified in terms of whether there were assaults committed or damage caused. Suffice to say, in paragraphs 7.22 and 8.95 of the report, mention is made of Mr C's violence. The panel express surprise in latter paragraph that "given the nature of the circumstances outlined by the family of Mr C it is somewhat surprising that Mr C was not taken into police custody on that evening for a Mental Health Act assessment."

I make an observation amidst a context of it not having been specified what the nature of the violence was and whilst inferring from the report that Mr C was within the family home at all times when the police were there:

There is no power to take him into police custody for a Mental Health Act assessment. Whether he could have been taken into custody for an offence arising from the "violence", is not clear without the nature of the violence being specified. But on the face of it, I cannot understand on what legal basis this assertion is made: even arresting him for an offence is not taking him to custody "FOR a mental health act assessment." It would be taking him to custody to investigate the offence, thereby criminalising him. Maybe that was justified – but as the report declines to specify the nature of the violence, who knows?

Maybe the officers at the scene could have contacted an AMHP and asked for a warrant to remove him to a place of safety for assessment? Such ideas link to an incident I dealt with recently:

WARRANT OR NO WARRANT?

My team was called to an incident where everything I have ever written about MHA assessments in private premises was writ large over an incident involving all manner of risks and uncertainties.

I spent a whole day at work in command of an event where we eventually had to use officers in protective equipment, often termed "riot police", to force entry with shields and tasers to detain a man under s135 MHA. This came about only because of difficult discussions with the AMHP involved about getting a warrant where the police were initially being asked to fudge an entry to a premises where the patient actively opposed it but where his mother had allowed access to the home.

I have dealt with many similar incidents in my service, but this one was very precisely the kind of incident where the police have no powers whatsoever: man in a house, locked in a part of the building and declining access to others, in possession of a knife. He wasn't breaching the peace in any way, not threatening anyone, just wanted to be left alone in the locked part of the house and it's worth reminding that it is not an offence to possess a knife in your own house.

In the absence of a warrant, the police would have to reply upon his mother's consent to force the two doors that were locked. His mother was understandably concerned about the tactics that the police would use to manage the situation – I'm sure that talk of what she thought of as "riot police" or the potential use of tasers would be concerning, but the risks involved were just sufficient to cause alarm at the wisdom and safety of a low-level, casual police approach by normal uniformed officers. The only responsible way of keeping the police and everyone else safe, was to have officers in protective equipment and *this was my call* as the senior police officer.

Eventually, after several representations by me about safety and legality; as well as about contingency amidst the potential for the patient's mother at any time to withdraw her consent to the police being in her house, a warrant was obtained. After many, many hours of negotiation, entry was forced and my fears about the level of resistance were vindicated.

I went home wondering whether any other kind of approach would have led to serious injury or even someone's death. I would suggest that even if there were some room in the debate with me last week about the approach to MHA assessments / warrants I have outlined on this blog, **nothing** will now deflect me from this being a balanced approach to the safe management of risks. Last weekend's incident has left an indelible mark upon my thinking because of having pushed this line through the resistance of others and been utterly vindicated in way that prevented serious injury to people.

In anticipation of some remarks in the next item of this newsletter, the incident took nineteen police officers eight hours to resolve. If Irish mental health law had applied, we would have resolved it in less than half that time, with fewer than half the number of officers: our police service's mental health law dates from the 1950s.

POLICE SUPERINTENDENTS' ASSOCIATION OF ENGLAND AND WALES

The superintendents and chief superintendents of England and Wales have a new President. Chief Superintendent Irene CURTIS from Lancashire Police, who you can follow on Twitter as @barrackslass, is now the leader of almost 1,400 senior operational police commanders.

In her opening remarks about taking on the position, she highlights mental health issues as one of four areas of significant challenge for the police and I'm personally delighted to see it given this level of emphasis. I've previously stated that some officers at those ranks either struggle to get to grips with the issue as a subject in itself and / or find the partnership environment in which we make progress, very difficult to navigate.

Chief Superintendent CURTIS said, "The police service needs to work with others to address the increasing demands created by gaps and reductions in other agencies' provision. When it comes to matters involving mental health, external services' expectations of the police have reached an unacceptable level. Police are always seen as the last resort, as the ones that will pick up the pieces. The responsibilities of all agencies involved in the provision of mental health services need to be agreed at both a national and local level, and be subsequently enforced.

"Currently, the police play too great a role in what is, after all, a medical emergency. Far too many people detained by police under the Mental Health Act end up in police cells simply because there is nowhere else to take them. It is not a crime to be unwell and the chronic lack of provision for mental health assessment places ("places of safety") needs to be addressed immediately, as well as the lack of training for officers to deal effectively and safely with incidents involving people suffering from mental illness.

"The legislation surrounding the use of police powers to deal with mental health is also in urgent need of review and clarification. Currently, under the Mental Health Act, officers cannot detain people who are not in a public place and, under the Police and Criminal Evidence Act 1984, officers can force entry to protect life but cannot detain a person in order to do so.

"Officers are also finding themselves dealing with matters which would normally require the presence of an ambulance. In some cases officers are simply replacing ambulances because there isn't one to attend. Police officers are neither trained nor equipped to deal with these issues and it is unfair to expect them to do so."

I wish her well in her role as I know that frontline cops would like her and her members every success with this priority.

29th March 2013

Section 5 MHA: Holding Powers –

A requested post, after this week receiving several queries at work and on Twitter about nurses' and doctors' "holding powers" under the Mental Health Act. Officers and patients have been asking what, if anything, various doctors and nurses can do to detain someone if they suspect a mental disorder and fear someone may come to harm if they leave a hospital area.

Whenever a patient is admitted to hospital as an inpatient, the Mental Health Act affords legal authorities to *all* doctors and to *just some* nurses, to "hold" patients for full MHA assessment, if required. This post covers just some of the issues arising from these powers, for officers to bear in mind as they interact with various situations. The queries that prompt this post seemed to assume that anyone who is "in hospital" can be detained under the MHA, if it seems required. As with a lot of things, this is not necessarily true, and is perhaps inevitable when we operate with legislation which essentially dates from the time of Ration Books and Buddy Holly records.

GENERAL POINTS

The holding powers concerned are available under s5(2) to registered medical practitioners in charge of that patient's care; and under s5(4) to nurses "of the prescribed class".

The holding powers are only of application to patients who are **in-patients** in hospital, which means that these authorities cannot be used for people who attend outpatient clinics or those in Accident & Emergency departments. A&E patients are not admitted as "inpatients" for the purposes of the MHA. If an outpatient or A&E patient who had attended for treatment were then admitted to a ward for further care, s5 MHA powers come into play from that point of admission.

- It is Chapter 12 of the Mental Health Act Code of Practice which covers holding powers.
- Chapter 2 of the Mental Health Act Reference Guide which covers holding powers.

Finally, it is often found that the potential for holding powers to be applied is considered on admission and reviewed whilst a voluntary patient remains in hospital. In some voluntary cases, there would be no question: any attempt to leave and holding powers should be applied and in other cases the opposite is true, although both presumptions are reviewed regularly to reflect a change in a patient's condition. It is worth remembering the duty of care that is owed to voluntary patients, especially those at risk of suicide, as shown in the case of Melanie Rabone. Whilst that was not about holding powers *per se*, it was about allowing of patients to leave hospital when risks were clearly evident. One can see legal parallels to some decisions not to apply a holding power.

DOCTORS HOLDING POWERS – SECTION 5(2) MHA

Any registered medical practitioner may exercise powers under s5(2) and whilst this will mostly be psychiatrists in mental health units, it is sometimes seen that they are exercised in general hospitals on medical or surgical wards. There is no requirement that the RMP in question be "section 12 approved" – this means "having special experience in the diagnosis or treatment of mental disorder."

For example, there was a case in my area some months ago where a patient had been admitted to a general hospital ward with medical problems and after a day or so tried to leave. The doctor in the case knew of the patient's serious mental health history and of recent threats to take his own life but did not apply s5(2) MHA and call security (or the police). The patient was allowed to leave, prompting a fairly urgent missing persons enquiry for the police. When the patient was reported missing and we asked for full details, we were told of the various medical problems in the person's case history that would cause him to be regarded as an urgent, high-risk missing person. We subsequently made safeguarding representations about the holding power not being used when it clearly could have been. The safeguarding lead for the hospital subsequently agreed.

Once applied, a doctor's holding power entitles the authorities to hold the patient for up to 72hrs in order for a Mental Health Act assessment to be undertaken. The AMHP and two doctors will then decide whether to detain the patient under s2 or s3, if at all, just as they would do an assessment in police custody or in the community.

Incidentally, in case you hadn't thought of it: when a person is 'sectioned', they can be sectioned to a non-psychiatric unit if there are other medical issues in play and a patient's MHA detention can then be transferred, under section 19, to a psychiatric unit once medical priorities are sorted.

NURSES HOLDING POWERS – SECTION 5(4) MHA

Doctors are not always immediately available – certainly in some psychiatric units the doctor on-call overnight is not necessarily required to reside at the hospital. Several on-call arrangements in mental health units merely require the doctor to be within a certain travelling time of the hospital, either 30 or 60 minutes. So nurses may have to make detention decisions.

These powers **cannot** be exercised by all nurses: only a nurse "of the prescribed class" may do so and this in practice means more senior mental health or learning disabilities nurses, like ward managers or deputies. Legally speaking, howeve – any registered mental health or learning disabilities nurse can use it. (See para 2.81 of the Reference Guide for more detail if you need it.) It is for this reason, that nurses on the general hospital wards mentioned above could not have detained the patient until the doctor got there.

Such "prescribed" nurses may detain under s5(4) if the relevant criteria are met and this authority will last for six hours or until either a doctor decides whether to hold the patient under s5(2), above or until an MHA assessment determines whether or not to detain under s2 or s3. So you can imagine the situation where a voluntary patient decides to leave, a nurse thinks the MHA is appropriate so applies s5(4) and then within six hours a doctor thinks s5(2) is appropriate so sends a report to hospital managers. Within three days, an MHA assessment occurs which may detain the patient under section 2 or section 3.

GEOGRAPHICAL LIMITS

It is generally accepted that the geographical exercise of some limits to the holding powers extends to the edge of trust property. So these powers can be exercised by patients who have, for example, stepped outside to a smoking area or gone for a walk in the hospital grounds, but once over the main road, most mental health trust's policies direct that the police be called and either s136 or s18 be used – for voluntary and detained patients, respectively – because holding powers no longer apply.

I want to tell a short story which intends to knock down the theory that nurses pause at the edge of hospital property and refuse to go any further. It occured about six years ago in Birmingham and involved a nurse following a patient to the bus-stop a few hundred yards from the hospital, trying to persuade the patient to return whilst they waited for the "number 11" but failing to do so. So the nurse got on the same bus, called the police

and talked my officers in to where the bus was. The patient was re-detained under s18 and returned to hospital with nurse in the police car. Job done.

ABSENT WITHOUT LEAVE

Where a patient who has been detained under either of these powers then absents themselves from hospital, they are AWOL for the purposes of s18 MHA and may be re-detained by an AMHP, a constable or anyone authorised in writing by the hospital.

There is no power of entry: if entry needs to be forced to a premises in order to re-detain a patient, then a warrant under s135(2) is required.

There are timescales to bear in mind –

- **s5(2) patient** – may be retaken for up to 72hrs after the doctor made the decision to detain.
- **s5(4) patient** – may be retaken for up to 6hrs after the nurse made the decision to detain.

Thereafter, officers may consider s136 if the patient is found in a public place or inform the duty AMHP of the patient's whereabouts if found in a private dwelling.

ACCIDENT & EMERGENCY

It should be clear from the above that where the police are called to A&E because of a difficult situation that may benefit from being subject to a legal framework, A&E nurses and doctors are very constrained in what they can do. These are the scenarios where officers are sometimes asked to implement section 136 MHA in the A&E department, either with a view to MHA assessment occuring there and officers supporting it; OR, occasionally, the patient being remove to the preferred place of safety for your area.

Neither s5(2) or s5(4) are of application to this situation and whilst it may feel counter-intuitive to do so, there will be some scenarios where police implementation of s136 will be quite appropriate. The fallout from various inquiries into untoward events shows that it is important that you understand the kinds of circumstances to which this distinction applies.

APRIL 2013

8th April 2013

Debating Police Powers –

Recent debate has surfaced about police powers in private premises to deal with mental health incidents. Readers of the blog already know that the police, on their own, have no such powers under the Mental Health Act 1983. The impact of this is that where officers attend a private house, unless there has been a criminal offence attempted; or unless they "apprehend a breach of the peace", they cannot resolve the incident by detaining someone. In the very rare circumstance that the incident involved someone who lacked mental capacity and was at imminently life-threatening risk, then the Mental Capacity Act could be relied upon to defend an officers actions for urgent intervention – but the application of the MCA will be possible far less frequently than some officers imagine.

This debate came up again for me in two situations recently: an operational incident that I attended and in comments made in response to Sunday Express article based upon Nathan Constable's blogs on mental health. Nathan had been asked to list three things which may make a difference to the ability of the police to act effectively and properly and his third option was "Changes to legislation to provide officers in England and Wales to deal with mental health crises in private places". And so inevitably, the conversation started on Twitter.

EXTENSIONS OF POLICE POWERS

I fully understand reservations about the police being seen to ask for extensions to powers. Even if you do agree that the current arrangements represents a dangerous loophole – and not everyone does – it is obvious that police powers are not the only way to resolve that issue. It is Parliament's current view, reminded to us by the judge the Sessey case, that where urgent MHA assessment is needed in a private dwelling, an AMHP and a DR be engaged to complete it and a warrant under s135(1) be sought in order to force entry and / or remove to a place of safety, if needed. The Local Authority are obliged to have sufficient AMHPs available – although I don't know of any area where we would agree that this is so.

And so any debate – necessarily political, if it involves questions of police powers – must not be seen as contributing to further criminalisation and

stigmatisation of vulnerable people. Where this has been discussed before, several objections arise, and they did again:

1. More police powers would inappropriately extend the ability of the police to control and victimize.
2. More vulnerable people would be "locked up".
3. The police are not the only solution to problems – this is better done by others.

In last year's piece "Mind the Gap", I wrote about this. I hope I made in clear that I didn't mind what the solution was to what I see as a very real problem: the inability of the state as a whole to keep people safe in these very limited circumstances. I argued it would be more appropriate to have better resourced and responsive MH crisis services, but unless we build capacity to have them at incidents within about an hour of being called, we are still going to have this debate. Nathan also had as his first solution to the broader police / mental health problems as "Better out of hours capability for mental health assessments: more beds and resources for Emergency Duty Teams." So if his first idea could be made to work, his third may not be necessary?

Let me explain a recent incident that shows the problem:

EVERY KIND OF PROBLEM

Last month, we started a late duty at 4pm and by 5pm I was driving with at speed to a report of a mental health patient who had locked himself in his bedroom with a knife. Upon arrival, we were briefed by MH professionals who had been there a few hours, having attended to assess him for potential admission under the Act. It quickly emerged that the man was one of our current "missing persons", having fled to London three days previously, in fear that he may soon be 'sectioned'. The incident which triggered his flight to had involved some generalised threats being made, but no criminal offences were being alleged by the family members who had been trying to support him.

The AMHP and Doctors present had no warrant under s135(1) and they had not yet 'sectioned' him so there were no legal powers available to us under the Mental Health Act. He had not committed a criminal offence, either three days ago or today: he was simply a man upstairs, behind locked doors with a knife, a mental health history presenting a certain level of risk to others. To keep the story brief despite it taking seven hours to resolve, we asked the AMHP to secure a warrant, which was initially resisted. When we started talking with the man's family about how we would try for as long as we felt was reasonable to persuade him out, we also made it known that if it came to the use of force, it would involve officers in protective

equipment with shields and tasers. (As I stood and weighed the risk information, that was the only responsible way to send officers into that situation even though he was still upstairs, quietly.) But the man's family started trying to dictate police tactics: happy with officers having tasers, but not happy with "riot gear". Conversations started between the police, the AMHP, the DRs and the family about the dangers involved of sending non-protected officers into that situation and there was clearly no agreement about it. "Can't you just pop the doors and send up those two with tasers?" It was my assessment that this would have been very dangerous indeed.

So I got myself to a position where I said this to the AMHP – to motivate a development, "If there is no willingness on the part of the householder to allow what I consider to be the appropriate officers with appropriate equipment into her house, I am not prepared to risk other officers' safety by doing the wrong thing. In the absence of a s135(1) warrant allowing me to take the right decisions, we will withdraw from here until you've got a warrant because I am unable to act."

DAMNED IF YOU DO / DAMNED IF YOU DON'T

Now this carried various risks, notwithstanding that I was furiously checking myself for any power to act immediately that didn't have to take account of the conditions being imposed by the house-holder. If the police withdraw completely, the man is then at liberty to leave the premises and go where he wants, maybe back to London; and although it would then be possible to detain s136, we'd have to be sure we first spot him leaving. Should he then come to or cause harm, I would be that policeman on the news who "did nothing" where "police blunders led to [insert your preferred catastrophe here.]" But at the same time, UK law offered me no option except to be wildly cavalier with the lives of the police officers present. So which risk would I rather have; what is the least worst option?

Various representations later and a warrant having eventually been obtained – after the failure of more patient negotiation, just prior to midnight, we forced entry and detained him. Suffice to say, that the situation unfolded in a way that vindicated *everything* I had considered from 5pm onwards and this will now be my MHAA story of choice when it comes to debating s135(1) warrants and whether or not extensions to police powers are needed.

My main point here: if this had occured in Ireland, the door would have been forced around 6pm – maybe 7pm at the very latest – without my having to sit on that risk of whether he would try to run off from the premises that I had to keep contained with a third of my entire resources, supplemented by force resources, for a couple of hours whilst a warrant

was obtained. Of course, if the structures that hold the police accountable, including the media, reported on these matters in fair, balanced way in light of the legal realities involved rather than the "something ought to have been done!" reality that we've seen before, that would help too.

SO WHAT IS TO BE DONE

I still don't mind whether any legislative amendment focusses on police or MH services. I don't mind having to secure the authority of an AMHP to act in private places: I just want to be able to do the right thing. Walking away from a man posing risks to others, whilst he was in possession of a knife and extremely unwell mentally, is counter to everything I joined the police for. At yet that is the express will of Parliament in those kinds of situations. In case it needs reminding: it is not an offence to possess a knife in your own home, until you threaten someone with it and that man had specifically threatened no-one with it.

As for the argument that it will lead to more people being vulnerable being "locked up?" Well, in some variations on this kind of scenario, you get criminal offences involved, mostly minor. Had this man at any stage threatened to kill any of the police officers of family members involved in this scenario, they were briefed to force entry and arrest him for the indictable offence. He then would have been taken to a police station under arrest and the MHAA would have happened there. Many of these kinds of situations are already resolved by the police choosing the offence available rather than worrying about the warrant that isn't available and getting on with things. An extension of police powers would leave the choice open – threats spoken whilst extremely unwell could easily enough be set aside whilst detention is made under mental health law, if that were allowed. So any proposal to extend police powers doesn't criminalise: it actually seeks to *reduce* stigmatisation by ensuring that the police don't have to arrest for an offence for a want of other options – they can prioritise mental illness and access to faster support.

It would also put to bed the concerning actions of officers in cases like Sessey and Seal: officers acting illegally under the MCA or MHA, because they believe – probably in good faith – that someone is at risk. But acting in bad faith, they used this legislation illegally and this is also not the answer.

Policing, let us remember, occurs where "something is happening that ought not to be happening about which somebody ought to do something now." (Bittner). Let's have this debate without automatically assuming that the police are 'up to something'. I'd like to ensure that where I'm looked at to ensure the safety and care of vulnerable people, that I am able to do it; and if we prefer to set up Crisis Services in such a way as they attend

incidents of this kind within about 60 minutes, then that is preferable on many levels. However, that also comes at a cost and it is not what some mental health professionals think those teams are for – despite the word "crisis" in the title, I've known them eschew the notion of "running about like a 999 service." So the problem remains.

12th April 2013

Royal College of Psychiatry Standards –

The Royal College of Psychiatrists chairs a multi-agency Mental Health Act group which produces guidance, standards and documents around "Section 136 of the Mental Health Act 1983 and the operation of 'Places of Safety'." Over the last five or six years, I have probably quoted their guidance several thousands of times when trying to push for services to improve or alter the way they operate, or in some cases to push them to exist at all.

The other organisations involved in that multi-agency group include: the Association of Chief Police Officers – representing the police; the College of Social Work – representing AMHPs; the College of Emergency Medicine and the NHS Ambulance Chief Executive Group, amongst others. It is also supported by the Independent Police Complaints Commission and the Care Quality Commission, along with equivalent organisations in Wales.

In other words, you'd imagine it to be the **final word** on what s136 and Place of Safety services should look like – and you couldn't be more wrong!

Although the position on these issues has improved considerably in the last ten years, there is still a long way to go. Some counties within England still have absolutely NO place of safety provision for those detained – none whatsoever. Everyone is taken to the cells, unless they go via Accident & Emergency because of physical injury / illness. Many more still operate 'exclusion criteria' of various kinds which prevent some people being able to access those services, amidst ongoing presumptions that cells can be used. As you've read on this blog before: this should not be presumed because to do so would not always be possible, by virtue of not being safe and legal.

2013 GUIDANCE TO COMMISSIONERS

The recent publication of the April 2013 'position statement' from the Royal College attracted my attention. I was keen to see what it involved and what it added to the 2011 Guidelines. Not much, although I welcome the publication because it is a useful document which presents relevant issues even more plainly than the guidelines.

In particular, I like the fact that this document is pitched at NHS Commissioners. Of course, April 2013 saw Primary Care Trusts (PCTs) in England ceasing to exist as GP-led Clinical Commissioning Groups (CCGs) take over responsibility for healthcare:

- **Pages 11/12** – summary of the main problems with s136 pathways and what should be a feature.
- **Pages 13/14** – a succession of questions which should prompt review of how effective PoS services are in terms of delivery.

HIGHLIGHTS

There are various statements worth highlighting and I'd like everyone to fully absorb how unambiguous this is. The challenge for us all is therefore not to keep debating, obfuscating and resisting this, but focussing upon how it can be realised –

- **Nearly all individuals detained under Section 136 should be taken to a place of safety in a mental health unit** – the main exceptions are those requiring urgent medical assessment and treatment and those too disturbed to be safely managed in a hospital setting.
- **There must be adequate provision for the anticipated demand** – this should include suitable provision to meet the needs of specific groups; in particular, those under 18 years, the elderly and people with intellectual disabilities.
- **Individuals who are intoxicated should not be excluded from the MH PoS** – unless they need acute medical intervention or are too behaviourally disturbed to be safely managed.
- **The MH PoS must have staff on hand to receive the individual from the police without delay** – there should be sufficient staff to cope with all but the most challenging behaviour, without recourse to ongoing police support.

This can actually happen – most of this happens, most of the time in the West Midlands. I'm not pretending it's perfect, all of the time – but I am saying that in a police force where around 1,000 people are year are being detained by officers, we have in two years had just 23 + 43 people in police cells, detained under the MHA. That is 96.5% of detainees directly accessing healthcare and a more appropriate environment.

You're not going to convince me that within that number there were no resistant or intoxicated detainees; no children – this can be done, and it does most appropriately sit with NHS Commissioners to ensure it gets delivered. As my previous experience with Commissioners in PCTs revealed people who had varying levels of knowledge and interest

around mental health and its interface with the police, this document is very welcome because it effectively summarises the guidelines and makes the important parts both blunt and obvious.

The only remaining question is whether we're going to do this, or not?

22nd April 2013

Declining Medical Treatment –

Does is get more ethically complicated than wondering how you ensure you've discharged a duty of care if a person you have arrested or detained is busy declining the offer of medical treatment which doctors are saying is very, very necessary to ensure health and wellbeing? It is especially difficult where someone has mental health problems where questions of capacity are front and centre. And how should the police react to patients exercising any right they have to decline treatment, if the consequences to that decision could be serious injury or illness, or even death? Police officers don't like the idea of being the one who had responsibility for a vulnerable or arrested person at the point where they die. It will trigger an automatic "contact-death" inquiry, very probably by the IPCC, and it will examine in detail the decisions that were taken, including with a view to questioning whether things could or should have been done differently. I have often referred in discussion with officers to whether we think that a proposed decision at an incident would pass "the inquest test"? During an Inquest, the family of a deceased person, or their legal representative, has the right to directly question witnesses and I often think it provokes careful consideration of a difficult decision to ask yourself whether you would be prepared to explain it to a person's family as being the best available decision in the circumstances, that took account of all the relevant facts.

UNWISE DECISIONS

Do you remember reading from previous blogs and Quick Guides about mental capacity? You will remember that the law presumes everyone has capacity to take any decision, unless a level of proper assessment suggests otherwise. It also reminds us, that a person should not be deemed to lack capacity purely by virtue of taking an unwise decision. If someone wishes to gamble his £100,000 life savings in a roulette game, that is their business; if they wish to resign from their job, despite lacking any obvious means by which to pay their bills and mortgage – that is their affair. Many patients take decisions towards the end of their lives to decline medical treatment, knowing it will hasten their death and this is carefully assessed and supported, where appropriate. **Unless, of course they lack the capacity to do so, properly assessed.** Capacity assessment does not just rear its head in regard to mental health incidents for the police:

recently, officers in my force arrested a man for allegedly taking a car without the owner's consent. The man had crashed the car and was arrested following the police response to the collision. He appeared relatively uninjured, despite having been bumped and thrown about in the collision and he was checked over by the ambulance service at the scene and deemed not to require A&E treatment. Having arrived in police custody and been detained, he spent a couple of hours in a cell before reporting that he was passing blood in his urine. A quick transfer to hospital lead to A&E doctors suspecting a kidney injury. They proposed various tests, but one of them involved the patient being injected with a dye that would pass through his kidney and would show on a CT scan whether or not he had a kidney tract injury. He declined this test. Over a period of several hours, no fewer than four doctors attempted to persuade the man to undertake the test, whilst assessing his capacity to take this decision. They pointed out that if the injury that they suspected had occured and was sufficiently serious, he was facing the prospect of kidney failure and deterioration that could lead, ultimately, to his death. Where someone is proposing to exercise their right to take a decision with such serious consequences, it would be necessary to ensure quite a high threshold for their capacity to take that decision. If someone had taken this decision whilst intoxicated and clearly unable to understand the consequences of it, a lack of capacity could be declared. However in this case, the patient was not intoxicated by drugs or alcohol, was not suffering from a head injury or any health problem that may affect his cognitive functioning and he had no history of mental illness. Doctors were satisfied that he had capacity.

POLICE CUSTODY

So the custody officer had a fit: here was a man, under arrest whilst potentially injured in a way that means he could quickly deteriorate with kidney failure and die, returned to his custody area with a written care plan from the A&E doctor recommending he be constantly supervised, allowed "best rest" and that with any further deterioration in his condition, he should be returned to A&E if still under arrest. He immediately took advice from the police surgeon service, to say "He declined all treatment and he's back here: what's your advice about his ongoing detention in custody?" and the doctor answered, "He's unfit to detain in the cells unless he's been treated, call and ambulance and take him to A&E." So we're now going around in ever decreasing circles: what is going to happen in A&E? He's just returned from there having spent three hours declining medical treatment he's entitled to decline. What is the purpose of taking him back there so quickly? It was fear that unless we did, it could be argued that we had allowed his condition to deteriorate and somehow be responsible for the consequences. There are only two questions to ask in this situation –

1. **Does his declining treatment still render him unfit to detain in police custody?** – in this case it did, but in other cases it would not. I recall a man who we thought had broken bones in his hand in a fight from which he was arrested. He declined medical care, so he spent a few hours in police custody being dealt with and he went for treatment after being charged with assault. Broken hand confirmed. << The point here, was his life was not at risk whilst he went untreated.

2. **Irrespective of the answer how do you discharge a duty of care?** – we can't just sit in the A&E waiting room with a man who has been seen "just in case" after he's lawfully exercised his right to take an unwise decision.

The urge was, to release from arrest on police bail whilst giving strong advice in writing, that he return to A&E for treatment and that if he chose not to do so, that he go to a place where he was with other people who could keep an eye on him and that if he or they perceived any further decline in his condition, that he call 999 for an ambulance. And that is what we decided to do.

CHALLENGING CASES

But what if a person was injured, and arguably lacked capacity? Again, this is not an example related to functional mental illness, but when I was a sergeant, my officers detained a man to prevent a breach of the peace who was running about making threats after himself having been head injured in an incident. He was intoxicated, although not paralytic and because of the head injury removed to A&E. As soon as he was escorted in by police and paramedics, the triage nurse turned him away after giving him a "once-over". He was formally banned from that department after causing problems there and assaulting staff. Because his injury was perceived **not** to be life-threatening, he was being turned away … great! A dash across Birmingham to another A&E from which he was not formally excluded and they triaged him. Whilst waiting in a cubicle for treatment, he became verbally outrageous and declined to calm down and stop being disruptive. He attempted to bolt from the cubicle a couple of times and had to be restrained, he became threatening and abusive to nursing staff and the junior doctor who came in. So we were asked to remove him, because he was instructing them where to stick their medical care. When I asked, in light of an as-yet undiagnosed head injury, whether they believed he had the capacity to decline treatment they just laughed. They laughed less after all their names were taken and my telling them that their

refusal to answer the question was going on the custody record and that they should familiarise themselves with the Christopher Alder Inquiry. But if it was the correct decision, what's to worry about? We were asked to leave.

DECISIONS, DECISIONS

We knew this bloke's name, but not his address and had no method of contacting relatives. We also had three options –

1. Try a third A&E department, which was many miles away;
2. De-arrest him and let him go on his way, whilst intoxicated, head-injured and a risk;
3. Take him to custody, get him seen by an FME and keep him under constant watch until the position changed.

The custody sergeant had a fit when we suggested he be detained. "But he's got a head injury! What if he dies in the cell?!" It is a legitimate concern. But he's been seen by two different A&E departments, he's violently and abusively declining treatment, so option 1 seemed fraught with futility in addition to there being very real risks associated with driving many miles with head injured, aggressive men in a police vehicle. Option 2 was unconscionable because he would either get himself hurt, hurt someone else or collapse. Option 3 seemed like the least worst option in the circumstances. It means he'll actually be seen by a Doctor, kept under supervision in a way that is guided by that Doctor's advice; he can also be re-seen at intervals by a doctor or nurse, if required – any suggestion that he is becoming unwell, 999 ambulance back to A&E with a revised set of circumstances. What happens if there is an adverse event after option 1 or 2 – potentially very massive criticism; after option 3 it could be argued "you tried you best, got him to a medical professional and kept him constantly supervised until the risks could be re-evaluated." In the end, after four hours in the cells, he sobered sufficiently and was taken to the second A&E where received treatment.

THE LEAST WORST OPTION

The main lesson of my career: policing is about choosing the least worst option from a range of imperfect choices: it is not ideal that patients decline medical treatment or are refused it by NHS staff for whatever legitimate or illegitimate reason. You are where you are and you police what is in front of you, not what should be in front of you or what you'd prefer is in front of you – sometimes, discharging a duty of care may be better done by keeping someone in custody, calling the police doctor or an ambulance to

custody and keeping someone supervised. To have thrust the head-injured man out of the police station to wander abroad on his own would have been seen as far more negligent in the circumstances than to call healthcare to custody and try your best. Sometimes, that's all you can do.

23rd April 2013

Diminshed Responsibility –

"Diminished responsibility" is a partial defence in law, to charges of murder. It is therefore something for the defence to raise, not for the prosecution to prove; and for it to be established, it must be shown on the balance of probabilities that the defendant "was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing."

This is covered in section 2 of the Homicide Act 1957.

I have previously written about insanity, which is a separate defence to a criminal charge; and like diminished responsibility, it is a matter for the defendant's counsel to raise in court. As with all prosecutions of suspects who suffer from a mental health disorder, a defendant is nonetheless "presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved." This was laid down by Lord Chief Justice TINDAL in 1843 in the "M'Naughten Rules."

Diminished responsibility sits somewhere in between the two legal extremes of insanity and sanity: but bringing expert psychiatric opinion into legal frameworks is where it all gets interesting!

NICOLA EDGINGTON

Early in 2013, Nicola EDGINGTON was convicted of murder. It was her second homicide conviction: she had previously been prosecuted for murder in 2006 after killing her mother and had been sentenced to a restricted hospital order after successfully raising "diminished responsibility". After her release from hospital in 2009, she lived in Greenwich for a couple of years until in November 2011 she again became unwell and after absconding from a psychiatric unit in Woolwich, killed Sally HODKINS and attempted to kill Kerry CLARK. When she was prosecuted, she faced charges of murder and attempted murder.

In some cases of homicide where the defendant has obvious mental health problems, the defence will submit to the Crown Prosecution Service the evidence upon which they will seek to rely in arguing "diminished responsibility". On some occasions this is sufficient basis for the CPS to be satisfied that the partial defence will succeed and agreement is reached that the defendant plead guilty to manslaughter on these grounds. This is what happened with Nicola's first homicide offence, but it is not always the case:

Diminished responsibility is, of course, a legal concept, not a medical one: whilst psychiatrists can offer opinion, it is nevertheless open to the prosecution in any case, to require the defence to put their argument to a court and see whether or not the jury accept it. Although Nicola EDGINGTON had pleaded guilty to the manslaughter of her mother, the prosecution in 2012 would not accept a similar plea – more information about her mental health was known because she had spent three years in a medium secure unit.

After the defence of diminished responsibility was put forward by her defence counsel, the jury rejected this and she was convicted of murder and attempted murder. It is important to point out, a criminal appeal is pending – both against conviction and sentence, because it is suggested that as a point of law, the jury were wrong and diminished responsibility should have been the correct outcome: that will be an interesting appeal to watch out for.

THE YORKSHIRE RIPPER

The other infamous example of a diminished responsibility argument: when Peter SUTCLIFFE first appeared at the Old Bailey, the prosecution were prepared to accept defence evidence of diminished responsibility and guilty pleas to the various homicide offences committed.

On that occasion, the trial judge insisted on questioning the basis upon which the various examining psychiatrists had reached their conclusions and recommendations. It transpired that psychiatric reports were written purely on the basis of interviews with SUTCLIFFE about the relevant events. Perhaps unsurprisingly, he told some lies during examination – lies that could be shown as such by other evidence gathered by the police. Because of this, Mr Justice BOREHAM put the matters before a jury and SUTCLIFFE's claim of diminished responsibility was rejected.

DOES THIS MATTER?

Where a defendant is convicted of murder, there can only be one sentence in law: life imprisonment. So Nicola EDGINGTON, having committed the offence whilst an inpatient in a mental health hospital and with a significant mental heath history, was sent to prison. Almost certainly, as was the case with Peter SUTCLIFFE, she will be transferred from prison to the hospital system under section 47 of the Mental Health Act, restricted by section 49. This means she will, in effect, assume the same status as she did when detained after the killing of her mother – that of a "restricted hospital order" patient, under s37/41 of the Mental Health Act.

So what is the point of all this, if those convicted of homicide whilst mentally disordered all end up in the hospital system anyway?

Well, those convicted of murder and given a tariff by the judge upon conviction – this is the minimum period of time that must be served before they can be considered for release. No such tariff is imposed upon those convicted of manslaughter where diminished responsibility is argued – they are most often sentenced to a restricted hospital order.

Nicola EDGINGTON's tariff was 37yrs – although I remind you that this is subject to appeal. If it is felt that it is no longer necessary for her to receive inpatient care as a s47/49 patient, she can be remitted back to prison under s50 MHA to conclude the remaining years of her tariff and her release is controlled by the Parole Board and the criminal justice system. When she first pleaded guilty to manslaughter and was detained under s37/41, her ongoing detention was governed by the clinical recommendations of her clinical team, overseen by the Mental Health Review Tribunal System.

In other words: this all amounts to a difference between the ability of the criminal justice system to keep control of people who were fully criminally convicted and sentenced for murder, until such time as their sentence is served, even if it does end up being served in a hospital.

25th April 2013

April Newsletter –

There is a lot going on this month, in the NHS and in the news, affecting mental health issues and the overlap with criminal justice. A whistle-stop tour follows! –

NHS CHANGES

This month there is a lot of business commencing that will change the way the mental health care is given – so a short summary seems in order. At the start of this month, Primary Care Trusts (PCTs) in England ceased to exist and they have been replaced by GP-led Clinical Commissioning Groups. There are 211 CCGs in England and taken they together they will control £65bn of the £95bn NHS Commissioning budget. This will affect decisions around the commissioning of mental health care in ways we do not yet fully understand.

One challenge for this area of business is the overlap with criminal justice: secure-mental health services and specialist offender health services will continue to be commissioned seperately and directly by the Commissioning Board of NHS England and each police force area will have an offender health commissioner whose role it is to ensure, amongst other things, that issues affecting the police are not lost in the distinction between local CCG commissioning and that directly arranged by the NHS Commissioning Board. As of 1st April 2013, Strategic Health Authorities ceased to exist – their responsibilities are now transferred to the NHS CB about which more information is available on the NHS England website.

Also coming into effect in April 2013 are Health and Wellbeing Boards – run by local authorities who take over responsibility for the public health agenda, these bodies aim to bring together on a statutory basis health and social care leaders to improve the health of their population and reduce inequalities in healthcare. Interesting point about these bodies: the police are not involved in them by right, but only by local invitation or as and when required. Given the vast amount of information the police have about health issues, including mental health issues as well as drug and alcohol abuse, it strikes me that the police should be right in there as active

participants. Areas are making their own decisions about this, as these boards get up and running.

ROYAL COLLEGE STANDARDS

This month the Royal College of Psychiatrists has published new guidance to NHS Commissioners – in the new CCGs! – on s136 Places of Safety. It mostly echoes the "s136 Standards" that were published in 2011, although with a new aspiration that police officers should be able to hand over patients to PoS staff and leave within 30 minutes of arrival. This is fantasy-land in many parts of the UK, but I truly welcome yet another document which allows police officers to arm themselves with argument ahead of meetings with NHS colleagues about the provision of these services.

Can it really be 30 years since the MHA was enacted and we still don't have PoS provision in every county of England? – North Yorkshire remains the only one and quite unsurprisingly they are now wrestling with this after a death in custody incident in York in June 2011.

The Care Quality Commission this month published their new strategy for 2013-2016 and within it, they stress a new emphasis on MHA, MCA and DoLS processes in their inspection regime: I truly hope that CQC inspectors use these nationally agreed guidelines and standards as a benchmark against which to assess PoS provision. Actually, I hope that commissioners will already be doing this for themselves without having to be asked – in particular I draw their attention to pages 11 and 13 which provide highlights about what "good PoS provision" looks like.

DIAGNOSITC AND STATISTICS MANUAL – 5th EDITION

This month, the American Psychiatric Association will publish the 5th Edition of the DSM – this is textbook which classifies mental disorders. I am not going to say too much about this because I am writing a full post on the DSM for next month. Suffice to say for now, that it is a controversial publication, not least because some clinicians argue that the whole classification system is scientifically invalid *per se*. Many aspects of its production and content are opposed by, amongst other prominent psychiatrists, Dr Allen FRANCIS and Dr Robert SPITZER – they were heads, respectively, of the task forces that put together DSM-III and DSM-IV. Chief amongst criticisms is the fact that this fifth edition has been produced in secret, with members of the task force signing non-disclosure contracts. There are also clinical objections:

DSM-5 introduces disorders not included in previous editions, such as "paraphillic coercive disorder" – a disorder in men who become sexually aroused by the coercive dimension of rape. Highly controversial – is this a medicalisation of what is simply criminal conduct? Some would say. Whole research papers by psychiatrists have sprung up to debate and oppose the validity of this particular suggested disorder. But one can forsee how its inclusion in a scientific textbook of mental disorders like the DSM will mean it is mentioned in criminal rape trial at some point in our future. There has also been controversy about the decision not to specify Asperger's Syndrome as a distinct condition, but to include it within the broader autistic spectrum.

Such debates have been part of the DSM's evolution since the earliest stages: originally, homosexuality was listed within the tables of disorders in DSM-I and II, but it was removed after protests at psychiatric conferences when DSM-II was reprinted in 1974. Psychiatrists in the United Kingdom and many other countries, often prefer the classification system ICD-10, published by the World Health Organisation, but the DSM-5 debate will extend to Europe, not least because those involved in its conception will be undertaking conference tours and debates across the world later in 2013. Nice work if you can get it.

ERNESTAS ANIKINAS

A very difficult case for the Sussex Coroner, arising from tragic events at Gatwick Airport – Ernestas ANIKINAS was a 33 year Lithuanian-speaking man who was in contact with Sussex Police at Gatwick Airport after becoming agitated. Having used a telephone translation service to establish why he was at the airport and why he was agitated or upset, it emerged that he had gone to the Airport in the hope of returning to his family in Lithuania. During converstations he was advised by his family to go to Victoria Station in London so officers escorted him from the Airport to the railway station. On the platform, Mr ANIKINAS suddenly took a bottle, broke it and stabbed himself in the neck causing fatal injuries and blood loss. The Coroner and Mr ANIKINAS's family praised the officers involved for efforts to save his life after the self-inflicted wound.

The IPCC were required to investigate the death, given it occured following police contact and they concluded that the restraint, involving the use of a taser, has been appropriate in the circumstnaces and that all efforts had been focussed upon saving his life. However, their report suggested that "more could have been done" to establish during the Airport encounter why Mr ANIKINAS was agitated. I admit, I'd like to know more about the case, not least because – if there are lessons to be learned for future encounters, let's learn them nationally. Chief Inspector Chris BALL from Sussex Police is on record as saying the officers had no powers to detain the man the

man at their first point of contact. I infer from the comment by the IPCC that "more could have been done" and them raising section 136 in their press release when it was never used by Sussex officers, that think he may have been detainable. Many IPCC reports are made public: I wonder whether there are issues to be considered that mean this one should be?

MENTAL HEALTH GIGS

I'm being asked to speak at various events at the moment – I like doing these things and do as many as I can, bearing in mind it's all in my own time. Upcoming in May is me going "home" – I've been asked the Northumbria University to speak at their AMHP training for local authorities in the North-East so I intend to get my accent back and enjoy the first event I've spoken to in Newcastle. I'm speaking at an AMHP event in Manchester later in the year. I'm sharpening my "Section 135" input for the inevitable debate about warrants, with my best case study yet at the ready!

It's good to talk.

KEEP AN EYE OUT!

- **24th April 2013**: the trial of two police officers for wilful neglect in public office arising from the re-detention of Colin HOLT, an AWOL patient from a mental health unit in Kent. Without the outcome of the trial yet being known, if offers learning for why restraint after detention needs to be carefully done and why it should be accompanied by calling ambulances to ALL MHA detentions and re-detentions.
- **09th May 2013**: the publication of the Adebowale Independent Commission report on policing and mental health in the Metropolitan Police. I had a chance to express views to the Commission along with many others and it will be interesting to see what they say. They had also come to a view that mental health issues contribute to around twenty percent of police demand.

26th April 2013

Restraint –

There is, in my professional experience, a very distinct difference between restraining burglars or street robbers who have been arrested for offences and restraining patients who have been detained or re-detained under the Mental Health Act. The concepts of resistance or aggression may be similar; the instinct of a police officer to contain the risks that arise from resistance or aggression may be similar, but I'm beyond doubt that arresting criminals and detaining patients are qualitatively very different.

It is the very fact that the two enterprises are NOT the same thing, that renders a similar approach to each to be far too crude. It is also a false disctinction to differentiate based on the legal framework officers are applying: arrest for crime / detain MHA. The approach should be governed by what we know about the person being restrained: arresting a criminal suspect for an offence where we know of serious mental health problems is something to which the caution in this post should apply.

This is a very difficult subject and I've waited ages before addressing it, although I've alluded to the use of force and medical emergencies from the restraint of patients in mental health crisis before. We know there have been deaths in custody which have become political issues and which have brought about protest; and we know that there have been adverse outcomes from inquests and inquiries suggesting that policing, although complex and demanding, has not reached the necessary standard. And there are ongoing investigations.

But it's not too difficult to conceive a different approach, albeit one that sits just outside the unilateral control of the police – and it rests not only upon policing, but upon those with clinical skills and better training around health and mental health. But we're going to have to challenge some inherited thinking in policing and health to do it.

I'm about to make a *massive* generalisation for the purposes of drawing a distinction: your focus should be on the distinction, not the generalisation – it has been my operational experience that where the police are detaining resistant criminals after arresting them for offences, they'll either resist until they know that they are properly caught and detained, and then they will desist into abusing you; OR, where offenders are drunk, may continue

to physically resist, but are able to be quickly removed to a cell where they concentrate on banging the cell door to annoy everybody.

I realise that this is an *extreme* generalisation – but I pose it deliberately to contrast it with my experience of detaining and restraining resistant mental health patients: patients are often so fearful of being restrained that they either start fighting in fear of their lives AND / OR they may have underlying health conditions or drug / alcohol complexities which mean a high-impact restraint renders it a difficult and dangerous situation – and sometimes, this protracts for a significant period of time, because the underlying fear of being detained or the background health risks do not suddenly go away. Qualitatively, it is a very, very different kind of thing to arresting burglars and domestic violence offenders.

RESTRAINT AS A MEDICAL EMERGENCY

I've written loads on this blog that is intended to help police officers navigate difficult operational waters, but if they remember NOTHING else, I'd want them to remember this: >> **the need for *ongoing*, especially-prolonged restraint of a psychiatric patient is a medical emergency – end of.**

And this is NOT just my opinion: it has a basis in both medicine and law.

I've stressed, "ongoing": when some restraint or coercion interventions start, patients often do decide to then comply with what is happening and the intervention can be scaled back or stopped entirely. It is when resistance begins and doesn't stop that we need to start thinking *clinically*.

There are a few reasons for this.

- **If patients are under the influence of drugs or alcohol as well as suffering a mental disorder, restraint can compound what is occurring to the patient physiologically** – this is where people start talking about things like Excited Delirium and Acutely Disturbed Behaviour, controversial though those concepts are for some;

- **There can be certain physiological side-effects to patients suddenly ceasing to take psychiatric medication like anti-psychotics** – some patients are more affected than others and again, impact where it occurs can vary depending on (illegal) drugs / alcohol consumed; and restraint can exacerbate this;

- **Mental health patients, on average, have much poorer physical health than the population as a whole** – as a rough rule of thumb, add 10 years to a patient's actual age and then start to comprehend how restraint would impact;

- **Think of the intervention you are applying from the patient's point of view: which may include, for example, paranoid delusions about who the police or what the police are trying to do** – if you genuinely feared that restraint was something qualitatively different to what you were being told, however delusional that belief were, would you not resist in fear?

NOT JUST MY OPINION

During the Independent Inquiry into the Death of Rocky BENNETT, various expert medical witnesses and experts in restraint, talked of the ongoing need for restraint **as a medical emergency**. It talked about doing so, only in a context where there were doctors and nurses trained in the use of defibrillators, appropriate medication and who are knowledge about of things like the NICE Guidelines on Acutely Disturbed Behaviour (2004).

We've seen during some critical incidents, that police officers were too slow to get people out of a prone position; too quick to use a police vehicle for the conveyance of that person, including over long-distances; unprepared to call paramedics for a range of reasons that may partly be attributed to (false?) presumptions that they wouldn't attend anyway; and far too quick to fall victim of the inherited thinking that has prevailed for years that anyone who is violent should always be taken to the cells. **This is where we get it wrong:**

Resistance, aggression and violence can be attributable to any number of things: head or brain injuries, some of which won't necessarily be visible; diabetes; epilepsy, strokes. Or it can be a natural reaction to paranoid delusions or auditory hallucinations – we need to know more before we start thinking "more force, police vehicles and cell blocks." The stakes are too high.

THE ROLE OF THE AMBULANCE SERVICE

We have seen criticism arising from police officers who are engaged in restraint of seriously resistant patients not calling paramedics to the scene. Although paramedics are not licensed to carry the kinds of

medications which the above-mentioned NICE Guidelines talk about, like benzodiazepines, they are in a position to administer some medications that may help and have other kit to monitor a patients condition. They are also positioned to oversee clinical wellbeing and of course to react to any untoward developments that occur whilst in transit. We've known patients suffer heart attacks and slip into diabetic comas in police vehicles after detention by the police under the MHA – previous conditions that no-one knew about where a paramedic with a bag of kit would have been quite handy to provide a swift-reaction.

It is these cases I think about when I hear that some ambulance trusts are pejoratively asking the police, "Why on earth do you need an 'intensive-care-unit-on-wheels' for someone who is 'just' mentally ill?!" << This is a question I was actually asked several years ago by a senior paramedic. And there are two answers to it –

- **Firstly** – because I haven't got a Scoobie-Doo whether the person I think is mentally ill is mentally ill or not because I'm a police officer; the first rule of good mental health assessment is to rule-out physical causation before concluding mental disorder and cops are not going to do basic obs like heart-rate, blood pressure, blood sugars, etc..

- **Secondly** – because the Code of Practice and the Royal College standards say this is the way it gets done – they amount to agreed statutory and professional standards signed up to nationally by everyone who is important. There is something here about patient dignity and reducing stigma in how we do what we do.

We should remember this – the Code of Practice to the Mental Health Act requires conveyance to be done by ambulance (as the only practical alternative to police transport which is criminalising) and where this is not possible, it is suggested good practice that a paramedic travels in the police vehicle with the patient. Only recently, there was a scenario on my team where a first-responder paramedic indicated quick removal was needed and as the situation occured near to a major A&E, he got into the police car with police officers and the patient; whilst another officer drove his ambulance service car to the hospital for him so he wasn't stranded afterwards.

It is also relevant to point out, that within the Safer Detention guidelines for the police, which pertain to detention in police custody, it talks about officers having awareness of conditions like Excited Delirium and the necessary responses = Accident & Emergency.

SAFE RESTRAINT

So, we can all name the cases where we have heard or even seen CCTV, of high-impact restraint by several police officers. There is a sound basis for thinking clinically where this is believed to be attributable to a mental disorder, especially where drugs / alcohol are involved and **call an ambulance**. In the West Midlands, where I can't praise West Midlands Ambulance Service enough for their approach to this stuff, we have an agreed set of criteria, known as RED FLAGS, which then trigger consideration of removal to Accident & Emergency. The need for ongoing restraint, amidst concerns about excited delirium, are RED FLAGS under this process which then allow the NHS in quick time to consider whether application of NICE Guidelines should apply, or whether another pathway into care is necessary.

As the risks of not getting this right are grave and have previously involved criminal investigation and indeed, prosecution of police officers and potentially in the future of health staff, it is important we don't get caught in the over-functionalised thinking that has previously believed we can sort this out at the road-side or at a police station. The stakes are too high, the underlying causation invisible and we are playing Russian roulette with people if we get outside our skill sets and gamble the odds. In risk assessment, high-impact but low probability events – let's be honest, most high-impact restraint does not lead to death, prosecution or untoward events – should be treated seriously and mitigated against in just the same way that fear of stroke or fears of heart-attack would be.

Any other approach is discrimination against some extremely vulnerable, however challenging, people at a very risky time.

MAY 2013

2nd May 2013

Police Mental Health –

I am aware that several forces are reviewing, revising or writing afresh their internal policies on mental ill-health for staff. Policies about a force's duty of care towards their police officers and employees. There are various reasons why this is very, very necessary and arguably overdue. Like any organisation, the police service will have staff who suffer from stress and anxiety related conditions because of issues at work; and others arising from personal and medical history. There will be a minority of staff who also have severe and enduring mental health conditions like bipolar disorder, etc..

I am aware from queries over the years that serving officers have been detained by their colleagues under s136 of the Mental Health Act and some police officers have been detained as inpatients in hospitals under the Mental Health Act. This happens to some members of our general population, including doctors, soldiers, academics – why should we think it wouldn't happen to some of our police officers and staff?

This is a short post, just to throw around some thoughts that indicate why all senior officers need to consider their policies and approach to staff mental health as well as all of us reflecting again on our attitudes which are reflected in some presumptions –

- **There is a raised risk of mental health disorders within the policing professions** – potentially arising from the nature of the work that we do. Despite this, some forces are having to restrict the amount of occupational health support that they can provide, by restricting counselling to those whose mental health problems arise directly from issues at work.

- **We are currently living in a period of economic austerity** – in the second year of a pay freeze which will effectively continue for several years yet as pay and conditions are reformed – the Police Federation will state that they are dealing with more and more officers who are getting into financial difficulties and seeking support for debt management and for issues like family breakdown arising from financial problems.

- **We have seen presumptions by the NHS** – that because police officers work in a large organisation with occupational health and counselling support, that less NHS input is needed where there is a diagnosed condition. Without liaison between the NHS and the police to ensure that this is the case, some officers have fallen in the gaps.

- **We have no specific national charity who champions the mental health issues of our police or our 999 services** – there is no equivalent of Combat Stress or Blue Apple Heroes and I know some "999 demand" has drifted their way, in lieu of people or families knowing where to turn. I know our ambulance service face similar problems for similar reasons.

- **Raised risks overall because the demographic profile of the service** – men are less likely to seek help for mental health problems and yet are at far greater risk of committing suicide in age groups which are relevant to policing, like men in their 30s / early 40s.

- **The impact upon people of organisational change programmes** – we know that every force is looking at its budget and its service. As things are rationalised, we see job cuts, pay-regrading for police staff and in some cases, discussion about redundancy including compulsory redundancy.

- **Some people are now responsible for things that used to be more than one person's job** – for example, in some police force areas, the "duty inspector" is responsible for a policing area that is literally twice the size of previous policing areas after boundaries were redrawn. Certainly what I will be doing this afternoon, used to be two people's jobs.

- **Training for first and second line supervisors** – What training, if any, do sergeants / inspectors and equivalent police staff managers have on mental ill-health identification and support? I once heard a story that after a police officer was booked sick with a mental health condition, supervisors told colleagues not to make contact with them whilst off. This was done in good faith for good reasons, but it happened to be the opposite of what the person wanted and it left them feeling isolated.

- **The culture of the police organisation** – officers and police staff deal very frequently with calls from the public which involve mental ill-health: around 20% of demand, if not more, is connected to mental disorder. This tends to be the more acute crises, situations connected to crime and risk or situations where officers wonder about the care that was being offered, or denied, from the NHS. This colours officers' attitudes at all levels, as can be reflected in some opinions and approaches to mental health work.

In other words: policing is a profession, especially at the moment, which is ripe for a combination of professional and personal factors which produces a higher than average likelihood that some staff will experience mental distress; just at a point where the organisation is less likely to be able to directly support and where supervisors may not necessarily feel confident in discussing it. All taken together, it has obvious potential to build towards stress, anxiety and interia that could become a mental health emergency somewhere down the line.

TIPS FOR FRONTLINE SUPERVISORS

Take time and trouble to offer to discuss concerns you may have if you believe staff may have a mental ill-health problem. Don't be offended if someone chooses not to and be aware that there could be any number of legitimate reasons why they prefer not to discuss something with you – because you're their boss. Be aware of internal support networks, staff associations, third sector providers as well as the ability of individuals to seek help from their GP who then has access to other NHS supports.

Don't make presumptions about what staff may want – the person who told me their boss had told the team not contact had done something in good faith, presuming it would be preferred, that was the opposite of what they would have hoped for. A colleague ringing or texting, maybe meeting for a coffee would have been welcome, so be clear about what staff want and need. Remember that where someone has been diagnosed as having a mental disorder, it becomes covered by Disability discrimination legislation where staff are subsequently entitled to "reasonable adjustments" at work if this facilitates their return to work and the performance of duties.

Finally, it's just a remark about attitudes and culture: I wondered aloud in a recent meeting about the extent to which our internal attitudes to staff mental health and wellbeing are affected by our professional experience of the jobs we've all dealt with, which are often very difficult or frustrating incidents where we see systemic problems in our societies response? I also wondered what rank in the police service would be the most senior at which someone could be found to say that they have suffered

from mental health problems? If culture and attitudes are to change in a male-dominated organisation with a certain type of operating culture with a demographic and professional profile which places us at higher risk as a group, we could do with some role-models showing that successful careers are not derailed by ongoing battles with mental health problems and start breaking cultural barriers to addressing issues properly.

The two groups in our society whose attitudes have remained fairly entrenched about mental ill-health are **the police** and **mental health professionals**. This needs to change along with the rest of the society in which they operate.

4th May 2013

Colin Holt –

The criminal trial of PC Maurice LEIGH and PC Neil BOWDERY was brought to an end today when the officers were cleared by a jury of wilful neglect. Various questions remain about the incident which led to Mr HOLT's death and to the events which preceded it – I certainly have loads.

This is not the first trial to occur after officers have been accused of wilful neglect in public office following the detention or re-detention of a patient under the Mental Health Act. I also fear that it will not be the last and I worry that it may be me or one of my officers next.

This blog is published at a point where my team are currently looking for an AWOL section 3 patient who has a history of being resistant on arrest, so who knows how things will go when we find him? For all these reasons that I have given the following advice to my team about the detention or re-detention of anyone under the Mental Health Act, and for that matter that arrest of anyone for crime who is obviously mentally unwell:

- **The Three As –**
- Arrest – make your detention
- Ambulance – call one **every single time.**
- Assess – either with the paramedics or on your own if they don't attend, assess the person for RED FLAGS

Then, you do one of three things –

1. **RED FLAGS to A&E** – if there are **any concerns at all**.
2. **No RED FLAGS to Psychiatric Unit** – either the place of safety for s135/6 cases or the hospital from which they are missing for s18/s138 cases;
3. **Police Station** – *only* when all else has failed, you can't improvise around it and you've no other option at all.

RISKS FROM RESTRAINT

Police officers need to understand and react accordingly, that **the restraint of psychiatric patients can be a medical emergency**. Every bit as

much of an emergency as a heart attack, a stroke and or a serious head injury. This is true because regardless of how alarmist this may sound, it is unarguable that where prolonged restraint is ongoing, we **simply do not know** the underlying health problems that may be causing resistance; or health problems that may be caused *by* resistance.

They need established before we make precipitous decisions about treatment / care / detention. So raised awareness of this needs to go beyond our understanding our training: it needs to be reflected in professional practice decisions like calling mental health professionals and ambulances to relevant incidents. Only recently, I wrote about this and so will say no more here.

AWOL PATIENTS

Obviously, the incident which led to the tragic death of Mr HOLT was part of a search enquiry for a missing AWOL patient. We should therefore remember what the Code of Practice says about this, bearing in mind he was found and re-detained and died in his own home:

- "If the patient's location is known, the role of the police should … be only to assist a suitably qualified professionals." << Para 22.13 MHA CoP. – Can anyone give an example of this happening? I'm sure there will be some, but I don't know of any.
- All conveyance of patients detained under the MHA – and this includes initially detained or re-detained by the police – should be done a non-police method. – In reality, this is going to mean a role for 999 ambulances because we cannot predict the need for police usage of ss18, 136 or 138 MHA.

I also have a concern about the fact that during the criminal trial, it is reported that when officers have first attended the address, there was no reply when they knocked. They have then proceeded to enter the building and I'm curious about what legal authority? There is no power to enter a premises without permission or a warrant unless it is believed that life / limb are at risk and this doesn't appear to have been the case.

More mental health LAW training all round – it's not the restraint / clinical awareness stuff that we need training on. More training on that would be better than what we get, but things like positional asphyxia are covered in training. What is missing from training, is legal training about section 18 MHA, s135(2) MHA and Chapters 11 and 22 of the Code of Practice. All of those have a bearing in this situation which is why as this case has unfolded since August 2010, I have followed it and progressively wondered how on earth it came about, given our legal and guidance frameworks.

DEFENCE AND AUDIT

Now, I understand that mental health trusts will often say that they don't have the staff to lead the recovery of AWOL patients, as per para 22.13 of the Code. Some ambulance services (which may or may not have been the covering service for some of the cases where officers have been prosecuted) will distance themselves from Chapter 11 of the Code, arguing that "an intensive care unit on wheels" is not needed for someone who is "just" mentally ill. << Their words, not mine.

Without wanting to sound harsh, I have to say that **I simply don't care**. Not one jot.

The prosecution of my colleagues in Kent arises because they were able to be accused of a kind of wilful neglect. Part of demonstrating that the detention and handling of patients was not done with a casual regard to their safety and dignity, is doing things as envisaged by law. So if there is a reasonable belief that a patient is at home and they need to be detained, officers tasked with the missing person enquiry are quite entitled to ask the MH Trust to provide resources to accompany them. Whether this comes from the ward staff, the crisis team, the community mental health team – I don't really mind or care but the answer to any resistance or protest about it is "Para 22.13 applies here, so if you're refusing, I'm documenting your name in my audit trail in case legal consequences follow on from this."

Staff and managers refusing should bear in mind the Munjaz case: Codes of Practice, whilst not being binding, are not mere advice that you can take or leave – they are statutory guidelines that should be complied with unless there are "cogent reasons for departure" and it is up to the departing organisation or professional to justify that. So it is for trusts to decide how they want to resource this business, just as it is a matter for Chief Constable's to decide from where they will suddenly get 50 detectives for a murder or several hundred officers for a riot, difficult thought that also is.

PREDICTING DEMAND

The re-detention of psychiatric patients is a predictable aspect of running a mental health trust. It therefore amazes me that so many are utterly unwilling / unable to do it. Any suggestion that they won't undertake such tasks, should never stop officers from asking for it. There is a legal basis for asking for it, so it should be done.

Equally, once they had decided to enter the address and they found Mr HOLT there, they should have called an ambulance, not least to discharge the requirements of Chapter 11 of the Code, but it then would have meant, after the violent episode in which he was restrained and handcuffed and

one of the officers injured, paramedics would have been able to take over the clinical monitoring of him and would have been better placed to react from the point of view of skills / equipment, if his deterioration had occured. South-East ambulance service may or may not agree with this approach, but that's a matter for them. There is a legal basis for asking.

The law of England is predicated upon mental health services providing certain services, undertaking certain tasks and doing it in reasonable timescales to ensure clinical wellbeing. These duties are under-pinned by Royal College Standards, NICE Guidelines and the fallout from a range of inquiries and cases which have proceeded through the courts. By not ensuring that we push for support or leadership from the most appropriate professionals, we merely create the conditions in which neglect can be alleged.

10th May 2013

The Adebowale Report –

Today a report was published by Lord Adebowale, the Chief Executive of Turning Point, into the handling of mental ill health incidents by the Metropolitan Police. The Commission he headed was set up by the Commissioner, Sir Bernard HOGAN-HOWE, to examine how they could better police incidents connected to mental illness. In particular, it was set up following the inquest into the death of Sean RIGG which concluded last year that the actions of Metropolitan Police officers "more than minimally contributed" to his death.

The Commission took a wide range of evidence from many people and the only police officer on the board of it was Chief Constable Simon COLE, the ACPO Lead on Mental Health and Disability. Controversy was suggested early on when organisations like Inquest and Black Mental Health UK were not asked to provide a panel member, but I hope those organisations feel they had ample chance to put their view across around deaths in custody and black and minority ethnic mental health issues. Obviously, the cross-over is where previous tragedies have occured involving the police, although not just in the Metropolitan Police area.

I was honoured to be asked to speak to the Commission: one of the members being Paul FARMER, the Chief Executive of Mind, he recommended by work to Lord ADEBOWALE after receiving last year's Mind Digital Media Award. I spent two very enjoyable hours talking to them about the whole nature and variety of mental health demand and was asked tough questions about canteen culture in the police, racism and leadership and mental health issues. As well as being able to explain some of my views about restraint indicating potential medical emergency and my "twenty percent theory" – I was interested they had concluded a similar number – I hope what I had to say was of some help to them.

Read the report for yourself – it is fascinating in many regards and it is tough: when I have fully digested it and have the time to quote and summarise it, I will write a response.

- The Full Report
- The Executive Summary

REACTIONS TO THE REPORT

- Metropolitan Police – press release from the Commissioner, Sir Bernard HOGAN-HOWE
- Mind – press release from our major mental health charity.
- Centre for Mental Health – press release.

- The Evening Standard
- The Guardian
- The Independent
- The Daily Telegraph

NB: *this picture is the mental image that sits in my head of policing the Olympics in London in 2012 as I was posted to duties at the ExCeL and the O2 arenas. A brilliant, world class city in which millions of people suffer from mental ill health.*

11th May 2013

My Reaction To Adebowale –

I thought myself very privileged to have been on the list of people to receive an embargoed copy of the **Adebowale Report** on Friday morning, two hours before the world saw it. Although I was due to be at work on an EARLY shift, I had made mental arrangements to prioritise reading it amidst my various duties, tweeting some headlines and expanding on a blog I had prepared in outline earlier in the week.

Best laid plans …. before 8am on Friday morning, I was out of my police car having driven on blue lights to an emergency and running through a local park to get to a footbridge over the M5. My Central Motorway Police Group colleagues had brought the carriageways to an eerie standstill at rush hour because of an incident where someone was threatening to jump and I was the incident commander to try to prevent this. No sooner had we talked them down after an hour of effort and taken them to hospital with mental health problems and possible hypothermia, we followed this up with no fewer than FOUR more resource-intensive incidents where people were threatening or attempting suicide. Adebowale would have to wait and hence this reaction comes quite late! But he was right, for all the reasons that delayed my digesting his report: **mental health is core police business.**

Eighty pages, twenty-eight recommendations.

A succession of headlines in national media about "police failings" and social media interest of all kinds. Some officers feel that the report attacks them individually and their profession collectively: one officer on Twitter said, "I literally give up. I cannot take this constant drubbing. I don't know why I bother." Others have looked at some of the inferences within the report about racism and the use of force and been concerned by the analysis and the sample sizes from which conclusions have been drawn. It has prickled a few of my colleagues, to say the least. To them I say this:

You can quibble over details of academic rigour or research methodology if you want to: but we all know that the broad thrust of this report is **spot on** – a lack of proper partnerships and infrastructure for mental health emergencies; a lack of parity across our society and especially within our NHS for physical and mental health care; and a police service which has been hoping that the need to deal with mental health

incidents would go away, if only partners would sort their resources and their responses. Well, it won't – **it's core police business.**

THE REPORT

Lord Adebowale makes 28 recommendations, falling in to three categories of business, which I will let you read for yourself in the full report:

- Leadership
- The Frontline
- Partnerships

If you read it cover to cover – the full report – there is ample opportunity to see that criticisms of what contributed to 55 deaths in contact with the Metropolitan Police, go way beyond policing. "The Met cannot do this alone", says the report. "The police are forced to mop up situations that mental health and social services should be dealing with" although colleagues in health and social care were quick to point out, that this sometimes works in reverse. One officer asked when the reverse is true, almost incredulous at the thought. I often find that police officers don't realise where we cause chaos and confusion: the misuse and abuse of s136 MHA; the all-too-often poor response to allegations of violence or crime by people with mental health problems, including where they are detained patients in psychiatric units. It's easy to wear blue and see the failings of a chronically under-funded health and social care system – harder to see what's right in front of us in our own organisations. << *Therein lies vindication for the report.*

But there it is in Adebowale – a lack of leadership which the report suggests needs to be rectified at the level of the Commissioner; a lack of training and effective joint protocols with health and social care organisations which leads to it being all "too common and too easy" for police officers, AMHPs and NHS staff to have on-the-ground disputes over tactics and responsibilities. Finally, a lack of established partnership structures through which to brigade all of this across the Metropolitan Police. Of course, the complexity added by the size of the Met should not be forgotten: my own force covers seven local authorities, four mental health trusts and eleven acute trusts – complex enough, thanks!

London is a confederation of 32 boroughs across which (I think!) 9 mental health trusts operate alongside ??!? acute trusts and 32 Clinical Commissioning Groups. To have an effective relationship with "the NHS", the Commissioner will need cat-herding skills on an unprecedented scale to brigade in excess of 100 organisations in the capital.

MENTAL HEALTH IS CORE BUSINESS

I was grateful for the chance to speak to the Commission: two hours of my time I was very happy to give and I'm delighted to find that my views and in particular my blog, have been represented in the report. A journalist who attended the press conference for the launch of the report informed me that my work was directly praised by Lord Adebowale whilst stating that "the popularity of [the MentalHealthCop] blog highlights a lack of education within the system."

Obviously, Lord Adebowale has stated that there must now be a comprehensive package of mandatory training, pitched at different levels for various roles within the organisation – I'm delighted to say that the Metropolitan Police have already asked me to assist with that. Some were quick to point out that training is delivered across the service and that this is updated. I'm reluctant to point out – this blog only exists at all because what training is there is not adequate for the duties modern officers must perform. No training contains reference materials about the recall or revocation of conditionally discharged or community treatment order patients; no national training specifies an approach to mental illness that seeks to recognise what needs to be treated as a medical emergency, including restraint and certainly no training tries to affect attitude.

If senior officer training were provided, there would have been little need and no appetite for the Superintendents' Association of England and Wales to circulate the Senior Officers' Checklist to 1,400 members nationwide (twice!).

Putting our house in order has to come first – senior officers, themselves properly trained and focussed on key priorities will need to "go in to bat" against agencies who will shout "resources!" at many suggestions of what is needed. We need people at ACPO level and superintendent level who can prevent the police being "had over" by mental health trusts who are inclined to want to 'bounce' half of all their s136 cases on the premise of various ridiculous exclusion criteria, pushing clinical risks into custody; we need senior officers to allow the expenditure of resources at sergeant and inspector level who can build day-to-day relationships with health and social care service managers to regularly resolve problems that are caused on either side; and if we think s136 has been the poster-problem, we need them to understand and work with partners on a problem that is potentially ten times as big – criminal suspects arrested for offences who are mentally ill. We need Liaison and Diversion Services and it's got to be something other that a psychiatric nurse working 8am-4pm who scans the cells first thing in the morning after the key legal decisions were taken last night and overnight and then refers people after the fact.

All of this is predicated upon one point I've made before on here: **mental health is core police business**. It always has been and it always will be. The only question is whether we want to plan and properly prepare for it as we do with many other areas of our work, or whether we can keep busking. Adebowale contributes to the view held by many including me: the time for busking and hoping we get away with it is long since gone. It's obviously from the court cases, the coronial inquests and the coverage in our media – we're not getting away with it any more and we need to put our house in order before tackling the partnership structures and this work will not be a project –

It will be ongoing, without limit of time.

- The Full Report
- The Executive Summary

REACTIONS TO THE REPORT

- Metropolitan Police – press release from the Commissioner, Sir Bernard HOGAN-HOWE
- Mind – press release from our major mental health charity.
- Centre for Mental Health – press release.

- The Evening Standard
- The Guardian
- The Independent
- The Daily Telegraph

NB: *the top picture of this blog is the mental image that sits in my head of policing the Olympics in London in 2012 as I was posted to duties at the ExCeL and the O2 arenas. A brilliant, world class city in which millions of people suffer from mental ill health.*

15th May 2013

Ambulance Drivers –

My colleagues in green seem a bit upset and not for the first time; my Twitter notifications are full of indignation and frustration. The Home Secretary delivered her annual speech to the Police Federation Conference earlier today and spoke for longer than ever before on policing and mental health issues – this in itself is very welcome, incidentally!!

During the speech, in an attempt to reassure the officers present that she was working to minimise the impact upon them, she stated:

"Police officers have many skills, but they are not in a position to be psychiatrists diagnosing and treating mental illness – nor are you meant to be social workers or **ambulance drivers**."

I'm well aware of social workers who object to the description of non-crime related police activity as "social work" and I just knew that the term "ambulance driver" was going to lead us somewhere we didn't want to be. It reminded me of the time another parent at my son's school asked my wife if she was pregnant when she wasn't … the world almost came to an end!! The dog and I were immediately placed on diets and we can all understand why our pre-hospital, life-saving superheroes felt well put-out today –

PARAMEDICS

Ella SHAW, author of the Ambulance Blog, has already written to Theresa MAY protesting the use of the term and pointing out the training that has to be undertaken to qualify as a Paramedic. Ella is not the first to point out to me today, that "Paramedic" is a legally protected term which we are all prohibited from using unless we have undertaken the requisite qualifications and registered with the Health & Care Professionals Council. We see the increasing promotion of the role with the College of Paramedics pushing professionalism and the importance of the inter-relationship between the police and the ambulance service is something I'm investing time in building, both on this blog and in operational life.

But for me, the term "Ambulance Driver" indicates a deeper point about the debate we're trying to have about policing and mental health when we're asking for the ambulance service to play a greater role, as the Adebowale Report suggested it should. If the only important point about the transportation of someone who has been detained by the police was the important-enough issue of patient dignity, I could actually just call a taxi.

But that's missing the point.

I don't just want paramedics next to me after the police detain someone under the Mental Health Act because of the big yellow truck and the implicit status of "patient" that it immediately affords the person I've detained: I want a paramedic next to me because they are highly trained healthcare professionals who have a mass of knowledge and kit that I simply do not have. They can help me establish whether my instinct to suspect a mental disorder is roughly on track; or – as with a real case in my force area – they could tell us that despite honest efforts, we got it utterly wrong and had detained someone with diabetes. Incidentally, I was very glad they were there to tell us how wrong we got it because the bloke collapsed in the ambulance shortly after the blood sugar test and was rushed to A&E in the big yellow truck. The consultant told us that this action could well have saved his life – it certainly averted serious medical problems.

Medical conditions that officers could confuse with mental ill-health are very numerous – a stroke or a heart attack, epilepsy or Addision's disease (which can lead to psychosis of a particular kind.) The list goes on … examples exist of paramedics pointing out to mental health professionals that someone being sectioned after what was thought to be a serious case of post-natal depression actually needed to go to A&E to have unusual physical symptoms checked out. It emerged they had a brain tumor and **required emergency surgery**.

And even where police officers were absolutely spot on, mental ill-health can also amount to a medical emergency –

Paramedics in any situation when police officers are having to engage in high-intensity instances of restraint to keep people safe are *crucial* – both in terms of the prevention of medical problems and in reaction to them. We know that the need for *ongoing* restraint is under-recognised as the medical emergency it is; and I don't want a medical emergency of any kind in the back of my police car on in my custody block. I want trained, professionals with drugs, kit and competence to keep the patient in good medical nick, whilst I try to keep everybody safe in terms of personal security.

#999FAMILY

I once drove an ambulance car – when I was a sergeant, a first-responder paramedic jumped into a police vehicle with some green bags along with two of my officers and the patient we had detained. Driving that vehicle to A&E so he wasn't stranded after delivering the patient into urgent care didn't make me a paramedic any more than him being in the police van rendered him an attested constable who should go and deal with a riot.

These two 999 services overlap more than people realise – we share 'customers' on so many occasions and paramedics do deal with situations involving crime and risk. They don't distance themselves from this any more than we should believe it's possible to prevent mental health demand coming our way or the occasional need to administer first-aid. We've seen ambulance services issuing stab-vests, because they recognise that some paramedic work is risky business. However, when a certain level of risk presents and they assess it as too high, they seek police support because we know how to manage violence and risk. If having done so, we find violence and risk with a clinical undercurrent, we need them back in the situation supporting our intervention and vice versa.

Every frontline cop and every frontline paramedic gets this: our affection for them is shown in every reminder we issue that they are the second best emergency service(!) and it's why you see hashtags on Twitter like #999family.

You need more qualifications and training to be a paramedic than you do to be a police officer (or for that matter a politician!) – it's why every police officer knows that our colleagues in green are far more than "Ambulance Drivers".

18th May 2013

Street Triage –

One thing arising from the Home Secretary's speech this week to the Police Federation conference was the idea of "street triage". In short, this means a system whereby better health or mental health support is made quickly or immediately available to police officers who are often paired up with health professionals.

Now there are various ideas floating around about what street triage could mean. Different ideas in different places leading to various propositions. Indeed, to different ways of supporting the police at different times given that demand is greater at certain times of day, like "out-of-hours" periods of evenings and weekends. We've seen the idea of community psychiatric nurses being deployed with a police constable; of an officer having access to a telephone helpline and although I'm not aware of it happening in the real world, I've been involved in numerous discussions with paramedics over the years, about what might be possible if certain paramedics were given better clinical and legal training around mental health issues and were deployed with a 999 colleague from the police who had also been given better mental health awareness and legal training.

One point in principle before I get into different ideas: these schemes could be perceived as trying to "do the wrong thing righter". Methods by which to better handle crisis events; or to better cover for other services. I'd prefer that we didn't have crisis events in the first place and that services were responsive because they were fully resourced. I've written previously that in some areas of our country, CrisisTeams and other mental health support services including 24/7 helplines are deliberately pushing health demands to the police. Interestingly, they are doing this after meetings that took place in rooms into which the police were not invited. I've had healthcare professionals who were present in those meetings make this directly known to me. So before we start "doing the wrong thing righter", let's keep in view, what the right thing is, in terms of inpatient and community mental health care.

Finally, you can find these kinds of initiatives in other countries if you look. Vancouver pair up an officer and mental health nurse; Portland in the USA pair up an officer with a social worker. It's clear there is no consensus and we're all still feeling our way through this. This post, ultimately, argues for another option! –

MENTAL HEALTH NURSES POWERS AND TRAINING

This is a controversial point, so I floated this on Twitter to see what the reaction would be: psychiatric nurses are less frequently dual trained as adult nurses than they were in the past and they have no legal powers whatsoever. So if the police and a CPN turn up to a house where someone is self-harming we still have that "mental health crisis on private premises" dilemma. No-one has a power to act and although the CPN, if they felt it appropriate, would have a hotline to services who could potentially arrange a mental health or Mental Health Act assessment, what would the expectation be if the patient was under the influence of alcohol or drugs? Are we then back to "she'll have to sober up first", which doesn't help us legally in terms of mitigating risks until an assessment or support can be given.

Secondly, if a mental health nurse and a police officer are deployed to a situation, whether it is in public or private, what kit are they deployed with? Is street triage going to be configured in such a way as to ensure proper triage of potentially physical causes of crisis events? It's all very well turning up to a job where someone appears to need support for acute depression, but what if they've got a brain tumor instead? … or as well?! Will psychiatric nurses be carrying kit to do basic medical obs, like heart rate, blood pressure, temperature and blood sugar? What training have they got in pre-hospital medical care?

This is what we see paramedics doing when we detain people under s136 and we know that them doing it has led to discovery of underlying physical causation. Many psychiatrists and mental health nurses have told me that the first thing you do in a mental health assessment is a physical examination so unless CPNs are going to be carrying that kit we will just be drawing upon ambulances as well where people are being considered for detention?

I'm not attempting to disparage a single CPN with these observations – actually a fair few of them agreed with me during my twitter crowd-sourcing on this that we need to know more precisely what problem we are attempting to fix, before we move to a CPN-orientated solution. What is it, *precisely*, that we think the police can't do or would be better done in tandem with a healthcare professional?

TELEPHONE ADVICE

I think we need to be careful about telephone advice for a few reasons. Firstly, the person giving the advice is never doing so with the benefit of actually *seeing* that patient and on the back of talking to and examining them. We've seen forms of telephone advice or screening for

years in areas where s136 protocols require the police to ring a PoS Co-ordinator to describe the patient and then be informed where the patient should go. What do we do if the person give advice and the police officer do not agree?! I can imagine telephone advice would be helpful in terms of quickly learning more information about someone – are they known to MH services; do they have a care coordinator; are there any risks associated with that individual, etc.. I'm wary, however, of telephone systems which may lead to remote-decisions being made. I'd actually go so far as to say that the only thing I want from a telephone system is information. The decisions would have to remain mine because I would be the one held accountable, regardless of the advice given – the advice giver would always have that get out of jail free card of, "Well I couldn't see the person, I went off what I was told!"

By way of example, I'd point you all towards the Birmingham Place of Safety scheme – if an officer wanted advice or potentially some information, they can ring the place of safety itself and speak to staff there. However, this is not a pre-requisite to making a decision, including a decision to go there with someone who has been detained. The clinical input to that process is provided by the ambulance service who get a paramedic to the officers within minutes of a call following detention. This then allows the paramedic to help assess any urgent physical healthcare needs, against the RED FLAG criteria that were agreed with A&E. It also allows for decisions to be taken *in person* about urgent healthcare.

PARAMEDICS

You may have worked out by now(!), I favour the idea of closer working relationships with paramedics; and if dual deployment is to be done, let's pair up the 999 services!

This has already occured in the north-east albeit, to address issues around the nighttime economy. I also think there is support for the idea in important places. Firstly, the Adebowale Report calls for far greater involvement of the London Ambulance Service in supporting the Metropolitan Police where they become involved in mental health emergencies. Secondly, paramedics and crews are highly trained in pre-hospital care. It was a paramedic who spotted the above 'brain tumor' example, after two doctors and an AMHP (mental health professionals!) had decided to section a patient during an assessment. Yes, I've heard reservations about the amount of mental health training that paramedics get – very little – but is that not a potentially easier problem to solve than the others mentioned around telephone advice models and CPN models?

Of course, paramedics do not always have access to certain MH pathways, like ease of referral to CrisisTeams, etc.. Here's a radical idea: **let's open**

them up! Paramedics are trusted to make urgent clinical judgements about strokes and heart attacks along with the decision to take a particular patient either directly to very specialist cardiac services or to an Accident & Emergency service. With training, why would they get this wrong?

Here's another thought about paramedics – they can be doing other NHS work when they are no mental health calls, because they are still paramedics. And if they were teamed with a police officer in a 999 response vehicle, they could also be jointly used for other reasons – like first responders to calls where ambulance would want police support or vice versa. It has the inherent advantage of flexibility, all subject to simply giving paramedics proper clinical and some legal training.

STREET TRIAGE

Despite my reservations – actually, despite my questions – it is beyond doubt that we need a better system of street triage to support police officers' decision-making. I'm simply arguing that this should always be done in person, by people appropriately trained. CPNs lack training in acute pre-hospital care; paramedics lack it in mental health (emergency) care. Which of those two things is easier to fix and from where would you retain the most flexibility to use your resources?

Let's remember as well, what problem are we trying to fix?

1. **Are we attempting to reduce s136 detentions?** – we know that in some areas, such detentions are too numerous and some, if not many, are inappropriate. Is that not about better training for the police, rather than how we bolt on a healthcare professional?

2. **Is it about the health professional having access to pathways that are not available to the police or paramedics?** – well let's open the pathways and understand the nature and the variety of demand that our police and ambulance services are currently managing under the radar, because they all-too-often can't access anything other than A&E, unless someone is detained or arrested.

3. **Or are we trying to improve on-street, clinical decision-making?** – who is best placed to do this and after what training for the role? Whether we like it or not, Adebowale creates an imperative for ambulance services to be looking at this anyway. I don't wonder whether "mental health paramedics", be that a few with significant MH training, or more general MH training delivered to all – or both(!)

– is ultimately a cheaper and more effective way forward, with access to advice lines from mental health services opened up.

Let us not forget that ultimately, the police officer in these types of situation is going to retain a legal right – actually, a legal *duty* – to make arrests for offences or detentions under the MHA where they believe the legal grounds are met. Either clinical need or legal duties arising from the Code of Practice to the Mental Health Act will demand that they call an ambulance anyway, notwithstanding the view of whichever healthcare professional is standing next to them. I have something of a nightmare in the back of my mind whereby health advice is not to detain someone who could have been detained or not to call an ambulance where one should have been called and in the subsequent inquiry it is pointed out to the officer, "the legal decision was yours to make, not theirs." We need to bear this in mind, whatever it is that we decide to do!

And finally, all of this is about better response to mental health emergencies. Sounds like a good idea, doesn't it? … who wouldn't want such matters better handled, especially after the Adebowale Report gave us all a much required kick in the pants? But where is the discussion about how we got to this place – this is all "doing the wrong thing righter" because I want to see fewer mental health crisis events, notwithstanding the need to handle far more effectively, those that occur.

22nd May 2013

May Newsletter –

An incidental introduction to this month's newsletter – this is my 300th post on this blog and not long ago, we surpassed the milestone of 300,000 hits. Averaging over 1,000 hits per blog is not bad going for the fact that I'm banging on about the potentially very dry subject of mental health and criminal law, as well as policing and mental health guidelines. I've now managed to set up a YouTube account (and have done a test post!) so I intend to start playing around with video blogs, to present a lot of this stuff in a different medium and to supplement the written versions you've already read. First of those should appear during June, so keep an eye out!

I will celebrate reaching these thresholds in the usual manner: after pay day I will crack open a new packet of *plain* hob nobs to enrich my morning coffee experience. **POLICE WARNING** – chocolate *ruins* hobnobs.

It has been quite a busy month! – hence a few more blogs than I would have intended, but there's been an exceptional amount to cover, including –

- The Adebowale Report
- The Home Secretary at the Police Federation Conference
- More MS v UK cases
- Interesting Crown Court appearances
- Taser Statistics
- MSc in Mental Health and Law

THE ADEBOWALE REPORT

The most important event of the month in policing and mental health has been the publication of the Adebowale Report. Although specifically about issues which arise from the handling of fifty-five cases in the Metropolitan Police area, the report has rightly been stated to be a report of national significance. The report doesn't pull any punches: it led to national newspaper articles which talked of "police failings" leading to avoidable deaths.

Thankfully, the balance of the report when you read it cover to cover, recognises the role that health and social care organisations have to play in both preventing the escalation of some crisis events and in supporting the police when they intervene in high risk situations. Of all things in the report, I was particularly keen to see mention being made of the ambulance service – their role in reacting to mental health emergencies irrespective of whether the police were already present; and in terms of dedicating resources to the issue of mental health, with pathways into primary and secondary care. I took a view that in the case of Colin HOLT who died after being re-detained under the MHA by Kent Police, that involvement of an ambulance would have contributed greatly to a better response and as it is a requirement of the MHA CoP to transport detained patients by ambulance vehicle, one should have been involved at an early stage.

The Metropolitan Police are implored in this report to introduce a range of mandatory training – I was delighted to take a phone call from a senior Met officer on the day the Report was published, thanking me for work in support of them and inviting me to contribute to the development of that training. I look forward to that enormously.

Read my full response to Lord Adebowale's report.

HOME SECRETARY AT THE POLICE FEDERATION CONFERENCE

The Home Secretary committed more of her annual speech at the Police Federation Conference to mental health issues than ever before. In recognition of what a priority it is for the service and for her as Home Secretary, she committed to "a drive" to stop police cells being used as a place of safety. In her speech, she managed to provoke some disquiet amongst our colleagues from the ambulance service when she referred to them as "Ambulance Drivers". My post about the use of that term is now the 4th most read post I've ever written and my blog dashboard suggests it was being widely read around the ambulance service! Given what Lord Adebowale said about the importance of the ambulance services' support for police interventions on mental health, it is important that we properly understand what paramedics and emergency technicians bring to the party.

The Home Secretary also made mention of rolling out nationally a scheme whereby mental health nurses accompany police officers. This is being done in certain areas of the country already, like Leicestershire. I don't necessarily object to that approach, but I have offered some views about "Street Triage" that I think are worth bearing in mind to those who are thinking of committing money and resources to such schemes. What problem, *precisely*, are we trying to solve by sending mental health nurses

to incidents and is it the most effective way of solving that problem? All views welcome – so post comments if you have any.

MS v UK

Do you remember the case of MS v UK? It was a human rights case which led to the UK government being fined for breaching Article 3 – the right not to suffer inhumane and degrading treatment. You may further remember, that one purpose of court judgements is to interpret the law in such a way as to define the standards expected.

It is therefore with regret that I recall a case this week in my own force area where a lady with a considerable mental health history had been detained by the police under s136 MHA. Because the NHS place of safety was unable / unwilling to accept the patient's detention, she ended up removed to the cells. She was obviously in a floridly psychotic and acute condition. By the time she had been removed from the police cells after 50hrs of detention, I was shouting "MS v UK" very loudly in the custody officer's ear in order to give him the words to press NHS buttons. It seemed a shame that onward removal from a police cell only occured when the police start saying legal things, implying challenge and sanctions and not because it was recognised that when you get to a point where you are naked in a police cell and drawing on the walls of the cell with your own bodily fluids, it's all starting to look a bit "MS v UK shaped".

In this incident, the lady concerned was acutely unwell – over the course of fifty hours in custody, she would not eat or drink; she would not consent to medication that was offered to her; she declined to allow police custody health staff to ensure her ongoing wellbeing by taking her medical obs. So concerned were we for her welfare that at one stage we called an ambulance to see whether our colleagues in green could persuade her to be examined. This was all because, the removal of her to the police station had not occured after good physical examination of her by paramedic or A&E colleagues. The paramedics who came to police custody were outstanding and after lots of patient negotiation over some period, managed to get her to consent to basics obs checks to confirm her basic health remained in order. I wrote to their boss praising their patient, persuasive skills.

Mental health trusts and NHS Commissioners need to recognise that case law from the courtss defines standards that are subsequently expected and to which vulnerable people are entitled. This needs to be reflected in our operating protocols and this incident got me thinking: what are MH trusts business continuity plans for situations where their s136 PoS is out of commission? Business continuity planning being a another legal requirement. I know what happens in my force if our cell block shuts down,

as it did last year for a major electrical fault. What happens when a 136 suite has to shut – bearing in mind paragraph 10.22 of the Code of Practice?

CROWN COURT APPEARANCES

You may have noticed: in the last few months two defendants who were arrested for murder, sectioned under the MHA and subsequently charged with murder have appeared directly at the Crown Court, bypassing the Magistrates' Court entirely. Why is this? It comes back to powers of remand under the Act – Magistrates can only exercise powers of remand after a person is convicted before them or found responsible for the incident. When a defendant first appears before them, they can either remand the defendant to prison or bail them – they cannot authorise ongoing detention in hospital.

The defendants who have been charged by West Midlands Police with the separate murders of Christina EDKINS and Amarjit Singh BAI were both arrested and sectioned because they were unfit to interview. I wrote about why this is done in a post after the first of these terrible events. It shows how, if mental health services and criminal justice agencies think creatively and work together, the twin-track system and MH / CJ can work together to ensure both safety and security in the name of achieving justice, as well as patient assessment, treatment and crucially, informative psychiatric reports which will be produced for both trials later in the year.

TASER STATISTICS

There was an interesting article in the Independent this month about a Freedom of Information application made to all police forces about the use of taser on mental health patients. The piece is headlined to suggest it looked at taser use on psychiatric wards but the article itself talks more widely about detention and conveyance, which are separate matters – so we need to bear this lack of clarity in mind along with the fact that not all forces responded to the application for information.

It is reported that 52 uses occured over a three-year period and we then read certain objections which we have heard before about the usage in the context of mental illness. I have replied to those objections before and since writing about it have had more direct operational experience of taser being used under my authority. I'm not sure that anything in this article or arising from recent incidents convinces me to change my view that a) we cannot hope to resolve all incidents to which the police are drawn without any of them involving the use of force; and b) taser cannot be ruled out, because it will occasionally, albeit rarely, be safer than the alternatives.

What we need to have, is awareness of the risks involved in this approach and an ability, often quickly, to weigh them against the risks involved in –

1. **Doing nothing** << bearing in mind the criticism that we know will follow if the police are perceived to have done too little where subsequent untoward events occur;

2. **Use manual restraint** << with all the recently-debated risks around positional asphyxia, etc.; and the risks to officers from trying this where dealing people who are armed with weapons;

3. **Use police batons** << this does mean hitting people with metal poles;

4. **Use of CS spray** << which often does not work on mental health patients and cannot be used in confined spaces;

5. **Use of firearms** << the risks of which speak for themselves.

You may also want to watch and read about the Buckingham Palace taser incident. The man arrested in this incident was yesterday pleaded guilty to two charges of possession of knives in a public place and sentenced amongst other things to a mental health treatment requirement. Another charge of affray was dropped at court.

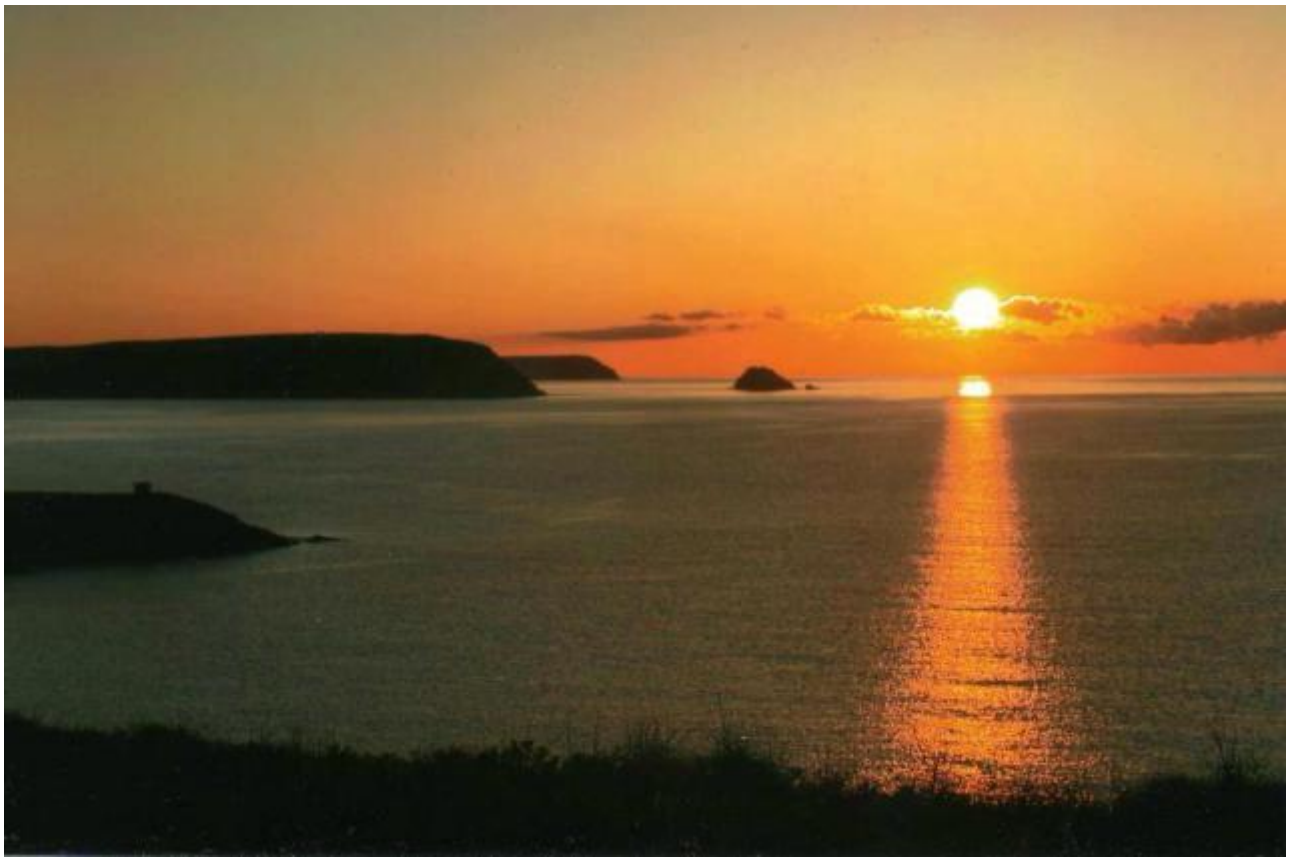
MSc IN MENTAL HEALTH AND LAW

I sometimes think I could have been a perpetual student! … I admit I'd love to do a PhD one day and I keep spotting MSc courses that I would have loved to do. I'm very conscious that I've got absolutely no qualifications whatsoever in this chosen area of interest and I keep looking about for some kind of course that I could do, to claim some legitimacy. I recently saw an MSc in Mental Health and Law, which will be available for the first time in September this year at Queen Mary's, University of London. This includes part-time and distance learning options, which may be more suited to some.

Having made some enquiries with the course developers, I end finding myself invited to contribute a couple of lectures to the course(!) and I'm currently enjoying putting together some materials for the next academic

year. So it occurs to me, that it may be my "qualifications" are the operational experiences as a police officer of fifteen years and that of lecturing on two post-graduate MSc courses at Russell Group universities?! That will have to do! Interesting to note however, that the Adebowale Report recommends that Mental Health Liaison Officers should benefit from continuing professional development, so maybe there is scope for a qualification in policing and mental health? Any university providers who think they'd like to develop a distance learning based qualification?! – please get in touch if you would, as I'd love to be involved and think there could be a market for it in the future.

Finally, by the time you're reading this post, I'll be waking up to this in my favourite place in the world! Much needed R&R and a two week break from blogging –



JUNE 2013

10th June 2013

Guardianship and Learning Disabilities

A few months ago, my first incident in fifteen years involving "Guardianship" prompted a blog for those who may also never have heard of it. As is the case with these things, I've now had several incidents in the intervening months. Amidst representations I'm hearing that the police are probably going to get more and more requests to support various forms "community coercion" in the form of guardianship orders, community treatment orders and others, I want to offer some more thoughts on Guardianship after I found my officers being asked to do things that I really wonder about.

If you didn't read my original post on guardianship or have not previously heard of it, give it a quick whirl before you read on. It's not a long post and just covers the basics of what Guardianship is and some of police powers around it. This post offers some additional thoughts about what legal authorities Guardians actually have over the patients placed in their care and what this might mean for the police if we are called.

THREE AUTHORITIES

The Guardian's rights or authorities are covered in section 8 of the Mental Health Act 1983 –

1. To require the patient to reside at a specified place;
2. To require the patient to attend at specified places at specified times for the purpose of medical treatment, occupation, education or training;
3. To require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, Approved Mental Health Professional or other person so specified.

There are further relevant comments to understand about it, from within the Code of Practice and the Reference Guide to the Mental Health Act:

Recent events for us involved a young man with learning disabilities and autism. Care being provided by a Guardian in a residential care home for young people with similar backgrounds, he was there under s7 Guardianship. Of course, such patients are not "detained" – these orders allow a level of autonomy and personal freedom. If the patient concerned wants to go to the shop, spend money or visit the pub, they may do so. Of course, it may be the case that a Guardian has certain 'rules' to the operation of that residential setting into which the patient enters as

something short of a contract, which may also govern certain behaviours. For example, it may be that the home operates a curfew for those who go out or that it has restrictions of usage of alcohol or the number / times of visitors – all of this is very reasonable and many residential settings of various kinds do this. It contributes to effectively discharging the duty of care owed.

But what if the person who wants to go and do something which a Guardian may think is unwise?

This could be for any number of reasons: maybe the person is intent on going to a place where they would be at risk of becoming involved in crime, whether as a victim or as an offender. The young man I am thinking of here, had a history of violence towards his family – what if he went out with the intent of visiting them? Should the Guardian stop this? More importantly, CAN the Guardian stop this?!

AWOL FROM GUARDIANSHIP

Well, the powers of the Guardian outlined in section 8 don't seem to suggest that they can. At what point does someone become AWOL? It is not specified. Maybe if a person packed a bag and left the place of residence, uttering words that indicated a permanence in their decision, you could almost immediately regard them as AWOL.

What if the said they were going to the shop to buy something? Probably not because guardianship does not prevent this, according to section 8. What if it was suspected without compelling evidence that the "shop" was in a town twenty-odd miles away? Does the patient need permission? Well, not according to section 7 or section 8, but local procedures may dictate otherwise.

What do those local procedures or policies mean for the exercise of police powers? Well, the situation that prompts this blog was not ambiguous: a young man who has autism and "mild" learning disabilities left his residential care home by indicating he was going to visit another town. Staff knew he was unhappy about living with them and that he did not want to live where he'd been placed. Staff were reporting him to the police as being AWOL, even thought his absence was minutes old and claiming that the police were under a "duty to return him". They were also claiming that they were not entitled to return him. << *This is another example of the "policy as law" fallacy*: the presentation of an organisational policy as being the law of the land, when in fact the opposite is true:

If there actually *is* a legal power to return from him on the basis of being AWOL, then section 18(4) MHA allows it to be exercised by "any officer on

the staff of a local social services authority, by any constable, or by any person authorised in writing by the guardian", which presumably will and which certainly *can* include staff employed in a care home where people subject to guardianship reside? The bigger question was, "does this power exist now?", minutes after he has left the home?

It's potentially unclear: of course, he's expressed views that he doesn't like living where he is and wishes to be elsewhere, but there are no legal conditions which can prevent him going out or getting on a bus. Whether he was in fact AWOL seems uncertain – he is not detained to the place of guardianship, the Codes and Reference guide make it clear that liberty is nowhere near as restricted as a patient in an inpatient ward, under s2 or s3.

FAILURE DEMAND

For whatever reason and not a matter for the police: this young man's placement had broken down. Over a succession of weeks, there was damage caused to the care home, assaults on staff and repeated, deliberate attempts to access the nearby motorway network to promote arrest. All the young lad would say on arrest is, "You going to get me somewhere else to live? Can I go home, I don't like it there." It was widely regarded that his "offending behaviour" was deliberate action to promote a police response because he hoped the police would pull levers the social care system could not or would not pull.

Of course, by the time staff are being assaulted and the hard-shoulder of Europe's busiest motorway is being wandered on, police hands were fairly forced, especially because various attempts to respond to such offences without arrest and by working with social services were not bringing about any change – he was pulled off the motorway twice before he was finally arrested on the third occasion, but imagine if by the third attempt he'd been killed, hit by an HGV at 70mph?

The fear had to be: someone is going to get seriously hurt unless "something different" happens.

SOMETHING DIFFERENT

So what can you do? Well, you can either seek attempts by social services to look at the failing placement in the context of events and come up with a new approach but returning him to the care home and chatting with managers was getting us nowhere. You could prosecute in the criminal courts for offences committed in the hope that the impact of the justice system will bring about various changes, either by motivating a change in behaviour or by the imposition of court-imposed measures which compel

change. This could be a bail conditions, a hospital order or other kinds of measures.

This gets you straight back into the "public interest" test – do we really want to see a young man with a host of challenges in his life, facing prosecution in a criminal court when really, he's trying to get a more satisfactory placement and doesn't understand the economic and other practical realities behind why he can't? … I certainly don't – especially when it was obvious that he was attempting to motivate change in a system that was failing to deliver what he needs and which was moving at a slow pace.

In one incident on a Thursday, I remember being quite relieved to hear that an "urgent meeting" was being arranged for all of this … "for Tuesday of next week". It reminded me that "urgent" in policing and social care can mean *very* different things. Urgent to the police means "within minutes" … "within hours", at most.

By the fourth phone call in 24hrs about ongoing offending and risks to the lad himself, after having had several calls the week before, we had become duty bound to prevent him wandering on the motorway so he didn't get killed because everytime he tried to provoke arrest, he took greater and greater risks with his and other people's personal safety.

But this is what you can't do: pretend that Guardianship affords you powers that simply don't exist and keep ringing the police to return people for being AWOL who are simply not AWOL at all. And what you can't do in police custody after arrest: is to promise to return the lad to the home, still subject only to s7 guardianship, and change the door code for exit so he can't leave. Because then you've created a *de facto* detention which breaches various laws.

11th June 2013

A CTO or s17 Leave? –

Before the introduction of Community Treatment Orders in the 2007 Mental Health Act, the way that mental health professionals often allowed patients to leave hosptial if they felt that full discharge in the earliest stages of recovery was too big a step, was to grant ever-longer periods of section 17 leave. We know that when first used, leave is often granted for just a couple of hours, possibly subject to conditions including a member of staff supervising someone. Last Christmas we were called to a patient on supervised s17 leave who had been given three hours to visit family on Christmas Eve and was understandably reluctant to have to return from and miss a happy family occasion.

But as recovery progresses, leave could become longer and eventually unsupervised and with fewer restrictions to it. It was not uncommon for leave to eventually last for weeks at a time and for it to be re-granted after the patient's return and a meeting with their care team, during which administration of medication could take place. This was a particularly useful way of ensuring that if patients decided after a short-while to stop their medication or not to turn up for what otherwise may have been an outpatient appointment, they could be returned by the police after failing to show up on the expiration of their leave and medication then given under Part IV of the Mental Health Act.

Community Treatment Orders were intended to be another way of achieving the same thing. Instead of someone remaining a "section 3 patient on leave", they would become a CTO patient and this order may carry conditions in addition to compliance with medication. It could include residence, curfew, drug-testing, etc.; and conditions could be amended or removed over time. Should clinicians be unhappy with a patient's lack of recovery, a recall notice could be served and the patient then must return to hospital or become AWOL and liable to return by force. When recalled, they could be compelled to remain in hospital for 72hrs during which time the CTO could be revoked entirely if this were deemed necessary.

CTO OR EXTENDED s17 LEAVE?

Community Treatment Order legislation did not ban the use of extended s17 leave – so which do you do? Well, leave under s17 which is "extended leave" – greater than seven consecutive days – should not be granted unless the responsible clinician has first considered a CTO. One obvious point from my perspective about the decision, is that CTOs are bureaucratic to operate when recalls are required. If someone fails to show up at 10am when their s17 leave expires, they are now AWOL and can be re-detained. If the patient had a condition to attend a monthly outpatient clinic at 10am and they fail to show up, the recall process must be instigated.

I am aware of a recent case where a patient had for months on end been refusing medication in the community and each time, he'd be recalled from his CTO, medicated by force in hospital and then discharged on his CTO. During the recall process, police officers were prone to misunderstanding the law around these situation because we have had no training on CTOs since their introduction. (I have written a "Quick Guide to recalls and revocations" to get you through it.) I once attended a meeting with a mental health team and a patient's family to discuss a police mishandling of a CTO recall and was told to give assurances that such misunderstandings will "never happen again". I proceeded to outline CTO and other recall cases where mental health professionals have got the law wrong, effectively asking the police to assault and falsely imprison people and I also noticed that direct legal questions I asked of the professionals present went unanswered, thus proving that even professionals with extensive training in this law get it wrong. << *We need far, Far, FAR more training on mental health law – all of us!*

IT'S GOOD TO TALK

The meeting led to an agreement that I would email all of my police area about this patient and explain the CTO recall process. I cut-and-paste the "Quick Guide" into an email and sent it over 400 officers, copied to the mental health team. Hopefully, next month, we will have a consistent approach to it all! …

Obviously, what I didn't countenance was that the responsible clinician would ditch the CTO plan in favour of the old-fashioned "extended leave plan". I also didn't countenance that they would fail to tell me that the management plan had changed for this patient. So I recently attended to work to find that patient's name on an incident log, with the police having asked all the relevant questions about recall notices and so on, only to be

in some difficulty communicating with the NHS and the preceding duty inspector telling me, he thought they were pulling his chain. I spoke to them. After some closed questioning of the type normally reserved for interviewing suspects, I managed to work out that they had resorted to old-fashioned extended leave and hadn't told us – **no wonder we were confused!**

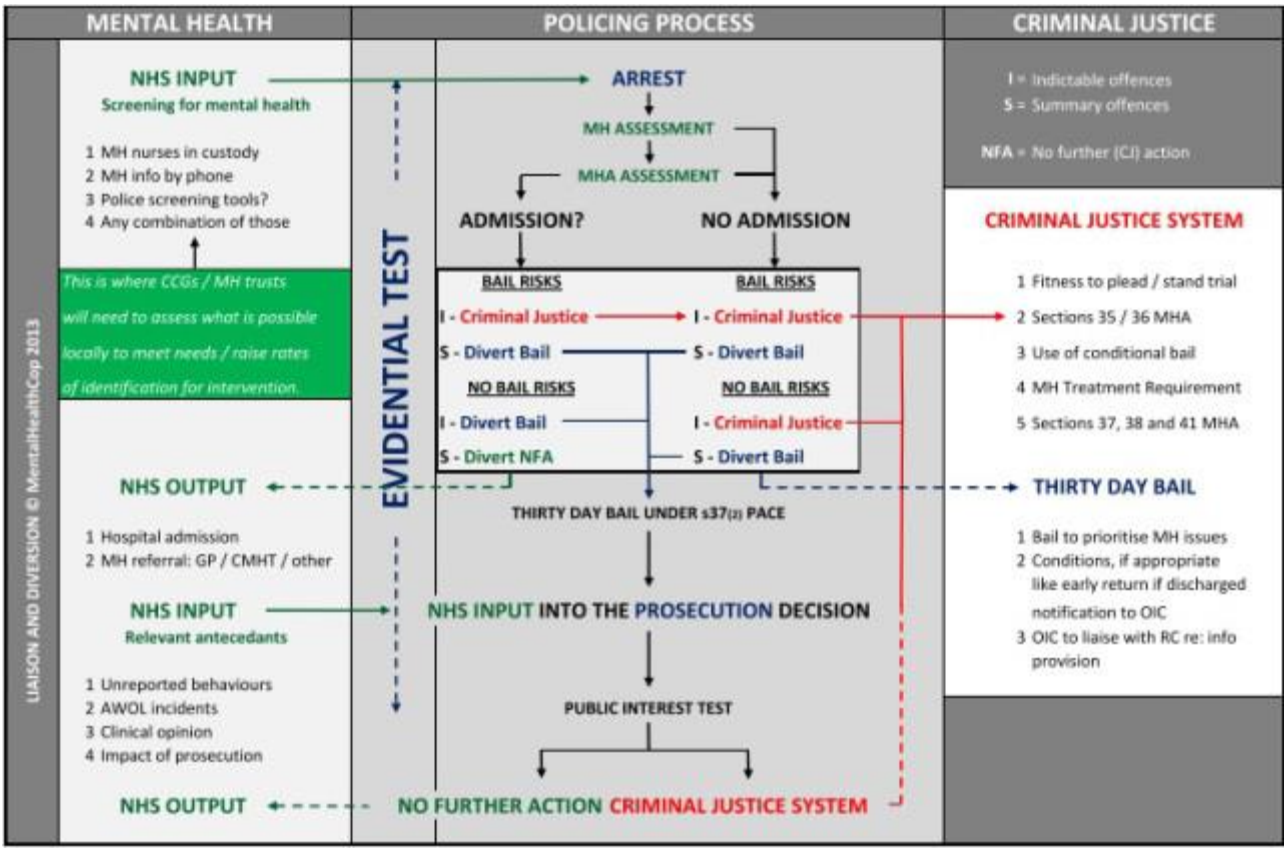
Police officers need to be sure that they have a lawful basis for their coercion of other human beings: not least because when it goes awry, their world can fall apart so they need to be confident they were acting properly in the first place. We need and are entitled to clarity about the laws governing a patient so we can make our own assessment of the legality of asking officers to coerce vulnerable people and so the officers may be defended if there is criticism of their legal action or inaction.

More training all round! – *jointly*, if at all possible.

12th June 2013

Liaison and Diversion –

I've been trying to think how to draw a one-page diagram of how I think Liaison and Diversion should work for several years! Bearing in mind that nationally, we don't have an agreed model on this and my previous views that some models we have seen miss the (legal) point however good they may be on health. Given that NHS areas will vary in the nature and amount of investment they can make in terms of either money or staff, etc.; and given that police decision-making has to occur regardless of how good / bad that investment is, I came up with this which I've shared with various colleagues and with the CEO of Revolving Doors, Dominic WILLIAMSON is working in this field –



** ***Explanatory note*** *– indicatable offences are the more serious ones, triable in the Crown Court. Summary offences are comparatively minor, triable in the Magistrates' Courts.*

- Liaison & Diversion – my thoughts in 2013, PDF version.

I've written before that in practical terms, in most areas, the single factor which triggers whether or not someone arrested for a criminal offence and suspected to suffer from a mental illness, is prosecuted into the justice system or diverted from it to the health system, is whether or not they are 'sectionable' under the Mental Health Act. In other words, whether they require hospital admission in connection with their mental health problem.

The issue that arises from this *de facto* approach, is that the Mental Health Act is designed to operate with someone mentally ill patients being prosecuted so that the criminal courts can balance the important issues of their individual right to treatment and care with any prevailing public protection issues. In other words, someone being sectioned under section 2 or 3 MHA may not be sufficient to ensure public protection, if that person has, for example, killed or seriously injured someone. Equally, prosecuting someone for stealing ten pounds worth of food after living rough and in crisis for several days would probably not be in the public interest if they pose no risk to anyone and are in need of admission for acute mental health problems.

We need a balanced approach – not least because, in reality, a lot of cases are in between those extremes and are set against complex personal and social backgrounds. The above hypotheticals are easy to conceive – reality is endless shades of grey and decisions needed may be about taking the least worst option available, rather than an ideal solution.

But to get there, we will need input to and output from the health system and we need the involvement in the criminal justice system for a few. How do we get the balance?

Well I submit a model in which there are broadly four circumstances we consider: serious or non-serious offending with either acute or non-acute illness. Against those four combinations, we will either be dealing with a person who, in terms of their **criminal** and **mental health antecedents** either poses a "bail risk" or does not. So you have eight situations – see this diagram.

USE OF POLICE BAIL CRITERIA

My contention is, that the severity of the crime alleged and the gravity of someone's illness should determine a way forward, with their treatment and care for their illness taking the immediate priority, unless that would compromise public safety. This seems to balance off the considerations involved. "Police bail criteria" from s38(1) Police and Criminal Evidence Act 1984 provides a useful framework to determine whether pausing the

criminal justice process would be proportionate and wise – I suggest it most usually would be wise to do so where a suspect potentially has complex needs. The criteria are –

1. His name or address cannot be ascertained or the custody officer has reasonable grounds for doubting whether a name or address furnished by him as his name or address is his real name or address;

2. The custody officer has reasonable grounds for believing that the person arrested will fail to appear in court to answer to bail;

3. In the case of a person arrested for an imprisonable offence, the custody officer has reasonable grounds for believing that the detention of the person arrested is necessary to prevent him from committing an offence;

4. In a case where a sample may be taken from the person under section 63B below, the custody officer has reasonable grounds for believing that the detention of the person is necessary to enable the sample to be taken from him;

5. In the case of a person arrested for an offence which is not an imprisonable offence, the custody officer has reasonable grounds for believing that the detention of the person arrested is necessary to prevent him from causing physical injury to any other person or from causing loss of or damage to property;

6. The custody officer has reasonable grounds for believing that the detention of the person arrested is necessary to prevent him from interfering with the administration of justice or with the investigation of offences or of a particular offence; or

7. The custody officer has reasonable grounds for believing that the detention of the person arrested is necessary for his own protection.

So let's try to get a process where we ask health to do two things to support all this police decision-making:

- Have input into the process which assist the police in identifying more people in custody who may have mental health disorder or history.

- Have input into the decisions which will be taken in slow time, through the use of police bail, about whether it is in the public interest to charge someone with an offence if they have a history of mental health disorders. *<< This is provision of information and opinion; not taking the decision which would always remain a CJ prerogative for police / CPS.*

How areas achieve these two things, is the challenge of Liaison and Diversion, but it could be as simple as a properly established phone-call mechanism between the police and mental health –

CUSTODY SCENARIO

When a person is booked into custody, if there are no mental health nurses based in custody to screen everyone – we know areas struggle to achieve this because of cost – why not ask the custody staff to ring a Mental Health Trust professional and give the name, date of birth and address of the suspect along with confirmation of whether the police / FME have reason to suspect a mental health disorder?

All we'd need back from the NHS in the phone call, is confirmation of whether they are now going to respond to custody and see the person. This would obviously occur if the police / FME had reason to have concern AND / OR if the Mental Health Trust knew that the person is or has been a mental health patient and they could vary by time of day who might respond: CrisisTeam for those who are not known and those arrested out-of-hours; patients CMHT / AOT in office hours? Obviously, those for whom there are no concerns and who have no mental health history would not need to be seen and this makes it a cheap and easy way of doing something, even in areas with few resources. And! – it has nothing to do with breaching anyone's confidentiality because the details of those who were not known to the MH trust would not be retained by them unless they subsequently became a patient. The police would initially be told little, until the initial screening had taken place and the outcome needed to feature, if relevant, in the police's decision-making.

The reasons this is important, is because when you let the police try to identify prevalence amongst those arrested, you get a number between 10-15%. In some areas, as many as 50% of those arrested either are known, were known or need to be known to the mental health trust.

OFFENDER PANELS

So, the arrested person had a pause placed on their investigation in order for a multi-disciplinary meeting to occur to share information and reach a more balanced view about the prosecution decision. We need input into this from health and areas just need to work out where this comes from. But are we saying that in the fifty-eight mental health trusts in England, they can't identify one or two staff to sit down with the police once a month for an hour or so and discuss about six to ten people? My research indicates in a busy custody area, that is roughly the demand that would arise from this model.

The more I think about Liaison & Diversion, the more I think you could do good things, for relatively little, even if you keep working out where you can get money from to do great, even better things. And the benefit for the police, is that the model I've outlined above, can be operated regardless of how much or how little input the NHS are able to give in your area.

13th June 2013

Criminal Offences under the Mental Health Act –

Obviously, we think principally of the Mental Health Act in terms of it providing a legal framework for healthcare. We don't immediately think about people committing offences contrary to the Mental Health Act. There are only a few, all listed towards the end of the Act but they have come in useful for me on more than a few occasions, when trying to bring policing situations to a safe or swift conclusion.

As I have just had cause to direct that some threats of potential investigation and arrest be made for possible offences under the Mental Health Act, it suddenly occurred to me that I have not really covered these things in a single blog post.

OFFENCES UNDER THE MENTAL HEALTH ACT

There are four specific offences under the Mental Health Act and I've hyperlinked each of them below, so you can read the full wording of each, if you wish. Some relate to offences which could be committed by professionals, for the protection of patients and the ethical administration of the Mental Health Act

- Section 126 – **the offences of forgery**: this means forging documents which are used to administer the Act itself. So things like 'section' papers – applications or medical recommendations – where signatures are forged. It is an offence to knowingly possess them as well as to forge them yourself. Anyone who deliberately writes false information on them with the intention of deceiving others, is guilty, also.

- Section 127 – **the offence of wilful neglect of patients**: this means deliberate neglect of patient's welfare and dignity. This offence was used to prosecute staff in the Winterbourne View scandal and it covers the full spectrum of neglect.

- Section 128 – **the offence of assisting someone to go AWOL** or of **harbouring them whilst AWOL**: this would cover helping someone to leave hospital when they are detained under the MHA and it would include allowing them to stay with you or supplying with assistance of various kinds, if you know they are AWOL under the Act. Doing something to prevent the person be re-detained and returned to hospital, is also an offence.

- Section 129 – **the offence of obstruction**: this covers the active obstruction of those authorised to act by the Mental Health Act for hte purpose of functions under the Act. So it will mainly cover AMHPs and DRs do various inspections, interviews or assessments in relation to the decisions they must take. It is not only an offence to obstruct them in their work, but also to fail to withdraw from a situation when properly instructed.

By virtue of these things being offences, police officers and others have **a legal right to use force** to prevent them occurring and the police may arrest people who commit such offences, subject to the normal statutory arrest test. Police officers would also have **a right to seize documents** which they reasonably believe to be forged, as evidence of an offence. In the context of section 129, the police could forcibly prevent anyone from obstructing an AMHP who is engaged in statutory functions of inspecting a premises, interviewing or assessing someone under the Act, whether under s136 of for potential admission under Part II of the Act.

FRONTLINE KNOWLEDGE

I recently asked that family members of a missing mental health patient be warned about harbouring and assisting. Although not quite at the stage where evidence existed to justify arrest, the police had formed a view during a missing patient enquiry that the man's family were less than cooperative and may be supplying him with money to stay in hotels and evade re-detention. To encourage them not to do so, warnings were given to his sister, brother and father. It is quite possible that someone could be prosecuted for these offences and in court could receive a fairly substantial fine or a period of imprisonment up to a maximum of two years.

I suggest frontline 999 response officers or neighbourhood policing officers who find themselves supporting MHA assessments and searching for AWOL patients need to know in general terms about sections 127, 128 and 129. Not least, we need to take seriously reports of neglect about detained patients made by patients themselves or by their families; we also need to know when families / carers may be venturing into assisting / harbouring

AWOL patients and when we can use s129 to justify the removal or arrest of obstructive people during s136 or MHA assessments.

Although a different Act of Parliament, it is also worth knowing about the offence under s44 of the Mental Capacity Act 2005 – the offence of wilful neglect of someone who lacks capacity. Again, this was used to prosecute some professionals in the Winterbourne View investigation, in Bristol.

All of this adds to a police officer's ability to safely control those mental health events into which we are drawn, or potentially bring them to swifter, safer conclusions.

16th June 2013

Fit To Be Charged –

In a lot of police forces, the form for medical assessment of someone under arrest contains three boxes to be ticked or crossed, as appropriate. It asks the doctor or nurse whether someone is –

- Fit to be detained
- Fit to be questioned
- Fit to be charged

We instinctively understand the importance of these assessments and the first two are legal requirements arising from Code C to the Codes of Practice to the Police and Criminal Evidence Act 1984, known as PACE.

But where does it say in law that someone must be "fit" in order to be charged? – actually, it doesn't. It's not in PACE itself, it's not the Codes of Practice to PACE. I've always wondered whether it arises out of the requirement to ensure that suspects in custody have had sufficient period to allow the effects of alcohol to wear off; and because we've asked that question about "fit to be charged" for alcohol, it has evolved in our thinking that this is a legal requirement? Where someone is arrested for drink-driving and they are found to be three times over the legal limit, they get around 12hrs B&B from Her Majesty before being prosecuted. This also happens for those who are drunk and disorderly or drunk and incapable.

WHY IS MENTAL HEALTH DIFFERENT?

When someone is arrested for a serious offence and the evidence exists to suggest they should be prosecuted, it may be necessary to do so even though they are acutely unwell. I find this completely counter-intuitive but bear with me on it.

I've written before about why there are particular benefits to a process where patients in need of admission are sectioned from police custody so that their health and wellbeing are prioritised and criminal proceedings can be instigated later, once someone's recovery is established. This also has the attraction of improving the potential that someone who was arrested

whilst very unwell will be fit to plead and fit to stand trial once they actually appear at court.

But this is not the only way to proceed – occasionally, it is *just not possible* to do things this way and it remains legal to initiate criminal proceedings even though a suspect may be "suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital." It has happened many times before, including in the case of Christopher HAUGHTON in London in 2011.

ISN'T IT INHUMANE?

I understand why such a view would be taken and I would agree that if often would be. When we remember that prosecution means appearance in the Magistrates' Court and that magistrates have no power under the Mental Health Act to remand a person to hospital for assessment / treatment after their first appearance at court, it can risk the possibility that a Magistrate would end up remanding someone to prison. Although reception prisons have mental health inreach teams, there are legal limits to the kinds of medical treatment which can be given and it is far from ideal.

But nothing prevents the Magistrates bailing the patient from court to re-appear at the Crown Court and stipulating a condition to bail that the person reside at the hospital which the assessing AMHP will have arranged for the admission previously indicated as necessary. When an AMHP has two medical recommendations for admission following MHA assessment, they last for fourteen days and nothing prevents the (senior) investigating officer informing the prosecutor something along the following lines:

"Whilst in police custody, the patient was assessed under the Mental Health Act and it was suggested that the nature and degree of the defendant's mental disorder made it appropriate for him to be in hospital for treatment under section [2 or 3]. However, because there was sufficient evidence to charge the defendant with serious offences and in order to balance his right to treatment and care with issues of public protection and the administration of justice, he has been charged and brought before the court. It is recommended that you advise the court to consider granting bail with strict conditions that the defendant remain at [name of mental health unit], pending his appearance in the Crown Court and admission along these lines has been prepared for by mental health services, if bail is granted. Following subsequent appearance in the Crown Court, the judge may make such direction under Part III MHA, as they see fit for the proper handling of the case ahead of trial."

SO WHEN WOULD YOU DO IT?

- **What about the situation in which there is no bed available within the NHS?** – we know that bed numbers have been cut, radically so in some areas of the UK. Although it's not a very fair argument to say "You're being prosecuted because of NHS bed shortages", there are some real situations in which the police decision is "prosecute or release from custody." We're back to the least worst option: clearly, if we are talking about vulnerable people who are alleged to have committed serious offences, the public interest may indicate prosecution in those circumstances because you can't have someone sitting in custody for days whilst a bed is found.

- **What about the situation in which the only beds available in the NHS are in non-secure units from which the suspect has previous absented themselves with ease?** – I can imagine the furor which would follow someone charged with a serious offence who had absented themselves from somewhere that was inadequately placed to ensure ongoing detention; especially if there was a subsequent serious incident of any description. I often check the AWOL histories of people who are arrested for offences when it comes to the "diversion" decision. Why would I divert someone from justice who has a history of not engaging with the very health structures to which they would be diverted?

- **What about the situation in which the patient's forensic mental health history indicates to the assessing mental health professionals that prosecution and the use of Part III of the MHA would be most appropriately** – we should remember, that when a patient is detained in hospital under Part II of the Act (sections 2 or 3, most usually), there is no automatic requirement on the responsible clinician to prepare psychiatric reports for the court process and to get into assessment of issues like fitness to plead or stand trial.

There have been recent examples I have known where police custody has reached a point where someone's MHA admission is indicated at a point where the (senior) investigating officer has obtained sufficient evidence to charge and CPS authority to do so. In those cases where someone being "sectioned" has taken the priority, it has been because of the availability of a medium-secure bed and because opting for admission has allowed for arrangements to be made that the person will be charged to directly appear in the Crown Court, thus allowing the judge to exercise powers under s35 or s36, as appropriate. If these arrangements are not available, it may

necessitate having to take a difficult decision which initially appears to disregard someone's health. It is a regretable aspect of the criminal justice system, that mere exposure to it can cause stress and aggravation to know conditions. This is true for everyone, not just defendants with known mental health histories.

WHAT ARE THE CUSTODY OFFICER'S OPTIONS?

So sergeants in custody, must take decisions based upon a combination of views from the assessing MH professionals and the (senior) investigating officer:

- **Bail the suspect s37(2) PACE and admission under Part II takes effect** – the (senior) investigating officer can either then manage bail for a necessary period until the suspect can return to custody and be charged; OR can arrange to postal charge the suspect whilst they remain in hospital.

- **Charge the suspect to court and bail them after charge, allowing admission under Part II to take effect** – this could be accompanied by the use of conditions, negotiated with the MH professionals so that no circumstances beyond the control of the defendant lead to them breaching conditions without blame.

- **Charge the suspect to court and deny bail after charge for early appearance at court** – whilst indicating to the Magistrates that admission was indicated and suggesting they consider bailing the defendant to hospital for appearance at the Crown Court.

One thing beyond the control of the police in the last option is the possibility that the Magistrates' Court may remand the defendant to prison – it has been known. Were they to do so, it would then be open to the Prison Service to apply for the defendant's transfer to hospital under s48 MHA, based upon the original mental health assessment in custody. Again, far from ideal.

I have written about a Liaison and Diversion model for police decision-making that brings about these considerations – all of this is just food for thought.

26th June 2013

June Newsletter –

I'm just going to focus on two reports this month which are worthy of note for different reasons but which both relate to the management of risks and the use of restraint:

The first comes from Mind following an investigation into the nature and extent of restraint in mental health hospitals; the second is a joint inspection from Her Majesty's Inspectorates of Constabulary and Prisons along with the Care Quality Commission and the Health Inspectorate for Wales on the use of police cells as a place of safety. These two reports are two sides of a coin and should be considered together.

Before I start on all that, don't forget that BBC3's season of coverage on mental health started on Monday night. You should watch "Don't Call Me Crazy" on the BBC's iPlayer – it is about patients in an adolescent mental health unit in Manchester and I thought it was really thought-provoking for a range of reasons under consideration in this newsletter. Issues around restraint are played out on this programme. Further episodes in coming weeks.

RESTRAINT

It is fifteen years since the death of Rocky BENNETT. He died in a Norwich mental health unit in 1998 after staff attempted to move him against his wishes following him being racially abused by another patient. The controversy surrounding his death led to an independent inquiry and the subsequent report was something of a "Stephen LAWRENCE" report for the NHS, because alongside the inquiry's substantive investigation into the events which led to a restraint-death, there was an under-current of institutional racism. Why was he the one moved, not the racist aggressor? When the report into his death was published it made a variety of recommendations not all of which have been implemented. Fifteen years on, Mind decided to investigate the extent of it all through Freedom of Information requests.

Obviously, Mind have reported on the answers they were given by mental health trusts. I always start reading these things with a large bucket of

salt by my side because I have seen enough poor recording of "stuff" in health and policing to be skeptical about data. That said, what was reported back was interesting enough:

Note on the numbers that follow: there are 54 mental health trusts in England – three of them provided no answer to the investigation at all. Because trusts record different things in different ways, they could not all answer every question posed to them.

- **39,883 incidents of restraint in 47 mental health trusts** – this ranged from 38 restraints in one trust to 3,346 in another.
- **3,439 incidents of face-down restraint in 27 trusts** – 4 mental health trusts reported no use of face-down restraint; another recorded 923 which is a quarter of the total.
- **4,300 incidents of restraint for medication in 31 trusts** – 1 trust reported 1 incident and another reported 592.
- **361 incidents of the police being involved in restraint in 27 trusts** – 100 of these were in just one trust and only three reported never using the police.

Interesting, isn't it?! I must say: I don't believe the figure about the police at all. When you look at particular areas, it amounts to such low prevalence compare to stories you'll hear in a police briefing room.

This is important stuff, because it speaks of organisational culture. It is also important to policing because we know that there are ongoing inquiries and legal proceedings following incidents where officers were called into mental health hospitals because of violence-related issues which led to restraint. I agree with this report, that we need national guidelines and expectations.

I would end by saying that I would have loved all of this data to be cross-referenced against two other pieces of information –

1. **Staffing levels** – were the wards who engaged in this restraint up to the required level in terms of staff numbers.
2. **Staff training** – were those staff on duty sufficiently trained in control and restraint to undertake this.

I routinely ask these questions when my team are called to attend wards in case the background is something I need to report or the context is something which influences my handling of any request made of the police. I am yet to get a "Yes" to either question.

HMIC / CQC REPORT

I didn't blog on this report when it came out – having read it, I couldn't think of much to say that I haven't already written about on this blog. Suffice to say here, that I wasn't especially thrilled with it. I'm not sure it told us anything we didn't already know; I'm not convinced it takes us particularly forward although it does make good recommendations (the clue is in the name) about commissioning and oversight of services.

The one thing I would highlight was that the report failed to call, as the IPCC had in their 2008 report, for a complete end to the use of police cells as a place of safety. This report calls for a clearer definition of when police cells should be used "in exceptional circumstances". It focussed upon the phrase "unmanageably high risk" as indicating the situation in which it would be appropriate for the cells to be used.

I have five things to say about that, although I could say more –

- Michael POWELL
- Sean RIGG
- Olaseni LEWIS
- Kingsley BURRELL-BROWN
- James HERBERT

All examples of the police having contact with individuals who at the time were presenting in a way that would have seen them captured by the definition of "unmanageably high risk", as considered by the NHS. Bear in mind, that last week I was contacted by a senior MH nurse giving an example of professional strife they have become embroiled in because of their decision to accept a calm, compliant patient into an NHS place of safety. This nurses manager's took exception to the decision purely on the grounds of a well-known history of violence towards NHS staff.

On that occasion, because of that background of risk, police officers willingly remained at the PoS in support in case anything escalated and nothing did. Now that nurse is having professional difficulty even though nothing went wrong, no-one was hurt or even threatened and a patient was assessed in a dignified way and admitted under the Mental Health Act.

TWO SIDES OF A COIN

We need to see the two above reports as opposite sides of the same issue: the safety of patients in contact with the state. We are reading about restraint in hospitals, including the involvement of the police to move

people, administer meds and we are concerned and calling for health inspectorates or regulators to do more to reduce restraint and the 1,000 injuries that resulted from it. Then in the next breath we are seeing the reinforcement of a framework that *wants* to see patients excluded from therapeatuic environments and potentially restrained – how else can a custody sergeant stop a vulnerable person from hitting their head off a cell wall, for example?

Eventually, we are going to learn that highly resistant or aggressive behaviour **should be treated as a medical emergency** – you can't handle medical emergencies in small concrete rooms with a first-aid kit. We need to "get" the highly counter-intuitive truth that some, just some, patients who are presenting risks to themselves and to others need to be taken *into* the healthcare system, not excluded from it. We need to build our health service and police service to accommodate this and work together in time-critical ways. Lord ADEBOWALE said so in his recent report; and Coroners have said so in their inquest judgements. It will be received wisdom at some stage in the future that restraint can be clinically-attributable and how quickly this point is grasped and realised will determine how many untoward events and controversial inquiries we have between now and then.

The NICE Guidelines on Acutely Disturbed Behaviour are not mentioned within this report. I wondered why not, bearing in mind that they tell us important things about clinical responses to resistant or agitated patients?

If you want to start delivering health equality between physical and mental health care problems then understand this: if a patient at a road-traffic collision was agitated or outright aggressive because they had hit their head during the incident and had become cognitively impaired and aggressive as a result, you would NOT see them excluded to police cells. You do not get taken to police cells for any other medical reason than mental health disorders and for as long as you do, it will be impossible to argue that we have parity. it is about discrimination, pure and simple.

Ongoing assertions that some mental health patients should be excluded from healthcare fails to learn the lessons from the above cases about clinical risks leading up to detention or arising from restraint and it puts people at risk. Any custody sergeant worth their salt would remember para 10.22 to the Code of Practice to the Mental Health Act at this stage; along with para 9.5 and Annex H to Code C of PACE in making decision in this context. We also need to remember the case of MS v UK. The patient in that case was "an unmanageably high risk" and the court ruled his detention in police custody became illegal. The likelihood of further MS v UK cases is greater now than when the case actually occured in 2004, because some areas have halved – yes, halved – the number of acute

inpatient beds against real-terms budget *increases* of 59% in the last ten years.

This report doesn't take full account of the laws and guidelines that govern us – in my personal view. I also think it a shame that South Africa and India can reach a position in the 21st century where their equivalent legal authority to s136 cannot, by law, lead to removal to a police station.

Why can't the United Kingdom do this?

28th June 2013

My Deepest Fear –

The history of disasters in policing and mental health arise from the fact that the police actually did *exactly* what the NHS explicitly sought or implicitly wanted them to do. Therefore, putting NHS staff alongside police officers, whilst it may bring very real benefits to some, will also bring an extra pressure dynamic to bear on operational officers at some critical times.

Imagine the scenario: there is a call from a desperate relative on 999. Their loved one has been living in crisis for several days and has been drinking throughout the afternoon. The triage car and other officers attends this call because there is a significant history about this patient that is known and it is in every sense a proper mental health emergency. Whilst the police officer is driving them there on "blues and twos" the police dispatcher is relaying a summary of attendances, warning markers and so on. We know that the person has previously been sectioned, that they've been AWOL whilst detained and have been detained at that location. We know that they have been resistant on arrest and that they've been drinking vodka today. Upon arrival, this man is in the street and his elderly relatives are asking for help. No amount of "tactical communication" is working – he is either too unwell, too drunk or both for either the nurse or the officer to persuade them out of the road. The triage car agree, he will have to be detained in his own interests.

Leave aside the debate which could immediately occur about whether to detain s136 or for a drunkenness-related offence, let's just agree that the person will be detained. Where do we now go?

If you look at various section 136 policies around the UK, it will say, because of alcohol and aggression and the risk history involved, the man should be taken to the cells. We can only imagine the nurse would encourage this course of action being right there at the scene and knowing that this is what the joint protocol says. After all, we can't assess the person under the Mental Health Act until the alcohol has worn off, can we? He needs to "sober up somewhere", right?

What about physical healthcare needs? – what about the possibility that the person is suffering an underlying problem that is being masked or fogged by alcohol and aggression? How do we take that into account and –

no offence to any mental health nurses anywhere in the UK – the triage car nurse would not be trained in the pre-hospital urgent care like our 999 colleagues in green. Remember, mental health nurses are (usually) not dual trained as general nurses. Would they carry with them, blood pressure cuffs, blood sugar testing equipment, thermometer, etc.? I realise that mental health nurses can / do physically examine patients, my question is "will they?" I'll be frank: mental health nurse or not, I'd probably still be calling an ambulance – chapter 11 of the MHA Code of Practice stands.

How do we get the person to wherever they will be detained? – in most of the 11 ambulance services in the United Kingdom, they wouldn't attend such a call anyway for various bureaucratic and on occasion discriminatory reasons. I'm pleased to say, the ambulance service where I work "get this" completely and would almost certainly attend, priority of unusual demands permitting. But yet again, knowing they may not feel obliged or able to attend, is no excuse for then doing the wrong thing – chapter 11 of the MHA Code of Practice stands.

You see the reason I have a deep, underlying fear of what is being suggested is not because I think it will fail to bring any benefits. I think there will be loads of benefits in terms of information sharing, s136 avoidance and I genuinely welcome that and more. Having said that, I can think of other, less resource intensive and probably cheaper ways of doing the same thing, but I do welcome it.

My deepest fear arises from the fact that the above case is **not** hypothetical: it is the *real* story of a UK death in police custody where the NHS actively *wanted* a police cell to be used for a patient who had received no pre-hospital triage and whose intoxicated, aggressive presentation led to a fast decision – a hasty one – that the *only* possible place we could remove the man to was police custody. The custody sergeant who **did not resist** that course of action by recognising the clinical threats involved was disciplined for gross misconduct.

I had some difficult writing this post, for two reasons –

- Firstly, I couldn't think which death in custody story to use for the "hypothetical" point – there were *several* candidate stories to make the same point;
- Secondly, I am really conscious that it appears to be flying in the face of the thrust of the street triage initiative.

DECISION-MAKING AMIDST UNCERTAINTY

What I know from the work I've done over the last ten years on policing and mental health, is that we must equip our police officers to make the

correct decision under pressure, which will sometimes, just occasionally, mean resisting the NHS and doing what they don't want us to do. The reason we know this is because we could list the prosecutions where officers have faced criminal charges of neglect arising from "doing as they're asked".

Various cases over just the last ten years, many of them highlighted on this blog, show that the NHS has not commissioned and integrated itself to react to the number or nature of mental health emergencies that this country generates – this is *precisely* why the CQC have just yesterday announced **a thematic inspection of emergency mental health care**. When I get back from holiday, I am going to write a blog for their attention, specific to my view on that whole business.

But for here and now, for the debate following the announcement of street triage: we have to define the problem we're trying to solve before identifying the solution. You could solve the "inappropriate s136" problem any number of ways without having to pay a nurse to stop the cop from doing the wrong thing. << This is the very raison d'être of at least one triage scheme already running – the NHS don't trust their police to get it right, so they resourcing an opportunity to stop them from getting it wrong. Why not just train them to get it right?! Is it because we still haven't defined what "right" actually means for s136? … probably. We know from reading the joint HMIC / CQC report on police cells as a place of safety and from the CQC annual reviews of the Mental Health Act that those who need to know about the police mental health interface don't actually understand it.

We all know that the volume of calls to the police could be far better managed with mental health support through information sharing and joint working. What I'm less convinced of, is that these joint working arrangements will take proper account of things that the NHS have historically been unable to brigade: the urgent, emergency reaction to unknown clinical risks, involving intoxication and aggression.

And again, we see the trap being fallen into – this stuff will not go wrong very often, but when it does go wrong it will go really, really, wrong. Bearing in mind that nurses also have very different training around the use of force and restraint, I'm also concerned that we will see again, nurses flagging concerns about the use of force even where officers are acting in a text-book fashion, according to their training. We've seen this in the Olaseni LEWIS case and others: we'll see it again until somebody defines the problem we're trying to fix and designs the solution to fix that problem.

I'm not hoping to fix the problem to which "street triage" is the answer – for that, you need to fix CrisisTeam services as a whole and it will take more than free security and a lift from the police. Street triage is "pulling

people out of the river". Eventually, as Desmond TUTU rightly said, "we have to get upstream and work out why they're falling in."

I worry that untoward events will still occur; and that in hindsight, they will appear quite predictable.

JULY 2013

15th July 2013

Male Mental Health –

There are various things going on at the moment that got me thinking about male mental health. Here are a range of different issues that have hit my radar over the last few years –

1. **We know that around 75% of suicides are men** – we also know that men are less likely to seek help when they need it. There are further, particular vulnerabilities within this: a report by the Samaritans found that middle-aged men, from lower socio-economic groups are more likely to be affected.

2. **We know that the criminal justice system can cause mental health problems** – and that those who suffer mental health disorders are over-represented within the prison system. So whatever the correlation / causation relationship: criminal justice incarceration is a discussion about male mental illness (amongst other important things).

3. **We recently saw an episode of Panorama called "Broken by Battle"**– this was previewed against the headline that more soldiers and veterans have died by suicide than following attack by the Taliban. Obviously, our Armed Forces are overwhelmingly male and we see an over-representation of veterans in the prison and criminal justice systems, linking back to issue number 2.

4. **Male Mental Health was the specific focus of the Mens' Health Week** – highlighting many of these issues and showing that male mental health is a core health issue, affecting millions of men in the UK and around the world.

5. **Across the whole lifespan, men are at greater risk from almost all major illnesses and injury** – yet often male health services and the funding of research into male health issues is often at a disadvantage. For example, the Mental Health Foundation report that 72% of people receiving treatment for depression are female. Correlate that with the figure that 75% of people dying by suicide are men.

6. **We know that unemployment in the EU rose between 2006-2010** – and it rose at **double** the average rate for people who live with mental

health disorders and at **triple** the average for men with mental health disorders.

RECENT DEVELOPMENTS

We've recently learned some more things, that cast light into the lives of young people in the area of male mental health:

Queen Mary, University of London last week published research led by Professor Jeremy COID, professor of forensic psychiatry, that the relationship between violent gang membership and the prevalence of psychiatric illness is insufficiently understood and significantly under-estimated. The report showed that 85% of (the predominantly male) gang members suffer from anti-social personality disorder, that two-thirds of gang members were alcohol dependent and one half were drug dependent. The sample of thousands of young men highlighted far higher incidence of psychosis than in equivalent populations.

There has been public discussion recently about domestic abuse. I know that recently, in some reviews of the mental health histories of offenders in domestic homicides, almost half of them have been offenders who were "open to services" prior to the incident.

WHOLE SYSTEM CULTURE

I know we know this: boys and young men are exposed to environment after environment that increases the likelihood that they will experience anxiety, depression and will turn to substance use as a coping mechanism whilst feeling they cannot access help or shouldn't need to. Whether through gang membership, service to their country and / or being embroiled in the criminal justice system we've built a culture where those most at risk from conditions which rank high on the World Health Organisations burden of disease are less likely to ask for and in some situations get, the cultural, social and therapeutic support they may need. I do wonder about the further impact upon all of this that will occur as ever greater numbers of children are born into a circumstance where they have no significant male role model – actually, I wonder about the whole construct of masculinity that we seem to propagate here.

I'm not putting forward any kind of academic argument: I'm just lumping together a load of things that recently struck me as being connected, correlated and causative – we are not adequately taking care of male mental health consequences of the way we run our society and that we need awareness raising campaigns, that we welcome intimate disclosures

from celebrities because it shows it's OK to be open; and that we are learning all the time about how little we know about this all …. just shows how much work there is to do.

For more information and for help and support, consider the following resources.

- Samaritans' 24/7 helpline – **08457 909090** (UK) or **1850 609090** (Republic of Ireland).
- Combat Stress 24/7 helpline for Veterans – **0800 138 1619**
- Mens' Minds Matter

16th July 2013

Section 45A Mental Health Act –

I've been waiting quite a while for a relevant case by which to demonstrate this rarely used, little known section of the Mental Health Act 1983 – even some forensic mental health professionals admit that they know of these cases only very infrequently despite that fact that all such patients would required admission within the secure, forensic system.

Section 45A of the Act relates to something often referred to as a "hybrid order" – within the legislation itself it is known as a "hospital direction". It can be imposed upon "a person convicted before the Crown Court of an offence the sentence for which is not fixed by law". The order, in short, allows the judge to direct someone's removal to hospital after conviction for the offence as long as two clinicians are satisfied "that he is suffering from mental disorder; that the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; and that appropriate medical treatment is available"; safe in the knowledge that once treatment is no longer necessary, the patient can be taken to prison to serve out the remainder of their sentence in prison and decisions about release be taken by the Parole Board, not the Mental Health Review Tribunal system.

So this order *cannot apply* to people convicted of murder – for which the sentence is fixed by law as mandatory life sentence – and it *cannot apply* to someone who had been found not guilty by reason of insanity or to anyone who had been found unfit to plead or stand trial. It *may still* apply to people who are convicted of manslaughter on the grounds of diminished responsibility.

WHY IS THIS DIFFERENT TO ANYTHING ELSE?

You may be thinking, "How does this differ to a (restricted) hospital order?" and indeed the court is required to consider whether a hospital *order* would achieve the best outcome before deciding on a hospital *direction*. The difference with the latter is that the Secretary of State for Justice may direct a person's removal to prison to serve any remaining part of their sentence if their Responsible Clinician indicates that continued treatment in hospital is no longer necessary. With a hospital order, the patient would be subject to release and community care.

So imagine a person convicted of manslaughter on the grounds of diminished responsibility who is therefore considered culpable and would normally be considered for a life sentence with a recommendation that they serve eighteen years in prison. Were a hospital order under s37 to be given, even where restricted under s41, if the responsible clinician became satisfied after five years that detention in hospital for treatment were no longer needed, there is no mechanism to serve out the remainder of the sentence in prison. Under a s45A hospital direction or "hybrid order", there is: the offender, once no longer in need of inpatient care, could be removed to prison for the remaining thirteen years of their sentence; with consideration for early release occurring in the normal way at the normal time by the Parole Board, as if the person had been convicted and taken straight to prison.

The hybrid order is designed to ensure that convicted offenders who could normally expect to attract a significant custodial sentence, do not end up serving significantly less time in the secure mental health system, but are also not denied access to necessary treatment for their mental disorder. If the judge in the Crown Court thinks it necessary, he can issue a "limitation direction" which 'restricts' the order in just the same way that s41 restricts a hopsital order under s37. And if the hospital bed is not immediately available on the day of sentence, then the judge may direct that the person be held in "a place of safety" until it is. In this context, place of safety does not mean the same thing as for ss135/6 MHA – it is slightly different, defined in section 55.

A final legal point, mainly for police officers who may bump into the scenario: those who abscond prior to their admission to hospital may be retaken under s138 MHA; those who abscond after arrival are treated, by virtue of s45B MHA "as if" they had been detained on a hospital order (with restrictions) and can be re-detained under s17 MHA as AWOL from the Act. There is no time restriction on re-detaining them and a warrant is required under s135(2) if it is necessary to force entry to do so, however such patients are also considered to be unlawfully at large, for the purposes of s49(2) of the Prisons Act 1952.

A REAL EXAMPLE

The case which prompts this post, occured in Birmingham in December of 2012 – Anthony BROWN was killed after being tortured by two of his housemates, all three suffering from various mental health disorders. Michael HERRINGTON pleaded guilty to manslaughter on the grounds of diminished responsibility at the start of a trial during which Joseph SNAPE, the main offender, pleaded not guilty. He was yesterday sentence to life after conviction for murder and HERRINGTON was sentenced to life with a minimum recommendation of eighteen years in

custody. HERRINGTON, however, was then subject to a hospital direction under s45A MHA with a limitation direction. So the judge issues a criminal sentence AND a bybrid order.

This means he will be removed to a secure mental health unit for treatment, but if the need for that treatment should conclude, the Secretary of State can then decide whether he is taken to prison to serve the remainder of his sentence or whether he is released on licence. It allows the future decision to be taken at the time, not predicted from this point when the duration and outcome of treatment is not known.

These orders are rare: in the case of **R v JENKIN (2012)**, the imposition of a hybrid order was challenged, argument being presented that the court should have imposed either a restricted hospital order OR a criminal sentence known as an "IPP" (an indeterminate sentence for public protection). The Court of Appeal ruled that the hybrid order was appropriate for reasons set out in the judgement.

ANOTHER EXAMPLE

John WARD was pleaded guilty in October 2013 to killing two men in Birmingham City Centre, Big Issue sellers Wayne BUSST and Ian WATSON-GLADWISH. Reading between the lines of media coverage, it would appear likely that he has also been sentenced to a hybrid order, because the judge set a minimum tariff on his sentence and mentioned the Parole Board determining whether or not he'll ever be released. Had he been sentenced to a restricted hospital order, no minimum sentence would be set and the Tribunal System and / or the Ministry of Justice would determine release.

The judge in this case has stated that WARD may never be released and he remains detained in Ashworth Hospital in Merseyside, one of the four High Secure hospitals along with Broadmoor (Berkshire), Rampton (Nottinghamshire) and Carstairs (Scotland).

FURTHER EXAMPLE

The conviction in December 2013 of Karl ADDO shows again where this order is useful. He pleaded guilty to the manslaughter of Sergio MARQUEZ on the grounds of diminished responsibility and has been detained initially at Broadmoor under s45A. However, in passing sentence the judge has remarked that he will be made subject to a minimum term of six and a half years in custody (this figure is reduced because of his guilty plea) and this is the indication that the particular order imposed is a hybrid order under this section. Given that this tarrif is relatively short, it does suggest a likelihood that ADDO will serve his whole sentence in hospital and may be

detained there for a great deal longer than the minimum period, just as if he'd been sentenced to a restricted hospital order.

However, should treatment in Broadmoor lead to recovery before that period has concluded, he will be transferred to the prison sytem and subject to the Parole Board in determination of any release decision. Very similar to both of the cases mentioned above.

MORE GUIDANCE –

- Reference Guide to the Mental Health Act 1983 – chapter 5.

23rd July 2013

Emergency Mental Health Care –

Last month it was announced that a newly invigorated Care Quality Commission will undertake a review of emergency mental health care. This follows on from several things and is much broader than the issues arising from the Adebowale Report – recently, this independent Commission into policing and mental health in London which has national implications. The Adebowale Report made 28 recommendations, two-thirds of which relate to health and social care and so it was well said that "The Metropolitan Police can't do this alone". It was (partly) in response to those issues that the CQC announced their review.

What else could be done? – well, most operational police officers could list a range of things from our experience and if anyone thinks I've missed any points here, you should feel free to let me know or add a comment to the blog below. I'm going to make sure via Twitter that members of the CQC involved in this, hear the views that are expressed to inform their inquiry. In the link above, the CQC list four areas likely to be covered and although they were not intending to limit or be prescriptive, there are many, many more issues –

I have nine things to say, restricting myself to a couple of paragraphs on each when in reality each issue is a big piece of work where we need to properly research and understand the dynamics at play:

1. CrisisTeams – clear and consistent terms of reference are needed and greater public understanding of what they are for. Do they have sufficient staff to meet the demand which exists; do we actually understand what that demand is? In some areas, CrisisTeam work becomes 999 work for police and / or ambulance services, but I'm not sure we understand the extent of this or why it happens. Do we keep records in CrisisTeams of how many times their work is deflected and do 999 services keep records that could allow us to know the amount of emergency mental health work that is "failure demand?"

We then have to link this to issues around staffing and duties – I often absorb demand that initially went to the CrisisTeam because of issues around staffing and terms of reference around deployment. If CrisisTeams have two members of staff at certain times of the day, it means that they can do one thing at a time if it is a job unsuitable for a lone-worker and if

they are doing two things at a time, they cannot undertake those more demanding or risky tasks. We also know from response times to police custody or A&E that CrisisTeams are understaffed for the demand which exists. If you do not resource your service to absorb fully the nature and variety of demand which exists, you generate "failure demand" which is inherently problematic to deal with and has all manner of impact upon your mainstream service. I am absolutely convinced that in some cases, an unresponsive, non-integrated emergency healthcare system means that the criminal justice system becomes obliged to criminalise people who would have benefitted earlier from a health or social care led intervention

The CQC should also bear in mind, that if you are a 999 worker stood in a private dwelling with a known secondary care patient and you ring the CrisisTeam after your attendance in a private home, the notion that you could get from that position to any necessary Mental Health Act assessment in fewer than four hours is fantasy. The implications of the "Sessey" judgement should be strongly considered when thinking about what a CrisisTeam may have to undertake.

2. Out of hours AMHP coverage – this links to some of the issues for CrisisTeams. In many areas, the duty AMHP is a social worker also carrying generic social work responsibilities including child protection responsibility, etc., etc.. The CQC need to consider the feedback freely available on various social media platforms that AMHPs themselves feel under-resourced and unable to deliver a proper service for emergency mental health issues. This means AMHP availability for s136 assessments in a place of safety (wherever that may be) as well as the co-ordination of MHA assessments, either in private premises which may need a s135(1) warrant or in police custody or A&E; AMHPs also have other statutory functions and it is certainly my experience that few AMHPs feel they work in an area where they have sufficient resilience to be able to provide a proper response to these issues.

For example, we all know that the Royal College of Psychiatry standards talk about a 3hr response by an AMHP after being notified of a s136 assessment – in many areas, it is frequently double this timescale and often triple or more. I have personal experience of it taking in excess of fifty – yes, 50! – hours for a s136 detainee to be seen by an AMHP.

3. Section 136 provision – we still read, in the joint 2013 report by HMIC / CQC that health provision of place of safety services remains patchy and that we're still far from achieving a national position where most people avoid being taken to custody. We also know that in many force areas they are doing very well at this, AND reducing use of s136 through better training of the police and / or street triage schemes.

My point about emergency mental health care is different: we don't seem to properly use the information generated by s136 usage, to identify other issues within the system. How many s136 detainees are current secondary care patients? – in some areas this number is 50%. How many s136 detainees are arrested out-of-area and known to their home mental health trust? – again we know that in some areas this is around 25%. How many s136 detainees are *repeat* detainees? – we know that in some areas there are people who've been detained many times. We could do with understanding these things so that we can think about the implications for care plans, so that in some cases we can ask why s136 became necessary or kept getting used.

We also need to think about the quality of emergency mental health care and I re-submit my view that no matter the difficulties, emergency mental health care provision will never have parity with emergency healthcare provision unless and until our response does NOT involve incarcerating people in cells whilst ill. I personally feel that none of the arguments about use of the cells stand up to full legal and medical scrutiny and I call for an end to their use in *any* circumstances. We build the NHS to have the capacity and capability to respond to complex, challenging medical issues: why not for those that are oriented around mental health disorders and that means emergency responses even where people may be intoxicated by drugs or alcohol or may be aggressive.

4. Liaison and Diversion Services? – could there be more of a crisis than for someone who is mentally unwell to be arrested by the police for an offence and taken to custody? We know that some versions of these services have not been put together to respond to demand in custody, but to operate at times which are bureaucratically convenient: there is little point operating 8-4 Monday to Friday because most people who get arrested whilst unwell, get arrested 5pm – 3am all days of the week with a greater emphasis on Thursday to Sunday.

Where people do get detained, it often falls to the CrisisTeam to respond to custody if and only if mental health assessment with a view to admission is necessary. Liaison and Diversion services would need to be able to manage predictable unpredictably: I know we don't know when people will get arrested, but we know it will cover all parts of the 24/7 clock and that the focus will be on evenings and weekends. Therefore, we need services that can respond to this. I'm also interested in urgent mental health care recognising the value of having an input into the detention of those arrested even if formal admission to hospital is not indicated. To give just one recent example: if someone is stealing food whilst ill, but not acutely ill enough to warrant compulsory admission, there could still be value in supporting people. Are their social care issues at play which if addressed could mitigate further offending? Who knows unless we get involved.

A previous post I wrote covered this on Liaison and Diversion, as well as posing a decision-making model for the police to guide all agencies through. It all hangs on how the NHS could get involved and I want to see a process as outlined in that blog which is about helping to identify more people coming through the system – because we know the police will only identify a third to a half of those who may need support / assessment – as well as providing formal MHA assessment where indicated.

If we don't get this right: we see acutely unwell people not being properly supported and / or public protection insufficiently considered in police decision-making; we also see moderately unwell people unnecessarily criminalised which is equally tragic.

5. A&E Liaison psychiatry services – we know that award-winning liaison services (like the RAID system in Birmingham) can add loads of value to A&E. Research has showed that mental health is a decent bulk of A&E demand: 1 in 6 people entering A&E have a mental health problem, 1 in 3 of those are there *just because* of their mental health problem. So it's 5% pure mental health demand; up to 15% medical and mental health demand (for example, self-harming or overdosing whilst ill.) So the NHS developed liaison psychiatry services: mental health professionals working for the mental health trust but who work in acute settings, supporting the mental health related demand on wards an in A&E.

I've often wondered why these services do not extend themselves to people who go to A&E in contact with or detained by the police? Surely clinical need is clinical need and I've never understood why healthcare available to others is denied because the patient is under arrest? Even in areas where there are no place of safety services available and where liaison psychiatry services exists, people can be denied access to them because of being in custody.

6. Out of hours CAMHS / LD provision – it would be remiss of me not to make a self-justifying statement about out of hours provision for children and people with learning disabilities. The number of times normal processes in emergency mental health care are brought to a grinding halt because there is no out-of-hours provision in these specialist areas.

7. The Role of the Ambulance Service – the Adebowale Report talked about the importance of emergencies in mental health care being given parity by the ambulance service with other medical emergencies. Most ambulance services have work to do on this. We have seen in some areas like the West Midlands, that ambulance services can bring clinical skills to emergency mental health care in terms of a de-escalating presence; they have also successfully identified where someone mental health patients are at raised risk because of additional physical healthcare complications.

Of course, the ambulance service already deal with many frontline mental health emergencies, but it surprised me in my journey into this part of policing to learn that the ambulance service get comparatively little mental health training. Some paramedics of years standing have a day's training in mental health. It also *stunned* me to find that many ambulance services are unable to access care pathways, CrisisTeams and many do not have access to very much patient information, to any established trigger plans for patients at risk or to GP information for primary care patients. That I once heard a senior mental health manager (not in my force area) shouting at the ambulance service when they asked for an ability to access information and 24/7 CrisisTeams sums up where many areas are with integrating the NHS services which face this kind of demand.

8. Bluelight 999 Support – we need to fully face the idea that mental health emergencies are going to come to the attention of 999 services and that we need to train, prepare and deploy our officers and paramedics to face this demand. It's not enough that they have access to other services, they also need to have professionally relevant training in how to manage vulnerable people, legal complexity and medical uncertainty. Our 999 professionals also deserve a clear plan B to initiate when we find that ideal plans about how mental health emergency should be managed do not survive contact with high levels of demand, individual professionals and so on. << **This is not to denigrate anyone**: it is to prepare for reality.

We also need to contemplate the potential of combining police and paramedic skills into fast-response cars. I know that the current fashion in "street triage" is to pair a police officer with a CPN and whilst I've welcomed that to a point, I also point out it is not a panacea. The answer to some mental health emergencies is a paramedic opening the care pathway into Accident & Emergency and providing clinical care from the first point of contact into the emergency system. We need to find a way of brigading all of this into quick, effective 999 response which can "access all areas" and manage uncertainty.

9. Availability of Beds – we know that in some areas of the UK, acute mental health beds have been cut by a third – *twice*. That means they have been cut by more than a half. All of this against a budget which has risen 59% in the last ten years (in real terms). We have seen amidst this, the introduction of Community Treatment Orders which are far more prevalent than originally contemplated with suggestion in recent research that they may not bring about the intended consequences of helping to stop a revolving door of admission > rehabilitation > discharge > relapse > crisis to re-admission.

We are at a stage where we see AMHPs on social media platforms, highlighting the intractable situations into which they are being drawn because having undertaken Mental Health Act assessments, they have no

beds by to which they may make applications. Naturally, problems are particular marked when AMHPs are searching for psychiatric intensive care unit beds (PICU) and other specialist or secure services. We have seen debates – frankly I've been pushing at a lot of them – about the potential problems and illegalities arise and we know that the CQC themselves are now publishing reports which criticise from the statutory inspectorate perspective about areas having de-commissioned too many beds.

Surely this is the definition of emergency mental health care: having a patient in need of admission to hospital because the pose a risk to themselves (or others) and being unable to do so for the want of resources. There is human rights law on these issues, both regarding the denial of Convention rights on the grounds of economics and on the issue of protracted detention in police custody whilst these issues are sorted out. It is against some of the things we now frequently see.

That should keep them busy at the CQC for a bit – and I stop writing conscious that this skirts over the nine issues and is just a policeman's perspective. I'm aware that there are other issues that service users and carers would wish to raise and that each of these topics requires greater depth, research and they are inter-related ideas within the broader area of inspection.

- For Nathan Constable's take on this, see his recent blog post which gives some great examples.

26th July 2013

BMH UK Conference 2013 –

In June 2013, Black Mental Health UK hosted a national conference in Wolverhampton hearing from an impressively significant cast of speakers. This kind of event was long overdue.

Alongside the BMH Director Matilda MacATTRAM and the West Midlands Police and Crime Commissioner Bob JONES, delegates also heard from Minister of State for mental health, Norman LAMB; MP Charles WALKER who made such a valuable contribution to last year's House of Commons debate on mental health, Chair of the Care Quality Commissioner, David PRIOR and then from Commander Christine JONES, the mental health lead from the Metropolitan Police.

Videos have started to emerge from this on YouTube and I wanted to post these highlights from Commander JONES's talk –

She absolutely hits the nail on the head for me when she talks about the most important thing for police officers to work on – at all levels – is how we build adequate insight into and responses to the difference between fear and anger: something on which we need to build understanding.

You also need to watch this 20 minute summary video of the whole event –

26th July 2013

Do Something! –

Can you remember one of my favourite remarks about policing from Egon BITTNER … you should by now, because I've quoted it enough! –

"Something is happening that ought not to be happening about which somebody ought to do something now!"

Well, a few years ago we had a 999 call … a psychiatric nurse in the liaison team wanting to tell us that Mr SMITH has threatened to kill his GP and that he had a gun. We start the ball rolling, because threatening to kill anyone is an offence, guns are serious business and we are the police – badness had obviously occured.

We check the guy out on our systems and find we've known him for years, he doesn't have a firearms licence or any previous connection with guns or violence and he has a massive, Massive, MASSIVE history of alcohol abuse. It emerges that the GP had referred the patient to the psychiatric liaison team "for assessment" of potential mental health problems and the GP had not rung us about the death threats at all, but instead had started enjoying a week off work. So we decide to ask a load more questions, not least because we need the GP's name and number because he or she is the witness to any offence that has occured.

The police were being asked to, "Do something" by attending his address – "he's threatened people, you have to do something!" It turns out that the psychiatric liaison team who called us don't do the assessment that the GP was asking for, it's done by the CrisisTeam and they won't attend because they will be shot, obviously.

So as we attempt to understand more, we speak with psych liaison and the CrisisTeam; and we start hearing different stories about what has occured. One version is that the threats weren't specific to the GP, they were generalised, non-specific threats that were not taken seriously and which would not constitute a particular offence. One of the teams tells us that the other heard these specific threats too; that team denies that they did. We say that we need to speak to the Doctor, because they are the key to all of this as the direct witness of what did actually take place. When we eventually get through to them on the phone, the doctor confirms non-specific generalised threats to no-one in particular, except that the man

had threatened to shoot himself with a gun – the patient had immediately told the doctor that he did not have a gun with which to do this and the doctor did not take the threats seriously or, himself, feel threatened.

DO SOMETHING!

So, we're starting to build a picture: only the psych liaison team and the GP are reported (by others) to have heard threats that would constitute an offence and when spoken to by the police, each denies that they did. So there's no offence! – so what is there?

There's an alcoholic man, whose alcoholism is so pronounced that he consumes 40-50 cans of beer (equivalent) a day and who will drink anything including lighter fluid and methylated spirits. He has severe physical healthcare problems to the extent that even the CrisisTeam are telling us, that should he at any stage be detained by the police he should go nowhere near a custody office because he could well die if he withdraws from alcohol. << Might remind them of this when they're turning other s136 patients away in future after consumption of a lager and lime.

So what are we being asked to do, now there isn't an offence? – a safe and well check?! We don't do those, because we can't. I can't look at an alcoholic man in his own house, assuming he answers the door, and tell you whether he is medically OK – neither could the best paramedic or A&E consultant in the country. In fairness, you've already admitted that he won't be because of his known problems so why are you asking us?!

What I can do(!) and what I *want* to do to keep you safe, is accompany health professionals as they go about their business of making a health assessment of needs and risks; of capacity and consent. And if he commits an offence, we can probably use that as a lever to safeguard him and you – and if he doesn't, you can do "health things." Obviously one problem I'm already anticipating is that you may not be able to do "health things" through a fog of alcohol, because this bloke will have had a few gallons of beer by now.

Since the overall threats and risks amidst the chaos of his lifestyle were such that he could be detained under s136 MHA if he were found walking down the road, why not get a warrant under s135(1) and remove to an appropriate place of safety where any withdrawal can be medically managed until he can be assessed, as per the GP's original referral and then appropriate pathways determined based upon this conclusion? << This is what I asked for and this is what they chose *not* to do. In fairness, the CrisisTeam agreed to attend, but without a warrant. So I explained the rules of the game from a police point of view, in terms of our legal powers, and we went along.

As the officers and CrisisTeam met and prepared, the bloke came wandering around the corner in the direction of his home address and he was detained s136 MHA. He was last seen by me in A&E having his physical / alcohol problems managed ahead of a mental health assessment. Officers were supporting that process, which isn't ideal, but it at least ensures that he remains engaged to a conclusion. However, they were put under *strict orders*: at **no** stage, will that man end up in a police cell, given what is known about the medical risks which are posed to him, should he withdraw from alcohol. Obviously, once A&E had given him a physical healthcare "once over" they asked for him to be taken to the cells for mental health assessment. Err, no. Nothing prevents the assessment being done in A&E and given ongoing risks, it is far more appropriate. We can disagree about that if you want, but you can't force police officers to detain people in their cells. And what about the health-based Place of Safety – what role could they play?

HERE ENDETH THE LESSON

So the issue here is: the police being asked to "Do Something!" about a situation which has Chinese whispered out of all control and which was, not-straightforwardly a health situation with an ambient background of risk. Firstly, the police always need to know *first hand*, what has actually happened. If I'd just shouted up the rank structure for Armed Police, the Chief Inspector would have asked the obvious questions about evidence and offences and I'd have looked like a complete muppet. As it stood, the Chief Inspector had been monitoring the incident because of the way in which it was originally described and he rang at the end to say "well handled" in light of the write-up on our incident log about threats and risks; laws and policies, etc.. Always nice.

Far more importantly: it shows how we need to be cautious about putting our arm in the mangle. Had we run off up there, armed police or not, and encountered this man on our own, unless we could have arrested him for an offence or s136, we would have been legally powerless to do anything and without the appropriate skills or training to get him the relevant healthcare support – whatever that may have been.

29th July 2013

So Who Is In Charge?!

Here's what's wrong with mental health care in the UK << *he modestly claimed!*

1. No one is in charge of it **– at all.**
2. *It's not a system* – **it's a coincidence.**

You might want to pop the kettle on before you tackle this one!

You've only got to follow the @Twitter feeds of a few MH trust Chief Executives (plenty to choose from) to see this phenomenon. In exchange with several of them, they may well agree with many criticisms and issues within "the system" and agree whilst saying, "our MH commissioners need to pay heed" or similar. And they are most usually quite correct to do so.

Several years ago, a senior police officer who was trying in good faith to get his head around the NHS structures that apply to mental health once asked me to "draw a map on one page of A4 of health areas." I will admit I wanted to pat him on the head and say, "Ah, bless!" … but that's not the done thing, so I smiled a wry smile and tried to explain:

Did he want a map of –

- **Mental health trusts** – they provide most, but not all of the mental health services.

- **Acute trusts** – they provide major hospitals, which includes A&E services to which some mental health emergencies must be taken and which have "liaison psychiatry services."

- **Ambulance trusts** – they do what it says on the tin, but may or may not be "commissioned" to provide MH related conveyance services, outside of emergencies. << Very best of luck defining emergencies.

- **Primary Care Trusts** – these are now called **Clinical Commissioning Groups** following the Health and Social Care Act 2012. This was the Act that ensured a top-down reorganisation of our health service, following the election of the last government.

- **Specialist trusts** – providing services like children's mental health services and / or learning disabilities services. Surprise though this may be: they don't always come under one "umbrella" mental health provider.

- **GP services** – they provide primary care services to around 83% of patients who have mental health problems.

- **Local authorities** – they oversee and warrant the Approved Mental Health Professionals who make MHA decisions. Sometimes they employee the AMHPs directly, other times AMHPs are seconded to or employed by the NHS. So this is not *just* about health!

He then tried just asking, "Who do I ring?!" Well, it depends what you're ringing about, Sir! The police find this all very hard because we have a Chief Constable (or Commissioner in London) and if all else fails, you ring him or her.

WEST MIDLANDS

Let's use the West Midlands as an example to see what this means –

There is one ambulance trust – West Midlands Ambulance Service: they cover the whole region and provide ambulance services to all **22 Clinical Commissioning Groups** across the West Midlands area.

This is covered by four police forces – Staffordshire, West Mercia, West Midlands and Warwickshire Police who in turn cover the area served by **19 acute trusts** (A&E and hospital services) and **8 mental health trusts**. Obviously, there is little co-terminosity! And of course, not all mental health trusts provide all mental health services, so you'll find in Birmingham, that the "acute" Children's Hospital Trust provide the children's and adolescent mental health services (for both inpatients and outpatients.) In Birmingham, the learning disabilities services are not provided by Birmingham / Solihull Mental Health Trust, but by Birmingham Community Healthcare Trust. But in Coventry, learning disabilities are provided by the mental health trust: Coventry and Warwickshire Partnership Trust. "Partnership Trust" is mainly an NHS euphemism for "mental health trust."

But even then, providers who straddle CCG areas may provide some services in one of their areas, but not in others – it depends what the CCGs have "commissioned" them to do on their behalf. Some of the services provided by Birmingham / Solihull Mental Health Trust are purely for Birmingham.

All clear?! – if this gets too intense as you continue, just pause on the pictures for a moment and imagine a long walk in the fresh air.

Of course the point where children becomes adults is blurred – CAMHS ends once someone turns sixteen but adult services start for those who are eighteen. What happens in between is often a lottery depending upon the service required and how local arrangements are set up.

NHS COMMISSIONING

Now – in terms of what services are provided –

It is the role of NHS Clinical Commissioning Groups to "commission" the services which they think they will required to fit their populations, demand, etc., etc.. This includes mental health services and they may be commissioned from "any qualified provider", including private sector organisations like Serco who provide the out of hours GP contract for Cornwall.

Quite why one area (Birmingham) may commission a MH trust to provide only adult and older adult MH services whilst getting their CAMHS and LD elsewhere; whilst in Coventry they commission the lot from Coventry and Warwickshire Partnership Trust: I have no idea. For example, I'm not immediately clear how Birmingham benefits from having two MHA Places of Safety – one for CAMHS, one for adults – when Coventry have just one for all. The distinction doesn't arise from clinical issues or even from demand (Birmingham detain over three times as many people), but from bureacracy around who provides what to the city and that's why the CAMHS PoS caters for people who are fifteen and younger whilst the adult PoS for those are seventeen and older.

"What happens to sixteen year olds detained under s136 in Birmingham", you may ask? The police improvise and attempt to persuade. But as the two services are commissioned separately by different commissioning authorities, they take a view as to what they will do and the knock on effect appears to be for others to manage on case-by-case basis.

Some CCGs cross boundaries like the Sandwell and West Birmingham CCG who commission MH services for Sandwell from the Black Country Partnership Trust and those for west Birmingham from the Birmingham / Solihull Mental Health Trust. Actually, in reality this CCG lets a lead-Birmingham CCG commission the west Birmingham service on their behalf and I'm genuinely unclear as to whether the lead commissioners discuss their service differences. This might be why those two areas of Sandwell and Birmingham who provide s136 PoS facilities differ in how it operates and how one CCG has ended up with commissioning arrangements which lead to two different standards of service from two different providers, either side of a local authority border that they straddle. Must be interesting living on Shenstone Road in Edgbaston – it depends which side

you live on as to how your 136 service and mental health service work despite the fact that the whole road has it's health services commissioned by Sandwell and West Birmingham CCG – one side of the road is Birmingham, the other Sandwell.

I imagine your head is starting to hurt now?

In the Black Country there are two mental health trusts, on describing itself as a "partnership trust" the other as a "mental health trust": one provides almost all services to all parts of the population, but it also provides specialist services (for learning disabilities, children's services and some secure services) to the whole Black Country. The other provides some but not all services to the whole population. So if you live in Dudley and have a learning disability, your provider is not Dudley and Walsall Mental Health Trust, but the Black Country Partnership Trust. Why? I'm sure we'd hear explanations like economies of scale around the provision of specialist services. But that's not how it happens in Coventry and Warwickshire …

In the CCGs there is a Chair to each CCG – the Chief Executive if you like, who is overall responsible for what is commissioned. So they are in charge …. except they're not!!

For mental health, some *specialist* services are "commissioned" by NHS England, not the CCGs. NHS England is the organisation that replaced the former Strategic Health Authorities when the Health and Social Care Act 2012 took effect and also took on board some responsibilities previously held by the Department of Health. So they are responsible for the more specialist services like high-secure hospitals and services connected to offenders with mental health problems.

Keep going – nearly done! Pain relief is available at the end.

GETTING STUFF DONE

So how do you get stuff done?! – let's imagine you work in an area where something that should be happening in health isn't happening. Who do you ring?! Well, if the service is commissioned but not working properly, you ring the Chief Executive of the NHS provider, like a mental health trust. But if it simply doesn't exist as a service or if it's not commissioned properly, you ring the CCG – they are responsible for ensuring what is needed gets commissioned properly. Unless of course, it was commissioned by NHS England … in which case, call them. What is commissioned on mental health / criminal justice by your CCG and by NHS England? Well no-one really knows because the structures are still new and it's still being thrashed through.

Why not ring your "offender health commissioner" – this is an individual employed by NHS England in order to ensure that the commissioning of services that affect offenders – whether by the CCG or NHS England – is joined up and ensures provision throughout the criminal justice system and for those diverted from it for mental health and / or drug or alcohol problems. I'm not sure if they would appreciate the suggestion that they are plugging gaps because the role involves far more than that, but they are a point of access into health for criminal justice organisations and all PCCs and senior officers who lead on mental health should know who they are.

Of course, the offender health commissioner will be very interested in what were sometimes called "secure services" – these are the medium secure units which are provided by one provider but for a regional intake. So Birmingham / Solihull Mental Health Trust provide two medium secure units in Birmingham for men and one for women / children, but those services take patients from many areas of the West Midlands and sometimes beyond.

The medium secure CAMHS service in Birmingham is actually a national service – a twenty-bed facility which constitutes around one a quarter of those kinds of beds in the UK. So absolutely not just a service for Birmingham / Solihull, despite the provider. When West Midlands patients need high secure hospital services, usually after serious offences and via the criminal justice system, they are admitted either to Rampton (in Nottinghamshire) or Ashworth (in Merseyside). Those are high-secure national mental health services, albeit it run by a local-sounding mental health provider.

The main reason that no-one is in charge is because the ability of "provider" trusts like mental health trusts or acute trusts to be able to argue about what they are "commissioned" to do. I have long since learned that if an MH Trust is not commissioned – *ie, paid* – to provide a certain service like a s136 facility, they have no problem in telling you that the absence of such a facility and the knock-on consequences for the police is not something for them to worry about however much they may agree with you that it should exist. When I waded into this stuff earlier in my career, I was just invited to contact the PCT (it would now the CCG). Some PCTs cared, others didn't – some PCT MH commissioners were interested to learn about this service omission and satisfy unmet need, others couldn't have cared less. This was often influenced by their perception (not necessarily founded on knowledge) about policing. It's good to talk.

And remember, the extent to which unmet emergency and other mental health demand is met by 999 services and / or by parts of the NHS like A&E is not understood. Far less understood is: what amongst that demand could have been met and what will always require a police or ambulance or

A&E response? As such, we could do with cross-provider research about mental health demand – where does it go, what does it look like and how could we prevent it, mitigate against it or react better to it?

We don't know – because no one's in charge.

If you are affected by the issues in this post I recommend a long, soothing bath with candles and whale music. Headache medications are available at all good pharmacies, which are not commissioned by the NHS.

AUGUST 2013

4th August 2013

A Public Nuisance? –

A scenario for you: 999 services are called to a person on a bridge, either over a major road or a railway line, and the person is either overtly threatening suicide or has been doing or saying things which mean it must be presumed that a possible reason for being where they are is the potential that they will jump.

Some of these situations are very public: it was a major motorway, the M5 just west of Birmingham, the last time I was directly in charge of one of these events. My sergeants have since dealt with several and I can assure you that the second thing going through officers' minds concerning the background is the potential that we're dealing with a vulnerable person with complex needs, probably connected to mental health disorders, possibly connected to the use or abuse of drugs or alcohol prior to the event. The first thoughts are always about wrapping a security blanket around the incident so harm is minimised – bringing the motorway to a halt, getting the trains stopped, diverting passersby, etc., etc..

Some law for you –

- Anyone on a bridge in these circumstances would be in a place to which the public have access, so assuming the other criteria are met, section 136 of the Mental Health Act is in play should it be required.

- **But it is not the only piece of law for this event:**
- It is a criminal offence contrary to s22A of the Road Traffic Act to put yourself on or over a road, causing a danger to road users.
- It is a criminal offence contrary to s34 of the Offences Against the Person Act 1861, to wilfully endanger the users
- It is a criminal offence, contrary to common law, to cause "a public nuisance" – this is an offence where injury, loss, damage or inconvenience is suffered by the community as whole, rather than one or more specific victims.

So, having attended the incident and wrapped a security blanket around it, the police would commence the process of attempting to get the person on the bridge down, almost certainly by negotiation and this may involve specialist crisis negotiators taking over from the first uniformed officers at

the scene. Assuming we get to a position where the person is persuaded, the attending officers then have two important decisions to make:

1. **Whether to detain the person** under one of the laws, above;
2. And if so, **which one?!**

If we remember that officers will be thinking about mental disorders and vulnerabilities and information may have come to light during the incident that confirms a service-user's background or personal history, section 136 of the Mental Health Act has been used a lot. This leads to a non-criminalising assessment, we hope in a hospital, which will identify someone's health and social care needs; either for the first time or in a way which establishes whether current care arrangements are sufficient.

WHEN MAY IT BECOME NECESSARY TO CRIMINALISE?

So given all of this, when would it be acceptable to arrest someone for one of the offences above, instead of using the Mental Health Act? Some would say never. When I tweeted an article earlier today, the reaction was almost unanimous –

- "Sounds like that man needs a thorough mental Health assessment and ongoing treatment – not arresting."
- "Sounds like maybe a lot of money & distress could have been saved by providing him with a proper MH service."
- "Clearly the man needs urgent medical & mental health treatment, not arresting for being a 'nuisance'."
- "Is this really the attitude the police are trained to have towards suicidal people?"

Of course it doesn't help the debate about the important issues, that the article is badly written and implicity pejorative throughout, but few of us would disagree with the thrust of the notion that where possible, a compassionate route to assessment and care would be best. So the rest of this blog is about a really controversial idea – the idea of criminalising a person who is clearly at risk for several potential reasons.

What if this was not the first time such an incident had happened? – what if following previous incidents, section 136 of the MHA had been used several times and thorough assessment had occured. Perhaps the person was repeatedly found not to be suffering from a mental disorder, but had an alcohol abuse problem. << *This is a real example.* Support services were offered, but the MHA cannot provide a legal framework of compulsion by virtue only of alcohol use / abuse.

What if the person was quite well-known to mental health services and thought to be suffering from a personality disorder? – despite a few admissions under the MHA earlier in their lives, it had been deemed correct to provide community care and support, not always welcomed as sufficient, but repeatedly the path offered after ongoing s136 detentions. *<< Again, a real example where MHA detention was thought to be counter-productive in the long-term.* Eventually, it was never selected as an option, but incidents kept occurring.

At what point do the police service have a right to say that diversionary approaches to treatment and care, to support and assistance, have been attempted and we cannot continue to keep making the same response to a situation which is not providing a long-term solution to behaviour which continues to put people at risk?

CRIMINALISATION

I cannot think of a single example where the response to an event of this kind appearing to be "one-off" has led to a criminalising outcome – it's always section 136 of the Mental Health Act or non-coercive route into a health or care pathway, like being taken to A&E. Health assessment whilst not under arrest having occured, referrals, support or admission was offered where appropriate. I can only think of examples of criminalisation occurring where those health pathways had been tried and failed, for whatever reason.

Now it maybe that in some situations, the care or support offered was inadequate or perceived to be inadequate and to the extent that putting yourself on a bridge is obviously a cry for help, if that help is perceived as insufficient, it doesn't matter whether it is considered the appropriate therapeutic or clinical response by the professionals offering it. But where there are ongoing risks to public safety, where individual autonomy and dignity has been previously prioritised, what potential does the criminal justice system offer?

I have written before, very early in the blog's life, about criminalisation. My view, is that it is the role of the police to take intelligent decisions about whether and when to criminalise people and research going back fifty years shows that the police will usually choose a diversionary response to "deviance" (deliberately chosen as being both non-medical and non-legal language) where it is thought attributable to mental health problems and / or to substance abuse. In fact, depending on how you define "criminalisation", it has been argued that the police actually *under*-criminalise vulnerable people, compared to the general population.

But the criminal justice system offers things that the mental health system doesn't. For a start, courts can impose various kinds of orders upon those convicted of offences and where mitigation is offered that offending arose from drug, alcohol or mental health problems, it often is. This can include drug / testing and treatment orders, mental health treatment requirements and anti-social behaviour orders with various conditions around relevant background triggers. Obviously the probation service will on occasions supplement mental health services in monitoring them and the courts retain a role in handling breaches of orders.

Perhaps more obviously, the courts can send the message that however caused and however mitigated, offending behaviour will have certain restrictive consequences. Although we will not enjoy the story, in one case of this kind about seven years ago, I remember we prosecuted a young woman with a history of alcohol abuse and a diagnosis of personality disorder, and the brief period of imprisonment whilst on remand the bridge incidents which kept shutting the M5 at rush hour just stopped.

Here is something even more controversial – for some patients with certain types of mental health disorder, I have heard it repeatedly said by a whole range of health and social care professionals, as well as criminal justice professionals, that ensuring people face consequences for their actions can be inherently therapeutic. I've even heard the phrase "therapeutic jurisprudence."

THERAPEUTIC JURISPRUDENCE

So when may it be correct to criminalise an apparently vulnerable person, found sitting on a bridge threatening or intimating suicide? –

My answer is that it may be necessary if the history of that individual is well enough understood for us to know that other, diversionary based approaches to ensuring social justice have been tried and failed. There comes a point where the balance between individual autonomy and rights to access treatment and care, conflict with broader issues of public protection. There comes a point where an individual who is continuously putting themselves at risk, not to mention those using road / rail networks, deserves to be protected and if this cannot, for whatever reason, be achieved without the criminal justice system, then it deserves a chance to work.

It is not perfect – nothing is. But those of us who have attended these incidents where someone has not been safely negotiated down have often wondered whether a different approach to the second or subsequent example might have led to a different outcome. Some of these complex

cases have shown that where legal orders, prohibitions and compulsions are ensured via the courts and the police, real human benefits can occur.

So the idea of prosecuting someone is not purely about automated, inhumane responses and the reinforcement of stigma – it can be about human dignity and public safety, as a last resort.

5th August 2013

Throwing Your Dummy –

You know when you say what you really think, and then really, Really, REALLY wished you'd phrased it better without wanting to withdraw the point you're trying to make …. *that*!

I often search @Twitter with the key words "police mental health" and see what's been tweeted the world over. Today, I came up with an article from the Police Federation of England and Wales which argues that their National Custody Forum in September 2013 will argue that "Police officers should not be able to detain someone under section 136 of the Mental Health Act as it can lead to inappropriate treatment and excessive time in custody." Instead, the Federation now appear to argue for the removal of **all** powers under the Mental Health Act for the police and a response by a mental health crisis team.

Let's consider what this means for a moment –

- **Vulnerable person committing an offence** – officers go to an incident where a vulnerable person with mental health problems is potentially very unwell and instead of being able to use s136 to remove them to a place of safety, they are obliged to think about arresting people for public order offences, breaches of the peace or other criminal matters. They are then taken to police custody 100% of the time, unless needing A&E treatement. This means, across England / Wales, tens of thousands of vulnerable people to the cells, more than is the case today where around half of the c25,000 s136 MHA detentions go to hospital. It could be far more – see below.

- **Vulnerable person committing no offence** – the person who is unwell in a public place and a risk to themselves and others cannot be proactively detained to keep them safe or to protect the public, if that were needed. The police are now busy calling the CrisisTeam asking them to physically come to where the police are and take detention decisions – what happens if they start attempting to take tablets to overdose upon arrival of the police? No power to detain. Why nurses and not paramedics? In Australia, one state has debated giving paramedics the authority to detain under the Mental Health Act.

- **Ring the CrisisTeam** – it is right to point out, CrisisTeams are busy slashing staff and introducing criteria to deflect more demand to the police, not accept more themselves. We've heard of staff reductions, we've heard of restrictions and access criteria changing – not conducive to them turning out from hospitals to support police 999 decisions. If they accept the need for the role … do mental health nurses want to take detention decisions; have we asked them? They will probably cite damage to therapeutic relationships and a lack of recruitment being focussed upon the necessary skills and physical-fitness abilities. Would they carry handcuffs and other restraints?

- **This will also alter the way in which the United Kingdom compares to other major western democracies** – many countries afford their police more, not fewer, powers under the MHA that the UK. Ireland, India, Australia, Canada and South Africa all offer legal frameworks which provide something extra: either the extension of s136-equivalents to private premises, or an outright ban on police stations being used as a "place of safety"-equivalent. So in many ways, this could be seen as a retrograde step by international standards.

POLICE POWERS

"Police powers of detention under the Mental Health Act should be removed." << *This quotation is in the middle of the article as a stand alone paragraph.* **It is neither qualified nor explained – it does not seem restricted to s136 MHA.**

Police powers under the Mental Health Act go way, way beyond s136 and this paragraph in bold moves to the use of a plural. Officers have powers to detain AWOL patients, under s18 MHA – those who have absented themselves from hospital. This is usually nothing to do with crime, either. Officers also have powers to re-take people who have been prosecuted into and in some cases convicted by, the criminal courts of this country: only the police may re-detain those offenders or defendants who have escaped from pre-conviction or post-conviction remand under ss35, 36 or 38. So for example, the defendant charged with the murder of Christina EDKINS, currently remanded under the MHA to hospital pending trial and having been charged with murder, would not be able to be re-taken by the police if the Police Federation statement was interpreted literally. How else should we interpret it?

Do we envisage a situation where nurses are called upon to re-detain such patients? I can't see it being considered correct for them to do so, I can't see it happening and can't see it as appropriate, either. If this point

appears flippant, I'm sorry: it is intended to highlight that the consequence of what is being argued for, is not fully appreciated in its significance. If we want to remove s136 MHA and keep other powers, why aren't we being careful enough to say so? If we're keeping some but not all of the other authorities, then let's see the argument for the distinction drawn and we'll consider it on its merits.

What we really seem to want, is the promised delivery of health based place of safety services, that work. This article, to me at least, reads like a "stamping of the foot" – I originally called it, "throwing your dummy" – because no-one's sorted it out yet. Except in the West Midlands and the Metropolitan Police and Leicesteshire, obviously. Others probably – I do find it hard to keep up to date whilst doing a 999 response job on shifts. Between 2008 and 2013, we moved from two-thirds of s136 detainees to the cells, to half. Not fast enough, but moving in the right direction and there's more impetus now than in 2008, not least because of the political notice this issue has received.

COGNITIVE DISSONANCE

The Federation are arguing in this article that it's either OK, or it's at least inevitable, to hold people in custody when they are arrested for criminal offences. People like Sean RIGG, for example? … he died in Metropolitan Police custody in 2008 having been arrested for a public order offence and there are many others: Even today, the IPCC has published news of a new independent inquiry into a police force in England regarding a vulnerable detainee with mental health problems, but who was originally arrested for a criminal offence and almost died. He had serious mental health problems, but was never detained under s136 MHA. The IPCC were mentioned in the above article by Federation officials who pointed out that mental health was a key factor in the report on deaths in contact as well as in suicides after release. Of course, the figures that went up, were those arrested for criminal offences and taken to custody, not those detained in police cells under the MHA, which is reducing and contact inquiries remaining stable.

I agree with their idea that when someone is in custody and MHA assessment is required, the PACE clock should be stopped, to ensure arrangements can be made, but the main point about vulnerable people both at the point of arrest and the point of being detained in police custody and beyond is that we need to be able to work out what is mental health and what is not and ensure a proper response to this clinical need, irrespective of the legal detention framework. It's the therapeutic needs of people that need addressing, not some arbitrary distinction being drawn between either the legal classification under which they are detained (MHA / PACE) or the type of professional who has detained them. If only the world were that simple!

We need to raise our game – all of us. More research, more education and more understanding. We see the HMIC and the CQC joint-publishing documents which tell us that they don't understand s136 MHA, now the Police Federation broaden it to the whole Act despite the fact that it will increase the likelihood of untoward events and achieve the opposite of what they are intending. This proposal would, in my view, increase the number of vulnerable people going to custody, increase the risks associated with that, and provide an environment where officers expected to "Do Something!" would find themselves impotent. I admit to thinking it quite an inane proposal and I was really surprised to read of it.

Go to Birmingham, see the 97%+ of people who are detained MHA being handled via the NHS, often within a couple of hours. See the cases of patients under the influence of alcohol who still get admitted and assessed and see the officers who (whilst not always agreeing with the need) support their NHS colleagues with challenging patients. There are other benefits to this scheme in the face of tragedies and untoward events which I can't comment upon yet, but which will come in due course.

It doesn't work perfectly every time, but nor does anything else and it is *way, Way, WAY* beyond the arrangements we see in some areas of the UK.

I'm now really worried this reads arrogantly; but I've been just a part of getting this sorted in one of the most demanding areas of the country. There is no reason why other officers, paramedics and mental health professionals can't sort it in theirs – how we did it this in Birmingham is all documented within this blog, so you don't even need to do the 10,000hrs of work that I've done because it's all there for you. This is sortable by those who want it sorted – the real problem is, that not enough people do. *<< That's the real tragedy of policing and mental health: people just want to push it away and not recognise it as core police business.*

That's why I suspect the Federation want to push away a legal power that probably keeps people safe and prevents them being criminalised.

6th August 2013

S v DEWANI –

It is not often we see mental health issues played out within extradition proceedings quite so clearly as we are seeing them with the ongoing case of Shrien DEWANI. For those of you who don't know the case, there is a very comprehensive timeline of events in the Guardian, on which the following three paragraphs are based.

Bristol based businessman Mr DEWANI married his bride, Anni in November 2010 and they flew to Cape Town for their honeymoon. On the evening of 13th November their cab was hijacked in a township on the outskirts of the city and whilst Mr DEWANI escaped (or was thrown out?), his wife was kidnapped and found the following morning, fatally shot and her body dumped in the cab.

Three days later, Shrien DEWANI left South Africa and within a week of the murder, three men from Cape Town were arrested and charged with kidnap and murder. By December 07th, one of the men has pleaded guilty and stated that he was offered R15,000 (£1,300) by DEWANI to kill his bride. That day, Shrien was arrested in Bristol by officers from the Metropolitan Police Extradition Unit and appeared before Westminster Magistrates for the commencement of extradition proceedings. He was remanded in custody pending a full extradition hearing.

Whilst on remand, he is thought to be suffering from a mental disorder and was transferred to hospital in Bristol – in April 2011 compulsorily detention under the Mental Health Act was necessary and in August, Westminster Magistrates Court ruled that he can be extradited to South Africa and the Home Secretary signed the paperwork to allow this to proceed. By this stage, a murder trial is pending for two accused who did not plead guilty and the South African prosecution system has announced that Shrien DEWANI will be indicted as the fourth murder suspect once he is returned to Cape Town.

EXTRADITION PROCESS

The process that has since followed has been subject of some frustration to many, not least Anni DEWANI's family and many commentators in South

Africa. Allegations that it has protracted unnecessarily will not be helped by today's news that application is to be made to take this case to the UK Supreme Court. The Magistrate Court had said "Yes," then the High Court said "Not yet – think again" because it would be "unjust and oppressive" to remove him from the UK until he had recovered. Claims were made that he would be a suicide risk in South Africa and that insufficient arrangements were available to ensure his continued recovery. After more psychiatric evaluation, by Professor Nigel EASTMAN, no less; the Magistrates reconsidered the issues and said "Yes" for a second time.

By this stage, arrangements had been reached with South Africa mental health services about the location he would be held until he was fit to take part in the criminal justice process and with reports on the hospital in the Valkenberg Hospital, a forensic or secure unit, which Mr DEWANI's lawyers have said meets their requirements in terms of standards of care.

The announcement that Mr DEWANI's lawyers will seek the High Court's authority to appeal to the Supreme Court is now going to further protract the process but for this application to succeed, his lawyers must persuade the High Court to agree that the case involves "a point of law of general public importance". We wait to see.

The Cape Town taxi driver Zola TONGO pleaded guilty and was sentenced to 18yrs in custody, reduced because he offered information against Shrien DEWANI. Xolile MNGENI and Mzwamadoda QWABE from the Khayelitsha township area of Cape Town were still pending trial but by the mid-2012, QWABE had pleaded guilty and been sentenced to 25yrs in custody; MNGENI – believed to have been "the hitman"- maintained his innocence and stood trial in Cape Town in October / November 2012.

I had the briefest of insights into the level of interest in this case when my family and I were on holiday in Cape Town in November 2012 during MNGENI's trial and having walked right past the High Court building in the centre of the city and to see the sheer level of interest and the size of the media scrum around the High Court was quite staggering – but then this case has attracted far more significant interest and protest in South Africa than the UK audience seems to realise:

In December 2012, just after MNGENI had been convicted of murder and kidnap and been sentenced to life in prison, a group of 500 women from the African National Congress's Women's League marched on the British High Commission in Pretoria to protest against the UK's inability to extradite Shrien DEWANI to stand trial, linking it to broader problems around violence against women in South Africa which is a massive problem.

MENTAL HEALTH ISSUES

Back in the UK, Mr DEWANI was assessed in 2011 by various clinicians as suffering from depression and PTSD. The additional evaluation that preceded his second extradition hearing confirmed this by some of the most qualified forensic psychiatrists in the land. The questions arising from his condition for the extradition process are slightly different to those that would apply if he were preparing to stand trial for these offences in the United Kingdom; or if he were already in South Africa. For both UK and SA law, there would be issues about whether he is fit to plead and stand trial and that would be an assessment of whether he can understand the charges, instruct his counsel and understand the legal proceedings he is subject to, etc., etc..

But for extradition purposes, those questions are not the immediate ones – it was an issue of whether he was "too ill to be extradited and whether he would be a suicide risk in a South African prison." The UK courts would have to consider his Article 2 right to life in the decision they make and the potential for him to take his own life is something the court is obliged to consider seriously. The initial hearing at the Magistrates court was occupied with this and an inevitable debate ensued about the South Africa prison system. Counsel for the South African government gave assurances, accepted by the court, that Mr DEWANI was sufficiently protected with the justice system and that the risk of suicide was not sufficiently pronounced to represent a bar to extradition. The High Court took a different view when they described it as potentially "oppressive and unjust" at that point in his recovery.

It was only in July 2013 that Magistrates again concluded, based on further medical evidence and upon greater assurances around the adequacy of treatment and care at the Valkenberg Unit in Cape Town, one of South Africa's major psychiatric units, that extradition was again agreed. Now we see notification that Mr DEWANI's lawyers are seeking the High Court's permission to appeal to the Supreme Court, we must anticipate further, specific arguments. However, they must raise broader questions of law of public interest" to achieve this.

The third anniversary of Anni DEWANI's murder is only a few months away – I just hope in one way or another, that this matter is brought to a conclusion. It is not just Mr DEWANI who is suffering psychologically – the strain on the victim's family must be enormous.

Further reading –

- Judgement of the Magistrates Court (2011) – first authorisation of extradition to South Africa
- Judgement of the High Court (2012) – regarding the first appeal against extradition.
- Judgement of the Magistrates Court (2013) – second authorisation of extradition to South Africa.
- BBC News from 06th August 2013 – all previous BBC News items from 2010 are linked at the bottom of this piece.

- Judgement of the SA High Court (2012) – S v MNGENI

10th August 2013

The Police Federation on Mental Health –

Earlier this week, the police Federation Magazine contained a call for the removal of police powers under the Mental Health Act. It struck me as an unusual and courageous idea and it prompted a response. Having since discussed it with the Police Federation lead on mental health and custody, Sergeant Kevin HUISH, I offered to publish any further remarks or replies he had. This is Kevin's blog:

2 + 2 Doesn't Make 10

Mental health should be subjected to healthy debate!

I first started the debate on removal of section 136 Mental Health Act powers from police officers at our annual conference in May this year but it didn't really take off. Well all that changed this week with the comments in the 'Police' magazine and that's a very good thing. Sometimes you have to put out what seems really unpalatable in order through the debate to get to the right solution. It is also very important to remember that the person in crisis is at the heart of our thinking and the best solution for their care is the outcome we should seek.

It's important to point out that it isn't Federation policy to seek the removal of the powers from police officers but an idea that through debate may prove unrealistic or inappropriate but then again if implemented correctly might just work. Michael has some very valid arguments and sound reasoning to think that complete removal of s136 powers from Police may be a step too far and I value his expertise and judgement but let's not just write the idea off without due consideration. Let's follow the debate through to its natural conclusion. I have no doubts the debate will continue at the National Custody Seminar in Stoke on Trent on 11th and 12th September check it out at – http://www.polfed.org/ranks/1439.aspx

Let me put some background as to how I came up with the decision to spark the debate. Like everyone else when it was first suggested to me (by a senior executive at MH charity) early this year that s136 powers be taken away from police I had the same reaction as many did this week, but then I thought long and hard about it and decided it warranted further scrutiny. That coupled with a senior member of the NHS speaking at a conference and criticising police for over and inappropriate use of the

power, questioning if we should have the power or not. I concluded that it could be a real possibility but only **IF** and **WHEN** the right people working in MH were properly resourced, trained and funded to provide the necessary level of service as first responders to people in a MH crisis situation. My suggestion is that MH Crisis Teams be the ones resourced and trained to provide that service 24/7, 365 days a year but there may be a more appropriate team.

In a submission to the Home Office I've said that it will take time, probably 3 – 5 years, before the removal of s136 powers could take place; that investment in Crisis Teams will be necessary to achieve this but that real long term savings could be made through patients' crisis being more effectively managed in the community leading to less use of Health Based Places of Safety (HBPoS) and greatly reduced admissions to hospital.

In the interim period other changes are required to allow us to be more effective and additionally I've asked for:

- Section 136 powers to be extended to include private premises with a power of entry;
- Provision of Appropriate Adults for adults put on a statutory footing;
- Police officers not called to MH premises to restrain patients;
- Section 136 detention at police station reduced to 24hrs in line with PACE (if transferred to a HBPoS then reverts to 72 hours);
- Mandatory MH awareness training jointly delivered by MH partners for all police officers (as per Lord Bradley's recommendations);
- The PACE clock stopped for those arrested for criminal offences but in need of a MH assessment (with statutory time limits for the assessment to take place);
- Abolition of informal exclusion criteria by HBPoS around drugs, alcohol, aggression, children and learning disabilities;
- Statutory requirement on commissioning boards to provide an adequate number of properly staffed HBPoS;
- Removal of police stations as a PoS under the MHA.

Interestingly, when I presented this submission to the Bradley Group (formerly the National Advisory Group to the Health & Criminal Justice Board) which is made up of all the leading charities, Lord Bradley, the Children's Commissioner, the National Appropriate Adult Network, the Royal College of Nursing, the Prison Reform Trust, Magistrates and Service Users amongst others – it was well received. They thought there was real merit in considering the transfer of s136 powers to MH professionals in the medium to long term.

I've heard it said that the 'street triage' scheme is seen by some as an expensive secure taxi service for MH nurses (and worse). It's too early for a full and proper evaluation but they tell us that in Leicestershire it has led

to a big reduction in the use of s136 powers by police, fewer admissions etc., and that's just one car on ten shifts per week. So why not go the extra yard and have an emergency response vehicle staffed by MH professionals equipped with the right training and powers? Do you really need a police officer sitting next to them? Or why not put a MH nurse in a fast response ambulance car? At least then when they're not attending a MH crisis incident they can still be of use whereas now Leicestershire have lost four PC's for ten shifts.

What I have also said in my submission is that of course the police will still have a role to play in supporting health colleagues if members of the public are at serious risk of harm or the person is considered so volatile that police support is necessary to contain and assist in a person's restraint in a public place. But other than to provide an escort to the HBPoS police involvement should cease once the person is restrained and controlled. Additionally we will of course continue to appropriately arrest people with mental ill health who commit serious criminal offences.

I will leave you with some information as food for thought: there is growing anecdotal evidence from around the country that police officers are not using s136 powers of detention but are instead arresting those in mental health crisis situations for a breach of the peace, section 5 of the Public Order Act or drunk and disorderly. To me this is a worrying trend and far from the aim of diversion from the criminal justice system. Is it because of the difficulty in getting a person into aHBPoSor because of a lack of them? Work is certainly required to ascertain the reasons and impact. It will certainly impact on the s136 figures and not be helping to give an accurate picture of those in need of help. It is not the answer to the s136 problem and we should not be criminalising those in need of medical care.

NB: *Top blogger and top chap @NathanConstable has responsed to Kevin's piece and it is well worth a read.*

12th August 2013

Unescorted Leave –

A news article this weekend gives rise to a common set of questions around what we can broadly call "risk assessment" that you often hear debated in police stations, usually just after officers have been despatched to take a report of a missing patient. On Saturday afternoon, a convicted murderer Daniel ROSENTHAL absented himself from hospital whilst he was on an unsupervised walk around the gardens of Tatchbury Mount Hospital, in Hampshire. He was found on Sunday morning in Southampton and returned to the hospital.

Hampshire Police were immediately notified of Mr ROSENTHAL's absence and commenced a "High Risk" missing person's enquiry, including Press Releases suggesting that the public should not approach the man, but ring 999, etc.. Without knowing the details, we could see from the way in which the media was released that there was a significant concern.

Many members of the public commenting on social media and I'm sure many others were asking, "If he was such a risk that no-one should approach him, why was he unsupervised and fully at liberty to leave?"

Most missing patients are not murderers! – in fact, most are not people who have been involved in the criminal justice system at all. But police officers see this sort of thing frequently: patients granted leave of absence from hospital who fail to return and the hospital's estimation of risk invites the question "so why grant leave?!"

RISK ASSESSMENT

Most police and NHS organisations for the purposes of AWOL patients agree on a low, medium or high categorisation of patients. High risk usually means life could be at risk, whether this is a risk of suicide or homicide or both; medium risks usually cover patients who will become unwell if they don't take medication, if they take drugs or alcohol or there is potential for them to self-harm. Low risk patients are usually not thought likely to present a risk of harm to themselves or others but may be vulnerable for a range of reasons around medication or their current cognitive or emotional state, etc., etc..

Firstly, can we agree? – most patients detained under the MHA, even including some who committed (serious) offences *en route* to their detention in hospital, are not going to spend the rest of their natural lives detained in hospital. If we do agree about this, then we have to accept that there will be decisions about treatment are care which will involve taking risks around the granting of leave and whether or not leave will be supervised or unsupervised, whether it will be tightly controlled, subject to conditions or more loosely managed. If we accept that decisions will be taken about the granting of some leave, do we accept that leave will gradually be subject to fewer restrictions and potentially granted for longer periods? Can we agree, especially as we are talking about patients, not prisoners, that this is a necessary part of recovery and rehabilitation.

THEORY AND PRACTICE

Of course I know that most people get this, at least in theory. In practice we have heard examples of leave being granted in circumstances where risks were insufficiently understood and where questions have been rightly asked:

I always think of the decision in the case of John BARRETT who was given a restricted hospital order in 2002 after committing several assaults in London. Having been conditionally discharged from hospital in 2003 – after a due process of recovery which involved the granting of leave – he again became unwell and was re-admitted. He was granted leave from hospital by a doctor on 01st September 2004, without that doctor actually having assessed or even seen him and without understanding his risk background. He murdered Denis FINNEGAN in Richmond Park on 02nd September.

But this is not an argument against ever granting leave for patients who may fail to return or who have risk histories. It is an argument for a public understanding of the benefits to us all of patients recovering sufficiently to live independent, valuable lives outside the confines of hospitals. Bear in mind that the re-offending rate for patients who were subject to restricted hospital orders is over 5%, compared to a prison re-offending rate of over 50%. So it is an argument for better risk assessment, better training and better scrutiny. I know, I know … we've heard this all before because when reviews are published into the treatment and care of people like John BARRETT, we read with shock and amazement that certain basic things weren't done. Who grants leave to a patient previously deemed to pose "a serious risk of harm to the public" without at least examining them?! Yes, we wearily and hopeless read promises that "lessons have been learned" in order that "such things could never happen again."

REPEAT PROBLEMS

The one thing I notice when hearing officers talk about MHA leave which has broken down: it is sometimes similar in tone to the conversations we hear about criminals who were granted bail with conditions and broke them. But patients are not prisoners: leave is usually about recovery and rehabilitation, even if the route to admission was via the criminal courts. Where leave is granted to a patient and it fails, does this mean leave should never been tried again? The reality is that it should be, although with due regard to understanding the reasons why it broke down originally and in the face of the risks being understood and mitigated. But if we agree that our model of mental health care is rightly about a community model of care, then we are going to have to understand and accept that MHA leave will fail. What we can be robust about, is understanding that when it does fail, we need to learn the lessons as to why and build that into future decision-making; and we need to understand that if it does fail, the recovery of AWOL patients is not (just) a matter for the police!

Even accepting that Mr ROSENTHAL was a convicted criminal, convicted over thirty years ago, he had assumed quasi-patient status by the prison service transferring him under s47/49 of the Mental Health Act to hospital. He was no longer detained in a high or even medium secure unit: Tatchbury Mount Hospital is a low-secure unit so it may be inferred that his care plan was aiming for discharge and that the Responsible Clinician was satisfied that security risks were of an order to grant unsupervised leave. Does this mean if leave failed, by him absconding from the grounds that he is high risk? – yes.

Risk assessment is (able to be conceived as being) based upon the probability versus the impact of threats: by any standards, a convicted murderer who has absconded is going to be high risk, irrespective of whether he was acutely unwell and experiencing psychosis having recently been admitted; or whether he was sufficiently stable to be granted unsupervised leave and is looking toward being conditionally discharged from hospital.

Most murderers do not live out their lives in prison or hospital and so we need to grasp the reality that professionals employed on our behalf who have to take these tough decisions may from time to time get it wrong; but they may make decisions which are perfectly balanced and fair which still lead to a failure in the purpose and outcome.

13th August 2013

Finalist for an International Award –

I was delighted to hear this week, that I have been short-listed for an international award for police use of social media! How cool is that?!

All eyes on Omaha in the United States on 25th September – when the winner is announced!

I find myself the only *individual* UK police officer to have been short-listed in any of the many categories and it was written, "Inspector Brown is widely known and recognized for his work in mental health policing. His work, especially his 'Paramedic Series' of posts on his blog *Mental Health Cop* has educated police officers, their agencies and others internationally. Inspector Brown freely gives of his time and expertise to mentor his colleagues at hospitals, ambulances services, mental health units as well as patients."

The ConnectedCOPS Awards are given annually at the SMILE Conference – Social Media In Law Enforcement – which itself has been running for several years to highlight good practice in police use of social media across the globe.

SMILE will be hosted for the first time outside North America when it comes to the UK and is hosted by West Midlands Police in 2014.

"This award is given to the sworn law enforcement executive of the rank of LT (or its international equivalent) and above, at any worldwide law enforcement agency who has demonstrated significant and sustained executive leadership to further the use of social media and internet technologies in law enforcement. This individual is a risk-taker and a pioneer in his or her promotion and use of social media in policing. The recipient of the Top Cop Award also gives his thought leadership and expertise freely to others."

This continues to show that UK police use of social media is amongst the best in the world and to be short-listed for putting together this blog and driving a Twitter account about something I'm passionately interested in is real honour indeed.

Fingers crossed!

14th August 2013

It's Just An Opinion –

I am well aware that not everything I say on this blog is agreed by all who read it – I usually try to acknowledge those things I'm saying that are not agreed and present the other perspective. Feel free to point where I've forgotten to do this. This whole enterprise is a place where I've brought together a lot of my own opinions in the face of laws and stated cases; professionals guidelines and the real world in order to offer some views about where this may be done differently.

But at the end of the day: this is just my opinion, a point of view. I hope to couch it in argument and I do hope to influence. If you've read my stuff and you continue to disagree, that's fine. I'd enjoy a debate to find out why, because I've admitted all along – I'm making this up as I go, hoping to bring it all together conscientiously after research and debate, but if I've missed something, let me know and we can talk it through. At the end, we may still disagree because the interface of policing and crime is about endless shades of grey, about choosing the least worst option and making various other decisions from uncertainty. So there will be room for opinion as we try to draw the balance between individual autonomy and broader public interest.

Ultimately, certain decisions rest with certain professionals and as they are accountable for them, they must be allowed to take them. I will happily hear your concerns about whether someone will be arrested / prosecuted, but I'm afraid I will retain the right to take that decision on my own terms. It's not going to be you justifying to my professionals standards department, senior officers or a court why an improper, unnecessary or illegal arrest took place. But I'll happily hear what you have to say about it.

So when decisions rest with mental health professionals or where there is a public debate, please don't fear the expression of a viewpoint and please don't misrepresent what I've said in expressing it. This doesn't mean that I seek to deny you your professional judgement or your personal view; merely that I wish to see it exercised in the face of knowledge that I often find missing and that I want to ensure was available. This is all lovely and vague so far, isn't it?! Let me explain! –

Two debates have recently resurfaced – they are far from new – on which I've expressed opinions on social media and during a conference presentation. It seemed to arouse strong feelings amongst some who accused me of "unilaterally deciding how AMHPs should conduct their professional business. It is not for the police to do."

MENTAL HEALTH IN PRIVATE PREMISES

Remember the debate about mental ill health in private premises? … the police have no powers in a private dwelling to anything coercive unless there is a crime or a breach of the peace. As such, when we get asked to attend an address in support of MH services to mitigate risks and keep people safe, we sometimes lack the powers by which to do so. If the AMHPs coordinating the assessment had a warrant under s135(1) MHA then all is well, from that point of view. But if they do not propose to get one, it might present a problem. I said "might", not "will" … anyway, this is *their* professional decision, not mine. I cannot, by law, ask a magistrate for such a warrant.

What I can do, is discuss something with the AMHP if I have concerns about a proposed assessment where I believe I am being asked to mitigate risks where I lack the tools.

I was asked to do this earlier in the year. The effect of the AMHP's / DRs' decisions were to ask me to do things in the face of what eventually became potentially fatal risks, without any legal authority to do so and in the face of relatives exercising their rights to determine which police officers can and can't enter their home. I believed that the non-availability of a warrant and the decisions by the relatives were pushing me into a corner where risks were building and where I, as the senior police officer present, was being asked to be responsible for things I couldn't control unless and until people were started to get hurt.

As it happened, there was a perfectly straight-forward solution to the problem: **get a warrant from a Magistrate under s135(1)** … the AMHP's decision, obviously.

My decision was whether I was going to send under-equipped police officers into a room to face a man with knife who has not committed an offence and is known to be very unwell. As he's not actively hurting himself or others and as the hurried entry of uniformed police officers implying he's about to be forced could well activate a response we don't want to see, we won't be doing that. We all know the dangers of running into crisis situations to use force, far too quickly and Canada are debating that right now, following the fatal outcome to the police shooting of Sammy YATIM just a few weeks ago.

Unless you get a warrant, the situation escalates without provocation by the police or until he comes out of the address where section 136 is in play, we will be containing the house and no more. << That is my professional decision, not yours! It was the *only* time in my career where I'd ever had to say this. Subsequent debate with the AMHP's manager led to a very quick volte face and they went to get the warrant. Twenty minutes after it was executed, the man was safely in legal custody, with only a minor injury where he stood on something sharp during restraint.

SO SHOULD WE EXTEND POLICE POWERS?

Now I've been misrepresented a few times during the debate about whether or not s136 of the Mental Health Act 1983 should be extended to private premises and service users have told me that it is not for the police to call for this as it is a political and civil liberties issue. So let me be clear –

I don't mind or care whether or not police powers to act in private premises are extended or not – all I want, is a recognition of the fact that the law currently leaves a legal 'gap' in our ability to keep people safe, because the police lack legal powers by which to do so and mental health services lack the capacity by which to do it. And I want that rectified so that we – our society – have the capacity and capability to keep people safe in predictable events.

Whether the police are (part of) the solution to that, as is the case in the Republic of Ireland, **is for our elected politicians to decide**. For what it's worth, I doubt that the NHS will ever get itself to the point where they prioritise emergency mental health care to this degree, that they will be able to ensure rapid response. Many mental health nurses have themselves pointed out on this blog that they are not an "emergency service" in the 999 sense. So I admit I do come back to thinking there is merit, with appropriate safeguards, in looking at the police as a solution to the 'problem of the gap' – but that's just an opinion. And it is for others to decide.

Incidentally, my views on s135(1) were at one stage different to those you've read about on this blog: I was heavily influenced by a mental health professional's *persuasive* argument!

15th August 2013

Searching Patients

When can you be searched by the police or mental health services, to establish whether you are carrying things that are either illegal or could be used to cause harm to you or anyone else?

Not as straight-forward an answer as you might think, I'm afraid! … I'm going to split this into several categories –

1. Search after being detained under the Mental Health Act by the police.
2. Search after being arrested or removed to a police station.
3. Search after being 'sectioned' or whilst detained on a ward.

Article 8 of the Human Rights Act applies to these issues, as they relate to privacy and personal integrity.

DETAINED BY THE POLICE MHA

The police can detain people or patients under various MHA provisions. These include –

- **Section 18** – when patients are AWOL from hospital
- **Sections 35, 36 or 38** – where patients involved in criminal proceedings abscond from remand or from an interim hospital order.
- **Section 135(1)** – when people are detained under the terms of a warrant for assessment of the need for admission
- **Section 136** – when people are detained by the police to be taken to a place of safety for assessment
- **Section 138** – when people are detained or redetained after absconding from various provisions of the MHA – this includes people who abscond after being "sectioned" but prior to admission in hospital, as well as patients who abscond from a place of safety.

The only important distinction to determining whether the police then have a right to search you, is whether you were detained under s135(1) or under the other provisions I have listed. If you *were* detained under the other provisions: they are all "preserved powers of arrest" by virtue of s26 and schedule 2 of the Police and Criminal Evidence Act 1984 and the police can then search you under s32 of PACE if the criteria are met –

"A constable may search an arrested person … if the constable has reasonable grounds for believing that the arrested person may present a danger to himself or others … for anything which he might use to assist him to escape from lawful custody; or which might be evidence relating to an offence."

This points bears a moment of clarification: by saying "arrested" the legislation is not saying "arrested for an offence." This is a tricky debate for the detention of patients who are unwell, because the word 'arrest' carries inherent connotations of criminality. Strictly and legally, arrests occur for many reasons and do not *just* apply to criminals or suspects. In a difficult case investigated by one of my officers last year, the victim of the crime was arrested on the order of the court hearing the case. Doesn't mean she is or was a criminal – but she was arrested.

So why not s135(1)? – put simply, because it is not a "preserved power of arrest" it does not come under the purview of s26 PACE. The warrant from the court does not allow a power of search of the patient either and this is a point that often gets debated when policies are being put together. Place of Safety service have quite often been known to say "Police will search the patient" for all detentions after s135(1) and s136 and there is simply no blanket power of search. Each search following s136 must be justified against there being "reasonable grounds to believe" that the item will be found. Where the person had been detained under s135(1) there is no explicit power given to search, so whether you can would hang on whether an officer felt there was a common law justification, in terms of the general duty to keep someone safe whilst in the control of the state.

As a warrant under s135(2) (for the re-detention of AWOL / absconded patients) is a power of entry to a location and any subsequent detention is then done under one of the provisions listed above, patients detained in their own homes after AWOL / absconding and forced entry, could be searched if s32 criteria were met. And for the same reasons.

POLICE STATIONS AND CRIMINAL OFFENCES

The police can search you after arresting you for an offence, subject to criteria. This remains true even if you are known to be mentally ill. Again, s32 PACE is the main authority immediately after arrest and the search may not just be about items that could be used to escape, but also to anything that is evidence of the offence for which you have been arrested. And if you have been arrested for an "indictable offence" (more serious matters, triable in the Crown Court) then a police inspector can authorise that your home be searched under s18 PACE if it is reasonably suspected that evidence for that or other similar offences may be found there.

After arrest, a search will probably take place at the police station – whether or not you were searched on arrest – as custody sergeants can authorise a more thorough search to ensure people in police custody for many hours are safe there, under s54 PACE. **This is still a general search** and does not involve the removal of clothing beyond layers of outdoor clothing:

- If there are concerns that someone may have concealed articles upon their intimate person that would not be found in a general search, **the custody sergeant can authorise** a strip-search if certain very stringent criteria are met.
- If there is suspicion that a person may have secreted items within their body **a police inspector can authorise** what is known as "an intimate search" if it is reasonably believed that the items cannot be found without such a search. Intimate searches are conducted by medical professionals and are usually done at hospitals.

All strip-searches are conducted and intimate searches supervised by two officers of the same gender as the person detained. There will usually be no-one else present, except any available appropriate adult for someone who is either a child or who is thought to be suffering a mental disorder and obviously the medical professional for intimate searches. Whether any authorised strip or intimate search could be delayed for the arrival of an appropriate adult would depend on the circumstances and the risks involved are weighed as carefully as possible.

PATIENTS ALREADY DETAINED UNDER THE MHA

Two situations here: firstly, patients who have *just* been detained MHA, for example in their own home; and secondly, inpatients on wards in mental health units.

Own home – where patients have been assessed and made subject of an application for admission under either s2, 3 or 4 they move into a condition of legally custody – that of the AMHP. An AMHP has a power to "detain and convey" someone to hospital under s6 MHA once they have made an application for someone's admission. None of these things is an arrest, so s32 PACE is of no application. If someone had been detained in their own home, then the police cannot use powers to "stop and search" because they are only exercisable in public places. I can't imagine a MHA assessment ever taking place in the street, so it would be highly unlikely that after being "sectioned", you could be searched under the provision of s1 PACE (stolen / prohibited articles) although particular search provisions like s23 Misuse of Drugs Act / s47 Firearms Act etc., are not restricted to public places.

On wards – this can be a tricky one. I have known several situations in which staff have sought police support on wards for patients who are believed to have secreted things like razor blades and where the staff honestly believe it would be dangerous for them to search the person. Firstly, the police would have no explicit power to search the person without arresting them on suspicion of an offence and then using s32 PACE. Locked psychiatric wards are not generally considered to be public places and hospitals are required by para 16.10 to the Code of

Practice to the Mental Health Act to have policies on searching patients. Subsequent paragraphs go on to detail considerations that should be applied to how that policy is put together. Whether the police could undertake a search which is deemed necessary by hospital policy but sufficiently risky to require officers to undertake it rather than staff is highly controversial and there is no clear answer. Searches under the Misuse of Drugs Act or Firearms Act could occur under relevant legislation.

Where hospitals have sufficient staff trained in control and restraint, it would be far preferable to see them take the lead. Let us not forgot, this particular point is the subject of review following the death of Olaseni LEWIS after officers attended a ward and restrained him. But this leaves the thorny subject of powers to search for blades – it would have to be justiable under established hospital policies and then the debate begins about what is for the police and what is for nursing staff.

Police officers should be aware – para 16.21 states a patient's Responsible Clinician should have been involved in any decision to search a patient without their consent and ask officers are only likely to be called to patients who refuse to allow a search, they should ensure they ask if it's authorised by them before doing anything and involve their sergeant or their inspector before doing anything than can be delayed for discussion.

GENERAL POINTS ON SEARCHING

As with all searches, they should be done in a way which minimises any impact upon dignity and privacy. Any force used to conduct searches without consent should be the least required in the circumstances. Where possible, searches should be conducted by a person of the same gender and usually with more than one officer or mental health professional present.

Laws and guidelines for police and mental health services all demand records be kept of searches done, with justifications and outcomes so they are capable of review and challenge, if need be.

15th August 2013

SCOOP IT! –
Policing, Mental Health and Criminal Justice

I have found a new social media toy to play with and I think it's quite exciting as it will supplement what I already do and save me some time, if I've understood it correctly – **Scoop It!** It turns out that far more people have heard of this than I realised(!) and are already busy using it productively but I came across it earlier today and have spent a few hours working it all out and experimenting.

I have set up a page called "Policing, Mental Health and Criminal Justice" – my natural Venn Diagram! Whenever I spot media content I want to share, as well as sticking it on Twitter, I can now "scoop it" onto this page which develops as a rolling barrel of material.

In terms of accessing it, it's absolutely up to you –

- **You can follow it via the website and you'll get an email** – click the link above and where the top left picture has a blue button with "suggestions" and a small red flag above the "Searching Patients" blog: that will read "FOLLOW" and you just enter your email address.
- **You can save the link above as a bookmark** – check it whenever you want to;
- **You could do absolutely nothing at all** – wait for me to promote it which I will do once a month with my monthly newsletter blog at the top of it.

I'm sure I'll learn more about this as I go and it may take me a while to work out how much to put on there and how to push it all around – but I hope you'll find it useful and I assure you I won't circulate it too frequently!

If you want it more often than monthly, I recommend you bookmark it or follow it!

18th August 2013

Coercion in the Community –

For years and years, the police were used to the idea that mental health care, as governed by the Mental Health Act, was "inpatient" business, connected to mental health hospitals: Patients were either in hospital as a sectioned or voluntary patient and the only application of the MHA outside the hospital were those instances where patients were first detained for admission or were re-detained having become AWOL. Very occasionally, one would hear of a "conditionally discharged / restricted patient" being recalled under a warrant from the Ministry of Justice, but the paperwork connected to those warrants provided a guide for officers who probably would never have heard of this legal power and would probably deal with it once in their career, if at all.

This impression of the MHA was not entirely accurate: guardianship, under s7 MHA, always had been there under the 1983 Act and the 1959 Act before that – and it *was* used. But I certainly did the first fifteen years of my police career without *ever* encountering a guardianship-oriented scenario that required any policing support. The police use s136 in emergencies, s18 when we re-detain AWOL patients and we sometimes assist in MHA assessments in homes, maybe under the terms of a s135(1) warrant. That's why police training pitches knowledge on these aspects of law.

RECENT MODERNISATION OF MENTAL HEALTH LAW

The challenge of getting to grips with mental health law around community based situations began to change in 2008 when the effects of the Mental Health Act 2007 came into force. This legislation has not long since been reviewed by the Health Select Committee of the (UK) House of Commons.

It introduced "Community Treatment Orders" to the Mental Health Act and Deprivation of Liberty Safeguards into the Mental Capacity Act which each provide a degree of coercion in the community.

CTOs imply the possibility of recall to hospital and can have conditions attached around residence, supervision of medication and so on – they supposedly allows for easier re-admission where this becomes

indicated. They were originally aimed at preventing the "revolving door" of crisis admission >> rehabilitation >> recovery >> discharge >> relapse >> further crisis. It was aimed at preventing relapse through the conditions imposing an imperative on the patient to comply or through allowing clinicians to recall patients to hospital before relapse reaches crisis. Of course, the beds crisis in the United Kingdom means there is often difficulty getting patients back in before the relapse becomes a crisis, but that is something else the Health Select Committee reported on, asking Parliament to inquire into it. The select committee and recent academic research suggests CTOs are ineffective and although wildly more frequently used than was first considered likely, they are not applied consistently across the UK.

We also saw the Deprivation of Liberty safeguards, known as "DoLS", added into the Mental Capacity Act which also introduces different legal dynamics to the delivery of care through restriction in the community, usually for elderly patients with dementia or patients with learning disabilities who do not require inpatient hospital care. I had a recent query from a Yorkshire police force – what power do officers have to recover someone who was subject to a Court of Protection imposed DoLS order to remain on a particular hospital ward, but who has left? I know mental health lawyers who don't know the answer to this, so what chance operational cops who also might get this query once a career, if that? Now if there was an easy answer to this query, we could stick it on the intranet or on a well-known blog on policing and mental health – but there isn't an easy answer! Specialist trainers on the MCA hesitated in their answer.

It has become obvious to me over the period since we started to see the rationalisation of inpatient mental health services that the implications of CTOs, the emerging instances of guardianship and also police-connected DoLS incidents are creating new imperatives for police officers to have knowledge or at least access to knowledge, which sometimes needs to be detailed.

As such, I have written a new "Quick Guide" on Guardianship, to sit alongside the existing one on "Recalls and Revocations" and I will do something on DoLS as soon as I can.

KNOWLEDGE OF THE LAW

I want to argue that everyone's knowledge of mental health law needs to improve – not just in policing. We need training and it needs to be delivered with a depth that reflect the demand and complexity it represents.

I have to do five days of public order training this year, recently increased from three and I have to do this every year. Now large-scale

demonstrations like EDL protests – of which I've policed a few; football matches – of which I've policed hundreds, are important business. I was sent to the Olympics as a public order commander and no-one wanted to see that stuffed up so training is important.

But so is mental health. In fairness, failures to police mental health incidents properly have got the police into similar kinds of controversy as failures to police public order properly, like at Hillsborough and the 2011 UK disorders. Responses to those matters tend to be inquiries (like the Taylor Report after Hillsborough) and although we've had the Adebowale Report (2013) we're yet to learn whether I'll be on a five-day mental health course so that as a duty inspector, I can get to grips professionally with the nature and variety of demand without damaging the reputation of UK policing and more importantly, without putting people at risk.

Senior officers need this, too – **I've seen too many of them fobbed off over the years.**

I handled a complaint last year which had suggested officers did not know their legal powers and had in effect, allowed a patient to become even more unwell through "their" inaction. During a meeting with the mental health team about this the opening remark from the psychiatrist was to invite me to give *guarantees* that "nothing like this would ever happen again!" Instead, I gave examples of where his trained or sometimes legally warranted mental health professional colleagues did not understand the Mental Health Act either, despite their training and wondered aloud how realistic it was for a front line police sergeant to get it right without detailed law training and partner professionals who are giving him little or no information?

Not realistic at all, I argued. Having spoken to the sergeant involved he acknowledged he had made "a bit of a punt" in good faith, but that he had done so after asking for clarity from MH professionals present and not getting it. And then there was today's high risk missing person … family frantically looking around the area of a care home where their mother / grandmother was residing. Quite advanced dementia to the point where she did not know her own name and struggled to recognise her children and grandchildren.

The 999 call came in and I started mobilising EVERY single available police officer on the area to search for her. Background discussion with staff whilst the search began that she was subject to no legal framework whatsoever, but they'd claimed that "she wasn't allowed out." Under what law is she 'not allowed out?' Adults can do as they please unless the Court of Protection has determined otherwise because of an established lack of capacity. She was found quite quickly, but that really was more good luck than judgement.

MAKING SIMPLICITY FROM COMPLEXITY

This legislation is complicated: I have three hours of mental health training to my name and **half it was wrong and the other half doesn't work in the real world** because the real world does not look as the Mental Health or Capacity Acts' Codes of Practice implies it should. As such, many people are making this up as they go, of necessity; and I don't say that proudly. We know now, if we didn't before, that policing comprises demand of which 20% is connected to mental ill-health. If you add in the effects of drug and alcohol abuse as a mental disorder, that number should be at least doubled.

Incidentally – the DoLS "re-detention query" answer is: no explicit power at all, which always inspires confidence when your trying to research the answer at 8pm on a Sunday for that once-in-a-career situation that your relevant health professionals don't know the answer to because they've had no training either. You can defend the proportionality of your intervention to return the patient against the criteria laid down in ss4, 5 and 6 of the Mental Capacity Act 2005. DoLS after all is part of that Act and is part of the solution. Clear as mud isn't it?

I wonder what they could have done to make mental health law more complex than fill it full of implication and then deliver almost no training? … and all for outcomes which scrutiny of various kinds suggests is little better than it was before for people living with mental health disorders.

21st August 2013

The Adebowale Deficit –

More debate this week about Street Triage in light of yesterday's announcement that the scheme is being extended to five new police force areas. As such, Minister of State, Norman LAMB went out on patrol on Monday evening with a triage car in Leicestershire whose scheme is leading the way in many respects. But yet again, my expressing just some reservations about the scheme have been interpreted as being "against" it; or me thinking it is "bad".

I can't say this any other way: **I welcome the scheme** .. I really do!

I welcome the scheme both for what it is and for what it's worth and I have consistently said so. My concerns are about what the scheme is *not* – it is not an answer to the crisis events examined by Lord Adebowale. I will henceforth refer to Street Triage, as well as other policing-and-mental-health arrangements, as having "**an Adebowale deficit**". << This is the 'gap' between that which exists and that which is required to consistently, professional and legally respond to ALL of the mental health emergencies facing us in order to provide effective emergency mental health responses across the policing, health and social care agencies.

So Street Triage *is* welcome, but **it's not the answer to everything**.

THE DEFICIT

It's exactly the same debate about Street Triage as we get when we are talking to the NHS about providing section 136 services – they also usually have "an Adebowale deficit". Indeed, several commentators focus upon the ability of Street Triage to provide alternatives to s136, thus meaning the police don't have to make those detentions and then sit around in places of safety for hours on end. Of course, the police shouldn't be sitting in Places of Safety for hours on end anyway because the multi-agency agreement, published by the Royal College of Psychiatry in their "Standards on s136", states that the police should be able to deliver s136 detainees in to the care of the NHS and leave. So in that sense Street Triage, in part, is a solution to a problem that shouldn't exist in the first place.

The police need to remember, though: one reason services don't exist as they should, is because the police over-use s136 in some parts of the UK and some officers misuse it. We need to acknowledge that.

Of course, even with the best s136 arrangements in the country, there will still be incidents where the police encounter individuals in the street and Street Triage provides the potential for them to be diverted away from detention. << You'll remember, historically, that s136 was introduced into the Mental Health Act 1959 as a method to divert people from being arrested for minor criminal offences and to consolidate various 19th century 'vagrancy' and 'lunatic' laws. So street triage is trying to divert people from diversion, as General MELCHETT nearly said. "What? Divert him from diversion as we continue to define diversion? – yes! Why not? … sounds rather fun!"

And when it comes to the inability of Street Triage to provide an alternative – on occasion, some vulnerable people are always going to need detention – we then hit "the Adebowale deficit". What happens when the person encountered is intoxicated or resistant? What happens if they're encountered in a private premises? … what happens in one of the more difficult incidents where patients who are floridly unwell is being restrained by multiple police officers and resisting detention to a massive degree? For some of these cases, you may still need the pre-hospital clinical skills possessed by paramedics. Street Triage doesn't address this and although some mental health nurses have balked at the idea that they may not be appropriately skilled in pre-hospital care, there are many more mental health and general nurses as well as doctors who have agreed with me.

When these difficult cases were discussed as our s136 processes were put together in the West Midlands a few years ago, an awful lot of health professionals said, "Well, if someone is being restrained by six police officers, they'll have to be taken to the cells." And the idea that anything else would happen genuinely seemed to be an affront to common sense. Of course, one answer to this remark is to say, "Michael POWELL" or "Sean RIGG." The fifth anniversary memorial for Sean RIGG will be held at Brixton Police Station this evening; and the tenth anniversary memorial for Michael POWELL will be held outside West Midlands Police headquarters on 07th September this year.

There are other names that could have been given, and I mean no disrespect to their memory that I didn't list them all.

POLICY AND GUIDELINES

Of course, in these difficult cases there has followed various kinds of legal investigation and activity that has lasted very many years, without really

providing the clarity or reassurance that anyone needs. But statutory inspections around police responses and healthcare provided tend to look at law and relevant guidelines.

When you do this for s136 you end up reading the NICE Guidelines on:

- Acutely disturbed behaviour
- Self-harm / Suicide
- Dual Diagnosis

You also look at –

- Royal College Standards on s136
- Code of Practice to the MHA
- Code of Practice to PACE
- MS v UK
- Academy of Medical Royal Colleges

- And of course – **the Adebowale Report**

Again, this list could keep going on and on – how many more vulnerable people have to die and suffer untoward indignity; how many more reports do we need before we look at our nation's emergency mental health care arrangements and realise the extent of "the Adebowale deficit"? Parity of esteem?! – when we lock up people in police custody for being ill, failing to recognising some mental health crisis as the medical emergency it is?

COMMISSIONERS AND PROVIDERS

We hear that the Care Quality Commission are undertaking a review of Emergency Mental Health Care, at least in part to Lord Adebowale's Report. We should rejoice at the notion that maybe something will come from this. Maybe it will, but I admit I'm doubtful for reasons beyond the CQCs control.

The CQC are a statutory body regulating providers of NHS services, essentially to check the quality of their provision. They don't inspect the "commissioning" of those services. If you're reading this from a non-NHS background, you may not appreciate the distinction. I wrote about NHS organisation recently, but basically Clinical Commissioning Groups decide what health care is needed for their area and "commission" those services from "any qualified provider." The CQC then regulates those providers. So what if the CCG is not commissioning correctly … or at all? That's up to NHS England so I look forward to learning where they will feature in this review, by examining commissioning gaps for specialist offender-health services.

The Adebowale Deficit has one further dimension: about legalities. Having been praised for the triage car initiative with Leicestershire Police, the Leicestershire Partnership Trust today published a press release. Keen to show the benefits it brings – I repeat: I don't doubt them! – the press release wanted to contrast the skills a police officer and a mental health nurse brings to the situation and claimed that the CPN could undertake a "Mental Health Act assessment", which of course they can't. By law, Approved Mental Health Professionals undertake statutory MHAAs with DRs and mental health nurses play little or not part in it, except potentially to gatekeep the need. It is an AMHPs decision whether or not someone is subject to an application for their admission to hospital. Nurses have no legal authorities at all whilst deployed in a triage car which means a triage response to mental health crisis in private places is legally powerless: just like the police already were.

So here's the Adebowale Gap in practice: the triage car turns up to support other officers dealing with a volatile situation involving a vulnerable person. There is little or no option but to detain under s136 MHA and this occurs in an area where the local PoS is not fully developed to RCPsych standards and is not properly staffed. A&E persist with the myth that they are "not a place of safety" and have always maintained that s136 detentions cannot be removed to their environment unless there are physical healthcare problems. The detention occurs and the patient, frightened for their life whilst suffering a terrifying psychosis, resists. Handcuffs, leg restraints are used after attempts to de-escalate have been tried and failed. An ambulance is called and it may or may not come to a s136 intervention depending on where in the country you live)

The patient is now contained, although still resistant and we need to expedite their onward movement to a more appropriate location than a street. Where are we going now? Who decides? I have asked this question of people directly involved or party to Street Triage schemes. The answer I've had to that scenario is depressingly predictable: **the cells**. And I've heard doctors and nurses as well as AMHPs and police officers say this.

The only answer that thinking after all the rationalisation has been tried and failed, *and on today of all days:* "Sean RIGG, Michael POWELL, James HERBERT."

Vulnerable people detained by the state deserve far, Far, FAR better, regardless of how hard it is perceived to be. This is "The Adebowale Deficit".

25th August 2013

Phone A Friend –

Remember a statistic I've pumped out a few times about the difference between the number of people suspected or identified in police custody as having a potential mental health problem in need of assessment and the *actual* number? For those who don't – research suggests that the police will identify around 12-15% of people who are arrested as needing to be seen by the force doctor because of mental ill-health. This is to establish, legally speaking, whether they are fit to be detained and fit to be interviewed. Medically speaking, it is to determine whether they may need assessment under the Mental Health Act.

We know that the police do not always manage to identify people in custody – in some sampling by a police force in the south of England, they provided their arrest data to the mental health trust's Criminal Justice team and found that fifty percent – *yes, FIFTY!* – were people that a) are known to the MH trust; b) were known previously; OR, c) need to be known by virtue of what has emerged from the arrest.

In fairness to the police, if someone's condition is not manifested in obvious, overt behaviour and unless the person concerned or someone connected to the incident tells the police there may be a history of mental ill-health, then the only thing that may prompt questions is anything on police records, like PNC markers. That of course only works if someone has been if contact with the police or arrested before.

So how do we improve the rate of identification? Well, it could be easier than we think –

I've wondered aloud on numerous occasions over the last two or three years why we couldn't just have a number within the mental health trust which the police ring 24hrs a day for everyone who is arrested. When they ring the police would simply say, "We've got Michael Brown with us" and give his date of birth and address before confirming whether the police doctor does or does not have concerns about his mental health or have indications of a history of mental ill-health. Then this next bit is key –

I wouldn't want the Mental Health trust to tell me anything about Michael Brown – no need to breach his right to medical confidentiality at all. I would only need them to confirm to me whether or not they are

coming to properly assess him in custody and to then decide, after a full appreciation of the legal and medical condition he is in, to decide whether disclosure of anything at all might enable a better decision by the police that balances his rights and entitlement with issues that arise, if any, for public protection.

This "assessment" would either be a generic MH assessment by a CrisisTeam nurse, OR a statutory MHA assessment by an AMHP and two DRs, depending on what the FME had indicated was needed. Of course, if the nurse arrived and felt a statutory assessment were required, the one could lead to the other.

CRISIS TEAM ASSESSMENT

I've written before on my idea of Liaison and Diversion. We've seen time and time again how patients can reach arrest after crisis without having sought help, irrespective of whether they are open to mental health services. We have seen that a timely sharing of information whilst we are still at the pre-charge stage could lead to better criminal justice decisions to don't unnecessarily criminalise people, as long as the police have got diversionary mechanisms open to them. I have also argued that diversion should not just be something that "kicks in" when patients are so acutely ill that the need to be "sectioned" after an MHA assessment.

Bringing the CrisisTeam in at this stage, opens up all those potential benefits and whether or not the alleged offending in that particular case is attributable to that patient's mental illness or not, could there be a more apposite point to intervene and re-consider what appropriate support could be than when a patient gets arrested by the police?

Just a point on confidentiality – you'll notice that the opening telephone gambit involves the police disclosing information and the mental health trust disclosing none, at that point. This breaches no-one's confidentiality, because the police have a duty when someone is under arrest to ensure appropriate clinical attention for detainees and to conduct thorough criminal investigations, which includes assessment of both the evidential test and of the public interest test. Disclosure at that stage of nominal details can be defended under the Data Protection Act against that background because the answers may well influence the police to do things differently.

NUMBERS

The big question Mental Health Trusts will probably have is "*what are the numbers?!*" However desirable the idea may be, it will hit the brick wall of

reality if the numbers are overwhelming. Well, the custody office area where I worked in the West Midlands, is usually around the third-busiest in a force, which is one of the largest in the United Kingdom. If it could be done there, I'd argue it could be done anywhere. There are around 24 adults a day arrested for offences, on average. Some days (far) more, some days less. But this clearly equates, on average, to one phone call per hour, to establish whether there is a potential to intervene to safeguard a vulnerable person and / or protect the public.

Is it beyond the wit of man for a police force and their local mental health trusts(s) to set up one telephone line that will be rung:

Sarge: "Morning, police station here. We've got Tom BROWN in, arrested for shoplifting – markers on PNC for self-harm and mental health. Doctor says he doesn't need MHA assessment. What do you think?"
Nurse: [Rumbles computer keys]: "Yep – Assertive Outreach Team patient. We'll send the CrisisTeam."

OR

Sarge: "Morning, police station here. We've got Joe BROWN in, arrested for assault – no markers on PNC for anything connected to mental health and Doctor says he's good to go."
Nurse: [Rumbles computer keys]; "Well, actually, he is a recent patient with the CMHT but discharged about three months ago. We'll send the CrisisTeam.

The End.

Of course, not all detainees would need a response, nor do I envisage them getting one. This process is about having a sound basis on which to decide to "screen-out" some detainees. If the police have no markers on their systems, no concerns or any information from the detainee or people connected to the incident and the Mental Health trust have no history with that person as a patient, there would be no need to turn out or do anything differently. The MH trust response would only been potentially required if the police doctor was indicating MHA assessment was needed OR if the person was known to services and it was felt beneficial to be seen by the CrisisTeam for a generic assessment.

All of this links, in my mind's eye, to the Liaison and Diversion model I previously outlined and for me, would significantly impact upon the number of detainees who receive inappropriately criminalising outcomes. To those who argue that it would increase the work of 24hrs CrisisTeam services: I would not disagree one bit and I know that this means NHS managers would have to work out how to do this against a background of budget restraint.

Maybe that's true – but if we don't provide the proper intervention at the right time, we'll see the failure demand replicated in criminalising prosecutions of which only one or two need to become forensic cases coming out of the criminal courts to blow the budget argument sky-high. We know from some areas, that failure to provide Early Intervention services, which absolutely should include Crisis Intervention in police custody, will lead to prosecution of some patients into the secure NHS estate at massive cost. So even if you don't get the human argument, above; the economic one is also there for those who prefer spreadsheets.

NB: *on the budget restraint, did you know that the Department of Health has, for the second year running, returned money to the Treasury in what was described as "an underspend"? Here's where some of that £2.2bn could have gone; or last year's £1bn. Could have been used here, and also in the adequate staffing of all NHS Places of Safety. Both of these areas should be considered basic mental health services.*

27th August 2013

Policing and Dementia –

I recently started a night shift and whilst taking the "handover" from the late shift inspector he was briefing me about a missing person for whom we would shortly take responsibility. When he said, "there are three missing persons enquiries, the most concerning of which is a dementia patient" I was immediately concerned it may have been a particular lady we had dealt with only the previous day.

My team had been involved in a Mental Health Act assessment in support of an AMHP having quite a difficult time ensuring the lady's admission because of a combination of medical problems, resistance and difficulties securing doctors to sedate her for safe transfer. It wouldn't have surprised me to hear that she had walked out of the hospital because she really didn't want to go when we had assisted the AMHP.

But it wasn't her – it was an elderly man who had gone missing during the 'early' shift that day. Later in that night shift, we took a subsequent missing person's report concerning a man who had just been diagnosed with "early onset dementia" as well as some other serious health problems. That was three dementia related calls and two of them vulnerable missing people in one police area in just 24hrs. Quite rightly, a missing patient can command exceptional levels of resource because of the vulnerabilities involved and can sometimes bring an area's day-to-day local policing to a halt as it's "all hands on deck".

My discussion with my colleague got us chatting more generally about dementia-related demands. The police see it in two situations in particular – missing persons investigations and supporting AMHPs and psychiatrists in Mental Health Act assessments. I have also known, although less frequently, requests for the police to "do something" about challenging behaviour in care homes for vulnerable adults. This is always difficult – the police can attempt to persuade or negotiate or we can use force to prevent crime or arrest people: but neither is necessarily guaranteed to be very effective at all; or even very appropriate.

We heard recently that Sussex Police were involved in a scheme were dementia patients could be "tagged", with all the connotations of criminality that tagging brings and leading to a quite predictable uproar. Of course,

the scheme was a local authority lead scheme, which wasn't to be forced on anyone, but it shows very adequately, the sensitivities involved here.

ALZHEIMER'S DISEASE

Dementia isn't a disease in itself: it is a symptom and can be attributable to a variety of health-related problems, including simple dehydration. More commonly, it is seen in relation to Alzheimer's disease, vascular dementia or Parkinson's. For more information, I would recommend you read the website of The Alzheimer's Society which is full of factsheets and information, as well as support and advice. There is a Helpline number available for those who want more information on **0300 222 1122** and you can also follow them on social media with links on the front page of their website.

In 2012 The Prime Minster launched a 'Dementia Challenge' as part of the Dementia Friendly Communities programme, something which was supported by Chief Constable Simon Cole on behalf of ACPO. Police actions with regard to incidents involving patients with dementia are obviously, especially sensitive. The Dementia Friends website is also useful to know about.

WHY CALL THE POLICE?

We understand why the police are called when vulnerable people go missing, but it is more difficult when the call is to restrain patients who have been detained under the MHA or are in residential care and exhibiting challenging conduct. I know that we are perhaps tempted to picture frail, slight patients with mobility problems and states of confusion that often come with being a certain age and wonder about the thought processes that went into calling the police or whether it is really necessary? But we also hear from some mental health professionals who have worked with older adults that the only time they have been assaulted in their careers was at the hands of some beyond retirement age and that some have been left with serious injuries, life- or career-altering, on occasions.

I am yet to be convinced that in most cases the police are asked to lead on, there couldn't have been earlier intervention. Indeed, I've had families complain of it to me when we've turned up: "Thank heaven's you're here, we've been trying to get help for days" … sometimes, weeks. I often wonder whether trained nursing staff would not be far more appropriate to most of those situations and whether appropriate de-escalation and / or C&R training would not have been sufficient to manage the risks involved? Even in such situations where the resistance being displayed was more significant

– a recent example included a patient who was hitting out with a walking stick causing black eyes – it begs the question what the police bring to the party that a trained nurse could not, with police support where that is necessary.

What we bring that others do not is batons and handcuffs; tasers and CS spray – and arguably, that is all. The legal powers we would have available to us are also equally available to others, the human ability to talk is not monopolised by the police. One might argue that the presence of uniformed officers is "motivating" – I've heard this many times. It is equally easy to cite examples where it has made little difference, or has even aggravated a situation unnecessarily. If one reads the advice from the Alzheimer's Society on dealing with aggressive behaviour, there is every reason to fear that suddenly introducing police officers could make things far worse.

If someone is – ultimately and as a last resort – going to have to get 'hands on' with a patient, there are risks about the way in which police officers are trained to use force, which need to be borne in mind. And to those who would say "I don't come to work to get assaulted" – neither do police officers and they are just as entitled to say so. This is not about who it is more appropriate to assault – it is about early, timely and appropriate intervention by people best trained to do so. If intervention is not early, it might be that the police are the appropriate people – but that comes with the risks associated in Humberside because the tactics for managing seriously aggravated resistance by anyone are few and they are blunt, especially where de-escalating things has been tried and failed.

POLICING AND DEMENTIA

I have certain particular reservations about what I see as the increasing role of the police in supporting services engaged in dementia care – saying this is absolutely *not* to argue that there should be no role at all and that the police should distance themselves from the issues. Clearly the police have a key role in searching for missing people, this will always be the case and vulnerable patients with dementia, especially the elderly, are always going to be a high-risk priority. They also do have a role in supporting those higher-risk Mental Health Act assessments.

Where my concerns lie, are in the incidents we are seeing more and more: the use of force on passively resistant patients who are being admitted to hospital against their will, detained under the Mental Health Act. I have previously written about the use of force and remain to be convinced that the police are the appropriate answer to certain problems we see emerging more frequently, including for calls that the police should "do something" about very elderly people in care home exhibiting challenging behaviour. But then it is fair to comment that training within the nursing profession to

deal with such challenges was a feature of the criticism in the Francis Report. One can see why the police are sucked into the vacuum created, however wrong that may be.

Without for one moment condoning aggressive behaviour towards professionals staff or being seen to imply that they should "get on with it", there is a reality to be applied to care home situations for people who often lack the capacity to make very basic decisions. Alzheimer's and dementia can be some of the most upsetting and distressing conditions, especially as adult children see elderly parents progressively deteriorating mentally and struggling to cope with everyday functions we all take for granted. Distressed by this and perhaps having lashed out or become aggressive through confusion, disorientation or basic unfamiliarity, how does it help to call the police to "do something?" As I have said before, the police, broadly speaking do two things: we persuade, negotiate and influence or we use force – to prevent crime, prosecute people and maintain the Queen's Peace.

We have seen in recent years, the fallout from certain incidents – the "Taser" incident in Humberside; the "Handcuffs" incident Greater Manchester. In courts and in the media we have seen criticisms and debate: should the police be involved at all; and if so to what extent and how? Ian Hanson, the Chairman of the Greater Manchester Police Federation summed it up very well after the Inquest into the death of Mr Alan BAILEY, "Whenever another agency is short on resources or where something does not fit squarely into their remit, then society has got into the habit of calling the police. We are then expected to be experts in everybody else's job and when we don't get things right then we get criticised."

Following the incident in Humberside when the involvement of the police was being debated and the nature of the force used contested by many, Jeremy Hughes, the Chief Executive of The Alzheimer's Society was interviewed on BBC Radio 2's Jeremy VINE show and was far more interested in pointing out something else, which I hear as a recurring theme in my operational experience: "It is a real failure of support and a failure of care, which I'd take back a step before the police's role. The police are doing what they are trained to do … why did it get to a stage where the Doctor hadn't been aware of a need for support earlier? It is very unlikely that you'd get such a rapid progression in the space of a morning where suddenly someone was in need of support where previously they didn't."

We talk a lot about early intervention, the reality does not always reflect this and that's increasingly why the police get called.

29th August 2013

Section 6 Mental Health Act –

Where an AMHP has made an application for the admission of a patient under the Mental Health Act to hospital, they will often seek police support to safely achieve admission where patients indicate they will resist admission and detention. Where do police officers get the authority to detain and convey patients and perhaps crucially, to use proportionate force in achieving this?

There are a couple of barriers to easily understanding this frequent question and I've had it posed a many, many times including twice this week alone and I've only just realised I hadn't written a specific blog on it so this one is dedicated to west / central Birmingham, where I began my career and learned exactly how little I knew about policing and mental health!

The barriers to a clear understanding arise because –

- Nowhere does the Mental Health Act specify police officer's responsibilities in the scenario of a resisted application for a patient who is not yet admitted.

- Nowhere does the Mental Health Act talk about the use of "reasonable force" in a way that is as clear, for example, as s117 of the Police and Criminal Evidence Act 1984.

LEGAL CUSTODY

Where an AMHP or Nearest Relative (NR) has made an application for the admission of a patient under either section 2, 3 or 4, the effect of this application is described in Section 6 of the Mental Health Act –

- *"An application for the admission of a patient to a hospital, shall be sufficient authority for the applicant,* ***or any person authorized by the applicant****, to take the patient and convey him to the hospital."*

The bold in the above is my emphasis: this is where police officers derive an authority to detain / convey, if they are requested to do so by an Approved Mental Health Professional.

A condition of legal custody emerges after the application, by virtue of s137 MHA, which states:

- *"Any person required to be conveyed to any place shall, while being so conveyed, detained or kept, be deemed to be in legal custody."*

- *"A constable or any other person required or authorized to take any person into custody, or to convey or detain any person shall, have all the powers, authorities, protection and privileges which a constable has within the area for which he acts."*

So the question arises about when AMHPs or applicants should ensure the detention and conveyance and when the police or paramedics become involved in supporting that process.

DELEGATED AUTHORITIES

There are a few points worth making about section 6 and the "delegated authority" to detain and convey.

Firstly, I would argue such authority should always be given in writing – this is alluded to in the Code of Practice to the Mental Health Act, which talks in para 11.17, about AMHPs "providing provide the people who are to convey the patient (including any ambulance staff or police officers involved) with authority to convey the patient. It is that authorisation which confers on them the legal power to transport the patient against their will, using reasonable force if necessary, and to prevent them absconding en route.

This is important: without a properly delegated authority, police officers and others have no legal authority to detain / convey. The Code of Practice is statutory guidance that should be followed unless there are "cogent reasons for departure". << This is a phrase from the House of Lords case which ruled on the significance of a Code of Practice.

Secondly, the applicant for admission – whether it's the AMHP or the patient's Nearest Relative – cannot compel another professional to accept their delegated authority. So no-one can force the police or paramedics to detain / convey. And this is where "local protocols" come into it and it all starts to get potentially very difficult!

Your local area should have a conveyance agreement, between the NHS, the Police and local authority about how conveyance gets done in all the predictable scenarios. This will include compliant patients, passively resistant patients and aggressive or violent patients. It is the responsibility of Clinical Commissioning Groups to ensure that transportation arrangements for their populations are properly commissioned, usually through the NHS Ambulance Services, but they could include private providers for some specialist kinds of conveyance.

The protocol should lay this all out and should cater for how the admission of resistant or aggressive patients is achieved, where they have been legally detained and I have written before that the management of resistance and aggression is not just a role for the police. The first reaction to any level of resistance should not be the police or threats of the police. If de-escalation is the watchword of mental health care, we can just proceed straight to the final tactic!

PASSIVELY RESISTANCE PATIENTS

Passive resistance is a phrase used in police training to describe people who are resisting a course of action, by doing nothing – sitting still, refusing to stand, verbally resisting, etc., etc.. I'm sure other professions may have different terms for this kind of resistance. Where such a situation applies to a patient for whom admission is sought and to whom section 6 applies, how do we navigate those waters?

I have argued that assessment of **RAVE risks** are key – this is my mnemonic for attempting to determine what is instinctively a "police job" and what is not (yet) a police job. It means –

- **R** – resistance
- **A** – aggression
- **V** – violence
- **E** – escape

RA should be considered first for de-escalation and this may be better done by non-police professionals – I know that many may contest this and say that the mere presence of police officers in uniform is "motivating" in the sense of presenting an implied consequence to ongoing non-cooperation, but I say two things. Firstly, I don't mean here that it may not be necessary to have the police hovering in the background in case things escalate. That may be perfectly sensible depending on the situation or the patient. Secondly, it is at least arguable that the introduction of uniformed officers could be aggravating – certainly the Alzheimer's Society caution against this in some situations because it present extra stressors and

unfamiliarity to patients who may be acutely unwell. *All cases on their individual merits.*

VE are very obviously police tasks – the management of violence creates that statutory imperative to prevent crime, including against NHS professionals and active attempts to escape do likewise. When things have reached this stage the proportionality of involving uniformed officers changes because the dynamics of the incident have changed. Very obviously, RA can escalate to VW and that is something that should be carefully considered when thinking about whether to introduce the police to a scenario. *All cases on their individual merits.*

GETTING PRACTICAL

So what is there to say about NHS or social care staff navigating the RA-type scenarios? Well, I've heard interesting debates about whether AMHPs or paramedics could / should / would put their arm around a patient or apply a flat palm to a patient's back and provide a very limited amount of force to attempt to move a patient by way of "active encouragement" whilst providing verbal instruction AND reassurance.

An AMHP told me earlier in the year that they would be reluctant to even touch a detained patient in case an assault was alleged and that this was not the case when they began their careers twenty years previously. I replied, "Even though the law that the police would use to move a patient with low level of physical encouragement is the very same law that you would use? What you're really saying is you would just prefer the police to take the assault allegation against the officer than against you?"

What about "proactive blanketing" by paramedics? Incidents involving elderly patients who may have additional physical frailties and who are passively resisting are not, I would suggest, situations where we immediately want to see force being used by paramilitary looking police officers. There surely could or should be something before this? I have seen some practically minded AMHPs and paramedics getting hands on, professionally and responsibly managing patients into chairs and pro-actively blanketing them. Is this not a more dignified way of managing vulnerable people when they are ill? We were hovering nearby in case things escalated.

SECTION 6

So there will be difficulties in discharging section 6 scenarios – not least when resource issues enter the debate! But we have seen and we continue to see, situations where absolutely no amount of physical force being used is contemplated by AMHPs or paramedics and let me be clear about what I

mean: no-one is arguing for actively resistant patients who are lashing out to be managed by social workers. No-one is saying people should risk being assaulted where those risks is heightened beyond the risk that any of us could be assaulted at any time.

I am arguing that NHS commissioning managers should think about the implications of all coercive force being a perceived monopoly of the police, in disregard to the will of Parliament who did not make it a police responsibility and unlike the Irish Dáil which legislated in such a way as to mean that the British police cannot be legally compelled to coerce.

As such, some things are very clear:

- The police **can** use force to compel the admission of patients – *section 6 MHA.*

- The police cannot be compelled to compel the admission of patients – *section 6 MHA.*

- So that means *whether* they do so, is about properly negotiated agreements which take account of patient dignity, welfare and the particular roles that agencies can bring to coercive care – *Chapter 11 of the Code of Practice to the Mental Health Act.*

And if you haven't got properly negotiated arrangements for detention and conveyance, you'll find that the shades of grey in this legislation cause difficulties. This is why it's a matter for commissioning and provider managers in the NHS as well as senior operational police officers to get round a table and get it sorted.

SEPTEMBER 2013

1st September 2013

Policing and Mental Health in Canada –

Once my interest in policing and mental health really got going, it seemed sensible to look at other countries to see the nature of challenges facing their police services and to see if responses differed and could offer something from which I could learn. It didn't take long to focus more on Canada and Australia than anywhere else, because both countries had experienced high-profile policing events connected to mental ill-health and when I began reading about them, it all sounded a quite familiar in tone. I want to focus on Canada in this post and give a UK perspective about the last few years of following news events.

Firstly, Canada being a federation of individual provinces and territories, legislation on mental health, policing and the governance of health and policing is done at that level, although there is a Federal criminal code. So there are many different Mental Health Acts, for British Columbia, Ontario, Quebec and all the other areas. What I first noticed about the Acts I've read, is that none of the powers equivalent to s136 Mental Health Act (England / Wales) allow detention in police custody and all them may be exercised in private places as well as public places, if the criteria are satisfied.

This immediately puts the Canadian police at an advantage – at least theoretically! – in terms of being able to access care for those detained, although reports about the usage of these powers suggest that they have quadrupled in just the last ten years. When you look at the numbers of detentions made, was stands out to me, is that for a country with just over half the population of the UK, the use of Mental Health Act emergency detentions seems very high. In the UK, recent figures suggest around 25,000 uses per annum, where as in Vancouver and Ontario alone, it is used over 10,000 times for populations that are about fifth of the size. I would love to know whether this is because the Canadian police can use MHA powers in private places; and I would love to know whether a theory from the police themselves that mental health intervention is now about crisis *intervention* rather than crisis *prevention* is driving this?

These facts and others have prompted questions across the Canadian debate about the extent of "de-institutionalisation" and the role of police officers as "front line mental health professionals."

LOST IN TRANSITION

In 2008, Detective Fiona WILSON-BATES of the Vancouver Police Department (VPD) wrote a report for Chief Constable Jim CHU about "how a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources." This caught my attention and as I read through the document it all seemed depressingly familiar: deinstitutionalised healthcare, underfunded community care, crisis services that are not able to absorb the nature and variety of mental health demand which is generated and a consequential knock-on for the VPD who found that 31% of calls in a sample period involved at least one person experiencing mental distress and in more deprived areas of the city, this figure rose to 49% – all at a cost of $9 million. In 2010, Inspector Scott THOMPSON wrote a second report, which adds weight to those original findings and a summary is available.

We have seen the UK begin to talk recently about Street Triage: Vancouver Police have been operating "Car 87" in the city for some years, pairing a police officer and a psychiatric nurse to make earlier health interventions in policing related situations and the Lost in Transition reports, which became the officially endorsed position of the Vancouver Police Department and the Vancouver Police Board, made recommendations for their health partners about improved services.

This report should be set against a background of third-sector questions about the expanding role of the police, for example from the Canadian Mental Health Association in British Columbia; and it is clear that questions are asked against a background of concerns about the operations of the health and social care system. Chief Constable Jim CHU, as the chair of all Canadian Police Chiefs, recently called directly upon the federal Government of Canada to "step up" and to "do more" to resource the mental health system, pointing out that his officers are detaining four times as many vulnerable people now as they were just 10 years ago. His point was recently echoed by the Mayor of Vancouver, Gregor ROBERTSON.

CRISIS INTERVENTION TRAINING

In reaction to these trends, the Canadian police in several areas started to look to the US model of Crisis Intervention Training to provide at least some solutions, and investing in new models of working. CIT is an operational model where a certain percentage of front line police officers undergo what is usually a one-week course in mental health and crisis intervention, aimed at increasing their knowledge of mental distress and improving their skills to de-escalate situations without resort to the use of force.

Various studies suggest that this training leads to reductions in the use of force by officers, reductions in injuries to both patients and officers and to improved "diversionary decisions" by the police who better identify where the root cause of an incident could be unmet mental health need. (Some of those studies have wondered whether these improved outcomes are the consequence of the training or the consequence of certain officers volunteering for the training who were less inclined to use force.)

Of course, none of that necessarily matters if those better trained officers are still experiencing difficulty in accessing mental health services and in several areas mental health professionals have deployed with CIT officers to develop what the UK have started calling "Street Triage" schemes. Again, doing the wrong thing righter, but potentially better than nothing at all. But something in particular keeps raising it's head when you look at Canada from the outside.

FATAL POLICE SHOOTINGS

Obviously, one of the most obvious differences with the UK is that our colleagues in Canada are all routinely armed. Controversy therefore arises from fatal shootings in a way we don't see in the UK. As the (UK) Independent Police Complaints Commission was busy reporting in 2013 that the UK did not fire a single bullet in the preceding twelve months, intense debate was being sparked in Toronto and beyond about the shooting of Sammy YATIM.

(The UK shouldn't be complacent or superior about this, we see greater numbers of restraint-related deaths in contact / custody.)

TRIGGER WARNING! *>> I will shortly make mention of incidents and provide video links to them. They relate to two men being shot and killed.*

Please carefully consider the impact of watching them — they are posted not for gratuitousness, but to show the tactics used by the police which prompt the debates.

To be clear from the start: there is *no evidence* that Sammy YATIM was mentally ill, although he was emotionally disturbed and it may well have been reasonable to wonder. However, in the case of Paul BOYD in Vancouver in 2007, it he suffered bipolar disorder and the video of the shooting only emerged last year and has prompted a re-investigation.

There have been other fatal shootings involving vulnerable people. The YouTube videos of these incidents are well circulated and in Sammy YATIM's case involve him being shot whilst alone in Toronto street-car, brandishing a knife and in a distressed state. I'm not going to say too much

at this stage about the incident, because the officer who shot him has been charged with murder and will yet stand trial. Suffice to say that when watching the video, I was stunned to see how the incident was handled.

In Montreal in 2011 Mario HAMEL was shot, alongside an uninvolved commuter after a police response to knife related attack and in 2010 in the Alberta town of Okotoks, south of Calgary, Corey LEWIS was shot in an apparent "suicide by cop" incident. These events and recent developments have led to calls that the police need to learn to de-escalate.

It is worthy of note, that since the shooting of Sammy YATIM just one month ago, the government of Ontario has already announced the expanded roll-out of Tasers to operational officers. The timing of the announcement, not long after the police officer concerned was charged with murder, has all the potential to be labelled a "knee-jerk" but in fairness, Ontario is reported to be behind other areas of Canada in providing this tactical option, which is now widely used around the world as a less-lethal option where force is required.

The overwhelming impression I have from following Canadian issues from the UK with my parallel interest, is that the police there having been very directly facing the issues presented by mental illness in a way that we only recently have in the United Kingdom. Despite the notoriety that inevitably attends the police use of lethal force, I have a feeling that there is very much that the we could learn from their experiences over the last ten or fifteen years. I also suspect, they could take something from UK policing, not least in terms of unarmed resolution to crisis events.

More Links –

- Study in Blue and Grey
- Canadian Mental Health Association
- Mental Health Commission of Canada
- Canadian Broadcast Corporation

4th September 2013

The Prevention & Management of Violence –

I recently spent twenty pounds on a new publication from the Royal College of Psychiatrists on the "Prevention and Management of Violence". An edited compilation of short essays by various mental health professionals, mostly psychiatrists, the document seeks to update us all on the College's view of this important topic. It admirably lists a range of important issues in its contents: risk assessment, violence in community settings, acute settings and liaison with the police and MAPPA, amongst others.

Most importantly: *this is a document for mental health professionals by mental health professionals.* Much of it is pitched at them doing their jobs and I assume, where it does not relate to the police, that it is both helpful and expertly written. I have no reason or qualifications to think otherwise and I've heard a doctor say so today. This blog is *entirely* pitched at those aspects of the document which relate to policing. So in what I'm about to cover, remember that I'm not reviewing the whole document: just those parts of it that relate to mental health professionals' interface with the police and the law.

I immediately poured a coffee and settled in for a long read. I hit concern at paragraph three of page one where, for me, the credibility was dented surprisingly early. It starts by listing the important legislation across the various jurisdictions of the UK and we read that the mental health legislation in Northern Ireland comprises the Mental Health (Northern Ireland)(Amendment) Order 2004. Am I being picky here? – no mention of the Mental Health (Northern Ireland) Order 1986 which is the main body of law surrounding compulsory admission, discharge and transfer; as well as orders from the criminal courts including hospital orders as well as various remand provisions and the powers for the police to remove to a place of safety.

I'm either being picky or it's a really basic error and although it doesn't alter many of the subsequent points, I also felt it immediately undermined credibility of this "expert working group" given that the prevention, management and response to violence and aggression is so often, a legal issue. So I went back to the contributors list: mostly psychiatrists of various kinds, plus a nurse, an AMHP lead and safeguarding manager – all edited by two consultant psychiatrists. None of them from Northern

Ireland; no lawyers and bearing in mind what it touches upon for what I'm about to write here: no police officers, despite being "multi-disciplinary."

The purpose of the document is stated as being an update to the Royal College's position since their previous documents from the turn of the century and in light of new evidence which has emerged since the NICE Guidelines of 2005 on the Management of Acutely Disturbed Behaviour. Fair enough – we learn as research develops our understanding.

THE POLICE

We read of the police doing various things in this document: there is a whole chapter on liaison with Police, CPS and MAPPA, but perhaps of more interest are the things that are within other chapters where the role of the police is assumed or where we fail to make links to policing that have implications for mental health professionals.

Page 72 is contained with a chapter on "Managing Violence in the Community" and with regard to routine community visits for ongoing MH assessment – **NB**, *not* Mental Health Act assessments: "consider whether the police should also attend, or if in a public place [sic] whether it may be more appropriate to ask the police to detain them and take them to a place of safety where the assessment can take place."

Consider whether the police should attend and do what?! It's like listening to the political debate on Syria – "Do Something!" Remember, the police service have *no powers at all* in someone's private dwelling unless there is a criminal offence or an anticipated breach of the peace; and how would you ensure a section 136 detention in a "public place" *[sic]* except by chance or by breaking the law? If we're planning a visit to someone's home and there are high risks, presumably we think that the patient is "being kept otherwise than under proper control" … sounds like we should be thinking of asking an AMHP (ASW – NI) to get a section 135(1) / article 129(1) warrant for a MH assessment which means the police could remove to a place of safety whether the person is found by chance outside the address OR whether they are inside the premises. Taking the police into an environment where they lack any meaningful powers risks them criminalising the high-risk vulnerable person by them ending up in the cells to "prevent a breach of the peace" or with people getting hurt because the police lack any powers to stop something from happening. Let's plan this properly, shall we!

Page 25-26 talks about restraint within a chapter on "Risk prevention and non-pharmacological management". Rightly referencing the recommendations from the Rocky BENNETT Inquiry, it's a frustrating aspect

of this document that it doesn't lead anywhere else to discussion of police-led management of restraint with which mental health services must become involved. If you accept what's written on these pages, one logical next step must be "and if my patient comes to police attention and is detained or re-detained, for example under s18, s136 or s138 – a29, a130 and a132 in Northern Ireland – what do these things mean for safe management of vulnerable people either in A&E, a place of safety or police custody." Perhaps something for one of the other chapters, but that's what editors are for: to weave it all together.

Mostly likely, you'd have to acknowledge that mental health patients in need of ongoing restraint could not be safely managed in police custody because, as this report acknowledges, the longer restraint goes on the more the risks build and the greater the likelihood of injury or untoward outcome. Let us remember: Rocky BENNETT died under restraint in NHS care, unconnected to policing. Restraint risks are restraint risks regardless of who is doing it: clinical issues arising and the need for effective management of violence and the prevention of untoward outcomes arise whether you're being restrained by nurses or police officers – or anyone else. It looks like the timing of this document is just too early for the Adebowale Report and I think that is a real shame, because there are so many implications for health and social care organisations in this area.

This point about not making links to police business that has implications for mental health or health services, continues on page 65: this calls for post-incident review of restraint not only in terms of ensuring wellbeing, but also of future prevention and / or criminal proceedings that may arise; page 98 calls for healthcare professionals to monitor the clinical welfare of those in prison with mental health problems during and after restraint, but nothing, anywhere in the document about such care for those in police detention. Why all this when restraint is done by healthcare professionals in hospitals or prison officers in prisons with NHS oversight but not when detained restrained by the police when the risks, by definition, are less knowable?!

Page 103 contains a list of protocols that should be agreed with the police within a chapter on "Police Liaison, CPS and MAPPA." Thirteen of them, to be precise. Whilst managing to omit the need for a protocol on a "Place of Safety" process, required by the Code of Practice to the Mental Health Act, it includes suggestion for agreed protocols that I have never, ever seen or heard of. If any potential respondent's reply to this criticism is to point out that there is a recommendation on p103 for a Mental Health Act assessment protocol, including for police stations, I point out that section 136 of the English and Welsh Act – and article 130 of the Northern Irish 1986 order! – is about *so very much more* than the assessment that occurs after detention: it is about quick decision-making in the street and the

identification of proper clinical pathways into care leading to assessment under s136 / a130 which is *not* a Mental Health Act assessment.

"The content of the protocols will vary from trust to trust?" Why?!!! – the law is the law all over the country and it is the very existence of such variations that cause endless problems in the real world. I worked the first ten years of my operational police service in Birmingham but have spent the last few years working in the Black Country: I might as well have transferred to another country in terms of mental health procedures. This is why you get AMHPs in one area arguing that black is white about s135(1) warrants whilst the AMHPs in another area just quietly nod – it genuinely puts lives at risk when assessments are being done and I can name you the seriously injured police officers to back this up if it helps? The *only* thing that should vary is the name of hospital buildings, the contact phone numbers and the nominated lead professionals in NHS / police areas whose job it is to liaise about affective operations and potentially training. Why would searching patients in Wolverhampton be appreciably different to that in Warrington or Woolwich? Why would a place of safety procedure or the circumstances in which a s135(1) / a129(1) warrant would be sought vary so much, if at all. Either the circumstances of your patient's assessment give rise to the grounds for it, or they don't.

Page 76-77 relates to planned Mental Health Act assessments in a chapter on "Managing Violence in the Community". Given that throughout the book, reference to MHA procedures does relate to the law that applies to it, I was amazed to find that this section, which refers to police attendance to manage risks doesn't mention s135(1) MHA / a129(1) *at all* – not once. It does manage to mention s137 / a131 and the condition of legal custody that patient is entered into if the AMHP decides to apply for someone's admission to hospital. I am over 1,000 words into a blog, which I'm all too aware is largely critical of the police related dimensions of this document, but I can't help wonder whether this is an omission? If this book is about mental health professionals' prevention and management of risk, s135(1) / a129(1) needs mentioning: it is the *only* legal mechanism available to officers to prevent the very risks that the chapter discusses without waiting for offences to be committed, which we can all agree hardly amounts to *prevention*, the first objective of the whole book. And a chapter written by an AMHP lead, too!

POLITICS – STRATEGY – OPERATIONS – TACTICS

That's enough for now – I could but won't go on about the political posturing of Zero Tolerance and various aspects about the presumed possibility or impact of prosecution, which obviously has a role to play. I didn't focus on those aspects because it strikes me that the points made are those where the issues arising from policing are directly connected to mental health

professionals – towards whom this book is pitched. **This book is not about policing**: it's about how policing interfaces with mental health professionals but how we write something like this without substantively talking about section 136 MHA and equivalent powers: I don't not know.

My summary is that this all too casually assumes what the police do and what they can do, officers' responsibilities appearing to have been considered with insufficient precision to foster a real understanding of the legal mechanisms that are available to get things done. It assumes that the presence of the police will always be factor that mitigates risk, whereas those of us working this area know we can quite easily ignite latent risks at the cost of criminalising people, as mental health charities often point out. Some patients suffer paranoid delusions about what the police are up to and even the best, most patient officers are still standing there in a uniform wearing handcuffs and quite possibly a taser implying "or else" which all rather makes a mockery of "least restrictive principles" when not properly considered.

So this document ends up being a broad brush strategic overview of something that is inherently very tactical – it's far from being a "tactical implementation plan" where it very obviously seeks to be; and if we know anything at all about policing and mental health we know it's *all* about the tactics, not strategy. The strategic intent of our NHS seen through documents like this and other Royal College and NICE Guidelines is consistently undermined by services which are not staffed, available or flexible enough to absorb the nature and variety of demands which arise for this most important of subjects. So again, we come back to shoving the police in and busking against a background of not defining what we want them to do or equipping the professionals who want them to do it with actual knowledge.

NB: *So many other Royal College Reports are free to download on their website – like the Standards on s136. I would have preferred to download this for free, especially as it takes me for granted, seeks to put me at risk and contains basic errors I would expect to avoid if I'm paying for it.*

10th September 2013

Panorama –

So last night's BBC Panorama was always up against it – all of policing and mental health in less than 30 minutes. We saw very human stories and in keeping with the proportions I see at work, most of them involved people with serious mental health problems who were actually arrested for a criminal offence, not detained under the Mental Health Act.

Tyler's case highlights everything perfectly – he called 999 from his home after being unable to access the mental health care that he recognised he needed. The police, having no legal authority under the MHA, detained him for the offence of threatening to kill someone and that guaranteed his detention in police custody. Detention in a MHA Place of Safety (PoS) does not occur after arrest for an offence and although there is no reason why it can't, legally speaking, it's just not the way they are set up to operate. Those of us working the frontline of policing know that if he'd been taken to A&E, as he would have been with a head injury that lead to equally disturbed behaviour, he would have been quickly checked out "physically" and then declared fit for custody. Why can't he get checked out "mentally", demonstrating a parity of esteem?

Dave's story was also interesting: he was arrested for punching someone in the street, which means officers recognising his mental health issues, could have chosen to prioritise his mental health by detaining him under s136 MHA instead. In Hampshire, this may not have made much difference because he would have been removed to custody anyway, given his resistance and aggression. However, officers in Birmingham could have detained him MHA and accessed the Oleaster Mental Health Unit where they would have stayed with Dave supporting our NHS colleagues in managing his risky behaviour. Dependent upon the outcome of the assessment, which would have happened faster, he could still have been prosecuted for assault, if that had been felt appropriate.

Speaking to Dr Lesley STEVENS, the Clinical Manager for Southern Health NHS Trust who provide mental health services to Southampton – so many of the problems for vulnerable people in the care of the police is the commissioning of services and the funding given to the providers. I'm sure if the cheque book were opened and Place of Safety services fully established in proper accommodation, numbers detained in police custody would shrink – as they have in the West Midlands where around 97% of

people detained do not go to police custody. And whilst Panorama hinted at it, I would have loved the point to be shouted far louder, that the number of patients detained for offences dwarves the use of section 136 MHA by a factor of TEN. Which means we need to see far, far better Liaison and Diversion services and I would have liked to hear that far more prominently.

But Panorama made a valient effort to raise awareness of the reality of custody and I agree it showed my working day very well. It seems the objective was awareness raising and I think it did that without telling us anything new. This comes at the inevitable cost of getting into the causes of the issues with some depth and moving beyond "Street Triage" as the solution to everything, because it really isn't. In a one-hour version of this programme, I would have wanted more from the medical and social care professionals and I wanted to hear the word "Adebowale" and didn't.

In particular, I would have loved to see an interview with the lead Commissioner for mental health services in Southampton's CCG. I heard nothing of Approved Mental Health Professionals (many of whom were shouting at their televisions as the programme broadcast) – the role of social workers is always going to be key in a system that rightly looks to operate a least restrictive principle, detaining people in hospital only where other support is not appropriate. I also wanted to hear why ambulance services are often not fully involved in this area of healthcare.

There was a particular distraction to the show, caused by the reporting of a side debate – Chief Superintendent Irene CURTIS, President of the Police Superintendents' Association was interviewed and – amongst other points made that weren't used! – called for an end to the use of police cells. Having discussed this with her, I know she means an end to the use of cells as a Place of Safety under the Mental Health Act, calling instead for A&E to be used where mental health units are unable to accept. This would merely put the UK on a similar international footing as countries like Australia, Canada and South Africa who do not allow cells to be used. Dr STEVENS's on-screen reaction was described as "Shock", stating that A&E would not be suitable. However, this betrays an attitude the police custody probably is suitable despite it representing an argument for the ongoing breach of Para 10.22 of the Mental Health Act Code of Practice. To deny Ch Supt's CURTIS view, is to argue for potential breaches of statutory guidelines and to increase the potential for patients to be held away from mental health care. And this debate is a red-herring: arguing about A&E or cells as the best back-up is like trying to decide which car you'd prefer to use if you were sailing to France. You obviously don't want a car at all, you need a boat – and this means properly established MHA Places of Safety so that 500 people a year in Hampshire are not detained in custody at all.

NB: *Having reflected further on this programme, I am going to do a follow up to this post focussing on how the tactical examples given did not serve the more strategic and political points being made.*

11th September 2013

The Superintendents' Association –

This year, I was privileged to be asked by Chief Superintendent Irene CURTIS, President of the Police Superintendents' Association of England and Wales (PSAEW) to run a workshop at their annual conference in Warwickshire along with Supt Paul BARTOLOMEO from Hampshire Constabulary.

This blog is intended both for those who were able to attend and those who could not, by bringing together some resources we used and referred to on the day, which may assist our operational leaders in their work.

For those wider readers, Superintendents and Chief Superintendents are the service's senior operational leaders: they run the local police areas on which we all live, providing 24/7 cover not only for leadership of critical incidents like homicides and serious public disorder, but also for command of firearms incidents as well as certain legal authorities for police custody and for the response to high risk missing persons investigations.

They are also in a significant position to influence local partnership arrangements on policing and mental health and it is around this area that the workshop was pitched.

Sir / Ma'am – here's your test!

- Who is the **offender health commissioner** for your area?
- Who is the **AMHP lead** for your area?
- Who in your CCG is the **senior commissioning manager for mental health** services?
- Who is **the lead GP**, who probably chairs your CCG?
- Who is the **Chief Executive** of your local mental health trust?
- What protocols and arrangements do you need to have in place to stand a chance of succeeding?

I pose the questions, because we suggest that the names of these individuals are not always known to police officers and there's a lack of clarity in our newly reorganised NHS as to what these roles now mean, two of them listed above being new. Some years ago, I wrote a one-side-of-A4 guide for senior officers to at least help with the last question: the basic requirements one might imagine are necessary to be able to understand

mental health related demands and improve on partnerships, protocols and processes. It has previously been circulated by PSAEW and the ACPO lead on MH, Chief Constable Simon COLE, so it is heads a list of resources to understand this agenda in 2013.

- The Senior Officers' Checklist
- The Adebowale Report
- 10th September Powerpoint from the workshop by Paul BARTOLOMEO and me.
- A blog which seeks to explain (or highlight?) the complexity of local NHS arrangements and how you may navigate through them when engaging in partnership work.
- The Code of Practice to the Mental Health Act for England; and for Wales.

PARTNERSHIPS

Getting the basics right – Having basic protocols in place for the operation of the Mental Health Act would be assumed a fairly basic requirement. After all, they are requirements of the MHA Code of Practice. You would be wrong to assume that every area has them in place; or that they have been updated and reviewed since the Mental Health Act 2007 and the latest Codes of Practice in 2008. You would also be wise to check that they have been legally approved by your own police force and / or the mental health trust they have been agreed with. Some of the major, more high-profile, untoward events have involved officers doing what their local procedures said they should have done. So assume nothing, believe no-one and check everything.

Invest in staff time and training – policing is at least 20% management of mental health-related demand, which is far more than the demand represented by burglary or robbery combined on each of which we normally have a detective sergeant with a team of specialist officers working in every BCU. Invest in analytics to understand the problem: we know that the police do not manage to identify all those coming through custody who have a mental health history, yet we still know that around 15% of those who come through are identified. How do we make our diversion decisions? My research showed we make them because of assumptions based on a supposed relationship between criminal responsibility and MHA admission criteria, without fully checking the history. See more on Liaison and Diversion.

LEADERSHIP

Going one step further – We have come to understand over the last fifteen years that mental health demands on the service are increasing – use of s136 is up; the number of missing people who are vulnerable is up; the amount of police time spent is up; we keep seeing the same tragedies over and over again with restraint related deaths and we have started to see human rights challenges in police custody. We know that the NHS is, because of rationalisations to serves, deliberately deflecting demand towards the police service which would previously have been CrisisTeam or Community Mental Health Team work.

As such, I submit we need to think differently about how we match this demand.

Legally and clinically, the police reaction to mental ill-health is always going to be complex: we need to recognise this in our deployments whilst shouting, "simplify, simplify, simplify!" We should consider programmes like "Street Triage" and comprehensive training to just enough of our 24/7 officers to ensure they are equipped to respond – this follows from the international development of Crisis Intervention Training in the US, Canada and Australia. My whole blog documents how much there is to know and it must be obvious that we're not going to get 135,000 officers to understand and freely recall it. But we could develop a couple of thousand across our 24/7 response and neighbourhood teams who then develop experience on the back of knowledge. My idea for training in this way, has recently been requested by the College of Policing, in considering their response to the Adebowale Report.

We would do this for other areas of policing, why not for mental health? – did you know that basic mental health law is not tested *anywhere* in the OSPRE part 1 legal syllabus for promotion to sergeant or inspector? That's why most officers don't know the difference between a s135(1) warrant and a s135(2) warrant. Be honest: do you or did you ever?

All of this will require senior leadership and not just at force level. It is probably more important at BCU level where local senior officers, in proper partnership with the five individuals mentioned above, bring together their staff in a way which could be genuinely impactive not only upon the lives of vulnerable people but also upon the demands and costs that all organisations face.

11th September 2013

Radcliffes LeBrasseur –

I'm finished off a trio of conferences last week in London by speaking at the Annual Mental Health Law Conference hosted by a prestigous law firm, Radcliffes Le Brasseur in Westminster.

I'm still not quite sure how I blagged my way into it, if I'm honest but it seemed to go well!

In general presentations about policing and mental health, I have a fairly standard template for covering the issues and I've been asked to share the PowerPoint so many times, I thought I'd stick on here for general consumption!

NB: *This is a very large PowerPoint which has grown and expanded over the years – I never use it all in one go!*

I normally blank out or move over the slides that are of no relevance to the particular audience I'm using it with, but I put it all up in one go here, so you can see if anything might be useful to you – feel free to use it as you wish. **I'll keep this page updated with any future amendments.**

- PowerPoint for my natural venn diagram – policing, mental health and criminal justice.

13th September 2013

Mind Media Awards 2013 –

Yesterday, I was unexpectedly caused to have succession of lovely flashbacks to November of last year, when I was absolutely proud as punch to win the Mind Digital Media Award 2012. It happened because I hadn't realised it was the day for announcing the shortlists for the 2013 Awards and I was thrilled to see what was within. The idea of the baton passing on to a worthy winner caused me to reflect on what I said I would do to develop my ideas further and more importantly, to reflect upon how this year's awards will help more very impactive digital media initiatives, most of them personal ones, to have yet more impact as they attend to "the discrimination and shame that too often attends mental health disorders." (Stephen FRY).

So you'll have to indulge me with a reminiscence from last year's awards and then see who is kicking digital media use in mental health awareness in a totally new direction for 2013 —

You can see the full shortlist for 2013 on the Mind website, but the short-listed entries for digital media are these:

- **4 Goes Mad**

Mad World explores schizophrenia, OCD and bipolar disorder as part of the Channel 4 Goes Mad series. The website enables users to tour inside three very different brains, with real experiences brought to life in binaural audio.

- **Purple Persuasion**

Charlotte writes about her experience of being a mother, partner, worker, woman and service user with bipolar disorder, including recent accounts of ATOS and the Work Capability Assessment. You can follow @BipolarBlogger on Twitter.

- **The Blurt Foundation**

A free online mentoring service for people with mental health problems. You can follow @BlurtAlerts on Twitter.

- **The Secret Life of a Manic Depressive**

A personal account of bipolar disorder, written with humour and sincerity. You can follow @brain_opera on Twitter.

- **It's OK Campaign**

Through this blog May Gabriel shares her experience of adolescent depression, and encourages followers to speak out. Her twitter campaign has over 12,000 followers and is a constant support to many other teenagers. You can follow @itsokcampaign on Twitter.

I'm looking forward to seeing who wins, but as with last year, all the shortlisters are doing much to get us where we need to be, so already – I applaud the lot loudly and want you to take time to read and access their stuff, as I do.

14th September 2013

Eight Dimensions to Street Triage –

Here's a postulation about mental health related police scenarios: they are comprised of a mixture of legal and medical issues, which boil down to three crucial things when officers meet the public:

1. Whether someone needs mental health and possibly physical health care support *immediately*.
2. Whether the patient objects to a proposed course of action to get it.
3. Whether we are in a place to which the public has access.

If the answer to all three questions, above is "Yes!", you can use s136 MHA and if there is an allegation of a criminal offence within the context of the incident, you can arrest for that.

You would not need to use section 136 if the answer to either of the first two questions were "No!" and you *certainly can't* use it if the last answer is "No!"

So the main issues are: will Street Triage create a "No" answer for either questions 1 or 2, where a police officer alone would have had to say "Yes" because mental health nurses have far greater skills and information on which to answer the questions? And most crucially, what does a mental health nurse add to a situation where it was all going terribly well, until we hit upon the "No!" for question 3. Against this, should the potential of street triage be judged.

These musing give rise to eight broad dimensions within which this decision-making must occur – four in public and four in private. The point of this blog, is to go through them all, highlighting whether Street Triage schemes would make a difference to an operational police officers ability to resolve the situation properly, with reference only to the ambulance service as medical back-up.

PUBLIC PLACE SCENARIOS

Situation 1: A cooperative person – in immediate need of care / control —– police officers would refer a person to health services, either by calling an ambulance to them or by referring or taking the person to A&E, as the only 24/7 health gateways available immediately. *Street triage*

factors — would open the possibility of the nurse providing the care themselves or by being able to access Community or Crisis mental health teams. This could also occur outside Street Triage if ambulance and police had access to referral pathways in their area.

Situation 2: A cooperative person – not in immediate need of care / control —– police officers here would refer the person to attend either their GP, or to contact their CMHT or CrisisTeam or A&E, as they saw fit. *ST factors* — opens the potential that for existing mental health patients the nurse could contact relevant teams for follow-up, either the next day or soon afterwards. Currently this can't easily happen if 999 services have contact with people, existing mental health patients or not, hence current referral practices.

Situation 3: An uncooperative person – in immediate need of care / control —– this is current Section 136 territory, where officers would have answered "Yes" to all three questions and be starting to think about detention. *ST factors* — I would imagine if the nurse present thinks the person does have a mental disorder, then we're potentially off down that route; but we know for example, in Leicester that section 136 detentions have reduced by 40%, so this is the area where triage is having an impact in terms of reduction. The nurse being able to offer something that a police officer can't, which turns an apparent situation 3 into a situation 1 or 2.

NB: *I will be interested to learn what happens if officers are dealing with those kinds of presentations we saw in Panorama where intoxication and resistance is involved. Elsewhere on my blog, because of lessons learned in previous cases, I'm wary about what would happen with resistant, intoxicated patients. Some suggestion that nurses are encouraging detention in cells when we know that's the wrong thing to do, both legally and medically. This is the scenario of my deepest fear.*

Situation 4: An uncooperative person – not in immediate need of care / control —– this is a difficult kind of scenario for officers, when encountering someone you think may have a mental health problem, they don't want to receive offers of help that you can make open to them and you don't feel that the issues warrant use of s136. Currently, it would be a case of offer a view about areas from which help or support can be obtained and respect the autonomy of people to make their own decisions, however unwise you may think they are. *ST factors* — individuals may react differently to a mental health nurse and perhaps that may make a difference, one way or the other. It remains possible for the nurse to refer someone back to a service that may know them, whether that be their GP or a community mental health team, if known to them. Those services could, if they chose, follow-up whatever referral took place at a later date.

PRIVATE PLACE SCENARIOS

Situation 5: A cooperative patient, immediate need of care / control —– this is the same as situation 1, above.

Situation 6:– A cooperative patient, no immediate need of care / control —– this is the same as situation 2, above.

Situation 7: An uncooperative patient, immediate need of care / control —– this is the kind of situation that could demonstrate the futility of Street Triage in some respects. The only variation from situation 3, is that being a private place, section 136 MHA is not an option. The nurse adds little immediacy to this situation having no extra legal powers and I'll be mischievous enough to wonder whether we'll hear examples of nurses 'wondering' whether a person like some fresh air to make them feel better and a brief walk?! *<< Don't laugh: I've heard CrisisTeams inciting this false imprisonment before.* If the situation involved a genuine ability to arrest someone for an offence or to prevent a breach of the peace, then the immediate threat would be resolved this way, as it always has been. This is the "Tyler" situation from Panorama.

Beyond the expediency offered by a criminal arrest, we are back to the "Sessey" dilemma. How do you keep someone safe. The judge in that case said you contact an AMHP and arrange a Mental Health Act assessment. I would hope the involvement of a Street Triage nurse asking for it, meant it was taken more seriously and agreed to more often, than if a police officer asks for it?

Situation 8: An uncooperative patient, no immediate need of care / control —– this is the same as situation 4, above.

IMPACT ASSESSMENT

So, let's see where that leaves us. The first thing to say, is that situations 1, 2, 5, and 6 involve cooperative people. So these situations for the police were always about signposting to the health system however quickly it may be required. It may be a mental health nurse can do this more appropriately, but it doesn't seem a situation that inherently requires a dual approach.

- **Situation 1, 2, 5 and 6** — these would get resolved roughly as they always did, with street triage possibly bringing faster, more appropriate referrals. I wonder how many of these kinds of incidents come to police attention only because attempts to access the NHS

have failed? For example, by the kinds of demand deflection that we know we've seen increasing over the last year or more.

- **Situations 4 and 8** — again, like situations 1, 2, 5 and 6, these outcomes would be comparatively unaffected save for the promising potential that a nurse could make necessary referrals based upon something of a clinical assessment and based upon whatever knowledge of the person was available to them from medical records.

- **Situations 3 and 7** — these two either stand as they are or become other kinds of scenarios because of the nurses increased skill base and information. **Scenario 3** – the police will either still detain under section 136 unless the added value of the Street Triage nurse can either turn the situation into a 1 or 2; and **Scenario 7** is still troubling, unless the nurse can be instrumental in bring together a fast Mental Health Act assessment. It still leaves you the sticky question of scenario 7 where the nurse's view or information may actually add to the urgency of MHA an intervention which may still be hard to manufacture with an AMHP and a DR and potentially the need for a s135(1) warrant.

Of course, we know that in terms of detentions by the police, ten times as many people are detained under arrest for an offence than we detain under section 136 of the Act. So wherever any of those situations involves a lawfully ability to arrest for an offence, we see that as an expedient way to resolve something that can't otherwise be resolved. Of course, that dimension to things is unchanged.

SECURE TAXI SERVICE

I'm going to put this view out in the open: some have started to wonder whether Street Triage is a secure taxi-service? One Assistant Chief Constable wondered why the police were giving a lift to a nurse to visit someone in their own home, who actively wanted NHS input. Why could that call not go to or be diverted to the NHS and their traditional mechanisms? This could have been to their GP or to a community or crisis mental health team – and this gets you back to the heart of a problem. Accessibility of whatever is the "right" NHS service for that demand and the reaction to any demand which is subsequently deflected to the police. We know from reactions to Panorama and other debate, that mental health crisis teams are not emergency services, running around to all manner of crisis situations. Some officers don't realise that they are there to be able to provide support which negates the need to bring about a hospital admission: not a reception team to triage demand that may be

crisis related and may or may not be primarily about severe and enduring mental illness.

I wrote this blog to make me think through what would the police traditionally do without Street Triage and what would it add? I can't help but conclude from the above exercise, that it would alter fewer than half the scenarios and whilst welcoming a reduction in 136 usage for scenario 3, it also gives rise to extra pressures for that situation to go awry by doing the wrong thing. It does nothing to resolve the "Sessey" problem which we see in scenario 7 and fails to address the Adebowale Deficit. No-one could object to a scheme which brings about better or faster referrals than could emerge from scenarios 1, 2, and 4; 5, 6, and 8 – but I ask whether a nurse in a car with a cop is necessary to make that happen? In some of those situations, available, accessible and responsive health services (whether that is a GP, a mental health community or crisis team or the ambulance service if we feel we should ring 999) could potentially achieve the same thing. I also wonder whether it would achieve it at less cost?

There is something else relevant here, which will be in my next blog: how do we get the police using section 136 correctly and consistently, because Street Triage pilots are about to start in areas that have significantly different usage of section 136, including some areas that must significantly over-use it. That is as important as putting a nurse with a cop. In fact, we know that some mental health professionals conceive Street Triage as important because it potentially allows them to stop or influence the police from doing the wrong thing by misusing the power in the first place. It's all "doing the wrong thing righter."

15th September 2013

Reducing Section 136 Usage –

The excellent Dr Jenny HOLMES remarked in her presentation to the Police Federation National Custody Forum conference this week, that she thinks the reduction in 136 needs to be health led. I don't doubt for one moment that there are things the NHS could do differently which would impact upon numbers in section 136.

Very briefly, these could include improving the responsiveness of some out of hours services so that we didn't see demand deliberately deflected to 999 services; improve monitoring of section 136 usage, so that repeat s136 detentions and the detentions of already-known MH patients is routinely reviewed to capture the learning that this offers. For example, in a sample of 1,000 section 136 detentions a few years ago, I saw over a dozen examples of multiple detentions (in a short period) and around 50% of those detained were current or recently discharged / disengaged patients from that trust. 30% of those detained were out-of-area patients, so presumably at least some of them were also repeats; and some of them were known patients, if these two features had been analysed over the borders.

POLICE LED REDUCTIONS

However, and whilst not disagreeing with Dr HOLMES, I also want to argue here that there is great potential to improve the police approach to section 136 in such ways that should lead to a reduction in usage across the country and to subsequently argue that this is probably necessary for Street Triage to succeed on any level, regardless of any arguments about the concept.

My police force detains around 1,000 people a year. Sometimes just over, sometimes just under – but always in the 950-1050 bandwidth and this was true before the introduction of health based places of safety that have seen 97% of people accessing the NHS. I could, but I won't, name you several police forces which are roughly half the size of mine who use the power as much, or more than we do. One in particular, when allowance is made for population difference and number of officers, uses the power four times as often. One has to conclude that outcomes for section 136 are affected by usage when we learn that in some other areas, nowhere near

97% of detainees are accessing the NHS for assessment and when we look at outcomes.

If demand is too great for capacity, you either have to increase capacity or reduce demand or you will continue to have access problems. If NHS colleagues and managers are sitting in their world wondering why the Force they work in uses section 136 so often and doesn't think about outcomes as (just one) indicator of appropriateness, you can imagine why they won't resource extra places of safety and staff them properly. It's spending money for somewhat perverse purposes.

OUTCOMES FROM SECTION 136

We've heard from some MH services that large percentages of detainees under s136 are released without follow-up. Professor Louis APPLEBY often remarks how approximately 20% of people detained are subsequently admitted to hospital. (These are based on national figures that I'm not convinced are counted correctly, but let's run with it.) In the piece that he wrote for this blog, he remarks upon how use of s136 has risen since his time as a junior doctor when he was concerned that the police threshold for using section 136 was too high. Now I'm the first to keep pointing out that "admission rates to hospital" is just one part of assessing how section 136 is used. I remember being told years ago that an area in the West Midlands would not begin to look at provision of a place of safety within the NHS until we "sorted out the problem" that officers were detaining 150 people a year and "only" 60 were admitted. Apart from thinking this a good percentage(!) I asked "how many people who are not admitted get referred to community mental health teams or their GPs arising from the assessment?" He didn't know.

I recently went to visit the Birmingham Place of Safety that I was part of establishing three years ago. Over a lovely cuppa – which they had to make me, because I took them biscuits – I enquired about updated figures on their outcomes and was astonished at what I heard, even though I knew they were good. They have an average of 45% admission rate, following use of s136. Yes: almost half those identified by the police require hospital admission. More importantly, in recent months there have been occasions where 100% of those detained by the police, received a health outcome — in August, 42% admitted, 38% referred to a community mental health team and 20% referred for mental health reasons to their GP. No-one was simply released without follow-up. << I submit this has to validate police use of the power and I did just wonder whether it may mean we're actually slightly under-using it?

My good friend Richard CLARKE, the lead nurse for PoS in Birmingham agrees on this point: if this can be done in Birmingham, it can be done

anywhere, given the will. Low use of s136 by the police, leading to high admission and referral rates by the NHS. It is no coincidence: before this service began, we made all significant professionals undergo a two-hour multi-agency training programme. Richard has spent many hours (of his own time!) flogging around police stations, delivering further inputs and Q&A opportunities to police response teams, who make the majority of these interventions. He also does the same for British Transport Police, who contribute to Birmingham's figures because s136 is used at New Street railways station a notable amount. I have done likewise with mental health professionals and I'm looking forward to speaking (twice!) to the Royal College of Nursing next month so we can all come to understand each other.

GETTING IT RIGHT

When I'm asked to summarise what is involved in "getting it right", I focus on two things —

1. **How officers approach the "arrest for an offence" or "detain under s136" quandary** – you will remember the case of "Dave" from the Panorama episode. He punched someone in the street whilst hitting the criteria for section 136 so could have been brought in for either issue. Hampshire police chose the substantive offence in Dave's case, which links on to my second point. Worthy of note that Dave subsequently pleaded guilty to assault. I think Hampshire got it right in that example.
2. **How to approach the question of "intoxication" where mental health questions form in an officer's mind** – we know that some argue that section 136 should literally never be used when intoxication is evident: how can an officer tell whether the presentation arises from drug / alcohol issues or from a mental health problem? My advice is to stay clear of section 136 unless you have objective information of a mental health background (police records, NHS information, third parties involved in the incident.)

So the guidance I normally give is that where officers have a "136 option" and another option involving arresting for an offence (including alcohol offences), you choose the offence, unless —

- It is a trivial offence, or actually a victimless offence.
- The victim is not ringing about the crime, but about mental health support for the person concerned.
- In all the circumstances, suspected mental health problems are the main issue in play.
- **Remember**: once you've started down the 136 route, you can subsequently revert to a criminal justice pathway, *but not the other way 'round*.

This means that section 136 is *not* used where mental illness leading to apparently "odd" behaviour is sheer speculation on the part of the police, it means that substantive victims are not ignored after being harmed by crime. It means section 136 *is only* used where there is very good reason to think mental illness is an issue and where there are few other options available, but to use it. This position then puts everything back in the hands of the NHS, to reduce section 136 yet further, as Dr HOLMES suggests; perhaps even via Street Triage.

"Never doubt that a small group of thoughtful, committed individuals can change the world. Indeed, it is the only thing that ever has." Margaret MEAD.

18th September 2013

Over-Simplification –

Even when I started writing this blog just under two years ago, policing and mental health received nothing like the coverage it now gets and there are various formal and informal ways of seeing this. We've seen prime time television coverage devoted to it in last week's Panorama, we've seen newly elected Police and Crime Commissioners getting interested in it, including Matthew ELLIS in Staffordshire who has hired a "mental health expert" to work for him on the issue; we've seen senior officers like Chief Superintendent Irene CURTIS giving the issues high-profile when she took on the job as President of the Police Superintendents' Association. We've seen the Home Secretary talking about it and her speech at the Police Superintendents' Association Conference in 2013 including two updates on all the issues I've covered in almost 350 posts: "We're talking to the Department of Health about this" and "We're rolling out Street Triage." Chief Supt CURTIS called very specifically for things which stand a chance of helping: ammendment of the Mental Health Act and end to the use of police cells as a place of safety.

RISKING THE WRONG REACTION

This post argues that others risk over-simplifying complex problems and therefore we risk having the wrong reaction to them by introducing simplistic solutions and making simplistic statements. For example, In the debate about the use of police cells, I have repeatedly heard the phrase "cells are no place for the mentally ill." What, *ever?!*

We all know what this statement probably means, it's probably a call for the end of the use of police cells as a place of safety under the Mental Health Act. But why over-simplify and call for an end, **full-stop**? What should we do with someone with mental health problems who has murdered someone else? It strikes me that police custody is *exactly* where they should be whilst that is properly investigated, with supporting mental health assessment and care whilst detained, obviously. Indeed, if someone has been accused of an offence, taking them to police custody may be absolutely vital in terms of detention there triggering legal rights for police officers to seize evidence, take forensic samples, search premises and draw inferences from silence to questions. So where else would we ever go?

Well, some mental health presentations are so serious that people should be removed to Accident & Emergency departments after detention by the police under s136 or for offences and if that is the case after an arrest, then so be it. The person can be transferred to police custody after the immediate medical issues are stabilised or assessed. This is no different to if the police had arrested someone for a serious offence who injured themselves trying to escape the officers: prioritise the urgent medical issues in play at the time of arrest, custody as soon as you can once done. Parity of esteem has to work both ways.

The reality is that about **ten times** as many people are arrested for criminal offences whilst mentally distressed as those detained under s136. In the majority of those cases, their mental health disorders are not so serious as to make any difference to the criminal justice process that should subsequently follow an allegation of crime against that individual. The outcome may or may not be different in light of any assessment or input that is undertaken by mental health services. And again, think about parity of esteem: the police service detain plenty of people for offences who have asthma or diabetes, cancer or heart problems – why should a person living with a mental health problem not be detained in police custody if an allegation of crime has been made against and they were lawfully arrested? Unless their medical condition is so serious as to render this dangerous and assuming their rights and appropriate safeguards are put in place, it could be very necessary step to achieving justice for victims. It is a complex balancing act that comes with the territory.

If this is not what was meant by "police cells are not an appropriate place for the mentally ill" (whoever they are), then we need to raise the sophistication of our public debate.

SIMPLISTIC SOLUTIONS

But this goes further —– if we are now having debate on the issues of policing and mental health, either because we want to see better integration of services, improved access to NHS services or less police time / money spent, then we need to see responses to the issues highlighted which also don't over simplify. It probably comes as no shock to anyone who regularly reads this blog, that I will immediately hone in on "Street Triage". It is a solution-version of the over-simplification in this arena: officers dealing too frequently or too ineffectively with mental health related demand, so let's give them a psychiatric nurse to improve things. No doubt it does improve things – 40% reduction in s136 usage; improved access to MHA assessment pathways, etc.. Who wouldn't welcome this?

Most of the section 136 processes that I have ever seen – and I get emails from various forces asking me to check over new policies and proposed revisions to current policies – massively over-simplify the complexity of the issues that people detained under this section of the Act actually have. We still see NHS organisations calling for "violent and / or intoxicated people to the cells" in a place of safety process. We see this even though officers have been prosecuted amidst suggestions of neglect that this approach placed people at risk. We've seen HM Coroners criticising the failures to see through a fog of aggression and intoxication to recognise a legitimate medical emergency and we've seen clinicians agreeing that the police are right to think of some aggressive, intoxicated presentations as representing medical emergencies. You need only look at the recent Royal College of Psychiatrists publication on the "Prevention and Management of Violence" to see this. But because putting drunk, violent people in cells is intuitive to some, including to some psychiatrists and senior NHS managers, it represents an orthodoxy even though it could be clinically outrageous to do so for *that* vulnerable person at *that* time. So how do we know what's what? Well we certainly don't do it by over-simplifying the process.

These things are the solution or process equivalent of "police cells are no place for the mentally ill". Street Triage leaves almost totally unanswered the issue of immediate needs in private premises of some vulnerable people and triaging of need by mental health nurses leaves the question of whether they are equipped to identify what could (also) be physically unwell people. And if we know that psychiatrists can miss underlying physical health care issues, are we confident mental health nurses will be better? Or will we still see police officers calling ambulances? I know I still would.

Directing aggressive, intoxicated patients to cells to contain them, leaves totally unanswered the potential of head injuries or brain tumours, diabetes or excited delirium to have brought about someone's disturbed and / or confused state.

STATES OF COMPLEXITY

The reality is the reality: **and it is complex**. We are policing in the twenty-first century, a deinstitutionalised model of mental health care which still hasn't reached a consensus of what causes mental distress and how best to approach it by using drugs or talking therapies which were barely conceived when the laws governing police interaction were written in the 1950s.

We then give very little training to officers, watch them get it wrong and decide that the solution to this is a range of over-simplistic notions that fail

to take (full) account of the complexity we haven't yet fully understood because no-one is researching it properly.

So this doesn't mean we can look at the equation on the left and explain anything by showing off our nine-times tables.

The police are doing what they do, whilst under-trained, alongside an entirely fragmented health system, still wrestling with the provenance and aetiology of mental health disorders and we are doing this in an era of cuts to public services and other financial cuts affecting individuals and increasing the mental health burden of disease in the UK – we see this in the rising suicide rate. The laws we have don't even allow our public services to keep people safe in their own homes without criminalising them and there seems little appetite to change that or do anything else to solve the issue, at the moment.

To think this is simple stuff that will benefit from simple solutions is quite naive but I will go further: to push for simple solutions amidst that naivety is to create further problems that compound the likelihood of adverse outcomes for vulnerable people. We know that things go wrong in policing because the mental health system we operate in the UK, implicitly *wants* the police to do the wrong thing because it isn't set up to work with the police in doing the right thing. There is just some potential for simplistic solutions to make this even more likely than it ever was before whilst superficially making it look better. And this is why we need more proper research by world-class academics and far less over-simplification by people who choose to put their two-penneth into the public domain on issues they either don't understand or have massively over-simplified.

20th September 2013

Place To Which The Public Has Access –

Section 136 of the Mental Health Act is often debated in terms of whether or not the authority can be used in particular kinds of place – debate consumed by whether somewhere is a "public place" and what this term actually means. Does it include and Accident & Emergency department, or a general medical ward of a hospital? Would it include the communal hallways of a block of flats where access is only given either by residents granting access or via a concierge system? If a place may be a "public place" is it a public place all of the time or only part of the time?

There is no single, legal definition of a "public place". The Public Order Act, the Road Traffic Act, the Highways Act: each of these Acts contain their own definition for the purposes of that particular legislation. Other definitions are available on request like section s139(7) Criminal Justice Act 1988 and s1(4) Prevention of Crime Act 1953.

Confused? You will be!

If you wanted some kind of rough-rule of thumb, I quite like section 9 of the Public Order Act 1936: a "public place includes any highway and any other premises or place to which, at the material time, the public have **or are permitted to have** access, whether on payment or otherwise."

But have you yet spotted why the above is all a waste of time, to a degree? I'm sure you recall that section 136 of the Mental Health Act does not refer to "a public place" but to "a place to which the public has access". We must assume that this change of language signifies something different otherwise parliament would have used the same term. In some legislation, they even cross-reference what is meant by some phrases and this is not done in the case of the Mental Health Act.

And it is easy to get confused. In the case of Williams v DPP [1992] a man was arrested in the communal hallway of a block of flats for being drunk and disorderly. This offence requires that the police find you in a public place. The man appealed against his conviction and won by arguing that this area of the block of flats was not a "public place". So does this mean he could not be detained there under the Mental Health Act? We'll see.

In the case of Harriot v DPP [2005], a man at a bail hostel had returned to find his room had been burgled. He placed two knives in his pockets and started becoming agitated in the communal reception area. He then went outside into the front garden area of the hostel and the staff locked him out and the police were called. After searching him and finding the knives, they arrested him for possession of sharply pointed implements and he was convicted. He won his appeal by arguing that the private, front garden area was not a place where this offence could be committed, merely because the public's access to that area was unimpeded. It is interesting that in this particular case, the language used by the judges frequently includes "place to which the public has access" and not just "public place."

All clear?! Maybe not.

We've known for a while that section 136 MHA could not be used in the front garden of a property: whether this is an individual house or, as with HARRIOT, of a larger multi-occupancy dwelling. Although there is a general right in law of certain people like postal and other delivery workers to walk up your front path in order to knock on your door or deliver mail, this doesn't mean your front garden is a public place.

But what happens if a person is trespassing in a private place – can you remove them as trespassers and then say that they are "found" in a public place or a place to which the public has access? I have argued for some while that you can, based on the judgement of the case of Winzar v Chief Constable of Kent [1983]. In this case a man had been taken to hospital by the ambulance service and a doctor examined him, concluding only that the man was drunk. He asked him to leave. Later, the man was found slumped in the hospital and the police removed him outside, to the nearest Highway. Because he was then (briefly) in a public place, they arrested him for being drunk in a public place and he was placed in a police car. The case relates to him challenging the outcome on the basis that he not been found drunk in a public place, he had been forced there by the police assisting the hospital to eject him. The court ruled that it made no difference because he had been lawfully ejected.

You could imagine another scenario where officers lawfully removed someone from a private place where they were trespassing and then used section 136 MHA — this is the stuff of railway trespass. British Transport Police officers have a right to remove trespassers from the railway network. Although it is a criminal offence to trespass on the railway network, if an officer formed the judgement that a major issue at play was a person's mental ill-health, WINZAR supports the notion that having merely removed the person as trespasser to avoid criminalising them, officers could then detain the person under section 136 in order access care and support.

For the record, in paragraph 39 of the judgement in Sessey v SLAM and the Metropolitan Police Commissioner, the judge made clear his view that **section 136 can be used in an A&E department** and he didn't concern himself with endless minutiae about swipe-access doors controlled by nurses or receptionists. There is, ultimately, no massive legal definition of "a place to which the public has access", but we can see from the above that there is still very clear scope to act in scenarios where we've occasionally found officers tearing themselves apart over the definitions.

22nd September 2013

Unfitness to Plead –

The issue of mental ill-health in criminal proceedings can lead to three different kinds of outcomes which would not otherwise be reached for a defendant who did not have a mental disorder. I have previously written about two of them: insanity and very specifically to charges of murder, a finding of diminished responsibility leading to an alternative conviction of manslaughter.

This post relates to the final issue: unfitness to plead and it is just a simple overview of the process about which more could be said —

If someone who has been charged with a criminal offence is to stand trial, they must be competent to understand the trial process and to instruct their solicitor. Where doubts emerge about these issues, the question of unfitness to plead arises. Where it is brought up, it is a matter for a jury to decide and they may not find someone unfit to plead unless supported by the evidence of at least two medical practitioners, one whom must be "duly approved".

It may be raised in a trial by either the prosecution or the defence at any stage, but often it is raised at an early point in proceedings, before a trial and often leads to psychiatric evaluation. The court may take advantage, if it deems fit, of the remand provisions of the Mental Health Act which allow patients to receive treatment and care whilst undergoing assessment for issues like unfitness to plead (or diminished responsibility). Unfitness to plead is also seen being raised at the start of defence evidence, after the prosecution have put their case.

The Criminal Procedure (Insanity) Act 1964 governs this process, although you will be glad to know it was updated in 1991 by a Criminal Procedure (Insanity and Unfitness to Plead) Act. Such an approach is the basis for similar considerations in many international jurisdictions like the Commonwealth and many of the United States and it allows the court to determine "unfitness" if one of four elements are satisfied, as laid down the case R v Pritchard [1836] –

1. to comprehend the course of proceedings on the trial, so as to make a proper defence;
2. to know that he might challenge any jurors to whom he may object;

3. to comprehend the evidence; or
4. to give proper instructions to his legal representatives.

Where these issues are raised in court, a different standard of proof applies, depending upon who raises it: the prosecution must prove *beyond all reasonable doubt* (the criminal standard of proof) that a defendant is unfit to plead whereas the defence must prove it only *on the balance of probabilities* (the civil standard). It is the jury who must determine whether these thresholds have been cleared against the "Pritchard" criteria.

A FINDING OF UNFITNESS

So what happens if someone is ruled unfit to plead or stand trial? The amended Criminal Procedure (Insanity) Act provides, in section 4A, for a "trial of the facts". In other words, the court will adduce whether or not the defendant "did the act or made the omission charged", irrespective of mental insight or disorder.

So for example, in the case of a defendant being charged with causing grievous bodily harm with intent, contrary to s18 of the Offences Against the Person Act 1861, a court normally occupying itself with whether or not a particular defendant caused a serious injury, by whatever means AND that they intended to cause that serious injury.

Following a ruling of unfitness to plead, they would be interested in establish whether or not the person (did the act or omission" by throwing a punch or using a weapon to cause the injury. The extra "mental" element of the mens rea – whether or not they intended to cause serious injury – would not come into question because of the "unfitness" arising from a disability. In such a case, it would then be available to the Court to make an order for the defendant's admission to hospital (see Schedule 1 of the 1964 Act) or for their supervision and treatment (see Schedule 2). In respect of Schedule 1 orders, these are, in effect, restricted hospital orders, as if made under s37/41 MHA.

Obviously, if it is not proved that the defendant "did the act or made the omission charged", then they would be released from the custody of the court, although I have known cases where this is almost immediately followed by a Mental Health Act assessment by an AMHP and two DRs for admission to hospital under s2 or s3. Indeed, it is sometimes the case that s2 or s3 has been applied before the hearing, in case of that outcome.

REVIEW OF THE LAW

The Law Commission has been doing some public consultation work over the last few years on potential changes to the law on both unfitness to plead and insanity. You will have noticed that the Pritchard case dates from the nineteenth century and the legislation was drafted in the 1960s, albeit partially revised in the 1990s. There is a general sense that it is overdue for reform and the Law Commissions work should report during 2014.

In the meanwhile, this remains the law: defendants whose fitness to plead is questioned in court have a special procedure within the criminal courts to establish whether or not they are unfit and if so, how any potential vulnerabilities may be managed. Someone who is found unfit and made subject to what amounts to a restricted hospital order are not convicted of the offence – it is a diversion from the criminal justice system, without conviction.

23rd September 2013

Abuse –

I can't begin to imagine the gradual build up of distress and despair that must overwhelm a person who has to watch their nearest and dearest be gradually consumed by Alzheimer's disease. To reach a point where one must wonder whether or not your parent or partner even still recognises you and the love you give them must be heartbreaking. If it were then learned that during a brief period of respite the police had attended a care home and restrained them using handcuffs, we can all agree we would have questions to which we would demand answers: from the police AND from the care home – and from appropriately senior managers.

It is for those reasons that I don't want to focus on the reaction of relatives to the recent handcuffing of 76yr old Keith HYRONS in a Malvern care home. Mr HYRONS had been placed there to afford his wife a period of respite from being his full-time carer and I'm sure all we can do is wonder how traumatic it must be to have found out that within twelve hours the police had been called and handcuffed him. I'd be furious and have questions, too.

I am a front-line police officer leading a team that answers 999 calls and I would argue that my team alone, in just one UK police area, is called to a residential care setting once a week whilst being invited to use force on a vulnerable person because 'agitated behaviour' or a 'behavioural disturbance'. In planning a recent contingency in a nursing home, I recently had to ensure that we had officers with both tasers and the police protective equipment which is better known as "riot gear". Such was the nature of the episode. Whilst we thankfully resolved that particular incident without anyone using any force whatsoever by playing a waiting game, it has not always been possible to do so. On other occasions inaction would have meant the very real probability that someone would get hurt

I have written on this blog about how I have perceived in recent years an increase in dementia-related demands for the police, so these kinds of incidents will potentially recur and cause further debate unless we learn the lessons now from what has already occured. It is against these backgrounds that I want to take issue with just one part of the reaction to this sad case.

ABUSE

It is the reaction of the Alzheimer's Society that particular engaged my interest when their West Midlands spokesman, David ASH, attacked the handcuffing incident. In fairness to them, they have published information about handling aggression in dementia patients and forewarned that introducing police officers to situations may exacerbate problems. They have also covered this issue in their magazine, arguing for a different approach and better training for officers. All of that said, the comment still bears scrutiny –

"Any case of abuse against a person with dementia is absolutely appalling. The most vulnerable people in our society should be treated with respect and dignity. Our care system in the UK is broken and underfunded."

Abuse? — can we agree on three things?

1. **None of the people talking about this incident in the Birmingham Evening Mail were actually present in Malvern, so do not know, ultimately, what occurred?** – if we are to reach a position where the officers' handling of the situation is labelled "abuse" let it be following an properly constituted investigation which hears all sides.
2. **Using force on anyone to prevent harm to others should be done only where it is necessary, as a last resort?** – given it is established form, we should assume the officers at least attempted to communicate the situation into a safe position, before resorting to force.
3. **Describing a use of force as "abuse" without knowing whether it was reasonable in the circumstances is premature?** – and when one considers the magazine article which calls for any needed restraint to be done in another way, we start to see that it is not *restraint per se*, that is the issue.

I have met and interacted on social media with many people who think it is *always* possible to avoid using force when dealing with vulnerable people – it often emerges from discussions where they're have been criticisms of the police for failing to de-escalate certain situations. Now de-escalation training, by that name, is not taught in police training. But the concept is and I've heard many people from health and social care backgrounds say that police de-escalation skills are usually first-rate.

It was recently a question on Twitter from a PhD researcher from a mental health nursing background – whether restraint could always be avoided? The consensus was that it could not always be avoided, but that we need a debate about whether we're doing the most we can to avoid the need for it. Suggestions of where we could do better were in the arena of staffing levels, staff training (in police AND health / social care) as well as

in access to relevant services and crisis support. If you read the Alzheimer's Society's full comments in the Birmingham Evening Mail, you see the attack is at the care system itself, into which the police were invited.

The above-mentioned magazine article calls for police officer to use velcro straps instead of handcuffs – presumably this means the leg restraints with which we are (mostly) already issued? And this moves the debate on to the more specific area territory of *how* dementia patients are restrained, if that is deemed necessary, rather than *whether* they are restrained whilst exhibited various kinds of challenging behaviour.

LAWS AND ETHICS

So I want to finish by highlighting the apparent clash of laws and morals in this kind of incident. West Mercia Police have publicly backed their officers using the language of law: highlighting risks and threats and having words like "rights" attributed to them. Meanwhile the remarks from the Alzheimer's Society show the background factors of concern to his family couched in moral terms; as well as the proper assessment of needs we hear language like "abuse" and suggestions of treatment like a "common criminal" inflaming our emotions about what occurred.

The problem here, as with the Humberside 'taser' case and the Manchester 'handcuffs' case before, is that BOTH are right. It is an outrage that things get this far but those of us who police know that we are often demanded to instantly restore order to situations which took months or years to deteriorate. By the time we are making minute-by-minute decisions in the middle of the night involving risks and threats with people who we know little about, we are are not talking about precise, nuanced interventions – we're talking blunt, crude options which may lack utility. This is the very real danger in these cases because the complaints the Alzheimer's Society spokesman had after labelling the intervention as "abuse" we're all about the care system: not the police. When the officers arrived, they had three choices: do nothing, do something without resorting to force, use force to prevent harm to those present and call for further medical assistance which we know was done, because Mr HYRONS was detained under the Mental Health Act in an older adults unit.

I'm sure we all wish him and his family well and regret the events, however necessary those involved may have considered them to be and I'm sure they would be further reviewed if that is what the family wish to see happen. But as with many incidents, the necessary actions to avoid the police use of force as a last resort, were things not in control of the police that needed to occur way before the 999 call was made.

27th September 2013

Peaks and Troughs –

When I start an EARLY shift at 7am, the cell block is usually quite full. There will be prisoners there who have been arrested but not yet charged, who await investigation and those who have been arrested, charged and denied bail who are waiting for the truck to take them off to see the Magistrates. Once that morning truck run is done, the cells are obviously emptier. We then spend the rest of the day filling them up again, whilst kicking out a few who have their investigations finished and released without further action, released on bail for further enquiries or charged and bailed to appear before the courts on a future date.

In the background of daily comings and goings we also have bail management – those offenders arrested last week and last month who were released on bail pending further enquiries who will answer their bail today. Some of them will be re-detained for interview and further investigation, some will be detained to be charged with an offence, some may just attend to have their bail varied if enquiries necessitate a further period of investigation beyond the initial bail hearing. Usually, custody systems allow one person to answer bail each hour, on the hour, so there is no rush of people arriving at once. Especially important as no-one could know last week and last month how busy or otherwise custody may be today.

Finally, there will be some detainees in custody who may be there for some while, comparative to your average shoplifter or burglar. You get immigration service prisoners: if relevant processes are completed to deport someone, it can take a few days to organise. We obviously detain some people under s136 of the Mental Health Act 1983 who can be there for two or three days and some prisoners under arrest for serious offences, can spend up to 96hrs in police custody, subject to court oversight.

Why am I boring you with all of this custody stuff? I want to make some comparisons with bed management.

CAPACITY

There is evidence if you look for it, that some managers think having greater use of capacity is inherently efficient. So if you have X number of beds and you use them 95% of the time, this is "better" than using them just 90% of the time. It's common sense, isn't it? Having empty beds only 5% of the time is better than having them empty 10% of the time, not least because you have to pay staff to provide for 100% occupancy, so the fewer prisoners / patients they have in, the less work there is to do, surely?! Maybe – but let's do some maths!

If you have 100 beds and you have an average 90% occupancy rate, there will be occasions where you have admitted fewer than ninety patients and times when you've admitted more. So on occasion, you may have 96% occupancy of beds and on other occasions 84%. We know, for example, that MHA detentions and vary across times of the week and at certain times of the year. The extent of the fluctuation should determine where you try and "run your average" rate because you need to leave room for peaks of demand. Unless of course, you have effective contingency arrangements.

This is not different in custody. My initial description, above, talks of custody on a typical day but a typical week would look different again. For example, courts don't sit on Saturday afternoons or Sundays so prisoners who are charged and denied bail after about 10am on Saturday morning cannot go to court until Monday morning – they spend that time in a cell that now can't be used for any other purpose. So when you analyse a week's cell occupancy, you will see a squeeze on capacity that starts to build around Saturday lunchtime and reaches a peak on Sunday evening and overnight until a lot of people are sent to court on Monday morning. And Sunday LATE shifts and Sunday NIGHTS shifts, see higher than average rates of fresh arrests, just to help!

I'm not an NHS bed manager, but I've heard it repeatedly said, that MHA admissions over weekends, bank holiday and especially over Christmas, puts a real pressure on supply to match demand. And of course where "beds" you refer are specialist in nature – CAMHS, forensic beds in medium secure units of female PICU beds, this problem is more acute because actual numbers of beds are low to start with a percentage point either way is a good slice of the overall resource.

FAILURE DEMAND

So you remember those 100 beds and cells? What happens when you have to detain the 101st patient or the 101st prisoner? You'll remember that

quiet Tuesday when you (briefly!) had 79% occupancy, well this is the point where your peak of demand hits you, although your average is still 90%. And you start improvising through external processes: the NHS will look at out-of-area beds or even private provision. If Birmingham doesn't have the right kind of MH bed, we wonder whether Coventry or Wolverhampton has one spare? Of course, that then eats into their 100 beds and increases the likelihood that they will also reach capacity and we look farther afield, like Manchester or London. So it becomes more important to understand how often we breach that upper limit of demand to avoid expensive contingencies that don't do much good for patients and their families either.

But let's imagine the Chief Constable and the local NHS commissioners reduce capacity by shutting a cell block and a mental health ward. Let's say that we now have 90 beds. Let's further imagine that reducing arrest rates and quicker discharge of some patients means that with 90 beds / cells we are now averaging 95% occupancy. This is not more efficient than before, even though it probably costs less on paper – you will still have peaks and troughs of demand and it will be now be harder still to manage the peaks, meaning you will probably have to do it more often. It doesn't matter how low your troughs are to bring down the average, if you've got 92 human beings who need admission or detention and only 90 beds, you now have two out-of-area problems and **they cost real money to sort**. And the more of these instances you have, the more it pressurises both your system and the back-ups into which you tap when you're pushed.

The difference I notice between the police management of cells and the NHS management of beds simply this: the police are far more relaxed about empty cells than the NHS are about empty beds. I doubt that cell occupancy is anything near 90% or 95% *on average*. NHS staff have told me directly, that because of the way services are commissioned, NHS hospitals must average 90% bed occupancy to break-even financially – even though peaks and troughs of demand show that demand can vary as much as 20% from the mean. This financial structure and the consequential planning for averages pushes the possibility that supply will not be available when demand comes along. That will create failure demand, which is infinitely more expensive than doing it properly. This is why we are seeing lots of media, currently, about how much is being spent on private provision by our NHS. It's probably just cheaper to do it properly.

CONTINGENCY PLANNING

I once took part in a series of exercises with NHS colleagues to test reactions to a major incident. How would NHS staff handle a major fire in a medium secure mental health unit if the building needed to be evacuated?

All three 999 services were there in order that NHS managers could bounce requests / questions off us, as undoubtedly all three would have a significant role if a medium secure unit were ablaze. Somewhere in the exercise, I remember asking, "Where are your contingency places for medium secure care?" Blank faces, so I followed up with "Surely all medium secure MH units run let's say, 90% occupancy rates, so that you have contingency for things like this? – unexpectedly high levels of demand, fires and other major incidents?" I admit that I knew the reality was that they didn't but I posed the question so I was able to say this: "If a police station with a cell block were taken out of play right now, we could either spread those prisoners around existing capacity in other operational custody areas OR, if we really needed to, we could select one or more of over half a dozen "mothballed" custody blocks that can be activated." We simply put the staff from the evacuated building into the mothballed building, turns on the lights and computers and off we go.

The next question was: "Could we put patients into your cell blocks if we also put our staff in there?!" It was a serious question. But I think we're missing the point!

OCTOBER 2013

2nd October 2013

So What Does That Mean? –

In March of this year, Phillip SIMELANE was charged with the murder of Christina EDKINS after a fatal stabbing occured on a bus on the Hagley Road in Birmingham. Today, he has appeared before Birmingham Crown Court and pleaded guilty to manslaughter on the grounds of diminished responsibility. I'm sure we all remember the shock and horror that accompanied the early morning attack on a schoolgirl on a Birmingham bus that stunned the country and that our thoughts are again with Christina's family on what must be the latest in a serious of horrendous days for them.

This blog seeks to explain what this outcome means and to explain both why it sometimes happens where defendants have originally been charged with murder and why it represents as significant a "sentence" as any life sentence that would have been given had he been convicted of murder.

I want cover four things that are being asked of me already. I'll summarise and paraphrase them as –

1. What is diminished responsibility and why wasn't he convicted of murder?
2. Is diminished responsibility the same thing as 'insanity'?
3. Why has he been "sentenced" to hospital and not prison?
4. Won't this all mean he's released early and free to do this again?

DIMINISHED RESPONSIBILITY

There are two routes to a defendant being guilty of manslaughter on the grounds of diminished responsibility. Where a defendant stands trial for murder and they have a background of mental ill-health, it remains available to a jury to convict them of manslaughter as an alternative, if they are satisfied that the criteria for this are met. Sometimes, the CPS insist upon a full trial of all the evidence including medical evidence before allowing the jury to decide and it is for a defendant's barrister to put forward the diminished responsiblity argument – you will recall this is what happened earlier in the year in the trial of Nicola EDGINGTON whose defence argued diminished responsibility and the jury rejected this, convicting her of murder. (That outcome is subject of a pending appeal.)

Alternatively, if the Crown Prosecution Service are satisfied that the criteria are met, it may be that they agree with a proposal by the defence to accept a plea of guilty to manslaughter. This second route is what has occured today and we should be very clear about this: **this is a criminal conviction for homicide** – it is *not* a diversion from justice.

The criteria for diminished responsibility are met if the *court* is satisfied the defendant *"was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts."*

I have written in more detail on diminished responsibility *for those who are interested in knowing more.*

THE INSANITY DEFENCE AND UNFITNESS TO PLEAD

Diminished responsibility and insanity are not the same thing, although both clearly relate to a defendant's mental state. Firstly, diminished responsibility relates only to the defendant's state of mind at the time of the offence. Insanity is a potential defence either because of mental state at the time of the offence OR at the time of trial. Insanity being a legal defence, it is for the defendant's legal team to raise this issue and to satisfy the court, based upon the nineteenth century M'Naghten Rules.

To establish a defence on the ground of insanity, *"it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."*

If you like, insanity is a complete defence to a criminal charge: someone who successfully puts forward an insanity defence is *not guilty* of that crime. Someone who argues diminished responsiblity **is still guilty** of a homicide and obviously has to have been fit to plead. Both can still lead to a restricted hospital order and they usually do.

I have written in more detail on insanity and more detail on unftitness to plead *for those who are interested in knowing more.*

RESTRICTED HOSPITAL ORDERS

Where a defendant pleads to, or is found guilty of manslaughter, they will usually be made subject by the judge to a *Restricted Hospital Order*, under sections 37 and 41 of the Mental Health Act 1983. This means that two forensic psychiatrists have indicated that detention in hospital for treatment

is appropriate (s37) and that the judge thinks this is more appropriate than a prison sentence in the circumstances. It also means that the judge has ruled SIMELANE to pose "a significant risk of harm to the public" which is why he has 'restricted' the hospital order under s41 MHA.

Defendants who are sentenced to restricted hospital orders and admitted as patients to hospital **will spend more time there, on average, compared to someone sentenced to prison** for a similar offence. So if anything, this sentence will probably lead to *more* time spent 'detained' than for someone sentenced to imprisonment.

This is important to note: it is *very* far from being an 'easy' or 'soft' option; two phrases I hear used about sentences to hospital orders.

This restrictions referred to are **not** upon SIMELANE: they are upon the doctors treating him. They prevent the medical team from discharging him from hospital, from transferring him between different kinds of hospitals or from granting him leave from hospital, unless they have prior authority from the Ministry of Justice Mental Health Unit. The MoJ is responsible, on behalf of the Secretary of State, for overseeing all 'restricted' patients, to ensure that public protection is considered during any decisions that are taken. They do this via the Mental Health Unit. They require documented risk assessments, second opinions and other counter-balances to any proposed leave, discharge or transfer, before it can occur and forensic psychiatrists I know have consistently remarked how cautious and thorough the MHU is.

I have written in more detail on restricted hospital orders *for those who are interested in knowing more.*

CONDITIONAL DISCHARGE

The question is already being asked about how soon SIMELANE may be released. The truth is, that no-one knows at this stage. Yes, it is possible to find examples where defendants have been released after three years – Nicola EDGINGTON being one such example. It is also true that some defendants are never released. However, I want to explain how decisions to discharge patients are taken and to explain the safeguards which will apply –

Restricted patients are never just fully discharged into the community. They are always subject to s42 of the Mental Health Act which is called "conditional discharge". It means that a community forensic mental health team – a multi-disciplinary team of psychiatrists and nurses, social workers and occupational therapists will work with that patient in their new home. Conditional discharge can impose conditions: geographical exclusion from

certain areas, it may involve a regime of drug and / or alcohol testing, it will almost certainly contain conditions are the supervision of medication being taken either during home visits or during outpatient clinics in hospital and all of this will be subject to oversight of the local Multi-Agency Public Protection Arrangements, known as MAPPA.

Conditional discharge means that if the team working with the patient after discharge is not satisfied with compliance with conditions or have concerns about any behaviour exhibited since discharge from hospital, they can ask the Ministry of Justice to issue a warrant for recall. This MoJ warrant allows the police to re-detain the person and return them to hospital, where they revert to being a s37/41 restricted patient.

I have written in more detail on conditional discharge *and in* more detail on MAPPA *for those who are interested in knowing more.*

BUT WILL THIS ACTUALLY HAPPEN AND WILL IT WORK?

I've used the example of Nicola EDGINGTON very deliberately in this blog, to compare the process – because this is an example of where you may argue things went awry: convicted in 2006 of manslaughter on the grounds of diminished responsibility, conditionally discharged after just three years amidst errors on the part of some which meant she was not referred to the Greenwich MAPPA panel. Within eighteen months of discharge she is arrested for a further homicide incident and then convicted of murder and attempted murder, the jury having rejected a second argument of manslaughter. You can find examples of where a restricted patient's stay in hospital is significantly less than any prison sentence they may have served for manslaughter and where the "aftercare" arrangements have not worked.

Such examples are very rare. The Ministry of Justice publish figures each year on re-offending, both for those sentenced by the criminal courts to a community sentence, to those who were sentenced to and then released from prison and for patients who are discharged from hospital. There are regional variations but –

- Re-offending after community or prison sentences is usually around the 50% mark.
- Re-offending by restricted patients after discharge from hospital is just 6%.

So as with all sentences and / or release decisions for someone found responsible for a homicide – there are *no guarantees* of anything. Firstly, there is no guarantee that he will be released at all and the Senior Investigating Officer, D/Supt Richard BAKER has expressed a view that he

will be surprised if he ever is. Some people do spend the remainder of their lives detained after these kinds of outcomes because the never reach a point where they are judged fit for discharge. What *can* be guaranteed is a series of checks and balances within the system that lead to a **significantly** reduced likelihood of further offending after any future discharge and **far greater ease of recall** should there be any concerns at all.

I hope this explains just a little of what this outcome means and we should remember that whilst Christina's family have indicated that they still have questions about his assessment, treatment and care before this awful incident, they welcome the fact that he has now been "taken out of society." I'm sure our thoughts are with them today.

5th October 2013

Take That Victim to the Cells –

If you are reading this on a desktop computer, right click this YouTube clip and have it running in the background on another tab whilst you read this blog.

Imagine this scenario and the fiction in which you think it may appear —- you are the victim of a very serious crime. So serious that it has life altering consequences, not least in terms of your mental health, because you struggle to come to terms with what happened to you. OK, let's be frank: you FAIL to come to terms with what happened to you. You know EXACTLY who hurt you, you can name them to the police and for a range of reasons that you fail to understand, that person was not prosecuted at all.

Meanwhile, back in your life, you continue to live or maybe, just exist, in a place where the person who hurt you can do as they will and you spend hours each day failing to grasp the enormity of it. Although you don't have any previous history of mental ill-health, you find with time that you have started to self-harm. It becomes serious enough for your family to express their concerns and they support you in seeing your GP. After a few months in which you are not able to control the urge to hurt yourself and you start to neglect your welfare, you agree to admission to a psychiatric unit and are admitted voluntarily, unable to stop thinking about the trauma you experienced when you were hurt and unable to control voices in your head telling you that it was your fault and that you deserve punishment for what you did.

After period of time as an inpatient, you are discharged, although you are not quite certain that the time is right as you leave. Later that evening, you cut yourself so severely, that you have cut to the bone of your leg and you find both paramedics and police officers at your home who are keen to help and safeguard you. You are not sure about what to do when the paramedics offer to take you to A&E so that you can receive treatment to the serious leg injury

Now it doesn't matter whether you are a man or a woman or what the offence is: this vignette is an amalgam of a few stories I've been told over the years. It could be a woman who was raped and publicly degraded; a man who was subject to GBH in a deliberate, disabling attack. There are versions of this story all over the place with many variations on the

background, the reasons for it and the consequences. Some victims who physically self-harm, some who overdose on medication in life-threatening consequences. This may occur in the weeks or months following an attack or some years later where the someone had been the victim of childhood abuse of one kind or another where children are forced to grow up in contact with those who so badly abused them.

CRISIS RESPONSE

So imagine what it feels like when the police step into your life and for legitimate reasons to do with keeping you safe and hoping to get you some support, assessment and care, you **find yourself incarcerated to the very cells that your attacker got nowhere near**.

Imagine what that must be like – you are the VICTIM of a crime. You know this because you were there and no-one else except your assailant was. Yet you are the one that gets banged up; and RIGHT next to the kind of people that offended **against** you, when you've done nothing wrong. **You've done nothing wrong.**

I've made this point before: we are *far too casual* about thinking police stations are suitable places to detain someone who is mentally unwell. Do we fully grasp the implications of this kind of action? Putting victims of crime, who are struggling to cope with the trauma that was caused by the offence they lived through, in the very environment their attacker may never have reached, but knowing that the person next door to them will quite potentially have done to others what someone did to them?

So it's not just about the environment — cells are cold, bleak places. Concrete walls, hard benches and stark furnishings. It's about the symbolism and the semiology. We don't put people in that part of a police station unless they are alleged to have done something wrong – rape, assault, theft; even immigration issues and matters connected to the administration of justice. All involve the suggestion that people had broken a law, of one kind or another. The provisions of the Mental Health Act seem the only exception to this principle, which is an interesting proposition when set against our commitment to international human rights law.

And think about what you see and hear in custody — they are noisy, disorienting places. I've heard prisoners singing songs all night, banging the hatch of the cell door all night and screaming obscenities all night. And I really do mean **all night** – for periods of 8 to 12hrs. I've heard men screaming threats of sexual violence: listing what they would like to do to the female custody officer or a male custody sergeant's female relatives, in detail that could not be repeated here. Imagine if that had been heard by the hypothetical rape victim, above?

And what if this was done at the express wish of the NHS — what if the the police have decided to use s136 to stop someone from hurting themselves and after treatment for those injuries there is a request to remove the person from A&E because they are now "medically fit" – this usually means in terms of physical injury. Local place of safety provision being unavailable, the view is offered forward, "well it will have to be police custody for MHA assessment then."

Against this known background? – seriously?! — and what if provision in the NHS was actually available, but the exclusion was against arbitary criteria or where PoS provision was available in the area immediately adjacent? A slightly longer journey across a bureacractic boundary or incarceration in the cells. Para 10.22 to the Code of Practice anyone?! << The last version of this story I was told, a PC who'd taken trouble to understand the background that A&E hadn't asked about once, just simply refused to move the person and explained why. Antagnoistic, but understandable?

In one area where there was a sticky patch in progressing to NHS place of safety provision, I took a senior NHS manager on a tour of custody. The large central custody area of Birmingham central police station is a 19th century gaol. Having marched him round what looked like the set from Porridge and shouted at him to make sure my voice was audible over the shouting and screaming, I asked whether or not he had any children and whether putting them in this environment when they were disturbed and ill would be acceptable to him? It did the trick.

These are nasty, noisy places and dangerous places for anyone put there. People put there with particular backgrounds like in our stories above, have got particular reason to think such a decision, however it ends up occurring, is an outrage. And I admit that I agree.

50% of people detained under s136 MHA still get taken to police cells as a place of safety —– it doesn't have to be this way. Just 3% of those in my force area are so treated – I still think that's too many.

7th October 2013

Criminal Victimisation –

Today, Victim Support has published a substantial report on the prevalence of victimisation in those who live with mental health disorders – **At Risk, Yet Dismissed**. It is a big piece of work, conducted by extremely reputable researchers from world-class universities like King's College and University College, London. It deserves to be taken extremely seriously, in my view.

Here are the resources for you —

- The Full Report "At Risk, Yet Dismissed."
- The summary report, including recommendations.
- Press release from Victim Support
- Press release from Mind, main supporters of the research.

THIS IS LONG OVERDUE

This report just documents what I've long known and all too often seen: that the service given to victims with mental health disorders is not as consistent as those given to victims without. More importantly, it documents the extent to which victims become victims *because* they live with mental health disorders and the extent to which people are often targeted precisely *because* offenders know that the criminal justice system will, more often than otherwise, fail to deliver a case against them into a court room.

This is why the criminal justice system needs to go the extra yard, to combat the stigma that pervades us all.

This report has far-reaching consequences and it contains so much of interest, I'll probably do a couple of blogs on specific issues after this one to just the report more widely distributed. Whilst I do hope that it's read at the highest levels of policing and criminal justice because we have work to do; I also hope that many of the frontline cops who read this blog, just open the summary document above and read pages 6 and 7. If you are intrigued by what it says, open the full report and read pages 30-40. This

will take you about ten minutes of your life and I hope you are both proud and ashamed, as I was, to read some of the feedback that is in there.

- 45% of people with a serious mental illness were victims of crime last year – three times the rate of the general population.
- 33% were victims of personal crime – assault, "mugging" or threats of violence.
- 25% were victims of household crime – burglary, damage, theft.
- Twenty percent of those with mental health disorders have been a victim of assault in the last year – this means people are five times as likely as the general population to be assaulted, but women are ten times more likely, with obvious cross-overs into domestic violence.
- The report makes **ten recommendations** (p12 of the summary, p64 of the full report) about how to make the world a better place.

Much of this does not necessarily need a massive strategy with an action plan and months of training – certainly not from the police point of view, although senior leadership will be very important. A lot of it is about individual police officers taking responsibility to accept the feedback offered and reflect upon it in terms of their professional practice ahead of your next encounter.

ISSUES FOR POLICING

Those interviewed in this study reported satisfaction levels with the police that were way below those reported by the general population. Victims with a serious mental illness (SMI) were as likely to report things to the police as the general population, as likely to progress through the justice system but were less likely to report respectful treatment. Of course, many people have positive stories to tell. The report reflects this and I regularly hear on Twitter that patients think individuals officers have often been caring, compassionate and considerate. Less often, I'm glad to report, I hear the opposite. But I still hear it too frequently.

Attacking people with mental health problems because they have mental health problems is a HATE CRIME – it comes under the banner of "**disability hate crime**" for ACPO purposes and it should be flagged up as such, so force policies around dealing with hate crime can be implemented. It is clear from this report that we have work to do, to improve. Turns out, it's not necessarily that hard for us to do so – just listen to what people say in this report, as a starter for ten —

- **Listen to what victims tell us** – this is basic stuff for all victims, including other vulnerable or intimidated victims. Why do anything differently for someone because they have a mental health

problem? Remember, even a specific vulnerability does not mean someone is less "reliable" as a witness. Keep in mind the case of B v DPP (2009) – this is the GBH trial that was discontinued by the CPS because a victim with schizophrenia who ear had been **bitten off** "could not give reliable evidence." There was no reason to think this, beyond him having schizophrenia and the court ruled it a breach of Article 3 of the European Convention. Police forces could be found similarly liable if they too quickly dismiss what they're told.

- **Leading on from listening, actually believe what you are told** unless of course, you have *specific reason or evidence* to do otherwise – in the case of "B v DPP", there were several witnesses to the incident. How we can disbelieve the likelihood that a grievous assault occured when a victim and several witnesses are saying it happened? Even if we haven't got immediately corroborative information (like injuries that need treating), how does the account offer up potential lines of enquiry to CCTV, witnesses and / or forensic evidence?

- **Validate this victim by looking for the evidence** – Maybe you won't find it: maybe it doesn't exist. But it validates the claim of victimhood if they are heard, believed and then officers investigate. Also remember this when there are power differentials at play. This could be a domestic violence victim with a controlling or oppressive partner; it could be a patient reporting institutional abuse in a hospital or care home. Reports of crime by care staff of any kind, should be heard, believed and taken seriously. We should go where the evidence takes us.

- **Don't pre-judge what the CPS might say or what a defence barrister may do** – remember: defence barristers will test the evidence of any witness against their client. We have long since realised we don't tell rape victims "you'll be ripped apart by the defence" or that their personal sexual history may be brought up. We dispassionately explain the justice process and support them through it. As and when it is necessary to do so, officers in the case outline the reality of criminal trials to prepare people for what they are going through and use organisations like Victim Support to assist. Telling a person with bipolar disorder who has been robbed that they won't be believed will not help anything, nor is it necessarily true! Finally, even if there were some aspect of unreliability in a victim's evidence: this is true of many victims who do not have a mental health disorder and there could be corroboration that sets aside any demonstrable unreliability. Imagine that "B" actually was unreliable for some particular reason: there were still independent witness to the attack.

There are many other aspects to the report and I encourage everyone to read at least the summary, which is only 12 pages long. I will blog on a couple of other things when I get the time.

Something very important for me, is that I opened this wondering whether I'd read something about the victimisation suffered by people mental health disorders, comparing it to offending rates by people who have mental health problems. You will have read the sort of thing I mean: "people with mental health problems are X times more likely to be victims of crime than offenders". I admit I've never understood that, not least because research about such matters is poor – I've always just thought that understanding victimisation rates compared to the general population tells us more about what living with mental health problems can be like and it illuminates the cycle of exclusion, victimisation and inequality that is probably far more important in the end. For that, this report is to be congratulated, read and taken all the more seriously because that is exactly what it does.

16th October 2013

Do As You're Told! –

I frequently can't help but wonder whether I'm irritating people? I think I've irritated a few people over the last fortnight or so and reaction to that is the reason behind my taking a few weeks off the tweeting and blogging – this post and a couple of others have been written and scheduled to auto-publish whilst I'm taking a break from it all and I'll reflect on this again at the start of November after a much-needed break in the North-East. I need some solitude on a Northumbrian beach in the cold, pre-dawn. It's been far too long. *(Look left.)*

It seems that by asking questions about what the police are asked to do, occasionally resisting or insisting upon other approaches is irritating. In so many aspects of the policing / mental health interface, I get the impression that people would just prefer the police not to ask questions and just do as they're told. It has happened many times in my career that I have been invited to put myself in a position where I could be blamed if things went awry and I will admit that I really don't like it very much. So where I think it is both necessary and professionally appropriate, I resist and push back; these being the cumulative lessons of policing / mental health tragedies over the last twenty years.

It wasn't my decision to under-resource our mental health system or to fail to prepare for the very predictable implications of our mental health law. When I find others occasionally quite desperate to be able to say that the police said everything was fine or that it was the police who used too much (illegal or inappropriate) force, I start thinking out loud. If anyone is under-resourced and I am in a position to help and support them, that's fine. Many cops challenge me when I say this, but there are some things that we really should muck and in a help with which in an ideal world we wouldn't have to. In that ideal world there wouldn't be any robbery or rape, either.

But I don't live in or police an ideal world. So I have to be able to see where I can make a positive contribution to our collective safety and distinguish it from where I can't. There are some things that the police should stay clear or even refuse to do. There are some things we could never do, even if we wanted to help.

ALIVE, BREATHING AND CONSCIOUS CHECKS

My team was asked to do a "safe and well" check a few weeks ago after a patient made a suicide threat over the phone to the CrisisTeam. It wasn't an obviously imminent threat, but standard practice is to tell the police and transfer responsibility for mitigating that risk to them.

Many mental health professionals think that police officers have training, skills and powers to do this. Pointing out that we don't often appears irritating and I could tell this when I rang back with my standard response. "She's here, she's alive, breathing, conscious and without obvious indications that she has self-harmed or taken an overdose. What do you want to do now?"

The reply showed what was really going on: "Well, as long as your satisfied she's safe and well."

Hang on – **I'll stop you right there!**

I'm not saying she's safe and well – not for one moment. I'm quite unable to confirm that, even though I'm trying to be helpful. I'm only saying she's alive, breathing and conscious showing no obvious indications that she has self-harmed, taken an overdose or is intoxicated. Whether she has taken an overdose: I've got no idea. She says she hasn't, but that doesn't mean she's telling the truth. Let's remember the power dynamic here: this is a vulnerable lady in her own home, who was STUNNED to see the police arrive and stated that when she spoke to the CrisisTeam no-one had made her aware that the police would be sent.

There are only two broad scenarios here regarding self-harm / overdose: either there is a raised risk of it in this incident, or there's not. She's told the CrisisTeam that there is a risk – hence they called the police; but she's telling the police that there is not. I've known this person for about seven minutes at the point where I'm being obliged to decide whether to take this inconsistency any further and I haven't read her medical notes.

I'M NOT A MENTAL HEALTH PROFESSIONAL

Far more crucially, I'm not a qualified mental health professional – I don't know this human being at all and I'm certainly not privy to the kind of history that you will have if she's open to your services. What I do know is that she must be thinking, "If I don't convince these cops I'm OK, I'm probably going to get locked up." Doesn't matter that we wouldn't have a power to do this, this patient may not know that. Even if she does, maybe

she's wondering if we're the "step outside for some fresh air, it'll make you feel better" police who will make s136 happen one way or the other?

So I'm sorry if I'm irritating you, but you'll have to excuse me for not wanting to put my arm in someone's mangle so the police can be blamed – as is currently happening to two officers from a southern police force who had a job exactly identical to that above and said, "Yes, safe and well." Now being investigated after the person committed suicide. Guess what mental health professionals are saying? "Police said the patient was safe and well so we deferred follow up until the next day."

Meanwhile, back in my scenario, I lacked any coercive legal ability to intervene so I passed this back for a decision about whether any mental health support was to be given, including whether any Mental Health Act assessment is needed. For the record: if she had been on a public street, I would have used section 136 MHA because I thought she was in immediate need of care in her own interests. I made that known, too.

But as she's wasn't, I couldn't, so I didn't – and back to you. Do let me know if support is needed to execute any s135(1) warrant or for any assessment that is organised. I'm not trying to irritate anyone or refusing to play my part in something I could help with. I'm just trying to resist being one of those who will be held responsible for a situation I didn't create by being unwittingly pushed into thinking I've got skills and training I simply don't have.

And that's another debate altogether that could have been the story of my irritating people: section 135(1) warrants. The implications of these warrants are still not widely understood more than FIFTY YEARS after they were introduced in the Mental Health Act 1959. The 1983 Act just carried them from the old Act to the new, untouched. And we still don't understand them.

Enjoy the other posts that I will appear whilst I'm away. See you week commencing 4th November.

18th October 2013

False Economy –

We've been reading a lot recently about the impact of cuts and rationalisation of mental health services – the Health Select Committee of the UK parliament recently published a document which highlights a lack of parity for mental health and physical health care, having been dogged by difficulties in patients accessing services and the ineffectiveness of community treatment orders.

Public demand for services, like energy, goes somewhere if not down the intended route and we have seen several examples of disaster, arising from the inability of some services to match demand and the attempts by others to react to it when it is unmet.

We saw more about this today, in the publication of a BBC and Community Care investigation into NHS mental health bed provision. The medical director of what is probably the UK's most prestigious mental health trust has claimed the system is now inefficient and unsafe. It was music to my ears to hear him say this morning that it was probably costing more to do it this badly. A variation on my frequent proposition that it would be "cheaper to do it properly." I remain convinced that this is true.

We see hidden costs in many ways –

1. **We have seen the tragedy of exclusion** – service users living increasingly desperate lives, unable to cope with poverty, financial restrictions and the stigmatisation of mental illness disappearing in to the background of our society and we see the links in police custody to poverty, mental illness and substance (ab)use.

2. **We have seen the tragedies of self-harm and suicide** – service users and others with unmet needs who may well not be known to MH services who are at risk, unable to access support they require taking their lives.

3. **We have seen the tragedy of criminalisation** – incidents of offending by people in crisis which may well have been preventable

which then lead to the victim-cost as well as the costs of prosecution into the justice system.

4. **We have seen the tragedy of untoward events** – we have seen incidents where someone in crisis (whether or not they have received adequate support) comes into contact with the police and for reasons covered by Lord ADEBOWALE, there is death or serious injury following contact.

Cost: human, economic and social – arising from problems of resourcing and from systemic issues (currently being reviewed by the Care Quality Commission) and all this against a backdrop of the overall mental health budget having risen by 59% in the decade to 2012; with a small drop last year. It is rightly argued that this increase only brought funding to where it probably should have been, if it even did that, and therefore there should be absolutely no perception that mental health services are now cash-rich because of budget inflation.

THE COST OF DEFLECTED DEMAND

But as we have seen restrictions and rationalisation of service (management-speak), we see the costs of failure demand and they often do come back against the NHS as a false economy. The costs of a prison sentence are covered by the government budget for the Ministry of Justice who fund our prison system; but if prisoners are transferred from prison to hospital as patients, the costs transfer to the Department of Health whose budget funds our hospital system.

So for example, Phillip SIMELANE was recently convicted of killing Christina EDKINS and inquiries are ongoing about the contact that MH services had with him whilst he was previously in prison for an unrelated matter. He managed to leave prison with inadequate housing support and the investigation is looking at whether he had adequate mental health care support, prior to killing Christina. Mr SIMELANE's mother has publicly claimed he was let down by "the system" and it is now the mental health system that is picking up the bill for his hospital order at around £300,000 a year, rather than the provision of appropriate outpatient or inpatient care after prison. I'm sure the inquiry will reveal whether or not they feel the incident was "preventable."

We also see mental health demand being deflected by mainstream services to 999 services: both the ambulance service and the police service are *de facto* front-line mental health professionals, only without the training or sometimes without the legal powers to cope. This is why we see "Street Triage" emerging: paying a nurse to work even further and deeper into the

crisis than ever before. Incidentally, what ever happened to "Early Intervention"? This is not a phrase I've heard for a while, as the commissioning focus shifts to other, baser priorities.

PREDICTION AND PREVENTION

Of course, **not all crisis events are predictable or preventable** and many involve patients unknown to their mental health trust or even to their GP as having a mental disorder. But we know in many areas, that up to **half** of s136 detainees – the people that Street Triage nurses will be seeing – **are already known to services**. What's going on there? – do we even ask?!

Data from a couple of years ago in one local authority outlined that 55% of their overall budget was being spent on the secure care of just 67 individuals in medium and high secure hospitals, each patient consuming around £300,000 – £400,000 of budget per annum. This means that around 45% of budget being spent on just under 2,500 other patients and every time one of them becomes in need of secure admission, it creates more pressure as the forensic bill rises.

So you can reduce bed numbers if you want and continue to do so beyond the point at which available beds only just match demand. We can conceive this as saving money because we are paying for fewer beds which cost about £125,000 a year. But by the time you've then paid for an out-of-area or private bed for the patients who couldn't access your service, by the time we've measured the costs in other ways and by the time crisis has become such as to mean the justice system has sentenced someone to a hospital order and detention in a bed which costs £300,000 to £400,000 a year, how much money have we saved?

It takes just one patient to be placed in medium or high secure hospital system to blow our the budget for decommissioning three beds. And the number of restricted patients in hospital has been rising steadily over the last eighteen years.

- In 1995, there were 2,478 restricted hospital patients.
- In 2004, there were 3,282
- In 2010, there were 4,404.
- I'm *very interested* in being quite unable to find statstics since 2010 – all help gratefully received!

And this is just about the money, mainly because that's what all too many people are focussed on – what about human and social costs? They extend way beyond vulnerable people and degrade us all.

Unmet need is unmet need: if we do not respond to it when first identified, then we will see this "demand" go elsewhere. We will see suicide, unemployment and ever greater social exclusion and discrimination than we've seen before. And when we sit down at the end to decide whether the books have balanced, we will have to factor in the cost in human life and human disadvantage. It's not just about money. It's not even about money.

21st October 2013

"We'll See", said the Zen Master –

Have you heard the story about the Zen Master and the Little Boy?! …

- The boy's father bought him a horse for his fourteenth birthday and everyone in the village said, "Isn't that wonderful, the boy got a horse?" and the Zen Master said, "We'll see."
- A couple of years later the boy fell from his horse, badly breaking his leg and everyone in the village said, "How awful, he won't be able to walk properly." The Zen Master said, "We'll see."
- Then, a war broke out and all the young men had to go and fight, but this young man couldn't because his leg was still messed up and everyone said, "How wonderful!" The Zen Master said, "We'll see."

MAKING PROGRESS

Not everything that looks like progress necessarily is; and even where we do see overall benefits, we will still see unintended consequences. We're seeing the amount of attention given to policing and mental health increasing. There was a Policing and Mental Health summit lead by a PCC several months ago, one more last week and I'm aware of a third later in the year. We're seeing the introduction of schemes to "improve" things ranging from street triage schemes, custody liaison and diversion schemes (8am-4pm, Monday to Friday, obviously) as well as forces adopting "tougher" stances towards what they see as inappropriate mental health related demands. Many of these schemes are being welcome and undoubtedly there will be consequences to these changes and **we'll see.**

Change will always bring about consequences: both intended and unintended —

- We saw the whole mental health system deinstitutionalised much of its inpatient care provision in the decades after the 1970s and it continues apace at the moment.
- Last week's reaction by the department of health to the BBC / Community Care investigation which revealed that the inpatient mental health system is now essentially full, was to comment that more than 6,000 patients now receive treatment in their own homes.

- It didn't really address the issue of whether there we now commission sufficient beds to match predicted levels of demand or how we manage the excess.
- Unintended consequence: incredible numbers of patient-miles being clocked up in order to access an inpatient bed.

We see other intended consequences. We have lost around 1,700 inpatient mental health since 2011 and then we learn that the NHS is concerned that the use of section 136 MHA by the police is rising. Well, we have been asking the police to "get better at mental health" for some while and we've seen forces posting people to full-time positions, implementing training and now very active in areas where they were traditionally reactive. And not all of that is getting it right, because all the cops working on it have three or four hours of mental health training and very little mental health law training. So … **we'll see**.

We have deinsitutionalised our healthcare, only to find we now have to imprison more people with mental health problems than ever before, a good number of which are restricted hospital order patients who created a victim on their way to an incredibly expensive care regime in a medium or high secure hospital which costs three or four times as much as the mental health bed that was decommissioned and that they couldn't access. Other versions of those unintended consequences involve stories of self-harm and suicide which are often far worse. So more community care sounds attractive, but … **we'll see**.

So we could tell the Zen story again: decisions being taken which appear to have superficially attractive consequences. Who can reasonably disagree with the proposition to deinstitutionalise for those who don't need inpatient care and who could lead very worthwhile lives with community based mental health care? As Winnie the Pooh would say, this is "A GOOD THING!" **We'll see.**

But then we hear stories of some of those patients being unable to access community care or being criminalised in order to access it, through section 136 in the cells or because they did something whilst in crisis and found themselves arrested for a public order or other minor offence. Some vulnerable people in these circumstances take their own lives and some end up in prison. We could all agree that this really is awful, but **we'll see**.

DEMAND IS LIKE ENERGY

We all remember from physics that energy doesn't just disappear, it goes somewhere. Intended or unintended: it is going to have to go

somewhere. I very much see mental health related demand in these terms. If someone perceives themself to be at risk or in need of support that they don't think they're getting when they need it, only one of a few things is going to happen to that "need" —

1. A person will seek informal supports from personal networks if they have them;
2. A person will seek support from 999 or emergency health services like A&E / CrisisTeams / Out-of-Hours GP services.
3. A person will fail to cope for themselves and take whatever instinctive or intuitive action they feel they have to – not always with positive outcomes.

An idea that I've been mulling over for some months however, is about the reaction of a predominantly medical model trying to "fix" people. I've read with interest many books over the last few years that people have recommended about the benefits / problems of a medical / bio-psycho-social model of mental distress. It's all interesting stuff but I sometimes wonder if we're over complicating it?

Sometimes people just want help — that can take many forms. In this week alone, in response recent blogs I've heard how some caring compassionate time on the part of two cops was just enough help and just the right time to prevent someone from taking their own life. Not treatment, just time spent trying to understand and support someone. It made me think of the WHO studies which suggested that recovery rates from mental distress in some developing countries without advanced healthcare systems is often better than recovery rates in the UK, Canada or Australia. In response to the same blogs, I've heard stories that people felt unsupported by attempts to diagnose them and medicate their problems away. These remarks are just to say something imprecise about the potential for human beings to help other human beings by not taxonomising their distress into inherently artificial categories like "personality disorder" or "substance abuse" or "functional mental illness".

A health consultant recently said on Twitter that the problem with our (mental) health system is that it is a "Fix Me" system for "Help Me" patients. Therein seems to lie certain problems with our various efforts to change how we do what we do, both within the mental health system and with the broader public services that they sit within. And we can be certain that there will be some unpredicted and unintended consequences.

We'll see.

28th October 2013

Shut Out –

A recent programme from South Africa on mental health provision in the country. I first looked at certain issues around mental health and criminal justice in South Africa ahead of going there on holiday last year. It was clear from visiting various urban and rural areas that there was much unmet mental health need and a chance conversation with two police officers in Blouberg, near Cape Town, revealed that much police demand is connected to the response to mental ill-health, substance abuse and associated crime and disorder.

However, officers had even less training and access to even fewer support and diversion services. We can see in this programme (25mins) the disparity in care in this beautiful country and how the South African police service get drawn in to demands. All too often, a criminalising response to vulnerable people being the only one available apart from doing nothing at all. You can view the programme on YouTube.

FURTHER LINKS / MORE READING

- The South African Mental Health Care Act 2002
- Recent research article on the South African Police Service use of "Section 40" MHCA 2002.
- Dr Vikram Patel talking about global mental health in developing countries.
- The PRIME website.
- The South African Mental Health Federation – an umbrella organsation for mental health charities.
- The World Health Organisation (UN) report on South Africa's mental health system (2007).

30th October 2013

Causal, Contributory or Coincidental –

The relationship between mental ill-health and crime is far from straight-forward. I've quoted Professor Jill PEAY many times after she remarked that work at the interface of mental health and criminal justice is amongst the most challenging that either group of professionals will undertake and I think she's correct. Perhaps because of the extent of that challenge we see simplification – actually we see over-simplification! – in the debate about offending and mental health. It is this simplification that I want to write about here.

So often we read of cases where a defendant's case was resolved with reference to mental health problems and then hear expressions from professionals or media that amount to, "oh, right" as if someone's mental health problem explains the crime. It is too often and too casually assumed that if someone has committed an offence whilst ill, they must have committed the offence *because* they were ill. That, in turn, links to assumptions or observations about people being unable to be held responsible for their offences.

I have seen this a lot over the years, not just from police officers who fall foul of this trap when asked to investigate things. I've also heard victims of crime, including mental health professionals and relatives of suspects, talk about how they don't want to see a prosecution because they know someone is ill. There's nothing necessarily wrong with a victim's decision not to seek a prosecution – the criminal justice system is victim led; but I do wonder sometimes about the assumptions that may sit behind that decision. What if the allegation in question arises in no way because of someone's illness or it is only part of the background? What role does substance (ab)use play, what about other factors that are precisely connected with liability like a wilful intent to legal wrongdoing?

THE CONFLATION OF THREE RELATIONSHIPS

I want to put forward the argument that this over-simplicity – about the fact that illness and criminal conduct are inherently linked – is actually the conflation of three seperate kinds of relationships.

- **The causal relationship** – the one where someone has offended, precisely because of their illness. These types of case will be far rarer than the others: those, for example, where someone is responding to auditory hallucinations, command hallucinations and delusions to hurt others.

- **The contributory relationship** – the one where someone has offended, partially because of their illness. These types of cases are the most difficult to identify but it is vital that we do if we are to explain

- **The coincidental relationship** – the one where someone has offended, irrespective of their illness. I wonder whether these types of case are under-identified because we are too quick to assume a link between ill-health and crime. We don't see these cases in the media very often because they are lower level despite being far more frequently occurring than either of the other two.

Something of a disclaimer >> I'm going to exemplify these claims with reference to cases you will have heard about or can look up. I've wrestled in writing this post with the fact that those cases where you can read more for yourself tend to be the more serious cases. Although it is certainly the case that offending is more frequently less serious, or even acquisitive crime – that doesn't offer much scope to use examples familiar to us all. It is also true that the level of proof of "intent" that is required for more serious offences of violence serves to make the point that this post is intended to highlight: that of how illness may or may not be related to crime.

"CAUSAL" CASES

Examples of this kind of case are there to be seen in high-profile, because they are the stuff of stigma and generalisation across our whole media system and include the random attacks against strangers that so often make front page headlines. If you remember from reading my piece on restricted hospital orders, you will recall that they can be imposed either after the full criminal conviction of a suspect for an offence, or following a finding of "unfitness" and finding by the court that the defendant "did the act" charged or was "insane" at the time.

So, that shows that the law recognises this distinction: one where criminal responsibility is not proven, but where the offence arose from behaviour caused by someone's (often serious) mental illness. I would argue that we see a very recent example in the conviction of Richard SVAGELJ in Hertfordshire – he was seriously mentally ill at the time, found "unfit" to plead and stand trial and given a hospital order to ensure his ongoing

treatment, without having been criminally convicted. The same applied to Darren BOOTH in Staffordshire, earlier in the year: he was found responsible for a sexual attack, but not convicted because he was unfit to plead and stand trial and given a hospital order to ensure his ongoing care.

"CONTRIBUTORY" CASES

Any murder prosecutions where the outcome at court was a finding of manslaughter on the grounds of diminished responsibility will fall into these categories – convicted of a criminal offence but where responsibility for that act was substantially impaired without being fully set aside. So here we will recall the convictions of Philip SIMELANE for killing Christina EDKINS, John WARD who killed two big issue vendors in Birmingham and Matthew TVRDON in Cardiff.

In each of these cases, it was accepted that a serious mental illness provided a background which cannot be dissociated from the incidents, but where there was sufficient evidence of criminal liability within. We see further examples in the cases of Nicola EDGINGTON (although that case is pending an appeal) as well as Christopher HAUGHTON who attacked a number of police officers in north London in 2011. Both defendants were fully convicted by the courts of the serious matters they were charged with, as was Matthew TVRDON of lesser charges that were included in addition to murder, and sentenced accordingly. Nicola EDGINGTON in particular was sentenced to prison.

"COINCIDENTAL" CASES

The coincidental cases we see are usually far less high-profile and certainly more numerous. These are cases I researched for my MSc dissertation about ten years ago – volume crimes, committed by people living with complex mental health and social problems who either fall into gaps between services or are just below the thresholds for admission to hospital. It is these people, for me, that would benefit most from much better and improved liaison and diversion services – if only we can get them to work for a greater part of the 24/7 period and based upon a model that seeks to integrate health and criminal justice decision-making.

There are not many examples to highlight here, because our media are far less interested in shoplifters, burglars and street robbers who live with substance abuse and / or mental health problems but who are not acutely ill. This probably does reflect the legal reality, but it also means that we see things like "mental health treatment requirements" not really being used effectively. It was reported some years ago that they are under-used

by the courts, often because of a lack of services to "require" people to engage with and also because of a lack of training for prosecutors and magistrates about their potential benefits.

WHY IS THIS IMPORTANT?

All I'm saying in this post: **we need to get better at examining this relationship** in order to weigh the evidential and public interest tests for allegations that are made. If we better understood the nature of any relationship, we would better understand how to design and interweave criminal justice and mental health disposals that reflect it.

I remind you that although the examples used here are serious crimes, it is for the deliberate purpose of demonstrating the legal point: that mental illness is less frequently the cause of crime than is imagined and represented in our media. It is more often *directly unrelated* to the commission of offences but provides a background that is too often exploited to provide a stigmatising narrative. This also shows the extent to which mental health services are not really structured at all to work with offenders across this domain: they mainly just respond to sentencing decisions by the courts, way after things have gone horribly wrong in a minority of cases that do not reflect the daily reality for many people with complex, unmet needs.

31st October 2013

Trespass –

When we think of trespassing, we usually think of trespass to land. It is also possible to trespass against the person or against goods, but this post is concerned with our intuitive thought of entering land or property belonging to other people. Such trespass is not, *per se*, a police issue – it is a civil tort. One person against the other and legal reparation for trespass is via the civil courts. It is for that reason I always laugh at signs like this one, which I think seek to cause people to think they could be arrested and *criminally* prosecuted for trespass. It probably should read "**trespassers will be sued**" if the landowner feels that strongly about it!

There are aggravated versions of trespass that are criminal offences, but the version of me standing on your property against your express will and without your permission, is a civil issue. As the property owner, you could forcibly eject me using reasonable force and seek redress by initiating your own legal action.

The police are often drawn into these issues: when trespassers will not leave private property, officers are often asked to assist in removing them and if transgressors insist in remaining or resisting, we start to see breaches of the peace, assaults and other matters emerging that are very properly police business where trespassers can be arrested. Crucially, they are not arrested or sanctioned for the trespass, but for the manner of the resistance to the legal requirement to move made by the landowner.

IMPLIED RIGHTS OF ACCESS

It is not the case that those who enter your property without explicit, advance authority are trespassers – it is far from being as straight-forward as having to have expressed permission. There is an implied right of access for people to enter your land or property for certain purposes. For example, if you have any form of front garden with a path, people can walk up it to knock on your door and deliver your mail, your pizza or to see if you want to come out to play. They don't need *express* permission for this. However, if you objected to the person's ongoing presence on your doorstep, you are entitled to ask them to leave your front garden. I do this

quite often when people interrupt my blogging and tweeting to influence my world view on various things from religion to double-glazing.

So it would be correct that police officers, mental health professionals and others would have a right to walk to your front door and knock on it, to make enquiries after someone's health and wellbeing, if need be. Having done so, whether they can enter the household or remain on the front door step is a matter of ongoing permission or legal authority. If specifically asked to leave your private property, then even police officers, mental health professionals and anyone else must do so, unless they can establish a legal basis to override that instruction. Such authorities are specific and very much the focus of training – or should be!

PERMISSION TO REMAIN

Permission is quite straight-forward when the occupant lives alone: they either give permission for you to enter / remain or they don't. If a person who lives alone tells you to leave their home or front garden, you must do so unless you have a legal authority to remain there. It all starts to get difficult when two people occupy the house and it doesn't matter whether those two people are married, in a relationship or simply flatmates — where one demands that you leave but the other invites you to remain, there is a permission to stay put as long as the person granting that access has the legal right to do so.

So where a service-user lives with their spouse or parents and MH professionals have been called because of concerns about someone's wellbeing, the MH professionals have a legal permission to be there if the spouse or parents give it, even in the face of the service-user objecting. If, for example, they are then able to form a view via a meaningful assessment, that someone should be subject to an application for admission to hospital, they may make it. Of course, that doesn't mean the objecting patient has to remain somewhere in particular to be assessed or interviewed. They are still at liberty to leave the premises, lock themselves in the bathroom or move about the property as they prefer. They are still entitled to peaceful enjoyment of their property, despite their spouse or parents.

LEGAL AUTHORITY TO REMAIN

It starts to get complicated when we talk about the legal right of someone to remain in private property against the owner's wishes. Some professionals have limited rights to disregard a landowner or property owner's view. For example, police and mental health professionals may

turn up to an address with a warrant from a Magistrate under either s135(1) or s135(2) of the Mental Health Act. These are the most intrusive powers, for it not only entitles them to trespass on land, but also for the police to force entry in order for them to do so. Once inside, they can then search for and remove certain people for mental health assessment, admission or re-admission against their will, which would otherwise be a trespass against the person.

There are further circumstances –

- Police officers have a right to enter or remain on premises against the owner's wishes, if they are doing so whilst intending to arrest people for indictable offences. Essentially, these are the more serious ones like burglary, robbery and theft; GBH, ABH and sexual violence.

- The police may also enter and remain to search for evidence in relation to offences – contrary to popular belief, they do not need a warrant to enter or remain in order to search for evidence if they have already arrested someone for an offence. Under s18 of the Police and Criminal Evidence Act 1984, an inspector can authorise a premises search and under s32 of PACE, arresting officers can search a premises in which they have arrested someone.

- Officers also have a common law right to force entry in order to prevent a breach of the peace or apprehend people for a breach of the peace which is ongoing.

WHAT DOES THIS MEAN FOR MENTAL HEALTH ASSESSMENT?

Well, it means that if any professionals are present at a property or inside it and they do not have a MHA warrant or any of the other lawful grounds to remain, they are obliged to leave a property that if they are told to do so. Only the police may remain in situ after such direction and even then, only where one the above justifications exist. There is no automatic right in law to disregard someone's direction to leave their property purely because you believe that they are suffering a mental illness or even if you think that someone is "in immediate need of care or control", as per s136 of the Mental Health Act.

Parliament limited the scope of s136 to public places for a reason so this legal principle becomes even more difficult if you genuinely believe someone is at risk. Of course, section 17 of PACE allows police officers to enter and remain against an occupier's preference where they can argue that entry is necessary "to save life and limb". And of course, you can then get into debates which I've covered elsewhere about what potential the Mental Capacity Act may afford you to intervene where you believe someone is at serious risk. But, in the absence of thinking that someone's life is (literally) at risk, people still have a right to peaceful enjoyment of their possessions and property, as a key plank of their human rights (Article 8). As the case of D'SOUZA v DPP (1993) made clear, warrants should be obtained under the Mental Health Act to enter and remove people where the threshold for using s17 PACE is not met.

This post arises from two things: a Twitter query about trespass from a service user who asked mental health professionals to leave their house and found that they just point blank refused to do so, even though the person was not "sectioned". Secondly, it arises from an incident another response team shift in my area dealt with where the same thing occurred. It puts the police in a difficult position: how should an officer respond when they are at an incident where other professionals are refusing to comply with a lawful direction to leave property? The answer might be "help that patient evict them." These are very difficult and sensitive issues but at the heart of them has to be respect for people's legal autonomy and human rights.

Very obviously, we are discussing these things through the prism of laws written at a the time of when Buddy Holly sang live music and all adults had a Ration Book whilst we are busy responding to a deinstitutionalised, community-oriented 21st century mental health system. But until the law is modernised, it's what we have to work within.

NOVEMBER 2013

2nd November 2013

Models of Illness –

There was a point in my journey into policing, mental health and criminal justice where ongoing debates about biology, psychology and sociology were just of passing interest. They seemed a touch too abstract to be of particular importance and somewhat detached from the realities of whether officers should detain someone under s136 MHA or whether they would divert from justice someone who had been detained for an offence. Every now and then, we see these debates erupt in the media and they are constantly simmering in social media.

We've seen books published by psychiatrists, psychologists and sociologists about the potential causes of mental distress and about the classification of human experience. We see debates conducted with some ferocity about it all and it took me a while – too long, actually – to realise that this stuff is actually at the heart of why some police officers find mental health professionals' responses to cases that we refer to them for assessment.

It is personality disorder and substance abuse that often raises questions from cops – those scenarios where people have been (repeatedly?) detained whilst engaged in risky behaviours whilst intoxicated like threatening to jump from a bridge or engaging in significant self-harm. We saw in the recent episode of Panorama how the worlds of policing and social work view the same people: whilst officers were busy talking earnestly to camera about the people they'd detained who were "mentally ill", I was reading on social media that AMHPs were busy turning off their televisions because the examples used were "behavioural" and connected to substance abuse.

Of course, the AMHPs declared victory when there was further footage of sober people drinking tea and talking about the previous evening. But then broke out the social media debate and officers quite rightly pointed out that it is not their role to diagnose whether behaviour that falls within the scope of s136 MHA arises from organic or functional conditions, or whether it is explained or aggravated by substance misuse / abuse alone.

TREATING A PATIENT'S ILLNESS

The use of the word "illness" in particular, seems very controversial for many. Richard BENTALL and several others have written about how

unhelpful it is to talk of mental distress as "illness". Others like Tom BURNS have argued that it lends validation to those who live with mental distress to have their difficulties recognised as an illness. Thus you then get into philosophical debates about what an "illness" is and into fairly pedantic debates about heritability, genetics and lifestyle. If you really want to get deep into the philosophy of all this, I recommend an excellent book by Derek BOLTON called "What is Mental Disorder?"

If you get into that debate, numerous others naturally follow about words like "patient" and "treatment" – we know how difficult this is, because organisations have issued guidelines about language in mental health in order to assist. Time for Change have a brief language guide advising us to stay of certain phrases. But it is right that they do: we don't want to unnecessarily stigmatise or criminalise people, but policing is there to criminalise some people. That's what the justice system does. Obviously, it should only do so based upon evidence and a public interest in doing so. How we assess those things is crucial.

But assess them, the police must: the person standing on a bridge threatening to jump scenario has become something of a classic dilemma. You will recall criticism of a police officer who had stated whilst an incident was still in progress that if the person could be persuaded down without jumping that they would be prosecuted. There was a superficially understandable outcry to what appeared to be a casual disregard for "obvious" unmet need. It transpired that many, many attempts had been made following previous similar events to signpost, support and assess need and ultimately, the person did not have a condition that warranted detention in hospital and was offered various other supports on a voluntary basis. And yet the incidents kept happening, bring roads and railway lines to a halt. So the underlying aetiological debate about biology, psychology and sociology suddenly does become important to the policing decisions — an established absence of certain kinds of conditions means the police needed to stop looking at this behaviour as something which section 136 of the Mental Health Act could assist with. They needed to think about the criminal law, both as a safeguarding tool for the individual and for the broader protection of the public.

NB: If we don't recognise the potential impact upon the public of these kinds of events, just imagine the impact upon you of being an HGV driver, progressing along a quiet motorway in the early hours of the morning, unable to swerve out of the way of a person who jumped from a bridge ahead; or one of the hundreds of train drivers a year faced with similar incidents on the rail network.

DOES THIS MATTER?

Well, it does raise profoundly interesting and difficult questions about policing when we think about the origin of someone's mental distress. Where someone, for example, has dementia and it is advanced to a stage where the patient can't look after themselves, does not recognise their immediate family and very occasionally lashes out when distressed, punching their spouse or adult son – we understand the issues that arise in looking at that assault from a criminal law perspective. If you repeat a vignette with a similar criminal act set against a different background, our perspective and our reaction starts to change – what about a 37yr old bipolar disorder patient suffering a depressive episode who assaults a paramedic trying to help them to hospital for assessment; what about a 14yr with ADHD who assaults a special educational needs teacher who is trying to help them with work they find difficult; what about a 26yr old man with schizophrenia and a very long history of voluntarily (ab)using controlled drugs that he knows worsen his paranoia who assaults a police officer attempting to detain him under s136 MHA?

The first patient is suffering from a progressively worsening, organic condition who has hurt a loved one who will be understandably reluctant to criminalise them; the second is suffering from a functional mental disorder who has hurt a professional less likely to be prepared to shrug off a violent assault. The third patient is a juvenile who also hurt a professional, but perhaps one less likely to think of criminalisation as being an option of first resort. Finally, what does voluntary (ab)use of drugs or alcohol do to our attitudes about violence by those living with mental health conditions?

I submit that attitudes towards patient 1 and patient 4 will vary, very significantly: we look differently towards elderly dementia patients than we do to adult men whose excessive use of intoxicating substances contributes to their condition, whether by cause or by effect. Some people look differently upon conditions like bipolar disorder and ADHD because of perceptions of validity – bipolar as a diagnosis is much less often questioned as valid, compared to ADHD which some clinicians argue does not exist. Of course, others argue it does. That debate is important if it may lead to some mitigation for a criminal act or an alternative form of sentencing. It is about understanding whether crime and "illness" is causal, contributory or coincidental?

FIX ME / HELP ME

I mentioned briefly in a previous blog a health consultant from Vanguard who bemoaned the "fix me" system that is trying to respond to "help me" patients:

Whether the person who hangs off a bridge and cries for help is there because they are suffering clinical depression, whether they have suicidal ideas because of bipolar disorder, whether their life is being slowly ruined by a progressively worsening anxiety disorder – if they are there at that place and time, interacting with a police officer or paramedic who is trying to talk them down, they are potentially looking for help. Whether "help" is a "fix" may not necessarily matter.

Think about last night's episode of Bedlam on Channel Four — various patients recognised that they may always live with anxieties like OCD. What mattered to some was not a "fix" but that the extent of their anxieties became manageable – something they could live within the context of a normal life, whatever that is. We also hear the "fix me" or "help me" debate when people discuss mental health medication — those who question mental distress as "illness" often go on to point out limitations, problems and side effects of psychiatric medication.

Why wouldn't you? If schizophrenia is not a disease entity – and a professor of psychiatry said exactly that to me in a lunch queue at a conference a few years ago – it must follow that drugs are not the long-term solution that they could be if it were. Whatever it is that's going on, I know that various mental health professionals repeatedly saying, "Yes, it is!" and "No, it isn't!" doesn't alter the legal duties of your police service: to prevent crime and bring offenders to justice; to protect life and property; and maintain the Queen's Peace.

We have to work out how this is best done against the uncertain background of several health and social care models which are in a state of constant tension.

6th November 2013

De-escalation –

It has been said more than once that the police need to learn de-escalation techniques when dealing with people experiencing a mental health crisis. We know about the risks involved in restraint and of course we hope to avoid them. We also know, that when the police do resort to the use of force – however lawfully or carefully it is done – it is never going to look pretty to those who witnesses it and having had the responsibility for investigating allegations of excessive force used by officers, it is true to say that many examples of lawful, proportionate force may still "look" heavy-handed.

So people call upon the police to de-escalate and adapt their training.

This word "de-escalation" is not a piece of language that the police use, so the idea of introducing "de-escalation techniques" into police personal safety training sounds attractive: here are some new techniques or tricks that might influence people in a way we hadn't imagined? I want to argue in this post that actually the police DO do de-escalation, it's just that we don't call it that. All personal safety training for the police includes the use of voice, body position and so on, to maximise the possibility that a use of force can be avoided and people can be influenced or persuaded. Clearly some officers are better at this than others, but that would be true of mental health nurses or teachers. And where particular serious or protracted attempts to influence or persuade become necessary, the police service has a cadre of trained crisis negotiators. It is especially difficult to qualify in this role, such is the standard of thinking and persuasion or influence one must demonstrate.

GOOD AND BAD

I've repeatedly had very positive feedback, both incident-specific and general, that police officers are, on balance, very effective at calming situations down. This has come from nurses who have called officer to inpatient wards, from social workers who have had officers with them during difficult Mental Health Act assessments in the community. And we must always remember one thing, which I state because I have detected

an undercurrent in some of the criticism that follows a use of force by the police:

Just because a police officer ended up using physical force on someone, it may mean that de-escalation failed but it does NOT mean that the officer(s) failed.

To think that it does, must mean we work on the assumption that everyone can be persuaded to do what other people want. As soon as you accept that we can't always persuade others to do as we would hope, we must accept that people may either need to be left to their own devices to make decisions we'd prefer they didn't take; or to be coerced within the limits of the law.

Humans being what they are, they react very differently to police officers. Some people find the sight of uniformed officers a naturally reassuring presence. Others find it unnerving even if they are in the law-abiding majority. I will admit for this purpose that I don't really want to life my life being constantly surrounded by police officers who are highly visible, I just want to get on with my life and know that the police are there should I feel I need them. Maybe that's because I work amongst it all day and need the break! Who knows …

But why should people living with mental health disorders be any different, especially when there is some kind of unmet need? Some patients massively object to what they see as the criminalising involvement of the police; some patients find that the police trigger thoughts that they would prefer to live without, either because of bad experiences in the past or because of delusions or paranoid ideas about what the police are doing. So try de-escalating that … against a background as challenging as the perception of being potentially ill-treated. Some may manage it with a certain style of influence, others may not.

POSITIVE IMPACT

Meanwhile, many patients have told me that they were very reassured by the police, even grateful that officers responded when they couldn't access other services, and found officers to be compassionate and supporting. One lady recently told me that officers saved her life: because they spent time with her just as she was thinking of enacting the plans she had made to end her life.

But my principal point is about de-escalation: the police train to defuse situations, we increasingly encourage patient time spent before the use of force. But we must always keep in mind what the police are there for – it is a somewhat broader remit than the individual at the centre of a crisis

event. The police sometimes have to balance individual rights with public safety and there is a limit to the extent that public safety can be compromised. If the presence of an unwell person on a bridge brings a road to a halt, then we can absorb grumpy feedback from motorists who were delayed. But if risks are escalating by inaction and a judgement is taken that we have reached that point where coercive action must be taken, it may be a police officers exercises their professional right to detain someone using force.

That someone else may have preferred longer negotiation or no use of force at all, does not necessarily mean that officers have failed to de-escalate something. I recall an incident where officers were called to an A&E department to a man brandishing a knife in the public waiting area and who had threatened people. Upon arrival the (large) knife was visible and two officers with tasers drew their equipment and told him twice to put the knife down. He didn't so they used force almost immediately. At the incident there were representations to me from members of the public and staff that they had acted too quickly and not given him a chance. The officers pointed out that the only way into the building for them meant that they could not get themselves in a position to contain him. Public and staff were behind him, further away from the officers from the man. If he had turned towards and attacked them, the officers would have been comparatively powerless to stop it. So they acted, having seen for themselves that the risks presented were not a risk of being shouted at, pushed or even punched. It was a potentially lethal threat and they felt a duty to protect others from it.

Maybe in different circumstances they could have set up a contained area and negotiated all day and night for a non-coercive outcome. That's why we must remember: all cases on their merits.

6th November 2013

How I Laughed Out Loud –

I spent a large part of this afternoon grinning like a drain, I will be honest. Two of my finest officers took a trip down to the Magistrates' Court this morning in order to give evidence in a summary trial. They ended up coming back victorious, not having had to give any evidence at all because of a sudden, last-minute decision on the part of the defendant to plead guilty.

Let me tell you why frontline cops should know their "Mental Capacity Act" from their elbow.

We took a 999 call some months ago to a report of a potential burglary in progress. A man had entered gardens and was trying the rear doors of a house, attempting to enter. Officers got themselves down there and shortly came across the miscreant. He was a heavily intoxicated man, who had also been seen on a flat roof at the back of the houses. Unfortunately for him, he'd fallen from the roof of the building and sustained what appeared to be a reasonably serious head injury. The extent couldn't be known, because we can't see inside his head for skull fractures and internal bleeding, but it looked quite serious so an ambulance was called. He was starting to get quite "tired and emotional" with the officers, offering various views on police procedure, police parentage and so on. He also offered a view about what the ambulance service could do with their concern for his welfare, but alas their professionalism prevented them from dismissing his needs.

He was taken to hospital against his will and once there, treated for his head injury. During this episode, his verbosity and self-expression grew to the extent that he offered various unbecoming views about the racial heritage of each of the officers involved who had been kind enough to ensure that he didn't die or seriously deteriorate from an untreated head injury and a judgement fogged by enough alcohol to source a modest social event. He was arrested by them under the Public Order Act 1986 for racially abusive behaviour and rightly so given the foul abuse he directed at dedicated public servants keeping him safe.

Not having found any evidence of burglary, attempted burglary or damage, he had not been arrested for a substantive offence. The main concern was his head injury. He agreed once in hospital, in the glaze of bright lights to have his injury examined and treated – he was subsequently removed to

custody where he fully sobered up. Having then been prosecuted, he appeared in the Magistrates' Court and pleaded not guilty to the offence. During the period when the full file of paperwork was being completed, it became clear that the basis of his not guilty plea was essentially, "You illegally dragged me to hospital without arresting me and my shouting and ranting was a somewhat misguided protest against your illegal action."

So it went to trial.

It was my view, having discussed the case, that the officers acted reasonably to ensure that someone who lacked capacity was subject the least restrictive intervention in his best interests, to prevent a serious deterioration in his condition, based upon paramedical advice. Hence the officers could rely upon sections 4B, 5 and 6 of the Mental Capacity Act to justify and explain their actions. Having therefore not acted unlawfully, there can be little doubt that the intoxication being voluntary, the abuse offered contravened the Public Order Act without any obvious defence, just as charged.

The officers made this known to the CPS and there was discussion at court between the lawyers involved. Having entered court confident that he would challenge his removal as illegal and hope to be found not guilty, the Mental Capacity Act was mentioned and he suddenly *pleaded guilty* – he was almost, but not quite, as confident as his solicitor.

The lesson of this little tale is this —

If you are an operational police officer, learn your Mental Capacity Act. This was *not* a man with an ongoing functional mental illness or an organic condition … he was just *drunk*. But drunk can still give rise to a lack of capacity, certainly having suffered a head injury in a fall. For whatever reason he was trespassing in someone's garden, we never found out. I am sure when he was busy racially abusing two police officers he wasn't thinking, "These buggers have dragged me up here without arresting me and I'm aware they appear to have breached the procedures of the Police and Criminal Evidence Act, so I will protest their heritage." He was being drunkenly and racially foul and abusive – ungrateful that 999 services could see what he couldn't, no doubt compounded by his bang to the head. But that was medically cleared after examination and some superficial treatment and monitoring.

I couldn't help but feel that the "illegal removal" argument was something of a game about perceived technicalities being present where officers were supposedly on dodgy legal ground taking people places against their will without *arresting* them. Wrong.

A small input on the Mental Capacity Act is of benefit to all – so read the articles on here, read the *Quick Guide*: not only might it help you safeguard someone who may otherwise die from an untreated head injury, it provides a lawful basis for acting against them when they gob off at you. It also means, as I personally suspect, that when a lawyer crawls all over the procedure to make argument that might provide a get-out-of-jail card, it takes the wind out of their sails as they as the say, "Oh" and realise that the officers knew more about the MCA than they did.

Hob nobs all 'round.

10th November 2013

De Facto Detention –

"The threat of detention must not be used to induce a patient to consent to admission to hospital or to treatment."

— Code of Practice to the Mental Health Act 1983, paragraph 4.12.

In a sense, this post is about something that is none of my business really … not something for the police. But it occurred to me that it may be worth explaining "*de facto detention*" to those of you who have not heard the phrase. This arises from the recent episode of Bedlam, the documentary series currently showing on Channel Four. I wasn't able to watch the show when broadcast and as I caught up the following morning and there was a point 34mins in where I did an involuntary exclamation of "No!!!" and the dog jumped up in the air.

Voluntary patients on mental health wards are free to come and go as they please and we met two of them: Dominic and Rupert. Although a hospital's policy may require patients to inform staff that they are going out, it cannot require them to ask permission because they are not detained. Moreover, patients should not be placed under duress to enter hospital or remain there on threat of being "sectioned" if they refuse. This is laid out in para 4.12 to the Code of Practice to the MHA, quoted above.

Well, 34 minutes into Bedlam we were watching a case conference meeting with Rupert and I'm not the only person who thought he was placed under duress to maintain his voluntary status.

DURESS

Rupert had left the hospital the previous day, supposedly for an hour and was reported missing to the Metropolitan Police when he failed to return on time. Staff on the Triage Ward at Lambeth Hospital were talking openly in the documentary about him having "leave" and we heard that he eventually returned to the unit eight hours after he was originally due to do so. Subsequently a meeting took place with the responsible clinician –

It was during this meeting that I caused my dog to jump – I was left with the very clear impression from this discussion, that unless Rupert set aside

his right to take certain decisions for himself, he would be "sectioned". Those words were just beneath the surface of the conversation we heard, but it was right there.

Now there has been some debate about this. Blogs began to emerge covering issues arising from the show saying the same thing – that a de facto detention had occured, arising from duress. But the debate that followed these observations surprised me even more, bearing in mind that we're talking about the coerced detention of some very vulnerable and complex people.

Apparently, all this stuff about diagnosis, behaviour and mental health is quite difficult to shoe-horn into the legal framework we have …… a tweet chat with the mental health trust concerned on Friday lead to the medical director saying that "it shows how difficult certain aspects of the MHA are in reality" …… one clinician offered the view that the MHA deals with complex uncertainties and that a comparison I made with the police being very clear about when people are "arrested" or "not arrested" and what people's rights are whilst detained was only viable because it's always very clear whether or not someone has broken the law.

I admit to being simply gob-smacked.

I'm not trying to over-egg this: I was sitting in my house, just *speechless* at the thought of it. The casual way with which the detention and rights of a vulnerable person were being debated after the dismissal of concerns raised about whether statutory guidelines were breached. Stunning. It is important that I put on record the potential for the editing of the programme to have affected how the interaction came across and also relevant to point out that the MH trust state they had full editorial control.

So let's put this another way — the police deal with detention and coercion every day, including during ambiguous circumstances. Can you imagine the outcry if it was seen on national television that the police had placed a vulnerable person under duress in order to have them succumb to a process that the police thought best but which was not supported by any legal framework that assured them their rights? We'd be pilloried; and rightly so.

HOLDING POWERS

You will recall from a previous occasion that section 5 of the Mental Health Act affords doctors and nurses the authority to detain patients in hospital for full Mental Health Act assessment involving an AMHP. Doctors may hold patients under s5(2) for up to 72hrs and you'll remember that prior to the case of Rupert, we saw Dominic detained under this provision. Nurses may

hold patients under s5(4) for up to 6hrs. Both mechanisms lead to an Approved Mental Health Professional being asked to co-ordinate a Mental Health Act assessment.

Of course in our mental health system it is the AMHP who is legally warranted and makes the civil liberties decision about whether an application will be made that legally detains another human being. By seeking to ensure a hospital stay continues on a "voluntary" basis, having implied that a decision to section someone would follow, the patient has been persuaded to agree to ongoing restrictions on his liberty. He remains a "voluntary" patient but is not allowed to leave. << *De facto detention*. This is something that is "repeatedly picked up by the CQC."

Doctors do not have the legal authority to section a patient – they may only ever recommend it and whether that recommendation is accepted is a matter for the AMHP. Of course, the AMHP was never involved in the situation because no Mental Health Act assessment was ever arranged, no holding power having been used. Had the patient been detained under s5(2), as Dominic had been, an MHA would have been required.

But in the end, these issues actually can become a matter for the police. Remember the incident about seven years ago that I wrote about where nurses had been put in the position that arose here of having a patient who can't leave, but isn't legally restricted? Those nurses started ringing the police when a female patient they were managing starting causing damage to the ward but in the absence of a clear legal authority for holding her, the question of legalities starting pointing towards the NHS staff. Well, what if Rupert the "voluntary patient" had then changed his mind about the "leave" he agreed not to have? Remember, it's not leave at all – he's free in law to come and go as he pleases if and until a DR or nurse applies a holding power; and given what had been discussed, are we not now in a state on confusion?

Had there been a confrontation, I wonder where questions of assault or damage would have pointed if the police had been called?

10th November 2013

Invictus –

Out of the night that covers me,
Black as the pit from pole to pole,
I thank whatever gods may be
For my unconquerable soul

In the fell clutch of circumstance
I have not winced nor cried aloud.
Under the bludgeonings of chance
My head is bloody, but unbowed.

Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds and shall find me unafraid.

It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate:
I am the captain of my soul.

— *William HENLEY* (1875).

11th November 2013

Human Rights Series: the UN CRPD –

This is the first of a few articles on human rights issues as they affect my area of interest. Of course, they are necessarily inexpert and superficial, aimed at raising general awareness amongst police officers and the public of the very basic tenants of domestic and international human rights.

In this first post, I want to start with the United Nations Convention on the Rights of Persons with Disabilities. Although it is perfectly fair comment to say that this will be not affect frontline policing very directly, it is something we should be aware of as at least partially driving the 21st century human rights agenda and something will increasingly affect our domestic law. The Convention is an instrument of international human rights law, tabled in 2006 at the UN following decades of work to draw together principles about responses to disability, of all kinds. The Convention stands to date as the UN instrument to have received most support on its first day of publication and it bolsters the UK commitment to human rights, in addition to the European Convention and our Human Rights Act 1998.

The CRPD, as it is often abbreviated – not to be confused with UK Crime and Disorder Reduction Partnerships! – consists of a Convention document and an optional protocol. The Convention is a framework of international principles that very many countries across the world have agreed; as well as an optional protocol which so far has mainly been adopted by developed countries with evolved health systems. The Convention establishes a committee and an inspection framework which produce reports on progress towards full compliance across signatory states.

So this is international human rights law for persons with disabilities and is something in addition to the general human rights frameworks in place through our domestic Human Rights Act and through the European Court of Human Rights. We see very clear overlaps with the UK Human Rights Act 1998 – the CRPD article 10 and the ECHR article 2 on a "right to life"; CRPD article 15 with the ECHR article 3 on "inhumane and degrading treatment", etc., etc.. There are many more overlaps. The difference is that the CRPD is concerned with establishing equality in domestic law and public policy for people with disabilities where as the ECHR enshrined in our Human Rights Act is about defining a framework for individuals arising from which individual challenges may be brought through British and European Courts.

AIMS OF THE CONVENTION

"What the Convention endeavours to do," said Don MacKay, Chairman of the committee that negotiated the treaty, "is to elaborate in detail the rights of persons with disabilities and set out a code of implementation". It is up to those states who have signed up to the Convention to work towards implementation of it and the inspection committee looks at progress and reports back to the Committee on the Rights of Persons With Disabilities. All signatory states were required to submit reports on their arrangements within two years of signing up and must submit further reports every four years on additional progress on disability rights. The first UK Government report was published in November 2011.

For those states who signed up to the optional protocol, like the United Kingdom, there are also obligations around reaction to complaints. The Committee has the "competence" to examine complaints made about a state's non-compliance with the Convention document.

In support of the UN Secretary General, Special Rapporteurs undertake certain functions with regard to the work of the United Nations. They conduct inspections in different countries, procedure thematic reports on particular issues and the CRPD work is affected by Special Rapporteurs on various issues. Earlier in 2013, the SR on Torture submitted a report to the UN Human Rights committee on Torture, Inhumane and Degrading Treatment. It is interesting to read this report in that the UN make it clear that certain practices in healthcare would meet the definition of torture in certain circumstances, including some issues around "psychosocial disabilities."

As an example of the work of the Committee itself, given that the United Kingdom has not yet been subject to inspection, I would encourage reading of the recent report on Australia. I came across this report some months ago in a news article about the impact of Australian mental health law and community coercion. This report implies that Australia should disband it's Community Treatment Order legislation on the grounds of it being ineffective. Recent research in the United Kingdom has suggested a similar lack of impact so one can only imagine what would happen here.

THE EQUALITY AND HUMAN RIGHTS COMMISSION

I would encourage any of you reading this, who find the ideas and structures interesting, to read the United Nations Human Rights website but also of interest will be the UK Equality and Human Rights Commission. They published a report in March 2012 about work in furtherance of United

Kingdom compliance with the UN CRPD that is of critical interest because they act as the independent domestic mechanism to promote, protect and monitor the implementation of the Convention in England and Wales. The Scottish Human Rights Commission fulfills this role in Scotland and in Northern Ireland the Human Rights Commission and the Equality Commission for Northern Ireland are jointly designated.

Within Government, it is the Office for Disability Issues that is responsible for leading and coordinating; checked as they do by the independent mechanisms mentioned in the previous paragraph. The EHRC has called for a national action plan for delivery against the Convention and Protocol by 2015. Obviously, the UK will be due to report again to the UN Committee by that time.

This UN work has the potential to affect British mental health law, in the way suggested for Australia. I remember a few years ago hearing Professor Phil FENNELL from Cardiff University talking about the CRPD and how it could be argued that to have seperate and distinct law for certain disabilities – ie, mental health disorders – is a potential breach of the Convention and that he saw the future of this UN Committee as being something to watch with interest.

RESOURCES / FURTHER READING —

- The United Nations Convention on the Rights of Persons with Disabilities.
- The UN Optional CRPD Protocol
- The first response of the UK government (2011)
- The Equality and Human Rights Commission CRPD Report (2012)

12th November 2013

Here We Go Again

This post should not be needed at all. *You've read it all before. Frankly, I've said it so many times before, that what you're about to read, is partly cut and pasted from other blogs – but here we go, again.*

You will have read over the last week of a new independent investigation by the IPCC into a death in police custody after detention under s136 of the Mental Health Act – another horrific story of human tragedy and loss. This

investigation may take years to conclude as those commenced in 2011 are still ongoing and in several of these cases the officers are being criminally investigated. I don't know any more about this most recent case than that which is in the media already, but that means I do know a person detained under s136 MHA was resistant upon detention, was restrained and taken in a police vehicle to police custody. I can therefore very easily see why a death following this procedure is being investigated as it is.

Nothing that follows in this post is further comment on the recent case, but general issues that we see again and again following these awful events. Officers may or may not have done this or tried to do this – I don't know. That's what the IPCC need to determine, along with a cause of death.

Let us be clear about this, yet again — another death in police custody or following contact could happen tomorrow in any area where the procedure followed by the police is not built to mitigate against unlikely but highly significant risks. Some police forces work in areas where their MH trusts work very closely in developing proper procedures, other police forces don't. But the duty of care owed by every officer and by every police force, is the same irrespective of where in the country they are.

The law is the law.

There are dozens of articles on this blog about all different aspects of this statutory provision for the police to detain people and I would encourage you to read them and build knowledge. It is my *strictly personal view* that almost all areas of our country, the s136 processes we still have in place "stack the risk deck" in favour of untoward outcomes and in deliberate disregard of various laws, statutory guidelines and nationally agreed partnership and clinical guidelines and standards.

Quite simply: it is not taken seriously enough and too many crucial people lack knowledge.

HOW TO DO IT PROPERLY

This advice applies to all detentions made by the police under mental health law, not just section 136 —

- Call an ambulance to EVERY detention under the MHA – **without fail**
- Remove anyone suffering from a potential medical emergency or physical injury to A&E
- Remove other detainees to the psychiatric place of safety in your area – it is not the role of police officers to pre-judge issues around

admission to a place of safety where drugs, alcohol or resistant behaviour is involved. That is for the NHS to decide.

- Only when all three have been done and any other (improvised) alternatives have been rejected, consider removing to a police station. It is a PoS of *last resort*, after all.

You do not need advance permission to ring an ambulance for someone you think is ill and in urgent need — chapter 11 of the Code of Practice states you should do so and that is your answer if anyone wants to rebuke you for doing it —– the ambulance service may not come as a result of *their* policy or the demand they face at that time. But that is then a matter for them. It is not for police officers to absorb the liability and risk that arises from Clinical Commissioning Groups not adequately commissioning emergency ambulance services for people who may well be very ill.

You do not need advance permission to remove someone to whom you now owe a duty of care to A&E or to an NHS Place of Safety in a Mental Health Unit — if you genuinely believe it to be necessary, perhaps on the advice of a paramedic, you are entitled and obliged to do so. Nowhere should have mental health nurses triaging patients over the phone to see if they are prepared to accept them. A&E may say, "we're not a place of safety" or "violent or intoxicated patients should go to the cells". But that is then a matter for them —– Accident & Emergency areas operate against various standards and guidelines and they know perfectly well, or they should, that some highly resistant and agitated behaviour arises from medical problems. It is not for police officers to absorb the liability and risk that arises from A&E or MH trust directives that we condemn people to police custody without adequate triage. (You may well need to remain in A&E to protect NHS staff, that is one of your obligations to keep them safe.)

You need to have an explanation ready for the custody sergeant about how you've applied para 10.22 to the Code of Practice to the MHA ahead of arriving in the cells, if that's where you end up — custody sergeants need to remember about para 9.5 and Annex H to Code C of PACE when making their statutory decisions about whether people with clinical needs are detained in custody. Can those clinical needs be met in custody, bearing in mind we often don't know what they are? If not, PACE says you transfer that person to hospital — it is not for the custody officer to absorb the liability and risk that arises from A&Es and NHS PoS services not being set up to deal with that reality. You improvise past that by ensuring sufficient officers in A&E or an NHS PoS to keep NHS staff safe. Not ideal if you're a duty inspector with limited resources but better than a death in custody.

POLICY v LAW

In the background of local policies and procedures are over-arching legal frameworks like the Human Rights Act and health and safety legislation. Local policies need to comply with those frameworks and where they do not, you must ask yourself how you will survive legal scrutiny in the event of a tragedy — so if your local procedure is not where we would prefer it to be, you need to ask yourself **now** what you will do if it is **you** makes the next MHA detention on your team tomorrow?

Do you comply with the local procedure or do you adhere to the law, as your oath of office said you would?

I don't even think that is a difficult question – ensuring the Convention Rights of people detained by the state is *not* optional and the health services are as much a part of the positive duty to ensure those Convention Rights as the Police service. But I'll tell you something else which I've said for some while now which I know won't go down well: street triage makes these events *more* likely, not less. If or when we get the scenario like those we've seen before and a MH nurse is standing over the shoulder of the officers providing professional advice, we'll see more of the "violent, intoxicated detainees have to go to custody" stuff that we've seen previously.

That is my deepest fear.

13th November 2013

Corporate Manslaughter –

Eventually the question will be asked more often about Corporate Manslaughter. I've raised it previously, about whether this legislation could have any impact upon death in custody investigations where the arrangements in a given area were deficient when compared to the standards expected.

We probably need to ask this again and more openly bearing in mind various inquiries ongoing into deaths in custody around the country and in light of the persistent difficulties that some areas have in delivering against known requirements. This is difficult stuff, but it is on the statute book for a reason and it should influence our thinking on public service provision in these most tragic and difficult of cases.

For those who aren't familiar with the offence: section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007 introduces an offence, which requires the authority of the Director of Public Prosecutions to commence proceedings and which applies to police forces and NHS organisations —

"An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised —

a) *causes a person's death, and*
b) *amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased."*

The offence is qualified in section 1(3) – "An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1)."

CAREFUL WORDING

Sections 2 to 7 go on to further qualify and clarify the wording very carefully as to how application of this particular offence is determined but section 2(7) does show that a person detained under the Mental Health Act 1983 is within the scope of the offence. Being owed a duty of care by the police

and the NHS, the offence can apply to anyone who is "a detained patient" and this wording is further qualified – those who are in lawful custody by virtue of s137 Mental Health Act 1983 are specifically listed as being "a detained patient", so it includes anyone who is detained subject to removal to a place of safety, under section 135(1) or 136. "Detained patient" for the purposes of the Corporate Manslaughter Act does not just mean an "inpatient" for the purposes of the Mental Health Act, like a s2 or s patient. It has a wider definition.

It also must be noted that there are certain exemptions to the application of this offence – when police forces are dealing with "serious disorder" or undertaking operations where "they come under attack of face violent resistance", there is some provision in section 5 of the Act to exemption from liability. We do not yet fully understand what this may mean for the detention of resistant patients under the Mental Health Act, because there is no case law on the matter, the offence being relatively new and so far, unused in that context.

Had it been used, we may have seen some section 9 "remedial orders" in operation: courts who convict organisation's senior executives can issue an order to demand systemic changes to the organisational problems which gave rise to the tragic event.

And of course, being that it is necessary to prove the parts of this offence to a criminal standard of proof, it would be necessary to show that any defective arrangements when a duty of care were owed, were actually the *cause* of someone's death. Not sufficient that someone died and that arrangements were defective: it must be as a result of the action or inaction of senior people, which is a necessarily high bar to clear.

POTENTIAL APPLICATION

We know from various statutory and clinical guidelines about the importance of certain things happening in the aftermath of a detention by the police under mental health law. The Code of Practice talks about use of the ambulance service to convey; the Royal College of Psychiatrists publish nationally agreed standards on section 136; NICE publish guidelines on issues like acutely disturbed behaviour and self-harm. We also know from European case-law that certain things amount to inhumane and degrading treatment and we know from domestic law about basic duties of care owed by the state to those who are detained and the law of negligence.

So what if we knew very fully that in one part of the United Kingdom there were local arrangements for s136 MHA (or s297 in Scotland; a130 in Northern Ireland) which fell *way, way short* of the required standard? Perhaps there were no health-based places of safety at all – or

it may be they operated exclusion criteria that pushed the most at risk patients towards police custody; it may be that A&E kept insisting they could not act as a place of safety? Perhaps the local police force, despite knowing that this was not satisfactory because the lack of provision meant it was directing its officers to use custody as a first and only resort because of inertia or active resistance by NHS partners, despite what paragraph 10.22 to the MHA Code of Practice says.

And what if we then had the hypothetical case where it could be argued, as worded in section 1 of the Act, that this "caused the death of a person"? What if we knew that senior managers in both health and policing knew that their arrangements failed to meet those required standards? What if, as a consequence, people were being detained in police custody despite the fact that if you spoke to the custody officers and asked them hand on heart to say whether or not they felt that the person in their care was getting "appropriate clinical attention" (para 9.5 and Annex H to Code C of the Police and Criminal Evidence Act 1984) they would say "no".

KEEPING OUR HOUSE IN ORDER

This is why I have said to senior officers in the past: you need to be certain, irrespective of your health service, that YOUR organisation's ability to discharge its relevant duty of care is beyond question. You need to be able to show this irrespective of whether or not your NHS partners deliver health-based places of safety to relevant standards and whether or your ambulance / A&E colleagues see a role for themselves in those pathways, when we know beyond all doubt in both law and medicine that they do, from time to time.

We **know for a fact** that police custody is wrong – sometimes legally, sometimes medically. So acquiescing to a view that it should be used in circumstances which breaches statutory and relevant clinical guidelines, which go against authoritative medical and legal opinion and which has led to disaster in the past is wrong, both medically and legally. So we should not do it without resistance, even if this causes some disquiet.

As I have stated previously – if the ambulance service don't come when we call them; if A&E or an NHS PoS turn officers and vulnerable people away or apply *ad hominem* techniques towards patients: that's for them to justify. It's not for individual officers or individual forces to absorb that liability and risk without having tried our best to agitate for vulnerable people in our care. Remember, we have a positive obligation to protect people's Convention Rights: to life and to dignity.

It is for this reason that I argued previously, that the police service are under a duty to change the way they handle section 136 detentions and

this may mean policy changing without the consent of the NHS. Very obviously, we'd all prefer partnership working and mutually agreed goals, jointly aspired towards but if that Plan A is not available, what is Plan B or Plan C to show the police forces and individual police officers are discharging their legal responsibilities properly? I would be asking this question if I couldn't name the people who have died to whom the questions apply.

It should be a very sobering thought for senior managers: a potential criminal prosecution for ineffective arrangements *if* those arrangements lead to the death of someone to whom you owe a reasonable duty of care.

14th November 2013

The Deadly Equation –

No big introduction, just crack on and read this. Written by Dr Jenny HOLMES, a Force Medical Examiner and Psychiatrist. Not all doctors appreciate what she has to say. Also bear in mind, this recent post by @NathanConstable – how many more deaths will we read about, before the

penny drops?

Today I have been at a conference full of eminent people in Manchester, discussing Policing and Mental Health. Police, Doctors, Psychiatric Nurses and many others along with those who have carried out important reports such as Lord Adebowale (who reviewed how the Metropolitan Police deal with mental health in the wake of several deaths and serious incidents). Lord BRADLEY was there to update on the progress of a National Liaison and Diversion service. And Drusilla SHARPLING who produced the HMIC report 'A Criminal Use of Police Cells' looking at s136 detentions

Drusilla said that having a person in a Police cell under s136 of the Mental Health Act *who had not committed a crime'* was wholly unacceptable. All day we talked about how to make this stop.

The case of 39 year old Leon BRIGGS who died after being taken to a Police cell under a s136 detention by Bedfordshire Police last week was mentioned. Michael and I went for a drink afterwards to discuss all things Policing and Mental Health then as we parted company and I checked my phone I found out it had happened again via an announcement on Twitter by the IPCC. Yet again a young man of 33, Terry SMITH, detained by Surrey Police under s136 and taken to a Police cell had become ill and died.

Two cases in two weeks. Young men in their 30s. Detained by the Police to get them a mental health assessment and help. Yet somehow dead. We cannot comment or speculate beyond what is in the public domain but here are two tragedies that perhaps could have been prevented and my thought are with the families

It may be oversimplifying things but I have begun to think of these cases as being a deadly combination of factors which contribute to the risk of death:

MENTAL ILL-HEALTH / DISTURBED BEHAVIOUR + POLICE RESTRAINT + POLICE TRANSPORT + POLICE CELL = RISK OF DEATH

Looking at these in turn:

MENTAL ILL HEALTH / DISTURBED BEHAVIOUR

Mentally unwell people have poor physical health. We know that someone with a major mental illness such as schizophrenia dies on average 20 years before their peers. This is due to a combination of factors such as heavy smoking (psychiatric patients are some of the heaviest smokers left in society) leading to early emphysema and heart disease. Drugs such as olanzapine can cause people to gain large amounts of weight which can lead to diabetes. Some psychiatric drugs also alter the electrics of the heart making it more likely to stop suddenly.

The mentally unwell often misuse drugs and alcohol leading to further ill-health. Alcoholics can have oesophageal varices, massive swollen blood vessels in the gullet, caused by liver cirrhosis and waiting to burst and cause death at any time. Many people without mental illness also misuse drugs and alcohol.

Disturbed behaviour can arise in the context of intoxication alone, many stimulant drugs such as cocaine, amphetamines and the many 'legal highs' can produce symptoms such as a racing heart, raised body temperature, sweating, hallucinations and aggression. By the time the Police get involved the person's body is often under immense strain, either from chronic illness and/or the acute effects of drugs and/or alcohol

POLICE RESTRAINT

The Police have a situation of risk to deal with. They are trained to deal with people who pose a risk to the public and to a lesser extent those who pose a risk of harm to themselves. They are not trained to assess medical risk. If I as a doctor was faced with this person in the street I could not fully assess the medical risk either. They are unknown to me, probably in a too agitated state to communicate and I have nothing more to go on than a visual inspection for injuries and obvious physical illness.

When the Police turn up its frightening. One or more blue lights screech up. Officers in protective clothing get out, on their belts they have batons / CS gas / pepper spray and increasingly a TASER. They approach the person, they do try verbal de-escalation but without success. Trust me, as a doctor

who prides themselves on their verbal de-escalation skills that when I see people like this in Police cells, I often can't de-escalate it myself.

The Police put a hand on and the person tenses up. Things can escalate rapidly. The Police have extensive training on the safe, proportionate and least restrictive use of force but force it still is with pain compliance techniques. The person is already frightened, many people who experience hallucinations and delusions whilst intoxicated or mentally unwell feel very frightened and paranoid and fear of the Police is often a feature. Things can escalate rapidly.

What are the medical risks? Well firstly we have a person who we know may be in poor physical health. Acute intoxication carries a risk of sudden death. The restraint process can bring a person from standing to the floor, often with a bang. NICE guidance states that falls from heights over a metre (and most people are 1.6 metres at least) carries a risk of serious head injury and a CT scan should be considered. Prone restraint (where the person is lying face down) can be particularly dangerous if prolonged. This is the position people are put in to apply handcuffs to the rear. Add obesity to prone restraint and the risks of asphyxiation are even greater.

The person's body is absolutely flooded with chemicals such as adrenaline, perhaps through the effects of drugs and alcohol and certainly through fear. The body's chemistry begins to change, perhaps with the blood becoming overloaded with potassium which can stop the heart. We know acute stress can cause heart attacks. A person who already takes medication that affects the heart's electricity is doubly susceptible.

As way of comparison when people are restrained by psychiatric staff a nurse trained to Intermediate Life Support is supposed to monitor the medical condition and a doctors review should be sought urgently.

POLICE TRANSPORT

I am no expert in this. But I know that such persons often get transported in caged vehicles for the safety of the officers. By this time the person is controlled but will have handcuffs and possibly leg restraints (Velcro straps) It can be difficult to maintain a sitting position in a caged vehicle and the person may get into further awkward positions aggravating the risks of positional asphyxia. Particularly if they are drunk. The worst near miss I saw of positional asphyxia was a drunk teenager, overweight, who had fallen asleep on the toilet with his head slumped forward, this had obstructed his airway and he was blue (we woke him up and he was fine).

There is no ability to monitor medical condition in Police transport and no one trained to do it and it is usually a quick trip to the Custody Suite. In rural areas the distances can be substantial increasing the risks.

POLICE CELL

Once the person gets to Custody hopefully the restraint will be removed and things get a little safer. However some damage may be done; injuries sustained during restraint, a heart under strain, abnormal blood biochemistry. Custody Suites do have nurses and access to doctors. Some Custodies have a nurse there all the time: with most it is a mobile service with a response time of up to an hour in a City and much longer in rural areas. The Custody nurse comes armed with a blood pressure machine, a temperature, a saturation monitor, a blood glucose machine and that's it. There might be some oxygen available and all suites should have a defibrillator which custody staff are also trained to use. We can't do blood tests/x-rays/ECGs (heart tracings)/CT scans etc. We can't drill holes in someone's skull to remove the blood clot that is about to kill them, caused when they fell to the floor. We are not an Accident and Emergency Department. And if we decide to transfer the person to hospital we have to wait for an ambulance involving more delay.

MEDICAL EMERGENCY

I have blogged before about how these cases, if not starting as a medical emergency, can rapidly become one. The two deaths tell us that alone. November 2013 should never happen again. The answer is simple to me – get Health into the pathway right at the early stages.

I met PC Alex Crisp today who is rightly proud of the new Leicestershire Street Triage Scheme. He would argue that if he had turned up with a psychiatric nurse that the situation may have been different and they could have de-escalated it and kept things safe. That may be right but I know from years as a Police Doctor (FME) that many of these cases cannot be quickly verbally de -escalated. I have spent many a long night trying to engage a highly agitated, intoxicated person in a cell.

I do have doubts about the street triage model because of the physical ill health risks and was glad to hear that Alex would have no hesitation in summoning a paramedic to assist in these cases.

These cases must have a rapid paramedic response at scene and Health transport supported by the Police as necessary. I believe they should all then go to Health Based Places of Safety and hope this blog illustrates why:

even without taking into account Drusilla SHARPLING's views that from a legal and ethical perspective a cell should never be used

In eighteen months' time my eldest son hopes to go to University. The late teens is a time of risk for men's mental health and also a time when they can drink excessively and experiment with drugs. If my son is found one night in a highly agitated and intoxicated state in the middle of the road by a Police Officer I would be grateful if they applied discretion and applied s136 instead of arresting him, perhaps jeopardising his future career. I will jump in my car and drive through the night to pick him up from a hospital and take him home and look after him.

I don't want to arrive at the hospital and be directed to the mortuary – let's stop this deadly equation **ever** happening again.

15th November 2013

Hold The Line –

In difficult times, it is generally acknowledged that we need leadership. It is also generally acknowledged that if we keep doing the same thing over and over again expecting a different outcome, someone eventually will remind us of what Einstein's once said. So we need leadership to do something different after a tragic fortnight where we have learned of the deaths of two people following detention by the police under section 136 of the Mental Health Act 1983 and removal to police cells following restraint.

And the most important leaders in the police service are our frontline leaders – sergeants. I look to all sergeants in the police service to think deeply about what they are capable of delivering, as the legal guardians of the safety, dignity and human rights of vulnerable people in the detention of our constables. Sergeants are just one step back from the difficulty and detail, able to take that broader view whilst not busy grappling, literally, with complex and challenging people.

Let me tell you why sergeants could make all the difference in the world, whilst the bureaucratic arguments between NHS commissioners and senior police officers continue about 136 pathways, or health care commissioning in police custody and offender health. And why support from duty inspectors to let them lead us, is vital.

INDIVIDUALLY ATTESTED

When I joined the service, I swore an oath of office in front of a Justice of the Peace and my Chief Constable.

I do solemnly and sincerely declare and affirm that I will well and truly serve the Queen in the office of constable, with fairness, integrity, diligence and impartiality, upholding fundamental human rights and according equal respect to all people; and that I will, to the best of my power, cause the peace to be kept and preserved and prevent all offences against people and property; and that while I continue to hold the said office I will to the best of my skill and knowledge discharge all the duties thereof faithfully according to law.

Think about that — I will "uphold fundamental human rights", the most fundamental of which is the right to life. It is a *basic expectation* of policing that when people come into contact with us, they don't leave that contact having died or suffered injuries or maladies from which they will die. *(Article 2, EHCR.)*

I want to argue in this post, subsequent to two fatalities, that if custody sergeants were really honest with themselves about their ability to undertake health-based risk assessments under the Police and Criminal Evidence Act, they would probably admit to an element of hope, notwithstanding the guidelines of "Safer Detention". (For non-police readers, Safer Detention is national guidance to custody about the expectation of safe operating standards.)

Some points about law in police custody – we, as police officers, are independently attested holders of public office. We are not employees who may always be directed. We know about the peculiarities of rank that I, as a duty inspector in the police, cannot *direct* a custody sergeant to act in a particular way or take a particular decision, despite seniority in rank. The sergeant must be satisfied that the decision is the correct one, for they alone remain accountable for it. Should I express a view that differs to that of the custody sergeant about a legal decision that is theirs to take, it must be passed above my head to a superintendent whose word is final. (There are just a few legal decisions which sit with me as a duty inspector, and those are mine to take and they bind the custody officer.)

Finaly caveat — what I'm about to suggest is not about custody sergeants "refusing" to do anything but it may involve not initially doing something because it could go profoundly wrong. If cops have tried and failed to secure timely access to paramedics, hosptials and / or places of safety in mental health units, then the custody office is and always has been a place of safety of last resort and it may be safer than nothing at all and horrible stories we have heard about patients locked in police vans. What follows is purely an argument that custody officers should exercise themselves, as we know they can, to ensure it **never** acts as a place of safety, except as a last resort.

Ever – **not even once**.

CLINICAL RISK ASSESSMENTS

So, let's talk about the law of custody — the Police and Criminal Evidence Act 1984 and the statutory Codes of Practice which support it are the main points of reference, but regardless of all that, Health & Safety law and

Human Rights law applies to the way in which duties under PACE are discharged. PACE has eight Codes of Practice, and it is Code C (2012) which relates to the treatment and detention of people in custody, regardless of what they are in custody for and it is quite clear about the responsibility of the custody officer —

"9.5 The custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person:

a) *appears to be suffering from physical illness; or*
b) *is injured; or*
c) *appears to be suffering from a mental disorder; or*
d) *appears to need clinical attention.*

9.5A This applies even if the detainee makes no request for clinical attention and whether or not they have already received clinical attention elsewhere. If the need for attention appears urgent, e.g. when indicated as in Annex H, the nearest available healthcare professional or an ambulance must be called immediately."

And remember this — the police service do not have a statutory responsibility to deliver healthcare. That responsibility sits with the NHS, by law. The medical staff in police custody are there to give opinions to help custody sergeants make legal decisions. That the FME or a nurse occasionally administers medication to assist with healthcare is incidental to what they are there for, under current law. If someone needs medical care: that is for the services commissioned by the NHS according to the National Health Service Act 2006.

So ask yourself this — when a person detained for any reason at all, but especially where detained for purely health purposes under the Mental Health Act (section 136 or otherwise), to what extent are you confident that if you do not transfer the person to hospital, by ambulance otherwise, that they will remain safe in custody, sufficient to satisfy the requirements of health & safety law and that if they are in a highly agitated condition, that there is no underlying condition causing this. If you want a medical view on these issues, read the recent guest blog by Dr Jenny HOLMES who is both a police FME and a psychiatrist. You will note that Dr HOLMES outlines various clinical causes of agitated behaviour that could not be handled in police custody, even by a doctor or nurse. This accords with the discussion I had with A&E professionals when developing s136 pathways several years ago and which led to the RED FLAG criteria, as they became known.

So if someone with known medical problems is resistant upon arrest and this becomes prolonged and is unexplained, how can a sergeant in custody tell whether or not someone has suffered a head injury or a brain tumour

– they aren't all visibly indicated? How do we rule things out or in, using the skills from our first aid course – we can't, can we?! So PACE says, "call the nearest healthcare professional or an ambulance." Those professionals need to then have regard to the sort of things Dr HOLMES wrote about in her recent post. Paragraph 9.5A makes it clear that these processes must occur, whether or not someone has already received clinical attention (ie, from paramedics) and whether or not they ask for it (uncooperative whilst exhibiting resistant behaviour).

ADMISSIONS AND TRANSFERS TO CUSTODY

As gatekeepers to custody, custody sergeants are also responsible for an important decision under the Mental Health Act Code of Practice. Paragraph 10.39 demands that if someone detained under s136 MHA is to be transferred from one place of safety to another, it must be agreed by the receiving location that they are prepared to accept the person. Transfers should not occur unless that agreement exists. It is also incumbent upon custody sergeants to have regard to paragraph 10.22 to the Code of Practice – this requires active consideration of alternatives to police custody, before cells are used as a last resort. So whenever any attempt is made to use custody, the sergeant should ask, "What else have you tried and considered?" If there is no satisfactory explanation, detaining officers should be advised to do so —

- Why not the local 136 suite – is it actually a good reason or would a discussion with a duty sergeant influence things?
- Why not A&E – we know that A&E see a role for themselves in some cases?
- Why not an improvised solution – like taking someone to their home or a relative's address?
- Why weren't these tried and considered, ahead of asking for cell-space? There should be valid, documented reasons.

And if these issues are not properly handled and have inadequate explanation, it comes back to that role of the custody officer to act as a guardian against the casual disregard of statutory guidelines: remember what was said by the House of Lords about the MHA Code of Practice: "It is guidance with which you should comply unless you have cogent reasons for departure." Remember too the case of MS v UK — not a death in custody case, but a degrading indignity upon the person of a vulnerable, agitated man. Unlawful, according to the European Court.

Remember other law, arising from the courts — we know that prolonged detention of highly agitated, floridly unwell patients can amount to inhumane and degrading treatment; we know about our fundamental duties not to restrict someone's right to life. These are important legal

decisions for custody sergeants to take and not something that the should be pushed into taking too casually, because it suits bureaucratic preferences in third-party organisations who are themselves acting in violation of Codes of Practice. Remember our health & safety laws: we have a legal duty to ensure that reasonable steps are taken to mitigate foreseeable risks to health and safety. So how foreseeable is it, that the health and safety of detainees will be at risk when people detained under the MHA, presenting in ways that medical people and coroners have previously suggested are "medical emergencies" will be at risk if held away from professional help and assessment? << That's not even a hard question is it?! — VERY!!

So WHY, would we have people in cells in such a condition where we'll have a couple of first aid certificates, a defibrillator and maybe a doctor or nurse with an unspecific response time and no kit without having tried everything else? Remember, trying everything else may well make the difference between a judgement that actions by the police were criminally negligent or not. Remember, police officers have been criminally prosecuted for this sort of stuff and more colleagues are going through the same.

Let's get this sorted by remembering our Oath of Office: if you properly think about these laws, it becomes hard to countenance the medical safety and wellbeing in custody of those who present in a highly agitated condition – if those individuals have arrived before a custody sergeant without having benefited from a paramedical triage and ambulatory transportation, why would we authorise detention without immediately then exercising or right and our duty under para 9.5 to Code C of PACE to call one and / or transfer someone to hospital?

Go on, tell me!

Duty inspectors have a role here too. I floated these ideas on Twitter as I prepared to write this blog. One sergeant came back and narrated a tale of untold pressure by the duty inspector to detain someone where these kinds of profound concerns existed. Here's news from one inspector to another: s39(6) PACE applies to that situation and you simply *lack the authority* to direct the sergeant in that regard. It is *their* decision to take and we need these people to **hold the line** to ensure the legal rights and dignity of detainees and to protect our constables from accusations that they were neglectful. It's your job to then take on the NHS structures which, for that patient at least, seem unable to deliver *fundamental human rights*.

Hold the line.

20th November 2013

The Dangers of Restraint –

There are dozens of police officers around the UK being criminally investigated for offences such as manslaughter and misconduct in public office, arising from the detention and restraint of people with mental health problems. Many, but not all, of these cases involved the application of section 136 of the Mental Health Act. Other detentions, like those involving Thomas ORCHARD and Sean RIGG, were under the Public Order Act 1986 but were made in relation to people who were suffering from mental health problems. There are various dangers inherent in police restraint and these are not just the medical dangers to vulnerable people.

In the last two weeks alone, we have learned of 13 police officers and several police staff placed under investigation subsequent to the deaths of Leon BRIGGS and Terry SMITH. Add to those the officers involved in the cases of Seni LEWIS, Kinglsey BURRELL, Toni SPECK, James HERBERT and the numbers now reach into the dozens – all of these are primarily tragedies for the families involved who now deserve clear, unambiguous answers to how their loved ones died. But nor should we lose sight of the impact upon the officers and their families as investigations commence against a background of procedures that are not always helpful to the chances of safe outcomes.

PARITY OF ESTEEM

In just the same way that when having a heart attack, you're still having a heart attack whether or not you're under arrest and regardless of what you're under arrest for, the same remains true of someone in a mental health crisis. The nature of your clinical need arising from that crisis exists regardless of whether a legal framework is wrapped around you and regardless of which legal framework was chosen by the officers involved. In fact, when police officers decide to detain you, the clinical risks to you as a person actually *increase* if restraint is involved. It's one thing to be experiencing psychosis, convinced that the police officers may be intent on harming you; it's quite another to be in a physical engagement with officers where you may start fighting for what you perceive to be your life.

Once you're being restrained and resisting, your body is producing adrenalin and we're off into very dangerous territory indeed.

Restricting myself only to criminal processes which have concluded, we could look at the cases of Michael POWELL and Colin HOLT: restraint related events where officers were investigated for manslaughter but subsequently stood trial for misconduct in public office. In each case officers were acquitted but a crucial aspect of the prosecution case, which undoubtedly would have contributed to the CPS decision that officers should be charged, was the extent to which the police sought medical support in these difficult cases. In one death in custody case, a Professional Standards investigator told me that if officers had taken reasonable steps to involve paramedics or had they removed someone to A&E whilst detained, the possibility of criminal charges being proffered would have reduced significantly. Of course, officers in the case of Michael POWELL and Colin HOLT were acquitted of the offence of misconduct. But it should be obvious that any investigation charged with examining a violent death in state custody will want to examine whether those involved in it acted lawfully and reasonably in making the detention; whether they did all they could to mitigate the impact of the detention and any restraint used; and whether they discharged their basic duty of care by not withholding or denying access to necessary medical services.

It is clear from more recent investigations that the IPCC examine these things with reference to whether the police engaged paramedics and / or removed people to Accident & Emergency services. Where officers have not done so, we see the commencement of criminal investigations into potential liability for manslaughter or for misconduct in public office. But let's remember: if we had detained a drink-driver after he crashed his car suffering a serious head-injury and then removed him to police custody without reference to an ambulance or to A&E to treat his head injury, we would absolutely expect to see a manslaughter / misconduct investigation if officers had not thought about or deliberately ignored the apparent medical need and he then died.

We can also see the IPCC taking a different approach in cases like that of Rafal DELEZUCH who died in Leicester in 2012. Although detained under s136 MHA then subjected to the use of force and restrained, he was conveyed by police car directly to A&E and I can find no evidence of that IPCC investigation being conducted as a criminal inquiry despite his death.

Parity of esteem works both ways.

DISENGAGING FROM RESTRAINT

If we are to talk about a new approach to restraint events, we will have to start discussing the circumstances where we simply do not enter it in the first place or where we disengage from it once started, if it is obvious it

may lead to the realisation of serious risks. I once reviewed a restraint incident where officers had attended a mental health unit at the request of staff who had been faced by a patient with a weapon. I could not help but wonder why, after restraint had led to the weapon being removed, that we had just then disengaged from any further restraint and *contained* the subsequent risks. That we should "contain not restrain" is a phrase I've used a lot in the last couple of years: is there scope for more of this?

We saw last weekend an example of where the police did exactly this: the M42 incident in Worcestershire. A man in mental health crisis, fully contained and risks minimised and the police negotiated their way out of it all. The thinking behind this, is that you cannot try restraining a man on the adverse side of a bridge because he may fall to his death, maybe taking a police officer down with him. The risks of detention and restraint are too serious in those circumstances.

Well why not apply that thinking to just some other situations where 136 is used in a street? After all, whether you fall to your death or are restrained to it, you are still dead and it is still a devastating outcome for all affected.

There will always be some situations where time is not on the side of officers to act – I can think of a recent s136 detention made by my team, where a man was intent on getting onto a railway line and if not detained, may well have ended up in front of a train. In that situation, risk of restraint was less than the risk from inaction and containment to prevent access to the railway line was not possible. In some other incidents I can recall, immediate police action to prevent an assault was needed. However, in a circumstances where time, space and number of officers permits, why not contain and negotiate patiently? It doesn't have to necessarily last 27hrs, as it did on the M42.

HEALTH AND SAFETY IN CUSTODY

The test of any section 136 or custody process in any area is not whether it delivers outcomes which suit bureaucracies in either the NHS or police: it is whether or not adverse outcomes end up being judged as unpredicted and unpreventable tragedies that occurred despite the best efforts of all the professionals, or not. Remember what was said by the medical and restraint experts in the Inquiry following the death of Rocky BENNETT in Norfolk:

- Any patient who required physical restraint was by definition in a **medical emergency –** *p52*
- Wherever a mentally ill patient is detained there should be a fully equipped resuscitation trolley;

- There should also be people who were capable of giving drugs and using the equipment, including a defibrillator. – *p55*
- There should be a doctor in every place where mentally ill patients are detained, or if that is not possible foolproof arrangements should be in place twenty-four hours a day to ensure that a doctor will attend within twenty minutes – *p55*

Read those again and *think* about the medical implications of the police service picking up resistant, fearful patients and then think about the clinical care that would be provided in custody. We couldn't deliver on any of this – *not even nearly*. Think about the physiological implications of restraint, especially where it may potentially continue for more than a few minutes.

We know that this advice is valid, because we know of cases where doctors were in a position to provide a rapid intervention to an acutely disturbed patient in A&E, something which prevented the need for ongoing restraint and allowed a far more thorough consideration of the medical causes without patients actively fighting the police. We also know about the NICE Guidelines on Acutely Disturbed Behaviour which is relevant for both A&E departments and inpatient mental health units.

So if you're a frontline police officer, learn some of this stuff so you can comprehend the risks and make the argument with paramedics and doctors. Don't be shy to point out these inquiries and guidelines, many NHS staff have not heard of them and may need prompting or reminding. And if you are a more senior officer charged with developing s136 processes, remember the test that will be applied after an adverse event, is not whether the police did what they NHS wanted them to do, but whether the police acted lawfully. The assessment of this will be set against a background of human rights as well as health and safety law.

It is about far, far more than whether the process was superficially consistent with the wording of the Mental Health Act.

21st November 2013

Words and Deeds –

If you were to try to determine the purpose and priorities of any organisation, you would probably need to look way beyond its spoken and printed words. You would examine what it did and what was critical, literally, to its leadership. So think, as an example, about the purpose and priorities of prison: we are repeatedly told that the prison is about the punishment and rehabilitation of offenders and yet what constitutes adequate punishment is way outside the control of prisons – it is determined by the courts; and any evident failure to rehabilitate rarely causes HM Prison Governors to have to resign. Inspection reports from HMIP often talk about rehabilitation and the improvements that need to occur, but the truly damning stuff in prison history tends to come from riots, escapes and other things quite unconnected to what they *say* their priorities are, like suicides and levels of violence or restraint.

So let's look at mental health and our NHS! —

WHAT THE SYSTEM SAYS

If you look around the system we have built, as it stands today, you can see how we have structured our priorities and purpose. We have divided the health system into over-functionalised silos: Emergency Services commissioned by one part of "the system" and mental health services commissioned by another. And at the risk of picking on A&E as a prime example, it is clear that they don't really want much to do with mental health issues, otherwise we wouldn't learn of such variable standards of care, in breach of national guidelines as we did today when we learned that more than 40% of self-harm patients leave without specialist mental health or psychological assessment. We know that some A&Es sub-contract their mental health operations to liaison psychiatry services, albeit that you can't access those services in many areas if you're in the custody of the police; and that other A&Es don't have liaison services at all. A&E will repeatedly say in official documents that they are "not a place of safety", when nothing in law gives them the right to opt out of the potential status that was imposed upon all hospitals by the Mental Health Act 1983. Far more importantly, some people with mental health problems in the custody of the police can lay a perfectly legitimate claim to having emergency, even life-threatening needs and they need a place of safety.

You only have to look at the College of Emergency medicine mental health toolkit to see the extent to which they are attempting to put distance between A&Es and mental health, especially when it is connected to policing. This professional body cared enough about it all to imply very straightforwardly that the Code of Practice to the Mental Health Act should be breached for s136 MHA detentions rather than them be affected by providing healthcare assessment to people who may well be ill. It is my experience that A&E will not blink before attempting to cover themselves by deflecting to the police requests for "safe and well checks" on non-vulnerable patients who have exercised a capacitous decision to leave hospital before obtaining treatment, but react quite surprisingly to the suggestion that they may have a role to play in clinically risk assessing whether people detained in the custody of the police who may or may not have a mental health problem or another physical condition that would put them at genuine risk in custody.

The impact of the CEM toolkit is that a 92yr old dementia patient detained by the police under s136 who cannot access a place of safety in mental health unit, should be gaoled by the police in custody rather than allowed to sit in an A&E cubicle, pending support from liaison services. Of course, whether she has dementia, or diabetes or a brain tumour, will be beyond the police officer. But let's just use custody anyway ……

This tells us a lot about its priorities. —

PARITY OF ESTEEM AND THE BURDEN OF DISEASE

We recently saw in Part 1 of the Keogh Review into Urgent and Emergency Care that mental health was mentioned just *once* and in passing. We also know that almost 10% of Health and Wellbeing Boards forgot to mention mental health *at all* in their recently published strategies and that many who mentioned it highlighted something specific, like children's mental health provision. Interesting that two recent political developments in the oversight of Health and of Policing have led Police and Crime Commissioners to state publicly that they are committed to tackling mental health disadvantage in our society and improving the lot of those in contacted with the police and more generally. And yet not all of our Health and Wellbeing Boards seem to think this is a priority, even in public words, never mind deeds. What was that about "No Health Without Mental Health"?

We know the government has repeatedly said that there should be a *parity of esteem* between mental health and physical healthcare and yet it is too easy to point out how the financial reality of healthcare does not match up to that, nor do the rights of access to treatment and care. We are not even

close. It is systemically built into our NHS to ensure that people with mental health care get a different experience, that they get excluded from services others would get into and that those most vulnerable who end up being detained and supported by police officers, get access to even less appropriate care. It's when you start hearing NHS professionals saying that unless severely unwell mental health patients are prosecuted for something (even when evidence doesn't exist) that they cannot have access to services that clinicians say they need , you realise words and deeds are two very different things.

Premature death following enduring mental ill-health is right up there on the World Health Organisation burden of disease, and is forecast to overtake heart-disease and strokes as a cause of death. We know that people living with serious mental health conditions have a life expectancy in the UK that is 15-20 years below the general population, which many would suggest is something of a scandal. We know that health inequalities in mental health are significant, with men accounting for 75% of suicides and particular male age groups being especially at risk – BME communities are massively disproportionately affected by MHA decision made by both the police and by mental health services. Yet work in the area of mens' mental health is so behind any measure of the impact it is having upon British men, that we need constant third-sector initiatives to try to raise awareness of what a problem it is. For BME communities, we know that the broader mental health process results extensively in the criminalisation and over-detention of many as a conditional gateway to care.

So that's where we see implications for policing and criminal justice. —

WHAT DOES THIS MEAN FOR POLICING?

As mental health care was deinstitutionalised in the last forty or so years, there was supposed to be a corresponding shift in investment to community care. It is broadly accepted that this has not happened and there are genuine question marks over the capacity of the mental health system to handle demand. Over the last three years, the number of mental health professionals of all kinds who have informed me that thresholds for GPs to refer patients to community services and for admissions to hospital are rising. We know that beds are in shorter supply, 9% down on a few years ago at a time when the number of MHA admissions is rising, having exceeded 50,000 in a year for the first time in recorded history. The police service are consequently playing a far larger part in picking up deflected demands. We see this in many ways.

The use of section 136 MHA has increased significantly over the last ten and the last twenty years – and yet we're still no closer to properly

examining that to understand the make up of demand. How many section 136 detentions are current, known MH patients or repeat detentions and what does that tell us about care plans and joint responses to repeats? A view of the police as the coercive arm of the mental health system has progressed apace in recent years – as mental health professionals openly state that they have become risk averse to undertaking coercion for themselves, something the Mental Health Act absolutely allows them to do. There is no operational capacity in the NHS to undertake therapeutically appropriate restraint for use when s6 and s18 MHA are being implemented.

As so we currently have a few dozen of your operational police officers suspended and moved away from operational police duties whilst the IPCC determine whether or not they should stand trial for criminal offences, in circumstances where officers have previously said or may be able to say again that regardless of what they personally may or may not become accused of, they were operating in an environment where expected standards of clinical practice simply didn't exist or they were actively resisted by (just some of) the health and social care professionals they work alongside. So we send officers into situations where they end of dealing with what are straightforwardly clinical risks, in a vacuum of support a lot of the time; and then resist them as they attempt to access support for the vulnerable people they have by then become responsible for.

WORDS AND DEEDS

Despite a stack of guidelines sitting on a shelf in my study about a foot high – each one of which, incidentally, will be an exhibit if I ever have to write a statement of evidence under caution about my operational role in death in custody – we find that those who are all-too-often managing crisis mental health events are uniformed people with a first aid certificate, no great amount of information and pair a of handcuffs. If you don't believe this assertion: read my last five blogs on the issues arising from recent death in custody incidents.

So what I see when I look at the NHS is a coincidence of seperate, overly functionalised organisations which are not sufficiently or effectively brigaded to give reality to stated priorities and purpose. As soon as we take the high-level documents mentioned above and start attempting to give effect to them in the real world, we hit up against bureaucracy that is intractable and quite incapable of seeing through a conflated plethora of contracts, commissioning and clinical confusions. It is the vacuum created by the bureaucracy and the politics of it all that sucks in the unsuspecting police officer, left managing vulnerable people with levels of clinical risk that some junior doctors wouldn't be prepared to handle without immediately bleeping the on-call specialist registrar.

And this where words and deeds differ greatly — because of systemic pressures on frontline staff and commissioning managers.

These people, we will remember, didn't build the system to start with. That is, very probably, the problem.

22nd November 2013

Bedlam –

A quick blog to put out the links to the catch-up episodes of Bedlam, the Channel Four documentary that has been shown on Channel Four over the last month.

Last night was the final episode and they will remain available online only for a limited period —

Episode One — Anxiety

Episode Two — Crisis

Episode Three — Psychosis

Episode Four — Breakdown

27th November 2013

Working in Partnership –

I have been thinking a lot recently about the phrase "working in partnership" given the extent to which we hear it said and the extent to which we see it written into the interface of policing and mental health. The Stevens Report from the Independent Police Commission wrote about this in Monday of this week. Of course, superficially, it's quite right: police officers have skills and legal authorities that mental health professionals often lack and vice versa, why wouldn't we want to work in partnership where all of those skills and experience brought together help to keep vulnerable people safe and potentially get them faster access to necessary support and services? The street triage pilots are perhaps a great example of this, superficially.

Mental health law being written as it is, there are various things within it that professionals could do to support each other in difficult circumstances, but which the law stops short of saying they *must* do and this is one area where working in partnership becomes very difficult. For example, after someone arrives in a place of safety, having been detained under s136 MHA, there is nothing in law that prevents the police from staying to support that person and our stretched NHS colleagues – doing so would help them out considerably. Section 136 suites are usually not sufficiently staffed to deliver the reality of the Royal College Standards on s136 – the receipt of those detained and release of the police within 30 minutes, even where the person brought in is exhibiting disturbed behaviour. Surely, officer, it would be best if we worked in partnership to keep everyone safe? Of course, there is no legal duty to do so – but local protocols are often written in such a way as to make it clear that unless the police surrender that legal position at the threshold of the building and agree to do as they're told, "no access for you, officer!" (Or the detainee / patient, which is actually far more important!)

I want to put forward some examples which show that the expectation is upon the police to "do as they could", when this is often not reciprocated. It is often not a two-way street and this has the effect of impacting upon the welfare and criminalisation of patients, as well as upon police resources and individual legal liabilities for police officers. It is also at the heart of the erosion and the corrosion of much-needed trust between the police and NHS on the frontline.

A TWO WAY STREET?

We know that if an AMHP has undertaken a Mental Health Act assessment in someone's house and made an application for admission under the Act to a hospital, they will often seek police support to detain and convey any patients that are resistant – including, resistant to any degree at all. So we understand this when adult men have barricaded themselves into a room armed with a knife and have a significant risk history of hurting people, but we have seen examples of very elderly, frail dementia patients. People with other physical health problems, mobility problems and so on, that have been subject to requests that the police use personal safety techniques designed for resistant young men who burgle, in order to compel them from their homes, to hospital. Well, we could do it, if we've exhausted all the other possible options; but strictly speaking, there is no *duty* upon the police to coerce passively resistant patients who are not committing offences or breaching the peace. Surely there's a better way involving nurses with appropriate training?! **Come on – let's work in partnership!**

We have seen those other examples of police officers being asked to stay at places of safety where there is no legal duty to do so and no real policing purpose served – it may even be a cause of fear for the person concerned. We see officers asked to attend MHA assessments in order to convey patients to hospital, because no ambulance is available or because it has been thought faster to ask the police to do it. In one area, over 75% of all post-MHA conveyance is done by the police. Around 10% by the ambulance service even though they are commissioned to do it. There are other examples, not least on the subject of being asked, directed or pressurised to detain people in police custody where it would be medically dangerous to do so or even illegal on the basis of established human rights law. And yet it keeps happening and it has already happened this week despite there their being two post-s136 deaths in police custody so far this month. Difficult to work in partnership when the police are having to resist incredible pressure from medical professionals to do things that would get those cops suspended and criminally investigated if it went awry and there is little, if any, support for that predicament. So why don't we have officers just stay in your health-setting with you, keeping you and other people safe from any potentially disruptive behaviour and you can do "health things", everyone confident in the knowledge that if someone does collapse under restraint they are not in a cell block a good half-hour from medical intervention. I'm sure I read that somewhere, so **come on – let's work in partnership!!**

I could go on.

Now there are a number of reverse situations: those where the police legitimately need to ask for health and social care support or action and where it is declined either because there is no strict, explicit duty upon health to do something that Parliament clearly inferred they should be able to do; or where decisions that frontline teams are under-resourced, lead to the deflection of demands to the police or ambulance service, despite a complete inability on the part of those professionals to actually cope with the incident sent their way. We know in the current bed-crisis where patients are being sent hundreds of miles to access beds, that police services are being asked to illegally detain people in cells without any lawful authority whatsoever to do it, because we should "work in partnership" and put the needs of the patient first. What about the patient's rights, not to be illegally held by the police?!

We see this in "safe and well" checks – I can't possibly tell you whether a mental health patient superficially exhibiting suicidal ideation is safe and well, not least because I will never be afforded any sense of their history. Turn up to confirm that the person is alive, breathing and conscious and then report the potential for ongoing vulnerabilities that mental health services will have to sort for themselves and it may well be "we haven't got enough staff" or concerted attempts to pressurize police officers into stating, "yes, safe and well" when it should be perfectly obvious they can't. **Come on – let's work in partnership!**

We see this in the difficulties that the police have in accessing medical support for people who must be considered, initially ar least, to be experiencing a medical emergency. Only this week, I am aware of an incident where someone presenting in a highly paranoid, psychotic state (this assessment was vindicated by him being subsequently sectioned by psychiatrists and an AMHP) was physically injured and highly resistant to detention, necessitating ongoing restraint. You may remember two deaths in custody following the use of section 136 during this month alone

I could go on.

REAL PARTNERSHIP

It is too easy to point out when health professionals are busy expecting the police to work in partnership by either doing illegal things or by spending resources on NHS business. You know what? I don't actually think I mind mucking in a bit with stuff that, strictly speaking, I don't have to do, as long as I see that reciprocated. I know that in rural areas where AMHPs and police and others are few, that they report more blurring of the boundaries, but that is on all sides. Where people can help, they often will.

But the concern I have in busy areas of high demand, based upon many emails and phone calls in the last few months, is the one-way street approach, where police officers are expected, literally, to do as they are told even if they know it may be foolhardy or even illegal, but they cannot see many examples of support coming the other way. The biggest "blag" of all in recent times are the health professionals who ask for police support to deal with a person who has a history of being resistant or aggressive and when the police arrive and find no sign of the other agency, ring to enquire after them, only then learn that "something else came in" and could the police just deal? With a healthcare issue?! **Come on – let's work in partnership!**

If we to legitimately build capacity in the public sector against a background of services being rationalised, we need to decide whether we're retreating into our trenches to throw things at each other. we have to release front-line staff to support each other, in a genuine arrangement that reflects roles and responsibilities, but allows them to improvise and work in partnership. We know that the NHS is over-functionalised into disparate silos anyway; adding the police into this system is not just adding another silo, but another operating culture entirely. This could be turned to the advantage of everyone if we thought properly about how to integrate and jointly operate the services, but we don't. We have insufficient consideration of the role of law, too much focus on insular concerns around resourcing and remits; too little thought about the needs of the person at the centre of decision-making.

If we did put people at the centre of decision-making, frontline professionals, operating within the law, would see that many small things could be achieved that would improve the world, if just marginally. It would reduce the burden on all professionals and allow us to serve the public, both individual and collective – now there's a thought! But to achieve this, we are going to need individual professionals to ask themselves "What can I do to help this other professional who broadly speaking, has the same objective as me?" Usually, people ask what others can do to suppor them and this is wrong direction of travel. It requires that managers in all organisations allow their staff to think about overall partnerships, not silos, bureacracy and what we call "our core business" – whatever that is.

We need to get out of the trenches and play football* in no-man's land – then we might start to know and understand each other – and then avoid the mistake of retreating back to the trenches to carry on as before.

* Rugby.

28th November 2013

Parliamentary Debate –

On Thursday 28th November 2013, the House of Commons discussed policing and mental health issues in a backbench debate. Brought by cross-party trio of MPs it lasted for 90 minutes in Westminster Hall and covered all of the major subjects of significance.

Due credit should absolutely be given to Madeleine MOON (Labour MP for Bridgend), James MORRIS (Conservative MP for Halesowen and Rowley Regis) and to Paul BURSTOW (Liberal Democrat MP for Sutton and Cheam) for raising the particular overlap of our policing and our mental health systems. It was evident that all three have taken time to understand the interface in some detail and operational police officers were tweeting along to it, saying how refreshing it was to see MPs with a grasp of the detail.

The debate itself is well worth listening to and it contains a suggestion from Keith VAZ, the Chairman of the Home Affairs Select Committee, that they will be looking at policing and mental health as part of their ongoing work, in 2014. I also must highlight and praise the exceptional contribution of Dr Sarah WOLLASTON (MP for Totnes, Brixham and South Hams) – a level of detail and insight about the broader NHS mental health system that you would expect from a GP and former police FME.

Once I have more time to fully blog on it, I will update this post with a few thoughts., but my general headline is "the main points were all covered" and whilst there was much sympathy with the predicament that many officers find themselves in, there was also criticism of where the police could do better, especially for example, on victims of crime who suffer from mental health problems and who are three times as likely to be victims of crime. This is absolutely correct and provided very necessary balance. I was also especially glad to hear acknowledgement of the impact upon police officers' mental health of the work they do, especially Madeleine MOON's comment that police officers "deserve to go home at the end of shift without feeling guilty" about giving a sub-standard service to a vulnerable person because of an inability to access the NHS.

I am *especially* grateful to both James MORRIS and Paul BURSTOW who were kind enough not only to mention my work on social media and elsewhere, but to do so in especially generous terms. Raising the profile of this under-noticed and badly misunderstood work is the whole point of my

efforts and in that regard they have helped considerably in the most prestigious of environments – a true honour.

But finally, Madeleine MOON has been a most enthusiastic driver of this backbench debate and you could hear the passion in her voice during her opening contribution. Her constituency has particular reason to regard these issues as absolutely vital and they will no doubt be glad of her efforts today.

Congratulations to all three of them, say I.

The Hansard transcript from the Mental Health (Police Procedure) debate is also available.

29th November 2013

Reluctance and Resistance –

We heard in yesterday's debate in Parliament the view of former Minister of State for mental health, Paul BURSTOW MP that the NHS institutionally discriminates against mental health patients; and in a variety of ways. I want to provide two examples from the real world, involving the same police officers in the same area along with the same Accident & Emergency department and the same ambulance service to show that this is true.

The examples are provided precisely because they are not isolated and because the proximity of occurence and the geography involved makes the point Mr BURSTOW was trying to highlight yesterday.

These examples occured in November in England —

- Police officers detained a man under section 136 MHA following dangerous behaviour found him leaping in and out of traffic and very obviously suffering from serious mental health problems. He declared a long history of mental ill-health and previous admissions to a psychiatric unit in the next county and was also physically injured from a self-inflicted injury to his hand that would require treatment. Because of the immediate need of care, he was detained and then significantly resisted. Officers were required to use significant restraint techniques, including handcuffs and the journey to hospital was very difficult. No-one knew at that stage what the medical issues were, beyond the behaviours that could be seen visually and his declarations.

- Three days later, the same officers attend the scene of a robbery where offenders had forced entry to a building and struck one of the victims to the head with a heavy metal bar. The result of this was to render the victim (who had been drinking) into an agitated condition and when the ambulance service were trying to respond to him, he was aggressive in his decline of treatment and was restrained by police officers and taken to hospital against his will (Mental Capacity Act).

THE RESPONSE

Firstly, no issues at all with the ambulance service: our colleagues in green took each case seriously, tried their very best in difficult circumstances to begin to get a basic understanding of this person, their health needs and a sense of what was needed next. They remained engaged in the process when police officers ended up going "hands on" to keep these people safe and, ultimately, to compel them to hospital under law. Good 999 team work – the difference emerged in hospital.

Obvious reluctance in case one, which eventually built up to requests that the man be removed from A&E completely and taken to the cells, even though no considered examination of him had been done. At best, a visual examination from a distance of about 3m was the extent of the triage and care before requesting the cells be used.

Meanwhile, the man with the head injury was brought in and very quickly sedated so that more meaningful examination could occur over time and pressure and strain upon be relieved.

It's self-evident that I'm not a doctor. I fully understand that we don't just sedate everyone when they're aggressive and that there are reasons for different approaches, of course. It's not down to me to make medical decisions, etc., etc.. But I would submit that the doctors and nurses in case could not have done a very thorough examination of man one from 3m away. We've read before on this blog about cases involving the police and sometimes paramedics, where casual dismissal of violent behaviour as either simple violence which is a police matter; or as arising *just* from mental health issues, has led to misdiagnosis. We also know what the Rocky BENNETT inquiry said about violent mental health patients in need ongoing restraint – "to be treated as a medical emergency" said the experts, most of them doctors. Remember the diabetes patient who collapsed after 136 resistance; the non-visible head injury; and the brain tumour patient? Remember all the unexplained deaths where pathologists simply could not agree on a cause of death and where the last intervention had been police restraint so it was argued – not unreasonably given everything I've just written – that the police should have recognised the seriousness of things and removed the person to A&E?

This is what families have argued for after the deaths of their loved ones. Wouldn't we all?

CONSISTENCY AND ISOLATION

But another reason for highlighting these examples, is that I have several personal experiences of detaining people like man one and removing them to A&E where they *were* treated like man two. In particular, I remember about seven years ago meeting a British Army doctor in an A&E setting in Birmingham who did exactly this.

I asked for a few minutes of his time given my interest in these issues and asked why he took that approach when many of his colleagues say, "Not doing it – take him to the cells!" He patiently explained a lot of the underlying problems that could be giving rise to such behaviours – even in people are are "just" mentally ill – and he mentioned the risks from restraint by the police whilst acknowledging that many other doctors didn't see it like this, but that he failed to understand why.

These are *not* isolated examples and clinical consistency *is* an issue.

But what good is all of that, if the police do exactly as families, Coroners, the Rocky BENNETT Inquiry experts and human rights groups like Black Mental Health UK and Inquest argue – only to find the doors of the NHS are **shut** to some such patients? We read elsewhere on this blog from medical professionals about the various medical things can be ongoing leading up to or arising from restraint and we know why the care received by both should have been equitable. Be violently resistant because of a head injury or a stroke and the doors are not closed, but mental ill-health? >> **Cells!**

And we know that this is the trajectory of many cases that lead to IPCC death in custody inquiries – where it is police officers who end up accused in some cases, of *criminal* wrong-doing.

The police officers involved in both of these incidents were the same people: they know that to all intents and purposes, the patients were very similar in terms of challenges presented to all and we know for a fact that officers were not expecting to drop either patient in the doorway of A&E and leave – they were prepared to remain and support NHS staff if that were required. But telling medical staff that one was "detained section 136" and the other was a "crime victim who has been hit to the head" made all the difference in the world and yet both were patients exhibiting behaviour that is explicitly written about in the NICE Guidelines on Acutely Disturbed Behaviour. One patient benefitted from the application or at least the consideration of these guidelines, the other most certainly did not.

It is the legal status of the patient and the assumptions around mental ill-health that make the difference to the healthcare received.

DECEMBER 2013

3rd December 2013

Assaults on NHS Staff –

New figures released today show the reports made by the NHS of assaults on staff across the whole organisation and broken down by "sector". NHS Protect, a special business authority of the NHS across England, exists to protect NHS staff and assets on all areas from violence against staff, to counter-fraud and corruption that undermines the NHS as a whole. They have published annual statistics for several years now, concerning incidents of violence against staff and they are worth examining —

Figures for 2012/13; for 2011/12; and for 2010/11

Overall, there has been a 5.8% rise in reported incidents and a 15.9% rise in sanctions compared to the previous year, but the first thing to say, is that the new 2012/13 data is not complete!

BROKEN DOWN BY SECTOR

The move from Primary Care Trusts to Clinical Commissioning Groups has thrown the report of assaults in primary care into disarray, so we can't see that for this year. I don't know whether there are plans to publish that later or whether it's lost forever! So this year's data is broken down by four areas: acute, ambulance, mental health and "special".

This year, we learn that 70% of reported assaults on NHS staff occured within the mental health sector, 2% within the ambulance sector and most of the rest in the acute sector. I admit to thinking, I'd like to know within the acute sector, the proportion of those that occured specifically in Accident & Emergency as it has always struck me as a particular area of concern.

When looking at the figures, you will see "assaults involving medical factors." This means the number of physical assaults "where the perpetrator did not know what they were doing, or did not know what they were doing was wrong due to medical illness, mental ill-health, severe learning disability or treatment administered." This is relatively new territory for the NHS. They have reported staff assault figures for many years, but it is only in the last three that they have attempted to get to

grips with assaultative behaviour which has a causal or contributory relationship to someone's ill-health or treatment. So for example, someone exhibiting distressed behaviour whilst suffering from dementia or after receiving a head injury who lashes out: this would be counted in the figures as "involving medical factors."

A quick word on the assaults on paramedics: there are 11 NHS ambulance trusts in England and they vary in size and in terms of staff numbers. Yet if one examines the number of assaults experienced (see p8 of this year's figures), we see a big discrepancy in the number of assaults experienced, the number of sanctions secured. It does make me wonder about the factors that bring this about; whether they be cultural attitudes to assault in the NHS trust itself, to police responses as well the systemic features of paramedicine and criminal justice in the UK.

THE MENTAL HEALTH SECTOR

It has been the case since the commencement of figures that the mental health sector has contributed to the largest proportion of assaults against NHS staff and this covers assaults within inpatient settings as well as amongst community mental health teams. 70% during 2012/13, up slightly from 67% the previous year. However, if we remember that the primary care figures missing from this year's data, we would expect to see a modest rise in that overall percentage figure.

Something I wish I knew, was the proportion of those assaults that were reported to the police, so we could then make sense of the sanctions. If you remember that 2% of assaults occured within the ambulance sector, also note that no mental health trust in the UK had more sanctions for assaults on staff than the ambulance service with the greatest success in this area. I know from my previous work in my own force area, that one major mental health trust traditionally reported around 16% of their assaults to the police, so 7 in every 8 cases were never going to lead to a sanction, because the police were never informed. This brings us on to "assaults involving medical factors" for the mental health sector.

If you look at pages 9 and 10 of this year's or last year's figures, you notice a number of mental health trusts who argue that all assaults against staff involve medical factors. You'll then notice one that thinks the opposite! It seems safe to say that mental health trusts are struggling with this – the totals suggest that 82% involved medical factors and 18% do not. But we can see significant differences in attitude. Is there good reason to suppose that an NHS Trust in south-west London is dealing with such significantly different issues to a trust in north-east London or north-west London? Overall, probably not. And yet we see a very different attitude to "medical factors."

The number of assaults reported is also of interest in itself. Some of the smaller trusts have the higher number of assaults. Research has suggested that levels of assaultative behaviour are contributed to by issues within the control of the care provider. Things such as staffing levels, ward environment and so on. But irrespective of that, given that it sits out of the control of the police, there are reasons to think that in some trust areas, they are under-reporting violent issues to the police where investigation and prosecution could do much to ensure a balance of treatment for individuals and safety for all.

I said something similar on Twitter today and was roundly criticised by a few individuals, but only earlier in the day, a senior police officer was talking about improving the confidence of rape victims to come forward and the need to improve the police response to reports of rape. Why should it be any different in offending on mental health wards, whether that be offending behaviour by staff or by patients, against staff or other patients? Surely it is everyone's interests to make our NHS as safe as possible and we also know that the Mental Health Act has a significant interface with the criminal justice system and the potential for "therapeutic jurisprudence" via the courts is part of our legal framework: only criminal courts can imposed certain kinds of orders and restrictions to achieve proper health outcomes and this does not always involve the criminal conviction of patients.

ISSUES FOR POLICING

I have said for years, that whenever police officers sit around bemoaning the fact that service provision in the mental health sector of our NHS is not where they'd hope it would be – lack of s136 services, difficulties accessing beds leading to massive, sometimes illegal, delays in custody, etc., etc.. – they fail to see some areas where we, the police, fall short.

I have written on this blog that we need to improve the investigation of criminal offences involving suspects who are mentally ill, move past the (overly) simplistic notions about the relationship between mental ill-health and crime. There is much to learn about the potential of the criminal justice system to support the health system.

We need to ensure that where staff or patients report being assaulted by someone with a mental health problem, even if that accused person is detained in hospital under the Mental Health Act, we don't just dismiss it as "not in the public interest" or assume that because someone us a s3 patient they may never be held to account through the justice system. This is far from being true, and even in cases where it were true, prosecution may still occur for serious offences, in order that courts can consider the use of (restricted) hospital orders to balance off people's right to treatment

with the publics right to protection. Prosecution is not just about the individual, but also the victim and the public.

If you are a police officer, please take the time to read some of the blogs I have written on investigation and prosecution – a feeling amongst NHS staff of not being protected by the justice system and not being able to seek redress where staff have become victims sits behind much reluctance by staff and managers to do some of the things that we complain about in private. Also, be aware that there is a formal agreement in place nationally between the police, the CPS and NHS Protect about basic standards to be expected during investigation / prosecution. You can help to break the catch-22 by ensuring that if you receive reports from NHS staff or patients that they have been assaulted, that it obtains a meaningful response. Think of it somewhat like domestic violence: we know in DV matters that the first report to the police will not be likely to be the first act of violence by the accused person. Well, in mental health we need to remember that for every report we receive, about 7 other incidents were not reported and that there will probably be a particular reason or a particular history behind the report being made. Let's find it out and act accordingly!

To see the extent of this problem, consider the recent case in Taunton of Ronald ASHWORTH: he was prosecuted for causing actual bodily harm in a private prosecution brought by NHS Protect after he punched and knocked out a member of staff, breaking their jaw. This private prosecution followed the Crown Prosecution Service deciding "not to prosecute a related matter".

We need to step up our record in this area of policing, to keep vulnerable people, our health colleagues and our NHS safe.

10th December 2013

Historical Legacy –

In a recent multi-agency event about the difficulties in our interface between mental health and criminal justice a classic scenario was hypothesised in order to raise questions for discussion about who bore responsibility for someone in a particular circumstance. How could agencies work together quite creatively to support each other and how could someone who may be at risk be safeguarded? I want to use this example to show the impact our legislation has upon our modern professional practices and our inter-agency working. It is the historical legacy bequeathed to us by previous generations who reformed the system of mental health care, without reforming the legislation that underpins it.

Bob is a hypothetical man who has recently lost his job. What begins as a personal journey of social depression and anxiety becomes a situation of concern as he starts drinking to excess. This causes difficulties for him in his personal relationships and as things become financially acute with on-going unemployment, his drinking worsens and there is no obvious solution to these issues. His marriage eventually breaks down. Feeling that everything has collapsed beneath him, Bob begins drinking even more and his disinclined to seek any support from his GP or elsewhere.

Eventually, there is an incident which leads to concerned neighbours calling the police.

Upon the arrival of officers, Bob is intoxicated, there are indications that may have made preparations to take various forms of medication but no indication that he has yet done so. It is obvious from the condition of his home, he is failing to look after himself – there is little if any food, the house is in filthy disarray and he doesn't have electricity because he can't afford to top up his payment card. The police have called the ambulance service who have ruled out any serious medical problems but paramedics are also unable to persuade him to attend any NHS service for assessment and support. They've suggested A&E more or less immediately or whether he could see his GP for an urgent appointment tomorrow. Given everything, they also feel he may need assessment under the Mental Health Act. A phone call to duty mental health services leads to a referral for MHAA being accepted, but the team will be several hours before they can undertake it. Those present have tried to contact family or friends, most

notably Bob's brother, and no-one is able to come to the address to be with him for a few hours or until the next day when assessment might occur.

The delay is for a couple of reasons: firstly, the team are committed with other emergency MHA assessments; and secondly, time needs to be allowed for intoxication to subside to make any assessment meaningful. The question then arose about how to manage the potential risks and safeguarding issues in the meantime, given that Bob is not consenting to any form of intervention and will not voluntarily attend A&E or allow a response from his out-of-hours GP?

HOW DO WE KEEP BOB SAFE?

This vignette is not an unsurprising one to choose: I have used similar ones on this blog to highlight the impotence of police officers to resolve some kind of safeguarding situations where there is no criminal offence being committed and no breach of the peace being occasioned. The kernel of the ethical and legal dilemma is to create that situation where everyone knows that something needs to happen to safeguard the person, but where there is no obvious legal route to doing so for the people present at the incident. We should remember this is a particularly British problem: in most other jurisdictions, police forces can act in these situations.

Here's the answer to this situation >> an Approved Mental Health Professional goes to a magistrate, out of hours if needs be, and swears out a warrant under s135(1) and this is executed at the house in order to remove Bob to a place of safety for up to 72hrs. This means he is safeguarded whilst the effects of the alcohol wear off and pending a full MHA assessment once fit to be interviewed. There would be genuine difficulties to any other approach. The police cannot act unilaterally; the Mental Capacity Act would almost certainly not apply and no other health or social care professional has a power to act to safeguard him without his active consent and cooperation.

Sections 135 and 136 of the 1983 Mental Health Act were lifted, almost unchanged, from the 1959 Mental Health Act – legislators even left the section numbers the same, I like to think because someone took a view that they didn't want to unnecessarily confuse the police! Either way, it remains true that the laws police officers are working with as we approach 2014 are the very same laws that were written in the late 1950s. In the sixty years or so since passed, developments in the model of care employed has led to an increase in the number of patients receiving treatment in the community.

It is not surprising that the number of police related interventions under the Mental Health Act has increased significantly in that time. I wish I had

figures from the 1960s about the police use of section 136 MHA 1959, but I don't – in some areas we struggle to get figures for 2012! There are various reasons to think that the use of section 136 MHA has risen considerably over the last twenty years as we've seen the number of inpatient psychiatric beds reduce from 55,000 to 17,000. I have heard AMHPs say similar things: those who have been in practice for several decades talk about Mental Health Act assessments being far, far more frequently required as the average duration of stay in hospital reduces significantly.

I can imagine that sixty years ago, the number of occasions where a Mental Welfare Officer – as AMHPs were then called – would have needed a warrant from a Magistrate's Court would have been very few and far between. I can also imagine that the scrutiny applied to any misuse of section 136 was much less and I know some professionals in policing, health and social care still regard the illegal use of section 136 as a necessary expedient. Don't forget, it took until 1997 before there was an incident where the misuse of this power was legally challenged in the case Seal v Chief Constable of South Wales Police and after various appeals through the British and European Courts. That case was only finalised in 2010.

LET'S GET REAL

But how practical is it, when the police are faced with a "Bob"-like situation that an AMHP is despatched to a Magistrate for a warrant? Even if it occurred in a fraction of necessary cases, it would still be massively time-consuming and I fully doubt whether many, if any, local authorities have anything like enough AMHPs to make this realistic. One ambulance service I know have 1,400 "Bobs" per month and accepting that they cover a region which will include many police forces, mental health trusts, etc., this is still a truly enormous figure.

When I suggested during this event that the solution here was a section 135(1) warrant, there was immediate reluctance although there was an acknowledgement that Bob probably needs to be removed to a place of safety to keep him safe until he can be assessed. Well, the route to a place of safety under current law is a warrant! The reluctance here arises from the bureaucracy involved in doing this properly and the inability to manage the implications on professional time, not from any particular disagreement that the outcome it would afford is the wrong one. And all of this is the consequence of our current law, as it stands; because if Bob had been encountered in the street outside his house, officers could have used section 136 MHA and no-one would disagree with that.

So let's remember: we're policing a twenty-first century mental health system oriented to community care, but we're doing it with mid-twentieth

century legislation oriented to institutionalised care. Until Britain looks to modernise (at least) the police parts of its legal framework we are where we are and the judge in the Sessey case reminded us that in the Mental Health Act "Parliament has expressly provided for the situation where the application is one of urgent necessity." Any observation that this lacks a practical appreciation of how difficult it would be in the case of someone like Bob to ring the duty AMHP and see the implications of the Sessey judgement as a reaction, is probably more a comment about whether the local authority is providing sufficient AMHPs to match predictable levels of demand.

THE VIEW FROM THE FRONTLINE

In any event, my role at the afore-mentioned event was to speak specifically about a view from the frontline of policing. So all of the above many be of interest to some, but finding oneself in the position of being the police officer or paramedic in the case of someone like Bob, the main lesson in this post is that we should not be dissuaded in asking for AMHP support in cases like this where it is needed. That the AMHP may not share a view that a warrant is the way to proceed, either because they have a realistic alternative or because demands upon them prevent them from attending a Magistrate for warrant is not something that should concern frontline staff. Recognising the situation for what it is, in the context of that Sessey judgement, and seeking the right support will be an important part of any audit trail that has to be offered up in the eventuality of an inquiry.

If an AMHP feels that it would have been appropriate to use section 136 on Bob had he been encountered in public, then it is fairly easy to argue that section 135(1) should be considered because he has been found in private. The bureaucracy involved should not be the primary issue: the need to safeguard Bob, is the main concern. So let's push for what we know is right, until such time as we discover whether reform of the law will occur. We only need to look to our nearest neighbours, the Republic of Ireland, to see how easy it could all be. And then I wouldn't have to keep banging out blogs hoping to help frontline staff to protect themselves from blame when the broader system within which they are managing a large volume of deflected demand, fails to support them as they seek to do the right thing.

11th December 2013

Dear Santa –

Dear Santa,

I think I've worked hard this year – managed to write a couple of hundred blog posts and put out tens of thousands of tweets to raise awareness within the police and beyond of various aspects of this stuff I'm interested in. As a result of the profile it has all gained, I have been invited to do some amazingly interesting stuff. I've been asked to give lectures at various universities to trainee paramedics and mental health professionals of all kinds and I've done this stuff in my own time and at my own expense in the hope of making a difference because none of this stuff is actually my job. I gave evidence to the Independent Commission led by Lord ADEBOWALE, my work was mentioned twice in the Parliamentary debate on policing and mental health and I was invited to present at next year's International Congress of the Royal College of Psychiatrists in London.

So if you think I've been a good boy, I'd like to ask for the following things for Christmas!

- Please remove the words "police station" from s135(6) of the Mental Health Act
- Please remove the words "place to which the public have access" from s136(1) MHA.
- Please provide a power of entry without warrant for use in connection with ss18, 136 and 138 MHA.
- Banish s135 MHA to the history books.
- Please change the timescale "72hrs" to "6hrs" in s136(2) MHA – if this is too much for your elves, I'll settle for 12hrs.
- Please ensure that s140 of the Mental Health Act is given real weight by making it an explicit duty on those hospitals specified under this provision to maintain contingency beds for urgent admissions and ensure a duty to admit patients where applications are made.
- Please allow Magistrates to remand someone to hospital after their first appearance in court, under ss35/6 MHA.
- Please insert into the Mental Health Act and the Code of Practice specific requirements around equality of access to healthcare for people suffering from mental disorders.

In addition —

- Please can all police officers be sent on a one-week mental health training course? I could even write the syllabus to save your elves some time?! (Actually, it's written already!)
- Can parts of that training please be multi-agency with colleagues from the ambulance service, mental health and social care services as well as GPs and A&E – and led by service users?
- Can we have legal tests and scenarios to ensure that frontline professionals understand the laws that govern the interface between policing and mental health?
- Can you please give the police service and emergency services the gift of an operating culture whereby professionals living with mental health problems feel encouraged to seek support and feel that they get it when they ask for it?
- There are well over 1,500 senior officers in policing and 2,500 frontline clinical staff in my local ambulance service: statistics alone suggest that several hundred people in each of those groups them will have experienced mental health problems during their lives.
- Can you arrange to write into law, something meaningful and enforceable about parity of esteem and access to services for people experiencing mental health problems.
- Please ensure that CCG commissioners think about the reality of the mental health work they commission and contemplate the predictable need to coerce passively resistant, but medically vulnerable people in the community.
- Can you make sure that the CQC point out the nonsense of denying children access to place of safety services (because they're not age appropriate) and then closing those very faciltiies to 136 detentions because it has been necessary to turn that 136 suite into an emergency CAMHS bed for a child!

Oh … and can I please have an Terry's chocolate orange and some brazil nuts and can you please deliver a small Christmas card from me into the stocking of all relevant professionals in the NHS wishing them well in this Yule Tide season and reminding them that A&E absolutely *_is_* a place of

safety where that is the appropriate clinical location for someone to be.

Thanks,

Michael./

12th December 2013

Fighting Crime –

When we hear some commentators discuss the impact upon policing of things like mental health related demands, we often hear the words of the Home Secretary tripped out to defend a preferred view that such things are not core police business. The Home Secretary said in a Police Federation conference that it was the role of the police to "reduce crime – nothing more, nothing less." So given that some twenty percent of policing is connected to mental health and that the legal duty upon police officers does actually go much further than fighting crime, where does this leave us?

Well, plenty of things support a view that it leaves us in a position where we are still going to have to pick up demands connected to mental health, even where there is no obvious link to crime, directly or indirectly. Searching for and recovering AWOL patients, requests to attend inpatient wards to restrain patients(!) as well as conveyance requests alongside or in lieu of the ambulance service. We know of ongoing problems in many areas – not mine, I'm pleased to say! – of provision for those detained under section 136 of the Mental Health Act and we know that officers are particularly anxious about the potential that they could be the next ones to be suspended and criminally investigated following a death in custody.

So we can agree, there is a lot for us to complain about in our police stations. And we do, bolstered recently by things like the Adebowale Report which states "the police cannot do this alone."

But the ultimate irony, as we bemoan the effect all this demand has upon our ability to fight crime, is that when the NHS get in to rooms without the police being present, one thing very high up their list of complaints about us is our unwillingness to fight crime at the intersection of these demands. Assaults on NHS mental health staff unprosecuted – often, not really investigated; decisions made not to prosecute offenders with mental health problems, despite clear professional opinion that it would both be possible and desirable in order to open up Part III of the Mental Health Act – provisions in there, only available to criminal courts, may better balance treatment and public protection; also there is a perception that the police think certain criminal obstructions of AMHPs should just be tolerated as they go about their statutory duties. I could go on.

I've seen this occur and have intervened to push things in other directions; I've heard officers recounting stories in good faith that show we really don't get it.

So for officers who really do think they're just here to fight crime, let's look at the opportunities to do so.

INPATIENT OFFENDING

In the last week alone, I have had numerous phone calls asking for advice about a situation after an incident, where officers wanted validation for their decision to do little or nothing to bring offenders to justice who had seriously offended. I'm talking multiple deliberate and sustained assaults on staff, thousands of pounds worth of damage, threats to people's intimate wellbeing that looked planned for implementation. I have in each case, referred those things back to senior officers suggesting we went awry – either in the way we went about reaching that conclusion; or in the conclusion itself.

There is nothing that prevents the investigation, arrest and prosecution of offenders who are currently inpatients within the mental health system. Obviously, this remark is subject to the relevant tests of evidence and public interest – I'm very far away from saying that all offences should be prosecuted; I'm merely trying to make the point that it will be possible and necessary in *just some* cases. The challenge is to ensure we have a decent way or working out which cases should proceed from those that shouldn't.

Seventy percent (70%) of last year's assaults in the NHS were against mental health staff. Put this against approximately 2% in A&E and 2% against paramedics and technicians in our ambulance service. Focus upon that figure: **seventy percent**. I write it in words and numbers in case you thought it was a typing error: I really do mean that just under three-quarters or just over two-thirds of all assaults in the NHS. It must follow that someone of those incidents involved people who were criminally liable for their actions. But if you look at the number of formal sanctions, they are exceptionally low. Bear in mind, that the starting point of our criminal law is that

There are numerous blogs on this site about the details of how to go about this properly, which I won't recount here. If you're a response or neighbourhood policing officer, please read them. Suffice to say here, there are a couple of things I hear which make me want to put my head in my hands —

- **Anything that includes assumptions that inpatient suspects cannot, ever be prosecuted** —– and that they will always be too medically unfit to be detained in a police station under arrest for investigation and interview. Some will, some won't – *all case on their merits.* Let's be honest: if we responded to an incident where a patient had killed another patient or a member of staff, we'd arrest them and take them to custody. If we accept that it is then possible, why not consider this when someone has committed a s18 GBH or a serious sexual offence? I'm not saying it's desirable, I'm saying it's possible and occasionally, it may be necessary.

- **Anything that includes tortured legal gobbledygook to justify shutting down investigations** —– sentences or questions like "has he got the capacity to form the mens rea?" or anticipating issues that are not the business of investigators but are matters for a court. Even if you think that question about capacity and mens rea means anything at all (it doesn't), why are you asking a nurse or doctor? You wouldn't ring a lawyer to take advice about a medical problem or to see pharmacy advice, yet we'll ask legal questions of medical staff and feel entitled to shut down the inquiry when they don't / won't / can't answer!

Read the blogs I mentioned: you only need to do three things when reports are made of inpatient offending.

1. Get relevant background information from the staff involved in the patient's care.
2. Preserve the evidence in the normal way (statements / CCTV) if the context means it is going to be proportionately investigated.
3. Reach a decision based upon that evidence and the public interest as to how to proceed – either NFA, or CPS for a charging authority.

In other words – it's no different to other kinds of crime investigation. Not at all!

OUTPATIENT OR NON-PATIENT OFFENDING

Offences alleged against people with potential mental health problems who are not currently inpatients is little different, except you may struggle a bit more with point 1, above. Depends on whether the person is known to mental health services and upon what outcome, if any, is reached in police custody about whether someone is so unwell that they need admission under the Mental Health Act to hospital. This is where Liaison and Diversion comes in.

But it is particular important than if suspects are arrested for criminal offences and decisions are taken about them being "diverted" (whatever that means) into the health system without being charged, that the police do not simply decide to take no further action at that stage. A lot of people who are diverted are admitted to hospital under s2 MHA (for assessment) and it may or may not become confirmed that they have a mental health problem. The police need to ensure that they follow-up outcomes with NHS staff before then deciding whether investigations should continue or be brough to an end and this should include requests for information broadly along the lines outlines above, for inpatients.

So custody sergeants have a very easy, yet important role to play to ensure people don't fall into gaps and to ensure public protection: why not make it a matter of routine that all patients diverted from custody under the MHA after being arrested for an offence are given police bail (s37(2) PACE) for 30 days? This then allows a period for medical assessment and for follow-up by investigating officers with NHS staff who can then help to decide whether police bail should be cancelled or to prepare for them answering it. This simple step can ensure that we avoid what we see with some patient-offenders whose offending behaviour and mental health condition is never that serious, but who is in a cycle of crisis > arrest > admissions > discharge > relapse > crisis.

As an incidental point, don't forget that there are several criminal offences within the Mental Health Act itself. Sections 126-129 cover them, but one of particular use to frontline officers who get frustrated to attempts to locate recover AWOL patients, is the offence under s128 MHA of harbouring or assisting an AWOL patient to become or remain absent. Always worth bearing in mind when families or friends are attempting or succeeding in obstructing the police in efforts to find and locate people. Also a useful thing to remind people of, should they find that patients come to them for help in remaining missing once they have absented themselves.

WHAT'S THE POINT OF ALL THIS?

Read again about the case of Christopher HAUGHTON. This case shows, more clearly than any other that springs to mind, the potential for unwell suspects to be taken all the way through the justice system and be held fully responsible despite them being so unwell that at all times, they reached the criteria for compulsory admission to hospital under the Mental Health Act. it is a case that should chime more with police officers, too – because he assaulted and tried to kill several officers in north London. many of whom were formally commended for their bravery (right).

Cases that we have seen time and again, show that the criminal justice system is set up to make fully informed decisions about offenders who have challenging and complex needs, but it takes thorough, proportionate investigations by the police, gathering appropriate information about background and context as they go about it. It requires officers to move beyond simplistic assumptions that "mentally unwell" means "not criminally responsible" and to recognise the potential for those parts of the Mental Health Act that provide for remands, assessment and sentencing of offenders with mental health problems, to provide potentially far better outcomes that balance the health needs of people like Christopher HAUGHTON with victims' right of redress and the public's right to protection from people who pose known risks. Understand for example, what "interim hospital orders" and "restricted hospital orders" are.

And if you see yourself as a crime fighter, this is all worth thinking about quite deeply – you start from the point set out by Lord Chief Justice TINDALL after the case of Daniel M'NAGHTEN:

"*Every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.*"

And once you do, you will see that there is plenty of crime to "fight" within and connected to our mental health system.

12th December 2013

Cross-border Absonding –

The United Kingdom for policing / legal purposes, operates in several seperate legislative theatres: a) England / Wales; b) Scotland; and c) Northern Ireland. There are then further jurisdictions for the Isle of Man and for Jersey and Guernsey – referred to collectively as the Channel Islands in English law even though they have seperate mental health law. This is further 'helped' in terms of clarity by the existence of extra health jurisdictions because England and Wales have separate health services despite their common legal jurisdiction for policing.

Before you tackle this post, you'll need to remind yourself of the various circumstances in which someone can become Absent Without Leave, known as "AWOL"; and those who have absonded. Such circumstances are broadly similar across the jurisdictions, but look at the Mental Health Law page of this blog to access the legislation directly.

So, now you're reminded and refreshed! – get yourself some paracetamol ready and consider this:

- If a Birmingham Community Treatment Order patient comes to the attention of police in Glasgow as being AWOL because they have been 'recalled' or their CTO revoked and they've failed to return to the hospital, can Scots' police detain him and return him to England?
- If a detained Mental Health Order patient from Derry, absents herself from hospital without permission and turns up in Swansea, can the Welsh police detain and transfer back across the Irish Sea?!
- What about police officers crossing borders(?!): can English police detain an English AWOL patient in Scotland; or Welsh officers detain a Welsh AWOL patient in Northern Ireland?!!
- These problems are a harsh reality for Northumbria Police and Cumbria Police, amongst others, where cross-border activity is more frequent. The police in Scotland are likewise affected.
- What about if a patient absent without leave from the Jersey's Mental Health Law 1969 is found in the Isle of Man?!

  Answers to the above: Yes, yes, no and yes.

LEGAL NIGHTMARES

These are the legal questions of nightmares to frontline cops because they are once-in-a-blue-moon situations. A common sense expert would tell you, that if the English police can detain and return a patient to an English hospital, then Scottish Police can do likewise. Irish police can do likewise and *vice versa* with all similar situations. Well actually, that's correct: **they can! … most of the time.** Officers can operate legally in their own legal theatres: ie, English police can detain in England, etc., etc..

The easiest reference guide to start with is the Mental Health Act Reference Guide for England / Wales. Chapter 31 provides various tables of reference which summarise this stuff, in terms of people AWOL and absconded from one jurisdiction who are found in another. Summarised frankly: there is no easy rule of thumb by which to remember this stuff.

For those who like references, here are some of the main ones:

The police in England or Wales can detain AWOL patients who are missing from —

- England and Wales – under s18 Mental Health Act 1983
- Scotland – under a8 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005.
- Northern Ireland – under s87 MHA 1983
- Isle of Man or the Channel Islands – under s89 MHA 1983.

The police in Scotland can detain AWOL patients missing from:

- England and Wales – a8 Mental Health (Absconding Patients from Other Jurisdictions) Regulations 2008.
- Northern Ireland – a8 Mental Health (Absconding Patients from Other Jurisdictions) Regulations 2008.
- Isle of Man or the Channel Islands – a8 Mental Health (Absconding Patients from Other Jurisdictions) Regulations 2008.

Northern Irish Police can detain AWOL patients:

- England and Wales – s88 MHA 1983.
- Scotland – a132 Mental Health (Northern Ireland) Order 1986.
- Isle of Man or the Channel Islands – *tbc!?!*

- **Isle of Man police can detain AWOL patients who are missing from —**
- Any 'relevant territory' under s95 MHA (IoM) 1998.

- "Relevant territory" includes England, Wales, Scotland, Northern Ireland and the Channel Islands.

Now – **is that all clear?!** There may be a test at some future point!

A WORD OF CAUTION

The main caveat to apply to all of this, is that regardless of geographical confusions, the ability to re-detain anyone who is AWOL or absconded is time-limited, even within one country. A person who absents themselves from a Birmingham hospital after having been detained under s2 MHA, can only be re-taken for period of 28 days after their original admission, even if found in Birmingham. This timescale would also apply to a Scottish constable, if that person were to be found in Glasgow.

However, if you are dealing with such a situation and finding yourself hideously confused or unable to obtain confirmations from health professionals about timescales or authorities: the urgent detention provisions of section 136 MHA in England / Wales, section 297 in Scotland and article 129 in Northern Ireland may still be used if the criteria are met. If it is subsequently established or confirmed that the person is AWOL and may still be detained, the subsequent AWOL authority can then be applied to return the patient to hospital.

Don't forget, as long as you are acting in good faith, there are protections from liability for police officers under section 139(1) —

"No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VII of this Act, unless the act was done in bad faith or without reasonable care."

So, take any available opportunity to confirm details or take advice from healthcare professionals and then act in good faith under what appears to be available law. If you do that, should there be any confusion arising from this hideously complicated state of affairs, you will be protected from legal liabilities that may otherwise arise.

27th December 2013

Urgent Transfers –

One vacuum into which the police have frequently been drawn is the area of urgent transfers between NHS hospitals. Transfers from a mental health unit to Accident & Emergency or another mental health unit. There are pitfalls to be anticipated in these kinds of requests and a legal framework in the background of incidents that is often worth knowing about. But to focus minds, it is worth remembering there are ongoing criminal inquiries into police officers *and* into mental health professionals arising from urgent transfers of patients between NHS facilities – there are liabilities to be encountered here, in Health & Safety or human rights law, as well as civil and criminal liabilities that may arise from the way in which the Code of Practice to the Mental Health Act may be violated.

So we need to get this right!

It is the responsibility of the Clinical Commissioning Group for each area to ensure that it has commissioned appropriate methods of conveyance for patients of all kinds, and this includes mental health patients. How the CCG goes about doing this is a matter for them, but typically they will group together with surrounding CCGs and commission their 999 ambulance service on a regional basis. They will also have to have regard to other situations of conveyance, for example the patient transport services which transfer non-urgent, immobile patients from home to hospital for outpatient clinics or, within our area of interest, the conveyance of patients subject to mental health law in the variety of circumstances that emerge.

These duties are made clear in **Chapter 11** of the Code of Practice to the Mental Health Act 1983 and a starter for ten here, should be that the urgency in situation should probably involve a threat to life to become something where the police get involved, thus triggering our legal duty to protect life.

PREDICTING FORSEEABLE DEMAND

It is a predictable feature of providing mental health care that from time to time, patients will need to be moved somewhat urgently. We know for example that patients detained in hospital under the MHA are far more

likely to have poorer than average physical health so problems such as heart attacks, respiratory problems or strokes are not impossible events. We also know that some patients self-harm or take an overdose and they may do so whilst on authorised periods of section 17 leave. The extent of this may require hospital assessment and treatment in A&E. It is also predictable that as patient care continues there will be a need to move someone from a unit that has become unsuitable to a more appropriate one. This will include transferring a person to a setting that has more or less security as risks to them and others alter over time.

As a general rule, such transfers should not involve the police. Apart from the over-riding principles of the Code of Practice stipulating that transfer should ensure dignity for the patient, it all comes back to many types of demand being foreseeable. We may not know on which day a detained patient is going to need transfer to a medium secure facility from a Psychiatric Intensive Care Unit but we know it will happen. So when the need arises, *how* will it happen without necessarily involving the police as an automatic response? That is what we should be asking now, if we're not already.

URGENT TRANSFERS TO A&E

By definition, most people attending A&E do not know that they are going to need to go until the something bad happens. If someone suffers a potentially life-threatening emergency like a heart attack, it is going to be a 999 ambulance involved in the transfer and, in theory at least, staff will accompany that patient. But you can already see why the police are sometimes drawn into this kind of situation – if need is truly urgent and there are security implications beyond the ability of staff to manage, then time may not be available to have long discussions about where extra staff can be found. This leads officers into difficult territory about whether get involved and how to extract themselves from the situation if they do.

There is no obvious legal barrier to the police becoming involved in this kind of situation *in extremis*. A person detained under the MHA is in legal custody and officers assisting NHS staff may use reasonable force to ensure that someone being transferred remains in legal custody. The urgent nature of some transfers may mean officers become involved initially to ensure that access to emergency care is not denied or delayed and that NHS managers then identify staff to take over from them at A&E or even upon admission to a general hospital ward. This is the kind of things duty inspectors end up having to discuss. At what point is it reasonable for the police to expect NHS managers and staff to have identified a plan arising from which officers are released back to their other duties. I know of a scenario like this where the police ended up remaining on a hospital ward for three days.

Bear in mind that these last two paragraphs could have been written with regard to a section 3 patient with little risk history and where police support is sought purely because a ward was understaffed and had too few nurses available to accompany the patient. Equally, it could have been written about a Part III MHA patient, convicted and sentenced by a criminal court to a restricted hospital order in a medium secure unit who represents a significant risk to the public – police officers may be needed to keep someone safely and securely contained, at least initially.

In these kinds of incidents, I have seen and heard of requests that arise purely from under-staffing on wards. It wasn't that the police *per se*, were required – it was that nurses attending A&E with one patient leaves dangerously low levels of staff on the ward of the mental health unit. There are two things that could be said about this —

The police service could take the view that it is not their responsibility to plug gaps and refuse to attend; OR we could recognise that there is a situation in which we could potentially contribute to saving someone's life and then row about the bureaucracy and politics of it all just as soon as that person is in A&E receiving assessment and treatment. All situations will turn on their merits but police and NHS supervisors should begin to work together just as soon as any PCs have jumped on board an ambulance and they should work out the medium term plan for exiting the police from the situation.

URGENT TRANSFERS BETWEEN MENTAL HEALTH UNITS

Urgent transfer requests are also often seen in between mental health units. In my experience, this usually occurs where someone has been initially admitted to a ward which is then deemed unsuitable for a patient's needs and where greater security and better staffing ratios are necessary to provide effective care. We sometimes see police officers called to these situations where patients have again become "unmanageable" in the opinion of staff caring for them and the dangers involved in transferring them via ambulance are too great to countenance.

There have been several incidents where officers have been called to disturbances on mental health wards and found that staff are involved in restraint and either wish to forced medication on a patient or have already done so and a clinical decision has been made to transfer to another kind of unit or to place a patient in seclusion. Where medication to sedate someone has been administered, there some particularly important issues to bear in mind if officers are even vaguely thinking of becoming involved.

The first point to make with regard to any patient who has been sedated, is that there is a particular requirement in the Mental Health Act Code of

Practice: paragraph 11.5 makes it very clear, "*Patients who have been sedated before being conveyed should always be accompanied by a health professional who is knowledgeable in the care of such patients, is able to identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so."* Paramedics will normally not regard themselves as 'suitable' professionals – there are issues around the drugs they are licensed to administer and the issue of not wanting to supervise patients where the dosage of medication was administered by someone else where it involves estimates about patients and travelling time.

Ambulance services often refuse to convey sedated patients where the trust who seek support for conveyance are not supplying a doctor or suitable nurse. **It is perfectly proper to suggest that the police should do likewise and for even more reasons.** *<< This is the stuff of inquiries.*

It is a perfectly valid position to say that the police should not be involved in these issues at all unless there is a risk to life.

STRATEGIC PLANS

Now, in an ideal world the police would not be called to any of these kinds of incidents. But I don't live in or police an ideal world. There are going to be some situations where the correct judgement is going to be for the police to get involved – either because someone really does need to be in A&E as quickly as possible and there isn't time to debate public sector cuts and staffing levels that may or may not satisfy the CQC. That having been acknowledged, it is incumbent upon NHS managers to plan for foreseeable demand and where officers have concerns about whether this has been done, it is perfectly proper to flag up the incident via their inspector and ask for it to be reviewed. It always comes back to whether CCGs have properly commissioned appropriate conveyance pathways but even then, events may dictate a dynamic decision has to be taken to get involved to keep people safe and / or prevent yet more calls for service to a mental health facility which is struggling to cope. Do the right thing to keep people safe – argue about it afterwards.

This blog arises in part from email queries that were waiting for me upon return to work after Christmas, so it's clearly an ongoing issue and the pitfalls worth avoiding.

And I will end by saying this, again – *conveyancing* is what you do when you buy and sell a house; **conveyance** is what you do when you move people and stuff.

31st December 2013

What The Hell Is Actually Going On? –

I didn't take very long of being more than superficially absorbed in this area of interest before people started recommending I read various mental health related books. Some of them were very general texts like the Willan Handbook of Forensic Mental Health and actually, for me, this became something of a substitute to being able to go on a training course of any relevance at all. There is nothing out there to help you chart your way through murky waters of mental health and policing so this volume with its multitude of chapters by a variety of people from disparate academic backgrounds, including psychiatrists, psychologists and mental health nurses and as well as lawyers was well worth having.

But what you learn when you start piling into this stuff head first is that there are a large number of unresolved significant debates that often appear to become spats between the professions within mental health – and often between particular professionals. As you realise the extent of these spats, the power dynamics going on between the different professions and the evidence upon which many rely for their claims, you realise what a precarious house of cards the whole thing is. But it's a house of cards into which we can currently compel people with a multitude of vulnerabilities, shut the door and treat them against their will. So inevitably, to an outsider, this can become quite fascinating and I admit I have become quite absorbed by the history of it all.

How on earth did we reach a position where we can force treatment upon people, when even the profession of psychiatry itself cannot agree what is going on? Expand beyond psychiatry to other mental health related professions and we just see the problems growing wider. There is a corpus of people selling books and doing conferences who are basically suggesting that the last fifty years of psychiatry and a drug-oriented model of care, with an acknowledged subordinate role for talking therapy and other psycho-social support, is flawed. Actually, it is claimed to be doing more harm than good.

So I'm genuinely interested: is this correct on any level that is relevant and important to what we're doing in our society and the role we expect our police to play in delivering that through the use of force?

BIOLOGY, PSYCHOLOGY AND SOCIOLOGY

The first book I came across that started to make me sense a house of cards was *Creating Mental Illness* by Allan HORWITZ. An American sociologist, his book looked at mental illness and the development of psychiatry from a sociological point of view. The book has various things to say about drugs, pharmacy and efficacy, all from a US perspective and is meticulously referenced. Somewhat inevitably, I came across Richard BENTALL, a British clinical psychologist and Professor at the University of Liverpool. Two of his books, *Madness Explained* and *Doctoring the Mind*, are fairly accessible texts and easily understood by a lay person. They question the claims made of mainstream psychiatry about the effectiveness of medication treatments without rejecting them entirely and again, the texts are fully referenced to scientific studies of various kinds.

Most recently, it was recommended I read *Anatomy of an Epidemic* by Robert WHITAKER – an American journalist and science writer whose journey into the practice of psychiatry and specifically the efficacy of psychiatric medication, was somewhat accidental. Having started as a journalist who had accepted without question the claims of psychiatry about drug treatments, his books chart the method by which he ended up questioning them and I couldn't help but wonder, why does a journalist feel there is something to write about here – why are professionals in these fields not dominating the market for popular writing on the science behind mental health?

In social media, I have noticed that whenever discussions emerge about psychiatry, drug treatment or coercion in mental health care, mere mention of these figures stirs up a hornets nest. It surprised me, I will admit, the nature and the extent of the personalised spats that emerge but then what these people are saying does strike at the heart of mainstream psychiatry. They all call into question the efficiency of psychiatric drugs *over the long-term* and BENTALL (as well as many others, including psychiatrists) questions the whole classification system of mental illnesses. Citing studies to back up this claim, including some that were never published, it is claimed that over the long-term, on an aggregate basis, outcomes for patients who are medicated for long periods, for example in excess of three to five years, are actually significantly worse than for patients who were never given anti-psychotic medication at all, or were only given it on a short-term basis.

I hope not to be too pejorative here when I say that the spats were somewhat child-like in their nature. One professional making a claim and others simply saying, "He's wrong!" or "You're wrong!" etc., … I could almost sense some people throwing their dummy and their toys out of their pram. Tweeters were being unfollowed and blocked on Twitter and refusing

to engage with each other. We see some professionals making highly personalised, dismissive remarks. My temptation was to lock them in a room surrounded by riot police and tell them they're not allowed out until they've worked out how to play nicely whilst actually engaging in the debate for the benefit of the public.

IN THE INTERESTS OF BALANCE

So it got me wondering: is there something missing from HORWITZ or BENTALL or WHITAKER that I'm just not sufficiently educated or trained to see for myself – something missing which enables books to be sold and newscopy spread around but which renders the work fundamentally flawed? One of the criticisms of all three of these authors that is repeatedly made – by critics in psychiatry and psychology – is that these men have selectively cited studies in support of their claims and / or misinterpreted evidence. So I asked the some of the critics what was omitted and what has been misunderstood? … I await their replies. I've been unfollowed on Twitter after merely asking some to help an interested policeman understand this stuff, whilst bearing in mind I ditched formal science education over 20yrs ago.

So in the absence of replies, I thought I'd try to do something for myself. What could I read that might amount to the other point of view – or another point of view – something that amounts to a defence of psychiatry as currently seen. There doesn't seem to be as much around but further reading suggestions would be gratefully received in the comments section below. The year 2013 did see the publication of a book by Tom BURNS called *Our Necessary Shadow: The Nature and Meaning of Psychiatry* and I've also resorted to social media and various bloggers to try to look at things from the other side of the fence. What I found either seemed highly partisan – the online equivalent of psychiatrists stamping their feet – or highly selective. Tom BURNS repeatedly claims in his book that "anti-psychotics work", quickly acknowledges that there are side effects to them, "as with all drugs" and moves on.

I was really looking for the debate to be engaged on the levels that WHITAKER or BENTALL tried to do. Especially if these blokes are in some way the enemy of reason. They take the time and trouble to explain why they claim that anti-psychotics don't work over the long-term, they acknowledge benefits in the short-term and do not claim that all use of medication is bad. I wanted to see the opposite claim made in detail, not just that it be made and be taken for granted. Why are these writers wrong, precisely?

It was whilst looking for psychiatrists to argue back that I ended up coming across the work of Joanna MONCRIEFF whose books are currently in my "to

read" pile. But it turns out that she is also widely criticised as an academic and practising psychiatrist because she writes about the ineffectiveness in the long-term, of anti-psychotic and neuropharmacological therapies. I have sensed frustration with her, from other psychiatrists who just seem to accuse her of somewhat banging on. And on. She's recently blogged about how her efforts to have the Royal College of Psychiatrists debate research which suggests the ineffectiveness of anti-psychotic medication in the long-term has been rejected. Why wouldn't such debate be welcomed?

WE NEED A RICHARD DAWKINS

So I haven't got a bloody clue what is really going on and this is largely because no-one is sufficiently explaining it, in accessible terms. And yet I am expected to quietly acquiesce to physically coercing people into a system that declines to explain itself in accessible terms. I don't need it dumbed down, just stripped down to something consumable because I haven't got the time to sit in medical libraries trying to decipher countless medical studies over decades – I wouldn't know where to start.

If Joanna MONCRIEFF is wrong, just tell me why. I don't need her to be slagged off, just her work critiqued. I am decently educated in a general sense and can be trusted to identify bias and motivation for myself. Actually, that's my area of work as I deal everyday with people who tell lies and advocate a particular position to secure advantage. So just critique the evidence, put forward your positions in plain language and I'll have a crack at it myself.

There are loads of things in this world that I'm interested in which are usually the domain of experts. Aspects of life that you would probably need to devote your education and professional existence to if you were to try to achieve any real kind of competence. I rather suspect issues connected to the definition, causation and treatment of mental health problems is one such thing and obviously, I'm a bit busy being a policeman and I didn't really stick in at school otherwise I wouldn't have just finished a NIGHT shift. I'm also interested, for what it's worth, in evolution, economics and philosophy but I haven't got the time to devote my life to any of those things, either – I rely, to some extent at least, upon certain experts bringing this material forward and allowing me an insight by explaining it clearly in clear terms. You could think about various writers for these subjects, but Richard DAWKINS is perhaps the best example of someone who has allowed a scientifically complex subject to become accessible.

We could do with someone like that in mental health and I don't know whether actually WHITAKER or any of the others may be that person because the vitriol with which their output has been received is too concerted to dismissed out of hand – but at least they're trying. Say what

you want about RIchard DAWKINS on his adventures in atheism but his scientific credibility on evolution seems to stand up and his ability to explain it in speech and writing is obvious.

Maybe the science of mental illness is not ready for that yet – who knows? But most of the propositions in mental health that we should be interested in seem eminently testable – what are short and long-term recovery rates for diagnosed patients both with and without the use of medication against a background of proper psycho-social support? It strikes me we should know this if we've reached the stage of coercing other human beings into systems of care that force things upon them, very physically, if need be. And as a policeman, I'd like some kind of reassurance that I'm not being taken for granted to coerce people into a system that some claim does more harm than good, especially since the critics of that viewpoint seem either to lack answers or they are not coming forward to explain them in terms patients can understand.

I'd be jolly grateful if someone could just tell me, what the hell is actually going on?!

End of Volume:
450 Pages
157,000 Words

Total to date:
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