MENTAL HEALTH COP

A VENN DIAGRAM OF POLICING, MENTAL HEALTH AND CRIMINAL JUSTICE

Volume Four – 2014

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

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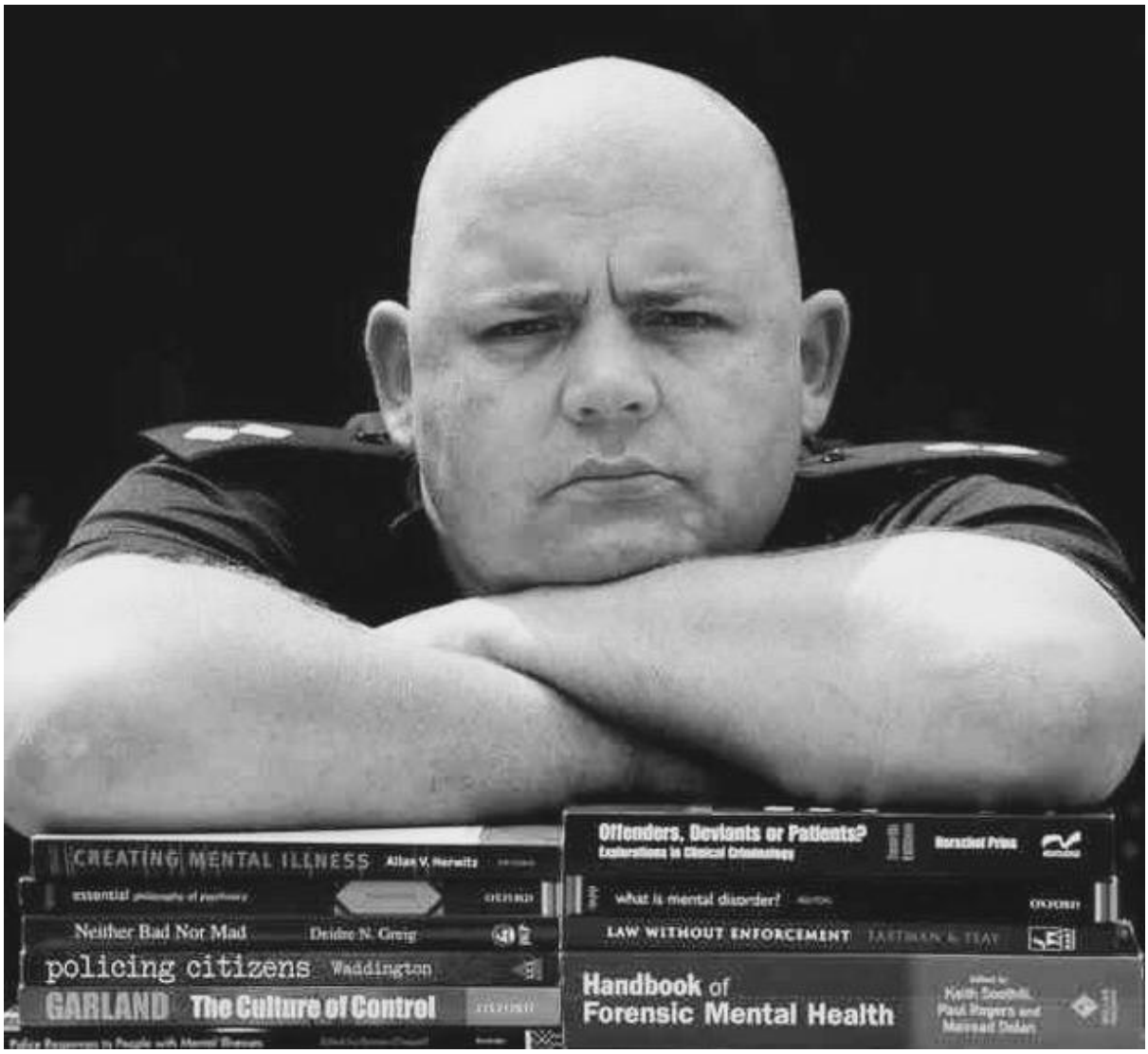

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2nd January 2014

The United States of America –

We've been seeing interest in the US approach to policing and mental health for some while now – more recently, since these issues became a feature of interest in British policing and as part of the continuing interest that British policing generally has in American law enforcement.

There is much of interest in the United States and much I would like to see for myself, but there are certain reasons why I suspect a lot of it may not translate easily to the UK. In 2013, two Winston Churchill Fellowships were awarded for travel to the US (and elsewhere) to examine mental health provision in policing and broader criminal justice. I'm looking forward to reading the reports but I'm especially keen to understand whether potentially good ideas could shift across the pond.

HEALTH AND MENTAL HEALTH

Firstly, let's focus on the US health system and their approach to mental health. The US does not have a publicly funded free-at-the-point-of-delivery oriented health system. This can mean that those of us who live with mental health problems cannot access any kind of mental health service whatsoever – the New York Times reported that in 2012, just over 15% of Americans had no health insurance cover at all and until 2008, it was legal for insurance companies to exclude mental health care from their policies, without further reason. Many reports exist of people in need having no access to any level of mental health care unless they happen to be in an area where there is charitable or third-sector provision.

Secondly, the US approach to mental illness is somewhat at odds with many other countries, not least since the publication last year of the fifth edition of the Diagnostic and Statistical Manual, the DSM5. It is published by the American Psychiatric Association and was subject to fierce debate in the years leading up to 2013 for its system of classification. The DSM5 is the basis of many US health insurance approaches care – unless you are diagnosed as having a condition listed in the DSM5, your health insurance does not cover you and it would cover you only to the extent of delivering treatment the DSM endorses as valid. This is (more?) often connected to prescription of psychiatric medication. The scientific under-pinnings of the DSM have been criticised since the third edition was published in 1980 –

criticised by many as almost entirely invalid from scientific point of view. Noteworthy amongst the critics of the fifth edition is Professor Allen FRANCES who was the chair of the DSM-IV taskforce. He produced an article at the time of publication stating, "Psychiatric diagnosis still relies exclusively on fallible subjective judgments rather than objective biological tests" and he "unpredictable over-diagnosis." It is worth remembering, that most British clinicians prefer to refer to the World Health Organisation International Classification of Disease, known as the ICD-10.

Thirdly, and a point that will be objected to by many is that if we read the work of US journalist Robert WHITAKER and of US sociologist Allan HORWITZ, we will see argument that within the US itself, the medical model of biological psychiatry over the last fifty years has coincided with an incredible rise in the number of people who are long-term disabled with mental health problems and in receipt of state and federal disability provision. Both authors cite various studies – and not just from the US – suggesting that psychiatric medication, especially antipsychotics and antidepressents, are widely over-prescribed in the US and have potentially contributed to exacerbating a public health crisis in the country. Many object to their analysis, accusing them of mis-representing studies and selectively citing what suits a pre-determined position.

But in terms of highlighting difference of approach, it remains important to remember that the concept of schizophrenia in the US means something different to a concept described by the same name in the UK – it is a much broader condition as defined in DSM5 along with a load of others that are simply and quite flatly rejected as scientifically valid by many in British psychiatry. Make of all that, whatever you will.

POLICING AND CRIMINAL JUSTICE

American police are routinely armed – let's start with the most obvious and important difference in the relationship between officer and citizen (or subject). Some US policing catastrophes in this arena of mental health have come from fatal shootings and to put things in context: the British police did not fire a single shot in 2012, the US police shot and killed at least 400 people. That is not adequately explained purely by population size.

Figures are not routinely collected on a national level, but if they killed hundreds can we assume they injured thousands either by firearms or by the use of tasers? Who knows, but we do know that there are significant differences in our two societies when it comes to gun laws, gun possession and the police use of force – it is a discussion about apples and pears.

The US criminal justice system incarcerates people at an absolutely enormous rate – it is the highest documented rate in the world with 743 people per 100,000 of population being imprisoned. Compare this with the United Kingdom at a rate of 154 per 100,000 of population and a European average of 102 per 100,000. The incarceration rate is more than double that of South Africa (331) and such is the effect of mental health and criminal justice policy in the United states that three of the largest institutions providing specialist mental health care are in fact prisons: Cook County Jail in Chicago; Rikers Island, New York and Los Angeles County Jail.

We know also know that the kind of offending and violent crime we see in the United States is significantly different to the kinds of crime we seen in the UK and that the incarceration policy does not necessarily impact upon this in the way that right-wing criminologists would hope. For example, there are 4.8 homicides in the USA for every 100,000 people and approximately 70% of them are committed with a firearm. Compare that with 1 homicide per 100,000 for the UK where 2.4% of them involve a firearm. You could go on to make various other comparisons on crime levels, but I provide homicide purely as an example – the substantive point is the frequency and nature of crime in the USA is very different.

POLICE MENTAL HEALTH UNITS

Who knows the combined effect of all of this? – but on almost every level, the United States is a very different place to the United Kindgom, both structurally in terms of health and criminal justice as well as socially, in terms of attitudes and approaches to crime, mental health and the role of the state.

What we know of how the US police have approached the issue of demand connected to mental health, is that some of the larger police departments, like Los Angeles, New York and Chicago invested a significant amount of resource in establishing mental health units. The LAPD for example, has a "Mental Evaluation Unit" of approximately 60 people and it has existed for over forty years. This includes a number of trained mental health professionals, employed directly by the police and not seconded from any health provider. Within the MEU there is a Case Assessment Management Programme to proactively attempt to reduce demand from "recidivist high utilizers of emergency services" via 911.

To put the size of that unit into comparison, the LAPD serves an area about one-third larger than West Midlands Police, both in terms of resident population and number of officers. So it would be like WMP employing 30 officers and 10 mental health nurses to target mental health related demand. Imagine the reaction of the NHS to the idea of it!?

CRISIS INTERVENTION

We have also seen considerable investment in the United States in Crisis Intervention Training. Arising from an initiative in Memphis, Tennessee, CIT programmes began as a way of improving police training to de-escalate mental health crisis situations and reduce instances of the use of force. The need for such a programme arose in Memphis in 1987 following a particularly controversial fatal shooting of a mentally ill man. By combining with local universities, mental health providers and others, CIT schemes overtly "badge" and brand officers as CIT staff as a way of reducing fear in those of us who live with mental health problems.

This involves a percentage of front-line officers undertaking a 40hr training programme and taking on CIT responsibilities in addition to their core duties. Claims to have reduced the instances of people with mental health problems being arrested for offences are made including fewer situations resolved by a use of force, and a corresponding reduction in injuries to both police officers and the public.

Heather BARR, a US lawyer and human rights advocate, wrote a chapter entitled Policing Madness in a 2002 book on Police Zero Tolerance in New York, which interestingly charts the withdrawal of community mental health services and the drawing of the NYPD into the vacuum that remained. It is a short picture of the dynamics at play in the US in recent decades and CIT is designed to improve how that works. << You'll recognise this as an example of *"trying to the wrong thing, righter."*

Crisis Intervention Training has become a brand that is now exported around developed countries. Versions of it, often under the same name, have emerged in almost all states of the US as well as in Canada and Australia. The United Kingdom has not attempted to do it in the same way, although similar kinds of ideas have been implemented in specialist firearms units, for example in Northumbria Police. Again, one can see issues of utility: British firearms units are more likely to lead on the kinds of incidents which in the US, Canada and Australia are led by first-response officers who are armed. The imperative is a different one in the UK and New Zealand where officers are not routinely armed.

SEPARATED BY A COMMON LANGUAGE

I have said for years we need to do more on mental health training for officers, but for these reasons and all those differences mentioned above, I am cautious about how directly American ideas on policing and mental health would translate across the Atlantic. One thing that is massively under-researched is the interplay between all of this: if the US are adopting a more biological approach to mental distress as illness and relying to a

greater degree upon psychiatric medication like anti-psychotics and anti-depressants, what impact does this have on policing and crime? Something I need to know far more about, is akathisia as it has been speculated and some studies have suggested that this may be linked to suicidal and homicidal ideation.

And so we need to be careful on several levels about how we handle good ideas for US cities without working on assumptions that things will be transferable because we all speak the same language, more or less. The good ideas that are then will just need carefully translating, as we often see with our joint approaches to the use of English!

2nd January 2014

Emergency Service –

I sometimes remember to marvel at some of my colleagues and did so again over the Christmas period – ordinary men and women doing an extraordinary job, away from their friends and families whilst we were at home – (it was my turn to be off!) Their pay has been frozen for the last few years with their pensions being eroded compared to those they were promised when they joined up; there is comparatively little or absolutely no training for some of the functions that they are expected to undertake in their role; and sometimes they are patronised and misunderstood by senior members of Government who don't really get their role at all.

CRIME, SAFEGUARDING AND PERSONAL BRAVERY

A while ago, one of them was at a job where a man had attacked his partner with a knife and the man was known to have a risk history that flags up whenever you attend the address. Back up was a distance away and consumed by an instinct to protect the woman and get to her aid, she went in to that unknowable environment on her own. What she did what she got in there meant the man fled with his knife, the woman was safeguarded from any further threat and it could be declared safe for paramedics to roll the ambulance up to the door. The man was arrested a short-distance away, but that early evidence meant we could prove that he *was* holding a knife during the incident. Crucial evidence, nicely preserved by a brave professional witness who put herself at risk.

You'll remember this blog was prompted whilst I was off work this Christmas: I remembered what it was like working on the frontline last year – Christmas Eve in particular was a real bender of a shift and resources were so stretched that by about 3am (on Christmas Day!) I was first on the scene of a stabbing. A man so badly injured that his wound was an open chasm in his neck and there were half-pints of blood all over the pavement. I was soon joined by another set of blue flashing lights and before much else could happen, my colleague and I were rolling on the floor with this bloke, fighting him to let us apply pressure to his neck wound so he didn't bleed to death in the road. We both got knocked about a bit, but nothing serious and wondered afterwards whether this man was as high-as-a-kite on cocaine? But the ambulance crew and more officers turned up and off he went to hospital.

Earlier this year, we had a very mentally distressed lady in police custody – a person in a condition of some particular agitation and obviously very unwell. As various medical professionals have suggested we should, I remember asking the custody nurse whether we could be sure that her basic obs indicated nothing was seriously physically wrong with her – was she actually safe in police custody? The nurse checked the custody record medical forms and admitted she didn't know. She agreed she should do them again to be certain and saw what I was getting at. Was her heart rate OK, her blood sugar, etc., etc.. The nurse being there with all of her gear, you'd hope and think that a nurse would be able to reassure someone perhaps to a greater degree than someone in uniform that they wanted to check them out, to help make sure they're OK? This lady couldn't see that and I patiently watched two of my colleagues spent 90 minutes of constant patient and compassionate conversation turn this into a position whereby the obs could be done and we could relax that she was not potentially seriously medically ill, as well as distressed.

EMERGENCY SERVICE

I could go on and on – the point I want to make here is that *none* of the colleagues I'm referring to above are police officers.

They were all paramedics from our ambulance service.

It was a paramedic first-responder that intentionally put herself at risk where a man had taken a large blade to his wife, to safeguard her and she unintentionally contrived to be able to provide evidence against him that helped convince the court he was a dangerous liar; it was a paramedic who got physically stuck in to a man who was bleeding heavily but *fighting* not to be helped; it was two paramedics who came into police custody and spent 90 minutes patiently persuading one of the most vulnerable, psychotic and distressed people I have ever met, to let them *care* for her.

I could still go on and on – the story of the paramedic in London who continued to provide care for a drunk man just after he'd been hit over the head with a fence post *by that man*; the paramedic in Suffolk this Christmas who ran into a burning building before the Fire Brigade could arrive to rescue a trapped woman and immediately give her respiratory support; the paramedic who accompanied three officers into a building where there was a risk of a gas explosion in order to assess a man inside – all were hurt when the building exploded, a risk that they knew they were taking.

It is my genuine privilege to work alongside these people – as we do every single day. Despite the very obvious differences between policing and pre-hospital healthcare, there are many overlaps and at the core of it all is dedicated public service at times like Christmas or during family birthdays

and other events. It is my view that paramedics are paid peanuts for what they do and they are probably more messed about and taken for granted with the rubbish that is thrown at them, than we realise. The stories of people ringing 999 for an ambulance because they can't be bothered to walk to hospital or see their GP; the Home Secretary contriving to refer to them as "ambulance drivers" in apparent disregard of the training and qualifications they must have and the media quick to pick up on paramedics not diving into a lake but aren't mentioning the one who ran into the burning building.

It just beggars all belief that they aren't considered an *emergency* service – I have certain views about that!

The practice guidelines for paramedics is a telephone directory sized book and it has four pages of information on about mental health, some of which is wrong! It probably isn't as widely known as it should be, how many paramedics will say that they *want* to be able to do **more** for people in mental distress – they want to access NHS referral pathways, have options for removal to care settings that are more appropriate than A&E and be trusted to take pre-hospital clinical decisions. Let them serve us better, because they want to do it and are currently blocked from trying. We trust these people to get to grips with our heart attacks and strokes and to know what to do when time is of the essence – surely we can open up the mental health pathways and trust their clinical judgements?

So I want to circulate my admiration for my colleagues in green and help build awareness of the stuff they do for you and for all of us each and every day.

We would notice if they weren't there to do it for us, trust me on that.

5th January 2014

New Liaison and Diversion –

In the overall scheme of UK Government spending, newly allocated money for mental health Liaison and Diversion (L&D) schemes in police custody is not that much, but we can agree that £25 million is still a substantial amount of money that we don't want to misuse. Bearing in mind that this is money allocated for just ten pilot sites, we can predict the overall spend for L&D schemes will be way more than double this figure if they were extended to all forty-three police forces; and bear in mind that the pilot sites do not necessarily cover whole police force areas. The scheme within West Midlands Police is for Coventry *only*, the scheme in the Metropolitan Police is for Bethnal Green.

I really do welcome this investment and the fact that we're actually going to *do something*! – I have said for years we need to do much better in this area of offender health, to improve the outcomes we get. But I also hope it's not being negative to say that I have questions and concerns. I voice them, because I have actually worked in areas with L&D services, been involved in setting one up and watched them fall flat on their faces for a variety of reasons at a cost of tens of thoustands of pounds and these questions weren't addressed in the overall design.

So I asked the question on Twitter yesterday: "Liaison and Diversion: what, precisely, are we trying to achieve?" I ask the question, because no-one seems to be *precisely* articulating it – plenty of broad-brush statements that no reasonable person could objective to about "better working" and "closer partnerships" and "better outcomes for individuals", etc., but I remain full of particular questions about what this actually means in the real world amidst reservations I have from other L&D schemes I've seen, that I've been part of and that I've read about.

I offer three things that we would all hope to see improved —

1. Appropriate identification of all those who may need MH assessment / referral.
2. Far better sharing of information between police / NHS.
3. Improved CJ decision-making – and not just about diverting people *from* justice.

We know that the police under-identify people in custody who may have a mental health problem. Most research I've seen suggests we identify approximately 15% of people in whom we suspect a mental health problem. Notably, I've seen information sharing between police and NHS which suggests that as many as 50% of people being arrested could be (currently or previously) known to a local mental health trust. So L&D services staffed by nurses with access to records, sorts out point (1).

We know that information is under-shared between the police and the NHS, amidst all those traditional fears of violating medically confidential information and NHS Caldicott Guardians warnings about the sharing of it. What is often missed in these debates when it relates to these kinds of MH/CJ schemes, is that you can share anything at all with the permission of the person to whom it relates – so why not ask them, especially if it may contribute to a less serious CJ response than would otherwise be the case. Furthermore, you can share a lot of things under the Data Protection Act 1998 – yes, even where it is medical information – if it *directly* relates to the legal decisions the police must make under criminal law with regard to an investigation. Section 29 and schedules 2 and 3 of the DPA '98 refer and everyone connected to these debates should read them – links to them all are in my post on the Data Protection Act.

And let's be frank: it is often the health information that should directly determine the criminal justice decision. If you want to see an example of that in play, read one of my really early blogs on diversion. That could take care of point (2).

IMPROVED CJ DECISION-MAKING

This then brings us to the point of it all, point (3) – once you've screened, assessed and researched someone in terms of their mental health background, the police have to make a legal decision of one kind or another. The person who came into custody was arrested further to an allegation of offending in the majority of cases (although L&D services will also see other categories of people in custody). It is ultimately for the police to decide what happens with someone after an offence is alleged and having taken account of L&D professionals from MH, it will be one of three things —

1. Some under arrest is fully and immediately diverted from justice – mental health pathways kick in for that person and the investigation is brought to an end. This will probably mean the person is admitted to hospital and that the offence and overall background is non-serious and the argument would be that there is little public interest in pursuing a criminal prosecution in those particular circumstances.

2. Someone under arrest is diverted from justice whilst being bailed pending further information – health pathways commence, probably admission, but the investigation is paused whilst more becomes known during assessment. Something in the incident or background means it is not immediately seen as trivial but which can be held in abeyance whilst health issues are prioritised.
3. Someone under arrest is still prosecuted into the justice system – notwithstanding that they are believed to have a mental health problem and any referral transfer into the mental health system occurs alongside the operation of the criminal justice system. This could include the courts using Part III of the Mental Health Act where there is a more serious risk to health and public safety that needs managing.

How do we hope to see the quality of the decisions improved? — we don't know a huge amount about the outcomes we get in custody at the moment and in the future we know that a research organisation will sit down to evaluate these £25m schemes to decide whether they should be rolled out nationally by 2017. So the first thing to say is we're not entirely sure what the bench-mark is for current practice. Here is my understanding of where we start in an area where there is no current L&D provision, based upon research I've done of 10,000 police custody records in Birmingham –

- **10,000 custody records were examined** from two different busy custody suites.
- 1,076 raised the 'mental health' question and were assessed by the FME

- **512 were assessed** by another medical professional *after* the FME – either CPN or AMHP-led MHA assessment.
- (The remaining 564 of the 1,076 were deemed fit for investigation.)
- 415 of those 512 were *not* in need of hospital admission on that day.
- (The 415 were 'managed' in custody almost as if no mental health problems existed at all. Appropriate adults were obtained where needed, but the overall CJ outcome was consistent with 'normal' CJ outcomes for other offenders.)

- **97 were in need of hospital admission** following their assessment.
- 9 were in need of admission under s3 MHA.
- 12 were in need of admission on a voluntary basis.
- 76 were in need of admission under s2 MHA.
- 97 were not prosecuted.
- 97 were not bailed pending the outcome of their MH assessment or treatment.

It raises a load of questions that I'm interested in knowing the answers to, but I don't know whether anyone is looking at this in appropriate detail —

1. How many of who were not "sectionable" when assessed in police custody were referred to MH services for an outpatient appointment or follow-up by a Community Mental Health Team and how many attended and engaged?
2. How many of those who were "sectioned" were found to have a serious mental health condition and detained for an appropriate course of treatment, for example as an informal patient or under section 3 MHA?
3. How many of those who were "sectioned" were found to be have a mental health condition, but not serious enough to warrant ongoing treatment in hospital and were discharged to a community mental health team with which they engaged?
4. How many of those who were "sectioned" were found to be suffering from no mental health condition whatsoever?
5. What does all of *THAT* mean for criminal justice outcomes and re-offending rates?

OUTCOMES AND RE-OFFENDING

If we knew the answers to questions 1-4, above, we could then reflect upon criminal justice outcomes and re-offending. If we put that all together we would know far more about the 97 people who were admitted to hospital after assessment on the day of their arrest. A minority of them would have been seriously unwell and further detained after initial admission; a minority would not have had any kind of mental health condition. A bulk of people would be found to have a mental health condition, but not serious enough to require ongoing, long-term hospitalization.

- So if we learned that one of the 97 was a very ill man, never been in trouble with the police before that he was sectioned after arrest for shoplifting a moderate amount of goods, and so ill that he ended up detained under s3 MHA for several months – we'd probably agree no particular need for a prosecution or even a caution.
- Equally, if we learned after one man had assaulted someone before being admitted and fully assessed in hospital and it was determined after his illegal drugs had worn off that he actually wasn't unwell at all and had been referred to his GP for follow up on his drugs usage – we may wonder the justice of things if we found out that he was never sanctioned for the assault.

What does all of that mean for criminal liability? Well, it depends what your theory (and your politics) is!

Some people argue that if a person with a mental health problem has become unwell – let's suggest that they have relapsed after ceasing to take medication prescribed for their condition – it is their illness that gives rise to the offending so the priority should be to treat the illness and thus reduce re-offending. This assumes a relationship between mental distress and crime that some researchers argue is simply not there yet we can see in the language used to describe these new schemes that this presumption, very far from being evidenced by research, is believed to be true. We heard the schemes were marketed as "mental health nurses to help police reduce re-offending." I vividly recall a few years ago having to legally review the detention of a man in custody being investigated for assault and thought to be mentally unwell. As I explained the delay in him being dealt with partly arose from delays in getting the mental health team to the station he said something quite succinct in the vernacular form, "For fuck's sake you don't need a mental health team anyway … I punched him because he's an arsehole not because I've got schizophrenia." Fair enough. He was duly charged with assault with a further referral going to the mental health team responsible for his care.

The majority of people who come into police custody whilst mentally distressed are not acutely affected sufficiently to require inpatient hospital admission and they have not offended enough to justify imprisonment. Therefore whatever health referral / assessment is perceived to be required can occur anyway. We know that the police identify between 10-15% of those coming through custody and that with mental health professionals in custody having access to NHS records, this number could rise to between 30-50%. In other words: the police are currently spotting about 1/3rd of the mental health related demand in detainees. It immediately begs the question of whether the NHS is in a position to handle referrals for less acutely ill detainees that are *triple* the current rate. Here's hoping that the £25m is partly to shore up other services like drug / alcohol or personality disorder services, not just provide the staff and structures for police stations. A potential tripling of demand!

BEYOND LIAISON AND DIVERSION

So if we triple, roughly, the number of people in police custody who are identified as requiring follow-up NHS care, where does that demand go? We know that 83% of people with mental health problems are cared for by their GP, but many of those in police custody require follow-up by secondary care mental health services, ie, the mental health trust for that area.

We know that beds are currently in very short supply and that the CQC are actually starting to push in areas that have decommissioned too many beds and can no longer meet levels of demand. We are also starting to hear

how equivalent pressures are affecting community mental health teams because of the increased push to provide community care, in light of the bed crisis.

So Liaison and Diversion: very welcome, but it needs to be widely known that the "Criminal suspects suffering mental distress" group of in custody is SEVEN times the size of the "section 136 Mental Health Act" group and we know how difficult it is to ensure effective 136 provision. It also needs to be known, that this will increase demand for NHS services that we know are already saying they struggle and it needs to be known *precisely* what we are asking them to do better or differently and with what objective in mind.

How will we know if this "works"?

OTHER LINKS —

- Liaison and Diversion Services (2011) – Offender Health Research Network, University of Manchester.
- Diversion (2009) – Centre for Mental Health.
- Turning Point Press release – Chair of the Independent Commission on Policing and Mental Health

MEDIA COVERAGE —

- UK Government press release
- Guardian
- Evening Standard
- Nursing Times

10th January 2014

PPPPPPP –

There are some decisions at work you can't just take one step at a time in light of events, you must sometimes plan for more than one eventuality. You have to know before you get to the fork in the road, roughly what you will do as you move in each direction, even though you may not have decided which way you will go when the time comes.

It has always been my impression that this sort of thinking should apply to how we react when patients in hospital say they wish to leave and decline the medical treatment that is on offer to them – most people are legally competent to take their own decisions and, properly informed, can decline whatever they decide they don't want. Other people, after an appropriate assessment, will not be allowed to take such decisions and will need to benefit from a reaction which puts an appropriate legal framework around them with resources to realise it in a dignified and humane way.

So I've always been surprised why we don't often see evidence of a plan for the fork in the road that leads us down the "declining medical treatment" route, just in case we suddenly hit that fork. Most of the time, that will be easily to formulate: we're going to let them walk out of hospital and the consequences of doing so are for them as individuals to manage. However, where we are not going to take that approach, we need to think about it and prepare for the reality of what we will do to try and keep people safe: both the patients who may require detention and the operational staff who bear the legal responsibilities for assault or neglect, dependent upon what they decide to do.

THINKING ABOUT SECTION 5

I recently attended an acute medical unit in a hospital to a report that a mental health patient was trying to leave. Upon arrival it was genuinely difficult to have someone establish which legal framework of the Mental Health Act the patient was subject to, if any; and on what legal basis it was being suggested that the police should stop him leaving. We saw that the hospital had already called their security team and the patient was begrudgingly sat in a chair complaining that he wanted to leave with NHS staff currently telling him that he couldn't. Some police officers that were present in the unit for entirely unrelated reasons had persuaded the man

to cooperate just for enough minutes to allow staff to decide what was going on and what might need to happen next.

"So which legal framework is the patient subject to?" I asked.

"He lacks capacity."

"That's not what I asked: which legal framework is he subject to? Is he a s2 or s3 Mental Health Act patient, for example?"

"Oh, I don't know."

"Why don't you know, if you're asking us to assault and imprison him? Can you find out please."

The patient became helpful, *"I'm informal. They can't keep me here."*

"Is that correct? Because if it is, he's right unless you do something else."

"Yes, I think it is."

"So is the doctor in charge of him proposing to utilise s5 of the Mental Health Act?"

"I don't know. Should I find out?!"

"If we're going to start assaulting this bloke, I admit to thinking that would be good!"

It took about 40 seconds to hear someone shout, "It's alright, he can leave." And off he went, back to the mental health unit on a voluntary basis as an informal patient. The issue in play had been, he'd taken an overdose and the mental health unit didn't want him deteriorating in their ward. He'd been moved to an acute hospital and admitted but had expressed frustration and made to leave before the normal period of monitoring and blood testing and treatment would allow the acute hospital to confirm his wellbeing.

So the first reaction to his effort to leave, was to try to stop him, despite no obvious legal framework by which to do so. Not necessarily a problem if that is for a very brief period, just enough to ensure he's fully aware of risks or for a doctor to be called to consider using s5(2) MHA, if appropriate. But there comes a point where you are at the fork in the road and either have to stick a legal framework around this incident or let him leave. Important not only in terms of the patient and their rights but also in terms of the liabilities of nurses, security officers and police officers that become drawn into *de facto* detention.

ADVANCE CONSIDERATION

I would love see appropriate advance thought put into this kind of thing: if you're asking your security officers, nurses or local police to detain someone, on what legal basis will you be making that request? You have to assume, by law, that people are competent to take their own decisions and that they are entitled to make unwise decisions. It is also only a matter of professional courtesy that if you are asking someone to take a legal decision on your behalf, you extent them the courtesy of a briefing that allows them as professionals their own insight into the matters in hand. This is not least because that professional becomes responsible for the assault they inflict and cannot subsequently say, "Oh, the nurse told me to do it." if challenged.

I decided to blog on this recent incident precisely because it is not isolated. Social media is replete with examples of informal patients telling mental health staff that they are briefly or permanently leaving and staff refusing to allow it on the basis of no legal understanding. Paragraphs 23.16 and 4.12 to the Code of Practice to the Mental Health Act should be things most mental health nurses can quote, in my view.

Incidents of a similar nature also involve the police getting into this sort of thing in A&E departments where patients decide they wish to leave. Such incidents are made more complex by virtue of the fact that section 5 MHA cannot be applied by doctors in A&E departments. Section 5 applies to only to hospital inpatients and A&Es are effectively massive outpatient clinics where you don't happen to need an appointment. So if someone is in A&E and them leaving is considered problematic in terms of risks to health or mental health, the options are section 136 MHA being used by the police or the application of the Mental Capacity Act, where justified. (Yes, you can use section 136 in A&E – see the Sessey judgement, if you don't believe me.)

But again, A&E should presume that people are competent to take their own decisions and plan for the fork in the road: if someone tries to leave, will the reaction be to call the police and have them commence a high-risk missing person enquiry? If so, it might be worth thinking in advance of the fork in the road and whether the police being called prior to the critical moment to consider section 136 was actually sensible risk mitigation? All too often we hear of incidents where people who are likely to become high-risk missing patients in need to detention under s136 or Mental Health Act assessment are not considered for police intervention until such time as they've gone. And PLEASE don't wait until they've gone and then ask for a "safe and well check" without beginning to think about the clinical and mental health support that those patients and frontline officers will need if

and when they find that person, especially if they're found in a private dwelling.

As many military characters will say – PPPPPPP or "the seven Ps" … "proper planning and preparation prevents p*ss-poor performance". It's not the time to be deciding which way we'll go at the fork if we've already decided to start wrestling people back into hospital because of some paternalistic instinct that they should stay there. It should be part of the thinking process as soon as we wonder whether someone is going to stay the duration. As I've said with the interpretation of section 136 MHA, you judge the necessity of legal compulsion not by whether it is needed to get someone into a process, but by whether it has become necessary to ensure that someone finishes it.

11th January 2014

Inherent Contradictions –

In the police, we take deliberate decisions to ruin lives and we do it every day. In so doing, those decisions often bring officers into direct conflict with the aims of other organisations, including other public sector authorities. Although this feature of our work does not make us unique, we have that duty to act in a broader public interest, often at the expense of individuals.

So you sometimes see police officers prosecuting drink drivers knowing full well the consequences of doing it will be that some man loses his job (because he drives for a living) and that such problems may lead to other aspects of his life falling apart: an inability to pay his mortgage now he's lost his job, consequential relationship difficulties and broader family breakdown. The decision to prosecute will affect third-parties, but we do it anyway, because of the imperative to reduce road deaths (still floating at more than triple the murder rate, incidentally) and to bring to justice those who would put us all at risk. We also see police officers taking decisions to put young people into the justice system in circumstances where we know that it will *massively* affect their educational attainment and broader life-chances as an adult. Perhaps not justified if they've shoplifted once or even twice, but if they've just robbed someone at knife point against a history of violence and acquisitive crime, it may well be necessary to do this in the broader public interest.

All of this appears to be done in the hope that subsequent services – whether they be health and social services, the criminal justice system or both, can reduce re-offending. But we must not lose sight of the "lock them up" dimension for people who have committed serious acts of violence, including sexual violence.

THE GATEWAY

The police are also in a somewhat unusual position of being gateways to both mental health and criminal justice provision and it is a weird position to be in, given considerable debates concerning those systems' effectiveness. We know that many organisations and charities question the effectiveness of our prisons – "an expensive way of making bad people, worse", etc.; – and we have seen movements over the last fifty years that

question the long-term effectiveness and even the fundamental validity of psychiatry and wider mental health services.

We would anticipate an outcry of outrage if the police started making judgements of what to do based upon certain impressions of what mental health and criminal justice systems may do but I'm not clear that would necessarily be justified given the mission of the police:

To prevent crime: nothing more, nothing less — so all bets are off.

There it is, at the bottom of it all – an inherent contradiction between what we ask our police service to do for us and what may be in the long-term interests of individuals or our society. We sometimes initiate proceedings that send people to prison for many years, causing their previous lives to fall apart and their mental health to be seriously affect – the criminal justice process itself is, for many, a pathway to poorer health and mental health. Yet despite all of this, it may well be a pathway we still need to go down and in reality the police do make judgements about whether the criminal justice system will make things worse.

Is there a role to say we should do likewise with mental health? Police officers are not clinicians, but we do know from published research that diverting people from justice is not always effective, either in terms of individual health or long-term health or crime outcomes. I think this is a debate that needs to start and about which research needs to be done: are we ever making things worse by diverting people from justice to health?

It's about attempting to weigh the public interest amidst uncertainty about how effective outcomes will actually be.

LIAISON AND DIVERSION

So this is where I'm going with this? At 5am the other morning, I detained a man who had threatened another with a knife. It was obvious within seconds he was a man who was acutely distressed and by about ten-past five we knew that he was flagged up all over police systems for a history of mental illness as well as violent behaviour – I'm not necessarily saying these things are linked. I wrote in my notes that I queried that he was seriously mentally ill and when I went to work that following night, I learned that he had been detained in hospital under the Mental Health Act and retained on police bail so that a view may be taken at a later date, after his health has been prioritised, as to whether he should be prosecuted. A view may be taken that he posed a "serious risk of harm" to the public and that if continued detention under the Mental Health Act were necessary, maybe it should be dictated by Part III in the criminal courts? Who knows?!

But on two levels the consequences of police action could make this situation worse, in the long-term: if he is retained within the mental health system and not prosecuted at all or if he is prosecuted within the mental health system under Part III MHA, it could be that the action is the beginning or a part of a long-term relationship with that system that worsens the likelihood of his overall health outcome. Perceptions of dangerousness that lead to a long-term compulsory relationship with antipsychotic medication and all the side-effects we know this holds. If he is prosecuted and managed within the criminal justice system, we know that outcomes for re-offending are questionable and that this may also come at a greater cost to his mental health than would otherwise be the case.

WHAT ROLE FOR THE POLICE?

So what am I saying?

It is the role of the police to make judgements about when something has become serious enough for them to take a decision to intervene in situations where they risk making things it worse in the short-term, but in the hope of a positive long-term outcome. That said, I've argued for years, to my cost, that we need better research about the efficacy of outcomes and if we are to get anywhere close to an aspiration of "evidence-based policing", we need to make sure that research is top quality. << That last sentence is a direct dig at the quality of the research we often see relied upon in mental health and criminal justice, for the interventions upon which we rely.

I often worry that I go to work and make things worse in the long-run, amidst the expectation that I will insert a crude, short-term intervention into a certain type of situation by referring things to rehabilitation experts in mental health and criminal justice, who are far from able to show that impact. I'm also conscious that as things currently stand, we have little other option but to keep doing so.

The criminal justice system exists to stigmatise *just some* people, selected from amongst us and at a cost to their health and our broader economy in *just some* cases. We cannot get away from that when we are making prosecution and diversion decisions which are inherently about far, far more than one individual's wellbeing and we need to make sure that we understand these interventions far better in the future to evaluate liaison and diversion schemes.

11th January 2014

Training Day –

On more than one occasion I have been involved in the discussion that arises from the taken-for-granted proposition that the police must need "more mental health training". From the record, at the outset, I want to say that I agree. We can hardly countenance the idea that officers are adequately trained if we are seeing independent commissions into policing high-profile events that went awry and if we are seeing the investment of millions into schemes like liaison and diversion and street triage. Even the narratives attached to these schemes imply the lack of training: I've noticed that mental health professionals are coming to "help" the police. Maybe.

So what would this training include. I've asked that many times of many people. I'll tell you the one they don't say and return to this theme at the end: no-one says, "legal training" on mental health law and human rights law. More of that later when I'll also address the "help" narrative. Focus tends to be upon what I will call "recognition" issues – how can officers better identify those of us who are potentially living with a mental health disorder, in order to adjust their decision-making accordingly? How can officers better communicate and interact with us, so as to de-escalate situations that might otherwise necessitate the use of force; how can we avoid unintentional behaviours that cause anxiety and fear?

We also see suggestions that officers need to have a level of appreciation for the various kinds of conditions that are seen in psychiatry: schizophrenia, bipolar disorder, anxiety and depressive conditions and personality disorder, for example. But over the years we have seen particular representations made in the wake of events: following the Fiona PILKINGTON case in Leicestershire we hear about the importance of understand learning disabilities; the ZH "swimming pool" case led to calls for autism training; every time we hear of force being used in situations that involve dementia patients we hear understandable representations that officers need to more about the condition.

THE MORE THE MERRIER

There's nothing here that one could really object to, is there – why wouldn't the police not want to know more? Well there are a couple of things worth saying on this:

We need the police to know enough about mental health to be able to police effectively, so it does involve a need to communicate in a way that minimises any anxiety or difficulty that an officer may unwittingly create; it involves a need to employ behaviours and language that de-escalate situations wherever a use of force may be required and it involves being able to work out which of us are "in" and which of us are "out" of pathways of referral or detention that officers may employ where they believe they need them.

But how much training is the required amount on any particular sub-category of mental disorder listed above. Organisations who specifically provide training will usually offer general awareness courses that last a couple of hours – for a fee, most usually. But if you list the different conditions where training could be given by a charitable group associated with it, I could easily list eight training sessions the police may need, without trying hard.

That's a three-day training course before we have even begun to talk about mental health law, how the NHS works and how officers may apply particular laws, tactics or referrals to advantage.

I have to make a disclaimer ahead of the following paragraphs: I am not arguing here that any one kind of mental health condition is less worthy, less serious or less impactive upon people's lives than any other condition. What follows is merely an argument about whether a particular condition is characteristically unique to mean that it requires particular consideration in police training.

To what extent would police reactions need to be distinct? Surely this must govern training. If officers are attempting to influence a suicidal person to climb back over a motorway bridge, does it matter whether they are there, suicidal, because of bipolar disorder or because of a personality disorder? Maybe it does. If the police have responded to a 999 call following a report that a member of the public is worried about someone who is acting in an agitated, distressed way in the High Street, does it matter whether that person is psychotic because of schizophrenia or because of post-natal depression? Maybe it does.

Where any vulnerable person has committed an offence whilst unwell, does it matter for the purposes of making the policing decisions whether the background is one kind of personality disorder or another, whether it is complicated by drugs and / or alcohol or whether the person is or is not known to mental health services already. Well, it probably matters that the police have enough training to make that early decision about whether someone will be detained under s136 of the Mental Health Act or whether they will be detained for the offence but once that decision is taken, it possibly doesn't – all that stuff about the "nature or degree" of someone's health will be unravelled in whichever location the person is taken to.

So my question about the extent to which it is *necessary,* strictly speaking, for the police to appreciate difference becomes important. When you sit with representatives from different organisations representing particular interests, there is a huge amount of overlap and similarity in what they say. Avoid jardon and acronyms, avoid metaphor and figures of speech, minimise surrounding confusion and distraction by turning radios and mobile phones down or off; listen non-judgementally, validate other people's experience and given them time and space wherever that is consistent with safety. This list not intended to be exhaustive or prescriptive – if you ask how it differs to the advice officers would be expected to bear in mind for other sub-categories of mental disorder, it usually doesn't.

The one exception I make for this point, as I have said before, is for autism. Having discussed this point many times, there are certain things you might add, as we saw in the "ZH" or swimming pool case, as it is often known. Autism is the only sub-category of mental disorder (if it is such a thing at all), that benefits from its own legislation, the Autism Act 2009. It is worth remembering that autism is a spectrum condition, affecting many of us in a wide variety of ways and those who live with autism can be affected by particular stimuli and can be especially affected by the bright lights of strange behaviours of policing. Worth looking into in more detail, for certain and there is a good guide for CJ professionals on the National Autistic Society website.

MENTAL HEALTH LAW

I mentioned the lack of legal training in the training ideas – this is probably the single most important point in the training debate, for me. As police officers, we should be very aware of how our actions fit into the law of the land – more precisely, we should be aware of how our actions are determined by the law. I'm not just referring to the Mental Health Act, the Mental Capacity Act and to those parts of the Police and Criminal Evidence Act 1984 that affect investigation and custody; I am also referring to a proper understanding of Health & Safety Act 1974, the Human Rights Act 1998 and other *ad hoc* pieces of legislation that affect this Venn diagram from time to time.

You can turn me into a mental health nurse if you want to, but if I don't know whether or how the Mental Capacity Act 2005 is implemented when necessary, then it all amounts to very little. My ability to turn up to any operational incident and either assess whether someone is "within" the consideration of particular pathways and approaches because of mental disorder, but also that this possibility arises from a personality disorder is probably not as important as knowing how s136 of the Mental Health Act needs to work to ensure that people are kept safe and treated with dignity

after its use. It is probably more important that an officer executing a warrant issued to an AMHP under s135(1) knows the law around how the warrant is executed, what can and cannot be done, how the conveyance must occur once someone is detained – given that the officer will be accompanied by a doctor and an AMHP, to what extent does it matter that the officer could not explain the difference between Alzheimer's and dementia?

Of course, none of this means that officers should not be taught about autism or Alzheimer's – far from it. It is merely a question of extent and determining what purpose that depth of training services, not least because there is a reality to be acknowledged here: training time is finite. Most officers have had about 4hrs of training as a national requirement (it has since gone up) that was supplemented along the way with an e-learning package and whatever local training was deemed necessary. Not all areas deem local joint training to be necessary so even if we were to obtain a mandate for new training, what form would this training take and how long would it last – a day, or two? … a week?!

TWENTY EIGHT DAYS

Whatever your answer to the potential timescale, remember that form follows function and we need to get back to what we actually expect our police to *do* as a result of their training. It is not their role to diagnose particular conditions and there is a very strong argument that they couldn't do this even if we wanted them to – we know from decisions taken in police custody by mental health professionals that it is occasionally necessary to detain people in hospital for up to 28 days to get a full assessment of the particular condition someone may be experiencing and to understand fully the "nature or degree" of that condition. So what chance a police officer in an operational incident can work this out when the fifth most important thing on a list of important things may be whether someone or not someone is suffering form a mental health disorder and what that particular disorder may be?

The last time I dealt with an operational incident at work involving someone who was found to have a mental health problem, *all* of the key decisions required of me and of the police were done before it became important to understand his health history. *All of them.* The slower-time, detailed decisions around mental ill health were taken later in a controlled environment, involving medical professionals. By the time the next set of important police decisions was needed, officers' ability to distinguish this condition from that condition was not relevant or important because it had all been handled during a full assessment under the Mental Health Act. Once this was completed, it was back to legal decisions about whether or not diversion into the health system should take priority or whether it

would be necessary to prosecute the man. Officers allowed diversion whilst retaining the person on bail – the correct legal decision.

So here, I am putting an argument that some training on mental health conditions is needed – indeed, vital. We need an overview of functional and organic conditions, including affective, autistic spectrum and personality disorders – we need to know how risk and immediate care are affected by drugs and alcohol. Police officers need to know how this all relates to approaches and decisions that they may need to take focussing on difference, only where it is *necessary* to those conditions and the law. Beyond that, the need for training is about the legal framework that governs police operations as well as something on the underlying philosophy we expect officers to take when exercising those judgements: what, precisely, are we asking them to achieve and how?

I suspect this will have to fit into a training day – one seven hour day that contains coffee and lunch breaks, so we need to be prioritise the "need to know" from the "good to know" and this will involve tough decisions. My personal view for some whilst has been that we should be selecting a certain proportion of officers across 24/7 and neighbourhood policing functions and giving them substantially more training – perhaps 3-5 days. I can almost hear the reactions of some senior officers to that suggestion, but I'll be frank: I've been doing the same three-day public order training course every year for the last ten years or so and yet in that time I've had no mental health training.

With mental health related demands comprising twenty percent of policing demand, is that sustainable given that we are where we are with this?

***NB**: What's the next number in the sequence: 2, 4, 6 … ? If you thought "8", you're leaping to conclusions as it could equally be "10" and you ultimately don't have enough information to know.*

16th January 2014

Communication and De-escalation –

It is a common feature of feedback to the police that we need to get better at "communication" and "de-escalation". When one looks at incidents like the "Humberside Taser" incident or the "Manchester Handcuffs" incident, the importance of patience, prioritising dignity and using force "only as a last resort" are a regular features.

I have seen, including recently, some absolutely excellent examples of patient, communicative and supportive interventions by police officers, not predicated on the use of force. I have also seen examples where officers have been too quick to think of force as the method by which to resolve incidents involving high levels of resistance and violence. Let me give an example:

YOU MIGHT HAVE TO TASER HIM

I recall being asked to attend a medium secure unit some years ago to a patient who had assaulted staff and "torn the place apart". Upon our arrival, it wasn't hard to work out which way to head because there was a trail of physical destruction that took us to a room where the patient had barricaded himself in, although it had to be said this mainly consisted of posters ripped from notices boards.

Being a modern unit, it was fitted with anti-barricade doors so this wasn't a problem, it was more a case of working out what the staff were asking us to do, how the MH staff and police would work together to achieve this and how to approach it all. MH staff said, – NB, not "asked", but "said" – "we need you to restrain him and take him to the seclusion room so we can medicate him. You might have to taser him."

We did have two taser officers present at the incident. Visual assessment of the patient in the room showed a highly agitated man, physically imposing and obviously very strong whose demeanour was concerning in terms of how we might keep people safe. One of the taser officers even had their equipment out of the holster, before we'd decided how to approach it.

The seclusion room was only a short distance away and there were just enough officers there to ensure that we could block access to other rooms and corridors so that the only natural method of moving anywhere was to go where the staff wanted him to be. Everything seemed geared up for a use of force and given two assaults on staff, who were injured enough to have got out of the situation completely, some level of physical intervention would have potentially been justified. So we prepared and I heard officers and staff talking about "red-dotting" him, which means pointing the Taser at him and focussing the red-dot to induce compliance with instructions amidst a direct threat of the equipment being used.

At this point I said, "Right, we're going to ask you to open the door and we're going to talk to him, put your taser out of sight. If that fails, we'll escalate things, but not until." So we got several officers out of view and opened the door, calmly and reassuringly asking, "Jimmy, can you come this way, mate?" And he did. He walked to the seclusion room and we never touched him. Staff then administered medication, again without the police touching him at all, although we were right there in close proximity in case when staff got near him his demeanour changed. Then we left having spoken to the assaulted staff to handle that appropriately.

No force used at all – despite everyone being inclined to think it would be needed: the lesson here is to ensure you try the least restrictive approach.

DE-ESCALATION

I think police officers are better at "de-escalation" than we give them credit for and that we think about officers needing de-escalation training because the training we do provide doesn't normally use that particular term to describe or explain what we want them to do. De-escalation is a mental health related term, so the police mustn't do it, right? Well, possibly.

Police personal safety training could be argued to encourage an approach to the use of force where officers go into a situation, using force above the level of threat to make sure it's contained with minimal danger to the officers. But we all know that "tactical communications" is a golden thread running through all police use of force. In one training scenario I had during annual refresher training, the use of force was considered a fail, because the situation had been designed to mean that officers with sufficient persuasive communication skills would resolve it without force. I asked the trainers about this and the vast majority of people be tested on that situation recognised this fact and passed. And this was against three days of training using batons, handcuffs and CS spray where instinct tells you that all you're preparing yourself for in assessments is that you can show lawful, effective use of your equipment.

We all know that there are some police officers (and some mental health professionals!) who can wind up almost anyone without trying hard, but I also know some police officers that could sell snow to Eskimos. Far more of them, in fact.

So I've always thought the police are good at de-escalation generally speaking and when they put their minds to it, as above. I've also seen mental health professionals call for the police to use force and officers have declined, resolving difficult situations without any force at all, as above. This is not an argument that the police are always spot on, although I do receive feedback from mental health professionals of officers attending wards or MHA assessments in the community and being persuasive and patient, avoiding a need for restraint. It must be said, I've also seen paramedics, mental health nurses and AMHPs doing likewise during assessments or in police custody.

In this time of resources being somewhat scarce in all organisations, it is worth remembering that most professionals in out health and emergency services were selected for the task because the recruiting processes they succeed in and the training systems they were put through, thought they had the skills to be patient, responsible professionals, capable of judging these issues. Although culturally organisations may differ, they may call things by different names, most of us are trying to do the same thing so the issue is not so much about whether it is "the police" or "mental health nurses" who need more or better training, it will inevitably be that some professionals in all of these organisations need to remember to get that extra, patient mile in avoiding the use of force.

And you can call that whatever you want!

17th January 2014

Emergency Mental Health Law –

*Since writing this post, the response has been extremely positive from a range of professionals across those mentioned below. Various senior people have expressed an interest in thinking this through a bit further and regardless of where that goes, I have decided to produce a short-written guide which reflects the ideas below. Not sure what format that will take when it's finished as I'm still thinking it through, but such is the reaction to the idea below that it strikes me as worth doing something that fleshes out the bare idea and then see how others could make it into something useful, whether by internet or a short-course via an organisation. —— **watch this space!***

I have written another post on this idea, starting to flesh out some ideas and asking for feedback, please take a look at it and leave comments if you have any.

Michael./

I want to get together an "emergency mental health law" course. Something that could be up and running, by distance learning or e-learning that gives a CPD certificate – a basic standard of law knowledge that we can all agree is required by everyone who is engaged in this business. Don't groan at the distance learning idea – I want people to stick their heads in books and read stuff, the actual law and what the judges said. Not some "old sweat" PC or AMHPs view on what the judges might have or should have said. Back to the source material and *question* it. Question Everything!

It should be jointly badged by the relevant professional bodies like the Colleges of Policing and Paramedics as well as Social Work and Emergency Medicine, plus the Royal Colleges of Psychiatrists, Nurses and General Practitioners. It should be taken by frontline staff in all those professions, or at least made available to them – in my humble view.

It should have reference and quick-guide materials available, electronically and in hard-format for us on the road. I hereby copyright this idea and should register a business interest!?

And here's the big thing: I don't want anyone in that group arguing that they "don't need to know that!" This is also about achieving a joint-understanding of what other agencies can do, so whilst a psychiatrist may not, for example, need to know whether or not the police can force entry to a premises in particular circumstances in order to be an effective psychiatrist, they may need to know such things if their job takes them into the territory of requesting police actions in support of mental health processes. So for example, a s12 doctor or psychiatrist who undertakes Mental Health Act assessments may need to understand it – I've certainly found them willing to offer me legal advice about my legal duties, so it would be nice if that were grounded in legal knowledge.

No police officer needs to know the precise difference between s5(2) and s5(4) of the Mental Health Act, but they do need to know that section 5 can be used to detain patients in a hospital and they need to know that it can be used in acute hospitals as well as mental health units, but not in A&E. If I had a fiver for every time I've heard of officers telling A&E nurses that they "should have used section 5" ….

MAKING STUFF UP TO SUIT YOURSELF

This week, I will admit to having had my fill, quite honestly – police officers advising other cops they should illegally detain people by misapplying the Mental Capacity Act; mental health staff asking the police to illegally force entry to a premises without a warrant; staff misunderstanding that they can apply section 5 MHA to an informal patient who is in the hospital grounds and wants to leave against advice and who will be considered a high risk missing person if not prevented from leaving. It's really, really basic stuff. And it's not the getting it wrong that I necessarily mind: it's the confident certainty of people who are busy getting it wrong that I marvel at.

We expect police officers to know their stop and search law; their powers of arrest; their ability to use section 136 correctly. Why shouldn't we also expect them to know the essence of their powers of entry for mental health purposes? This week, "Inspector, we've got officers at an address searching for a missing patient, they think he's inside his home address can they force entry?" We should know this.

This post is not pointed at anyone group of professionals – we're all at it, for various reasons and we can think back to loads of other examples given in this blog where misunderstanding the law has got people into serious difficulties. You can be the best in the world within your profession, but if you don't know when you can or can't detain other people, when you can and can't force off their door or what your partner professionals can and can't do, you will struggle.

STATUTORY GUIDELINES CASE LAW

Legal knowledge needs to go just beyond the statutes as well – into the territory of case-law and knowledge of the significance of a Code of Practice. If you want to look hard enough, you will see the Code of Practice to the Mental Health Act being wilfully breached without worry, including at the organisational level and in many published joint policies that exist between the police and the NHS. (It does make me wonder what Trust and Police solicitors are checking when they approve these things.)

Every professional involved in this interface needs to know that the House of Lords (now the Supreme Court) has said you should follow the statutory guidance that Parliament has bothered to publish in a Codes of Practice unless you have "cogent reasons for departure." So if you are departing, what justification do you have? If none, you're in the wrong place, legally speaking.

Only this week a nurse has asked me about direction that is given in her hospital to informal patients. Despite being told upon admission "as an informal patient you are free to leave at any time. You do not need permission to leave but you are asked to notify staff of your intentions should you choose to go out" there is an informal practice of telling patients that they "can't go out" until seen by a doctor. I'm sure we can all think of sensible justifications for this approach, but what if the doctor is going to be a few hours until they can see the patient; what if they are not actually available until tomorrow morning? Are we preventing the patient from leaving because of that policy, or not?

We now have someone who wishes to exercise a legal right that they enjoy, to leave somewhere they are not obliged to remain and they are being prevented by policy – but that policy has to be enforced by a professional, in this case a mental health nurse. What law will that nurse rely upon to justify denying that patient the right to leave? I feel confident that few answers measure up against paragraph 21.36 of the Code of Practice, bearing in mind that the nurse could choose to use s5(4) MHA if they think the grounds are met. Why decide to detain and not apply s5(4)?

IMPLICATIONS

We also need to bear in mind further implications: what if the patient starts to become resistant or even aggressive to the nurse in question, perhaps attempting to force their way out of the hospital – is it not a lawful defence to false imprisonment to show that you merely used reasonable force to extricate oneself from unlawful detention? Yes it is. What if the nurse(s) uses force to keep the person there – on what lawful authority did you do so? None – so that's an assault.

I must be frank, if you locked me in a building and said I couldn't leave without explaining the legal basis of your decision, I would call the police and ask them to help me exercise my legal right to use appropriate force to extricate myself or my loved one – to which s3 of the Criminal Law Act 1967 applies.

WE NEED TO KNOW THE LAW – just sufficiently to apply it!

***UPDATE**: I have written another post on this idea, starting to flesh out some ideas and asking for feedback, please take a look at it and leave comments if you have any.*

RESOURCES —

- MHC mental health law page – *links to various websites containing legislation, codes of practice, etc..*
- MHC case law page – *direct hyperlinks to some of the main cases in policing / mental health*
- MHC "What Do All The Sections Mean?" – *a popular summary of the English / Welsh MHA sections.*

20th January 2014

The View From the Frontline –

I've never known what the "frontline" of policing really is, but I was asked last year to give a presentation on policing and mental health from that perspective. Given that my main role in the police is that of a 999 response inspector, it is actually the viewpoint I take from my work and so working on the theory that "frontline" means uniformed policing and police custody, I try to summarise that view in this blog.

I start by highlighting one thing that pervades my view now that I've done a lot of work on the police side of the interface between policing and mental health. Worry. I worry each and every day about this stuff, because I am confident in the knowledge that during a tour of duty, I could well be asked to become legally responsible for individuals with clinical needs that no junior doctor would manage without seeking support from more senior medical colleagues. And I worry precisely because I could be asked to manage such needs in a vacuum, without necessarily being able to engage the health service of this country. I start each day worrying whether I'll actually be able to see quickly as some of the more complex challenges present themselves and whether I will have the time and capacity as well as the strength and professionalism to consistently do what is required of me.

I worry about that, every single day I put on a uniform.

THE DILEMMA THAT IS NOT A DILEMMA AT ALL

It is my view from the frontline of policing that in order get through any working day that involves responding to mental health emergency incidents, I will be repeatedly required to *choose* between adhering to local policies and procedures; OR adhering to the law. I cannot always do both because the services that exist where I have worked are not set-up to deliver outcomes that are always consistent with the law. This is true of much of our country in many different aspects of the interface.

There is a constantly implicit expectation – it is very often made an explicit expectation – that I will put aside considerations made clear in law in order to deliver outcomes that suit the set-up of local services and procedures that are legally inadequate. It's important I provide examples: we know

that the humiliating and degrading condition into which the claimant from the MS v UK case deteriorated was a clear violation of his human rights, because the courts have ruled on it. And yet, where people are detained under mental health law by the police, there is often an expectation that vulnerable people in such a condition may be detained *ad infinitum* where beds don't exist for them or where services exercise exclusion criteria on their "Place of Safety." I have seen this and heard of it multiple times in 2013 and once had to threaten to take legal advice about the position in which the frontline police officers I was supervising were left.

I know that I have seen countless examples in both practice and policy of mental health professionals preferring that paragraphs 10.22 and 22.13 of the Code of Practice to the Mental Health Act didn't exist – but they do exist and the Munjaz case heard in the House of Lords (now the Supreme Court) reinforces how important it is that we adhere to these frameworks. The Lords ruled that the Code of Practice is not binding instruction, but it is statutory guidance with which we should comply unless there are "cogent reasons for departure." We know from other European case-law that not delivering upon someone's Convention rights cannot be defended by arguing "no money" or "not enough money."

If I do what the a local protocol says – if it exists at all, because joint protocols on required business have not been agreed everywhere that should have them – I may find myself in legal difficulty if untoward events occur; but if I try to give practical reality to the law as I've understood it, I may find myself in direct conflict with frontline professionals in other organisations whose managers have in effect assured them that the police will disregard the law for their convenience and their benefit.

So what will I do?!

Actually, this dilemma is not very hard at all because I've got a family to provide for and more importantly, I took an oath of office to uphold the law. So I would take on inter-agency conflict to the extent that it is necessary to show that I've done everything in my power to access healthcare for people who I think may be ill and in a sincere effort to deliver a lawful outcome. Whether or not I succeed, I then refer it to the appropriate managers to debate, resolve or ignore as they prefer.

DEFLECTED DEMANDS

It is my view from the frontline that mental health related demands placed upon both our mental health and broader health systems inappropriately deflect some of that demand to the police. This occurs even though the police would be quite unable to ensure such demand is adequately managed from either a clinical or legal point of view.

Too often assumptions are made about what police officers are capable of doing, both clinically and legally. I can't possibly tell you whether suicidal ideation by a mental health patient represents a high risk vulnerable person who needs safeguarding immediately, or whether the risks arising from certain behaviours or utterances are less serious than that. I can't do a mental state examination or a mini-mental state examination and even if I could do those things, mental health services sending me to such an event in a private home means I'm legally powerless to do anything anyway.

Parliament do not want me there, as things currently stand – they want AMHPs and doctors there and this is the reality of our mid-twentieth century law. The fact that we've revolutionised our mental health provision in the sixty or so years since it was written doesn't alter the fact that someone in a private home experiencing a sub-criminal or non-criminal mental health crisis is not someone they envisaged the police would deal with.

It is my view from the frontline, that the playing field of partnership working is not equal. And I say this, notwithstanding that there are many known short-comings in policing where officers and organisations fail to identify the policing and risk issues inherent within certain mental health incidents and take the necessary interventions, as required. For example, I know that some officers don't know how to approach the decision-making that is required when an incident involves a vulnerable person who could be arrested for a crime OR detained under the Mental Health Act. Which should they do? I've seen it many times that the police get this wrong and that means the view from the frontline is insufficiently influenced by proper training on mental health and associated legal issues.

My view from the frontline is entirely unclear about whether managers in all of the relevant organisations are spending enough time in rooms together. I know that in some areas of England, some or all of the four basic protocols required by the Code of Practice to the Mental Health Act don't exist and some that do exist are quite hilarious in their bias and their illegality. I reviewed this week on behalf of a front-line police officer in the north of England who reads this blog and was simply stunned that a formal governance process in a mental health trust AND a police force approved it for signature, bearing in mind that trust and force solicitors will have been asked to approve it. So I have to conclude, from the frontline, that the people who have to put our partnership structures together don't always fully understand what they're doing.

ARE WE MAKING THINGS WORSE?

My final view-point from the frontline, is that I worry we're just making things worse. It is not always clear to me that creating a situation where we call the police to psychiatric wards to restrain patients for medication

makes things better. How does having place of safety arrangements in place that send very distressed people to custodial environments make things better? I'm still to be convinced that the models of liaison and diversion for suspects in police custody are thought through sufficiently to represent a sound model that appropriately balances wellbeing and public interest.

We are seeing the start of many initiatives and improvements in this area: I just hope that they are properly evaluated by people who know what they're doing so we don't throw good money after bad. The amount of project money spent on liaison and diversion services that just fall flat on their face despite warnings that we do exactly that is depressing beyond words. And meanwhile, we know that some people end up unnecessarily criminalised because of it or diverted into a contact with a mental health system where there are good grounds to raise concerns about whether, at the population level at least, it is actually doing more harm than good.

The view from the frontline: there is LOADS of work to be done and when we do it we need to be wary of the "Do something" instinct that convinces us "this is something, so let's do this!"

22nd January 2014

I Need Your Help! –

Last week I published a post on an idea I've had for a while – an Emergency Mental Health Law course. I was really delighted by the response from the full range of professionals at whom the idea was aimed and I've also been contacted by some academics and senior people expressing interest in the idea and potentially thinking of what might be done to realise it.

I'd now like to ask for help —– I have started fleshing out some ideas of what such a course may involve in terms of legal issues. But obviously, this is just one policeman's view and if such a course is going to be useful to those in other professions I'd need a wider viewpoint!

In particular, I want to know what those of us who use mental health services think – what is it about issues around mental health law in urgent or emergency situations that you think professionals need to know? Perhaps based on experiences of where things were well handled or where it could have been better.

Remember(!), the point here is not just about issues a particular professional would want to know (more) about – it is also about coverage of issues affecting all the relevant professionals that you think others need to know about. This is about attempting to achieving greater consensus about the law, as well as an enhanced understanding of it.

PROPOSED OUTLINE

So the following ideas are outlines and initial thoughts only – I think I've spent about fifteen minutes putting this together (whilst watching tennis!) and I'd like any comments you have in the comments section below.

- **Principles of emergency mental health law** – human rights, health & safety, least restrictive principles, etc.. Section 1 MHA.
- **Emergency detention** – s136 MHA, s135(1) warrants, s18 AWOL patients inc revocations and recalls of CTO and s42 patients. Definition of a "place of safety".
- **Entry and Inspection** – warrants under s135(1) and s135(2) MHA, s17 PACE, s115 MHA

- **Mental Health Act admissions** – informal patients, s2, s3, s4 and s5; planning, preparation, s6 MHA, s135(1) warrants
- **Urgent deprivation of liberty** – emergency application of the Mental Capacity Act
- **Obstruction and the Criminal Law** – obstructions offences against police, AMHPs and emergency services; other offences under the Mental Health Act; offences of wilful neglect and misconduct in public office.
- **Liaison and Diversion** – assessment in police custody; prosecution decisions and links to MHA admission. Use of police bail during MHA admission.
- **Codes of Practice** – to the Mental Health Act (England / Wales) and the Police and Criminal Evidence Act

I'm sure there will be additional details that occur and contribution of your ideas is welcome below as well as feedback on whether I'm missing anything huge and obvious! If I am, I was writing this whilst watching MURRAY v FEDERER and will be sticking to that excuse!

Let me know your thoughts.

Michael./

23rd January 2014

Section 140 Mental Health Act –

Another blog that is long overdue, but it has come up recently in queries and other conversations, so it seems right to put this out now. As so many people haven't heard of or actually read section 140 of the Mental Health Act, I'm going to write it out in full —

"It shall be the duty of every Clinical Commissioning Group [England] and of every Local Health Board [Wales] to give notice to every local social services authority for an area wholly or partly comprised within the area of the CCG or LHB specifying the hospital or hospitals administered by or otherwise available to the CCG or LBH in which arrangements are from time to time in force. —
(a) for the reception of patients in cases of special urgency;
(b) for the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years."

So here's the breakdown — every CCG and LHB has a legal duty to specify hospitals to the AMHPs in their area(s) those hospitals which can receive patients in cases of special urgency and which has facilities suitable for under 18s.

In a strictly personal capacity, I recently submitted in excess of thirty Freedom of Information requests to CCGs asking for their "section 140 lists." Many of them replied in ways that didn't actually answer the question – several acknowledged that they had not specified any hospitals under this provision for either purpose and others either listed one or two locations in their area or just listed *every* hospital in their area. No-one who did specify a particular hospital, specified whether it was for purpose a) or purpose b).

One CCG were honest enough to just admit that they didn't understand the question! Something of a mixed bag of responses, to say the least when in reality it should be obvious there are only two possible replies:

1. **We have not specified any hospital** – presumably followed by some undertaking to correct this omission given it is enacted as a duty.

2. **Here is is a list of the hospitals we have specified** – presumably followed by a list which breaks down whether the hospital was specified for purpose a) or purpose b), above.

Richard JONES points out in his Mental Health Act manual (2013) that "this section does not oblige the specified hospitals to admit patients" and I have heard this said of all applications for admission. Of course in the wording of this section it does not say "and it will be the duty of such hospitals as are nominated under this section to admit patients when urgent applications are received" or similar words. There are many things not said in the Mental Health Act that are still a factual matter of law so I'm far from convinced that this ends the matter as finally as is sometimes suggested. If you can tolerate a small diversion –

The Police and Criminal Evidence Act 1984 governs the arrest and detention of people in police custody, which obviously includes arrested whilst actively resisting. To cater for scenarios in which people may be coerced because of resistance, it provides (in s117 PACE) that "where any provision of this Act confers a power on a constable … the officer may use reasonable force, if necessary, in the exercise of the power." So this covers powers of arrest, detention and search, etc.. The Mental Health Act 1983 contains no such wording at all, despite the fact that it is also concerned with detention and search as well as with more intimate and sensitive issues like enforced medication of patients. There is no MHA equivalent of s117 PACE.

Does this mean that professionals engaged in realising the provisions of the Act cannot use reasonable force? Of course not – it is clearly inferred without being explicit that force may be used and other guidance indicates this to be true, like the MHA Code of Practice and the MHA Reference Guide. This is why when I read section 140 MHA and see the language of "duty" upon CCGs it is very obviously an obligation and what would be the point of creating such a legal duty in the first place if it does not end up in a situation where realisation of its intentions is delivered in the real world?

Interesting that section 140 MHA is not mentioned, even once, in the Mental Health Act Code of Practice. Why do we think this is?

BREACHING SECTION 140

So what effect does specification under s140 have for those hospitals, if it creates no duty upon them at all, despite the duty to the CCG that some be specified? What consequence does it have for CCGs if the commissioning of services and the specification of certain hospitals translates in reality to no different method of managing them and no requirement, for example, to reserve certain beds and / or contingency

plans for those circumstances where s140 was envisaged to be of application?

I've always taken this section to directly infer, that those hospitals so specified have to have contingency plans in place for urgent admissions and of course, the providers of those hospitals should be discussing in contracting how that looks in reality and how they keep the necessary beds, infrastructure and staffing available to be able to realise an admission when indicated. It is the express will of Parliament that this is achieved, otherwise why did they bother legislating for this section at all?

In a public conference today, the Chief Executive of Birmingham and Solihull Mental Health Trust stated that as an indicator of pressure on the mental health system, he had checked bed occupancy in his trust and found that 475 out of 477 beds in his trust were occupied at midnight. He had a further 9 patients from Birmingham and Solihull in beds provided by other mental health trusts, out of area – some were a considerable distance away. Now I don't know what Birmingham CCGs think of section 140 or how they see it administered, because they were amongst the CCGs that didn't answer the question posed in my FoI requests.

But whichever way we look at this, section 140 could well be being breached. If the CCG has *not* specified any hospitals at all, then the legal "duty" referred to in s140 is not complied with – so who's policing that? If they *have* specified hospitals but in reality they are not managed in a way that gives effect to the implications of s140, is that not then an issue for the CCGs to manage with their chosen providers; and an issue for the CQC or NHS England to take up with providers and commissioners respectively?

Why in some areas are there no longer "arrangements in place" for these "cases of special urgency" despite what Parliament clearly intended in s140? An indicator that the implications of s140 generate more compulsion that appears accepted elsewhere seems clear from s39 of the Mental Health Act, which is remarkably similar. Section 39 falls within Part III, which is concerned with patients involved in criminal proceedings. This provision in full –

"Where a court is minded to make a hospital order or interim hospital order in respect of any person it may request— the CCG or LHB for the area in which that person resides or last resided … to furnish the court with such information as that CCG or LHB have or can reasonably obtain with respect to the hospital or hospitals (if any) in their area or elsewhere at which arrangements could be made for the admission of that person in pursuance of the order, and that CCG or LHB shall comply with any such request."

Again, the words "could be made" indicate that the details being furnished have to be capable of leading to the hospital making the order concerned. If the hospitals so mentioned are full, then they are not

hospitals at which "arrangements could be made". There is a level of obligation in this language, surely? The Care Quality Commission reference this provision as being in need of improvement on page of their 2012/13 monitoring report on the Mental Health Act

NIGHTMARES IN CUSTODY

The discussion about all of this most usually occurs when we are talking about a person arrested for an offence, admission to hospital under the MHA is indicated and there are no obvious beds available. I have blogged (twice!) before about this and won't repeat the point here. Suffice to say, that if one potential solution could be to consider a course of action that utilises plans that are in place "from time to time" in certain hospitals, it does rather call into question how implementation is being overseen and what challenges could be posed to CCGs and providers after difficulties in ensuring urgent admissions. Let us not forget, the mental health trust in the MS v UK case was found wanting for a human rights violation (article 3) arising from an inability to manage admissions. Arguably, between them and the CCG, they were in breach of section 140 MHA, also.

So hospitals presumably need to be managing beds in such a way as to mean they have contingency plans for high peaks of demand. Whether that means running at no more than 90% occupancy levels until "urgent admissions are indicated" or some other approach, is up to them to determine. We know from a range of media sources over the last six months or so how we've lost about 10% of inpatient psychiatric beds nationally and this is now giving rise to some patients, including some children, undertaking a journey of several hundred miles to be admitted. In some areas, they have lost half of their inpatient beds. (I still really enjoy the example of a MH trust who decommissioned beds to save £1.4m and subsequently had to spend £4.1m on out of area and private placements.)

But unless someone is going to "police" compliance with both section 140 and its implications, we are in a difficult position where it is quite possible the affected third parties, whether they be police services or Nearest Relatives could consider civil action against CCGs or providers where urgent admissions cannot be realised. They could, for example, challenged the lack of provision and or any lack of application by an AMHP for the want of effective s140 arrangements by judicial review. "Why are arrangements not in place for the reception of patients in cases of special urgency?"

This is what happened in Manchester in 2004 – the police service took the NHS to court, in order to safeguard the police officers involved from any suggestion of liability and arising from a failure to ensure admission to hospital after a man spent three days in custody. I would argue this situation happens several times a week in many police forces around the

country as we continue to see difficulties with bed availability. I also know of an example of a mother threatening legal action after her son spent 36hrs in a place of safety where admission was indicated after a few hours, but where failures to identify a bed led to suggestions that the boy be sent home despite open admissions from the professionals involved that it was not really an appropriate course of action. It was the potential of legal action which ensured that efforts to improvise a bed were re-doubled and something found. Let's just hope the solution wasn't the closure of the Place of Safety in order to improvise an area to which someone could be admitted – because the CQC had something to say about that last week, too.

Difficult issues – but they won't go away by us ignoring them and frontline professionals need to be especially wary of the liabilities that could befall them if they don't robustly challenge the sorts of positions where the inability to admit someone gives rise to other problems, like protracted detention in custody beyond the legal limits allowed.

24th January 2014

Mind: the Police and Mental Health –

In 2010 our leading mental health charity, Mind, published a guide on policing and mental health. It was a widely disseminated, well received document that highlighted issues for the public and for police officers in complex area of work.

So much has happened in the intervening few years, that it has been revised during the last few months of last year and the Mind guide (2014) has just been published on their website. This time, it is also approved by Victim Support after last year's groundbreaking report "At risk, yet dismissed."

I **strongly advise** all police officers to have a look through this booklet. I also recommend it to victims of crime and those who come into contact with the police in other ways, during crisis incidents or having been accused of offending.

There is suggested good practice from around the country in here – there is proper emphasis on the all-too-often misunderstood issues that affect those of us with mental health problems who have become victims of crime.

Please share it around as widely as you feel you can.

I'm especially grateful to Mind for the generous plug-in the document for this blog – it still remains a highlight of my life and an honour to have won the Mind digital media award in 2012 and for it to continue to be highlighted by them as a reference tool for operational officers and more widely is extremely rewarding for me personally.

www.mind.org.uk

29th January 2014

Monitoring the Mental Health Act –

Yesterday saw the publication of the 2012/13 report by the Care Quality Commission on the Monitoring the Mental Health Act. Here are just some headlines for you –

- The MHA was applied over 50,000 times **for the first time in history**.
- The number of people subject to the frameworks of the MHA is up 12% on the previous year, against a number of years where it is rising.
- There have now been over 19,000 Community Treatment Orders, with almost 4,500 in this reporting year.
- Only 83% of acute mental health wards and 76% of rehabilitation wards had sufficient staff to allow patients to take supervised leave.
- There were just under 22,000 detentions under section 136 MHA – this is down 7% on the previous year.
- Of those 22,000 section 136 detentions, 7,500 were removed to police custody as a place of safety – this is just over one third of all detentions.

The report itself is well worth reading, there are also various easy access formats available on the CQC website.

All of the CQC reports are available on my blog if you want to look at other trends, etc.. There is much in there that could be focussed upon in this year's report, but I want to highlight just two things. This is why I'd encourage you to read the thing for yourself, as there is much of interest that I haven't got space to cover here – although maybe I'll do a subsequent post, who knows?!

POLICE USE OF SECTION 136

The figure being thrown around on Twitter is 17%, often just after the word "only" in italics, capitals or with some other emphasis. Just 17% of people detained by the police under s136 MHA are subsequently admitted to hospital and this is down 1% from the previous year. It means that one in six people detained are admitted. The data we have, as collected, doesn't allow us to know for certain how many people detained s136 were released

without follow up (although some areas write to everyone's GPs that section 136 was used.) The inference always is that 17% or 18% is quite low and there are a few things to say about this.

Certainly, the figure has reduced massively in the last five years, as the use of section 136 has increased. In 2007/08 the percentage of patients subsequently admitted after assessment was 29%. As the use of section 136 has gone up, the number of people admitted has remain, roughly speaking, the same – hence the overall percentage has dropped. From figures in particular areas, I know the higher use of section 136 is associated with higher numbers of people who need little follow up and so this all gives rise to questions about how the police use this power in the first place. Is it appropriate?

On the one hand: officers are not mental health professionals so are not making diagnostic judgements when they are decided whether they think someone is "suffering from a mental disorder and in immediate need of care or control." On the other, officers should be thinking carefully about whether it is *necessary*, strictly speaking to detain someone at all and if so, whether this is the appropriate power by which to do so.

The previous Code of Practice to the Mental Health Act (1999) always used to make it explicit that section 136 should not be considered a substitute for the use of other powers. This phrase was taken out of the current Code of Practice which is being updated and I already know that some have put forwarded the idea that it should be re-instated. I think it should be put back as it links to how s136 is used in two key scenarios that I argue affects overall (mis)usage –

- **If someone is drunk in a public place and officers are querying mental ill-health, should they detain s136 MHA or for alcohol-related public order offences?** – assuming a situation where the police feel they cannot avoid some form of detention. After spending hours and hours debating this with all kinds of professionals, I come down to this viewpoint: officers should assess whether they think someone they might detain or arrest is capable of being described in law as "drunk". If they are, stay clear mental health legislation unless there is objective, third-party or documented information that person lives with a mental health disorder. If they do, then section 136 is in play and may add certain benefits to safeguarding the person, once sober.
- **If someone has committed a substantive offence, like any kind of assault, theft or damage, should they be arrested for the offence or detained under s136?** – again, after much discussion about public protection and public interest, including how to balance off people's right to treatment, dignity and care with broader considerations, I come back to this: the presumption should be an arrest for the offence *unless* – the offence is victimless or trivial; if

the person reporting more focussed on getting help or support for someone and in all the circumstances it looks and feels more like a mental health

CONCERNS AND FRUSTRATIONS

Once you've spent hours with mental health nurses, AMHP and others, this sort of approach seems to balance off everyone's concerns. It also seems to account for everyone's frustrations. We could probably all agree – we don't really want the police arresting people for public order offences or possession of small amounts of cannabis when officers have been called by family members to a distressed relative experiencing psychosis in the road outside their house. We also don't want individuals who are alleged to have committed very serious offences indeed, detained under the Mental Health Act without consideration of a full investigation and prosecution. We don't want section 136 suites full of drunk people, but nor do we want detainees excluded from assessment and purely because they've consumed a tolerable amount of alcohol.

And we have to acknowledge that this will involve tolerating judgements by others that we may not take: it is up to the police to decide what to arrest for, but it is difficult for a mental health nurse to understand why yet another drunk person is being brought to the 136 suite if there's no real belief that they have a mental health disorder or background. Whilst it is up to the PoS staff to decide whether someone is going to be allowed in for assessment, it is fairly difficult for police officers to understand why someone is excluded to a cell block if they've consumed an amount of alcohol that would still render it legal for them to drive a car.

All professionals need to see the catch-22 that is generated here:

- Police misuse or abuse of s136 leads to NHS areas developing tactics to cope with high levels of inappropriate demand. We see this in the form of exclusion criteria at PoS facilities, disinclinations in A&E departments and other resistances. Put simply: in some areas, just some of the time, NHS staff think the police are "taking the Michael." So we need to use section 136 far less, in a more targeted way and use other powers of detention more often, even where there may be some MH concerns in the background.
- NHS staff need to see, that officers have very legitimate reasons for sometimes detaining very drunk, sometimes resistant people under the MHA and need to be appropriately supported in clinical risk management that is way outside the scope of their first-aid certificate. This applies to A&E departments where it will sometimes be appropriate to go, as well as to PoS facilities in other locations, like MH units. We need to see the under lying emergencies and

human rights challenges in some cases and appreciate the legal context within which police officers are operating.

We need to learn more about each other's perspective! #timetotalk

SECTION 140 MENTAL HEALTH ACT

I was particularly delighted with the level of focus in this report on section 140 of the Mental Health Act. Having only blogged about it last week, I read the various remarks in this year's document with a broad smile on my face. If you can tolerate an explanation as to why: I first read about and raised the issue of section 140 to health professionals in my local area in 2006.

It always struck me as a piece of law that was largely ignored, disregarded or simply not known and understood – various health professionals have told me over the years that it is a "red herring" and that it "lacks teeth" etc., etc., and my attempts to suggest that it implied obligations and imperatives on Primary Care Trusts, as they were called at the time, fell on deaf ears.

In fact, when I have referred to being laughed at and patronised early on in my work on policing and mental health, it was with regard to s140 that some of this occurred. It also occured during 2013 when discussing it in a forum or two. Like any legislation: it is only going to be effective if those it affects are willing to comply with it or if it is properly policed. It has always struck me as a piece legislation that is neither of those things, hence CQC attention to it today is very welcome. It also partially vindicates some of the things I've said for years, which have been ignored so *that* is why I have been smiling broadly.

I won't repeat my recent blog except to say this: there is debate amongst professionals about what it represents. The CQC took over the legal responsibility for overseeing the MHA from the old Mental Health Act Commission which offered advice to the professionals that we now call AMHPs as to how to deal with situations where applications for admission are indicated but they cannot be realised for the want of a bed. The MHAC advised a course of action which Professor Richard JONES describes as being of "doubtful legality" in his Mental Health Act Manual. Of course, the MHAC themselves took legal opinion from counsel before publishing that advice and it obviously conflicts with Professor JONES's view.

That's OK: that's what we have courts for. It has been my unhappy pleasure to inform a couple of AMHPs and DRs that their inability to realise a bed for admission is giving rise to illegalities that will need to be challenged in court and legal action has been threatened to protect

vulnerable from languishing in custody (like MS v UK) and to protect custody sergeants and police forces from very real liabilities.

SECTION 140 CONTINGENCY PLANS

This is all about NHS commissioning with contingency plans – I have written before about attitudes towards the use of capacity in policing and mental health, highlighting a different attitude. Last night at work, I started the shift with a custody block that was 75% full and I was nervous about whether we would end up with new prisoners from incidents displaced around the force area. 25% spare capacity is not much to play with when I know that in some NIGHT shifts we can arrest enough people to more than half fill our custody area. I was fully vindicated in my fears, because we were full by 1am and displacing prisoners elsewhere.

If we put this really simply: section 140 MHA implies (to me, at least) that CCGs have to commission services in such a way as certain units in their areas maintain empty capacity so that they can still admit urgent cases when they arise, above and beyond predictable levels of demand. Running wards at 98% capacity and above, means you will never, ever have sufficient slack to manage unpredicted demands. It should also be borne in mind that this will probably need to apply to a range of kinds of inpatient beds from acute admissions, to psychiatric intensive care units and within the medium secure estate. This also has to apply to gender specific admissions pathways and to age appropriate accommodation – it is *always* going to be harder in specialist services where overall beds numbers are fewer.

Is this realistic? Many NHS managers seem to think it isn't and disregard it on that basis; either wifully or by omission. All I will say is that public services have a clear legal duty to do many things that should not be needed very often, that involve rare elements of complexity – this includes your Chief Constable planning and preparing for riots, child abductions and armed sieges, even though they are thankfully rare events. In no-way, shape or form, is it acceptable for the Chief Constable to disregard these legal and operational realities. The same applies to NHS services because in this particular instance, Parliament has legislated and we learn from this report that many CCGs are ignoring the will of our elected Parliament and that 87% of surveyed AMHPs do not know what their local "cases of special urgency" provision is.

I am aware that two police forces are putting this omission on a more formal footing by giving CCGs and providers formal notice that there can be no expectation that police forces will illegally hold patients in detention, because of a failure to prepare for the implications of this legislation. As such, the CQC highlighting it seems timely and welcome.

29th January 2014

How To Use This Blog –

A short, somewhat functional post in order to increase ease of navigation around this (ever-expanding!) site. There are numerous ways of looking for different things on this blog and certain parts of it may be more relevant to some people than others. As such you can think about the following things and the links will take you to relevant parts that narrow down to material more likely to be of interest.

- **A general search** – top right corner of the page you're reading and on every page of the blog is a "search box". Just enter the thing you're looking for, like "section 42 Mental Health act" or "taser" or "prosecution". Every blog I've written that touches on your search criteria will be shown, starting with the most recent blog and getting increasingly historic.

- **The full index** – a list of almost every post I've ever written, broken down by different categories like "Section 136 MHA" or "Prosecution of Offenders". Each link under those headings is a blog I've written on that subject. The index is in the process of being revamped so it's even easier to use than very long list of posts.

- **The Quick Guides** – specifically intended for operational 999 staff or mental health professionals, it is something of a functional summary of "Emergency Mental Health Law". Each of them is formatted as punch bullet-points, summarising most things in fewer than three hundred words. If there is a need for further topics summarised in this form, let me know on mentalhealthcop@live.co.uk

- **The Paramedics Series** – specifically intended to help the interface between these two emergency services. In addition to covering operational and practical expectations of each service as they call upon the other, there is coverage of the legal issues at play, including offences against emergency services and the application of the Mental Capacity Act.

- **Mental Health Nursing** (*in development*) – specifically intended to help the interface between policing and mental health nurses in all the areas where they overlap: section 136, inpatient offending, supporting models of community care and crisis intervention. *(This should be up and running by April 2014.)*

- **Reference Materials** – all contained with the tool bar that runs across the top of the blog. The page on Mental Health Law contains links to legislation, codes of practice and to the court transcripts of particularly relevant stated cases; the page on MH & CJ Resources contains links to guidance published by government, by professionals colleges and bodies as well as charities.

31st January 2014

Social Work and a Spot of Psychiatry –

I won't lie: you often hear cops grumbling about being "social workers". This usually accompanies tasks that are not seen as "real police work" (whatever *that* is) and any analysis of policework is going to have to address this extent to which policing is predominantly not about crime. Even where it does involve crime, it is not predominantly about law and enforcement, despite the popular myths.

So if the police are busy not enforcing the criminal law and attending to crime by bringing offenders to book, what do they actually do all day? The Economist seemed surprised to find that it involved "social work, relationship counselling and a spot of psychiatry." We've known this since the beginning of policing. It's absolutely nothing new.

OFFICER, WHAT DO YOU DO ALL DAY?

There probably isn't a police officer in the land that hasn't offered marital and financial advice, who hasn't sat with someone at the lowest point in their lives and held their hand, listening. Most of us have assumed responsibility for people who are likely to cause themselves harm and so there are various reinforcements as to why a complaint is made that we are *de facto* social workers, therapists and psychiatrists. We do see out of hours social services deflecting demand to the police that is better managed by them in the ideal world I don't live in. We know that some of this demand is deflected *purely* because of other agencies' inability to service it. Many of these tasks do not *need* a police officer, strictly speaking, either for legal or any other reason. So we see the requests for "safe and well checks" on the elderly or children who may be at risk, just as we see those same requests coming from mental health crisis teams, who have in some instances decided (without reference to the police on whom such duties then fall) that they will no longer undertake any work at all that isn't situated in A&E or police custody. And if this work *could* be done by social services or mental health crisis teams, even if it *should* be done by social services or mental health teams, does this not mean that I'm becoming a social worker if I'm doing tasks that more properly sit with them?

Of course it doesn't – although there is a difference between the police going to an address where it is necessary to prevent a breach of the peace

and with a view to using powers under the Children Act 1989 that only the police have, and going to an address just to do a kind of check-up that any competent professional could undertake whether that be a social worker, a police officer or a teacher. But it is not that difference that defines policework. Most police work involves the police doing a multitude of tasks that many professions and individual citizens could do. So it has to be something else that defines it.

This moves us on to the need to do "a spot of psychiatry". I don't recall doing a medical degree or ten years of post-graduate training and qualification, but here I am, called upon in the middle of the night to make certain kinds of medical decision. Often without the ability to get any support from the health system about whether someone's presentation should be triggering alarm bells of a particular volume, I am expected to discern criminal and behavioural issues from medical and mental health ones. (As if those things are in any way discreet entities!) I've sometimes had to decide on healthcare pathways for people with medical needs I haven't got the first clue about, in circumstances where the decision may have long-standing medical (and legal!) consequences. The role of police officers in responding to incidents involving mental ill-health has been noted for fifty years in policing research, going back as far Egon BITTNER in the 1960s. Very memorably for the purposes of this post, US academic Linda TEPLIN referred to police officers in the title of one of her pieces in the 1990s as "Street Corner Psychiatrists." I suppose, in fairness to the proposition, I should admit possession of a copy of the Oxford Handbook of "Emergencies in Psychiatry" in my collection. (It's always best to know thine enemy!)

On the other hand, we know that the political vision of policing at the current time is that we should "reduce crime: nothing more, nothing less" and we keep hearing the rhetoric about "single-minded crime fighters." This was always going to jar with reality. The very body of policing research that I referred is replete with findings that crime plays only a very small part of the overall demand faced by the police – and that crime may actually not be the most important thing to the public anyway.

READING THE CHILDREN ACT

I reflect upon the last month at work and can recall many, many conversations with members of the public about legal and social issues that were absolutely nothing to do with the police and / or the criminal law. A particularly rewarding hour was spent with a woman and her 16yr old daughter discussing the Children Act because of ongoing dispute with her ex-husband about access to her younger daughter, whom Dad had not returned as per their court agreement. Not unnaturally, the woman thought, "He's breaking the court order" and she phoned her solicitor. The

solicitor said, "You need to go to the police and tell them it's their duty to go and find the girl and return her to you." So even less unnaturally, she came to the police and didn't fully understand why front office staff told her that the issue was not a police matter and she should contact a solicitor. Surely solicitors know more about the law than the police? Not always. Suffice to say, that by the end of the hour, I'd convinced her that we wanted to be as helpful as we could possibly be despite having no legal authority in her situation and having quickly reminded myself of parts of the Children Act that don't feature in police training – because they don't affect the police – I gave her references to the law, some practical advice and off she went armed with the right information to take the issues forward. She even rang me the next day to thank me and tell me how it had worked and that her daughter was back, safe and well. She would address the longer-term problem via the courts and her solicitor.

Not police work. Not even social work. Just advice to the public, hopefully helpful.

I've never seen those parts of policing that are connected to social care and family law processes as "social work". I don't see those parts of policing that are connected to mental health as "a spot of psychiatry." To go back to BITTNER, whose sociology and criminology I admire, policing is what happens when *"something's happening that ought not to be happening about which someone ought to do something NOW!"* It is the word 'NOW!' that defines policing, regardless of how we got here. If someone needs access to mental health services and they somehow come into contact with the police, officers don't usually detain that person under the Mental Health Act – they don't even do it very often. Far more likely, the officer will give advice or support, sign-posting them to people who can help, contacting those people on behalf of the person or enabling access to relevant services, possibly via the ambulance service or A&E. This is quite correct – just like officers have to judge whether a dispute about the sale of goods is a civil matter where people are sign-posted to the Citizen's Advice Bureau or a solicitor; or whether it has involved a deception and become a fraud.

Other academics like WADDINGTON have characterised policing as "order maintenance." Your mental health emergency can be sign-posted or referred where it is unconnected to any form of social disorder where you are threatened or threatening. Once that social disorder threshold is passed – irrespective of whether that constitutes an offence – officers are expected to start intervening. This may involve starting to think in terms of detention to ensure the restoration or "order", but sometimes we influence outcomes by just talking to people.

DOING EVERYONE ELSE'S WORK

Police officers sometimes clear up debris after a road collision – we don't make the road immaculate and take the detritus to the tip, we just shift it to the side of the road so no more accidents will happen. Once that is achieved, the actual clear up of broken cars and road furniture, the proper repair of the road and it's accoutrements as well as disposal of it all is a matter for the local authority who we contact. This initial shifting of the debris is not local authority work – it's policework because it needs to happen NOW! and is connected to the maintenance of safety and order (on the roads).

Police officers sometime help people shift their furniture upstairs when they are about to be flooded – we don't stop doing more important things than that when lives are at risk, but where officers are free in circumstances of social emergency, they have been known to muck in.

That's why police officers sometimes agree to move mental health patients from one place to another, despite guidance saying that the ambulance service or mental health services should do it. Agreeing to muck in, might mean that we prevent the patient going missing for the fourth time in two days and the investment of a couple of cops doing a twenty-minute job might mean we save hours and hours of police time in preventing further absences by a patient clearly unable to be contained in the place he is currently detained. I have been known to say "No" to requests to move people, because saying no is sometimes without consequence to the police and the public at a time when other 999 demands mean I can't spare the resources. But last week, I proactively offered help when no request was made, because it was in the interests of the public at a point where I could spare two cops for twenty minutes.

"Something's happening that ought not to be happening about which someone ought to do something NOW!"

A definition of policework which means I might get to do any number of things that might be better done by others and which falls squarely under their remit. It's just that they're not here, for whatever good or bad reason. Everything that the police do is necessary because somebody, somewhere either isn't able or willing, they aren't competent or responsible, but most usually they are just not there, for whatever reason. Whilst you're busy debating it all, this thing it still needs doing NOW, because it contributes to social order and social safety – and that means it's down to the police, more often than not.

FEBRUARY 2014

5th February 2014

Not Guilty By Reason Of Insanity –

It's not very often at all, that I could highlight the use of an insanity defence. They are comparatively, very rare indeed. You will probably recall the incident at a Birmingham mosque in June of last year where a man stabbed worshippers before turning on the police officers who answered the 999 call and were on scene within four minutes of it being made. PC Adam KOCH (*left*) rightly received praise from senior officers and across the community after he continued in his efforts to detain Mohamoud ELMI after he had been stabbed.

PC KOCH was very humble following the incident, offering his thanks and his praise to those present at the mosque in their efforts to assist to detain the offender and in assisting him pending the arrival of paramedics. If you look at the West Midlands Police press release issued yesterday, there are various photos and links to help you better understand the incident and hear the officer himself describe the incident. There is also an interview with the East Birmingham Policing commander, Chief Superintendent Alex MURRAY. I'm sure we're all glad that PC KOCH has returned to health and is back at work doing the job that we can all see the man clearly loves. I've never met him, but it's my privilege to supervise young, keen police officers just like him, working hard to keep us all safe and I'm sure we're glad he's back at it.

Here's the briefest of summaries of the legal issues involved, with links to other blogs that cover the topics in more depth —

NOT GUILTY OF ATTEMPTED MURDER

Yesterday, Mr ELMI pleaded not guilty to two counts of attempted murder on the grounds on insanity. This was a legal issue that was given to the jury and they took two days to consider the evidence of potential insanity. It again goes to show, that insanity is a *legal* issue, not a medical one – regardless of the opinion of forensic psychiatrists in this case, the question of whether Mr ELMI was insane was entrusted to twelve men and women from the community in which this event occured who are not bound to find grounds for an insanity defence satisfied.

In the end, they ruled that it was and the defendant was given the only outcome that court was likely to given – a restricted hospital order. This ensures indefinite detention in a secure hospital after the jury ruled that his actions did amount of offences of attempted murder and unlawful wounding. In other words, he "did the acts" of which he was accused – he stabbed the victims – but not fully responsible in law, because he was —

- Suffering from a "defect of reason"; AND
- Owing to "disease of the mind";
- Did not know the nature and quality of the act; OR
- Did not know that what he was doing was wrong.

Some people charged with serious offences choose not to put forward an insanity defence because in some cases, the outcome will be more serious for them than other likely outcomes. It does not follow that everyone suffering from even a serious mental disorder will be legally insane and it is interesting to contrast this case with that in London of Christopher HAUGHTON who was fully convicted of stabbing police officers whilst seriously mentally ill. He was tried and sentenced to a restricted hospital order having been fully convicted of the offences, despite his illness.

However here, charges of attempted murder were always likely to lead to significant sentences, if proved and he has entered an insanity defence after pleading not guilty. It means Mr ELMI will be subject to a restricted hospital order which ensures ongoing detention until such time as the clinicians in a medium secure unit and the Ministry of Justice are satisfied that it is proper to discharge him. Once released, he will remain subject to conditional discharge which ensures he can be quickly returned to hospital if necessary and will become subject to multi-agency supervision through local Multi-Agency Public Protection Arrangements. But all of that is long way off yet.

5th February 2014

Ignorance Is No Excuse –

I went to a job today where a man had been seriously injured in a car crash. He was trapped in the vehicle and his leg was partially crushed, preventing him from being easily removed. We could tell he was bleeding and in a lot of pain and after the provision of some reassurance and some first-aid, officers gave way to the paramedics who turned up.

The fire brigade also emerged to start trying to extract him from the car. As we started trying to piece together what had happened, I couldn't help but notice that the victim was screaming in some distress. The paramedic was talking to him and being very reassuring, but I noticed that she wasn't administering any kind of pain relief to this man.

As the bloke was making a horrible noise, I felt it was appropriate to ask if she intended to give him something for the pain? She opened up her kit bag and I couldn't believe what I saw next: she pulled out what seemed to be IV morphine and started explaining she was going to get a cannula into his arm to administer it. I know that paramedics carry different kinds of pain medication and it seemed really obvious to me that she should have been giving him IV paracetamol – morphine can have various fatal side effects, can't it? So again, I felt I should say so. What I didn't know was the patient had already explained to her whilst I was busy with something else, that he was allergic to paracetamol and so to my utter amazement, she disregarded my advice and did her own thing! Unbelievable – I've got a few friends who are paramedics. I've even read some of their clinical guidelines and done a few lectures on mental health law on some of their university courses.

Of course the above three paragraphs are **utter nonsense** – I'm sure you worked that out prior to here! *Of course*, I did not go to a road collision and tell a paramedic which drugs to administer to a patient in pain. I wouldn't dream of doing so, as I would predict being told where to stick my traffic ccone and it would be altogether quite ridiculous, woudn't it? I'm hoping you questioned it and wondered what the hell I thought I was doing! I'm also trying to imagine the disciplinary hearing at the Health and Care Professions Council where the paramedic was facing gross misconduct charges after administering a drug they knew would be inappropriate which had caused serious damage to the patient and saying, "But a police officer at the scene said he thought IV paracetamol would be better!"

It wouldn't get off the ground, would it?!

ONCE UPON A TIME

Guess what happened? The complete reverse happened, some months ago now. Police officers were called to a house by a man who had indicated he was intent on harming himself. Upon arrival, the man answered the door by opening it slightly and appeared distressed. When the door was fully open, he was holding a kitchen knife in the hallway of his house and pointing it at officers as he backed away, making threats to harm himself. Officers entered the building and having used a taser to control the situation, detained the man in handcuffs to prevent a breach of the peace which they feared was imminent.

The ambulance had been called early in the process and paramedics entered the situation once the man was handcuffed. Attempts to engage him were futile, he appeared to be highly agitated and suffering from some form of mental health disorder. The paramedic felt he needed to be checked out at A&E because of high skin temperature, possible head injury and the after effects of being tasered. He'd also consumed some alcohol. The paramedic also had one other view: **the man should be detained under section 136 of the Mental Health Act**.

All I can say to that, is you're entitled to your opinion!?

This is where it gets messy: the officers duly obliged! They did *exactly* what Lady Justice HALE said you can't do during her judgement in the case of Seal v Chief Constable of South Wales Police [2005] – she stated that by removing someone from a premises having apprehend a breach of the peace and then by applying section 136, the officers acted **illegally**. You *cannot* lawfully detain someone in a house, remove them to the street and *then* detain them under the Mental Health Act. **You just can't!** In no way, shape or form can that be said to involve someone who was "found in a place to which the public have access."

And if you find yourself getting questioned, grilled or investigated over allegations of unlawful arrest, you certainly cannot say, "The paramedic said we should do it because he needed Mental Health Act assessment!" It just is nothing like sufficient to pass responsibility for legal decisions to an unqualified, untrained professional from another organisation and hope it will provide you with an element of protection. So the punchline of this post is —

YOU NEED TO KNOW YOUR LAW!

You *really* need to know it – and you have to take responsibility for the legal decisions that you take. As the police often say to the public when investigating allegations of crime, ignorance of the law is no excuse. It may be fair to say that legal training in emergency mental health law is inadequate. It may also be fair to say that the incident being policed was a private premises situation where the Mental Health Act does not apply and where resolution to incidents can be difficult. But given the imminence of someone who may well hurt the officers having pointed a knife at them, you can justify the legal detention and removal to custody of such a person in any number of ways.

It was said to me by an inspector on my second day in the police: you need to know your law, because knowledge is confidence and confidence gives you authority. This is why I've faced this very request numerous times in my career and just said, "No!" before proceeding to try for another solution. I recently refused to illegally force entry without a warrant to a patient's house, too. There are numerous resources kicking around on mental health law, many of them on this blog or linked via it. If you haven't ever read the parts of the Mental Health Act that apply to the police, or read through the stated cases that are key to operational decision-making, take a couple of hours to do so. Pick a NIGHT shift or a Sunday morning on EARLIES and spend a few hours that represents an investment.

In particular, try to digest the "Part II" and "Part X" of a my short summary of the MHA. And see a short post which amounts to a knowledge check – the latter contains links to things you might want to read more about. And don't forget, you can also bookmark on a smartphone these "Quick Guides" to a range of different operational situations – there really isn't an excuse!

Because I will be honest: when I hear of officers using section 136 in a private premises I just think, "How ridiculous – it's well-known to be illegal and highly inappropriate. There is just no excuse for it under any circumstances." Just read back the first three paragraphs and remember how ridiculous it sounded – a police officer telling a paramedic which drugs to administer. Well, the same applies to legally detaining people – it is ultimately a matter for the police, having heard whatever opinions might be floating around at the time.

And the same applies to decisions *not* to detain people – it is, *ultimately*, a matter for the police.

CASE LAW BLITZ —

- D'Souza v DPP (1992) – you need a s135(2) warrant in order to force entry to a premises to detain or redetain a person under the MHA, unless s17 PACE applies.

- Syed v DPP (2010) – you cannot force entry to a premises because of a concern for someone's welfare. Officers need to have reasonable grounds to believe that life or limb is, literally, at risk.

- Seal v Chief Constable of South Wales Police (2007) – incidental judgement that arrests under the MHA are unlawful if they follow people being removed against their will from a dwelling to a public place under other provisions in order to then be detained under s136.

9th February 2014

Clinical and Security Risks –

Imagine the scenario —

A person is detained by the police under the Mental Health Act and removed to an Accident & Emergency department because of injury or illness that prevents them being taken anywhere else. Following assessment of that condition in A&E it is decided that they need to be admitted to the acute hospital for medical or surgical treatment of their condition. This could be for any number of reasons:

Let's imagine various situations —

Perhaps after detention by the police it is thought that they have taken an overdose of a kind that puts their broader physical health at risk and blood tests in A&E confirm this. Perhaps they were detained and complained of chest pains, necessitating observations in a cardiology ward. There are any number of situations, including head injuries, broken limbs, and problems connected to all manner of medical situations where admission may be indicated.

So far, I have deliberately not specified under which particular mental health law the police were acting when they detained the person.

It could have been —

- **Section 136 Mental Health Act** – to detain someone at the instigation of the police who is in immediate need of immediate care or control and removal to "a place of safety".
- **Section 18 Mental Health Act** – to detain someone who is absent without leave from hospital, either because they have left the hospital without appropriate permissions OR because they have failed to return to hospital when required to do so.
- **Section 135(1) Mental Health Act** – to remove someone from a dwelling to a place of safety for assessment, but following execution of the warrant of detention, it is thought best that someone is checked out in A&E.
- **Section 138 Mental Health Act** – to detain someone who is liable to admitted to hospital under the Act or who has absconded from "a place of safety" or whilst *en route* to it.

What happens if that person then needs admission as an inpatient to hospital? These legal powers have started, certain duties exist to be fulfilled but are being halted by this diversion into acute care.

What do we do about that original objective?

Of course, most people take to A&E are triaged and seen in a relatively short period of time, without being admitted to a ward as an inpatient. It is comparatively very few of us that require hospital admission. Of course, such admission cannot be forced upon a person purely by virtue of their having been detained by the police under the MHA. Three out of those scenarios above do not (yet) involve patients who are fully admitted to hospital under the Mental Health Act and in any event, the Act cannot always be used to force patients to have treatment for medical conditions and injuries. So if the patient in our vignette had badly broken their arm to an extent that it may require an orthopaedic operation, they cannot be automatically forced to have it without their consent.

HOSPITAL ADMISSION

If a person is admitted to hospital, following our scenario above, it will most usually occur because they have consented to that admission. In a minority of situations it will be because full assessment under the MHA has concluded that admission criteria are met and because the psychiatric assessment is that Treatment Without Consent provisions (contained within Part IV of the MHA) allow that physical / surgical problem to be treated under the MHA.

When that admission occurs, what happens to the originating power of detention and its original objective? —

Following s135(1), s136 and some situations in s138, the purpose is to ensure that a person is seen by a DR and an AMHP for assessment and this could happen on a medical ward, if need be. Such assessment may or may not lead to an application for admission to hospital and that application could be made to a medical or surgical ward. Following detention under s18 and certain other situations under s138 it is to return the person to the mental health unit from which they are missing or within which they are legally liable to be detained.

How do we handle the period whilst the person is still subject to those original laws where they have also consented to admission to a medical or surgical ward? — specifically, are the police obliged to remain in situ, in that hospital whilst medical / surgical treatment is undertaken, pending the person being assessed under the MHA or returned to the mental health unit in which they are liable to be detained?

The first thing to say is, **there is no single answer** to this situation. The rest of this post is devoted to pushing back against an understandable instinct to make it simple by saying that the police should just stay and sort it out. The second thing to say, is that **the NHS does not have one answer** on this, either. Practice varies from hospital to hospital, sometimes from professional to professional and answers are offered on the basis of what the NHS believes the law to be, others predicted upon hospital policy. As I have written before, these are not always the same thing and they vary (considerably!) from place to place.

HEADLINES AND PUNCHLINES

Having given away the punchline early on – that there is no answer, specifically – it therefore needs to be considered in local policy and procedure, which the Mental Health Act Code of Practice requires be agreed between the Chief Constable and the relevant health bodies.

You could point out the following —

1. Acute hospitals are often not fully integrated into protocols about how the MHA operates, despite it affecting them every day. In my experience it was always extremely difficult to engage acute hospitals as they see the MHA as a matter for mental health trusts and often don't attend local meetings.
2. You could point out that all of the relevant guidance, statutory and professional, leans away from the police being unnecessarily involved in prolonged sitting-around, with people who have been removed for assessment or detained.
3. You could point out that there is a legal ability to ensure the detention on a ward of patients who were originally detained under s135(1), 136 or (some circumstances of) 138 so why don't the hospital crack on using s135(3) or s136(2), respectively, to detain the person?
4. Once a patient is admitted to any general or acute hospital as an inpatient, any doctor can use section 5(2) of the Mental Health Act to detain that person and stop them from leaving.
5. But finally of course, there is a legal duty on the police to prevent crime and bring offenders to justice so where admitted inpatients are actively assaultative, there is something of duty around keeping medical staff safe where officers leaving would obviously render them liable to assault.

But here are the two most important legal facts, that give you an unsquareable circle —

1. There is no legal duty on a general or acute hospital to accept legal responsibility for the ongoing legal detention of someone originally detained by the police.
2. There is no specific legal duty on the police to remain in a health-setting to "guard" people who may or may not leave, pending their assessment or return to a mental health unit.

In other words, you could build whichever argument suits the position you'd prefer to take or the point you'd like to make and **no-one will be able to say you're wrong** – *but so can your colleagues!!*

UNSQUAREABLE CIRCLES

You now have your unsquareable position – the police don't want to be sitting in hospitals all day with people who have consented to be there and who pose no more level of risk than any other patient but the hospital don't want to accept legal responsibility for people who may choose to leave even though they do this quite routinely for people not brought in by the police. The Code of Practice requires *cooperation* and *agreement* on how all of this will be managed and it should **not** be left to frontline professionals to battle it out, case by case. Professionals or even organisations just adopting a unilateral position and saying "that's the end of it" is just a destructive way for public sector services to work, when actually what's most important are the effective management of risks, both to the individual who should be at the centre of decision-making and to the broader public. Instead, it usually because a bad debate about organisational resources and organisational willingness to accept risks.

So we need to work out a compromise and a partnership arrangement –

Preferably one where no-one feels that the other is just unilaterally forcing their agenda on the other, especially where that agenda could fall foul of frontline practitioners confident enough to return to legal structures that inadequately bind services together. If we got into a room and talked it though, we would probably find easy common ground on some basics principles to get us all chatting –

1. No-one thinks it's a good idea, to have officers sitting around to secure people who are low-risk, consenting patients to a hospital admission.
2. No-one thinks it's a good idea, for officers to leave a person in a health setting where that person represents an ongoing risk to either their own or others' safety.
3. No-one thinks it's a good idea, for one public agency to force things upon an other in the absence of a clear legal authority to do so, where a structured partnership agreement could be brokered by managers that actually takes liabilities *away* from frontline staff.
4. No-one thinks it's a good idea for frontline staff to be improvising their way through these complex issues based upon nothing more than their own professional agenda, with scant regard to that of others.

IN PRACTICE

Here is a (real) situation —

The police detain and 83yr old female dementia patient under 136 late at night in winter. The lady is cold, not appropriately clothed for the weather and disoriented. It is obvious she has other mobility issues. After A&E assessment she is more or less straight-away admitted to a medical ward for elderly adults amidst concerns for her dementia, but also for her physical health. All of this happens after the s136 detention, but before an AMHP and DR can complete the assessments. No-one knows for certain how long she was outside in poor clothing for the weather, she as only discovered "missing" when her family called at her home and found her to be absent and the front door wide open. She seems very frail. Her family has attended hospital and are by her bedside with two cops stood nearby who have been told by the hospital they cannot leave, because the s136 is still active.

What prevents this being left in the hands of the hospital? —

An unresistant, elderly woman who is frail. Her family are there and she is making no attempt to leave and there is no indication she will try. What purpose are these officers serving? Should the lady suddenly decide she does wish to leave, several legal and security options are open. Her family could well be positioned to assist in preventing her from leaving, nursing staff and / or security could do this also. (When I say "do this", I mean legally speaking.) She is still detained under s136 MHA until the AMHP and DR complete their assessment, and the lady may still be detained there under s136(2) because despite what the hospital may say in tortured legal arguments to the contrary, they are acting as a "place of safety" for the purposes of that particular 136 detention. Even if this argument is not accepted, she is now an admitted inpatient on a ward – any DR may use section 5(2) MHA to keep her detained pending assessment and nursing and security staff may assist with this (legally speaking). Either way, there is a clear basis for acting.

Repeat that scenario but substitute the 83yr old dementia patient with a 24yr old female schizophrenia patient who has self-harmed to such a degree that she has seriously damaged the internal mechanisms in one of her arms. Quite potentially, she needs reconstructive vascular surgery to minimise a permanent loss of movement and dexterity in her hand. She has a history of drug use and violent self-harm, possession of edged implements which are mainly for her own use, but which have been brandished towards NHS staff in various situations. She is detained under a s135(1) warrant and was removed to A&E because of the injuries that were evidenced upon police forcing entry to her flat at the request of her

community mental health team. After initial handling in A&E, she has been admitted onto a surgical ward as an urgent case. Full assessment will occur before surgery because she is not fully consenting to the procedure but a view has been taken that she can be detained and then treated under the MHA, because the physical injuries sustained are as a direct result of her mental disorder.

Why would the police not remain initially engaged in this situation to ensure the safety of those concerned until at least the full assessment has been done with a view to detaining the patient under the Act? There are clear duties to keep both the patient and NHS staff safe and the ongoing situation can be reviewed after assessment. For example, once a patient is detained on a medical or surgical ward, the mental health trust will have a duty to provide staff to support the hospital in their ongoing treatment and care. But these kinds of situation need to be thought through in advance and made subject of training and protocols. Apart from anything else, my next blog will make it clear why in the situation of the 83yr old dementia patient mentioned above, I could well be tempted to act unilaterally, in certain circumstances. It might be the only way of discharging those *professional* responsibilities that often sit with me *personally* as a duty inspector.

11th February 2014

Managing Stress –

A week in which we're hearing a lot about stress, depression and anxiety in policing: firstly, a national broadsheet telling us the financial cost of almost 800 officers being off sick during a snapshot survey recently undertaken. (The true figure will be higher as only 35 of 43 police forces responded – the Telegraph speculated it would exceed 1,000.)

Then today, we learn that one police force in the North-East of England has seen days lost to mental health related conditions quadruple over the last three years. In some forces, 1.5% of the workforce is off sick with a mental health related condition. All of this in a profession that tends to employ more men than women, at ages where men are at greater risk of suicide than at other times in their lives.

Most of us know someone who is off work with stress, depression or anxiety – or we are someone who has been off work with such conditions. Of course, not all of that is because of policing. I have supervised many people over the years who have been through difficult personal periods in their lives, coping with bereavement, divorce and financial problems. Officers who have had to endure serious illness, child access problems and other complex problems, including disciplinary investigations. So as with any profession or job: the police are made up of ordinary men and women doing a difficult job and it has its pressures, but they are also people with personal lives that give rise to stresses and pressures too. Very obviously.

ORDINARY PEOPLE – EXTRAORDINARY JOB

It would be easy to identify certain drivers for stress related conditions within policing and assert that all of these things taken together will, for some people, represent the requirement for a quite unsustainable level of effort: let's start with an unprecedented period of change in both police service structure and in terms of officers pay and conditions – many officers are getting used to the fact that the timescales for their professional service and the point in their lives at which they may expect to retire whilst watching their pension contributions rise against a backdrop of stagnated wages. Add to that a period of internal change in which officers have seen restructures that have altered their role and their hours because Chief Constables have had to think of new ways to make their budgets and their

resources match the (rising) demands on the police – sSome officers have been taken from centralised, specialist departments and redeployed to frontline response or neighbourhood policing teams. And finally, all of this against the background of a quite extraordinary set of duties and responsibilities – police officers deal constantly with nNegativity, tragedy and pressure – critical incidents, involving death and serious injury as well as a constant volume of drug and alcohol related crime and disorder. Being abused by a significant proportion of those who are arrested, going to work most days preparing for a fight – many of these things change people's personality over the years they spend doing the job.

And of course – it would be easy to point to all of this and observe that the police are far from unique in these kinds of changes: not in the public or private sector. It is also easy to point out that many people have faced far worse in the form of wage reductions, redundancy and job relocations. But this is the thing about stress related conditions and mental health problems generally: what affects one person and becomes clinically significant for one person, may not do so for another. To point out that someone else has "coped with worse" is to fundamentally misunderstand the nature of mental distress. As Stephen FRY once remarked by way of example, asking why a famous person has become clinically depressed (with all their access to money, travel and career) is like asking a painter why he got cancer when someone else smoking and drinking a similar amount didn't.

It's just not how distress happens and no two situations or people are the same.

But there is one unique aspect to policing that *is* often overlooked. I go back to the MSc I took about ten years ago when I first realised this point. During a lecture by an academic who had a specialist research interest in what is known as "private policing", the point was being attempted that there was nothing particular unique about policing. Private companies and other public institutions could and did undertake policing functions to prevent, reduce and investigate crime. Whether it ranges from private citizens in wealthy areas of London employing a security company to patrol their neighbourhood, or NHS professionals investigating certain kinds of crime – there were numerous examples to show that policing is not unique. Right?

Wrong – the unique difference is that officers are **obligated** – and it seemed to come as a shock to him to contemplate it. To perform certain duties, at certain times and this can include short-notice obligation to work in another part of the country and there is a weight of law behind such instructions. I have worn riot gear on the streets of Birmingham and Bristol in recent years – I have lived in London for a week and sat in the woods near High Wycombe overnight for 15hrs at a time. Not of this fitted in particularly easily with my childcare responsibilities for a little boy who didn't understand why Dad isn't coming home. And in some of those

circumstances, to have said "No!" and gone home on time would have been a criminal offence. That is the difference in duty. If your private security company forget or fail to patrol your area, you may have a breach of contract, but that's about it.

OBLIGATION AND RESPONSIBILITY

We have known for a while that police officers have always operated at raised risk of suffering from clinically significant stress, depression and anxiety – part of which, in my humble opinion, because the command and control imperative to deliver outcomes within a framework of a highly discretionary profession. Research in Australia at Monash University made passing reference during a study on stress, depression and anxiety in mental health nursing that police officers (like paramedics) are *four times* more likely to suffer from these conditions than the general population of the same age. When we also remember how police officers are a higher-risk group for suicide than the population as a whole and that the profession is predominantly male, we start to see the problems.

So all things taken together, I wondered aloud when I read the "almost 800" figure that "I'm surprised it's that low." In a sense, it makes me think that police officers are quite a resilient bunch overall OR it makes me think that many more officers will be operating near their psychological limits in an organisation where they prefer not to reveal ongoing mental health problems – I suspect a bit of both. Any officer worth their salt will be quite unsurprised to learn that a colleague is suffering from a clinically significant condition – most of us can name highly effective officers who have been off work and some of us know officers who became so unwell that they needed a period of recovery in hospital, detained under the Mental Health Act. I'm not sure it has occured to some members of the public, but there are some officers in receipt of ongoing psychiatric care who have previously been detained. I'm referring to highly effective officers who I would be delighted to see policing events involving my family and there should be absolutely no surprise that this is the case.

I keep remembering that 1 in 4 figure that we hear from major mental health charities: that 1 in 4 of us will suffer from a mental health problem during our lifetime. I also keep remembering that police officers are four times more likely than the population to suffer from mental health condition, especially stress, depression and anxiety and I do the maths that my nine-year old could do — whether because of the job itself, the impact of policing upon people's general health and wellbeing or because of the difficulties in assimilating that into a family life, to choose a policing career is for many, to choose a life with significantly worse health outcomes than may otherwise be the case. It there gives rise to something of a covenant between the public and the police service – as there is between the public

and the military – that the requisite support will be there for police officer who struggle psychologically and mentally in fulfilling what is required of them. I have heard it said more than once, "All I wanted and needed, was some support." Quite so.

12th February 2014

Armed Police on Mental Health Wards –

We have seen for some while a story circulating on the internet and social media that "armed police on mental health wards, FoI reveals." My immediate concerns were raised because the wording of this headline denoted to me either that it was being reported to have happened more than once OR that it was some kind of routine thing to incidents on wards. I suspected both things to be false.

The piece itself follows on from concerns that 48 officers, including armed police, riot police and dog handlers were called to River House in south London, after a disturbance. River House is a medium secure unit in the South London and Maudsley NHS Trust and there are understandable sensitivities around the location and the police being called to it, because this is the place where Metropolitan Police officers responded to another incident which led to the restraint-related death of Olaseni LEWIS. So we can all agree that scrutiny and concern about further police responses to such incidents is justifiable. We can also agree, that preventing the need for further police responses to incidents can never be guaranteed because unpredictable events can always occur.

I've resisted for some while the urge to blog on this, as I admit to thinking it something of a non-story, but it keeps persisting in its circulation, so I have given in to better judgement. I stress for the record, that I was not involved in the incident because it occured in another police force and I have no inside information from officers in the Metropolitan Police nor have I discussed it with them. Beyond mentioning things that are contained within information confirmed by the police involved, I reserve myself to other observations and considerations about responding to disturbances on mental health wards and to considerations that go through your mind when you are in command of these events. Following on from this article, some things just appear to need saying, because of the unchecked inferences about what actually occured.

ARMED POLICE NOT ON MENTAL HEALTH WARDS

Firstly – and most importantly: the Metropolitan Police issued a release when contacted with respect to this incident in which it made *categorically clear* that armed officers were **not** directly involved in the resolution of it

but *were* in the vicinity of the hospital as a contingency. I will explain more about this later.

Secondly – the Metropolitan Police said that they were called to River House following reports of a serious disturbance involving a number of patients and that staff had been forced to abandon the immediate area of it because of fears for their safety. It was at staff request that the Metropolitan Police were called.

Thirdly -the officers were told that several patients were involved in violent conduct, would have access to knives. At the risk of pointing out the obvious, a medium secure unit is the kind of location where some patients pose "a serious risk of harm to the public" and are detained following criminal trials for serious events.

Fourthly – there is absolutely no barrier in law, protocol or procedures that prevents the police being called to such incidents and no ability to dictate the operational terms upon which police commanders restore safety to a situation and prevent further crime. It is down to the police commander to bear this responsibility.

So take all of these things together and we see a complex, unfolding and dynamic operational environment of some gravity where officers may face serious physical resistance and / or personal attack. But they may not. And we don't know what resources may ultimately be needed to minimise harm to patients, staff and infrastructure, if any beyond the local 999 response team.

COMMANDING UNFOLDING EVENTS

It is my role in my day job, to lead the police response to these kinds of events and other critical incidents, if they occur. So I thought it might be useful to go through some of the thinking processes with reference to one of my own jobs? I have been that police inspector who asked for armed police to support an intervention in a mental health incident and with this in mind, it outlines why it was perfectly proper for several different reasons to ask for it —

Some years ago, the police were asked to detain and convey a man from his mother's home to hospital for assessment under the Mental Health Act. The problem was, he'd locked himself in the upstairs front room of the house, with a knife and the man had a significant history of violent behaviour and weapon possession.

It posed a proper problem for the police, because he had committed no offence and the AMHP leading the assessment had not obtained a warrant

under s135(1) MHA which would allow the police the right to detain him and remove him to a PoS. It was my position that to act properly and safely, and to then justify the use of any force we may ultimately have to resort to, we would need to firstly, spend an appropriate amount of time genuinely attempting to negotiate a non-coercive outcome; and secondly, obtain a warrant under the MHA which the AMHP didn't want to get and which would take time to obtain even if I did manage to persuade.

So we had several hours ahead of us and who is to say what would occur during that time, whilst we aimed for a peaceful, non-coercive outcome? The man could decide to leave the room with the knife for any number of purposes; he could have chosen to start using it to hurt himself. There are plenty of other scenarios which could have unfolded. As the police commander at the scene, it is your job not only to start policing what is in front of you, but to think ahead to a multitude of different scenarios. You can call them whatever you like – but I'll go with "Plan A and Plan B and Plan C".

PLAN A – PLAN B – PLAN C

You initially plan for and start trying to deliver the most desirable outcome – Plan A. This is the one you would choose from the "solutions catalogue" for mental health incidents. You use the resources initially there to start attempting to deliver it and first-things-coming-first, you obtain whatever support is needed to that situation to maximise the chance of it happening.

So the first two cops on the scene establish the facts of it and start attempting to negotiate for the outcome you need. I start getting a few more officers there for different reasons and one of the sergeants came down. I get a negotiator contacted by the control room. If all things go well, these resources will be able to deliver "Plan A" and all resources for Plan B and Plan C will just be released.

You also then also start taking care of the indirect implications – at an incident like this, there were also concerned family members to manage. Firstly, in terms of making sure that they know what's going on and what the police are thinking and what they're up to. Secondly, as they included the house owner, one of them had explicit rights to control what was going on in their own home and this needed to be respected in the decision-making that is needed. I need an officer to available to them – to answer questions and convey messages, and frankly, to stop them controlling me as I have wider responsibilities. And you also start planning for what you will do *if* and *only if* Plan A fails – you will resort to the use of force to resolve the matter, *if* and *only if* the AMHP secures the necessary warrant, in this particular example. We'll call this Plan B.

But you also start planning for the outcomes you genuinely hope you don't have to manage – inevitably, Plan C. What happens if events in the room begin to develop? If there is the commission of a criminal offence, then the legal framework alters and as the incident commander, I then get certain rights to determine how things proceed. Should this happen, what am I going to do? Well it depends on whether the offences is one that requires immediate action or not. If he threats to kill someone, but makes no attempt to try, then we continue as for Plan A and get ready for Plan B. If he actively starts attempting to do so or starts harming himself, then an urgent physical intervention may be required and Plan C kicks in. But if things escalate, am I sending in officers dressed and equipped normally officers to deal with a patient with a knife and significant risk history of violence? No, I'm not. So the sergeant gets an instruction to arrange a unit of officers to get into public order equipment (riot gear) with shields. These officers are maintained at a discreet distance away from the incident. I hope not to use them – they are outside the address as part of Plan C and Plan B, if instigated.

You also then start planning for the consequences of untoward outcomes – what happens if someone gets injured? At what stage do we call an ambulance? This could be necessary in either Plan B or Plan C but we don't want to tie up an ambulance for hours and hours if our Plan A is patient negotiation. So we set an instruction – 999 is called if events suddenly escalate or fifteen to twenty minutes before we give up on negotiation and move to a use of force. Meanwhile, we're telling them family all about this – if you look down the street you will see what you think is riot van and officers in riot gear. These people are coming nowhere near your property unless the events here escalate unpredictably and someone may get hurt. They are in that equipment because it is merely protective equipment to stop the officers getting hurt.

THE USE OF FORCE

Once our incident developed to the point where negotiation had failed and force was to be used, we called the ambulance. There wasn't one available in any quick time because it was a very busy Saturday night for the ambulance service. So I asked for firearms officers to be in the location. Why? Because they are trained in first-aid to a standard that way exceeds the first-aid training given to most of the rest of us AND they can operate in risk environments that some paramedics may not wish to enter. So if an officer was stabbed or the patient injured in whatever way, I want someone with more than a basic first-aid certificate on standby bearing in mind that I was warned by one of the psychiatrists involved that "this is the next death in custody for your force unless you handle it right." No pressure, then.

The AMHP had been persuaded to obtain a warrant, I executed this warrant on the householder and then directed officers in the correct equipment to enter the room and detain the man under s135(1) MHA. As soon as they tried, after some final negotiation, he repeatedly tried to stab the officers with the knife. It all ended with a couple of minor injuries to officers and a cut to the patient's foot after he stood on something during the restraint. It could have ended so much differently, if we hadn't carved this up into Plan A, Plan B and Plan C and determined individually what was required to undertake each.

ARMED OFFICERS ON MENTAL HEALTH WARDS

So what does this tell us about the original incident in London? It tells us that when you see 48 officers including riot police, dogs and firearms you need to break that down into what they're all doing. And it won't be easy to tell, because they're not carrying a placard to show which scenario they are there for. Some were there because they are the local response team who own the job and would have a role to contain the general area, so those officers tasked with their Plan A or Plan B could operate with others focussing *outwards* from the incident as they focussed *inwards*.

Some of them were supervisors and commanders. Some of them were "riot police" because entering a hospital to a disorder of the kind indicated could be highly dangerous business and for a mental health unit with dozens of patients, a police public order unit, trained in tactics to sweep and contain buildings, deploy in groups of 25, led by an inspector who would not be the duty inspector for that area. That accounts of over half of the officers present. You also need officers controlling out perimeters of buildings whilst that main group is going in.

Dogs, firearms are all part of the contingency planning as the Metropolitan Police made clear – armed officers did NOT enter the hospital. We can only speculate about the particular reasons they were there, but whatever your speculation: armed officers don't just point guns at people with a view to shooting them. They are highly trained first-aiders, they also carry "less-lethal options" like Tasers but the commanders quite possibly felt that an armed response might – just might – be required if Plan A and Plan B did not go to plan. This last point is just speculation on my part, but I can imagine what might have been thought.

When I looked at the street after my incident described above, which was on a much smaller scale and only involving one patient, I saw a fleet of emergency services vehicles. I was joined at the end by other sergeants to conduct an independent debrief of the use of taser, to take over the scene so other officers could clear to hospital and start the considerable administration that was subsequently required. It involved nearly two

dozen officers and anyone standing in the street watching could have said, "Blimey, they had about nine police cars, vans and they had riot police and firearms there!" All of them, in my humble view absolutely justified – but none of them walking around carrying a banner to explain their particular role and whether it fits into Plan A or Plan B.

When viewed from the outside, it's all just a mass of flourescent jackets wandering about and why do you need riot police for just one bloke?! Well, having watched the incident unfold when officers entered that room to face active attempts to stab them, I was astounded by their bravery and wouldn't have been too surprised if one of them had been more seriously injured despite having done everything possible to mitigate against that possibility. It was their bravery that meant a very unwell man was safely admitted to hospital under the MHA.

21st February 2014

What Would It Take? –

Paul JENKINS, the outgoing CEO of Rethink Mental Illness, has been a keen supporter of this blog for a while. I vividly remember hearing a loud "Woop!" when Stephen FRY read out my name at the 2012 Mind Awards and was later informed that it was Paul somewhat leaping up from his chair. He was amongst the first to email me during a recent social media hiatus offering his support.

He is moving on to pastures new as Chief Executive of the Portman and Tavistock NHS Foundation Trust, he has commissioned a series of blogs on mental health issues from a wide variety of people under the banner of "What Would It Take?" – all being published on the Rethink website.

I was honoured to be asked to contribute this short piece as one of these essays to a question set by Paul himself. I know Rethink do wonderful work – I've seen some of it, and I know Paul is key to their success.

So I wish him the very best of luck for his new role and absolutely no luck at all with regard to our mutual love of rugby! Don't forget, Paul: Twickenham on 09th March – *unfinished business!*

What would it take to make sure the police had the support they need to best support the people with mental health problems they come into contact with?

I want just two things to ensure that the police are able to support people with mental health problems —

An accessible NHS service, open to the provision of emergency mental health care — the NHS is complex, varies by geography and is difficult to penetrate. This is true for service users and emergency services alike. Police officers have just four options open to try and obtain support for someone who wants it or who the police think needs it –

- *Urgent or out-of-hours contact with the person's GP* — if they have a GP; and if that GP has timely capacity to see them. Some GP services are excellent or have effective primary liaison services. Others put out-of-hours mental health at arms length and refer patients to Emergency Departments or the 999 services.

- *Secondary care community or crisis teams* — variation in service is huge as demand upon these services rises (16% in the last two years). We see deamnd deflected to Emergency Departments or the 999 services. Some Crisis Teams have started restricting operations so that they provide support by telephone or they see people in A&E or police custody only. Support required at home often leads to deflected demands.
- *Emergency Departments* — we all know well, the rising pressures. We know that many have liaison psychiatry services, but some do not operate 24/7. We know specialist support for people who have self-harmed is patchy, with 40% of people securing specialist psychological assessment. ED, for very valid reasons, has always had difficulty in providing effective responses to mental health issues.
- *Legally detain them* — the police do not have legal powers in all situations so by virtue of law, there can be difficulty ensuring an effective response. We know the difficulties Place of Safety provision and still hear that is not always staffed, available 24/7 and that exclusion criteria operate which have the effect sending up to one half of all detainees to custody. Street Triage schemes are making a difference to some of these kinds of problems, but it is still early days for them. We'll see!

Training for police officers on their duties and opportunities around mental health law —

The heart of my interest in this area is my feeling that I started under-trained to cope with the operational realities. Much has been done to provide better guidance and training, including at a local level where we see joint training and agencies delivering inputs to each other. There are two dimensions to training problems —

- *Mental health awareness* — to what extent do officers need training on particular types of mental health disorder? How much of available training time is devoted to awareness raising? Schizophrenia and bipolar; conditions related to dementia and personality disorders; learning disabilities, autism and Asperger's; conditions that may *appear* like a mental health disorder but are related to other conditions like acquired brain injuries, diabetes, Addison's disease?
- *Mental health law* — at the end of raising awareness, officers need to know what they can and cannot **do**. Can they force entry to a premises, or redetain an AWOL patient? What powers do AMHPs or nurses have in various situations to which the police are called?
- *Integration of law and awareness* — and finally, how does this all weave together? Where police officers and others could legally fulfil a task, who should do it? Where is the threshold for police involvement and how do organisations work together, across their boundaries to protect vulnerable people?

If we could sort out that lot, I think we'd stand a chance. Until then, I suspect everything else is just a complex form of busking.

22nd February 2014

Crisis Care Concordat –

We've felt the temperature rising for some time. Mental health and crisis care have been creeping up the agenda and policing has often found itself front and centre, connected in various ways. Whilst we've seen a few areas of the country making different kinds of progress on issues that have dogged the police for years, there is a general acknowledgement that change is too slow and improvements too patchy. So some areas have more or less sorted Place of Safety provision; we've seen the emergence of initiatives like Street Triage which seem to have appeal for many in the areas where they operate; some of us have known for years that a few areas have always had good liaison and diversion provision that adds real value.

So what's the point of a Crisis Care Concordat, given that we could argue we've heard it all before? Well, before we go any further, please make sure you've **read it for yourself**, especially if you are employed in this field. It is not an overly long document and won't take more than half an hour. There are then a few important things that we could then say about it.

Firstly – this is NOT a *POLICE* Crisis Concordat. The development of the document was not lead by the police, not was it intended just to address issues in crisis care that the police have historically sought to highlight, like section 136 MHA and Place of Safety provision. The document is endorsed by a large range of professional organisations across health and criminal justice including medicine, nursing and social care and the emergency services. Most importantly, the development of the document has had service user and third-sector involvement. So this is about far more than places of safety and street triage provision.

A lot of the poster issues for emergency mental health include the police as principle protagonists – deaths in custody, the kind of media coverage we've seen around over use of police cells and the inquiries we see into homicide and suicide events involving service users: all of these things tend to have a police dimension, for one reason or another. Yet this document is not police led: it is a Government reaction to the issues which have been around for decades. Some may say it is yet another document and we've seen this sort of thing before – we'll see, said the Zen Master to the Little Boy.

Secondly – this is NOT just about piles of money that we know we don't have. We know that the overall costs of doing certain things properly are less than the costs of doing them in an uncoordinated way, where agencies look out primarily for their own interests. To demonstrate points like this, I was recall the presentation I saw several years ago about investigating half a million pounds into a new liaison and diversion scheme. By the end of year 1, the service had successfully reduce the number of people per year who need to enter the secure mental health system by 3. At the time, medium and high secured beds would cost around £300,000 per annum, more than paying for the initial investment.

There are other benefits along the way which were about organisations educating each other. We know that some police forces are over-using section 136 MHA. Rectification of this doesn't lie in money – it lies in senior officers choosing to prioritise proper training in mental health issues for frontline staff, so that they know when to use section 136 and when to choose or methods of legal detention and when not to detain at all. That takes about 2hrs, tops. We also know that some NHS organisations give insufficient training to their staff about how to react to police decisions – for example, every person answering a phone in a mental health trust to news that the police have detained someone under s136 MHA should know the reality of para 10,22 to the Code of Practice to the Mental Health Act 1983 if they are contemplating not accepting the person for assessment. This paragraph obliges consideration of alternatives to police custody, rather than a vulnerable person being condemned to the cells and the Concordat gets into this sort of detail. Again, this won't be just about money.

Thirdly – this is NOT a document which identifies the solutions and dicates from the centre what they should be. In due course, all local areas should agree and publish a '**Mental Health Crisis Declaration**' – I'm not yet sure whether this is at the CCG or the police force level. We should then see what the local actions are and how those identified needs will be met.

Much of the Corcordat is reinforcing what should already be happening. We should already have four joint protocols in each local area, jointly agreed (not imposed) that discuss Places of Safety, Assessments in Private Premises, Conveyance and AWOL Patients. It doesn't take huge amounts of money to get areas sitting around a table discussing these things and writing or improving local arrangements. We should already be thinking about training: what training do police officers need from mental health services – but please, please, please don't forget that the opposite will also be true. This is not a one way street. The Concordat is about something else: putting strategic framework, at the level of Government, around these issues that have proved problematic for years, if not decades. It is therefore about providing a framework of expectations that areas get on with what they already know is needed.

PARITY OF ESTEEM

NHS England are doing a lot of work on the concept of 'Parity of Esteem' – the notion that mental health care should receive an equal priority in all aspects with physical healthcare. Whether you look at this from the point of view of funding, research or the ability to access emergency services in a crisis, it is acknowledged that there is much to do. Lord Victor ADEBOWALE is chairing the group for NHS England that is overseeing this. When one remembers what he has said publicly about emergency mental health care since publishing the report of the Independent Commission on Policing and Mental Health, there is every reason to be positive about that drive, especially as it is recently backed up by law in the Equalities Act 2010 and the Health and Social Care Act 2012.

On page 8 of the Concordat we see the section entitled "When I need urgent help …" and it attempts to list those features of emergency mental health care that people should reasonably expect to be met. It does very quickly touch on ALL the issues I have written about for the last two and half years without specification of the detailed answers: access to preventative emergency mental health services, through mental health crisis teams or similar; place of safety provision; commissioning of ambulance service to reflect parity of esteem and provide dignified suitable transportation services. It also gets very quickly into difficult issues around restraint and drug or alcohol use. All the issues that we know areas have struggled with, historically.

So it is those specifics in the Concordat around certain these difficult 'parity' issues where I have unanswered questions. Perhaps the answers will come in the local mental health crisis declarations in coming months, but there are certain things that beg questions —

1. We know that some areas have not commissioned or resourced their place of safety provision properly, because they cannot justify prioritising the necessary money to do so – if there is a locally identified need for new money, where is it coming from, given that last year the overall mental health budget was cut (by 2%), albeit on the back of a 59% rise over the preceding 10 years. I've suspect it would be cheaper overall, and in the spirit of proper early intervention to have proper section 136 services working roughly as the Royal College of Psychiatry Standards envisages; but I know that some people don't agree with me about that.

2. We know that there is a direct tension between mental health services and acute providers about the provision of emergency mental health care – people are often deflected to police custody because those in need of emergency support have been unable to secure it from a mental health

trust and ended up in the A&E system who, because of an inability to provide a safe service, have asked the police to step in.

3. We know that the Concordat itself is not necessarily listing very much that is new, but bring together under a high-level political banner those requirements and opportunities that are already listed in documents as wide-ranging as the Code of Practice to the Mental Health Act 1983, to the various guidances that the police and health / social care agencies have already published – so if a statutory Code of Practice, the importance of which was reinforced by the highest court in our land, has not led to compliance with those frameworks, will the Concordat realistically add to that? Well, it will depend how it's 'policed'.

JUST ANOTHER DOCUMENT?

So could this be just another document that sits on a shelf? Well, yes – in a sense it could. The Concordat manages to list a large number of high-level policy documents in it's exposition of aims and commissioning intentions across local and strategic partnerships. I've got copies of these various reports printed off on a shelf that are current sitting nearly two foot high (yes, I've read them!) and they include Royal College Standards on s136, they include documents by the Academy of Medical Royal Colleges that commence by suggesting that the need for another overarching, cross-organisational document is a quite disgraceful indication of provision; they include *No Health Without Mental Health* and the *Bradley Review* as well as others.

We've seen police documents providing guidance on how these things should happen; we've seen inquiry reports, stated cases and other documents. What, if anything, makes the Concordat different?

Potentially, it's profile and it's plan for delivery – which includes full deployment of the statutory inspectorates from Her Majesty's Inspector of Constabulary to the Care Quality Commission. We saw Minister of State, Normal LAMB, appearing on television with Frank BRUNO as well as Commander Christine JONES representing ACPO to launch the document and there is every chance that the intentions and the plan within the Concordat would survive any outcome in the 2015 General Election. It arguably arises from work begun by the last Labour government in the *Bradley Review* and continued by the current government. But this document is direct product of Her Majesty's Government, instead of being put out by a police, health or umbrella organisation. It is signed off by senior representation in all the of the organisations which are listed on page 4.

So this stuff now lies in the hands of senior people driving it through their leadership – by giving time and space to existing staff across the partnership to develop the joint local approach under a coordinated Mental Health Crisis Declaration. It means that they should find it easier to hold each other to account and it gives them a greater ability to imply the need for various kinds of change. Like I've often noted in discussions on policing and mental health, we are taking about the ability to deliver strategic partnership arrangements that allow frontline professionals to consistently deliver safe, dignified outcomes for vulnerable people against a background of complex laws which are themselves under review. It will take great skills to negotiate partnerships that allow this to occur, whilst organisations trade off their own priorities and their financial realities. It will take leaders who get sufficiently into the detail of things, to know why certain initiatives that appear to mitigate risks, actually build them – so let's hope they know how.

26th February 2014

Querulous Paranoia –

Some years ago my chief inspector rang me up and told me he'd left an envelope on my desk. He'd appointed me investigating officer for some complaints made against various police officers and the file of paperwork which had come via the Independent Police Complaints Commission and the force's Professional Standards Department was bound together in the envelope. When I saw the package the first thing I knew I'd need was a ring binder and some divider cards. The paperwork over an inch thick with copies of police incident logs, custody records, letters already written. There was a lot of material there.

I was given an advance clue: I'd been appointed as the investigator because of the links within the investigation to mental ill-health and was told the job would be 'fairly challenging' to resolve. It seemed clear straight away, I would need to involve the complainant's mental health team, if he'd agree to that.

Having given the file a skim read and it being the day before Christmas Eve, I decided to ring the complainant just to introduce myself and inform him that with the amount and detail of material involved I would read the whole thing over the Christmas holiday period and ring him in the New Year to meet and discuss. By the end of that phone call almost 90 minutes later, I had started to wonder about '*querulous paranoia*'.

This language dates back to the Victorian era, was written about by the seminal German psychiatrist Emile KRAEPELIN and has been written about in psychiatric journals. Querulous, or querulent, paranoia is usually defined as the propensity to make persistent complaints about comparatively trivial issues, sometimes where there is no foundation to the complaint(s); and to pursue those grievances to the point where the damage done to oneself from the process and any dissatisfaction with the outcome is even greater than the original issue. And possibly, to then further complain about the inaction to the original complaint or dissatisfaction with its outcome.

There is not a huge amount of material that I can find about this condition but it is one that complaints related organisations consider to be very important indeed and those of us who take and investigate complaints need to be aware. And we can all see what a difficult issue this is – clearly, people regardless of their mental health are entitled to complain, whether

that be about police officers, mental health professionals or anyone else. Everyone is entitled to expect their complaint to be taken seriously and investigated professionally and impartially, with appropriate oversight and appeal mechanisms. Some complaints are upheld against professionals every day in this country, whilst others aren't. Those complaints vary in seriousness and complaint processes seek to find the balance between reparation with ongoing learning for professionals, and punishment and sanction for serious or repeated failures where there is less mitigation.

But in some instances, no matter how minor or unfounded a complaint may be, any outcome below the most serious will be insufficient.

CONVICTION AND SENTENCE

And of course there are always two aspects to any investigation: the issues of *conviction* and *sentence*. If a member of the public finds their complaint against a paramedic or an A&E nurse is upheld and vindicated, are they then satisfied by the organisational reaction to that complaint? Maybe the A&E sister of senior paramedic believes informal advice or perhaps a written warning will suffice. What if the complainant thinks that nothing other than sacking the staff member concerned will do? How do we reconcile the differences?

One aspect of querulous paranoia, as it was once explained to me by a psychiatrist, is that such complainants often do feel further slighted by 'sentence'. If someone did their job improperly, they should not be doing that job: end of. Anything less than sacking them often further compounds the problem amidst fears that those who have err'd have been inappropriately protected. Hence further complaints about the complaint investigation. At one point in the investigation mentioned above, I was being investigated for allegedly mishandling the investigation I was still doing before I'd had chance to reach my conclusion about the very very many complaints made against the different police officers.

The academic paper mentioned above suggests methods of early detection and alternative approaches, remarking that a "persistent complainants' pursuit of vindication and retribution fits badly with complaints systems established to deliver reparation and compensation. These complainants damaged the financial and social fabric of their own lives and frightened those dealing with their claims." This rang true with me when I had to deliver news about my investigation that I knew would not be welcomed. Thought was given, in advance of breaking the news, as to how I would respond to the reaction and particular supports around how I would arrange to have the news delivered.

DISTINGUISHING FROM INJUSTICE

The literature distinguishes this condition of querulous paranoia from the relentless pursuit of redress after serious injustice. So for example, years or decades of campaigning after deaths in custody or miscarriages of justice would not qualify for consideration of this kind of label. An example of something that would, may be a police officer saying something that they believed to be true at the time which then transpired not to be correct at all, and a relentless pursuit of that officer for "lying."

Clearly, some investigations into public services establish that some employees have lied. On other occasions it is quite provable that someone acting at a particular time was simply unaware of certain information that would have caused them to take a different decision and there was no dishonesty to their actions. It is the perception that such matters are conspiratorially acting against aggrieved individuals, to the protection or cover up of corruption that attracts consideration of this concept.

Another challenging feature of all complaints processes is how the system reacts to factual doubt. In my investigation, one officers was alleged to have said something to the complainant when they were at the original incident and there were no witnesses one way or the other. I simply could not *prove* in the legal sense which one of the two men were telling me the truth, if either. Because the complaint was a criminal one, where the standard of proof is *beyond all reasonable doubt*, there was no ability to prosecute the officer because there was considerable doubt as to what was said, if anything. In the context of this complaint however, it immediately invites the question, "Why do you believe him not me?" In reality, it wasn't a question of believing the officer – it was a question of being unable to prove to a criminal court that he did do what the complainant alleged beyond all reasonable doubt. But of course, I understand why the man walks away with a perception that the police inspector investigating his complaint has just appeared to dismiss his complaint by taking sides.

I was given advice as a young, ignorant sergeant by a wise old inspector when handling complaints: try to understand what people are trying to achieve, try to understand what they want from the complaint and what you might do to resolve it in those terms, if possible. When the answer to those questions is along the lines of "I want my life back" we start to understand that it may be genuinely difficult through a complaint alone to deliver this. And most incidents that lead to complaints are a point in someone's lives where things have become difficult enough for the police to be called, so there is often a far broader personal context to complaints. There was in this case.

I have found that mental health services are excellent at seeking to provide support to individuals who are complaining against the police. I would advise any investigator to ask the complainant about whether they would like to see their mental health services involved in supporting them. It was through doing this, that services were able to put in supports that addressed the problems which led to the incidents which led to the complaints. Hence the original issues began to progress and whilst complaints never became irrelevant – and nor should they – the importance of them abated as life began to improve.

28th February 2014

NHS Change Day –

You may or may not be aware of NHS Change Day – a grassroots initiative within our health service where individual people of all levels and professional backgrounds pledge to do something, however large or small, to improve the NHS.

In a stroke of genius by Dr Kate GRAINGER for example, she has pledged to make sure to introduce herself properly and by her first name to improve how personalised the service she gives, feels to those who receive it. "Hello My Name Is …" has become something we see all over social media as her extremely simple idea has paid off.

If you doubt the value of something so small, read the Francis Report into Mid-Staffs.

We will see Change Day itself, on the 03rd March, which is Monday of next week and you can read more about it in various places on the internet and in the media. But having been compelled to admit earlier in the week that I didn't really know what it was about or why it was happening, I read up and concluded that this is something I could contribute to, also. Most police officers could because our work overlaps with the NHS every day. Frankly, I have been a direct and intimate part of our country's mental health system for most of this last week because of a succession of incidents at work where the police worked ahead of NHS mental health interventions, or subsequent to them. It got me thinking, frankly ……

MY PLEDGE

This could be as big or as small as you want it to be, should you think about pledging to do something positive to improve our NHS. You could climb Kilimanjaro to raise funds and give it to Great Ormand Street if you want to. Most of us won't be able to go that far, but it doesn't mean that you couldn't do something really simple that would make a difference to our NHS's ability to operate safely or more efficiently – or in way where the wheels are oiled between the professionals in our police / NHS that interact daily, if not hourly, keeping our country safe. And that's the key to all of this: regardless of whether you are an A&E nurse, a mental health social worker or a police officer: we *all* come to work to keep our country safe in

various kinds of way and we give of ourselves in doing it. It is a noble business and we could always, always be supporting each other more.

So accepting that I could bang off a list of stories of where our NHS has frustrated the life out of me and I've gone home from work to stick my head in my hands, this post is about me *taking responsibility* to lift my head back up and ask myself, "What could I do, me, to make this better in support of NHS Change Day?"

I want to ask all police officers to take a moment to do the same.

I have various ideas and I'll publish a short blog ahead of 3rd March outlining what my contribution will be. This post is about planting the idea in the head of others and having them ask, "What could I do the next time I'm at work, to support our NHS and make it better?" This could be various things —

- **You could undertake a couple of hours reading back through your mental health law** – to remind yourself of your legal rights and responsibilities: that when you are next called by the NHS you don't fall in to one of the many pitfalls where, because of your own misunderstanding, you end up providing less of a response than you otherwise could. Doesn't have to be the whole legal syllabus: just pick a topic or two. When did you last actually read the Mental Capacity Act, which is often misunderstood? I can't actually remember hearing its use correctly rationalised so most officers could do this and that's just one example.
- **You could reflect upon the allegations of criminal wrongdoing against NHS staff** – remind yourself that 70% of violence in the NHS is in the mental health sector and that paramedics and A&E staff are disproportionately likely to experience violent crime. Ask yourself about the police response to allegations, whether we're preserving evidence properly, whether we're making sure that those who keep us well are safe as they do so.
- **You could undertake to "drop in" to your local A&E department without any particular justification** – "patrol" it for fifteen minutes or so at a busy time and if they're free enough, talk to staff. You might even get a cuppa with security or the receptionist if you're lucky. I certainly managed many of my basic hydration requirements satisfied at City Hospital in Birmingham when I was a PC, got to know the names of the nursing staff and listened to their frustrations about us. Occasionally I gave a bit back, got into some banter with them (Yes, A&E *is* a place of safety!) and built some relationships. Little things.

I put no great amount of effort into thinking of those three – you'll have your own far better ideas. But the whole point here is not to look at managers and systems for solutions to everything. There are little things in all our organisations that can make a big difference and NHS Change Day is about you working out one of two of them for yourself and deciding to make a difference on your own terms. Give it some thought.

MARCH 2013

3rd March 2014

A Dozen Little Details –

The Code of Practice to the Mental Health Act 1983 is almost *four hundred* pages long, divided into thirty-odd chapters and it is an awful lot to take in. I did read it right through many years ago and vowed I would never do so again! I will probably have to do so at the end of the year, because they're currently updating the 2008 version and we will apparently see a 2014 update. I've been mentioning the importance of the document on this blog since the very beginning and, if anything, I have become more convinced of its importance over time.

I have contrasted the weight placed upon it in some situations by with that placed upon the Police and Criminal Evidence Act Codes of Practice; I have highlighted one particular paragraph of the Code – paragraph 10.22 – because of its importance the extent to which it is often ignored; and I have written about the stated case of *Munjaz* in which the highest Court in the United Kingdom reminds us that this is not a document dispensing advice that we can take or leave depending upon whether it suits us – this is statutory guidance with which we must comply unless there are "*cogent reasons for departure.*"

So this stuff is the law to be followed in the vast majority of situations.

IMPROVING WORKING KNOWLEDGE

This morning, I sent out one tweet with a link to the Codes of Practice which listed the main paragraphs that I think a police officer needs to know about, in order to police effectively. Knowledge of these paragraphs is key to knowing whether to say "Yes" or "No" to certain questions that operational officers will encounter and they cover the main issues: places of safety, MHA assessments on premises along with the recovery of AWOL patients and the conveyance of patients in all circumstances. I have often seen the wrong answer given because of a lack of this knowledge.

So, if you're not quite at the stage where you are prepared to give over a few days of your life that you'll never get back, here are a dozen little details to focus on. Whether you commit them to memory, or just focus on

remembering the summary of what they're about, it should improve your ability to police effectively in this area ——

4.12 – **Don't threaten patients with being "sectioned" to induce them to agree to voluntary admission** – The threat of being "sectioned" should never be used to persuade a patient to enter hospital. How voluntary is it anyway, if it only occurred after being threatened with legal detention?

4.47 – **Explain why police are still needed at a MHA assessment without a warrant** – Where a Mental Health Act assessment is going to take place in a dwelling but where no s135(1) warrant is in force, the AMHP co-ordinating the assessment should explain why police involvement remains necessary if it is sought.

4.55 – **MHA assessment does not always have to be delayed until the effects of drugs or alcohol have worn off** – It is often said that "You can't assess someone under the MHA whilst they're under the influence of substances. This is the paragraph that shows this is not correct. The paragraph certainly advises delay where possible, but it may not always be possible.

4.90 – **Applications for admission under the MHA must be made to a specific hospital** – it is not sufficient to specify the mental health trust to which the patient will be admitted.

10.10 – **You can make applications for s135(1) warrants without previous attempts to gain entry** – It is often said that you can't obtain a warrant without previous attempts to gain entry having been made. This is the paragraph that shows this to be incorrect. It stipulates that if applications are made without previous efforts, AMHPs need to set out the reasons for the Magistrate. This is in order to draw their attention to the fact that they can and to the reasons as to why in this particular case.

10.22 – **The police station should not be the automatic first or second choice as a place of safety** – this is the paragraph that custody officers and detaining officers should bear in mind when considering the use of the police station as a place of safety. What else did you consider or try, before resorting to it? If you can't answer that question, you've got more thinking to do before seeing the custody sergeant. If you're the custody sergeant, I'd ask the question!

11.5 – **Sedated patients should be accompanied during conveyance by a suitable professional who is trained in the care of such patients** – this will normally not be a paramedic because they are not licensed to adminster drugs to sedated patients. It will normally be a nurse of a doctor and officers asked to assist in the transfer of patients from one place to another, should bear in mind this requirement and ensure such a professional is involved.

11.17 – **Police involvement in the conveyance of patients under the MHA should be based upon them being violent and / or dangerous** – this is obviously a far higher threshold than patients being resistant to admission or transfer and officers should be certain to ensure that they are acting according to this part of the Code. It may be that local protocols assume all coercion under the MHA should be done by the police: this appears to be outside the intentions of Parliament who gave others the power to do so and this paragraph sets the bar somewhat higher than a patient being merely resistant to admission / transfer.

21.36 – **Voluntary patients cannot be required to seek permission to leave hospital** – but they can be asked to inform staff that they are leaving. This is important in situations where officers are called to mental health wards to reports of offending, involving voluntary patients. The Care Quality Commission repeatedly warn of the dangers of *de facto detention* whereby patients under no obligation to remain in hospital are 'denied' leave for various reasons. Where a voluntary patient chooses to leave hospital, either briefly or completely, they should be allowed to do so unless the nurse of doctor involved applies a holding power under section 5 of the Act.

22.13 – **The recovery of AWOL patients whose location is known is a matter for MH services** – but the police can be asked to assist in the risks involved suggest it is appropriate. So where, for example, a s3 patient who has been granted s17 leave fails to return on time and telephone enquiries by the ward reveal they are at home, it is up to ward staff to co-ordinate re-detention. It is for NHS managers to ensure they have access to resources by which to do so.

22.20 – **All unauthorised absences by patients should be reviewed to identify risks and prevent recurrences** – it is a requirement that all absences be reviewed. Given the frequent involvement of police resources in searching for patients who are absent, it seems reasonable to for the police to have an input into this process, especially because the police will have a record of that persons absence history which may cut across different hospitals or even different mental health trusts. That could very well assist the management of risks.

This list is NOT exhaustive: there are other paragraphs in the Code of Practice where it may be worth committing the thrust of it to memory but in order to keep this list manageable, I have capped it at a dozen things. I would encourage frontline police officers (in which I include custody and communications staff) to read the full text of these paragraphs and consider them in operational situations. They can make the difference as to whether you say "Yes" or "No" to requests that are made of the police.

11th March 2014

Abandoning Police Cells –

Yesterday in Parliament the Care Bill 2013 reached its report stage in the House of Commons. I learned via social media that certain MPs, including former care minister Paul BURSTOW and former GP and police surgeon Dr Sarah WOLLASTON, have tabled an amendment to the Bill, additionally suggesting that the words "police station" be removed from s135(6) MHA. This would have the effect of preventing police stations from being used as a Place of Safety under the Mental Health Act and would bring the UK into line with various other international mental health acts: including the Republic of Ireland and South Africa, as well as the states of both Canada and Australia.

What's not to like?! – I have to admit, I was actually quite excited at the prospect of it! Well, Twitter was not entirely convinced … the concerns were broadly of three types ——

1. There is no point removing the words "police station" until we know what the contingency arrangements are within the NHS;
2. There will always be at least some situations where use of police cells is necessary;
3. The police have always been responsive and caring to enough that individuals who have valued the humanity they have experienced were less concerned by the location.

DEFENDING THE INDEFENSIBLE?

I want to explain why these three reasons are *not* significant —– firstly, even with the current legal framework, the extent to which we use police stations gives rise to illegalities of various kinds, all of which touch upon the three objections to even greater change. We know that *MS v UK* saw human rights violations being inflicted in police custody; we know that police officers have been prosecuted in the criminal courts for relying upon police cells where they had little other choice but in the sorts of circumstances that are usually given to justify the second claim, above.

We know that the current statutory framework demands that police stations be used only on an *exceptional* basis. Whether we regard 'exceptional' as being 1 instance in 10, 1 in 20 or 1 in 25 will probably vary amongst us,

but we know that the national figures currently indicate that we are using police stations for 33% (or 1 in 3) of all s136 place of safety detentions. So after five long hard years of effort since the IPCC reported that 66% (2 in 3) of those of us detained were being taken to custody, we only managed to dent the problem by half, which is hardly '*exceptional*'! A long way still to go!

- **Contingency plans** – even if the amendment were successful, it would still be a matter for the Secretary of State to determine an implementation date. Nothing requires that to occur before the NHS is ready. Having watched a large number of health areas have to put their PoS arrangements in order, I know it can easily be done in 6 months – so let's give everyone a 12, or even an 18 month, deadline. Of course, that is exactly what the proposed amendment does: it would require no use of cells for under 18s by April 2015 and no use for adults by April 2017. This stuff can be sorted in under six months – I've seen and made it happen – so it's *perfectly* do-able.

- **Some situations** – we know that when some people list the situations in which police cells would always be helpful, they will say certain predictable things that have seen disasters previously. Resistant or aggressive detainees, especially those who are affected by substance (mis)use should be taken to the cells. We know that this raises the risks of contact deaths and has been the very point of criticism that such attitudes prevent proper identification of medical risks connected to these presentations. The Royal College of Psychiatrists "Standards on section 136" don't agree.

- **Positive experience** – I'm always really touched by feedback that people have found the police officers they have met have treated them with dignity and courtesy and nothing would prevent officers displaying a positive, supportive attitude when accessing more appropriate locations. But I admit to thinking, that however heart-warming this is, it's not sufficient justification for ensuring that one-third of people affected by s136 should be locked up in custody.

THE REAL REASONS

All of that having been said, I've suspected for years that there are other reasons behind the continued support for the use of police cells. Some of these other justifications are often entirely unspoken.

- **We haven't yet properly ensured appropriate use of section 136 by police officers** – in too many discussions we still see the

expression of attitudes by at all levels that supports the use of 136 in indefensible circumstances. So for example, we still see uncertainty about substantive criminal offending and about how to handle incidents involving the obvious consumption of alcohol. In some areas, we still hear frequently of section 136 MHA being "used" in private places and of frustrations between agencies about all of the above.

- **We don't know how to ensure that place of safety services survive contact with the realities** – we know, to put it very bluntly indeed, that a sufficient proportion of professionals working in health and social care, simply disagree with the move towards greater use of health settings for those detained under s136. Perhaps because a good proportion of those detained subsequently emerge from the assessment process without the need for inpatient admission, possibly because of understandable nervousness about the security implications for health – we know that in some areas, the NHS won't want this because they won't know how to make it work.

- **We don't have adequate trust and confidence between our police and mental health services** – largely because we don't actually see proper debate about the inherent tensions that exist between the objectives of our health and justice systems. There are plenty of notable people from each background who are prepared to publicly demonstrate not only that they haven't absorbed the learning from the section 136 disasters that have befallen us but also that they don't get the day-to-day problems that we see each agency causing for the other or a real sense of how we can manage our way around those problems.

- **We have an abundance of guidance that not everyone agrees with and is perceived by many as unrealistic** – it's all very well the Mental Health Act, the Code of Practice and even the Royal College of Psychiatry Standards saying certain things about the section 136 process: the first thing that has to be said about the totality of those frameworks is that plenty of people of importance just don't agree. The notion that officers could or should deliver a detained person to the NHS and leave them in the care of health professionals within 30 minutes "even if they are quite disturbed" is just laughable, to many.

And sitting there at the heart of it all, is the difficulty for section 136 that troubles everybody – even some of the better examples of section 136 provision in the UK at the moment still don't fully comply with the Royal

College Standards and there are genuine obstacles to overcome in terms of commissioning, even where the will exists to do it properly. Many areas of the UK have genuine geographical challenges because of the large areas that they cover and the relatively low use of section 136. Herefordshire, for example, sees section 136 MHA as a once-a-week thing. Northumberland is over 100 miles from south-west to north-east with a population concentration that is not in the middle. So how do you structure 24/7 health services in such a way as to mean that neither of those counties struggle when there is no contingency fallback of police cells?

In reaching answers, we can predict the need to go over old ground: how do we provide an environment that is safe both in terms of clinical and security risks for those who are detained; to what extent will ongoing police support in health-settings be required for those detained whilst resistant, aggressive or intoxicated? I personally massively welcomed the idea that police cells could be excluded from section 135(6) but it draws into sharp focus the work that will be needed despite a three-year lead in. This sounds like a long-time doesn't it? I mentioned above that this can be done in under six months where the will exists – in some cases it takes years to build the will but I suspect primary legislation amending the Act itself would be the necessary lever to make progress – **because we'd have to!**

13th March 2014

Ever Greater Utility –

Imagine you are driving your car along a main road in my policing area and you manage to transgress a red traffic light, having recognised too late that you were approaching a controlled junction. I've spotted this violation and pull you over just after the junction with a colleague. Imagine the interaction went like this –

- **ME** – "I've asked you to stop because I want to deal with the fact that my colleague and I saw you pass through a red traffic light." and we then caution you (as the law requires, having pointed out an offence.)
- **YOU** – "Sorry, officer, I admit I hadn't noticed the light until it was too late and I couldn't stop in time. It won't happen again."
- **ME** – "What's your name and address and are you the registered keep of the car?" (Just so you know, I am entitled to an answer to these questions because you have committed an offence and you are driving a car on a road. Once I get these details, I can consider checking whether or not you are banned from driving and writing out a ticket that gives you three points and a fine.)
- **YOU** – "I'm sorry officer, I can assure you it won't happen again."
- **ME** – "I am arresting you for contravening a red traffic light because you have declined to provide me with your name and address, rendering a summons or ticket to be impracticable, so please now get out of the car." I start cautioning you, having arrested you.
- **YOU** – "Arresting me? For a red light?! Is that *really* necessary?!!"

At this stage my colleague and I use force to open the door of the vehicle, physically pull you from the front seat whilst you remain startled at the unfolding events and handcuff you because you don't appear to be willingly coming with us to our police car. (For the purposes of this situation, the force we use is a text-book example of how personal safety and restraint tactics should be used.)

Reasonable? Imagine you weren't the offender, but a witness to these events … perhaps you're a passenger in the car or standing at a nearby bus-stop: would you think the police had acted reasonably? The police saw an offence and were going to issue a ticket, because someone declined to give a name there was an arrest and now we're off to police custody. All lawful, isn't it?

So it's all reasonable, isn't it, because doing lawful things is inherently reasonable?! Of course not. Doing lawful things in unreasonable circumstances is the story behind many incidents that cause massive public concern about what exactly the police get up to.

THE USE OF FORCE

Using force on other people or their property has limited utility: it contains, hurts or kills people; it moves, damages or destroys things. Whether those actions, in turn, create other conditions in which more important objectives are achieved, will depend on the context in which that force was used.

Traffic law is important, but enforcing it in an excessive, intolerant or discriminatory way can start riots. I don't just restrict myself to traffic, this also applies to stop / search or the application of public order law. We can probably agree, that there will be some occasions where a contravention or incident may be more appropriately dealt with by a gentle word in someone's ear and a reminder of potential consequences of behaviour?

Actually, some of the best cops can make non-enforcement of the law a way in which public confidence in policing is built, not eroded. This can be done whilst simultaneously achieving the goal – in this case, increased awareness on the part of a driver, leading to improved road safety. Perhaps this incident took place at the junction of a semi-rural road at 3am when there were no pedestrians or other cars around? Why not simply advise the driver to be more careful and wish them well?

Repeat the traffic scenario at 3pm on a Friday afternoon, just outside a primary school where parents are gathering to collect children at 3:15pm and where the nursery children are already leaving. The decision to ticket would be appropriate and if an arrest resulted because of refused details, then so be it. But perhaps we should have spent a few more minutes first seeking to persuade the motorist to give details, on threat of arrest if they don't? Was that person *really* refusing to give their details, or did they simply not realise that the question was a legally significant one, which triggers a power of arrest if it is not answered? After all, who knows that you can *ever* be arrested for such a minor offence?!

What happens if we change the offence? Let's say it was a hit-and-run road collision where a child has been seriously injured outside the school? The conversation may have been similar, but it would not include consideration of tickets and any decision not to engage in the investigation process would make an arrest by the use of force look justified. It all just looks far more reasonable now it's a more serious offence and the stakes are higher. If the child had died, the different legal considerations around the incident would mean an arrest may well be justified straight away. Who would question

arresting a driver who has allegedly killed a child, if it ensured a thorough, speedy investigation?

What has this got to do with mental health? Well, it is to make the point that doing legal things because you can, does not automatically legitimise them. **Very far from it.**

And this principle has wider application.

PUBLIC CONFIDENCE

Imagine the Mental Health Act assessment whereby a resistant patient has been made subject of an application for admission to hospital under s2 of the Act. Having refused to move to hospital, the police have been called to use force to compel the admission. So far, we've got no idea whether this will be reasonable, proportionate or justified, because we have only an outline of information. If we learned that the scenario involved a 24yr old male patient, a forensic patient with violent convictions who is now barricading himself in the upstairs bedroom of a house with a weapon, we can imagine it would be. It would not be realistic or fair to expect anyone other than the police to manage the risks that are involved the detention and conveyance of such a patient. Such situations are, thankfully, very rare indeed. (I can count on two hands the incidents I've had involvement with, in sixteen years.)

But what if it were a 42-year-old female patient, sitting in the living room and refusing to move? Does this effect the assessment of the use of force? Well of course, it must. For a start, the previous example may well mean specialist officers in protective equipment – sometimes called 'riot gear'. It may well involve half a dozen of them, because the pre-planned safe restraint of other adults would easily involve the need for an officer for each limb, one for the head / supervision of the incident. But with this second patient, a 42yr old passively resistant female patient, you are going to struggle to justify six officers in riot gear. Two in standard uniform should be sufficient unless things escalate. But some may question whether it is immediately a role for the police. If that 42-year-old woman were in a ward and a decision had been taken to move her to another hospital or to a seclusion room, for whatever reason, the first reaction of staff would not be to call the police.

What if a 73yr old dementia patient with physical health problems including respiratory difficulties and problems walking unaided were resisting admission, passively? How does this mean we approach the issue in the planning stage? (Yes, there should be planning stage!) An actively resistant 73yr old, regardless of gender, is still capable of inflicting damage on mental health professionals. But what if that person is sitting in their living

room, simply refusing to move, but not *actively* resisting detention and conveyance? Is this something that the police should be involved with at all?

If you've just answered "yes" to the last question, ask yourself whether this is because you have a strong view that *all* coercion of mental health patients outside hospital *should* because of principle, be done by the police or whether this reflects the practical fact that few mental health trusts ensure that trained staff are available for lower level restraint interventions where the Mental Health Act is being invoked in a community setting? I'm referring here to the original detention of someone, or their re-detention after becoming AWOL.

There are no easy answers to this: but what I do know is that seeing the police as the sole agents of coercion in order to administer the Mental Health Act was not the original will of Parliament, it is not consistent in all circumstances with important principles of least restriction in the Code of Practice to the Act and it is not consistent with the important principle of public support for the coercion of vulnerable people. As such, assuming otherwise is to risk compromising the safety and dignity of patients, and ultimately, the utility with which force is used.

20th March 2014

A Gilded Cage Is Still A Cage –

The long-awaited judgment in "Cheshire West" case was made public yesterday. It is being seen as a somewhat radical decision in the extension of protection to vulnerable people and it all concerns the phrase "deprivation of liberty" for the purposes of the Mental Capacity Act 2005.

So anticipated was this verdict that mental health professionals were tuning in to live internet streams of the UK Supreme Court at 9:15am to watch it live and then there was frantic activity on social media as people attempted to secure the hyperlinks to the ruling itself and some associated commentary.

I can't recall a case over the last few years, where the verdict was so keenly awaited. Watching social media reminded me of how literally excited I became waiting for the MS v UK verdict in 2012. I couldn't get my hands on it quick enough and was barely able to take it in as I read it the first few times.

So – what was all the fuss about?!

The "Cheshire West" case was an appeal to the UK Supreme Court consolidating the points of law that arose in two seperate cases, but has become known after the appeal case of Cheshire West and Chester Council v P (2011). In that case, a 39-year-old man with cerebral palsy and Down's syndrome who required 24hr supervision had lived with his mother until he was 37. When her health deteriorated the local social services authority obtained orders from the Court of Protection that it was in P's best interests to live in accommodation arranged by the authority. He lived in a staffed bungalow with other residents near his home and has one-to-one support to enable him to leave the house frequently for activities and visits. Intervention was sometimes required when he exhibited challenging behaviour and original judge in the High Court held that these arrangements *did* deprive him of his liberty but that it was in P's best interests for them to continue. The Court of Appeal substituted a declaration that the arrangements did *not* involve a deprivation of liberty, after comparing his circumstances with another person of the same age and disabilities as P. It ruled that it was 'normal' for people like P.

Also considered was the seperate case of P and Q v Surrey County Council (2011). These two sisters, known throughout the process as MIG and MEG, are sisters who became the subject of care proceedings in 2007 when they were 16 and 15 – both have learning disabilities. MIG was placed with a foster-mother to whom she was devoted and went to a further education unit daily. She never attempted to leave the foster home by herself but would have been restrained from doing so had she tried. MEG was moved from foster care to a residential home for learning disabled adolescents with complex needs. She sometimes required physical restraint and received tranquillising medication. When the care proceedings were transferred to the Court of Protection in 2009, the judge held that these living arrangements were in the sisters' best interests and did not amount to a deprivation of liberty. This finding was upheld by the Court of Appeal

THE SUPREME COURT RULING

Those mental health professionals who make decisions about a deprivation of liberty have eagerly anticipated this case. It was known, one way or the other, that the Supreme Court would provide the framework which ensured clarity around how a deprivation of liberty was to be defined. In the two cases, the first courts to hear the cases had taken a different view, admittedly in non-identical cases. The dilemmas were brought together in the Court of Appeal judgment that ruled they were not deprivations, despite the fact that in each case, the individuals were not free to do as they wished and were subject to supervision, physical containment and restraint, on occasion.

Lady Hale delivered the main ruling of the Supreme Court and the judgment is encapsulated nicely in the memorable phrase, "A gilded cage is still a cage." ––

"In my view, it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities. Far from disability entitling the state to deny such people human rights: rather it places upon the state (and upon others) the duty to make reasonable accommodation to cater for the special needs of those with disabilities."

The ruling seems to have been very widely welcomed as making it straight-forward to determine what will in the future, constitute a deprivation of liberty although Professor Phil FENNELL from Cardiff University law school

expressed the view that it will now mean that far more people come under the scope of the Deprivation of Liberty Safeguards which will mean greater strain upon the public system to assess and review to ensure ongoing compliance. That said it seems to be particularly welcome that the concept of "relative normality" has been abandoned. The Court of Appeal sought to judge the intrusion into the freedom and liberty of the individuals concerned based upon what other individuals with similar disabilities would have been subject to. In this ruling, a deprivation of liberty has been defined without reference to disability, but on whether action taken or care provided does, in fact, represent an intrusion and restriction on the lives of individuals. That this may be done in good faith, with the intention of enhancing the dignity, safety and / or wellbeing of others is not the point: it is still a deprivation of liberty.

A gilded cage is still a cage.

- The full judgment of the Supreme Court.
- The press release from the Supreme Court, summarising the issues
- Coverage in the Guardian – "More Safeguards to ensure rights for the disabled"
- A really useful summary of the case and its implications from Doughty Sreet Chambers, who barristers represented interested parties in the case.
- House of Lords report (2014) on the Mental Capcity Act 2005

21st March 2014

Civil Contingencies Act 2004 –

If you ever find yourself at a literary loose end – perhaps shortly after you've exhausted all of your Dostoevsky *and* your Mills and Boon – you could turn your hand to the less-than-riveting read of the Civil Contingencies Act 2004. I will admit: it's not really a page-turner and there's no interesting plot twist toward the end, but you'll learn some amazing things. Having learned them, you'll probably then spending some time thinking about your police force or your NHS trust and wonder.

Imagine this —– a police force finds that a police station is taken out of commission and cannot meaningfully operate, for whatever reason. Let's imagine a security alert that means the whole place is evacuated for safety reasons because of concerns of an explosive device. The custody block with 12 prisoners in it needs to be evacuated; the 999 response teams cannot operate there any longer so they cannot access the computers report crimes, update incident logs and build prosecution files; the radio batteries can't be accessed to ensure radio communications can be sustained; the control room can no longer receive phone calls from the public and the controllers can't use computers or the police radio system.

So what happens?! Well, the police could just pack up and head home early for a few extra days off, right?! Obviously not – things still need policing.

Imagine this —– a mental health trust finds that a specialist psychiatric hospital is taken out of commission and cannot meaningfully operate, for whatever reason. Let's imagine there has been a fire that means the whole building had to be evacuated. There are several different wards in the building, with different groups of patients of differing need. Some of the patients are Part II patients, but others are there under Part III: in hospital subsequent to criminal proceedings and including violent and sexual offenders. The hospital is not going to be useable until significant repair work has been completed.

So what happens?! — well, could the trust just send the patients home for a few days, until the work is done?! Obviously not. Care still needs to be provided.

CIVIL CONTINGENCIES

Each of these situations is a civil emergency, as defined by the 2004 Act. This legislation places a duty upon police forces and NHS trusts, amongst other public bodies, to ensure that they have planned and prepared for these kinds of things. The above examples are not hypothetical. Several police stations have been shut down at zero notice for security reasons. Chace Farm Hospital in north London, a medium secure unit, partially burned down in 2008, resulting in many of the 60 patients sleeping on mattresses in a gymnasium.

The Act itself defines what an emergency is, it defines which public authorities are covered by the Act and outlines very clear expectations in section 2 that those organisations will "assess, plan and advise" with respect to the potential for emergencies, which is exhaustively defined in section 1.

There is a duty to undertake periodic reviews about the potential for emergencies and to maintain plans that have the effect of —

1. preventing the emergency
2. reducing, controlling or mitigating its effects, or
3. taking other action in connection with it.

So if you work in the public sector in organisations like policing or mental health, you should be able to ask your boss if you can see the "business continuity plans" for what would happen if your building ceased to be operable. Obviously there are other kinds of emergency, but these serve the purpose.

MENTAL HEALTH BEDS AND POLICE CUSTODY

I have written previously about the difference in approach between policing and mental health to the management respectively, of cells space and mental health beds. I have just checked the custody computer at work at the cell block is currently 25% in use, 75% of its capacity is spare and we view this as a positive thing. It is (very rare!) respite to the custody staff who 24hrs ago had a full cell block and were run off their feet, but it means if my officers arrest a large number of people at a pub fight or out of a stolen car, they can easily be accommodated. It also means that if neighbouring police areas are having an especially busy time and they fill their custody space, we have capacity tonight to help them, just as they helped us last night.

By contrast, many NHS organisations run their hospitals at near 100% capacity. I'm told that in some areas the contracts between CCGs and the 'provider' trusts mean that unless hospitals beds are 95% in use, the provider can't cover their costs. This is perceived as efficient because it means the beds we're paying for and the staff we're paying to provide care are used almost to the maximum degree, most of the time. I've always looked upon it as inherently inefficient, because if the local police detained three people under s136 MHA, it may mean there is no local bed to admit them to. It means that we'd start looking at other hospitals and nearby areas, who are also running their hospitals at 95%+.

So what happens if something burns down or suffers catastrophic electrical failure? Well, if my cell block shut down right now, I'd transfer the prisoners to one or two nearby custody blocks. Every surrounding custody block in my force right now, has capacity to accommodate all of the prisoners from my cell block. Even if this happened last night when we were literally full, they would have been able to be spread around a number of cell blocks and there is one other possibility. There are three police stations near to my area with cell blocks that are not routinely used. We could just open one of them up, put the custody staff from my station into the other station and use a different building. If the station where the 999 response officers worked was out of commission, they would use computers elsewhere, get batteries from other main stations and so on. If there was a difficult period answering 999 calls during the first hour or so after the emergency being realised, surrounding police areas would help to police mine. Just as we have done for them, when they have major incidents and emergencies.

What happens if a medium secure hospital with 60 patients like Chase Farm is taken out? We don't have spare medium secure units standing empty 'just in case' – to be fair, the Act doesn't impose such a strict duty to have a spare building. But neither do we ensure that all medium secure units maintain an empty ward, so that they could accept an additional 10% of patients to their normally commissioned numbers at short-notice, should business continuity plans be invoked following an 'emergency'. If this were the case, patients from one medium secure unit could be dispersed around the nearest five or six surrounding units – but again, such a particular requirement is not in the Act itself. So how should it be managed? Some medium secure units accommodate 90 men – where would they go, if that unit were taken out and how would they get there? It is probably for all these reasons that when I was once involved in a major incident, desktop-style exercise that was modelled on the 2008 Chace Farm incident, it didn't take long before I was asked whether the detained MHA patients could be moved to police custody as a temporary step and would the police take them there? Little knowledge of this Act emerged when I asked what their business continuity plans were?

The point here is this —there is a *legal duty* on police forces, mental health trusts and others to have business continuity plans in place for most reasonably forseeable contingencies, including the less-likely but obvious major problems like the loss of your main building to natural events or security breaches. These plans should be maintained and reviewed at regular intervals and where necessary published. I simply ask the question, in light of the realignment of all our public services over the last two years: do we have revised business continuity plans and how would we handle the sudden inability of a major building to function, especially where that building accommodates legally detained people like mental health patients?

Do we have joint plans in place with police, fire and ambulance for how we would react in reality and dare I ask, *have we practised for it?*

23rd March 2014

Overcoming Inertia –

Imagine a world in which the NHS mental health system endures a particular kind of problem which centres around the police consistently not doing their job or not doing it properly. Imagine an issue of some importance to mental health professionals and patients alike, because it concerns their safety and their physical integrity – the potential that they **could become victims of crime**. The police are not, in the opinion of plenty of people who voice it, competent and consistent when it comes to the investigating allegations of criminal offences committed within inpatient settings. There are other areas, I know, where NHS staff would say that the police fall short of what they would hope and expect, but I want to focus on this particular issue, to make a certain point – *the problem is not hypothetical!*

Whether staff are assaulted by patients, patients by other patients or patients by staff, it is fair to say that many of these matters will violate our criminal law and bear close investigation to determine whether someone should be dealt with by the police. Whether 'dealt with' means advice or a warning, a caution or a conviction – some patients and some staff who offend in inpatient settings will be criminally liable for their conduct and there should be some response by the criminal justice system to this fact.

Did you know, incidentally, that 70% of all violent incidents within our whole NHS, occurs within the mental health system? It is not an insignificant issue, by any stretch.

IMPROVING PARTNERSHIP WORKING

I've known various things happen over the years, in response to it being thought that the police had declined to act – formal complaints have made against officers; informal representations by NHS managers to police supervisors at both the level of police inspectors and local police commanders. I've known mental health trusts write to Chief Constables asking that formal procedures be agreed between the services so that frontline staff know what is expected of them. We've even seen the national NHS organisation NHS Protect agreeing memoranda of understanding at regional and national levels with the police and the CPS.

More interestingly and stretching back for several years, we know that NHS Protect has felt obliged to privately prosecute some offenders for assaulting NHS staff. This has been going on for over fifteen years where the public justice system decided against prosecution. We have seen people sentenced to custodial sentences for GBH where the police or CPS decided that the prosecution, usually of a detained MHA patient, would not be in the public interest because of their current status detained under s3 of the MHA, for example.

Not edifying at all to see successful prosecutions which, by their inherent nature, render the decision-making of police officers and / or prosecutors null and void – the CPS are often directed to pick up the bill for successful private prosecutions where poor decision-making has preceded the inaction of the criminal justice system. So there is a lot that could be said about all this. The typical reaction I've known from a range of NHS professionals on this subject – from nurses and psychiatrists to local security management specialists – is that they have found themselves in a position where the felt they had to step in because of a vacuum in the system and that they'd really rather they didn't have to.

What they really wanted was a positive relationship with the police whereby allegations are taken seriously, investigated independently without presumption as to guilt or innocence and on the basis of some reasonable understanding about what mental ill-health can mean when offences are alleged. Crucially, this is as much about understanding that patients can be victims of abuse where power dynamics are against them, as much as it is about assaults on staff or damage to NHS property.

INCH BY INCH IMPROVEMENT

Imagine a local senior officer charged with sorting this kind of thing out for their area. One response that they could make would be to point out that the reduction of crime and disorder, as well as the management of disturbed behaviour, is core NHS business in mental health care.

There are many grounds for suggesting it is, given the coercive nature of psychiatry and extent to which it has influenced the legal frameworks that govern care in the United Kingdom and elsewhere. But if we accept that premise, we will also point out that it has limitations and we come back to practical suggestions for when disturbed or violent behaviour should resort to being a police issue.

We come up with two ideas: and I wonder which one the NHS would want to argue for, given a choice? —

- **We could provide a police officer for a certain period of time each day or each week** – they could work alongside NHS staff as they investigate their own allegations, offering advice about evidence gathering and about legal requirements. Initially, this would be a telephone system where NHS staff rang the station and information was shared that would assist. But where more serious issues arise, we could look in the future at the officer attending and then deciding whether to refer the matter to a police team who would deal with it.

- **We could train police in mental health and deploy them correctly around the investigation of allegations** – they could then proactively and reactively ensure the appropriate action to reduce crime in partnership, investigate allegations made and bring offenders to justice, if appropriate. This would mean that crime and disorder in the context of mental health is managed no differently within NHS walls to how it is managed elsewhere, except to the extent that mental health conditions present certain considerations that we do not see elsewhere in society.

Which would you choose and want to see if you were an NHS professional looking to ensure a proper response to offences against you, your colleagues and your patients? Would you want to be helped to get things right that you don't see as your core role, or would you like your partners to do their bit, as they are constituted to do? If the only thing on offer was option 1, would you go for it, or would you argue for option 2, partly fearful that if you agree to option 1, the possibility of option 2 becomes less likely than it was before? Or you would see option 1 as a stepping stone to option 2?

This post is absolutely not about allegations of criminal offending in inpatient settings.

25th March 2014

After Cheshire West –

We saw last week's judgment from the UK Supreme Court on deprivation of liberty safeguards in the case that became known as "Cheshire West" – it may be worth refreshing your memory about the ruling ahead of this post unless you've follow the issue as keenly some. I've spent the week watching with interest as the implications of this ruling unfolds for those individuals who undertake assessments of whether to make someone subject to Deprivation of Liberty Safeguards. These people are known as a Best Interests Assessor (BIA) and they apply DoLS, where needed. (BIAs are often Approved Mental Health Professionals who are additionally qualified, but there is no specific need to be an AMHP.)

The implications of the ruling seem fairly widely agreed in one important aspect: **this judgment will render more people subject to DoLS**. For reasons that are clear in the words of Lady HALE, deputy president of the Supreme Court who gave the main judgment, this is something we should welcome. It makes more equal the world in which we live for disabled people. It ensures greater oversight and scrutiny of the circumstances in which some disabled people live where they could be subject to restriction, if not restraint; and coercion through compulsory medication. It has to be right that such things are done within a legal framework, to protect rights?

Before I say anything in particular, **I also want to be clear about what I'm NOT saying!** I am **not** about to claim that we are soon to see a tsunami of demand connected to DoLS – my point is not mainly about the volume or frequency of these things, although if we are currently seeing some DoLS related police requests. My principle point, however, is not about the frequency of these kinds of demands because overall they will still seem merely occasional – my point is about the vagueness of the answers and the difficulty in finding the answers if you're not familiar with this stuff.

A GILDED CAGE IS STILL A CAGE

So the ruling being welcome, there are some obvious implications for public organisations and that will include the police. Although rarely, I have known requests be made of the police in connection with the Mental Capacity Act and to DoLS in particular. They all sound very similar to any officer who has responded to supported Mental Health Act assessments,

conveyance or absenteeism. Could officers help move someone from here to there who is resistant or refusing; could officers help find and return someone who has absented themselves from a place where the were supposed to be?

Standard stuff in many respects, until you hit upon that feature of the incident that is markedly different to these kinds of requests where they happen under the Mental Health Act: this is *not* law that is clear about powers and procedures and it is not even as familiar as the MHA might be to police officers – not that the MHA trips easily to the frontal lobes when policing, let me tell you.

So here are scenarios for frontline officers to contemplate —

1. Do you have a power to return a person against their will to a residential care home, for example, if they are subject to DoLS? – could you outline your power by which to do so, if you think the answer is yes?
2. You have attended a domestic address because a BIA has undertaken an assessment of a young man with a learning disability. Because his father recently died and his mother is in poor help, he is to be accommodated in a nearby residential setting but is distressed at leaving his home and has become disturbed. Officers are being asked to assist in moving him there.
3. You have been asked to attend an inpatient unit for patients with learning disabilities where a woman who had been sectioned under the MHA is now going to move to step down accommodation, subject to DoLS. You have been asked to convey her from the one place to the other.

Do we even know what this means? Had I posted all three of those questions with regard to MHA scenarios, I suspect plenty of people would get the answers wrong. As soon as you introduce DoLS and the MCA into it instead of the Mental Health Act, it becomes a legal car crash waiting to happen for reasons that are plainly obvious. As I have noted before —

- There is no explicit answer to question 1 in the MCA or DoLS – none whatsoever.
- There is *no explicit answer* to question 2 in the MCA or DoLS – *none whatsoever!*
- There is **no explicit answer** in question 3 in the MCA or DoLS – **none whatsoever!!**

Helpful, eh?!

A LACK OF CLARITY

And, as with the Mental Health Act, you cannot point to the MCA or DoLS and say, "there is the section that allows people including police officers to use reasonable force in realising the coercive aspects to this legislation." So even if you felt you could argue "Yes" to any of these questions – and you can, see below – the stuff is not written in a way that affords confidence to those who rarely deal. Police officers like that sort of reassurance before they go around coercing or even hurting people for a living – from where do I derive legal authority to do this. They will regret the lack of clarity provided by the Police and Criminal Evidence Act 1984 (s117) for the use of force when arresting, searching or seizing evidence; or by the Criminal Law Act 1967 (s3) when preventing crime.

The MCA is all "best interests" and "least restrictive principles" – it is all fogged, as is the MHA, with the fact that decisions are bound inextricably to the judgement of other professionals to instigate legal frameworks that are not for officers to question. However, officers then have to judge whether coercive force by the police capable of justification against the principles of the MCA. It this the 'least restrictive thing' in someone's 'best interests'? So, in seeking to answer my three questions, above, you need to go back to you general understanding of the Mental Capacity Act.

When the House of Lords reviewed the MCA in a report which was published last week, some commentators had observed when giving evidence to the committee that DoLS in many important respects was a different Act of Parliament altogether. In fairness, DoLS was not originally any part of the MCA – the 2005 MCA had Royal Assent and was on the statute books before DoLS was introduced by the 2007 Mental Health Act. This inserted DoLS into the MCA to plug legal problems that arose from precisely the kinds of cases that were heard in Cheshire West: the long-term detention of patients in residential care settings. The House of Lords also agreed that the MCA has various problems, citing that there could be tens of thousands of people who were illegally detained.

So Cheshire West now lends verisimilitude to that view: we should only expect police-related demands arising from this to go up, not down.

LEGAL KNOWLEDGE

I argue that all of the answers to the three questions above, are "Yes!" in principle – but subject to two conditions. There would be a legal ability to return someone to a residential setting if they had absented themselves outside the freedoms they are permitted under their living

arrangements. There would be an ability to support a BIA in achieving the admission of a person to a residential setting where they have been moved after a change in circumstances or condition. There would be an ability to help health or social care services transfer a person from one living arrangement to another.

But my two conditions are important conditions, to do with other kinds of problems we've seen in police support to MHA processes and we can reasonably be expect these things to be considered amidst any review of the appropriateness of police involvement or police actions —

The "could" versus "should" problem – just because the police *could*, in theory, do something to support BIAs in their work does not mean that it *should* be something the police support and difficult situations arise from a joint failure to consider how this partnership interface would work in reality. Do you really want police officers using police restraint techniques on dementia patients or teenagers with Down's Syndrome? << Not unless it is absolutely unavoidable and an absolute *last resort*. We know about the problems of police involvement with vulnerable people outside of situations where we are referring to criminal behaviour or seriously aggravated risks and we should be able to plan around the need where we are referring to passively resistant people who are simply refusing, perhaps from nothing more than fear of the unknown.

The oversight or "governance" problem – we know that not all areas put together protocols and procedures for how the MHA will be delivered in a local area, despite this being a requirement of the Mental Health Act Code of Practice. As it is not, *strictly* speaking, a requirement to have similar arrangements for issues connected to the Mental Capacity Act, it would now seem wise that these sorts of operational situations highlighted above, are considered so that we do not have ad hoc responses and reactions, like we have seen in various incidents in care homes and other residential settings. PPPPPPP, etc..

I repeat an earlier point to end – this is not about trying to scaremonger about the potential influx of high levels of demand. These things will still be rare events indeed. It is simply to say that the implications of this ruling suggest they will arise "a bit more often" and there will be slightly more need for the police and partner organisations to have thought about this interface and to consider providing leadership for frontline staff as they go about their work.

27th March 2014

Inquiry and Review –

The government have today announced a review of sections 135 and 136 of the Mental Health Act 1983.

This does not appear to be something that individuals can directly contribute to but the press release from the Secretary of State for Health makes it clear that this is a joint review with the home office and will take account of a wide range of stakeholder views, including the All Party Parliamentary Group on Mental Health and the recently announced inquiry by the Home Affairs Select Committee chairman, Keith VAZ MP. You can submit your views to that (*see below*).

No particular mention is made of a timescale by which this will be done – but I wouldn't expect to hear anything significant until towards the end of 2014. The press release makes it clear that one option at the end of the review will be to do nothing at all, either to the primary legislation OR to the Code of Practice. There could be amendments just to the Code of Practice or to both.

REVIEW OF PRIMARY LEGISLATION

The full press release from the Secretary of State for Health —

I am announcing the details of the joint review between the Department of Health and the Home Office of the operation of sections 135 and 136 of the Mental Health Act 1983. These provisions are aimed at giving support to a person experiencing a mental health crisis, by giving the police powers to temporarily remove people who appear to be suffering from a mental disorder, who need urgent care, to a 'place of safety', so that a mental health assessment can be carried out and appropriate arrangements made.

The review will consider whether the primary legislation supports our overarching objective for all public services to respond to the needs of people experiencing mental health crises at the right time, and improving the outcomes for people experiencing mental health crises when they come in to contact with the police. The review formally starts today and a briefing paper setting out the aims and timescales has been placed in the Library.

Copies are available to hon Members from the Vote Office, and to noble Lords from the Printed Paper Office.

Work on this issue was initiated by the Home Office, since when the Home Secretary and I, the Minister for Care and Support and the Minister for Policing, Criminal Justice and Victims have been working together to find the right way forward. We know there is a lot of interest about the way that Sections 135 and 136 of the Act operate in practice, and the impacts both on the person detained, and on the use of police and health services' time and resources. In particular, police officers can be called upon to make decisions on how to help someone experiencing a mental health crisis, when they may not be the best people to do so.

We want to look at the evidence and to make sure that this part of the legislation is fit for purpose, clear, and workable. The review will bring together evidence and cover a range of options, which may include leaving the legislation as it is and making changes to the associated Codes of Practice, or proposing amendments to the legislation. We will be engaging widely on developing the options with practitioners as well as those affected by the legislation. We will also seek the views of interested hon Members, including the All Party Parliamentary Group who recently led a debate on the matter. I welcome the current Home Affairs Select Committee inquiry into Policing and Mental Health, which will explore the relevant evidence.

INQUIRY BY HOME AFFAIRS SELECT COMMITTEE

If you do wish to give a view, including on the above matters, then the Home Affairs Select Committee is asking for written evidence by 07th May, ahead of taking evidence from interested parties later in the year.

The Committee would like to hear your views on Policing and Mental Health. We would welcome any relevant views, but are particularly interested in hearing about:

- What groups might have particular mental health needs when they come into contact with the police? For example, people with autism or Asperger's syndrome
- What impact does the policing of individuals with mental health problems have on front-line police resources?
- What examples of best practice are there in effective working between the agencies responsible for mental health? And what have been the results for those who suffer mental health problems, the police and health care providers?
- How have local initiatives, including the street triage pilots, improved effective working between mental health nurses and the police?

- What improvements could be made to the training and guidance available to police staff that regularly come into contact those with mental health problems?
- What more could be done to reduce the number of people who die or suffer serious injury during and immediately following police custody?
- Should s136 of the Mental Health Act 1983 be reformed? And if so, how?

The Committee would welcome views on these and any other matters that may be relevant to the inquiry. Individuals should not feel obliged to address all the points above. We would particularly welcome responses from those who have experience in the front-line delivery of mental health care and policing. Written submissions for this inquiry should therefore be sent online via their web page.

The Committee invites written submissions on these issues by **noon** on **Wednesday 7 May 2014**.

Each submission should —

a) be no more than 3,000 words in length

b) be in Word format with as little use of colour or logos as possible

c) have numbered paragraphs

d) include a declaration of interests.

30th March 2014

Barricades, Weapons and Hostages –

This last week has brought a number of queries about the role of the police in restoring or maintaining order on psychiatric wards where disturbances have occured. This is a difficult and controversial subject because we have seen incidents on wards involving the police which have then become subject to protracted inquiries after deaths in police custody or following contact. Olaseni LEWIS and Kingsley BURRELL-BROWN are just two examples of ongoing enquiries where criminal investigations became necessary after tragic events.

So it is not unsurprising to learn that the police are becoming alive to the to the risks and sensitivities of intervening in medical settings where disturbances occur. And yet, there is an inverted point to be made here about parity of esteem: the police are frequently called to intervene in Accident & Emergency departments, despite the presence of security staff there. The police are often asked to intervene if disturbances occur on wards, whether involving patients or their families. I spent a phenomenal amount of time as a young PC in City Hospital in Birmingham dealing with crime and disorder that arose in those environments. This was a far greater amount of time than I ever spent at All Saint's Hospital, which was the nineteenth century asylum in my area.

But these debates carry on —

I recently attended an event in another force where a Chief Inspector gave an overview of a situation in an acute admissions ward where a patient was reported to have taken hostages and threatened them and staff. When the police arrived, these two individuals had been released but there was now a barricade situation in the patient's room. Staff in that unit had called the police and officers were firstly interested in what "tactical options" the NHS staff had.

So this gets in to the debate: to what extent should the response to or the management of disturbance on NHS wards be "a part of the job" for mental health nurses and other professionals? We know that mental health care will give rise to disturbances, because at least some of it is delivered coercively. There are very real legal disputes and frustrations in mental health care, which mean staff train and prepare – to an extent – to respond to that. We know that some NHS staff have control and restraint training.

We know that institutions which provide higher levels of security also train to a higher standard and have intervention teams.

But this is not across the board – *and for very good reason*.

DIFFERENT MENTAL HEALTH UNITS

Mental health units differ in their constitution, their purpose and their levels of security. Even within a particular mental health unit, there are different kinds of wards. In the main local mental health unit – not a low, medium or high secure facility – there will be acute admissions wards as we as rehabilitation wards. There may be individual wards for particular conditions or split by gender or age. There may also be seclusion facilities and in some instances, a psychiatric intensive care unit. As new build facilities have opened in the last ten years or so, financed by various PFI schemes, we have seen the construction of some mixed estates – distinct areas within one building, providing different levels of care and security for different client groups.

So in some instances, within the same building, you have non-secure MH facilities, but one wing or ward may be designed to a more secure specification for a small number of low or medium secure patients. All of this affects who managers and staff will look at their extent of their role in the management of disturbances. It may be more readily expected that PICU staff prepare for the reality of managing disturbed behaviour compared to, let's say, an elderly adult ward or a rehabilitation ward. So beyond the provision of staff with training in control and restraint for pre-planned interventions to medicate someone under Part IV of the Mental Health Act, there may be little further tactical capability to deal with disturbances in the less secure settings.

Contrast this with High Secure hospitals: Broadmoor, and Rampton; Ashworth and Carstairs – these units are able to mobile staff in protective equipment, much as the Prison Service do with their "Tornado" teams. Of course, it's a debate to be had, about whether we see this as something the NHS should do or whether it is a role for the police.

There are different views on these issues: quite often genuinely held and *argued for good reason in good faith*.

TWO DEBATES

The operational tension that can arise from these discussions sometimes occurs because two debates are occurring simultaneously. NHS staff, faced with a disturbance that they assess as being beyond their ability to cope

call the police, the police then turn up and ask why it is beyond their ability to cope. In other words, NHS staff are asking for help in their operational reality; police officers are wondering *why* it is their operational reality and *why* thought hasn't been given to equipping and training NHS staff to have options available to them. But this is to massively miss the point, isn't it? – it's like the police turning up to a car crash and putting the cause of the collision ahead of casualty management and public safety. You start to investigate the cause of the crash *after* you've prioritised the injured and started first aid, as well as having secured the scene of the collision as best you can. You start getting other 999 services there before you start interviewing a blameworthy driver about due care and attention.

It is certainly my view and that of others that there can always be situations that where there is a need for police support. It is also my view, that regardless of what NHS managers could or should have considered and what they might have done to better prepare or respond, if you have frightened staff and patients asking for help because situations have occured where there are threats or risks consistent with the type of thing the police would have responded to in acute medical settings or other places, then there are certain duties arising from that. I've written about this elsewhere. You are where you are, regardless of how you got there.

Suffice to say, most mental health units, that are not High Secure hospitals do not have tactical capabilities to deal with anything beyond verbal, minor or short-lived disturbances. That means it is the job of operational officers to decide how to best police what they are called to, and the job of senior officers to discuss with mental health trusts (and possibly CCGs) what activity is best done by police officers and what is best done by health professionals. I'm confident, if there were ever a scenario where a lethal or near-lethal threat emerged on a mental health ward, we would agree with the principle that the police should be involved. Where disturbances occur of a far less serious nature, there should be capability within our NHS to respond to that.

We know that front line professionals on both sides can get this wrong: stories exist within the NHS of police officers being too quick to say, "This is a matter for you and refusing to get involved." NHS staff have been known to ring the police for trivial issues like a patient throwing a mug at a wall, breaking it. **NB**: not throwing a mug and engaging in any ongoing crime or disorder a one-off incident which was over just after it begun.

BARRICADES, WEAPONS AND HOSTAGES

Over the years, I have formed an impression that you can use the three criteria "Barricades, weapons and hostages" as a clue to things. Where any of these matters are present in an incident of disorder, there will be some

kind of role for the police, not least because within such events you could well have criminal liability that may need investigating. Let us remember: there are legitimate concerns within the NHS about the police's competence and willingness to investigate criminal offending. We know that a minority of offences on wards are reported to the police, so it is usually done because staff have thought through the incident enough to believe that the police should investigate.

But where we have barricades being erected in wards by patients stacking furniture behind doors and threatening to harm themselves or others; where we have hostages taken or weapons being brandished towards staff and other patients, this all sounds serious enough for me to want to be involved, even if it is just in support of NHS staff or to investigate the incident if criminal complaints are made. And if certain NHS establishments do have greater tactical ability to resolve disturbances then they can choose not to ring the police or cancel them.

So I'm sympathetic to the idea that senior managers and senior officers could be talking to each other more, about certain situations do not need to involve the police. Other situations are better led by health professionals appropriately trained and equipped and some situations should involve the police just as they would if they occured in other contexts. Within all of that, we need frontline staff to understand how that partnership works so that NHS staff to recognise that part of their role is the management of disturbances and calling the police about coffee mugs being thrown during one-off events is inappropriate. That said, police officers need to recognise that not all criminal justice responsibilties stop at the hospital wall and that it can be unrealistic to leave NHS dealing with barricades, hostages and weapons.

We need to remember: *we are policing the world we actually do live in, not the world we would prefer to live in.*

31st March 2014

Webley v St George's (2014) –

The police were called in April 2010 to the home of Mark WEBLEY in London. During the incident, he appeared agitated and threatened police officers with furniture before then climbing on to a window ledge, with the appearance that he would try to jump. Officers restrained him to prevent him harming himself, he was arrested for affray and then detained at Wimbledon police station.

It was known at the point of arrest that Mr WEBLEY suffered with mental health problems but Metropolitan police officers encountered him in his own home so could not detain him under the Mental Health Act. He was assessed the following day by an AMHP and psychiatrists and an application for his admission to Springfield hospital under section 2 of the Act resulted.

In considering conveyance of the patient, the AMHP delegated authority to the police under section 6 MHA and as officers moved him from the cell to an ambulance in the police yard, Mr WEBLEY ran and was detained a few yards away. Once in the ambulance and en route to Springfield hospital, Mr WEBLEY appeared to suffer from a fit and the ambulance diverted to the Accident & Emergency department at St George's Hospital.

Having arrived and been triaged by an A&E Sister, it was noted in his records that he was a "high risk patient, risk of absconding." Police officers remained in A&E until hospital security came and took over responsibility for his ongoing detention. The officers left around 3pm and two hospital security guards, along with staff in A&E, became responsible for his security and immediate welfare. Around 4:30pm, Mr WEBLEY managed to leave cubicle 9 in A&E and walk out to a nearby ramp and jump from a height of fifteen feet. As well as causing various fractures and other injuries, he sustained a significant head injury which has caused permanent damage and had a lasting effect.

He initiated legal against the hospital and against the Metropolitan Police for negligence and judgement was recently given in February 2014.

A COMMON LAW DUTY OF CARE

This is not a long court judgment, so I would encourage interested parties to read it in full. However, the judge stated that the case against the police depended upon whether the officers had made it known to staff that Mr WEBLEY was detained under the Act, whether he had made attempts to escape and that he was still a high risk of absconding. It was accepted that the officers had done all of this and had not left the A&E department until they were satisfied that hospital security were on hand to take over from them. They had discharged their "common law duty of care".

Stephen MILLER QC, acting for the Metropolitan Police, accepted that this duty of care included three components:

1. A duty to take reasonable steps to ensure that he did not come to physical harm while in their custody;
2. A duty to take reasonable care only to release him into a safe environment;
3. A duty to provide relevant information to those into whose care he was transferred.

Because the court found these three things fully satisfied, *the case against the Metropolitan Police was dismissed*.

In reaching a judgment concerning the liability of the hospital trust, the Court examined in detail the movements of security guards, their comings and goings and whether they could be said to have been observing Mr WEBLEY or actively guarding him. Whilst much debate occured in court about what would constitute the "least restrictive" approach, the court rejected suggestions that a less intrusive, less restrictive approach was reasonable because of the risks that were known about the potential of Mr WEBLEY to abscond. In particular, there were two doors in the cubicle where the patient was detained and the security officers did not position themselves in such a way as to block both exits. The second security officer, who arrived after the police left, had not been briefed on the issues highlighted by the police about the risk of absconding.

Paragraph 53 of the judgment summarises fourteen seperate considerations put forward by those acting for St George's. They make interesting reading! The courts view on the approach to striking the balance between intrusion and least restriction, the detail of briefing and planning that should have occured amongst the security and clinical staff, in the court's view.

It was for all of these reasons, that the court found the hospital trust liable for the injuries that Mr WEBLEY suffered and the fact that he is now in a

secure hospital facility, detained under s3 of the Act having suffered life-altering injuries.

IMPLICATIONS

One thing that struck me reading this judgment, was the issue of whether and to what extent the A&E department were obliged to take responsibility for Mr WEBLEY. After all, he was in the police's legal custody having had authority delegated to them by an AMHP. An easy way of acute trusts with A&E departments avoiding the kind of liabilities that arose in this case, is to decline to allow their security officers to take over the legal responsibility from the police. I have known A&E departments do exactly that and as Stephen MILLER QC accepted, the common law duty of care is not discharged until the police have released him into a safe environment.

Another argument for improved partnership arrangements! … yet there has to be some duty upon the AMHP who made the application to become re-involved in the issues around that patient, in light of the new information that took the patient to A&E. But as with all things "policing and mental health", unless these kinds of things are discussed and agreed in advance and expectations achieved between organisations, you will get the uncertainty and unwillingness in the NHS that is potentially more likely as a result of cases like this.

APRIL 2014

1st April 2014

More Thoughts on Mr Webley –

I've been thinking since the weekend about the recent judgment of *Webley v St George's* (2014) the subject of my most recent post. I've come back to it again because the more I've thought about it, the more it raises a whole host of problems of a legal and practical kind.

I want to explore them here, so we not only maximise the chance of avoiding such an outcome again, but also so that we consider the potential for managers to plan around this whilst we continue to debate what role our police should play in our extending mental health system.

If you haven't read the previous post, please do so before continuing this one, otherwise it may not make sense! And this post is not going to be an easy read, for some of those affected by the case's implications!

LEGAL ISSUES

Some of the legal issues that I see, which would benefit from closer examination —

- **The A&E Department's legal duty to accept responsibility for MHA patients who are liable to be detained** – Mr WEBLEY was subject to an application for admission under s2 MHA. He was not (yet) an inpatient having not (yet) arrived at Springfield hospital where he was due to be admitted. This was unavoidable: an unexpected medical emergency made it absolutely appropriate in the opinion of the paramedics overseeing his medical wellbeing *in transit* that he be taken to A&E.
- Accident & Emergency departments are under absolutely no duty whatsoever to accept responsibility for the legal detention of patients where that legal custody was initiated by others. Had a slightly different version of events panned out, they almost certainly would not have done:
- Imagine a patient who had been detained by the police under s136 MHA and was being taken by police and ambulance to a Place of Safety at Springfield hospital, but again diverted to A&E because of an unexpected medical emergency, then would they have accepted

legal responsibility for that patient pending assessment by a DR and AMHP?

- I submit they would not have done so and would be under no duty to do so – so why did they do it here?! Having discussed this with a good friend who is a security manager in an NHS acute hospital, he initially thought that security accepting the detention was right and proper, having reflected, he emailed to say he saw my point! – why would you do it, if you were an A&E department when you had no obligation whatsoever to do so?!

- **The police "further delegating" authority under s6 MHA to detain and convey** – the Metropolitan Police were delegated the authority by the AMHP who made the application, the right to detain and convey to Springfield hospital. Accepting that no AMHP could or would object to 999 services reacting as they saw fit to a medical development, once the patient arrives in A&E, they remain in police custody under s6 because the AMHP has delegated to them, not to anyone else.
- Would the AMHP delegate to hospital security whilst in A&E if told of the circumstances and given the option? – maybe, but maybe not. Some who have commented on social media have suggested they would be very unlikely to do so.
- Do the police exercise unilateral authority to make that assessment on behalf of the AMHP without consulting them? – probably not. Again, suggestions today have suggested that they could not and this particular point of law was not under debate in Mr WEBLEY's case.
- The AMHP may have delegated authority to the police in this case – they may have delegated to nurses or paramedics in other cases – but they, the AMHP, remain *responsible* for the overall detention / conveyance. So I submit that the duty AMHP should be re-contacted, told of the developments and afforded the chance to get involved again – even if this is via phone because they're at the next job.

PRACTICAL ISSUES

In reflecting on this case, though, you can see a whole stack of considerations that are about organisations avoiding the lion's share of risk or liability. A&E seem to have put themselves forward to accept responsibilities in areas where they simply could have said, "No". I wonder that this case makes it more likely that they will say "No!" in future? This would mean, in such cases where A&E exercised that right, the police being expected to remain for protracted, indefinite periods of time whilst they re-contact the AMHP and try to negotiate an outcome that releases them. What chance would there be that the mental health trust would

dispatch nurses to A&E to ensure the patient's ongoing detention? I would suggest there is little chance, because the patient was not yet an inpatient.

In fairness, if someone had been admitted to a mental health unit and suffered a medical emergency shortly after being accepted there as an inpatient, nurses *would* have accompanied them on the ambulance and they would have been there in A&E, ensuring they remained detained. Whilst A&E security may have supported this process, given the less secure nature of the environment, it would still then been a legal detention led by the mental health trust, and only supported by A&E. But that then raises the issue of why the legal position in which a patient happens to have a medical emergency, affects the care arrangements that can be enacted, given that everyone in the process would agree that the situation relates to: a patient with assessed mental health difficulties; a patient who is subject to legal frameworks because of their health problems; a patient who poses a certain kind of risk to himself, etc.. The only thing that is different in this case compared to a similar one that may have resulted had the emergency presented itself thirty minutes later, is the ability to argue legalities.

The AMHP was of a view that authority to detain / convey should be delegated to the police. On the police's part, they had agreed to escort someone in an ambulance from Wimbledon police station to Springfield hospital, which is just over 3 miles by either road you would choose . It would have taken half an hour with the administration responsibilities at either end. Had the AMHP said, "Oh, and when you get to hospital, we need to wait an indeterminate length of time" the police may not have agreed to accept the s6 authority, bearing in mind that they were under no specific obligation to do so. Yet a diversion to A&E whilst *en route* to Springfield, does amount to them becoming involved for an indeterminate period in ongoing healthcare management. Some would ask: is this a role for our police service?

IMPORTANT THINGS

And guess what *all of this* debate about?! – organisations: their resourcing issues and liabilities. It is therefore *not about* Mr WEBLEY or patients like him who should be at the **centre** of our decision-making. There is an extent to which it **doesn't actually matter** who is keeping patients safe in these circumstances as long as someone is – but the reality of our developing interface is the need to see organisations working more closely, in partnership. << This is the phrase we hear when others want to see greater police commitment to certain issues: I submit it is a two-way street! Few managers in any policing, health or social care agencies will have sat down during discussions to ask the question: "Who looks after the detention of patients in A&E if they are diverted there having become unwell

after the MHA application but before arrival at the identified hospital?" and everyone will feel it unfair and unreasonable if the fingers point at them.

I suspect we just haven't really thought about this: and since I anticipate that this case will make A&E reflect upon the extent to which the put their arm into a mangle, it will then fall upon the police to ensure people's ongoing security – thus further criminalising the entry process to our mental health system – unless we do think about it. The only way around that is to consider in advance of these kinds of events what the solution might be. I wonder whether police officers might ask, ahead of accepting s6 authorities, "If we get diverted to A&E and it looks like we'll be there for hours, what's the plan?"

Then we're straight back to the very same dilemma for AMHPs that we see in other areas of their work: we see it when they are undertaking assessments in private premises, or where patients who are passively resistant are refusing to consent to admission. AMHPs are often backed up professionally by no-one at all in the important, legal work they do – *responsible for everything, whilst having control of nothing*. They are often spinning plates, coordinating multiple statutory duties at once with only one of them on-call out of hours. I really hope no AMHP sees it as a criticism any of them to suggest that if the police were to put in a call to say, "We had to divert to A&E and anticipate being here for hours", there will be little support on which an AMHP can draw. The answer is likely to be, "Sorry, there's nothing I can do." Whether that AMHP would think it acceptable for the police to delegate further to hospital security pending further assessment / treatment of the patient, I don't know.

What I do know is this >> A&Es are under no particular duty to do what was done in *Webley v St George's* and to be frank, I wonder why on earth they'd *ever* consider it!

2nd April 2014

Hicks v The Commissioner –

Another post on some recent case-law that arises from an incident which was nothing to do with policing and mental health. However, upon learning of it strikes me as very relevant to the way in which officers use their Common Law power to prevent a breach of the Queen's Peace. I submit that all officers who are likely to make or supervise arrests and the custody officers who detain people in the cells need to know of this case.

Cast your mind back to the Royal Wedding in 2011. As part of a large security operation on that day, officers from the Metropolitan Police detained several people whom they suspected were *en route* to protests where crime and disorder would result.

Several people were arrested to prevent a breach of the peace and taken to custody where they were held until the likelihood was over. The question that arises in the Appeal Court, is whether or not the detention in police custody amounts to 'internment' and violates Article 5 of the European Convention. But let's start with the basics of what a Breach of the Peace actually is, for those who don't know.

BREACH OF THE PEACE

Referred to as a Common Law complaint, a Breach of the Peace (BoP) can trace its legal antecedents back to the Justices of the Peace Act 1361. This is the oldest Act of Parliament I've ever come across in policing. Police officers and all citizens are entitled to detain those whom they reasonably anticipate will breach the Queen's Peace and bring them before a Magistrate to be "bound over". The court can require the person to enter into recognizance to be of good behaviour, lest an agreed sum of money be forfeit. So you may appear in court and be told, "You will be bound over for six months in the sum of £500" and you only ever pay that sum if you are brought again before the court.

Breach of the Peace is not an offence, strictly speaking, it is a complaint. Where officers arrested individuals for this, they may do so as soon as they imminently anticipate a breach of the peace or having come across a breach in progress, may arrest to apprehend that breach. The person is then removed to police custody. If it is still anticipated that a

Breach of the Peace would occur when a Magistrate becomes available, the person must be brought before the Justices for that area to be bound over. If there are grounds for arguing after arrest but before appearing in court that the anticipated breach is no longer feared, or if the breach that occured is not likely to recur, then the person may be released without being brought to court.

THE CASE OF HICKS AND OTHERS

Mr HICKS and others were amongst those arrested on the day of the Wedding. Having been detained for several hours, the Wedding having concluded and protests ended or dispersed, they were released.

Several people then brought civil action against the Metropolitan Police (2012) in a judicial review. This original action questioned the legality, proportionality of arrests, stop / searches, etc..

The original judicial review led to a long, detailed judgment but the conclusion was that all of those initial claims were dismissed.

This post arises from the Appeal of some of the original litigants, in which particular parts of that judgment were questioned. Mr Brian HICKS and others (2014) argued in appeal that their detention in Metropolitan Police custody amounted to a deprivation of liberty, contravening article 5 of the European Convention. Obviously, the ECHR is violated if the state deprives someone of their liberty in circumstances where And here's why —

- **Everyone has the right to liberty and security of person** — no one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
- a) the lawful detention of a person after conviction by a competent court;
- b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
- c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
- d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
- e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

- f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

I draw your attention to A5(1)(b) and A5(1)(c) which are pertinent to the appeal. I also have to confuse you by pointing out that whilst a Breach of the Peace is not, strictly speaking, an "offence" under British Law, it is regarded as an "offence" for the purposes of European Law! Helpful, eh?!

(Also note A5(1)(e) which is how various provisions of the Mental Health Act are compliant with the European Convention.)

THE RULING

After considering various cases from European Law and other domestic legal issues, the court ended up focussing upon A5(1)(c) as the crux of the matter. The detention of Mr HICKS and others would be lawful if it complied with that provision, it would if it didn't!

Simple, isn't it?!

On the face of it, how could the Metropolitan Police have complied with this? They arrested the protestors and released them only a few hours later, the Wedding having finished. So it all comes down to the intention behind the arrest. The police submitted that the protestors were released as soon as they were satisfied that no breach of the peace was likely to occur. This point in time happened *before* they get the protestors before the first available court. Had the breach of the peace still been anticipated at the point where the Justices sat, then the protestors would have been brought before the court to be bound over.

It was therefore their intention at the point of arrest to bring protestors before the court if they still anticipated a breach. That fear having receded, they were released. The court's ruling was that the officers acted "for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence."

The appeals that the detentions in custody violated Article 5 were **dismissed**.

POLICING AND MENTAL HEALTH

So it follows from there, that the more generalised point about the implication for policing mental health related incidents, especially is private premises, is a brief one. We are all familiar with the difficulties police

officers can face in private dwellings. Without an ability to use s136 MHA and with no other legal provision allowing unilateral action oriented around a vulnerable person's wellbeing, officers can feel hamstrung, where they feel they must act. In very rare cases, the Mental Capacity Act may apply, but as I keep saying again and again(!), the extent to which this can be relied upon is really *over-estimated* by paramedics and police officers alike and if people looked hard enough, they would find the circumstances in the case of *Sessey* are far from being a one-off incident. (Yes, I have flagged it up, where I've seen or learned of it.)

So where officers feel they have to take some immediate action to safeguard someone, they fall back on some traditional options –

- **They arrest someone for a substantive criminal offence** – see the recent judgment in Webley v St George's (2014) for an example of that.

- **Officers have been known to arrest for a breach of the peace and once a person is outside the premises, de-arrest them(!) and then detain them under the Mental Health Act** – we know this is unlawful because of *Seal v Chief Constable of South Wales Police*.

- **Officers arrest to prevent a breach of the peace with a view to securing Mental Health Act assessment in custody** – this practice is where this judgment in *Hicks* becomes very interesting indeed for its wider implications!

We now know from the (civil) Court of Appeal that it must be in the mind of the arresting officer to bring the person "before the competent legal authority" in order to survive a challenge against Article 5(1)(c). Arresting a person to prevent a breach of the peace without any intention at all of placing that person before a court, will violate this European Convention. So it appears that officers need to ask themselves when making any arrest for a breach of the peace and certainly it might be regarded as the "Ways and Means Act of 1829" – whether they would be trying to place that person before a court or whether, in reality, it is a *proxy* arrest to deal with a situation the Mental Health Act doesn't cater for?

This also has implications for AMHPs when planning Mental Health Act assessments in private premises and considering, firstly, whether or not to request police support; and secondly, whether or not to secure a warrant under s135(1) MHA. Even before this case, AMHPs would clearly need to have in mind what police powers might be needed. For example, if they were attending because the risk of crime and disorder at the address came from a third-party, the police may need nothing more than knowledge of the criminal law: specifically, the rights of AMHPs to enter premises and the criminal offence of obstruction of the AMHP under s129 MHA. If the issues

are that a patient is likely to be resistant and aggressive and prevent a meaningful assessment occurring, then reliance upon police powers to prevent a breach of the peace may now be misplaced.

Previously, where an AMHP had not obtained a s135(1) warrant – for example, because access was possible and a view was taken that rendered an application unnecessary – it has occasionally been relied upon (consciously or unconsciously) that the police will detain patients to prevent any anticipated BoP or criminal offence, and that Mental Health Act assessment can conclude in the cells if it had been prevented. I submit that such action, in the absence of an intention at the point of arrest to place the person before a Magistrate may well be questioned as a violation of article 5 in the context of this ruling. If any one disagrees with me on this, I'd love you to leave a comment saying why.

3rd April 2014

Capacity –

Is it OK if this post is a somewhat indulgent off-load of something exacerbates my stress levels and causes my blood pressure to rise? Thanks. Far too many times in the last few weeks, I've heard versions of these kinds of things in operational situations or during some presentations I've done to police / healthcare professionals –

- "I need you to help me get this bloke to A&E because he doesn't want to go and he lacks *capacity*?" said the paramedic.
- "Doctor, I can't prosecute this man unless you give me a statement confirming he had the *capacity* to forms the mens rea." said the police officer.

AAARRRRGGGGGHHHHHH!?!?!?! – **STOP IT!** … please, stop it!?

Capacity – is this just a word that a lot of people have latched on to, having misunderstood it and because they think it can easily make them sound like they know what they're talking about and doing, when justifying their own action or inaction?

There are two things going on in my above examples: legal capacity as a method to determine whether or not the State may intervene in the best interests of a patient; and the use of the word 'capacity' as a proxy for proper understanding of the legal issues that arise during criminal investigation. Let's take them one at a time!

LEGAL CAPACITY

A few weeks ago, the House of Lords published a report on the operation and effectiveness of the Mental Capacity Act 2005. I recall reading sometime around the release of this document that there was discussion about what 'capacity' actually meant and one respondent stated –

"Saying that someone lacks capacity is totally meaningless."

And so it is!

Some of us having been saying so for years! Capacity is decision-specific: you may simultaneously lack capacity for one decision, whilst retaining the capacity for another decision. This is because the information necessary to weigh the issues appropriately may vary in their complexity rendering some people unable to understand one issue, without affecting the other.

Imagine this — a person who is detained in hospital under the Mental Health Act is deemed to be in need of a life-saving operation for a general healthcare issue. In the opinion of the psychiatrist and the other specialist consultant, they form the view that the patient is unable to understand the implications of their condition and the fact that they may die without treatment. There could be a scenario in which a view is taken that this patient lacks capacity to take the decision about whether to accept or decline medical treatment. Imagine that whilst these deliberations occur, the patient is offered a cup of tea by a nurse on the ward and they decline – it does not follow that because the patient is deemed to lack capacity on the first issue, that they must lack capacity on the second. If the patient were at life threatening risk from dehydration, they wouldn't be being offered tea there would be a more medical response to that, so assuming the patient eats / drinks more or less normally but is simply not thirsty now or would prefer something else, no-one would countenance forcing Earl Grey into them.

It is also true that a decision for which someone has capacity now might something for which they will lack capacity in an hour's time, or less. Capacity is fluid and assessment of it is specific to time and context – imagine a person who is intoxicated and injured to the head, following an assault upon them during a night out. It may be that when the police and ambulance service turned up they lacked capacity to take decisions around medical treatment for an injury that may well be serious. Four hours later when the alcohol is wearing off and medical obs have been performed a few times, they be deemed to have regained capacity and when they decide to leave without completing treatment there would be no good grounds to stop them and no serious or lasting consequences to that decision.

So when I turn up to an ambulance job and hear "He lacks capacity!" I just want to do a small interpretive dance. For WHAT, precisely, does he lack capacity? Paramedics tend to deal with illness and injury: if the paramedic is proposing to dress a superficial wound and the patient is refusing to let them, this could be akin to the person declining a cup of tea – it may be almost entirely without consequence. To leave some minor wounds undressed may expose them to a minor risk of infection and may not look great, but they are certainly not going to die (from that, today). It also may be that the decision to decline was influence by alcohol or drugs that will wear off in a few hours and the question of wound treatment can be put to them again.

And even if someone *has* self-harmed by causing cuts to their arms in their own home and then declined medical treatment, it may be the case that they "lack capacity" around medical treatment, but other parts of the MCA would not allow the person to be immediately coerced to A&E. *Remember*: to engage in anything which amounts to a deprivation of liberty under the MCA (and Cheshire West means that more situations *are* such deprivations), then paramedics and police officers would have to be able to show that it was a "life-sustaining intervention" or necessary to prevent a "serious deterioration in someone's condition".

INVESTIGATION PROXY

Things become even more absurd when we start seeing "capacity" as a proxy for other legal considerations. Capacity, is not a relevant term when considering our criminal law. I won't regurgitate many different blogs I've written on this topic, but would summarise the following points and I know that I'm simplifying this, potentially just a touch too much to make the point to non-lawyers and to non-investigators. *Please bear that in mind because I know holes could be picked!* –

- **The cognitive side of criminal offending is governed by the laws around concepts of intent and recklessness** —
- Offences of simple intent require almost no conscious mental element at all, the *mens rea* – insanity is *not* a defence to offences of simple intent.
- If you're found driving a car on a road, you either do or do not have a driving license, insurance and an MOT. What you thought you had or how your cognitive state is affected by your mental health problems, other illness or substance use is neither here nor there.
- Such issues may very well affect the public interest in a prosecution or may affect sentencing by the courts, but the basic ability to satisfy the evidential test for those offences is unaffected.
- Even offences of *basic* or *specific* intent may not be affected in terms of proving the evidence exists to prosecute – either someone's fist did hit someone else's face unlawfully, or it didn't and if that person understood it would hurt or injure, that is sufficient to prove the assault.
- The fact that someone hit mental health nurse or police officer because a delusional condition made them incorrectly apprehend that person to be someone intent on causing them harm, is not a make-or-break factor.

- **Criteria which indicate someone is very seriously mentally ill do not necessarily obviate criminal liability** – see the case of Christopher HAUGHTON in November 2011.

- He was arrested, charged, remanded and prosecuted for attempted murder, several GBH and ABH offences and **at all times from arrest to conviction**, he was so seriously unwell that he met the criteria for admission to hospital under the Mental Health Act.
- Ultimately, he was sentenced to a restricted hospital order which reflected this assessment of his serious mental ill-health, but none of that meant that he "lacked capacity to form the *men's rea*" or similar nonsense – he was still convicted.
- Bear in mind that in terms of a specific intent to form *men's rea*, attempted murder is the most difficult offence on the statute book to prove – to prove murder there must be intent to kill *or* seriously injure, but for attempted murder there *must* be an intent to kill.
- All cases should be assessed on their individual merits and we must resist the temptation to confuse and conflate the evidential test with the public interest test.
- It may not be in the public interest to prosecute a seriously mentally unwell person for causing actual bodily harm to another but we should not think it impossible to prove the evidential part of the offence purely because we don't think a prosecution has utility.

So there you go – and it's now all off my chest! Please spread the word as I will reluctantly admit **it does my head in**! Far more importantly, it means we hear of cases where members of the public in the first set of circumstances are either removed from their homes in circumstances where the *Sesser* judgment makes it clear they should not be. In the second misuse or abuse of the concept of capacity it means we may be missing a chance to bring people before criminal courts who should be there in order to let criminal courts take decisions that they alone can take.

There is work to do here – *please help me get it done!*

10th April 2014

Review of Section 135 and 136 –

I mentioned that the Government had recently announced a review of sections 135 and 136 of the Mental Health Act 1983. Well, the public consultation is now out and you have your chance to have your say. I would encourage as many people as possible to answer this request for views, whether you are an interested member of the public or a professional of any kind.

The final deadline for this consultation is 3rd June 2014 and it consists of a questionnaire with opportunity to add free comments. You can read about the review and see the questions posed and you can also email the review team, should you wish to provide case studies of relevance to your view. Their email address is —

reviewofS135andS136@dh.gsi.gov.uk

Review of S135 and S136 Project Team,
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You can also obtain Braille, large font or audio formats of the consultation via the contact details or email address, above.

Bear this in mind as you contemplate your response: the legislation we currently use to ensure the safeguarding and wellbeing of vulnerable people was written in the 1950s. This was before we rightly deinstitutionalised our mental healthcare system, before antipsychotic and anti-depressant medications were widely used and before we saw the retreat of our mental health services and the erosion of emergency mental healthcare. The police service has become relied upon more and more to ensure people don't fall through the gaps and we've seen in case-law over the last twenty years who officers have felt obliged to become "inventive" using other laws, to safeguard people. We have also seen, like in cases such as Webley v St George's how the police are often compelled to criminalise vulnerable people in order to keep them safe, for a want of other options.

I merely make the argument that we do have a problem. The solution could take many forms and I fully accept that we need to ensure human rights and civil liberties protections in anything that we decide to do. We need modern mental health law fit for the 21st century, but that could look like any number of things. It has been said that the police becoming increasingly vocal on the issue of our legal and health systems is overpowering the argument. I can actually accept very fully that this is true – it is therefore important that the other professionals and the public, especially service users, put their views forward to ensure we get the law we need, with any necessary safeguards we require, to keep people safe.

This opportunity to modernise the legislation used in emergency mental health care may not happen again in our lifetime – **so make sure you have your say**.

16th April 2014

Flavours of Street Triage –

New money is making further investment in street triage schemes possible in many areas of the country and we have seen new schemes emerging in the early part of this year. Some NHS areas must be convinced of the value of them since they are funding them directly, without pilot funding from the department of health. In new extensions of the concept, we are starting to see variations on what street triage looks like and I know forces yet to go down this route are also thinking of even more variations on this theme.

For example, West Midlands Police is operating in trio with Birmingham and Solihull Mental Health Trust and West Midlands Ambulance Service – thereby enabling paramedics to have input into these 999 situations and we can easily see why this may be helpful. Immediate attention to physical health issues, including injuries from self-harm and the potential to identify presentations which may indicate A&E is required. In the Lincolnshire Police area, they are also including paramedics in the triage car itself, but they are not including police officers. Their arrangement is a pairing of a mental health nurse and a paramedic, able to respond instead or as well as the police when 999 calls are received.

There are (at least) two ways of looking at this: localism should allow for local leaders to make decisions about what suits their locality – what works in Newcastle may not work in Northumberland or vice versa because of geography and / or population density. So a "one size fits all" model may be futile. In furtherance of that same point, schemes starting in various areas are doing it against different backdrops: I heard a presentation last year by Cleveland Police about street triage and learned that officers in that force, prior to the commencement of triage, were using section 136 of the Mental Health Act around 500 times a year, which is high for the population of the area. In fact, it is roughly similar to the usage in Birmingham where the population is twice the size but in important respects, the outcomes were very, very different. Approximately 125 subsequent admissions in Cleveland after 136 assessment but around 225 in Birmingham – in other words, the number of MHA admissions correlates, at least roughly, to the population size, not to the use of s136. So schemes to match local need may vary for various reasons. Use of s136 in Cleveland is perceived by some others to be excessive and triage is seen as a way of helping to reduce this – we should also remember that per capita funding for mental health

varies across the country, so certain things may be affordable in some places but not others.

Having said all of that, triage schemes in their various forms need, presumably, to be consistent to at least some degree on what, *precisely*, they are trying to achieve? I wonder how these intentions may be affected by approaches that see the police remaining outside the triage car – in other words, where frontline officers call upon a response from another professional agency who then either makes telephone contact to provide information / advice, or who turns up if they see a need to do so. I'm also wonder about whether it matters if the professional involved is not a mental health nurse? Original intentions in the schemes in Cleveland, Leicestershire and Sussex were to have nurse-led input into situations that the police could not legally manage anyway; and identification of situations where a legalized police response is not justified because of other less-restrictive interventions that a nurse can either provide or call upon.

How would those situations be handled by other health / social care professionals and what pathways would be open to them?

OTHER MODELS OF TRIAGE

One of the embryonic triage schemes I am aware of is looking at the deployment of a social worker, probably qualified as an AMHP, to act as the professional mental health advisor. The UK would not be the first country to do this: Portland in the United States has also looked at this approach, whereby emergency calls to the police that do not include suggestions of violence see a single agency, social work led response and calls involving threats and risks see the police supporting those professionals.

We only need to remember Panorama from last September to see how many of the "mental health issues" were in fact social, behavioral and substance abuse issues and who is to say that social workers, professionals in mental health are less-equipped than mental health nurses to undertake a triage function?

What about the use of a mental health nurse who is ALSO an AMHP, as in Sussex?

A qualified AMHP could certainly better gate keep the legal considerations as to whether the MHA could be of application but it is interesting also for this reason: those qualified as AMHPs have very have few legal powers when acting alone, in their own right – those they do have would be of limited applicability to 999 calls to emergency services because they wouldn't that add much to the legal authorities the police already have for themselves. So the ability of an AMHP to do legal things, would depend

upon their ability to call upon an s12 Doctor and that varies from area to area.

I am aware of five police forces who have indicated that they do not wish to put a police officer in a car with a health or social care professional. Some argue that geography and demand renders it unjustifiable from a cost-benefit point of view to ring-fence officers to deal with nothing other than street triage calls. Others argue that a different model of response suits them better and that whilst they fully intend to close the ties between mental health and policing, it will probably not be in the format of a double or triple-crewed multi-agency vehicle. For clarity, these are not just rural forces covering large expanses of sparse population – they include some large forces covering major cities. They just prefer closer working ties where professionals call upon each other as required, all supported by better policies and improved (joint) training.

I'm not sure what Hampshire Police think of street triage as originally conceived (police officer + mental health nurse) but I do know that they have started a pilot whereby a mental health nurse is based in their control room and able to share information with police controllers to assist front-line officers in policing incidents. Bearing in mind that in Leicestershire, the street triage car does not deploy to 90% of the incidents where a street triage input is considered, a model that bases a mental health nurse in a control room achieves most of what street triage can do without having to ring-fence officers for the purpose, information-sharing being key. I know that in Kent, their model of street triage is firstly an information-sharing model, undertaken by telephone. It is secondarily, a model of deployment where a nurse can deploy to an incident, not from a double-crewed multi-agency car, but in support of the front line officers already there. That is how the Cleveland scheme works, too.

When you consider the eight-dimensions to street triage, we see that the attendance of a nurse at an incident may affect one quarter of the types of calls received – and even then, only where there is consent or cooperation from the person at the center of the call or incident. *Note:* this is not one-quarter of calls, but one-quarter of the *types* of calls. We're yet to fully understand the demands through formal evaluation and we're yet to understand the impact of different models of working when compared to each other and when compared to what existed before.

WHAT ARE WE TRYING TO ACHIEVE?

I keep coming back to this point, whilst genuinely trying very hard indeed not to *be* negative or to just *appear to be* negative: the extent to which localism is leading to different improvisations of what street triage looks like, may be evidence in itself that we're not sighted on a particular goal.

Are we just hoping that we can "do something?" In one force, it is the privately stated ambition of MH services to "stop the police misusing 136". In another, where little or no misuse occurs, it is to provide alternative pathways that negate the need for 136, even if it could have been legitimately used had a nurse not been present – there you have two schemes that are intent upon achieving very, very different things: all under the banner of *street triage*.

When we see consideration of the different kinds of MH professional that could be involved, we start to see that we're not sure whether we are focussing upon assessment of clinical issues or broader assessment of social circumstances or the reduction of misuse. I admit to being interested in making sure that police officers detaining or referring people are not misunderstanding the presentation of someone as "behavioural" in nature, for something that is actually seriously pathological that places health at risk. Obviously, that cannot be a consideration in a model of street triage that employs an AMHP rather than a mental health nurse, and pre-hospital clinical capability is different again if a paramedic is involved. I still hear the debate ongoing about whether a mental health nurse should be undertaking pre-hospital screening of people in contact with the police whose identities and backgrounds may be unknown.

Given we can exemplify psychiatrists getting clinical presentations badly wrong, should we be putting mental health nurses in that position? Some of them say, no; others say yes. **Even they can't agree.**

It was once joked amidst a discussion on all of this, that maybe we should have a triage bus?! – something large enough to enable a police officer and a paramedic as well as an AMHP, a mental health nurse and a psychiatrist to travel in a together? A one-stop shop for all eventualities. Of course, such jest was quickly put to one side because we can imagine how enormously expensive that would be and how most of the time, most of the people in that bus would not be strictly necessary to the proper resolution of a particular call. Of course, that is true of current schemes to different extents in different formats.

The same principles of cost-benefit against a thoroughly understood demand profile have not yet been done – and I very much look forward to reading them in due course. When they're undertaken, I also want to read something the legal and ethical issues involved because in the media material I keep seeing I just keep being told that it "helps". Meanwhile, I remain concerned that the lack of proper emergency mental health law training for those involved – *especially* on the Mental Capacity Act 2005! – and the lack of vision around what to do when mental health emergency conflates with criminal law, may be leading to perverse outcomes. This needs addressing if we are to get convincing about the overall benefits. Just saying, "it helps" is very far from enough, without detailed answers to the understandable questions that arise.

16th April 2014

Place of Safety Progress –

The Care Quality Commission have today released an interim update on the progress being made in Place of Safety (PoS) provision, shown in map format (*see a snapshot, right*). This is just a short post to put out some highlights from it as well as some thoughts and observations —

There is a particular emphasis in the update on many PoS services excluding children. The BBC news covered this with the headline, "Under 16s refused access to safe havens." I can't be the only police officer in the country who has looked at the empty PoS room in a hospital and asked, "Are you seriously telling me that you WANT this child in the cells when this room is standing empty are the law inclines towards it being used?"

But given the emphasis that has emerged on child access to PoS services, I can tell without doing too much work, that the map is incomplete or incorrect, in this regard. If you zoom in on Birmingham, you will only see one PoS service shown is to the south-west of the city. This is the service for those who are 16yrs of age or older at the Oleaster mental health unit in Edgbaston and it services both Birmingham and Solihull local authority areas. The map does not show you a green flag somewhere east of that which is a specific children's PoS at Parkview, the regional CAMHS unit in Moseley, Birmingham. So I wonder about the rest of the map. The BBC cited Birmingham's facility as not accepting u16s, whilst also failing to mention Parkview.

The update also notes that the only "upper tier" local authority not to have access to a health based PoS is the Isles of Scilly. Despite almost 100% coverage in England, the report details how 35% of those restrict access on the basis of age and many of those are in our larger cities where a disproportionately high number of people are detained under this provision. So whilst in theory, our map is now covered, we are still bedeviled by exclusion criteria.

GEOGRAPHICAL AND OTHER EXCLUSIONS

It still raises issues about geographical coverage and boundaries or borders — the only place of safety in my home county of Northumberland is in the south-east of the county. If you are detained in Berwick or Hexham, you

can be a good hour's drive away from the PoS service. The same is true in Cornwall and North Yorkshire. How realistic and practical is it for police or ambulance services to transport people so far? Accepting that the report is not a final analysis, it also doesn't touch upon exclusion criteria like drugs, alcohol and violence. We know that around 20% of PoS services will exclude children, but how many would exclude someone who has been drinking … and what threshold or method is used to determine whether some alcohol is too much alcohol in those particular circumstances? What about those who are resistant or aggressive? We know that Royal College Standards have something to say about that – is it delivered in reality in some, all or none of these services?

In particular, I'd love the above map to reflect whether or not these services are *staffed by mental health professionals*. How many of them involve the police letting themselves into an empty room or being allowed in by a nurse who decides whether or not the person can be assessed there before disappearing back to a ward and having no further part to play. How many of these services involve the police providing security, outside the vision of the Royal College Standards, for three hours or more. Sometimes for as much as twelve or fifteen hours at a time?

What does it *really* mean when we say "police cells only in exceptional circumstances?" And there is another remark that really made me blink and re-read it. This map is overtly described as being something that "would help the police to identify the nearest health-based place of safety – where a suitable one is available – to avoid people being taken to a police station when what they so badly need is to be assessed in a therapeutic environment." This, at least to me, implies that officers who make a detention are at liberty to choose where to go. Realistically, areas only ever accept those people who have been detained within their local authority boundary. So if the police from Area 1 detain a 15yr old when there is an age restriction on access, they cannot simply go to Area 2 if they don't operate such exclusion grounds. I remember distinctly a complaint a couple of years ago where the police in Area 1 detained a man who lived in Area 2 within Area 1's boundary. Access to a health PoS having been denied in Area 1, they took him to the PoS in Area 2 who were happy to receive him. The Area 1 PoS complained about Area 1 police for doing it. The answer to this complaint, incidentally is, "paragraph 10.22 to the Mental Health Act Code of Practice applies."

There was a short response from the Royal College of Psychiatrists, who oversee the multi-agency group on s136 that sets the Royal College Standards, last updated in 2011.

All of this means we continue to need strong, clear commissioning of services that operate to agreed standards. Until we get that, we're gambling with equality, safety and human rights issues that we've been burned by before. The progress we are seeing is still painfully slow given

that this legislation was introduced 55 years ago. I could testify in a court to having sorted this in one area in under six months from start to finish – it isn't actually that hard and it's not a matter of resources: *it's a matter of will on the part of commissioners.*

I look forward to the full report in the Summer of 2014.

19th April 2014

The Dangerously Mentally Ill –

You know what I'm referring to here, don't you? Just that term, "the dangerously mentally ill" tells you all you need to know about the group of people I'm referring to. It's such a self-justifying, explanatory term that it doesn't really need any further explanation or clarification – you're delivered straight to a vision of those in our society that are caught by this classification, right? Surely, as a policeman, I meet people from this strata of our society all the time and they're easy to recognise – maybe it's those who would do harm to strangers or their close family and friends?

But what do you think I mean by 'dangerous'? … and what do I mean by 'ill' or 'mentally ill'?!

If you haven't already realised: **these words take us almost nowhere at all** – let me briefly explain why and let me tell you the reasons behind labouring the point —

Have you ever listened to a psychiatrist and a lawyer discussing terminology and definitions, especially legal ones? It's worth buying popcorn and setting aside time because those discussion can go on and on and they're highly entertaining – lawyers are from Mars and psychiatrists from Venus. You see, the concept of 'dangerousness' was so problematic when the Mental Health Bill 2004 was making its way through Parliament that the whole thing fell and we were deprived of a new Mental Health Act. The previous government had hoped to create new laws for dangerous and severe personality disorder, allowing pre-emptive detention of individuals like Michael STONE who was convicted of murdering Lin and Megan RUSSELL in Kent in 1996. But once discussion began about the ethics, the labelling and the role of psychiatrists in our society, it became clear that it would be very difficult indeed to work out who was 'out' and who was 'in'.

So the whole Bill collapsed and we lost potentially decent reform of other legislative problems like the inadequacy of sections 135 and 136 of the 1983 Act, again <u>being reviewed by the Government</u> ten years down the line.

PROBLEMS OF DEFINITIONS

There are some of us in society who live with mental distress every day and in some circumstances we know that violent or dangerous things have occurred. It's not merely semantics to ask that we try to define what we mean by 'dangerously mentally ill', if we are going to use the appropriateness of that term to determine responses to complex situations. We know that the interface between policing, mental health and criminal justice is about creating pathways and diversions for those we decide are covered by the terms and language, whilst leaving others to the exclusive majesty of the police, courts and prisons. So if special procedures need to exist, we have to know how to identify those of us who are 'in' and 'out'.

All becomes rather difficult, if we can't get very far with that!

So what do we mean by mentally ill? … and by 'dangerous'?! — well the Michael STONE case highlighted this issue too – he was diagnosed with a personality disorder. In terms of mental health law, it means he's 'mentally ill within the meaning of the Mental Health Act'. So he's 'in', right?! Not necessarily. A feature of inquiries in recent years has been that people who in hindsight appear to have been very likely to do dangerous or violent things, were not detained under the Act and when those risks and threats became realised, there was outcry that 'nothing' had been done. This is far from a British problem. The book *Neither Mad nor Bad*, by Deirdre GRIEG is devoted to the discussion of one man in the context of how psychiatry interfaces with the law.

Garry DAVID from Melbourne, Australia was a convicted criminal with a serious personality disorder who spent time in prison making very serious threats to inflict incredible harms upon the public when he was released. These threats, along with the seriously mutilating self-harm that he used to undertake, prompted much debate about how to ensure the public remained protected from his potential given that he was "obviously mentally ill". But for some years, the Victorian state authorities could find no psychiatrist in the land who would put their professional reputation to a diagnosis of mental illness. In the end, the Parliament of Victoria introduced legislation specifically for him: the Community Protection Act 1990. It allowed for his detention after the expiration of his sentence on the grounds of his dangerousness. A quite remarkable case and a book worth reading.

Another book for your reading list that I would highly recommend is *Mental Health and Crime* by Professor Jill PEAY. This book, perhaps more than any other, drives home the problems of attempting to doubly classify people and their conduct under the term 'mentally disordered offender'. Even

harder to extrapolate further and label people as 'the dangerously mentally ill'. These words seem to defy easy explanation because science is still struggling with objective classification of what the medical textbooks call 'mental disorder' and almost everywhere, that leads to legal definitions that seem to suit no-one. It is probably for that reason that our modern mental health law is still derived from the 19th century definitions we saw of vagrancy and insanity – we know it's not great, but can't seem to agree on anything better.

POLICE ONE

This post was motivated by an article I came across online: from the US e-magazine *Police One*. Entitled, "The Dangerously Mentally Ill: spotting the signs to prevent tragedy" I admit I struggled to get beyond the first four words in the headline but forced myself to try. I wrote last year about the many differences in the US compared to the rest of the world and I was reminded of them all whilst reading this article.

The United States typically sees mental distress through a far more medical lens than elsewhere, has particular challenges around its healthcare system and has a culture around law enforcement and criminal justice that is sufficiently different to matter. So put that all together and you are not comparing apples with apples when you discuss the comparative issues that arise. We see in this article references to Kendra's Law *(New York*) and Laura's Law (*California*) which alludes to the legal frameworks which allow preventative detention of individuals on the basis of their propensity for future types of behaviour – this would include dangerousness and violent behaviours. These are the kinds of laws to which UK psychiatrists objected in the lead up to the collapse of the 2004 Mental Health Bill.

I've long since thought that police jargon is not suited to the kind of discourse we need to see about mental ill-health and distress. The legal tendency to label in all kinds of different ways; the very fact that legal processes have to determine who is 'in' and who is 'out' of consideration for the application of those processes – these things has a propensity to reinforce stigma, especially in terms as awful as 'mentally disordered offender'. Given these problems of labels and discrimination also arise from lived experience of significant mental distress, it's a real double whammy when access to mental health systems comes via the criminal justice system and people find themselves labelled as 'the dangerously mentally ill'.

Most police officers have seen plenty of danger in crisis situations, but by far the most severe of it has been the danger that some people pose to themselves, not to others. In the most serious crisis related events of my career, I have been worried mainly about whether someone would cause

themselves significant harm – not whether they pose a risk to others or the public at large. Indeed, some of those incidents that will stay with me forever are those where people have done exactly that. So whatever it is that we mean by 'dangerously mentally ill', we need to see that the use of such a term, in itself, creates and perpetuates the stigma that attends mental health disorders by implying most often, that danger is outward facing. We know that does happen, but we know that the reverse is often true. So the term is not necessarily a helpful one and it emphatically *does not* inherently indicate a cogent group of people to whom it will apply.

We need to do better than this otherwise police attempts to argue that we have improved attitudes towards this most sensitive of subjects will never really be taken seriously.

In case you're wondering about the Anthony HOPKINS picture, above – it's from one of his more famous films in which you'll remember he played a psychiatrist.

21st April 2014

Undiminished Responsibilities –

I read a throw-away remark on Twitter this week, about mental health professionals – specifically psychiatrists – being the experts to determine whether or not someone's mental health condition has caused offending behaviour or whether it was quite coincidental. This self-evidently obvious statement is, in fact, quite wrong! It is, ultimately, a matter for courts, not psychiatrists to determine such things. Specifically, it is a matter for inexpert juries of lay people who may have to wade through complex, contradictory material relating to psychiatric diagnosis and reach a view about what was going on inside someone's head at the time of an offence.

We've seen this in several fairly high-profile trials over the last year or so – here are just a couple of examples –

1. Nicola EDGINGTON – prosecuted for murder and attempted murder whose offer to plead guilty to manslaughter on the grounds of diminished responsibility was rejected and a full murder trial held. The jury rejected her argument and convicted her of murder.
2. Aras HUSSEIN – prosecuted and tried for murder, also having offered plead guilty to manslaughter on the grounds of diminished responsibility. The jury found him guilty of murder and he was sentenced to prison despite acceptance that he had serious mental health problems.

Meanwhile, the Appeal Courts also have a role to play in getting this right. It has been known that following convictions for murder, defendants return to the higher courts to present new evidence. In the infamous case of farmer, Tony MARTIN – the man who shot a burglar in Norfolk – the Court of (Criminal) Appeal substituted a conviction of manslaughter on the grounds of diminished responsibility after hearing new evidence. This was also true of James PETROLINI, who was convicted of murder along with another man. The irony of this latter case, is that upon the Appeal succeeding, his prison sentence was replaced by a restricted hospital order. The timing meant that as his accomplice was released from 18yrs in prison, he was moved onto an order which guaranteed his indefinite detention until the psychiatrists in charge of his care and the Ministry of Justice were satisfied it was safe and appropriate for him to be released!

GRADES OF RESPONSIBILITY

So the law has a suite of checks and balances to keep challenging outcomes and a range of verdicts to suit different kinds of relationship that some defendant's mental health has to their offending. We saw during 2013 that the man who attacked PC Adam KOCH in a Birmingham mosque was found not guilty of attempted murder by reason of insanity. This occurred relatively soon after another attack against police officers in London led to the conviction of Christopher HAUGHTON for the same offence of attempted murder, despite the fact that he was so unwell that he was eligible for detention under the Mental Health Act from the point of the committing the offence, right through to sentencing. In other words there are three kinds of relationship between offending behaviour and mental health, according to the law —

1. **Not guilty by reason of insanity** – a defendant is not criminally convicted for their actions.
2. **Guilty on the grounds of diminished responsibility** (*alternative only to a charge of murder*) – responsible for actions, although liability is diminished because of mental ill-health.
3. **Guilty as charged** – fully responsible for actions, notwithstanding evidence of mental ill-health.

It is a feature of law, however, that whichever of the outcomes is reached, there is just one likely outcome: a restricted hospital order. This outcome is also likely if the prosecution case did not get as far as a trial because of a defendant having been found unfit to plead or stand trial. It remains a likely outcome for convicted defendants, too – only those convicted of murder will be sentenced to a mandatory prison sentence and even then: there is still provision within the Mental Health Act to transfer such prisoners to hospital, if required.

The point of this short post is twofold — to ram home again and again, that all of these complex decisions are legal issues for juries, courts and legal officers, not medical issues for psychiatrists. Of course, it is right and proper that those providing care for vulnerable people have a say in the process but we also know that psychiatric opinion can differ and that the resolution of all of this is the trial process and the ultimate arbiter: a jury. The second purpose is to show that when trusted to get on with it, juries sometimes go with the flow, the sometimes forge their own path through the evidence and regardless of which, the higher courts exist to challenge outcomes or hear new evidence.

I rather like our legal system in this respect – I'd even say I'm very proud of it and we should remember: it is the basis for the mental health and criminal justice interface the world over.

22nd April 2014

Nearest Relatives' Rights –

I took a bit of stick on social media month or three ago, for trying to help a family who were clearly at their wit's end with worry and frustration, arising from a situation involving what they claimed was a mentally unwell relative. It's a slightly odd position that I've found myself in, being active on social media, that I've been approached by relatives and individuals for advice in how to access services or assessments that they think were necessary. It's the kind of query that I've seen pointed at mental health professionals, too – and whilst they're obviously unable to give situational specific advice, I have plenty of examples of "Call your GP", "contact the care coordinator" or "you should discuss that with your psychiatrist" etc., etc.. This post arises from my finding myself, at work and on social media, in a position where someone has found themselves in a cul-de-sac of worry and frustration, not knowing where to turn to and with just a tiny bit of knowledge of the Mental Health Act, I've thought, "If that were me, I'd know I've got rights I can exercise and opportunities I can utilise, to move this on." And so I've said so – me being me.

So it surprised me to find a modest backlash after advising what seemed to be a "Nearest Relative" that they probably were, in law, a nearest relative and that if they could confirm this, they might choose to do one or two things that could get them out of a catch-22. I was only trying to help!

PROFESSIONAL MONOPOLIES

"It is for Approved Mental Health Professionals (AMHPs) to determine who is someone's nearest relative – we are trained and it can be very complicated." Well yes, of course. But firstly, you'll notice the way I worded that sentence: with conditional language, subjunctives and qualification – of course it is for AMHPs to determine but we also know that when AMHPs see what they think might be crimes, they feel quite entitled to say so and advise people of their right to ring the police. I can just imagine what would be said if I then popped up and declared, "You shouldn't be advising people that being punched makes them a victim – the police are trained in these matters and it can be complex." So can we agree to leave that argument there and agree we're all trying to achieve the same thing?! Informed dialogue across professions and patients and those relatives connected to them.

In case you're not aware, AMHPs are usually mental health social workers who are warranted to take legal decisions under the MHA. Occasionally, they are mental health nurses, similarly qualified.

I also admit to wondering from these various connections: why are Nearest Relatives not aware that they are nearest relatives and that they have certain rights?! When we arrest children or vulnerable adults, we bring in 'Appropriate Adults', re-explain everything to them that we've explained to the suspect themselves and as those appropriate adults have certain rights, we give them a leaflet. Strikes me as strange that a handful of people got wound up at the idea that Nearest Relatives should know their rights!? *Heaven forbid!*

So here are (just some) of the Nearest Relatives rights –

- The right to ask for consideration of a Mental Health Act assessment – this is in s13(4) MHA and it is important to note: NRs don't have the right to get a MHA assessment led by an AMHP, only the right to have the need for it considered.
- The right to make applications for their relative's admission to hospital under s2, s3 or s4 MHA (as long as they have an appropriate Doctor, prepared to make the medical recommendations.) – this is detailed in s11 MHA.
- If you do make an application for admission, you then have the right to detain / convey someone to hospital and to seek AMHP, ambulance and police support to achieve this, where needed – this is detailed in s6 MHA.
- The right to apply for the discharge of a relative who is in hospital under s2, s3 or s4 MHA – this is detailed in s23 MHA and it requires 72hrs notice to come into effect.
- The Nearest Relatives right under s23 may be restricted if, during that 72hrs, the psychiatrist in charge of the patient's care furnishes a report under s25 MHA arguing that if discharged, the patient "would be likely to act in a manner dangerous to other persons or to himself."
- Nearest Relatives have the right to delegate this function as NR to others, if they think fit – but you cannot be forced to delegate those rights if you don't want to. You can also take it back again, if you wish.

In the interests of balance and fairness, there are also certain pitfalls to be aware of if you are a Nearest Relative, as AMHPs are legally warranted officers with rights and opportunities of their own and sometimes act with the support of the police –

- AMHPs (and other relatives) have the right to apply to the County Court to displace a Nearest Relative

- AMHPs have the right to apply to courts for warrants to enter and search the home of someone whom they think requires assessment and the police can force entry into a home for that purpose.
- AMHPs and police officers also have the right to apply to the courts for warrants to enter and search a private home where they suspect a person who is "absent without leave" may be.
- In dealing with any processes under the MHA which involved AMHPs or police officers, you need to bear in mind that it is a criminal offence to obstruct either or both of them from doing what *they* are legally entitled to do.

And finally – are YOU actually the Nearest Relative? Ultimately, it's up to the AMHP to decide based on the available information and whilst it *can* be complicated, it can also be nose-bleedingly obvious sometimes! The full legislation on it is s26 MHA and there are various important things contained within the Code of Practice to the Mental Health Act (see chapters 2, 4, and 8 in particular.)

This is necessarily a very short blast through some stuff that can be complex, confusing and intimidating but it arises from learning of situations where relatives were worried and sometimes frustrated with the systems they came up against when trying to safeguard their loved ones. Some reported that they had asked for GP home visits and been told that patients "have to come to surgery otherwise we can't do anything" whilst people immediately countered with stories saying, "My son's GP didn't say that – he came out and couldn't have been more helpful." Families have different experiences via social services, not all bad by any stretch – but some including NRs asking for things that they are, as above, entitled to seek and they were denied. So whilst recognising that this post may irritate some, I make no apology for attempting to arm people with information that they may find useful and I do so in full certainty that if this was a reverse position, others would be telling people to "keep chipping away at the police". Advice that I have given, on occasion.

If you think anything needs to be added to this post, please leave a comment – they're always welcome.

My favourite website for mental health law >> **MentalHealthLaw Online** – summary of MHA '83 for Nearest Relatives

25th April 2014

Coercing Other People –

Policing and mental health services have many things in common (as well as some potentially insurmountable differences) but I want to consider one issue that is arguably the most controversial aspect: they are each systems of social control which involve the coercion of other people, by the threat of and the use of physical force. It is when force is being considered, threatened and used that we see these social infrastructures at their most controversial and we have noted for decades the tragic outcomes from restraint related deaths in both our police and health services. We have also come to learn how the misapplication of force can erode trust and confidence in these institutions, both in terms of affecting towards whom force was deployed and the confidence that the general public have arising from that.

Using force directly usually does one of two things: it hurts (or kills) people and it damages (or destroys) things. In civil institutions like these, hurting people and damaging stuff is never the objective in itself so whether a use of force is successful is judged in whether it is seen as legitimate in helping achieve other objectives. This is usually assessed with reference to whether conditions were created by a use of force within which other more desirable outcomes arise.

- A police officer punching a member of the public in the face sounds like a truly abhorrent notion, but let's imagine we were to see on CCTV that an officer had done such a thing in order to stop that person from stabbing someone else with a knife? Imagine that we saw an armed agitator advancing towards a victim and an officer with only seconds to make a judgement who did so and successfully – would we view this use of force as successful and legitimate? Very probably.

- A mental health nurse restraining a patient by declining to allow them to leave a ward, physically obstructing them from trying to do so because of fears for their safety. All sounds very reasonable, doesn't it? What if the patient was there voluntary and has every right, in law, to leave? We see this use of force in a different light, unless done after the nurse has applied a holding power under s5 of the Mental Health Act, to render their actions lawful.

CRIMINALISATION

The ideas I'm flirting with above are not my own: I have written before about the influence upon me of a book by General Sir Rupert SMITH – *The Utility of Force*. It was one of those reads that shifted my thinking in a major way about how we ensure the legitimate use of force and how we judge its utility. Whilst policing is not warfighting, General SMITH's main argument about the shift in the paradigm of war – to a form of *war amongst the people* – sees many parallels with policing because he argues in this book that the use of force in modern conflict is not an end in itself, given that we do not see (very often) country-on-country interstate war. We are seeing states and multi-national organisations like NATO or the United Nations conducting operations and engaging in conflict of a very different kind, where force used must be done in such a way as to capture the will of the people whom it effects.

You only have to hear this to recall the words of Sir Robert PEEL in his nine principles of policing. PEEL wrote about the use of force in two of his principles, both of which are worth bearing in mind when we consider how the police are used in supporting our mental health system —

1 – 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.
2 – To use physical force only when the exercise of persuasion, advice and warning is found to be insufficient to obtain public co-operation … and to use only the minimum degree of physical force which is necessary on any particular occasion for achieving a police objective.

So there are two things to say about the legitimacy, or the *utility*, of force. Firstly, we see a very genuine difficulty in the use of force by the police within our mental health system and you only need to survey social media and patients' experiences to see this – calling in the Rozzers is usually seen as inherently heavy-handed and a stigmatising, criminalisation of vulnerable people. Secondly, we can see that mental health services themselves must wrestle with this issue –

LEGITIMACY

I admit to having often wondered about the mindset that sits behind a desire to be involved in the coercion of other people, where there is little or no willingness to actually *do* the coercing. I'll admit to also wondering why someone would wish to be employer in a role where they coerce at the whim of others, without insight into why that would be appropriate – this

is the position in which the police are often invited to stand when being asked to take direction from mental health professionals and it's a very odd place to be; not least because the legitimacy is not just in force used, but in the way it is used. The decision to potentially hurt or damage is inextricably linked with the extent to which that impact is minimised in the particular circumstances. Separating the two carries all the potential for two mindsets to undermine the overall point.

When I have made this point previously, some have suspected I'm having a direct dig at mental health professionals when in reality staff are not recruited or deployed with the equipment and training to undertake these functions. I do recognise that perspective – but this is neither my point nor my intention. Our mental health services are large organisations, many of them employing thousands of people with budgets of hundreds of millions of pounds. We know that it is within the core business of such organisations that from time to time, they will need to take decisions to coerce other people. So my concern is that we do not design the organisational need to coerce and use force into the way these organisations operate, with the one exception of administering medication forcibly under Part IV of the Act.

It has long been remarked that our mental health trusts lack the ability to coerce the admission to hospital of a passively resistant, elderly dementia patient (*implied by s6 MHA*); they lack the capacity to coerce the return to hospital of an AWOL patient whose location is known (*implied by para 22.13 MHA Code of Practice*); and difficulties in ensuring that where Part IV of the Mental Health Act is going to be used to force medication upon others, that there are sufficient nurses available to do so. Bear in mind at all times, that there is a difference between people being violent and dangerous, with those who are resisting. This is not a point about ending all police involvement in supporting the NHS.

But there is an additional and particular challenge for psychiatry which remains unaddressed: the increasing challenges being made to the claims upon which psychiatry ultimately rests as the basis for legitimate coercion. We are hearing more and more from a range of professional sources, including some psychiatrists, but also psychologists and sociologists, that the evidence base for a predominantly medical, drug-centred model of mental health care lacks evidence and is, at best, ineffective in the long-term. At worst, it is actually capable of being seen as causing more harm than good. For as long as such debate is able to rage, we can expect to see some survivors of mental health services claiming that they have suffered long-term irreversible damage.

So in the end, this point is not really about ensuring that the police are not sucked into a training vacuum to undertake tasks officers would prefer not to do. It is more about achieving legitimacy and utility, in the use of force: by ensuring that when force is used, it builds public confidence in both policing and mental health care. This is achieved by ensuring that where

the police are called into a mental health unit to use force, it can be seen as a legitimate decision to do so – for example, because of a serious disturbance involving barricades, weapons or hostages on a ward. It is also achieved by ensuring that where lower level incidents require coercion, our mental health services are prepared to manage it themselves, in accordance with the key professional principles that govern mental health care – for example, the principles of least restriction and the preservation of dignity.

If we are to ensure legitimacy in the occasionally coercion of vulnerable people, it is important that we strike this balance. If we fail to do so, people will just end up wondering why we keep hurting people and damaging things whilst doing more harm than good.

29th April 2014

Somewhat Exasperating –

I sometimes think we're getting somewhere with this stuff and then quite unexpectedly, I come across apparently minor and incidental things which make me suspect all the progress we think we're seeing is an illusion – somehow apparent because of cosmetic changes that seem both intuitive and convincing.

- If we build a load of place of safety services and get 97% of people into them whilst 3% of people go to the cells, surely we can make massive claims of moving forwards?
- If we get clinical decision-making to the point of detention, surely we can influence not just *whether* someone is detained, but also the pathway (or route) that they take whether detained or not?
- If we have mental health provision in police custody and at the Magistrates Court, surely we can prevent unnecessary access to the criminal justice system?

Why wouldn't we do all of this?! – it makes *sense*, doesn't it? Well it's not just what you do – it's also *how* you do it.

LEGAL PROFESSIONALS

When I ask police officers what they would do in the event they instigated use of section 136 and were then advised by a mental health nurse or paramedic to remove someone to the cells because of highly resistant, aggressive behaviour – very possibly brought on by an immense overwhelming fear for that person of what the officers are actually trying to do – I am yet to find an example of an officer who knows when it would be wise, legal and in furtherance of proper guidelines around the dignified medical management of people to ignore that advice.

Yes, **ignore it**. Disregard it and plough another path.

I also sometimes ask police officers and mental health nurses whether they can conceive a situation in which someone wants to access a form of support or assessment and is willing to go with police, ambulance or mental health services and where this should also be disregarded. Why would you

choose a legalised restrictive route when there appears to be another, less-restrictive option available which the mental health nurse or paramedic would like to follow? I cannot recall answers that reflect the learning from some tragic events we've seen where the key issue was whether someone who needed assessment and care *finished* it. Easy enough to start something on a voluntary basis, but what if the consent or acquiesance is removed before the process finishes?

When is it acceptable to take that risk and when should we not gamble with the issues – and who decides?

It is with enourmous distress that I keep reading and hearing of some influential people and some professionals operating in the new schemes we are seeing who are actively pushing the proposition that people who are "violent" (*their words*) need to be removed to police cells after the use of s136. Because where else would you take a resistant or frightened person suffering from mental distress?! Of course, I will speculate that the people who advocate such things have never spent years of their lives battling and campaigning on behalf of a deceased loved one for answer to why their sons, brothers and fathers died in the custody of the state; they've probably never been interviewed under criminal caution by the IPCC, prosecuted in the Crown Court for criminal offences ranging from assault to misconduct in public office; they have probably never seen their Chief Executive officers being personally criminally investigated for Corporate Manslaughter arising from policies that raise the risks of deaths in custody.

It's such an intuitive argument isn't it? — the police lock up violent people in cells, this is a violent person *ergo* they must be taken to the cells. But it's actually anti-logical – here's the evidence why we should not do such things anything like so casually —

- Faisal AL-ANI
- Leon BRIGGS
- Kinglsey BURRELL-BROWN
- Rafal DELEZUCH
- James HERBERT
- Colin HOLT
- Matthew LOVELL
- Andrew JOHNSON
- Olaseni LEWIS
- Thomas ORCHARD
- Toni Emma SPECK
- Michael POWELL
- Terry SMITH

…… and this is just in the last five years and is not an exhaustive list during that time: I could keep going and going to really ram home the point. In case you are unaware: each of these people died in contact with the police

or in custody, whilst thought to be experiencing mental health problems. That is thirteen families who have been to hell and back wondering what on earth happened to their nearest and dearest and many of these families still don't know, years after the original tragedy.

MEDICAL OPINION

I remembering reading in a reputable handbook for emergency medicine the following phrase: "Most violent people need a policeman, not a doctor." Remember, this is a medical textbook – written by people who studied science and the scientific method to postgraduate levels over decades and are the cream of the cream of our country's academic attainers. This quotation is in a handbook for the ease of junior doctors' reference, written for them by more senior doctors, including consultants in psychiatry and emergency medicine.

So here's a different way of saying exactly the same thing – "Some violent people need a doctor, not a police officer." Or perhaps they need both? Either way, it's *exactly* the same thing, isn't it?! … although I managed to avoid the gender stereotyping from the original version!

Of all the things sitting behind violent behaviour, most people will need a police officer and some will need a doctor. Most will be drunk and / or angry and / or hateful and others will be injured and / or ill and / or intoxicated. This therefore gives rise to the following quandary: how do we tell the difference between the people who come into contact with our 999 services who are so violent they need a policeman and those who are so agitated they need a doctor? And when you set about answering this question, bear in mind that the causes of agitation in some people are invisible, unknowable and sometimes beyond the wit of paramedics with bags of kit to tell.

How does a police officer approach this question, replete with a basic first-aid certificate?

Does this mean that everyone who is violent should go to A&E? – of course it doesn't! But it *does* mean we need to train police officers to a certain level of understanding about agitated behaviour and health risks. If someone is drunk and angry with a visible head injury, we know that the injury needs checking by paramedics and / or A&E and medically clearing before we start decanting them to the cells. If we know that someone is suffering a serious mental health problem and they are exceptionally resistant to being detained to keep them safe from other risks that can't be ignored, we also know that various expert opinions (see the Rocky BENNETT Inquiry, for details) argue that the ongoing restraint of those of us with mental health problems is a medical emergency. We know that such

views have been expressed in Coroners' Courts by medical experts and also such views have been offered by families who would expect a serious mental health crisis to lead to medical assessment, probably via ambulance.

The quandary about how to distinguish the one group from the other, is essentially a clinical judgement. It can be taken by police officers in the most obvious of cases, but when subtleties and complexities become involved, it becomes more important for paramedics and doctors to become involved. What role mental health nurses play in this, I don't know – and listening to debates between mental health nurses and emergency nurses about pre-hospital clinical screening doesn't reveal a clear and settled view, either.

SUBLIMINAL MESSAGING

So why, despite repeated mentions in Coroners' Courts, untoward incident inquiries and other authoritative documents do we still keep seeing non-police professionals arguing that the police should keep doing what the police have done before. I refer to the kind of incidents which Lord ADEBOWALE spent six months of his life reviewing in order to conclude that we all need to do better all 'round – health and social services services included? Ironically, he concluded these things after an advisory committee included some who can now be spotted saying these sorts of things! It was with some dismay last year that an influential figure in the whole s136 / mental health debate told me quite casually in a lunch queue "of course, violent patients need to be taken to custody – that remains right". WHY?!! Haven't you read this stuff? Haven't you at least followed the news?! It's highly disingenuous at best, to issue such blanket statements in defiance of all that has gone above.

Far more importantly – such views are not binding on any UK police officer as we're not obliged to do as we're told where it conflicts with our legal responsibilities – we all took an oath of office to discharge our "*duties faithfully according to law"* ensuring *"dignity, fairness and fundamental human rights."* << I'll be busy doing that, if it's OK with you.

There is a subliminal message hidden within this narrative – <u>the police should just do as they're told</u>. It's when the (untrained or poorly trained, quite frankly uneducated) police ignore the advice of the experts in these issues that we see all manner of problems, according to some.

Actually, I'd argue it's *because* the police have followed such implicit advice in the past, that we have seen some of the tragedies we have. The officers in the case of Michael POWELL in Birmingham in 2003 did *exactly* what the structures of the NHS expected and wanted them to do at that time. Having

done so, they were suspended for three years and criminally prosecuted in the Crown Court. The officers in the case of Colin HOLT in Kent did *exactly* what the NHS expected and wanted them to do at that time. Having done so, they were suspended for two years and criminally prosecuted in the Crown Court. We could keep going along this line, but I think you see my point.

Meanwhile, it seems the wholesale breaches of large tracts of the Mental Health Act Code of Practice that gave rise to these contexts were not sufficiently important to be challenged by anyone. (For the legal significance and importance of a Code of Practice, read the Munjaz case.)

How many of these incidents do we need to see before we realise three vital things? –

- Mental health awareness training for cops is **not good enough**
- the legal knowledge of health professionals is **not good enough**
- the integration of health and police services to delivery lawful, safe outcomes is **not good enough**.

Absolutely none of this is going to get any better as long as we keep hearing reputed professionals casually offering opinion that flies in the face of history, law and the NHS's own guidance on these things. Read the Royal College Standards (2011) – read the NICE Guidelines on the Management of Acutely Disturbed Behaviour. It's all there. It's not just 'hearsay' or my opinion. Read the legal judgments in the case MS v UK (2011), Webley v St George's (2014) as well as the Coroner's verdicts from the death in custody cases above, which have progressed to that stage. I will admit that I find it truly startling: the notion that you could read and absorb all of this material and yet still form a view that "violent people should go to the cells" is an acceptable blanket statement.

Perhaps it is just rhetoric? An almost political device to keep the police absorbing risk and liability. To claim that "Most violent people need a policeman, not a doctor" is about as anti-scientific as things can get and the public and our police officers deserve far better, quite frankly.

MAY 2014

9th May 2014

Late Intervention –

For many years now, we've heard the repeated mantra of early intervention – both in terms of treatment of mental health problems and in terms of diversion from the criminal justice system for those who come into contact with the police or the courts. We've heard of and seen services explicitly branded with an Early Intervention label, for example in first-episode psychosis services.

Of course, early intervention of any kind poses a particular kind of problem, whether in mental health or in youth justice and child protection where we also see this kind of discussion. If we did nothing other than sanction children who were caught shoplifting, not all of them would begin an inevitable decline into drug taking, acquisitive crime and custodial sentences. It is far from inevitable that if someone experiencing their first episode of psychosis in their late teens or early twenties does not receive an appropriate early intervention service, they will end up detained for long periods as an inpatient and / or caught up in the criminal justice system.

So how do we identify those children, those first episode psychosis patients and those of us with mental health problems who come into contact with the criminal justice system after an offence that will go on to experience a life-altering decline of offending, substance misuse or mental distress? Difficult. But we know we have to find a way – the Centre for Mental Health will state that for every £1 spent on early intervention services, £8 is saved later in the mental health and / or criminal justice systems and £15 of savings for the overall economy. Of course, because budgets are in silos, that benefit is not usually felt by those who would have to spend, so it's almost nothing more than a theoretical benefit and whilst we know this from research and we know we need to do something to give a reality to this kind of thinking, we are currently seeing something else happening instead.

We've seen in the last couple of years various attempts to rationalise mental health services: Community Care reported last year how the workload of CrisisTeams had risen by 16% at a time when budgets were cut by 2%. We frequently hear anecdote that the threshold for inpatient admissions has increased as the hospital beds in some areas have been cut by something like 33% or even as much as 50%. Consequently, community mental health teams have seen an increase in their workload. It has been a trend in mental health care for many years now that average time spent

as an inpatient is decreasing as people are discharged earlier to more and more community care, in the hope that initiatives like Community Treatment Orders will end the cycle of "crisis > admission > recovery > discharge > relapse > crisis" etc., etc.. Except they don't.

CRIMINALISING VULNERABLE PEOPLE

If you consider the complexity that is added whenever any of this stuff is done with people who are in contact with the criminal justice system, you start to comprehend what a difficult system we've evolved for ourselves – perhaps one that you wouldn't ever design, if you built it from scratch.

But as we now see the emergence of particular initiatives in response to the lobbying that the police service has been engaged in for the last few years, we have to consider again the extent to which our evolved system is criminalising people. So for example, in many areas the remit of the community mental health teams and their out of hours CrisisTeam colleagues was to provide enough support to people to prevent hospitalisation. During the period of time that both of these kinds of team have reported their workloads increasing, their budgets decreasing and their remits narrowing, we have seen the introduction of Street Triage and Liaison and Diversion schemes. So where some patients have reported that their contact with some NHS services has led to that demand being deflected to the police, they can now expect in some areas that the police will turn up with a member of NHS staff, which may have been all they were trying to access to begin with. Equally, this could be pointed out for Liaison and Diversion services – will PoS services for 136 and other structures in the NHS be *more likely* to say, "take that victim to the cells" knowing that such a decision now puts people into direct contact with trained NHS staff from mental health services. We need to be mindful of unintended consequences.

Of course, there have always been some situations where it is quite unavoidable that some of us with mental health problems will end up in contact with the police and some of those will end up in custody, either detained under s136 of the Mental Health Act or for a criminal offence. Surely, street triage and liaison and diversion is a positive thing in those circumstances – providing screening, support and referral to those who need it and might not otherwise receive it in those particular circumstances. I've *never* disagreed with the general thrust of that kind of argument – however, what I have increasingly wondered, is the extent to which we're cutting services in one area, whilst increasing them in other areas, the effect being that we increase the extent to which you have to be in contact with the police or criminal justice system to access certain levels of support? Another version of the criminalisation contingency?

If we've got money for extra mental health nurses to operate in street triage and liaison and diversion schemes, why don't we put them into the teams where they could give reality to the concept of early intervention? Why better fund and better resource that part of the mental health system that we should be trying to minimise because it is so extraordinarily expensive as well as ineffective – *the criminal justice interface*? There is a real argument that we're seeing Street Triage and Liaison and Diversion as increasingly necessary, because we've rationalised other mental health services to a point where it is difficult to access them in a timely way, if at all. We know that this process is ongoing as NHS England have recently committed to cutting mental health services by a greater extent than non-mental health service in forthcoming budgets. Disparity of esteem in action.

Of course the answer is and always was: that the financial benefits of funding proper early intervention and preventative services is not felt by those who would have to pay the bill for it. Which is why it doesn't *really* matter to the right people – it badly matters to all the wrong people. So instead, we see the increased propensity to criminalise vulnerable people and focus on all the different ways in which we could do the wrong thing, righter – and ever later in the system.

12th May 2014

Fit To Be Detained –

I know we keep hearing about the unacceptability or undesirability of those of us living with mental distress being detained in cells. I've always agreed about this when we are discussing detention under the Mental Health Act. I still think is a bit medieval to contemplate a country that can't ensure such matters are handled without the need for police custody and I've covered those reasons elsewhere on this BLOG.

I've always said that things change as soon as you are discussing individuals who are accused of offending. Offending means that it is no longer just the rights of the detained individual that need to be considered, but the rights of the victim (if there is one) and the broader public order that have to be balanced.

Once a person with any medical problem whatsoever is arrested or arrives in police custody, officers must give consideration to their medical needs. Some arrested suspects are taken straight to A&E before they go to the cells, others see a police nurse or doctor in custody. Some who make it to custody appear OK to start with and become unwell later, or more becomes known about their health and they are subsequently transferred to hospital from custody. So the assessment on arrest and the assessment once detained are crucial to understanding what appropriate action may look like. This is all under the banner of "fit to be detained" — is this person medically fit enough to be detained in police custody?

It gives rise to particular challenges when we look at mental health and that is what this post is all about – fitness to be detained when we know that someone is mentally unwell. In addition to considering the issues generally, I'm also going to focus on some of the problems when the offence is alleged against patients are detained under the MHA.

FIT TO BE DETAINED

A couple of general points and caveats first of all. In the political parlance we've seen in the last few years we often hear broad-brush generalisations like "It's never acceptable to detain someone in a cell when they're mentally ill." We saw a little bit of that in BBC's Panorama programme last year. When I read things like on Twitter I tend to reply, "What,

never? What if that person has killed or raped someone?" This is not merely intended to be facetious – although we all know the well rehearsed debates about violence, crime and mental health, we can't get beyond the fact that the police do, from time to time, have to arrest people for crimes of all kinds, committed whilst mentally unwell. In an incident my team dealt with in 2012 there was no way I was going to contemplate *any* other course of action – two people were dead and we quickly located the killer in a place where the Mental Health Act could not be applied by us anyway. Any suspect in such circumstances would be arrested for murder and taken to custody – despite it being immediately obvious that his mental health wasn't the best. None of this means we wouldn't also call an ambulance and consider any advice paramedics may give as to whether the suspect goes to A&E first.

Ultimately though, suspects for very serious crimes go to custody, whether or not they are mentally ill. This happened after many serious events in the last few years including the awful killing of Christina EDKINS in Birmingham. There are sound legal reasons for this, too – only when people are arrested for offences do the police get certain powers of entry, search and seizure to ensure that evidence is properly preserved for the courts. Only when people are arrested *for criminal offences* and detained in custody do the police get further powers of search and seizure that allow investigation to efficiently occur. For example, certain forensic samples from suspects cannot be taken unless a person is "in police detention" which is a legal term defined in PACE and it means arrested and having arrived at a police station; police inspectors cannot authorise the search of relevant premises under s18 PACE unless a person is arrested for an indictable offence. So there are very sound legal reasons for needing to detain suspects for offences and hold them in the cells. The question here, is how the decision is taken that it would be reasonable and as safe as possible to do so, in the particular context of mental ill-health?

Once in custody there, normal procedures ensure that suspects are seen by a police nurse and / or doctor and then subsequently by the NHS if a statutory Mental Health Act assessment is needed. It is the police nurse and doctor's job to give us an assessment on anyone who is arrested as to whether the person is "fit to be detained". Now, accepting that some psychiatric presentations amount to medical emergencies; accepting that some of us with mental health problems are going to be traumatised after involvement, alleged or otherwise, in a serious criminal incident and by the process of custody — accepting all of that, how do we decide who is OK in custody whilst important legal issues are attended to, including a Mental Health Act assessment, if need be? Some of the most floridly unwell people I've ever met, including those who are highly agitated, actively attempting to hurt themselves in custody, those who have engaged in efforts to drink from the toilet or smear themselves and their cells in human waste have been deemed "fit to be detained". All because they were arrested in the

street, there's nowhere else that would "accept" them directly, so custody became the default position. So why are some legal categories of patients, quite obviously nowhere near as unwell as that, deemed "not fit to be detained"?

ARRESTED FROM INPATIENT CARE

From time to time, the police are asked to investigate offences alleged to have occurred in psychiatric units, often allegations that inpatients have assaulted staff or other patients. This brings a special set of considerations in addition to the above and there is much myth and folklore about it. There are also very practical problems that mean we need to ensure the medical and nursing staff in hospitals are talking to or communicating with those in custody. On more than one occasion in my career, including recently, I've been to a mental health unit to find assaulted staff, including those with physical injuries that require A&E assessment and treatment. I've also sometimes found patients who are described by the medical and nursing staff who know them well as "fully understanding the nature and the quality of the act" they are alleged to have committed. I've never been part of arresting anyone in a hospital without asking the question, "Is there any medical reason, in your opinion, that would prevent his safe detention in custody for up to 24hrs?" I've also usually spoken as arrests take place about the potential for the FME to want to speak to staff who know the patient well and for the investigation to end at short notice and the patient to be returned to the original ward. This also allows staff to plan that they patient should return to another hospital or ward, if they think the original place is no long suitable.

So in one example a few years ago, a s3 patient was arrested from a medium secure unit after an allegation of GBH against a nurse (fractured jaw) and interviewed in custody. The FME spoke to the Consultant Psychiatrist as part of the "fit to detain" decision and after the patient was interviewed with an appropriate adult and solicitor, they were returned to the same medium secure unit. Some weeks later, after the evidence had been reviewed by CPS, they were charged with GBH contrary s18 of the Offences Against the Person Act 1861 and appeared in court. Having pleaded guilty, they were referred to the Crown Court on a subsequent date where a restricted hospital order was imposed. Back to the medium secure unit they went, but now subject to legal frameworks that would balance health and public protection. The patient also saw that there were consequences for seriously assaulting nursing staff.

Things don't always go so smoothly, however – I have other examples in my service where the fact that the patient was a s3 patient was sufficient for the FME to say "Not fit to be detained". What, *at all*?! With physical healthcare, it normally means that someone is in need to fairly rapid

medical care in A&E, lest they suffer adverse consequences. We see people in custody with less-than-as-serious health problems all the time and as long as they are fully seen and assessed, then suitably monitored in accordance with the Doctor's advice, those risks are tolerated as part of the overall picture. And in those cases I've seen where NHS staff say "No problem" to the prospect of a patient being briefly held in custody during investigation only to then find the police doctor say "Not fit to be detained", it causes real problems. Dr Jenny HOLMES alluded to this in her recent blog on this site: faced with a consultant (forensic) psychiatrist, who has known and treated a patient for weeks or even months, and an FME who has seen them for half an hour or less and who may not know their history, why would we think the FME better placed to make a judgement on someone's fitness?

More to the point, to what extent is it someone's status as a s3 patient that is influencing this decision? Would that assessment by that FME be different if the person with an exactly similar psychiatric presentation if the person had been arrested in a street for assaulting a police officer and brought into custody? I sometimes doubt it would because of course the police do arrest suspects for alleged offences whilst very unwell and bring them into custody and then see assessments that someone is "fit to be detained" although perhaps "not fit to be interviewed" pending further information or even MHA assessment. We also know that being currently detained under the MHA is no automatic barrier to being interviewed by the police about an alleged offence: as long as the legally required safeguards are in place (solicitor, appropriate adult) then it can, in principle, occur. The question is whether it should and I accept that is a difficult decision – perhaps one better taken by someone who knows the patient and their history very well indeed?

LIAISON AS WELL AS DIVERSION

What I'm suggesting here is: we need greater understanding of the complexity of some people and some incidents. It isn't legally or medically correct to say that just because someone is mentally unwell they can never, ever be detained in police custody. Nor is it correct to say that just because someone is mentally unwell, even profoundly so, that this automatically renders it immediately dangerous to continue their detention in custody – otherwise, why aren't all seriously unwell patients transferred out ASAP, either to a mental health place of safety or a A&E department. And then, in those cases where it is correct to argue that someone's mental health emergency does render them unsafe in custody, to where do we return or transfer them? I'm alive to the possibility in some cases, that the correct response to disorder in health settings, even some of the more serious stuff, is not to arrest, contain the situation there until someone can be transferred to a more appropriate unit. However, failure to fully investigate

and appropriately prosecute those who hurt NHS staff and other vulnerable patients when there is no obvious medical barrier to this and the offence was serious enough to call the police, is something I still feel we have a LOAD of work to do on. I hope it is on the radar of liaison and diversion services to better oil the wheels between custody healthcare and inpatient mental health care.

Remember, 70% of all violence against NHS staff is within the mental health sector, as reported by NHS Protect. It is not an inconsequential issue and it deserves full discussion and appropriately sophisticated responses when it occurs. Get it right on "fit to detain" is an important part of that and we're far too inconsistent about the clinical risks in custody to be confident that we are.

19th May 2014

Restricted Restraint –

Right, here's a restraint related situation for you! —

It doesn't matter which of the following three scenarios we're contemplating or whether you're thinking of your own – it could be a police officer dealing with a drunk person who is offending and needs to be arrested; a mental health nurse attempting to safeguard a patient or administer medication that is required; it could be security in a pub or A&E attempting to remove a disruptive customer. Of course, there are plenty of other possibilities.

Just imagine you are the person who will have to engage in the restraint of another person and they are exhibiting what the police would described as passively resistant behaviours. In other words, they're not attempting to hurt you or anyone else, not armed with weapons and not lashing out to hit people. The person is just refusing to move or leave; or consent to medication. This little thought-experiment starts after considerable efforts have been made in the circumstances to persuade, influence, encourage etc., and you have now reached the view that restraint is necessary and unavoidable.

What you do has to amount to reasonable and proportionate force, the least restrictive method of achieving the objective and as you approach the practical issues involved, you must have regard to the various rules or conditions laid down by your employer as to how restraint should occur.

Here are the rules –

- You can't deliberately hurt the person in order to gain their compliance – no wrist locks, application of pressure points or other painful holds being used to prevent further agitation.
- You can't use any kind of mechanical restraint – no devices or handcuffs, no leg restraints and certainly no tasers.
- You cannot use any incapacitant sprays – so no CS "gas" and no pepper spray of any kind.
- You cannot hold the person in a prone position, face down on the floor – not at all, not ever.

Now! – your scenario is this: you must restrain a 6'1", stocky, heavy man who is 31yrs old and move him to somewhere that he doesn't want to be. So you're moving him against his will – either under arrest to the cells, to

a seclusion room or from a pub to the street depending on which of the scenarios you're envisaging. On you go! – make sure you keep the rules in mind.

Given the rules, you're probably thinking of pushing them there or getting them into a form of bodily hold and hoping to walk them to where you want them to be, whilst in hold. Can we think of any other way?

CONDITIONS OF RESTRAINT

All trained systems of restraint impose conditions and qualifications upon those who are trained in its approach. There are various noteworthy differences between the training that police officers and mental health nurses receive, for example. You would expect this – police officers deal with a far broader variety of circumstances and are still expected to face situations from which mental health nurses are encouraged to back away so their training must reflect this. But my point is not about the differences between the sorts of things that different professional groups face; it is about how the police and a mental health nurses would potentially deal differently with an identical situation.

Let's imagine that for various reasons that are quite legitimate and proportionate, staff in an inpatient mental health ward have decided to seclude a patient. The patient is in their own room, having caused damage to it and is refusing to move to the seclusion room. When mental health nurses attempt to restrain and move him, he resists. The various kinds of hold that would be available would not be holds that allow for pain compliance and no mechanical interventions allowed. So if the patient was held, bodily by staff and then started to push and resist, the success of the intervention would depend upon whether those staff could keep the hold in position and then move the person, without resort to the deliberate application of pain or to equipment used in restraint by others.

What happens if this is unsuccessful? – were the police to be called, they would then consider their full array of tactics and techniques to move people. They include *all* of the things banned, above!! One might ask what cultural change we invoke and what ethical advantage we secure by invoking rules that are predicated on very worth virtues of dignity and well-being, only surrender the importance of them should it become too difficult. Except we're not just setting aside those principles, we're also criminalising the escalation process.

Of course this is only the case if the police were to be called and then actually do attend – there is uncertainty as to whether they could, whether they should or whether they would, depending on which police officer or police force you speak to. In the debate about the extent to which the police

have a role in inpatient mental health units, my previous post, Weapons, Barricades and Hostages sums up what I think and we know that some forces have reinforced the limits they see for themselves. So there's uncertainty about issues connected to safety – not a great place to be.

NEW GUIDANCE ON NHS RESTRAINT

Why am I bothered about this? Well, the Government published new guidance last month on restraint – *Positive and Proactive Care*. I'll be amongst the first to endorse and celebrate much of what is said in the prefaces to these documents about the need to see change in operating cultures within mental health services. I have often found myself called to a mental health ward to use force on behalf of nurses who have assessed that force is necessary and that the nature of the threat renders it appropriate for the police to be the agents of coercion. In the majority of situations, things get resolved without resort to the use of force and when I've observed this phenomenon previously, the usually reply is something about police uniforms engendering something that mental health nurses cannot manage. I accept that point but I honestly do not think this fully explains why officers sometimes decline to use physical force on patients – it sometimes simply isn't necessary.

So I have a few questions: if the NHS are now, in effect, banned from using restraint techniques in the above circumstances, have they been taught how to implement other tactical options that either do not involve restraint at all or which involve acceptable tactics? It's all very well removing options from the list, but what replaces them? Surely the culture change spoken about is not just about listing all the things that staff must not or cannot do – surely, it is part of a positive approach that enables them to do so.

The status of this guidance is listed on page thirteen and it is "relevant for the police." Notwithstanding that, relevance doesn't explain the extent to which the police – called to such incidents without notice on the majority of occasions – are expected to set aside their established training and guidelines. What happens if officers who've tried are then investigated after an untoward event? You can almost anticipate the reaction of some! And if the effect of restricting tactical options is that the NHS more frequently assess a threat as being something beyond their ability to cope and they call the police to use the very tactics that they, themselves are banned from using, does it not actually make the situation worse? All we will have done is ensure that when restrictive interventions are perceived to be necessary, we call upon other people to act who are not subject to the same rules, restrictions and regulations and who are perfectly at liberty to do all of those things and more, according to their own training guidelines.

I see this document as a cultural signal of intent rather than a tactical template: but it is precisely for this reason that I worry. Not for the first time, we're talking in vague terms about precise situations in which decisions have to be made. So it's all very well further stripping away the ability and thereby the willingness of mental health staff to lead recovery oriented interventions, but unless they are equipped (and staffed) to have other options, it will suffer – like other initiatives – from the law of unintended consequences. I am already getting emails from health staff telling me that this guidance from the Minister of State will mean that the police are called more frequently to be the agent of coercion in our mental health system. This is precisely what our Home Secretary is hoping to avoid!

21st May 2014

Home Affairs Select Committee –

This is my written submission to the Home Affairs Select Committee Inquiry into Policing and Mental Health.

Advance warning: it is much longer than a normal post, written differently and posted here mainly for reference; but feel free to wade through it if you wish!

BACKGROUND AND SUMMARY

1.1 I am currently serving as a police inspector with West Midlands Police, with over sixteen years' experience. During my service, I have been posted to uniformed police roles in Birmingham and the Black Country as well as having spent over three years in a specialist position dealing with policy and practice on policing and mental health. I have been seconded to work for the Association of Chief Police Officers and the former National Policing Improvement Agency during which time I have supported most police forces in England and Wales with development of their approach. I continue to support such work in addition to responsibilities as an operational police inspector on a 999 response team where I see the reality of this each day.

1.2 Between 2009-2011 I was responsible for establishing seven *place of safety* services for those members of the public detained under section 136 of the Mental Health Act. This included one service specifically for children and they were highlighted in 2010 by Her Majesty's Inspectorate of Constabulary and the Care Quality Commission as national best practice and contribute to over 97% of those police referrals for assessment being undertaking in an NHS setting. Previously, 100% of assessments involved the use of police cells.

1.3 In 2011 I started using social media to raise awareness of the issues faced by the police at mental health incidents. In particular, blog has drawn attention having won the Digital Media Award in 2012 from our leading mental health charity, Mind. The intention behind this was to educate and inform police officers of the various legal and clinical difficulties into which

they can inadvertently be drawn and encourage them to mitigate risks to the public and themselves by improving their legal knowledge and basic mental health awareness. For several years, I have been a visiting university lecturer – on the MSc in Forensic Mental Health at the University of Birmingham as well as on undergraduate training programmes for paramedics and mental health nurses.

1.4 **This submission is my personal view and does not represent any organisation to which I am or have been in any way been connected.**

1.5 I was specifically invited by the committee to disregard the word limit publicly indicated – accordingly, this is a 5,000 word report.

1.6 This submission will argue – there is a *de facto* mental health role for police officers; that initiatives we are currently seeing to better manage those responses are under-researched, unevaluated and done in the absence of proper training for officers to tackle such incidents. This submission will further suggest that there are other, potentially cheaper ways of achieving the same thing and without having to criminalise vulnerable people who are increasingly coming into contact with criminal justice services in order to access care or as a proxy for it.

POLICING AND MENTAL HEALTH

2.1 We know from the Adebowale Report (2013) that mental health issues are a contributing factor to 20% of police demand. We know from research by Victim Support (2013) that those of us with mental health problems are significantly over-represented in the profile of all victims, being at least three times more likely than the general population to experience crime – in the case of women with mental health problems likely to suffer from violent crime, this rises to as high as ten times as likely. Every year in England and Wales the police detain approximately 22,500 people under section 136 of the Mental Health Act 1983 and my own estimates as well as other limited research suggest that the number of people arrested for substantive offences who may be experiencing a serious mental health problem equates to between 25% and 40% of all those detained. The Independent Police Complaints Commission has consistently reported that mental health is a feature in many of the complaints they receive, including annual reports that just under half of the deaths in police custody and two-thirds of those following contact include individuals experiencing mental distress.

2.2 This is a *significant contributor* to overall police demand and amongst the most complex and sensitive areas of all the work undertaken by police officers. In my day-to-day role as a police emergency response inspector,

my team deal with mental health crisis situations almost every shift, frequently many of them in a single day. It is a larger feature of my day-to-day work than robbery or burglary. More importantly, this work is crucial to public confidence in policing as a whole because it focusses upon the ability of government to ensure the basic safety and wellbeing of citizens.

TRAINING AND PREVALENCE

3.1 Most police officers receive between four and eight hours of mental health related training at the start of their careers and this must cover raising awareness of various types of mental disorder, legal frameworks and as well as the implications for operational policing, including crime investigation. There are many examples of localised training being delivered by mental health trusts to those police areas they cover. Nevertheless, overall, it is inadequate and we frequently hear of "a lack of mental health training" for police officers. Having witnessed local training provided by mental health trusts, I have also been alarmed at how wrong some of it is, legally speaking. If nothing else rings loudly from this submission, it should be the urgent need for validated, professional training for police officers *at all levels*.

3.2 The increased demand connected to mental health issues has been seen over the fifty or sixty years since mental health services began to move away from a heavy reliance upon institutionalised models of care. The introduction of antipsychotic medication in the mid-1950s and the unaffordability of our old county asylum structures in the post-war era forced us to look at new ways to provide care. Since then, police forces around the world have reported a steady increase in the demands they face which are connected to mental ill-health. Models of care have shifted, quite rightly, to a less restrictive, human rights oriented model of community care where possible. However, we have seen an increasing tendency to criminalise the behaviours which arise from mental health crisis and the inability of our NHS system to manage the implications of deinstitutionalisation is seen in the issues examined by your inquiry.

3.3 We know from research in police custody (JAMES / RIORDAN) that around 12%-15% of those arrested for offences are suspected of having a mental health problem and we can also infer that this represents an under-identification of individuals – it relies upon police officers screening those who are detained. We know that where police forces have engaged in better information sharing about those arrested, as many as 50% of individuals are known to mental health trusts, currently or previously, and would benefit from referral after arrest. The prevalence of suspects in custody who live with disorders and / or substance abuse problems has given rise over the last few decades to local initiatives in what we now call "Liaison and Diversion" – these have previously been *ad hoc*, uncoordinated

programmes which ensure some screening in custody and referral if required. Even as recently as April 2014 when the Centre for Mental Health published a report *Keys to Diversion*, it has been the case that research and discussion in liaison and diversion is focussed primarily on health, with much less focus upon justice. The evidence base for Liaison and Diversion is not as robust as we might hope it is something the Centre for Mental Health acknowledges and little of it focussed on re-offending rates.

3.4 We know that police forces face significant challenges in implementing the implications of the Mental Health Act Code of Practice because in many specific instances, NHS services are not commissioned, not managed and not integrated in such a way as to give effect to it. For example, para 10.22 of the Code of Practice requires that officers who detain a person under s136 MHA should not choose police custody as a place of safety, other than as a last resort. They should consider alternatives available even if the primary identified location – presumably a mental health unit – is unavailable. One option, for certain kinds of patient, could be an Accident & Emergency unit and yet today, despite at least one former Strategic Health Authority writing to all Emergency Departments directing them to desist from the mantra that "A&E is not a place of safety", it is still a widely perpetuated position statement. I fully understand why this is said because I recognise the unsuitability of those kinds of environments for certain kinds of patient with mental health problems. And yet separate developments in health are seeking to ensure that all A&Es have liaison psychiatry services. Denying access only to those in the custody of the police is likely to have a disproportionate impact upon BME communities and more complex patients.

3.5 If a uniformed police officer who has detained an elderly person with dementia or a 15yr old girl with depression and an inability to access a mental health unit as a place of safety emerges, they are left with the choice of somehow improvising a pathway or using police custody. In some situations A&E would be a preferable, if far from ideal location for some. Not all, just some. Far more importantly, if those patients had been in contact with the ambulance service and been referred to A&E because paramedics have few other pathways available to them, my experience shows there would have been few objections by A&E staff. There is a problem around equality and parity of access and esteem for those of us with mental health problems.

3.6 Paragraph 22.13 makes it the responsibility of mental health providers to lead the re-detention of AWOL patients whose location is known. I am yet to encounter an example of mental health nurses or other suitable professionals undertaking this. Every time in my operational work I draw this provision to the attention of a hospital who is reporting a patient missing where their location is already known, they will simply reply, "We don't have the staff and if you don't bring the patient back, it will be your

responsibility." As if that settles the matter definitively. This small example is at the heart of the problems that have emerged over the last decades: assumptions that it is acceptable for mental health services not to organise and structure themselves in such a way as to envisage how these responsibilities are discharged. I'm confident no Chief Constable would get away with organisational level disregard of PACE Codes of Practice, for example. This gives rise to questions for the Care Quality Commission and NHS England about the detail of inspections they undertake.

PLACE OF SAFETY SERVICES

4.1 Section 136 of the Mental Health Act and access to place of safety services has been the poster-issue within all of policing and mental health for decades. As recently as 2008, the Independent Police Complaints Commission published a study indicating only 33% of those detained were able to access the NHS. By 2013, the Care Quality Commission published in its annual report that this figure had risen to 66% – still some distance from the vision in the Code of Practice that police stations should only be used in exceptional circumstances.

4.2 Having been involved in discussions with partner organisations between 2005-2010 about the establishment of place of safety services, there are certain problems faced by NHS organisations in delivering the kind of services envisaged by the Royal College of Psychiatry Standards on Section 136 (2011). In particular, there are problems around the management of detainees who are under the influence of drugs and alcohol as well as those who are physically aggressive or resistant. Also, there are quite remarkable problems in achieving access to NHS services for children, who are often excluded from place of safety provision because of misguided concerns around safeguarding.

4.3 The issue around drugs, alcohol and resistant behaviours is worth emphasising – we know individuals who present in this way to officers can represent management difficulties and can pose a risk to the safety of others. We also know that alcohol and drugs can mask other; underlying medical problems and those resistant, aggressive or even very violent behaviours can be connected to medical problems. In the Royal College Standards there is specific mention of place of safety services being commissioned in such a way as to allow for this reality. Obviously, mental health services should also have in mind the Rocky Bennett Inquiry (2000). Mr BENNETT was a patient in Norwich who died following a restraint intervention by mental health nurses and the investigation that followed heard from experts in the medical implications of restraint. The Inquiry recommended that restraint of psychiatric patients should be treated "as a medical emergency" and that it should be undertake only by trained staff with access to drugs, defibrillators and the ability to call upon a doctor to

arrive within 20 minutes (p55). The police service often deal with similar vulnerable people who face and pose similar risks but without officers having anything like as much knowledge of the individual, the only way to give effect to these kinds of recommendations is to advice an ambulance to every section 136 intervention and removal to A&E to allow them opportunity to consider the NICE Guidelines on the *Short-Term Management of Acutely Disturbed Behaviour* (2005).

4.4 We know that in various death in custody inquiries – Sean RIGG, Michael POWELL and James HERBERT – it was a feature of the criticism of officers that they did not treat the incident as a medical emergency and attempt to secure removal to an Accident & Emergency Department via ambulance. Yet it is my experience around England that when one attempts these discussions with partner agencies, many professionals in those areas of the NHS think this is blatantly preposterous. It was only last week that a senior professor of psychiatry stated public on Twitter that police station cells should still be used as a place of safety in exceptional circumstances "for those who are violent". This statement was not further qualified and is an example of why it is difficult for police officers, unqualified and inexpert as they are in mental health issues, to undertake partnership work which delivers the realities that Royal College Standards, NICE Guidelines and the Code of Practice.

4.5 A final point on place of safety provision which I know is in the background of NHS concerns about ensuring effective provision. The police in some areas massively overuse and occasionally abuse, section 136 MHA. Nationally, the CQC will state that 17% of those detained by the police are further detained by NHS. Whilst accepting subsequent admission to hospital is not the only indicator of appropriate use, it does give a sense of it. When examined more locally areas vary enormously. In Birmingham, the Place of Safety service sees around 45% of people subsequently admitted. Many more are referred for mental health problems to community mental health teams or back to their GP. Only a minority of cases lead to no need for further follow-up and in most of those, nursing staff were mainly satisfied that officers had reasonable grounds to suspect a mental disorder.

4.6 By definition, these statistics mean that there will be other areas getting nowhere near the 17% average that we see nationally. I am aware from a police force in the north of England that fewer than 10% of section 136 detentions lead to admission and most lead to no further follow-up at all. This suggests very strongly that officers in that force are misapplying the power and need further direction and training. I know from mental health professionals in that area, that this is training the local force is not willing to give and they see few problems in their decision-making and this disregard is why street triage was conceived to be necessary. We need better training for officers, in my view. Otherwise, we are expecting the NHS mental health crisis system to operate as a dumping ground for

problems the police wish to push elsewhere. There particular problems in the use of this power when the police encounter intoxicated people and those who have committed offences whilst unwell. I have written more about that on my blog.

STREET TRIAGE

5.1 Street Triage schemes, as they have become known in the United Kingdom, have come into operation around the world in various forms. In US and Canadian cities there are examples of police officers working together with mental health and / or social professionals. We have seen models involving literal partnership working, in the sense of an officer and mental health nurse patrolling and responding together as well as other models based upon the ability of officers to ring mental health professionals for information and advice, sometimes from nurses based in police control rooms.

5.2 The reception of these teams has been extremely positive and has been linked to significant reductions in the need for the use of section 136 MHA. In Leicestershire it has been associated with a 40% overall reduction in use and in Cleveland the reduction has been greater still (during the hours the scheme operates).

5.3 During the time that street triage schemes have operated, I have taken as much opportunity as I can to learn about how these schemes operate and discuss them with people involved. It is fair to say that most of those involved in the schemes are especially enthusiastic about what they deliver. Whilst I can fully see why they are, I have learned various things that alarm me about street triage, notwithstanding these acknowledged benefits.

5.4 In particular –

- I have repeatedly put the scenario to nurses and police officers involved in these schemes about how a situation should be handled if the police are called to someone who is floridly unwell and highly resistant and aggressive. Nurses and police officers have repeatedly stated that in such scenarios police custody is the only place that could safely contain such detainees. For reasons I have written about at length on my blog, such actions are the stuff of death in custody inquiries – Sean RIGG, James HERBERT and Michael POWELL amongst others. I have therefore been forced to conclude so far, that street triage schemes could potential raise the risks of such tragedies, not mitigate against them.
- I have had cause to raise concerns about the misapplication of the Mental Capacity Act by street triage schemes – for reasons outlined below; there are problems in bringing easy legal solutions to mental

health crisis incidents in private places. The Metropolitan Police were successfully sued in 2010 for "using" the MCA to resolve such a situation – in the case of *Sessey v South London and Maudsley and the Commissioner of Police for the Metropolis* (2010).

- I have been contacted by police operational supervisors and force incident managers from three separate police forces for my advice in connection with situations that street triage schemes have attempted to resolve, concerned as they were at the legality of following the advice that was given or the action proposed. On all occasions, I have had to agree with their concerns.
- Finally, street triage schemes were introduced in some places because mental health services were extremely concerned about the overuse and indeed, the abuse, of section 136 by their local police force. One AMHP lead informed me that the trust worked out it would be easier and cheaper to deploy a nurse in support of the police "to stop them doing the wrong thing" than to process the high volume of drunk people who were being processed into their place of safety service when other legislation should have been used. I have no difficult in accepting their concerns given the published volumes of s136 in that force area.
- These schemes are not about improving the ability and knowledge of police officers to resolve situations appropriately – I am not aware of any validated training schemes for any of the professionals involved. They rely upon operating cultures in policing and health being shared. We must hope they were appropriate in the first place and we know in some areas, they were not.

5.5 Street triage schemes normally introduce a nurse into a situation where previously, only a police officer would have been. In some schemes there is also a paramedic involved. This is clearly of enormous benefit in assessing clinical risks and assists in identifying the appropriate pathway required. However, despite nomenclature, street triage does not just respond to situations in public spaces – they are often called to domestic addresses. If the person within the incident does not wish to engage with the nurse or paramedic concerned, then those health professionals bring no additional legal powers to those already enjoyed by the police officer. We are then back to a long-standing, complex problem: the safe resolution of mental health crisis in private premises when it is thought that immediate intervention is needed. This is why I have heard of incidents from colleagues that triage cars have encouraged illegal use of section 136 and of the Mental Capacity Act – just as some police officers did when previously acting alone.

5.6 That said – I wish to re-emphasise that these schemes *are* bringing obvious benefits when they encounter people in public places or those who wish to engage and most of the above concerns could be corrected by effective training for all involved. If set against evidence that they are

actually cost-effective schemes to operate, then I would welcome their expansion. My own view is that if police officers were properly trained in mental health, including mental health law and if mental health services were sufficiently accessible to those in crisis or seeking help, then we would not need street triage and as long as we have capacity problems in inpatient units and amongst community teams, it raises the question of what street triage are referring people *to*. If we are not careful this could be the opposite of early intervention which is so cherished for its impact in other areas of mental health care.

LIAISON AND DIVERSION

6.1 In 2003, I completed a Master's degree in Criminology at Cardiff University and undertook research on 10,000 police custody records, to examine the decisions made about offending for those who were suspected on arrival to custody to be mentally unwell. This research concluded one important thing which is almost entirely unmentioned in all of the research, material and reports I have read over the last ten years — in practice, the one thing that determines whether a person is divert from the justice system without prosecution is whether that suspect, on the day of arrest, is so potentially unwell as to need admission to hospital under the Mental Health Act: were they "sectioned".

6.2 There are several problems with this observation –

- Firstly – whether or not a person meets criteria for MHA admission is nothing whatsoever to do with whether they can or should be held criminally liable for any offence committed. Examples exist of extremely unwell people who have been prosecuted for serious offences and been found fully responsible in court and convicted, despite meeting MHA admission criteria from the point arrest to the point of being sentenced.
- Secondly – most people (75%) who are 'diverted' under the MHA are admitted under section 2 of the Act. This provision allows for full assessment of someone's condition and in many cases concludes that no significant mental health problem exists and a patient is discharged. If a person has released from police custody without further action, where does that leave the victim and notions of justice?
- Thirdly – on what basis is this decision made? Despite mental health professionals recommending MHA admission, it still remains open to police and prosecutors to commence criminal proceedings where Part III of the Mental Health Act (patients concerned in criminal proceedings) can ensure treatment, care and full information to the courts concerning someone's mental health. Such information is

normally not known or made known to police officers and prosecutors taking diversion decisions.

6.3 When are we liaising? When are we diverting?! – who is making the decision and how? I am concerned that a lack of clarity and research about this is stacking the deck *in favour* of expedient decisions to remove just some people from the criminal justice systems who would be far better cared for in the long-term, if they were within it or diverted from it later in the process. Diversion can occur at all four points of justice – police, courts, prison and probation – we need an overarching strategy for how this is determined. I am also concerned about the impact these decisions have on public protection because of their ability to contribute to a revolving door of crisis intervention – admission – discharge – relapse.

MENTAL HEALTH LAW

7.1 Those parts of the 1983 Mental Health Act which affect the police were carried over from the preceding 1959 Act and were unaffected by the 2007 amendments. As such, police officers are policing a 21st century, deinstitutionalised and diverse society which leans towards a human rights oriented model of community mental health care. In my sixteen years of experience, I have formed the view that I am ill-equipped legally to ensure a professional policing response which supports that approach because I lack the ability to safeguard vulnerable people who are at risk in their own homes. I am no better placed to do this if accompanied by paramedics or mental health nurses. I cannot rely upon legal safeguarding powers under the Mental Health Act without calling upon an Approved Mental Health Professional and a section 12 qualified Doctor – but nor are those partner organisations with whom I must work able or obliged to respond in timescales which would support me in mitigating risks to vulnerable people. In the several hundred times in my career when I have called upon an AMHP to assist in a crisis situation that had not been foreseen by them, I can only give one example of a response and it took in excess of four hours to achieve and frankly, it surprised me that it was so quick.

7.2 Instead, we see people arrested for offences or to prevent a breach of the peace to achieve assessment in police custody – the antithesis of what we should be aiming to see where the main concern is mental wellbeing and another example of our national system needing criminalise those who are mentally unwell.

7.3 I am aware of the current Government review into section 135 and 136 of the Act. If it were agreed there is an operational problem we could conceive responses which do not involve altering the law. If crisis services were structured in such a way to provide a nurse-led response – and where needed an AMHP / DR response – then the law would be fit for

purpose. This is what the judge said in the *Sessey* case. However, such a view is contingent upon mental health services being willing and able to support 999 services asking for a crisis team type response or an urgent Mental Health Act assessment. Many do not agree they should provide their services in such a way and they do not do so.

7.4 So a health and social care response to mental health crisis in private would be welcome but we should also consider how to equip 999 services to safeguard vulnerable people without criminalising them unnecessarily where such a response cannot or does not occur. To ensure such provision would be consistent with many other nations from the Republic of Ireland, to South Africa and the states of Canada and Australia.

7.5 There are other difficulties with the Mental Health Act, which I suggest could be massively simplified in the interests of clarity to the police service – for example, there are in excess of twenty-five different timescales which apply to patients who absent themselves from admission under the MHA or fail to return from authorised leave. It is envisaged by the Code of Practice where patients are missing that officers be informed of the timescales by ward nursing staff. I estimate that in excess of 97% of the time they do not know – because legal training for mental health professionals is parlous, with the exception of Approved Mental Health Professionals.

CONCLUDING REMARKS

8.1 Mental health is core police business and needs to have greater prominence in the strategic management of the overall workload. We need to see vastly improved training for operational as well as senior police officers. However, we need to ensure through proper partnership structures at national, regional and local level that this is done on the basis of recognising what our police service, and our emergency services as a whole, are actually for – and on the basis of far more research and improved legal training for all. We currently see significant disparity between the way resources are allocated in physical and mental health when in reality there is no proper distinction of that kind. We see a significant lack of legal knowledge amongst health and social care staff at all levels, as well as in police officers that contributes to the creation and perpetuation of myths and folklore about how the interface between mental health and criminal justice is managed.

8.2 Our mental health system as a whole is still wrestling with very basic questions about mental distress in terms of whether we should view people's experiences and behaviours as disease, distress or dissent. We read unresolved debates about the efficacy of drug treatments and talking therapies, including claims that these approaches lack evidence to support the claims we frequently hear. We have also seen the efforts to which many

professionals, charities and service users will go to put distance between the notion that those of us suffering from mental health issue of various kinds are violent or likely to commit crime.

8.3 And concepts like street triage and liaison and diversion, by their existence, are recognitions that we need different systems to those we would otherwise employ, in the effective response to those of us in crisis, in disorder and / or when accused of offending and we are contemplating them without a robust evidence base for their inherent claims. We need far, far more research. I am mainly concerned that the emergence of these schemes will have unintended consequences elsewhere in our mental health and social care systems – will it become even more normal that access to services is achieved through the criminal justice system and what impact will this have on the poorest and most disenfranchised in our society?

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21st May 2014

Inspectors' Central Committee –

A little post by way of signing off for a much-needed period of annual leave! I've had an absolutely frantic and fairly fraught six months since I last had some time off and I'm ready to fall into a long, deep and peaceful sleep sometime soon.

I need to start finding a bit more time to look after myself, too –

I was in Bournemouth on Tuesday at the Police Federation's annual conference. The Inspectors' Central Committee were kind enough to invite me to be part of a panel of guests answering questions on issues identified by the inspectors of England and Wales as important issues. Policing and partnerships were two of those issues. It was an honour to do it, sitting alongside a Chief Constable, a Police and Crime Commissioner as well as Her Majesty's Chief Inspector of Constabulary and a Russell Group Professor. It felt a bit like gate-crashing a party but I keep kicking myself to remember that I'd been invited to be there!

The inspectors asked questions that are well covered on this blog: section 136, out of hours NHS responses and so on. Plenty of passion in the room to make things better and frustration that progress on these issues is slow. You can watch the session for yourself on the Police Federation website. (It should be uploaded any time now.)

PEER RECOGNITION

Having done my bit I sat down with my colleagues from West Midlands Police to wait for lunch only to get somewhat hijacked. As the Chairman of the ICC, Alan OGG, started to wrap things up, he suddenly announced that he was presenting a special recognition award from the Inspectors of England and Wales – to me. Alan spoke some extremely generous words and then invited me back to the stage to receive a beautiful, inscribed glass bowl from the ICC. Impromptu, I then blurted something about why I wrote a blog and how I was just glad to know it was supporting inspectors and the police officers we lead to do better for vulnerable people and to help keep cops out of trouble.

It's quite something to be recognised for your work, but I came away thinking it was something very special indeed to be honoured by your peers who've noticed this is mostly done in my own time. So I am especially grateful to the ICC and to Inspector Paul FORD whom I suspect was plotting and scheming to keep this a surprise! I drove home feeling rather humbled and somewhat emotional about it, if I'm honest. So I give my grateful thanks once more to the ICC and my peers, the Police Inspectors of England and Wales.

I've got a busy period in June – some really exciting opportunities to be involved in a few international conferences, but this will be the last post for a while as I've got a 9yr old son, a wife and a dog who are very overdue a highly disproportionate amount of my time. Oh, and a stack of books to read in the tranquility of our Cornish hideout – with **Twitter turned OFF!**

And finally, remember this: people in suits rule the world – people in uniforms let them!

JUNE 2014

1st June 2014

Criminalisation –

This is a much bandied about word – **criminalisation** – meaning various things to different people and academics have argued for some while about extent to which society now seeks to criminalise the vulnerable in managing the ways in which we access care. Two US academics in particular have written about this: Professor Linda TEPLIN who has argued we overly criminalise the vulnerable and Dr Melissa MORABITO who has argued the opposite. Each acknowledges various academics who came before them like Egon BITTNER who did research on police decision-making and on police mental health encounters in the 1960s.

So what do we mean by 'criminalise'?!

It could mean a few different things, and this seems to be why TEPLIN and MORABITO disagree with each other. If you mean accessing care – or *only* being able to access care – via the criminal justice system, then you may have a point. We know of many cases over the years where families have seen their loved ones convicted after an offence only to then point out that they were asking for help well in advance of the crisis incident that led to offending behaviour. So the argument goes: you want / need help now but don't manage to secure it, but you are forced into it after a serious untoward event: you have just been criminalised because you would not have had to go via that route for any of form of emergency medical assessment or care. This is an intuitive, quite instinctive type of definition: having to tolerate exposure to criminal justice agencies to a far greater degree than would have been experienced in any other area of health or wellbeing. This compares mental health with physical health and opens up the *parity of esteem* debate.

Conversely, it is argued that in a model of care that is a broadly deinstitutionalised, human rights-oriented model of community support, vulnerable people are, from time to time, going to have contact with police and criminal justice services. This is true of society as whole, so why would it not be true of those of us who live with mental health issues? The key thing to establish would be to assess and understand the extent to which this is different, for those in mental distress. Research by Melissa MORABITO pointed out that if you compare samples of contact with the police, samples of arrests and then of prosecutions, what you learn is that those members of society in distress are far less likely to be arrested or detained at all, more likely to be detained under mental health law if an

immediately coercive intervention is required and less likely to be prosecuted if they were originally arrested for offences.

In other words, from her research and according to the definitions of criminalisation to which she works, mental health is a contributory factor to people being less criminalised than they otherwise would be if they were not unwell or in distress. So maybe it depends on whether you accept her premise that you measure criminalisation with reference to the extent to which we do it for those of us considered mentally disordered compared to the extent to which we do it for those who are not and compare the way the justice system treats each group. This approach obvious rests upon it being possible to define 'mental disorder' and 'mentally disordered offender', so that we can easily establish who is 'in' and who is 'out' of any approach whereby we need to distinguish. These definitions, as Jill PEAY points out in her remarkable book Mental Health and Crime (2010) survive attempts to be precisely defined, especially by definitions that survive contact with both law and medicine.

So which conceptual construct of 'criminalisation' works for you?!

THE CRIMINALISATION CONTINGENCY

This post arises from a Twitter exchange – passing reference to the above and my explaining that in some cases, you can get access to mental health services only if you are 'in contact' with the criminal justice system; or that access is faster if you are. What do I mean by this, given that I've argued for years that we do not have a fully functioning emergency mental health care system in the UK and that the police and criminal justice system plug gaps? Regardless of which of the academic debates you find more interesting, we do know that there are some services in the NHS that won't touch you, unless the police are involved:

Think about section 135/6 'place of safety' services – they exist purely and simply for those in immediate need of care or control who are detained by the police. You cannot access a PoS service, *unless* you are legally detained. So we have emergency mental health triage, care and assessment for those who may not want it, but where is that equivalent for those who do? Well, it's available via your GP or Accident & Emergency but neither of these involves direct access to specialist mental health professionals. If you happen to be under the care of a mental health trust already, you may be able to access the Crisis Team, but their ability to respond to your needs will depend on many things and we know that such services are experiencing large increases in demand at a time where budgets are shrinking. But PoS services are an example of rapid access to assessment / care, only for those who are in contact with the police and legally detained

by them. Otherwise, you can sit in A&E and hope to be seen – if you can wait that long and aren't put off by the idea of waiting a long time.

There are other examples: I've known several detentions in police custody where mental health professionals have suggested that certain types of care are required, but have requested that the police prosecute patients in order to ease their access to those services. I've never really understood why the legal framework to which someone is subjected should affect their ability to access a clinical service deemed necessary, but it's happened so often over the years. If you're legally detained under s2 or s36 of the Mental Health Act, you're still legally detained against your will and can be treated accordingly under the law.

And this is the most important point to remember: whether or not the criminal justice system can stick that legal framework around you, is uncertain and nothing whatsoever to do with your health and wellbeing. I have numerous examples in my career, but I prefer to use the one of the young man who was arrested on suspicion of murdering his ex-girlfriend after a missing person enquiry led police to an address where they found the young man present and discovered her body there. He was very obviously mentally unwell and assessment immediately declared him unfit for interview and in need of urgent admission to hospital. Given his own history and the present circumstances, everyone was saying that medium secure care was needed and full forensic assessment.

This makes sense, doesn't it? Requests were made for him to be charged with the offence but the senior investigating officer had to point out, that there was insufficient evidence to charge anyone at that stage. All the detectives had, in terms of criminal evidence, was the police having found a body in a house where a mentally ill young man was present and clear indications that the victim had been killed by someone else. That didn't prove beyond all reasonable doubt that *he* killed her: forensic enquiries were not yet complete; he had not yet been interviewed about the matter because he was too unwell; and there were other enquiries still ongoing to gather other evidence.

FASTER ACCESS TO SPECIALIST CARE

So my only point here, is that some parts of our MH system are *only* open to those in contact with the police and that some other parts, prefer to see criminal justice frameworks imposed which are inherently unconnected to clinical need. And they prefer this, even if the legal criteria for criminal justice service intervention are not met. This was true in the MS v UK (2012) case.

A young man had, in all probability, seriously assaulted his aunt. She declined to support any kind of prosecution against him for his acts, knowing that he was seriously mentally unwell and just being glad the police had safeguarded him by using section 136 of the Mental Health Act. In custody, he was profoundly disturbed and unwell – as highlighted in the judgment – and the police and CPS did consider whether he should be prosecuted for an offence committed. It was determined that he could not be prosecuted, because there was no admissible evidence to place before a court: his aunt declined to support a prosecution and would not give evidence against him, there was no other corroborative evidence of any kind. And yet his prosecution was still requested for reasons that were partly connected to accessing a medium secure mental health bed. Presumably, the man either met the criteria for admission to an MSU or he didn't? … we know that MSUs don't *only* admit patients concerned in criminal proceedings.

This is what Linda TEPLIN would argue is criminalisation: accessing services via the criminal justice system when that wouldn't be necessary for cancer or pediatric services. Where are the PoS services for those who know they need them? They don't exist. Where are the specialist mental health services (like secure services and inpatient CAMHS) for those who have not been prosecuted by the police because opportunity to intervene early has been recognised either before an offence has been committed or before the evidence exists to prosecute someone? They often don't exist. Doesn't structuring mental health services' access criteria around crime, offending and contact with criminal justice reinforce stigma and prejudice that mental health issues are implicitly linked to crime?

And it is against this backdrop that some of my concerns about street triage schemes rest. We know that in many cases, some of the demand for crisis intervention shifts to the police because people cannot access mental health services in a timely way. As BITTNER said, "Something's happening that ought not to be happening about which someone ought to do something now." The police, having been found wanting in some of their responses, have moved into close partnership working with mental health professionals and can now get a mental health nurse into the heart of the incident. We know from those schemes that have run for a couple of years, that many, if not most, of the incidents are resolved without the need for police intervention at all. For me, this raises questions about criminalisation: your crisis care now comes wrapped up in a police car with a security dimension in case you need to be coerced and it puts a dynamic into the incident that may not always help. I know why we've found ourselves doing it, but the extent to which people in crisis may want to be criminalised by implicitly coercive nursing care, I don't know.

I put it out there, for what it's worth. But what I do know, as with the American experience over the last twenty or thirty years, is we are finding

increasingly inventive ways to weave together our mental health and criminal justice systems in an approach to crisis intervention that means they are starting to look the same as they see distress, dissent and different through a similar, blurred lens that is neither one thing, nor the other. And I also know that some patients don't want the police to be involved in their mental health crisis – whether because of previous poor experiences, because of paranoid perceptions about the police or simply because it makes them feel like criminals because we wouldn't call the police to become a routine part of any other kind of medical treatment.

That's why we're criminalising vulnerable people and leaving gaps in the system we operate through which people will fall.

6th June 2014

Cape Town –

This blog is specifically aimed at those attending the biennial conference of the International Council of Police Representative Associations in June 2014. The ICPRA have been kind enough to invite me to speak at their gathering in Cape Town. **Yes, really!** This is a particular honour, to return to this wonderful country to talk about policing and mental health at an international conference – I could hardly be more chuffed at the chance to go!

Those attending this conference should consider this to be background material for two weeks' time! —– I hope those who are not going may find it interesting anyway.

TWENTY PERCENT OF DEMAND

Mental health has for a long while been an increasing proportion of police work in almost every country and it is directly connected to some of the most sensitive and controversial incidents we encounter – fatal police shootings, restraint related deaths in police custody ranking amongst them. Regardless of particular legal, political or cultural jurisdictions, police forces around the world report large proportions of high-profile, untoward events involving vulnerable people with challenging, complex needs.

- A half of fatal police shootings are thought to involve vulnerable people in distress.
- A half of deaths in police custody, often whilst under restraint, involve vulnerable people in distress.
- More than half of deaths following police contact, often by suicide, involve vulnerable people in distress.
- A third to a half of people arrested are those of us with mental health problems, learning difficulties or disabilities.
- All of this is made far more complex by substance misuse or abuse which can confuse and conflate the recognition and identification of people.
- All of this is made far more complex given that science is very far away from reaching anything like a settled view across all mental health professions about 'what works' in mental health care.

- There is even research from the World Health Organisation – much debated as it is – which indicates recovery from mental distress is more likely in countries that do not have developed psychiatric healthcare systems.

So where does this leave policing and criminal justice when most countries seem to suggest we should be diverting vulnerable people into appropriate health care, where available? It leaves police officers standing at the interface of two massive systems of state coercion and control, making decisions that are the most complex of all those professionally required of us. I will outline at the Conference why it this leaves us highly uncertain of how policing should operate and how partnerships with mental health care should be structured given how fragile scientific discourse actually is about mental distress, but it is against this uncertainty that police officers are required to turn endless shades of grey into black and white, yes or no decisions.

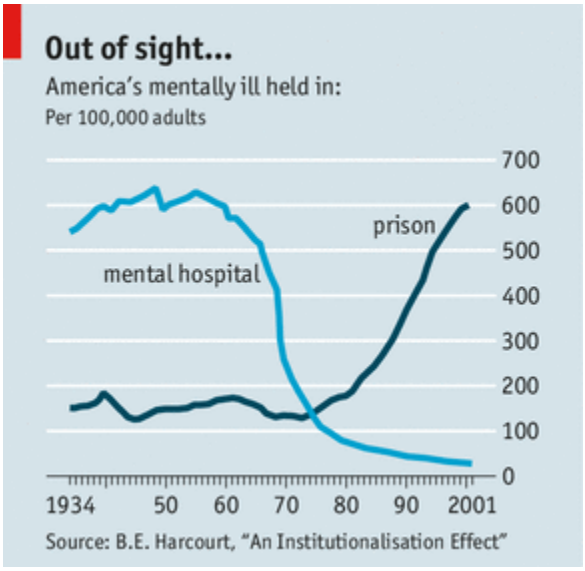
And all too frequently, police officers are seeking to find nothing more than the least worst option.

HOW DID WE GET HERE?

Many countries' mental health services around the world began a process of deinstitutionalisation approximately sixty years ago – after World War 2 and especially following the development of anti-psychotic medication in the 1950s. Police forces were not aware of how fundamentally this shift in mental health care would affect their profession and did not prepare for it. In fairness to the criminal justice system, promised investment in community mental health services did not appear and contributed to a process whereby vulnerable became increasingly criminalised in order to access care, or as proxy for care. Using our host country as an example, South African mental health services began deinstitutionalising mental health care somewhat later, following the end of Apartheid – and the process continues today – but community mental health services in the country have not expanded to take account of this and there is a considerable shortage of mental health professionals, especially in rural, poorer communities.

So it's back to policing and we know from research in the US, that police officers' decision-making when dealing with encounters where they recognise people are suffering from mental health problems will be affected by the options available to them to avoid arrest or prosecution. If police officers do not have health related options to keep people safe or to refer them to relevant services, they will opt to criminalise them where this is

necessary to protect the public. Hence we see high rates of mental disorder in imprisoned populations and this is true in South Africa just as it is in the United Kingdom and elsewhere. This fairly notorious graph of US mental health care and the imprisonment rate of those US citizens who have mental disorders betrays a very clear trend –



You could probably draw a similar graph for the United Kingdom, for Australia or Canada – certainly the UK there are *three times* as many people with severe and enduring mental health problems in British prison system than within the UK's secure mental health services. You would have to have *quadruple* the health service capacity to transfer those people from prison, but the cost per person of care, rather than incarceration would also quadruple, at least. This gives us something of a clue as to why it does not happen! And *none of this* takes account of those in prison with less serious mental disorders that would not require inpatient mental health care and it does not take account of how the criminal justice system itself can cause or exacerbate mental distress.

Around the world we see policing playing its part in two contexts of mental distress: and this is a very imperfect distinction –

1. Responses to mental health emergencies
2. Responses to criminal suspects who are mentally ill.

POLICING MENTAL HEALTH

So we've seen officers around the world responding to situations involving risks and public disturbance, encountering people with unknown backgrounds possibly involving mental health, drugs, alcohol and social problems, having to take blunt decisions about whether or not to detain, whether or not to use force and whether to choose mental health or criminal

law. We know that officers are taking these complex judgements without clinical training and with comparatively little mental health training. Initiatives around the world like 'Crisis Intervention Training' are seeking to improve this situation, but it remains far from settled as to what' good' looks like in policing and mental health. We are yet to see schemes properly evaluated by good quality academic research.

Meanwhile, our hosts are undertaking high-profile trials where Oscar PISTORIOUS and Shrien DEWANI are being tried for homicide offences in hearings which have become embroiled in difficult questions about the interface between law and psychiatry. We've seen in these cases that definitions of 'mental disorder' vary between lawyers and doctors and this says much about the interface of law and psychiatry where police officers often find themselves standing. A must-read academic analysis of this for those who are interested in greater knowledge, is *Mental Health and Crime* by Professor Jill PEAY. To see the extent to which these problems can cause crippling political problems, read *Neither Mad nor Bad* by Deidre GRIEG which highlights the case of Garry DAVID in Australia in the 1990s.

And finally, we must look at ourselves –

- In most countries, 25% of the public will suffer from mental health problems in the course of their lives.
- Research suggests police officers are around four times as vulnerable to suffering from mental problems such as stress, depression and anxiety.
- We know there are particularly problems in achieving proper psychological support for officers suffering from PTSD.
- We know that suicide rates in policing are way above that seen in society as whole.
- We know that men are more likely to die from suicide than woman, as much as three times as likely.
- So in a male dominated profession that operates a culture where admitting to experiences of distress may well be met with negative organisational as well as peer responses, why aren't we fighting stigma and discrimination internally?
- We could learn a lot about ourselves by recognising that very few police officers are open about their experiences of mental illness.
- Why do we think this is?!

RESOURCES FOR SOUTH AFRICA

Here are some resources and policing, mental health and criminal justice in South Africa and a documentary that is well worth watching.

If you're going to be in Cape Town for the conference, I look forward to meeting you in a beautiful city that you're bound to love, as I do.

- The South African Mental Health Care Act 2002
- Dr Vikram Patel talking about global mental health in developing countries.
- The PRIME website.
- Taking Stock: Mental Health in South Africa
- Suicidal Ideation in the South African Police Service
- The Mental Health Gap in South Africa: a Human Rights Issue.
- The South African Mental Health Federation – an umbrella organisation for mental health charities.
- The World Health Organisation (UN) report on South Africa's mental health system.
- Recent research article on the South African Police Service's use of "Section 40" MHCA 2002.

NB — *I want to provide a background note to my attendance at this event, in order to head off certain questions that may naturally arise.*

Firstly, I am attending this conference *entirely* in my own time – I have taken two days' of annual leave in addition to the four days off afforded by my shift pattern to create the opportunity to go. Secondly, all travel and accommodation costs are being met by the organisation who have invited me to talk to them on policing and mental health. It has therefore cost the British taxpayer **nothing** in terms of time or money for me to attend this event.

14th June 2014

Section 4 Mental Health Act –

This post has been specifically requested by my colleagues in the Metropolitan Police, texting me to say "Do you have anything on section 4?!" The fact is I didn't and I was surprised I'd never thought to cover it, so this song – sorry this post – is dedicated to the Met because their request made me realise I haven't written *any* substantive posts on the normal civil, admissions sections of the Mental Health Act 1983. I've explained them a few times in different posts and on reference pages, but never in a normal post. So here we go —

- **Section 2 MHA** – allows for a patient's admission to hospital for assessment of a suspected mental disorder if founded on the application of an AMHP or a patient's Nearest Relative and two doctors, one of whom must be 'section 12 approved'. Once the patient is admitted, they may be detained for up to 28 days to allow for this assessment to occur and that period may not be extended at all. Of course, a new application for detention under s3 could be made.

- **Section 3 MHA** – allows a patient's admission to hospital for treatment of a determined mental disorder, founded upon the application of an AMHP or a patient's Nearest Relative and two doctors, one of whom must be 'section 12 approved'. Once the patient is admitted, they may be detained for up to six months to allow for treatment to occur and that period may be extended, by a second six month period.

- **Section 4 MHA** – allows a patient's urgent admission to hospital for assessment of a suspected mental disorder, founded upon the application of an AMHP or a patient's Nearest Relative and just one doctor, who must be s12 approved and where there is insufficient time to arrange a second doctor. Once the patient is admitted, a second medical recommendation 'turns' a section 4 admission into a section 2.

So section 4 admission, is rather like a section 2 application, but undertaken with only one doctor. It is used where the admission is "of urgently necessity" and where waiting to gather two doctors together would cause "undue delay". Use of section 4 is quite rare – I have never known it used

and on social media I can recall many AMHPs stating that they've never used it either. Given that most applications under the MHA are made by AMHPs, I'm only going to refer to them in what follows but Nearest Relatives' rights allow them to apply if they have one medical recommendation, perhaps from their GP. AMHPs are obliged to support NRs, where appropriate.

There are a few things to bear in mind about section 4 itself ——

SOME MORE TECHNICALITIES

If a Mental Health Act assessment takes place for potential use of section 2 or 3, any medical recommendations generated can be held by the AMHP and used at any time in the next fourteen days. So let's imagine the AMHP, was not immediately convinced that admission was the right thing to do, but the doctors were happy it was justified, the DRs could leave their medical recommendations, the AMHP could arrange whatever community support they thought necessary and if it were subsequently thought that admission was required, the AMHP may still use those original recommendations for up to two weeks. With section four, the AMHP may only rely upon that single medical recommendation for up to 24hrs. This is also the timescale within which a patient has to be conveyed to hospital if section 4 has been used.

There is much written in the Code of Practice to the Mental Health Act about this kind of application. I'm sure you recall that it is chapter 4 in the Code that deals generally with applications for admission. That chapter is still relevant to these urgent applications, but so is chapter 5 which is specific to them. Chapter 5 stresses that there should be a genuine emergency and section 4 MHA should never used for administrative convenience. the AMHP and DR should have evidence to support their claim that it is an emergency, including one or more from –

- An immediate and significant risk of mental or physical harm to the patient or to others;
- Danger of serious harm to property; or
- A need for physical restraint of the patient.

Timescales for patients absconding from detention under section 4 vary from the norms we understand for section 2 or section 3: if a patient absconds *before* arriving in hospital, that s138 may be used for up to 72hrs from the time they abscond. If they absent themselves from hospital *after* arrival in hospital then s18 MHA may be used for up to 72hrs after they first arrived in hospital. In each case, there is no power of entry so a warrant would be required under s135(2) MHA and this can be obtained by

an AMHP, a police officer or anyone authorised by the relevant hospital managers.

Given that section 4 was an application for urgent admission because of various potential risks and dangers highlighted above, finding a patient outside those timescales should probably cause officers to think about using s136 MHA if found in a public place and contacting an AMHP for an urgent MHA assessment if found in private. Of course, if the AMHP decides to attend urgently with just one doctor to do a further assessment under s4 MHA, they will need a warrant under s135(1) if they need the police to force entry.

All clear?! Excellent!

WHY IS NOT USED MORE OFTEN?

This is one of those provisions that we do not see being used very often, although the judge in the Sessey case did make it clear that this provision is there to be used. I have often thought that where the police or 999 services are called to mental health crisis incidents in private premises and think the situation is something where section 136 MHA would be used if only the officers were not in someone's private home, section 4 may provide a useful way of speeding up the AMHP-led assessment. Bearing in mind, that if officers are suggesting that 136 would be appropriate if only they were in a public place, they are in effect stating that immediate intervention is needed, potentially by restraint because of various dangerous indicated above. You'll remember in the Sessey case that the Metropolitan Police 'used' the Mental Capacity Act as a proxy and then agreed in legal proceedings that it was inappropriate to do so. The judge pointed out to everyone that local authorities have a duty to ensure sufficient AMHP provision to undertake urgent assessments and this would mean use of section 4.

That having been said, it would have to be for the genuine emergencies, but how hard should it be for an AMHP to attend a crisis incident with one doctor if 999 services are highlighting an immediate need for care or control? This is the answer if debate about extending police powers is to be extinguished and as I've consistently said – despite my being frequently suggested to have said otherwise(!) – I would welcome a mental health care response as the most appropriate, least restrictive method of assessing whether or not to intervene: more appropriate professionals, less restrictive, stigmatising practice. However, if Local Social Services Authorities don't have sufficient AMHPs to respond in about one hour with one doctor, then it starts to become unrealistic. That is the choice to be faced, do we have enough AMHPs properly deployed and if we don't, do we want to employ more or extend police powers? Failure to do either, is to

cause a Sessey type situation where the legal answer may be to leave someone unsafe and that is also unconscionable and unfair on the police officers concerned.

If you've never stood in someone else's private home with everyone, including AMHPs and Doctors, staring at you to "do something" when you know you are legally powerless to do 'anything', nevermind do 'something', you won't understand what I mean. It is gut-wrenching. Section 4 and a 135(1) warrant could be the answer, but we need AMHPs and DRs available to do it.

16th June 2014

Partnership Working –

Not for the first time, I was recently told during a discussion about the police / mental health interface that solutions to problems will be found in partnership working and that "we need to stop talking about what is your job and what is mine." I admit to having had a small cerebral dysfunction as my brain immediately condemned this kind of insight to the bin. I tried really hard to reflect on my reaction and lift this feedback into the light so I could see it more clearly.

The more I thought about it, the further into the bin I wished to put it because it struck me as a very bland kind of patronising response to elicit more examples of a mental health system is guilty of creeping criminalisation and contingency, via policing. I also immediately reflected that policing does this too, to our mental health system. So as you read onwards, don't think I'm *just* being critical of mental health services!

Let me show you why I object ——

Scenario 1 – a patient in a mental health unit who has been exhibiting aggressive behaviours has improvised a pointed weapon by snapping the head off a disposable razor and has dragged a nurse into a side room, barricading the door with furniture whilst threatening to sexually or violently assault the nurse. Imagine if as the local duty inspector I replied, "We need to work in partnership and stop talking about what is your job and what is mine. Let me know when you've dealt with it, I hope everyone is OK at the end."

The problem in these kinds of jobs is ensuring that the police don't react by saying, "Haven't you got security on" or asking, "Why can't you deal with it?!"

Scenario 2 – a mental health ward is running understaffed overnight – it doesn't really matter why. Around 2am, a patient has become aggressive and staff believe he needs to be moved to a seclusion room and given medication against his will under Part IV MHA and they call the police for help. Upon arrival at the unit, officers ask for a supply of the relevant drugs and some hypodermic needles so that once they've either talked or coerced the man into the seclusion room, they can give him his injection.

The problem here is NHS understaffing and / or a lack of contingency arrangements for the administration of medication without consent.

I hope by now you're laughing at how ridiculous this is. Scenario one, despite it being in a hospital, is a police responsibility. Nurses and doctors don't deal with weapons, hostages and barricades do they? — we can agree: that is my job. But it's no more frightening than the idea of police officers grabbing drugs and needles to inject people, is it? — again, we can agree: that is a role for properly trained medical staff.

We do, by nature of our professions, need to be talking about what is your job and what is mine at this difficult interface!

GREY AREAS

But not everything is so clear – there are many things at the interface that any number of professionals from various professional groups in policing or mental health could do. Surely *that's* what people mean by not talking about "what is my job and what is yours?" – the non-obvious stuff? Surely, when there is ambiguity or ambivalence in laws or guidelines, it is important to work in partnership and not debate the rights and wrongs?

I suspect that is little more than the traditional expedience over principle argument –

Scenario 3 – a patient in their own home has been placed in legal custody following an application that they be admitted to hospital under the Mental Health Act. The AMHP attended the incident only with the two DRs who made recommendations and they have now both left the house, the patient is refusing to move. Because the NHS have historically never supplied staff to such assessments who can or will coerce other people, this must mean it's a police job, surely?

Should we stop talking about what is my job and what is yours and work in partnership by the police just mucking in?

Scenario 4 – a patient who was given s17 leave from hospital over the recent weekend has failed to return to the ward at 10am on Monday morning. A phone call by staff confirms via his family that he is still at home and has decided not to return because he feels OK. Staff have now rung the police to report him AWOL and want officers to attend the address and make him return.

Should we stop talking about what is my job and what is yours, disregard para 22.13 of the MHA Code of Practice and just work in partnership by disregarding statutory guidelines?

We could go on and on couldn't we?! ….. I won't.

Here's the main point: as soon as you accept that it is an exclusively police responsibility to deal with armed hostage situations and a very bad idea for police officers to be injecting mental health patients with drugs, you are accepting the proposition that some things are my job and some are yours. That any number of professionals are entitled to use physical force to coerce a vulnerable person, doesn't mean that it *always* is a job for the police – Parliament gave those powers to AMHPs and nurses *for a reason*. If we see a situation where mental health services have unilaterally decided to withdraw from undertaking functions that Parliament obviously intended them to consider at some stage, it is reasonable to ask, "So when is this my job and when is it yours? It can't always be mine just because you would prefer that it were when I have valid professionals concerns."

FOR THE REMOVAL OF DOUBT

I could evidence that we have seen police officers and police forces massively criticised in courts for these kinds of things and I could give examples where these debates are linked to deaths in custody or following contact. Incidents of the most sensitive and tragic kind which mean we need to debate this stuff *far more:* some things are my job, some things are yours and solutions to problems in those areas will, ultimately, be unilateral. No police officer can make more mental health beds exist and we know that some problems we've seen are connected to that. No mental health professionals can ultimatately make police officers use s136 MHA in a proper fashion, so problems arising from that will only really be addressed by proper training and police leadership.

The debate is for those areas of ambivalence and ambiguity where we may find a conflict between the ideal world of NHS and statutory guidelines and the real world of rationalised services on all sides: and *here* we may make partnership working more effective without getting into the territory of one organisation feeling 'left to it' by the other. For the avoidance of even yet more doubt, I am also thinking here of situations where the police fail to take their responsibilities seriously, too: leaving section 136 patients in A&E or an mental health unit Place of Safety; or by failing to properly investigate criminal offences which occur on inpatient wards. We know that guidelines state the police shouldn't be involved in the ongoing detention of a s136 detainee in hospital, but it still happens. We also know that the police shouldn't be pushing people into A&E and looking to leave automatically, treating it as if it were a fully set-up s136 suite, like we find in mental health units.

So this is not just about the police being disgruntled —– **we do these things to each other!**

But there are clues to look for in all of this. The restraint of medically unwell elderly people may be better done by trained staff from older age mental health nursing because the restraint skills for these tasks is designed for the purpose and not, unlike police training, predicated on the deliberate application of pain. There are NHS guidelines on this – what is the point of NHS restraint guidelines that say "no prone restraint" only to call the police and ask them to do it? Other statutory guidelines exist for a reason: we shouldn't just be tossing them aside because of expedience where the recovery of AWOL patients is concerned because the families of those who have died under restraint in such circumstances deserve to see improvements in our partnership working as a result of learning from their tragic experiences.

Some things are my job, some are yours and this will never change and it's only fair and part of an ongoing debate to highlight this. We each need to be influencing senior managers to deliver strategic arrangements that allow this to be reflected in practice. Otherwise hand me the needles and a copy of the BNF – we'll crack on as best we can.

27th June 2014

Concerns for Welfare –

It is currently flying around social medical that the Metropolitan Police is being asked to undertake 5,000 "safe and well" or "concern for welfare" checks per month. I'm not sure whether this number is even vaguely accurate, but if even remotely correct that amounts to over 150 such calls per day across London. (My intelligence sources tell me that it is a considerable under-estimate!)

Not all of these will be mental health: some will be regarding the safety and wellbeing of children and others will concerns elderly adults who have dropped out of contact with family and friends, but some will involve adults living with various kinds of mental health related issues.

I've written before about the difficulty the police have in doing these checks and I'm not going to repeat all of that, but I am going to outline a clear model I have developed in my head since that post to help officers understand their limits and to understand how a situation which breaches these limits needs to be referred back to whoever asked for the check to be done or someone with the letters N, H and S on their job badge.

I submit that officers can do little more than find someone and then confirm the following things —

A – alive
B – breathing
C – conscious

I – ill
I – injured
I – intoxicated

And **that's it** – so **STOP!**

It may be tempting to infer from these things whether or not someone is 'safe and well' — **don't! Think -**

ABC - III

If you attend a house and find someone **a**live, **b**reathing and **c**onscious who is not **very obviously i**ll, **i**njured or **i**ntoxicated, then visually speaking, that person may well seem 'OK'. Emphasis on the model being a visual one and upon not all illness, injury and intoxication being obvious. Indeed, the person may well be fine but let me remind you why such an assumption is a (potentially dangerous) step too far because of your inability to undertake a proper mini-mental state examination. Your assessment does not determine whether the patient who you were told was suicidal or likely to self-harm is or is not *actually* and *actively* suicidal. Remember to look at the situation from the outside:

A police officer is talking to a potentially distressed person about their safety and wellbeing. What does that service user think the officer will do if the person is unable to convince them that they are, in fact, OK? That person has either already walked out of A&E whilst waiting to be seen by mental health services or whilst waiting for an inpatient be to be identified; or maybe they failed to show up for an outpatient appointment earlier that week or said something on the phone to the crisis team that causes concerns to be raised in the minds of professionals.

Might the person fear that officers will detain them under the MHA or some other law, to ensure they remain safe? I have often heard from mental health professionals that the police checking on someone can be very reassuring for those who are isolated, distressed and unable to access any other supports. I accept that in principle, but can equally counter that some people find the opposite and have been quite distressed to find officers suddenly on their doorstep, thumping on the door. How can officers know which welfare check will be welcomed and which resisted?

The dynamics in these kinds of encounter are weighted heavily towards the police officer – they are dealing with a vulnerable person who may have a suicidal intent and is anxious to avoid detention – it is for that reason we need to be careful how the encounter is managed. If the officer is not entirely convinced of safety and wellbeing, they will be thinking about whether they can detain or remove the person to a place of safety, etc., and the person themselves may well know this. The situation where someone finds themselves detained may be the very thing they are hoping to avoid, whether because of previous poor experiences of police or mental health services or for any number of other reasons.

MISSING PEOPLE

Obviously, in some circumstances reports voiced as 'safe and well' requests also amount to reports of people who are now 'missing' as defined by ACPO and force guidelines. Many will be high risk reports, so nothing I'm writing here is trying to suggest that we should receive these calls and simply say,

"No, we're not attending that." I know one force who took legal advice on concern for welfare checks where the location of the involved person is already known and it was argued that there is no specific obligation upon the police to undertake such checks on behalf of another organisation unless there are threats to life or concern that criminal offences are involved (like child neglect, etc..) But there may well be duties to find people whose location is not known, where vulnerabilities may place them at risk?

The difficulty is that when people are found, to what extent do the police take responsibility for confirming the health and wellbeing of people whose backgrounds were often not fully communicated and where officers lack the skills, training and education to make an informed decision? How do we handle those situations where we have undertaken to find or check on someone whose potential suicidal ideation caused sufficient concern for the police to begin looking for them?

Various things –

- Get health professionals involved to assess medical wellbeing – this may be an ambulance, a street triage scheme if you have one and don't forget the role of out of hours GPs if you can establish who it is.
- Consider the use of s136 MHA if the encounter was in a public place.
- Use the above tool ABC-III to report back to the caller advise the caller of the person's location
- **Always stop short of confirming 'safe and well'.**
- Ask them what action they are now taking in light of the fact that safety and wellbeing can't be assured – document the response.

Furthermore –

- If A&E were the callers, they may have limited ability to do more than liaise with a MH crisis team
- If a situation where you cannot use s136 MHA gives rise to concerns about the "immediate need for care or control" then contact the CrisisTeam for support / advice.
- Consider asking whether a nurse could attend to support; and / or
- Whether an AMHP / DR could attend to undertake a s4 MHA assessment.
- Document all responses given.

Then, having referred the situation to those who can help, you have to make the decision – always involve the duty sergeant / inspector! – as to whether you can legally do more, or having made the appropriate referrals to relevant agencies, you advise the person to return to hospital and resume to other duties.

Remember, the police service have no legal authorities in private premises under the Mental Health Act 1983, limited ability to justify action under the Mental Capacity Act 2005 and can only otherwise act by detention if there is a criminal offence of a breach of the peace. The most important thing, however, is to not give assurances that someone is 'safe and well' where you lack the skills, information and training to tell – get NHS support and advice on this, **always**.

JULY 2014

16th July 2014

The Code Of Practice Revision: part 1 –

I'm going to do two blogs on the new draft Code of Practice to the Mental Health Act 1983. In this first post, I'm going to give some details about the consultation itself and how you can contribute to it if you have views you want to put across. I'm also going to zone in on the new Chapter 16 of the Code of Practice which relates to police powers and is the equivalent chapter to the current chapter 10 from the 2008 Code. I will also say some things about what is NOT present in this draft. In a second and subsequent post, I'm going to cover the other chapters that are of relevance to the police but in neither piece am I pretending that this is exhaustive or all that I have to say – that will be going to the review team whom you can also contact if you have a view.

There are many things in this draft Code to be welcomed, not least the new Chapter on the interface between the Mental Health Capacity Act 2005 and the Mental Health Act itself. I also think many things carried over unchanged have been presented in a clearer, more helpful way. Having obtained the hyperlink to this whilst lying in sleeping bag in a field in Kent with no 4G or 3G, I couldn't download the document to read it properly. In a tense evening with little sleep, I came to realise how ridiculous my life has become that all I wanted to do was drive at 4am to a signal area and download the bloody thing. Having made myself wait until skipping through Kent's glorious medieval history, I managed to steal a glance and felt quite disappointed, overall.

But my punchline on reading the draft – I still think we've got a lot of work to do. Some stuff remains too vague and too ambiguous, some stuff is wrong (by omission and commission) and other stuff potentially reinforces the need to do things in a way that sits at the heart of various disasters and tragedies we're still wrestling with. We need to do more and better than this – this draft Code still leaves many unanswered questions and we have until 12th September 2014 to realise this and get the replies in.

CHAPTER SIXTEEN

It was in only the second paragraph that I first paused and thought, "Oh, no" – hints at the end of 16.2 about the grounds for obtaining a s135(1)

warrant. They don't just include patients who are ill-treated or unable to care for themselves, but also patients who are 'neglected' (including self-neglect) or 'kept otherwise than under proper control' – awful language but still part of our current law. So we kicked off by only listing half of the grounds upon which a warrant can be obtained, including the most important one of all to the police arguments about the management of risks and safety during MHA assessments in private premises.

I then read on –

Paragraph 16.6 pleased me greatly – it is making explicit in the new Code something which I have argued for years. That obtaining a warrant purely for the purposes of removing someone to a Place of Safety is perfectly acceptable and was within the original intentions of the Act. This is a point I have stood in rooms full of AMHPs and made several times, only to find copies of the Richard JONES Mental Health Act manual being produced and vigorously thumbed. Professor JONES was kind enough to email me ahead of the last edition of his Mental Health Act Manual (2013) to say my BLOG had caused him to revise his advice and the new Code of Practice makes this explicit, at last.

Paragraph 16.21 needs clarification – it refers to the practice of s136 being used in hospitals and states that hospitals should not call upon the police to use section 136 on inpatients – instead, holding powers under s5 should be considered. Whilst this is correct, it could do with being über-emphasised that patients in Accident and Emergency are not inpatients and holding powers cannot be used there. Whilst I'm usually dubious about having to use s136 at the request of A&E staff, I do accept that it is often lawful and sometimes necessary, but without this Code emphasising the A&E is not an inpatient setting and s136 may still be necessary, I just have visions of officers declining to use the power and saying, "No – paragraph 16.21 of the new Code says …"

WHAT'S NOT THERE

It not a only question of what is in the draft Code of Practice, but also what is *not* in it – there is only one reference in the whole document to section 140 of the Mental Health Act. Many who have followed this BLOG for years will know it is a section of the Act that is very under-explained by previous Codes, by the CQC in their Annual Reports and by legal commentators like Professor Richard JONES in his Mental Health Act manual. For those who don't recall, section 140 obliges CCGs to specify to social services which hospitals in their area are designated for urgent admissions and which are for children and young people.

I sent off three dozen Freedom of Information requests to CCGs last year asking about their section 140 MHA arrangements and **not one of them** could answer the question fully. In fairness to the CQC, they made mention in their latest report about how they will be examining section 140 compliance in the future. But for me, the new Code of Practice was the ideal opportunity to flesh out some expectations here.

I take the view, that if you read section 140 you should conclude that it was Parliament's clear intention that CCGs should commission and provide their services in such a way as to make sure that when a lone AMHP is standing in a house, ring-mastering a difficult and sometimes dangerous situation, they should *never* be left in a position where they cannot make an application to a hospital, to bring that person into a condition of legal custody.

Ever.

Now if I'm wrong about the intentions of this section, then fine – but something should be outlined in the new Code to bring together the disparate, emerging and existing conversations about section 140 with some clarification about the responsibilities on CCGs and provider trusts. How should these be interpreted to prevent punters like me shouting up with interpretations that seem at odds with NHS Commissioners, the implications of which seemingly scaring the life out of them!

DEATHS IN POLICE CUSTODY

Let's remember why the police had to become so very interested in policing mental health emergencies much better – it has been the catalogue of deaths in custody which are so very controversial and still subject of vigorous debate. Only last week, we learned that four officers and several other NHS staff who had been under investigation following the death of Kingsley BURRELL in Birmingham in 2011 would not face criminal prosecution for a range of offences that were under consideration from manslaughter to health & safety offences.

Some of the other high-profile deaths in custody have involved the removal to police cells of patients exhibiting highly agitated presentations and they have either died there, or died whilst en route there: Sean RIGG, James HERBERT and Michael POWELL to name just some. It was when working on developing new ways to respond to those cases that I encountered a certain mentality which persists to this day, that where the police come across those rare incidents where exceptionally psychotic, floridly unwell people are exhibiting a risk to themselves or others, they should be taken to custody. Well, we've been doing that for years, folks – and we see two

deaths each year in the IPCC's death in custody figures as a result of that approach.

The problem with the new paragraph 16.36 is that it leaves unaltered the wording of the old paragraph 10.21, albeit the wording is rearranged. It talks not only of police cells being acceptable on an exceptional basis where people pose an unmanageably high risk; it still talks more specifically about that risk being to staff and other patients without reference to the potential of the police to contain such risks whilst urgent assessment is done. Well, Michael POWELL was reported to be posing such a risk, as was as was Sean RIGG AND James HERBERT – because of their clinical conditions. After very lengthy investigation we don't see a consistent understanding of the outcomes from these across health and social care – not least because it is usually CJ inspectorates who conduct the inquiries and reviews. When police officers are prosecuted and then acquitted or not prosecuted at all, we hear on the one hand reactions which talk about officers undertaking extremely difficult work with limited training but we also every understandably hear families still struck by grief and injustice in disbelief that those who hands were upon their sons and brothers at the time of their deaths were not guilty of them. That's why I wanted the Code to do more – although some may argue this is not the point of a Code of Practice.

Remember what a Code of Practice is: the *Munjaz Case* (2005) reminded us that whilst it is not 'binding instruction', nor is it mere advice that you can take or leave. A Code of Practice is a statutory document issued by the Secretary of State for Health under authority granted by the Act itself. It is powerful, statutory guidance which should be complied with unless there are 'cogent reasons' for departure.

This is why it is important that the new Code reflects what we've learned since the last two updates to the Code in 1999 and 2008. We know that you can't just say "violent patients to the cells" and hope to get away with criminal neglect where the circumstances amount to that. So we need a Code that prevents some interested parties from arguing for the *status quo* where this would actually continue to put vulnerable people at risk.

In the second post of this subject: I am going to look at other chapters of the new draft which still affect the police – those on AWOL patients, MHA assessments and conveyance.

17th July 2014

The Code Of Practice Revision: part 2 –

This is my second post on the subject of the current review of the Mental Health Act draft draft Code of Practice . The first post covered my response to the new chapter (sixteen) on police powers and to some things that are not covered in the new draft. This post intends to look at the rest of the Code, only in so far as it affects the police and suggest what should be in it. Remember, any of us can contribute to the Code of Practice review and the Department of Health have a website with various versions of the consultation documents and methods by which to provide your view.

I've often remarked of the current Code of Practice that as a police officer, you only really need to read chapters 10 and 11, plus 21 and 22 – and that if you're really feeling keen, read chapters 4 and 5 as well. In the new Code the chapters have been re-arranged so to achieve coverage of the same issues, you would now need to read chapters 16 and 17, plus 27 and 28 – and that if you're keen, read chapter 14 and 15.

These chapters cover –

- **16** – Police powers for things like section 135 & 136.
- **17** – Conveyance in all of circumstances where transport is required.
- **27** – Leave of absence from hospital for detained patients.
- **28** – Patients who become absent without leave.
- **14** – applications to hospital.
- **15** – urgent / emergency applications to hospital.

Of course, you could read all 337 pages, if you wish!

POLICE SUPPORT TO THE NHS

All of the other chapters that I will focus on in this second post involve police response to or support for NHS processes: whether it is around applications being made under the MHA to hospital or in connection with the search and recovery of patients who are absent. As I went through the chapters I could help but think, "This isn't really changing anything." For the most part, the wording and requirements of these chapters have been lifted wholesale from the current code and given new paragraph references numbers. It is for that reason I am not going to document a long list of

specific references to compare and contrast. In the examples which are too numerous to list fully without it becoming quite tedious for us all, this means that certain tensions and ambiguities that exist today about which organisation does certain things will still exist in the future.

AWOL patients is a good example of what I mean –

Numerous times police forces are asked to despatch officers to a patients home, to re-detain them under s18 of the Mental Health Act after that patient had become absent without leave – it doesn't really matter the manner or way in which people became absent, as long as we know that they are. Now, the current code states in paragraph 22.13 –

"The police should be asked to assist in returning a patient to hospital only if necessary. If the patient's location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital."

The wording of paragraph 28.13 is *exactly* the same and so several problems will remain. The use of the words," if necessary" and "wherever possible" give a get out clause to whoever wants one and if NHS organisations arrange themselves so it's *never* possible for either inpatient or community mental health teams to recover patients who are AWOL where their location is known, they will understandably seek to take advantage of those words. "It's not possible officer, we've only got three nurses on the ward and we can't leave the ward unstaffed to return the patient, so it will be necessary for you to do it." How do you argue with that? Well, you could ask them why the community mental health team won't undertake it – "Oh, that's not their remit." So it's a police role by default of it being no NHS team's role, because we didn't design the recovery of AWOL patients into our mental health services' operating systems despite the fact that the Code of Practice clearly envisages less police involvement than we currently see.

Remember: this draft Code of Practice will become guidance that must be followed unless there are "cogent reasons for departure".

MORE DETAIL

There are many other specific examples: with regard to the circumstances in which mental health services may ask the police to convey people. The new paragraph 17.12 refers to the circumstances in which the police are asked to support conveyance processes where patients are "violent or dangerous". As I've previously said, not all resistant or agitated people are "violent or dangerous" and of course, local procedures and protocols could and should clarify these things. But they too often don't, which is why we

have seen situations where elderly dementia patients have been subject to restrictive restraints by the police and complaints and controversy result. So I just wonder whether the way in which the Code is drafted could assist in resolving those ambiguities about expectations.

We see no progress in Chapter 14 on this issue of detention and conveyance after Mental Health Assessment of a patient who is subject to an application for compulsory inpatient admission. There have been operational tensions for years between police officers, paramedics and AMHPs about achieving the admission of resistant patients, the delegation of authority to detain and convey under s6. This material remains largely the same – AMHPs may delegate s6 authorities, no-one is forced to accept them where AMHPs do wish to delegate them and it should be sorted in a local protocol. How, if there is ongoing unilateral expectation by some areas that it is always the business of the police to do the coercing?

There is a theme running in my view of the chapters being reviewed here: how do we achieve a clearer understanding of whether the Secretary of State really does think it's always for the police to coerce the vulnerable and OK that mental health organisations deflect this demand to the police? I wonder what the Home Secretary thinks of that idea given the importance on 'reducing crime, nothing more, nothing less'?

LOCAL PROTOCOLS

So is it about local protocols – perhaps it is not the role of a Code of Practice to tell Newcastle or Manchester how to sort this out? The Code of Practice stipulates in all of the important chapters which cover close partnership working that local areas must agree policies and procedures for four things; and this requirement remains unchanged in the 2014 draft –

- Place of safety processes
- Conveyance of detained patients.
- AWOL patients.
- MHA Assessments on private premises.

To what extent should we regard it as the role of the Code to be precise about how things should be done or by whom when there could or should be room for local arrangements to prevail in such a way that suits those areas? This would allow account to be taken of demographics, geography and other organisational factors that influence how partnerships work and I fully understand how there are differences between Cornwall and Camden and between Herefordshire and Handsworth.

Maybe it is just me, but what I need from a Code of Practice is just one or two more degrees of greater precision about the things that relate to the

core values of the Code, of which there are five stated at the beginning of Chapter 1. I don't want or need everything specified, but I need to read things that move beyond the ambiguous, beyond the potential for unilateral decisions by organisations in their own interests, without explicit consideration of the impact upon others. A recent operational situation brought to my attention highlights this perfectly: could officers attend an address to force the return to hospital of a s2 patient? All sounds normal enough so far, but we were then told, "She's 29 weeks pregnant." When asked about the implications of using force to return her, the availability of MH staff to attend with the police and MH services taking a lead using staff trained in therapeutically appropriate restraint techniques, it all hit a wall. It turns out that MH services wanted the police to do this, despite what paragraph 22.13 says.

Of course, you could just say, "No – not doing it. Paragraph 22.13 says, so go and tell your boss and ask them to support your problem in an appropriate way." But it doesn't sit right does it? – officers fear the consequences of both action and inaction, partly because the Code is written in such a way as to support the application of pressure by mental health services who haven't fully considered its implications or are choosing to disregard them.

POLICING THE CODE

Here's the big rub: who is policing this document? It requires and suggests many things – but that only achieves proper significance when some of them happen and some of them don't if there are consequences to these things not happening. As the code itself makes clear in the pre-amble, failure to adhere to the Code could give rise to legal challenges so how is it policed? Non-adherence to the Code has contributed to some of the disastrous outcomes we've come to learn about and I keep thinking of certain jobs I've known and been at where I'm left standing responsible for the medical management of patients with problems so complex that I question whether any junior psychiatrist or junior A&E doctor would go anywhere near the person without bleeping the on-call Registrar or Consultant.

And yet there I am – me and my first aid certificate.

If we are going to refresh this document and re-emphasise its importance, I could without the ambiguities that never get resolved and which have led to a creeping presumption over the last fifteen years, the role of the police is to coerce the vulnerable, on demand. It seems OK to ignore the Code of Practice where adherence has significant implications for mental health and other health services and yet violations of the code which can push demand towards the police and police custody are to be tolerated and taken less

seriously. These kinds of double standards – known about by the CQC – could be addressed by a more robust, less ambiguous Code.

I have said previously that I asked a wise old sergeant what a Code of Practice was whilst I was a probationary constable and he replied, "For your purposes, it's a list of requirements just like an Act – you bloody do it unless you have a damn good reason not to!" That's how the PACE Codes of Practice are largely seen within the police. The Mental Health Act Code of Practice has never benefitted from being seen in those terms and I ultimately worry that this document in its current draft form is too similar in content to its predecessor document to affect the standing in which it is seen or resolve the operational tensions that arise. For that reason, despite many things in it that seem attractive, I worry what greater effect it will actually have, if any.

I will be putting my views in to the consultation and I encourage you to do this same, whether or not you agree with anything I've written in these two recent posts.

18th July 2014

Raising the Bar –

We started deinstitutionalising our mental health care in the 1960s, not long after the beginning of a psycho-pharmacological revolution which suggested we had found effective drug treatments for psychotic diseases. In fairness, it wasn't just pharmacology that drove us: there were also concerns about the ethics of mass incarceration of those of us who were not just mentally unwell, but deemed socially inept for a variety of non-medical reasons – vagrants and single mothers included. Post World War II, the sheer cost of mass incarceration was a concern and we sought to implement alternatives for all these reasons and more besides. It was a complex socio-medical movement and overtime, it has become 'harder' to become a mental health inpatient.

So what, over time, has been the consequence of rising thresholds to inpatient psychiatric care?

I assume we all accept the principle that we subject citizens to inpatient detention less readily today than we did ten, twenty or fifty years ago? If you don't think we have, please leave a comment below outlining why – I'd *love* to hear your view. I think – for what it's worth! – that this is a *good* thing as long as it doesn't got too far. However various mental health professionals have suggested to me that this is what has been going on in our NHS over the last few years, building on that reform over decades. The threshold for inpatient admission has risen and is still rising for as we have fewer inpatient mental health beds to use, so must they be targeted on those who need them most. Although the 2012/13 CQC report indicated that use of MHA had exceeded 50,000 for the first time in a single year, it is also safe to report that average lengths of detention have reduced over time. So the Mental Health Act in the United Kingdom is being used more frequently but for fewer days each time it is used.

So what evidence that the 'bar' is rising?

SHIFTING SANDS

Aside from the anecdotal evidence that professionals keep offering up, the inference that could be drawn from the increased usage of the MHA, but for fewer days each time, there is also the views of GPs that we have seen

voiced. They are less able to make referrals to secondary care than they previously were. And most importantly for this post – why am I banging on about it?!

It is because of the relationship to the use of section 136 MHA.

It's a view frequently expressed – not least by Professor Louis APPLEBY on this blog – that the threshold for use of section 136 is falling. The main argument for this is the proportion of people assessed under s136 who are subsequently admitted to hospital: it has reduced over time. Whereas once, *most people* were admitted as inpatients, *most people* are now discharged from it. The current figure is 17% of s136 detainees are admitted to hospital under the Act, down from 20% the previous year. Of course, other factors contribute to how usage has changed and how outcomes have altered: improved police training and awareness, the effects of mass deinstitutionalisation combined with a community mental health system that almost everyone acknowledges is underfunded.

But what of that initial barometer – that AMHPs and medics admit fewer patients now than they previously did? Are we assuming that the medical 'bar' has remained constant when there is every reason to think otherwise? We know that people are spending less time in hospital because of bed restrictions; we know that more and more admissions are occurring but that the rise in admission numbers is not accounted for by more people becoming unwell. Some patients are in a cycle of short admissions and early discharge before being placed on Community Treatment Orders, the effectiveness in breaking the admission-discharge-relapse cycle has been questioned. May it be the case that a partial explanation for rising use of s136 nationally is that people detained by the police are less likely to be admitted by mental health professionals who are obliged to exercise greater caution about admissions?

Community mental health teams have commented that many patients now on the books of CMHTs or Assertive Outreach teams are patients who would have been inpatients only a few years ago if they were that unwell. With far fewer beds available to serve the population, it now means a combination of three things:

- Some patients who previously would have been admitted now being supported in the community;
- Some patients who are admitted remain in hospital for a shorter period before being discharged to community treatment.
- Community mental health teams are also under massive pressure of workload and GPs are reporting that fewer referrals to secondary mental health care are accepted.

So it's harder for GPs to get patients into specialist mental health services; it's harder to achieve an inpatient admission amidst reports that inpatient

admission is unlikely on a voluntary basis. If you want evidence that this has gone too far to cope with predictable levels of demand, just look at the recent announcement that NHS England have order to commissioning of more CAMHS beds, because this sector of our mental health system in particular has been squeezed too far with stories of children being transported hundreds of miles, sometimes in the middle of the night, to achieve an inpatient admission.

SIGNIFICANCE OF 136 CONVERSION

So we need to look again at s136 conversion as a proxy for effective use of the power by the police. No doubt, some forces overuse and some officers will from time to time abuse what section 136 is for. But simply looking at the percentage figure of those detained by the police who are subsequently admitted to hospital is not an examination that tests police decision-making against a constant feature. Threshold decisions for the use of the MHA by AMHPs and DRs is a moving target so all other things being equal, we would still expect to see fewer patients being admitted, having been subject to section 136.

The rising use of section 136 nationally and the declining admission or conversion rate have been used to suggest that police officers are becoming too quick to use this legal power and that more training is required. Maybe – and in some areas of England, I don't rule it out at all. But we do know that some areas use section 136 very responsibly and always did have far better conversion rates: as high as 45% in Birmingham. All of these things need careful deconstruction to ensure we're not leaping to conclusions about what is going on in an area of business that is little researched and where data is notoriously unreliable. Meanwhile, it's harder and harder for patients to access secondary or inpatient mental health care amidst many reports from professionals that some patients are spending too little time in hospital, waiting too long for specialist support in the community and being increasingly cared for by GPs who are anxious about their own training and capacity in dealing with complex mental health problems.

Whatever is going on in policing and section 136 — it is a symptom of broader problems with our social responses to mental health issues and a reaction to a mental health system which is increasingly focused on late intervention.

22nd July 2014

What Are We Trying To Fix?

We know that the use of police custody as a place of safety (PoS) shouldn't be happening very often – only on an 'exceptional' basis according to the current and to the next Code of Practice to the Mental Health Act. I was delighted to find out recently that since the work I did in 2009-11 has really settled in, we are now seeing single figures of detentions in police custody in a police force where over 1,000 people a year are detained under this provision.

Since ideas were turned into reality, West Midlands Police has seen more than 98% of people assessed in an NHS facility. I will be dining out on that for the rest of my life – that's thousands of people who have already been saved the indignity of detention in custody and numerous officers protected from legal liabilities that arise from having to 'muddle through'.

Some other police forces are not yet as fortunate, for various reasons to do with capacity and because in some instances their NHS partners have not comprehended how it is possible for the NHS and police to work in the sort of partnership that Birmingham now expects in the management of detainees who are aggressive, resistant or under the influence of substances. So in some cases we still see a majority of people taken to police custody. It's all just too hard to comprehend or deliver upon. For some.

Meanwhile, and quite separately, street triage initiatives have sprung up around the country and depending on which area you examine you will find that between one-third and one-half of all previous s136 detentions are no longer happening, because the presence of a mental health nurse allows a less restrictive intervention that does not involve a place of safety, police cell or otherwise. What we have seen this morning in a BBC news article is the celebration of street triage as a method of reducing the use of police cells as a place of safety. I want to spend the rest of this post outlining why this is faulty logic and why it doesn't significantly reduce risks in forces where custody was still used routinely.

DO THE MATHS

** I can assure you these numbers are hypothetical, so no point trying to guess which force I'm referring to! I'm not referring to any in particular.*

If you have a police area where around 1,500 people a year are being detained and to keep things easy, 50% are accessing NHS PoS care and 50% are still being incarcerated in custody, you could think of introducing a street triage scheme to reduce 136 demand and it may have the effect of reducing reliance upon cell space. Let's imagine that the reason half of all detainees are still going to police stations is because the NHS still operate what I call 'exclusion criteria' around those detainees who are under the

influence of substances or who are – or have previously been – physically aggressive.

Let's imagine, upon introduction of your street triage scheme you have reduction benefits like Leicestershire, of 40% overall. You are now diverting 600 people away from any kind of place of safety and continuing to detain 900. You might hope that these reductions would be split over the two kinds of Place of Safety being used so we end up without around 450 going to each place, rather than 750.

But this is not the way such things work in reality: re-examine the population groups going in either direction –

- 750 non-intoxicated, non-aggressive patients going to the NHS, many of whom are wanting to access care but where it is proving difficult to do so
- 750 people going to the cells who are intoxicated, aggressive or unfortunate enough to be detained during peaks of high demand when NHS PoS facilities are already in use and unable to receive them despite an absence of challenging behaviour.

Who do we think street triage is diverting away from s136?!

Well, in the main, it is the first group: those who would have been able to access an NHS PoS for help: patients who are potentially known to services and who are hoping to access support of some kind, where the CPN in the triage car can make arrangements for further follow-up the next day and where this satisfies everyone's expectations and is consistent with managing risk. Those who wouldn't immediately benefit from triage, in the sense that section 136 may well still be necessary, are those where deferring intervention is not wise, where there is an immediate need to manage risks, including those posed by challenging behaviours whether or not aggravated by substance (ab)use. Such individuals are those more likely to have been pushed towards the custody areas of our hypothetical police force.

Of course, each of these groups – the NHS group *and* the police group – will see a reduction in the use of s136. From examples I've gleaned around the country, we can expect the NHS group to reduce significantly and the police group to reduce far less. You might expect on these hypothetical figures that the NHS group to reduce by more than half and the police group by a quarter or less. Figures like 300 to the NHS and 550 to the cells.

NOT FIXING THE REAL PROBLEM

You see what's happened now, though?! Police custody is being used *more often* than the NHS because we didn't address the section 136 management of those more difficult cases – vulnerable people with challenging behaviours and backgrounds. If we look at street triage as a method of fixing the use of police custody, we will eventually realise that we were fixing a problem that shouldn't have existed in the first place and which is fundamentally unaddressed in what we've done.

The health pathways for individuals who died in police custody are unaffected by fixing place of safety problems by the introduction of street triage in areas where police stations were being used on a more-than-exceptional basis. Where police officers detain resistant, distressed individuals in an area where there is no clear clinical protocol in place, you still end up in stand-offs between A&E, MH PoS units and custody as to where should be used. Inevitably, the police get caught in the middle and told to take to custody. It is for reasons like this that we are still seeing deaths in custody in the second decade of the 21st century which look and sound like those we were seeing over 30yrs ago and more.

Street triage and section 136 place of safety processes must be seen as *separate* issues, notwithstanding the obvious overlaps. Street triage is about providing less restrictive alternatives to detention, referral to existing community teams or back to GPs where required. Place of safety processes are about ensuring the existence of clinical care pathways for those who are detained – in all the wide range of presentational circumstances that vulnerable people become unwell. This includes those rare cases which are more likely than other mental health crisis incidents to generate calls to the police: resistant, aggressive crisis events where there is some potential risk to the public.

If your place of safety pathway doesn't know how to deal with that today before you introduce your street triage scheme tomorrow, it won't know how to deal with it tomorrow, either – and such vulnerable people are still likely to be detained section 136 despite the street triage scheme. In some instances – but not my own force, I'm delighted to say! – I am worried that the existence of a street triage mental health nurse in the decision-making where areas PoS services are under-developed when compared to the Royal College of Psychiatry Standards (2011), is actually more likely to lead to calls of "violent patients" to the cells. It is for this reason that I repeat my position that mental health / criminal justice interface training is **urgently required** across the police and NHS.

And to such simplistic clinical judgements, as "resistant patients to custody", I say only this —

- Faisal AL-ANI
- Leon BRIGGS
- Kinglsey BURRELL-BROWN
- Rafal DELEZUCH
- James HERBERT
- Colin HOLT
- Matthew LOVELL
- Andrew JOHNSON
- Olaseni LEWIS
- Thomas ORCHARD
- Michael POWELL
- Terry SMITH
- Toni Emma SPECK.

And that's only this century – I'm sorry to say we could go back further but I think the point has been made.

26th July 2014

Parity Of Esteem –

I want to highlight a case that has been covered in the media this month which shows exactly why we need to be careful about the false dichotomy of mind-body dualism and why we need to be really careful about the ridiculous things we hear some frontline staff saying and doing. It is a case which really shows how much work we all have to do if parity of esteem is to become any kind of reality in the United Kingdom healthcare system.

The case is exceptional because it has a very tragic outcome. It makes me angry precisely because it is so unexceptional for being the kind of case that could happen far more frequently than it does. Just take in how wrong this can all go from circumstances that most professionals in the police, A&E and mental health services will recognise. I doubt any of us in these professions will be surprised at the narrative that precedes the outcome and will be thankful it wasn't us in the Coroner's court. And when we get over ourselves, we'll also wonder what on earth we would say in court, with a vulnerable person's family listen and watching.

I've been somewhat monitoring this case since hearing of it, because when I first learned about the circumstances I just though, "That's all kinds of wrong." it seems Her Majesty's Coroner agrees and if you want more background and detail, there were two pieces in the local, Berkshire press. The first was published after the arresting officer gave evidence during June, the second one emerged at the conclusion of the inquest earlier this month.

It's just heart-breaking.

TERRIBLY SAD AND QUITE AVOIDABLE EVENTS

Stephen CHURCH woke up on the morning of the 13th May 2011 with a "sense of mission" that he should kill himself. Around 11am he took the decision that should get himself in front of an oncoming train and made onto a railway line. A young police officer took the decision to go "trackside" and pull him away from danger, detaining him under the Mental Health Act 1983.

The officers present then took decisions around his medical care, calling an ambulance (that didn't come) and removing him to an A&E department. Amidst pressures about whether the police should stay or remain in A&E, and amidst confusion about who should do what and when, one officer left the hospital and while the detaining officer was talking to a Doctor, Mr CHURCH left the department.

He was able to throw himself from the multi-storey car park at the Royal Berkshire Hospital in Reading.

When he was detained earlier that day under section 136 of the Mental Health Act 1983 he was actively suicidal and physically injured. Not unreasonably, the police officers took him to an emergency department rather than a place of safety facility in a mental health unit. Most PoS units will not receive patients who are also physically injured: most A&E departments seem to look at people in police custody who are physically injured and mentally ill as if the only issue for them is the physical injury. Amidst these false distinctions, what happened next was referred to in the Coroner's summing up and used as the headline of the second news article, above:

"A chain of failures contributed to death of suicidal man who was left alone."

The circumstances of this poor man's death just show how, when all of the long-standing frustrations of different agencies conspire together, we end up with vulnerable people who can die. What could be more important than making sure that the needs of people like Stephen CHURCH are put in front of the bureaucracy of Berkshire or the views of agencies like the Royal Berkshire Hospital or British Transport Police which fail to take full account of statutory, clinical and other relevant guidelines?

There is so much to say, I barely know where to start —

POLICIES, ATTITUDES AND GUIDELINES

British Transport Police's policy on section 136 was written by a superintendent who gave evidence in the Inquest. He admitted during question that he did not know about the existence of the Code of Practice to the Mental Health Act. The policy stated that British Transport Police would only stay in areas to which people under s136 were removed for two hours. I'm not sure where that two-hour time period comes from, but it certainly wouldn't satisfy the law of negligence for two cops who have detained an actively suicidal man to just walk out without further regard to what happens next. In fairness, the BTP duty inspector on duty that day actually did instruct the officers to remain there. Eventually one of those

two officers left and when the remaining officer was taken aside to be spoken to by a DR, the patient absconded and ended his life.

If any police force wants to see how any alleged negligence is viewed by civil courts, look at the case of Webley v St George's from earlier this year. It shows, that in order for the police to discharge the duty of care they owe to people in their custody, they *must* ensure they are handing responsibility over to willing, competent and fully briefed professionals who then assume that duty.

The Royal Berkshire Hospital stated in court that they were not a "designated" place of safety, as if that settles matters or absolves them from responsibilities. This case should be a salutary lesson for all A&Es and those who work within them. Firstly, there is **no such thing** as a "designated" place of safety. The word designated appears in the Mental Health Act Code of Practice only twice and neither time in relation to section 136 and places of safety. This concept of designation has been made up and this case shows what utterly dangerous nonsense it is, for its potential to pervert the process by which vulnerable people are managed. The MHA reminds us in s135(6) that a place of safety is "local social services accommodation, a hospital, a police station or anywhere else temporarily willing to receive the patient." The RBH is a hospital – by anybody's standards – and it is a matter of record that they allowed Mr CHURCH access to their treatment facilities. In what sense were they not a place of safety? It's highly disingenuous to suggest they weren't. You can't have some highly alternative reality in which the hospital can accept him clinically (hand injury) but not legally (s136) – he is a full package: a legally detained patient with injuries and potential mental health issues who has legal rights of various kinds whilst in that environment. More importantly, this kind of approach assumes you can separate mental health from physical care problems and that mental health issues can just wait until 'the real medicine' is done.

A MATTER OF SHAME

If anyone reading this thinks I'm being somewhat harsh, I just remind you of the opening lines to a 2008 document from the Academy of Medical Royal Colleges, signed up to by the Royal College of Psychiatrists, the College of Emergency Medicine, the Royal College of Nursing and the Royal College of Physicians. You really should read the document and this opening really sets the tone for what it is trying to do:

"It is a matter of shame that this document is needed, but needed it most certainly is."

The document goes on to talk about how we need to consider mental health issues for acute trust patients more keenly, how liaison psychiatry services can reduce the health burden and improve patients' outcomes and experience. But of course since publication, the College of Emergency Medicine has produced its 'Mental Health Toolkit' which effectively pushes back against this. In the toolkit the CEM effectively tells us that they are not aware of the latest edition of the Royal College of Psychiatry Standards (by referring to the 2007 edition, obviously unaware it was updated in 2011) and it allows casual language to create confusion. It states (p12) that A&E should only be used after the instigation of section 136 where there is an "acute healthcare need". It seems to me that running towards a train in the hope of ending your life is a fairly acute emergency. Are the CEM using 'acute' as a euphemism for 'physically injured'? Most psychiatric emergencies are fairly acute, by medical standards. Anyway, how does any doctor know whether psychotic behaviour arises from a functional mental disorder or some other condition, unless they examine for it? Exactly.

And taking this further for both BTP and the RBH: the Code of Practice makes it clear that when a person arrives at a place of safety – which we are now reminded they *are*, the Coroner himself having given that position very short shrift – then an AMHP should be notified of the detention so that preparation can be made to assess the man. Neither the police nor the hospital contacted an AMHP and I'll wager a bet that no-one explained to Mr CHURCH his rights whilst detained under s136, either. These rights are laid bare in s132 of the Mental Health Act and apply wherever anyone is detained in hospital. For the purposes of s132, 'detained' means under any provision, not just the full inpatient admission provision, as so it applies to s136. Mr CHURCH would also have rights under the Police and Criminal Evidence Act 1984, to have someone informed of his whereabouts and to legal advice. Was he made aware of this? I don't know – maybe he was. So many patients aren't.

PARITY OF ESTEEM

This case and hundreds more like it raise loads of issues for me –

- The extent to which some police and NHS organisations are just making stuff up to suit themselves.
- The extent to which some of this nonsense puts vulnerable people in harm's way.
- The parlous state of legal education amongst our professionals – and I throw this one equally at the NHS and the Police.

There is no reason whatsoever why Mr CHURCH could not have had a mental health assessment in the RBH, either before or after his hand injury was addressed. I've known MHA assessment take place before

treatment of physical injury and here's why: you cannot force medical treatment on people unless justified by law. Mr CHURCH was not going to die from his hand injury so it wouldn't be possible to rely upon the Mental Health or Capacity Act to do anything about his hand injury before MHA assessment. In another case I heard about a man had been detained under s136 after he jumped from a bridge and had very badly broken his leg. He was fully assessed under the MHA and sectioned to an orthopaedic ward before an operation to address his protruding fibula which had broken through the skin. Because his physical injury was deemed to be a direct result of his mental disorder, he was treated without consent in an operation where he received a general anaesthetic. Rare, but possible and shows that on some occasions, MHA assessment should be the priority – but we can't discuss that unless AMHPs and DRs start talking to each and they can't do that unless the AMHP is informed.

Whenever you see discussion ongoing on Twitter about physical versus mental health or 'mind-body dualism' you often see doctors and nurses pointing out, in reality, such a dichotomy doesn't really exist. It's a false distinction and many medical conditions traverse this divide: dementia is often dealt with by mental health services, but it is caused by organic conditions in the brain; psychosis can arise from conditions that are caused by physical healthcare problems like Addison's disease. More to the point, the AMHP and the A&E Doctor could talk through the best way to deal with any individual case if they had been told. Informing the AMHP as soon as possible isn't in the Code of Practice because anyone envisaged them running to the location as fast as they could do an assessment. But it does allow for early discussion about how and when assessments will be handled; it allows for the planning of workload and it allows for an exchange of information that might influence risk assessments – for example, about whether it might ever be safe and wise to leave a patient in NHS care without police support!

But beyond the specific case, this kind of situation also gives rise to something else. RHB evidence at the Inquest indicated that they only saw their role as being the treatment of Mr CHURCH's hand injury. The 'mental health' side of things was not down to them, apparently. This attitude is common place in A&Es after police instigation of the Mental Health Act. In terms of the seriousness of the overall situation, which of the two matters was the greater emergency? It wasn't his hand injury but his mental health problem that killed him – by any assessment, that was the medical priority. But we often see physical treatment given priority over mental health care, as shown in this case where A&E were interested in addressing the smallest aspect of this man's broader clinical presentation and where his legal rights were not explained to him, nevermind afforded him. Add to that the confusion and pressure around a police force who want to be able to get out of there as quickly as possible and it is a recipe for the disaster that it tragically became.

How do we achieve parity of esteem if a life-threatening psychiatric emergency is not as serious as a broken hand? It was his mental ill-health that killed him, not his hand – and in the opinion of a court, the Royal Berkshire Hospital and the British Transport Police contributed to that because of what looks to me like pre-occupation with issues that were nothing to do with Stephen CHURCH.

28th July 2014

A Little Knowledge Is Dangerous –

Mental health has been creeping up the agenda in policing for some while now. I will confess to mixed feelings about this progress and I imagine that might surprise you. On the one hand, I've spent years banging on about mental health in the hope of its importance being recognised and slowly but surely, it is. I really think we're on the verge of getting somewhere with this. However, I'm also concerned about a trend over the last year or so, in particular – this trend arises partly from the fact that the police are having to manage remaining resources ever more closely as they become scarce; it also arises from that old adage that 'a little knowledge is a dangerous thing'. The next part of that phrase is "A little **want of knowledge** is also a dangerous thing." As more officers are told to undertake work on mental health, I see them struggling with the gaps in their legal knowledge just as I did when I began.

I first piled into doing proper work on this topic over ten years ago, when a Chief Superintendent in Birmingham asked for volunteers to get involved in revising all the operating procedures with the newly merged Birmingham and Solihull Mental Health Trust. Ten years later – three years of which was spent working full-time on mental health – and I've learned just a thing or three. It is therefore with a wry smile that I notice some of those more recently involved police officers falling into the traps and pitfalls I was falling into in 2004. This blog was always intended, in part, to help police officers avoid those traps but only last week I heard a senior officer talking about 'capacity' as if it meant anything at all in the context of criminal offending. He was bemoaning the lack of written statements of evidence by psychiatrists to confirm it is acceptable and possible to prosecute someone. He looked really confused when I asked why we were asking doctors legal questions given that we rarely take medication prescribed by lawyers.

Whenever I do talks to groups of police officers about this interface with mental health, I often ask, "What is it that really annoys or frustrates you in how our mental health system or our NHS works?" and you always get a flood of answers. It will usually include something about section 136 facilities; having to wait around for hours; being asked to do things which are, properly considered, health responsibilities and lots more besides. I don't ask the question because I particularly care about the answers – I ask it in order to set up another question: "What is that you think really

annoys of frustrates our colleagues in mental health about police officers and the police service?"

This question is ALWAYS greeted with *total* silence.

Which means we either have no idea or it means the police must be perfect. I can tell you for free it's not the latter, but I think you knew that already! We seem to have no insight into our own shortcomings and how they affect mental health services. So let me enlighten you, because I have repeatedly asked mental health professionals this question and they always have a long list of answers!

IRRITATING HEALTH & SOCIAL CARE

This is not intended to be an exhaustive list, but there are usually a consistent range of complaints:

- Officers failing to take seriously assaults on health / social care staff: a lack of proper investigation and a lack of rigour behind decisions not to arrest or prosecute patients who have hurt NHS staff — I have never known NHS staff be unreasonable when you inform of a decision not to prosecute after an investigation which they know has been diligently conducted but where the outcome is not what they hoped for. It's only where officers shrug shoulders and say, "Isn't this part of the job?" or similar things that objections arise.
- To give just the most recent example drawn to my attention: one force had officers attend a mental health unit where a s3 patient had stamped on the ankle of a member of staff, breaking it, bitten someone else's nose and attempted to gouge out someone's eyes and the attending officers didn't even record a crime — no investigation followed, all because the perception was that the patient wouldn't be prosecuted so why bother. It all had to get looked at again.
- A lack of legal knowledge about the Mental Health and Capacity Acts leading to officers saying things which just sound silly to people who know what they're talking about — examples include talking nonsense about 'capacity' as a proxy for various things; officers confusing the circumstances in which warrants are needed from those were they aren't. In particular, the thought the AMHPs who have 'sectioned' patients need warrants to remove them from premises after a MHA assessment – which they don't.
- Overuse, misuse and abuse of section 136 of the Mental Health Act — this is still happening on a large-scale, in particular where officers are detaining people MHA who should be arrested for drunkenness offences or more specific criminal offending.

- Difficulties in securing support for patients who become resistant to detention after being 'sectioned' — AMHPs calling 999 for support and being told that the police aren't coming when there is no way the call handler or sergeant making that call can know it's correct to decline to support.
- And a very modern trend I've only been hearing about over the last year or so – officers refusing to attend premises with AMHPs who have warrants from the courts to locate and remove patients — the two warrants contained within section 135 can only be executed by the police and telling staff to go to premises anyway and "ring us if you have any problems" is often not acceptable.

PROXY POLICIES

Some years ago the Metropolitan Police introduced a policy which in effect meant they would not support Mental Health Act assessments in private premises, unless the AMHP had obtained a warrant under s135(1) MHA. It was argued that the sorts of situations which required police support would always give rise to the grounds for a warrant being met. As such, because police officers are fairly powerless to manage risks without a warrant, they would ask for one in order to make sure that they did have an ability to intervene and keep people safe. I admit to thinking that warrants are sought less often than they should be and that the Met were trying to prevent frontline cops from difficult discussions by making it easy to process. Finally, the "no warrant = no police" debate reduced various fairly complex situations into overly simplistic scenarios where the warrant issue becomes a proxy for a more considered debate about whether it was right for the police to attend. It somewhat over-simplifies things.

They are (at least) two problems with this "no warrant = no police" debate —

It is quite possible to conceive MHA assessments where the grounds for a warrant would not be met and where the police would still be required to prevent crime or a breach of the peace. Where anticipated risks of crime or aggression arise not from the patient to be assessed but from third parties present at the scene, officers may still be required. Remember, it is a criminal offence to obstruct an AMHP in the course of their duty and AMHPs have legal rights to enter premises in conjunction with their warranted, legal responsibilities. It is not unreasonable as they are agents of the state, also, that they may need police support from time to time. Finally, if you read the new draft Code of Practice to the Mental Health Act, it shows a current intention to include a paragraph that outlines a requirement for the police to be told why their attendance at a MHA

assessment is required if there is no warrant in force. Why would this requirement be there unless there are situations in which warrants are not possible, but police support is still required?

But secondly, even where the grounds for a warrant are met, certain circumstances in which an MHA assessment might occur make it clear that no sooner will professionals have entered the premises, than a decision to apply for admission will occur

This is the best example of why police officers and policy writers need to be careful about grabbing at a simplistic proxy position as a way of resisting demands that many be drifting their way. But for heaven's sake! – if we've badgered away asking for warrants to obtained more frequently, let's not mess about when AMHPs actually get them and then ask us to execute them. There is a growing trend of nonsense where officers have asked AMHPs to execute them (they legally can't!) and where officers have suggested AMHPs should try to get through without police support and without executing the warrant.

PUSHING BACK

I'm the first to think that there are too many demands connected to mental health that make it to the police and there are too many assumptions about what the police could or should do. I very firmly subscribe to the view that there is far too little early intervention and far too little Crisis Support that does not involve the criminal justice system and some kind of criminalisation contingency. But none of that means that police forces are perfect and that failings all sit with mental health services. Very far from it.

Of course, one of the problems with police officers getting into legal debates with AMHPs about the Mental Health Act is that it's like watching a David and Goliath contest: police officers with their four hours of mental health training debating law with professionals qualified to post-graduate level in mental health law. Let me just say it took many years before I started to feel confident I could hold my own. Many, many years of being interested and working on this stuff full-time … and it still took **years!**

Why am I boring you with this post about police shortcomings and problems? Well, I write enough about everything that I think is wrong with our health and our mental health systems, so it's only fair I balance it out! But there's a far more important reason, too – if the police aren't careful and if individual officers don't ensure they're well briefed or prepared, they will take this new-found enthusiasm and a just little bit of knowledge and get something horrendously wrong. I worried in the last post on this BLOG about policies that ask officers to walk out on their duty

of care after a (quite arbitrary) two-hour period; I worry about officers not executing warrants issued by the courts and I worry that some junior PC will make a decision because he or she has picked up some fragment of knowledge or received wisdom. We all need to be aware that our lack of formal training and of the extent to which many things in policing in mental health are received wisdoms that may or may not be right.

A little knowledge is a dangerous thing and a little want of knowledge is a dangerous thing.

AUGUST 2014

1st August 2014

College of Policing –

A few months ago, I was asked if I would write a short piece for the College of Policing newsletter to coincide with Mental Health Awareness week. I never did get 'round to publishing it on the BLOG, so here it is, reproduced below. Remembering to do this now nicely coincides with another development for me personally, which involves the College of Policing —

From the start of September, I will be seconded from West Midlands Police to work for the College full-time on mental health issues. After more than three years of "mental health policing" not actually being my 'job' and my efforts to contribute to this being mainly via social media, I am about to start a full-time posting which involves me having the opportunity to focus upon nothing but this. Exactly what this role involves will emerge over coming weeks as I'm sure the College will have in mind a list of things they've been asked to do and the new ACPO lead on mental health, Commander Christine JONES from the Metropolitan Police will no doubt make her views known on this matter, too!

I **couldn't be more chuffed** about all of this – and before publishing the newsletter piece below, I want to finish on a slightly naughty point, concerning something I said in 2011 as my previous posting on mental health came to an end. I had a strong conviction leading up to my return to operational policing that the profile of mental health issues within policing was still rising and that we were far from having sorted it all – very far from it. More and more forces were appointing mental health leads to drive this agenda, more senior officers were becoming interested in it. I had previously been seconded part-time to the College's predecessor organisation, the National Policing Improvement Agency and saw for myself the efforts some police forces were beginning to put into this area of work and the extent to which a few were still sleep-walking. I had a strong feeling that there was still a lot more we could and should do and those ideas instead became the material you've read in this BLOG over the last three years. It was partly written so that when questions flew my way, I could point people to the BLOG rather than keep answering the same questions – a bit of self-preservation and demand management – but it was partly to outline how much further we all need to travel.

So in February 2011, with that sense of a job not yet done and with queries flying my way from around the country as new officers began the steep learning curve of being required to work on mental health without any

training on the matter, I remarked to a former boss of mine that I thought I would keep being sucked back towards this work and that the phone would probably ring around August 2014 with an opportunity to get involved in this again because more needed to be done. It turns out I was wrong: but only by the small matter of eight hours!

So a very exciting new opportunity beckons me – to be a part of developing and updating training and guidelines within the College of Policing that will be used around England and Wales by all police forces and to support those forces, if required, in taking forward the increased focus that is now being given on policing and mental health. As this secondment was being negotiated, the College asked me to contribute to their newsletter and this is what I wrote —

COLLEGE OF POLICING NEWSLETTER

There is much to be said about policing and mental health that could improve the world. We could talk about fairness in health funding or how NHS services are commissioned and delivered. We could get extremely specific about place of safety services, ensuring a proper response to incidents in private premises or the difficulties encountered when managing vulnerable detainees who are also intoxicated by drugs or alcohol.

However important all of that is, absolutely none of it – ultimately – is within our control and I have long since thought that whatever our view of our mental health system or wider NHS, there is much that individual police officers, individual police forces and now the College of Policing could do to improve our ability to manage demands connected to mental distress in society.

Three years of using social media to raise awareness of all things policing, mental health and criminal justice has taught me that most officers want knowledge and training on this.

Most of the questions I receive – dozens of them each week – are legal in nature:

- What powers do officers have, what are the responsibilities and powers of other professionals?
- What is it we could do and what is it we should do to ensure the safety and wellbeing of others without trespassing on the responsibilities of others?

The more I learned about mental health law, the easier it has become to police operationally – including in those situations where partnerships are not operating in an ideal way, for whatever reason. Even if the system

doesn't work perfectly, I understand how I can do the best that is possible to survive scrutiny with criticism.

We need knowledge – predominantly of the legal kind.

I would love to see the College of Policing develop a set of training products and resources that reflect the needs of all officers – mental health touches every area of policing, at every rank. Build our knowledge and thus our confidence to impact on this expanding area of business. The queries I receive come from response officers, custody sergeants, neighbourhood policing teams, investigators of all kinds from uniformed volume crime teams, to detectives and SIOs. They also come from inspectors, superintendents and ACPO officers about how to better structure partnership arrangements.

Duty inspectors and Force Incident Managers have particular needs, I would argue and I remain convinced that the United Kingdom needs training programmes of depths that reflect the complexity and the risks inherent in this work.

We also need to utilise technology to deliver support to decision-makers: internet resources, smart-phone apps with clear legal materials and it would be ground-breaking if the College of Policing could work on that material jointly with other professional colleges, including paramedics, social work and the medical/nursing Royal Colleges.

If the solutions are inter-agency, then the leadership and training needs to be too.

7th August 2014

The Public Interest –

I keep encountering stories of incidents where potentially very serious crimes may have been committed and the criminal justice system appears to take no action because we have 'transferred the person into the care of mental health professionals' or similar. Responses to crime where we fully and completely divert people into the mental health system without necessarily knowing the nature of the relationship between a suspects mental disorder and the act they are alleged to have committed. That is, if there was any relationship at all. I first wondered about all this when I was a custody sergeant – it seemed to me that if someone came into custody for an offence with mental health problems, they were never prosecuted if they were thought so unwell on that day to need hospital admission.

It seems fair enough that we give priority in most circumstances to health issues, but surely that isn't the end of it if the original offence is serious? … or where someone is offending a lot?!

It's all about how police officers and prosecutors interpret Home Office Circular 66/1990. This is the current – yes, the *current!* – government policy on diversion of mentally disordered offenders from the criminal justice system. This document is now approaching its twenty-fourth birthday and has not been superseded or updated. It's really is worth clicking the link to see a facsimile copy of a typed document! … *that* is how old our current government policy is.

It's all very twentieth century, along with our mental health laws.

IN THE PUBLIC INTEREST

I often wonder about crime incidents where no specific reference is made in the police press releases we see about what is going to happen next. For example, a man in Essex recently discharged a high-powered air rifle towards police officers and mental health professionals who were there to conduct an assessment under the Mental Health Act. Having shot at them nine times he was swiftly arrested but all we currently know is that he was sectioned. What happens with the firearm side of things? … if you shoot at the police nine times you generally expect to face a judge at some

point so I would always expect to hear why this isn't happening or that the investigation is continuing pending more becoming known about the suspect's mental ill-health. It's about the public understanding how they are protected from future armed threats without a prosecution that has the potential to imprison someone.

I use this merely as an example because of the wording of the media coverage: not being involved in this particular case it may well be that the investigation is ongoing and the man is on bail. My point is that we don't know because this sort of thing isn't mentioned by press releases. Some may be wondering what business it is of the public to know this information, given that someone being sectioned is a medical matter and attracts considerations of confidentiality? We saw following the murder of Christina EDKINS in Birmingham (2013) a press release which announced the suspect had been sectioned and it made no reference to the investigation continuing – it inadvertently created the impression that him being sectioned was the end of the matter and there was a predictable public uproar, especially on social media. Whether we like it or not, the investigation of and the police response to serious crime is something which attracts public interest and it is in the public interest to understand why some of us who offend seriously are not prosecuted.

You will notice in some other high-profile cases in recent days that we have been told suspects are retained on police bail after being sectioned under the Mental Health Act. I would like to see this more often – it either reassures the public that matters are still looked into or ensures we explains why they're not. The recent examples include the 47-year-old man who was arrested for a bomb hoax on a Qatar Airlines flight into Manchester Airport; and also the 23-year-old woman who was arrested (by my response team) on Monday evening on suspicion of administering a noxious substance to numerous people in a residential care home. In each case, the inquiry is still active despite the person being 'sectioned' and both police forces were content to say so.

This means that once psychiatrists have established the nature and degree of any mental disorder, they can then decide what support is required and whether or not a prolonged stay in hospital under s3 of the Act would be necessary. In due course, investigating officers can determine whether the psychiatric issues and the broader circumstances of arrest still give rise to the need for a prosecution in the public interest. If a prosecution does follow – which it usually should for indictable-only offences, those triable only in the Crown Court – then Part III of the Mental Health Act 1983 allows the courts all the options it needs to manage any risk to the public whilst still ensuring that people receive any necessary treatment or care.

OUTCOMES FROM DIVERSION

Let's not forget this: diversion was never intended to mean that people responsible for serious offences do not face justice and in the main we do expect to see people charged where they have committed more serious matters. Being charged and going to court does not presume guilt, but it does allow the courts to request full psychiatric reports and allows them to weigh the circumstances – criminal courts have a huge range of options available to them that are not available to the police and prosecutors or to doctors and AMHPs. We should never forget that most people who are diverted from police custody under the MHA after arrest for an offence are under section 2 of the Act. This simply means that mental health assessment is occurring against a certain. background and it may conclude that there is nothing to know.

Examples exist of patients being sectioned only for the conclusion to be reached that they are not mentally disordered – at all! So imagine if this conclusion was reached after someone had been arrested for a serious offence and then diverted? … what happens with that original allegation and the victim's rights to justice? Perhaps nothing, unless the suspect had been retained on police bail when sectioned or otherwise followed up by an investigating officer who didn't close their mind to the possibility that someone's mental health problem may be quite incidental and entirely unrelated to the original circumstances. Perhaps more importantly, diverting people from justice and taking no formal action on criminal allegations assumes a relationship that often just isn't there: mental disorder does not usually *cause* criminal behaviour. There are normally other contributory, far more important variables in play likes drugs and alcohol. And even if you did have a case where someone's mental disorder was a causative feature of a serious offence: Part III of the Mental Health Act may still have a role to play in balancing public protection and the right to treatment.

Hospital Orders are the main sentencing option in Part III – they authorise the inpatient admission of those who have committed acts of crime, irrespective of whether they were found guilty of an offence or whether they were thought to be insane or unfit to plead or stand trial. The fact that hospital orders can be imposed both with and without conviction is what shows us that the law makes no assumption about the relationship between mental health and criminal offending. Where a hospital order has been imposed – whether or not it was restricted under s41 – the person concerned will then be subject to MAPPA processes upon discharge from hospital. MAPPA will ensure a risk management plan is drawn up after information sharing across relevant agencies and this will form the basis of ensuring as far as we can, that any risk of further offences is

minimised. But MAPPA only applies to mentally disordered offenders who have been made subject of a hospital order.

If you don't prosecute someone for something, you can't get a hospital order which means they will never be subject to MAPPA and other risk management processes that the police service and probation services have. All well and good if that offender was arrested for shoplifting in an isolated incident but not if they've shot at the police nine times causing the AMHP to be run for their life or if their offending behaviour is more serious and / or repetitive.

I've written specifically about my vision for liaison and diversion elsewhere on this blog and it addresses what I see as real shortcomings in the way we hear these new services currently framed. We need to be thinking about potential sentencing outcomes and public protection frameworks when suspects are in police custody otherwise we will end up building hidden risks and *that* is not in the public interest.

9th August 2014

Are We Failing Police Officers? –

TRIGGER WARNING: *this post discusses suicide and mental ill-health very specifically amongst police officers – those affected by these issues should carefully consider whether or not to read on. There is support available via the links and phone numbers at the bottom of this page, if needed.*

Two separate news articles from opposite sides of our planet caught my attention this week: each of them referring to suicide and mental distress amongst police officers. In the state of Victoria in Australia, the Chief Commissioner has set up two separate, but clearly related, external inquiries into police deaths and depression. These reviews emerged after seven police officers in the last two and a half years took their own lives. Set against a workforce of over twelve and a half thousand, that number may not seem large but that department estimate that as many as thirty officers are currently at risk of suicide.

Meanwhile, a police sergeant in Toronto took his own life after leaving a suicide note specifically attributing his decision to work-related issues and his battle with PTSD. His family is calling for the inquest to examine the officer's claims against a background that includes other police suicides and a former police sergeant's criticism of the support he received for PTSD. And let's face it: these two countries are *not* alone and this issue does not just affect police officers. There are more deaths of US police officers after suicide than after homicide each year. Queries a year or two ago to Her Majesty's Inspectorate of Constabulary revealed that police forces here do not collate data on suicides, but we know there have recently been several and that policing in the UK is considered one of the higher-risk professions.

So, are we failing police officers? … or emergency first responders?

POLICING AND MENTAL ILL-HEALTH

Mental ill-health in policing generally is a subject we don't discuss very much: having asked these men and woman to go and do a pile of stuff the rest of us wouldn't do, it should come as no surprise that the police, like paramedics, are four times as likely to suffer from stress, depression and

anxiety when compared to the population as a whole. When I do talks that touch on the broad subject of mental health and policing, you often find questions asked about mental health *in* policing. You don't have to look hard to find something to say, either – individual anecdotes of suicides by serving officers, perceptions of in-house support and more general comments about the extent to which we don't seem to have fully understood this. We know from research that acute levels of stress in policing are probably connected to non-negligible levels of mental illness.

If you spend even a short amount of time on social media, you will bump into numerous examples of current and former officers living with mental health issues and plenty of those will say that they felt unsupported at key times. It must be said, that prevalence of distress and suicide risk has been linked in some instances with criminal or disciplinary procedures against officers so it is always going to be difficult in some cases to be both impartial prosecutor and supportive employer. I'm aware of several legal actions ongoing by former officers under employment law for alleged failures in a duty of care or because they have alleged failures to support employees suffering from mental distress or give proper regard to mental ill-health when it comes to personnel processes. Of course, mental health problems are classified for the purposes of the Equality Act as protected characteristics. Officers who experience mental health problems at work are – in theory, at least – no different to officers who become physically disabled after an assault or accident. And as with physical health problems, disability can arise for all manner of reasons, including work related reasons.

So where is the narrative that talks about police work as a line of work that can carry a cost in terms of mental health?

Asking this question is not to ignore that other professions – including other emergency first-responders – are also at raised risk of inflicting psychological distress upon their staff. In particular, rates of PTSD in police officers (and in other first-responders) are concerning. More concerning still, are the support mechanisms available in many cases. We know that amidst public sector cuts, some police forces are having to reduce the counselling and other support that is able to be offered to staff and that NHS support for counselling and CBT can involve as much as an eighteen month wait.

POLICE SICKNESS

The demographics of recruitment and retention don't help trends in police suicide and mental ill-health. Reporting on suicide in the population as a whole puts young and early middle-aged men right in the danger zone, when it comes to predicting overall probabilities. The Samaritans produced

a very comprehensive report on suicide in the UK and Ireland this year and it provides detail on age and other demographic factors.

So in a profession that is still comprised mainly of men, the profession-level risks become amplified and obvious. Every time I read initiatives about male mental health, I must admit I think about my predominantly male colleagues up against a culture that suggests you should be able to cope and a structure that may struggle to support you anyway.

You can see clues about police culture all around and much academic time has been given over to studying it. Suffice to say here: none of the seven police officers in Victoria who took their own lives sought help from their employer. So where suicide is the leading cause of death generally in men from certain age groups, we should be concerned about the risk of suicide in a profession that has higher than average rates of psychological distress and mental disorder and which is predominantly male. Of course, female officers are affected too and whilst female suicide rates are much lower than those for men, female rates of self-harm are much higher. It means we need think about how staff may be differently affected and think way beyond suicide.

The above report from the police in Victoria is not the first to make the claim that more days are lost to sickness in the police to mental health and other psychological problems than to physical health problems. And sickness days lost to stress, depression and anxiety is on the rise. Reports suggest that since 2010, sickness arising from mental health and psychological problems is up significantly. In the North East of England, three police forces reported percentage rises of 260%, 122% and 37% compared to three years previously. Even a 37% rise is significant and despite my efforts, I couldn't find a news article suggesting that any UK police force had seen a decrease. Let me know if you find one.

It's worth noting the emphasis placed by forces upon the potential for personal circumstances to give rise to this trend. In response to the story of north-east forces as well as elsewhere, senior officers have been keen to stress this and of course, that will be part of it. But it must be said, there seems to be a lack of acknowledgement of the role that police work pays in causing distress and illness amongst officers. In 2007, psychological problems were listed at the top of those reasons that cause long-term absence in a report by the Health and Safety Executive. It would be really interesting to read an up to date version of this report.

IT'S TIME TO CHANGE

For some while now, I've felt that we need to see the development of a charitable organisation specifically aimed at supporting police officers (or

999 personnel as a whole) suffering from psychological distress and mental health problems. I keep seeing the effort, the work and the impact of Combat Stress in drawing attention to and supporting our Armed Forces Veterans. The issues in policing and emergency services work being different, with obvious overlaps, it strikes me that there is a gap that needs filling. So it seems we could be doing a whole lot more and talking about this would be a good start – the Time To Change initiative has long since focussed its message on the importance of an open dialogue about mental health problems, but they also highlighted that policing is in the top two professional groups to be comparatively unaffected by its campaigns. Yet how many times have we heard police officers who have found themselves living in distress say something similar to, "I would have thought I was the sort of person to affected by mental health problems."

There is the knuckle of the problem – there is no type of person. It's about the broader human condition and the way we live our lives. In my humble opinion.

Are we failing police officers? – let's just say we have a long way to go. **Who's protecting the protectors?**

NB: if you have been affected by the issues in this post, you can talk to the Samaritans for the price of a local phone call on **08457 909090**.

12th August 2014

Voluntary Attendance –

This post is about trying to ensure a non-prescriptive framework for how police officers should consider whether or not to detain someone under the Mental Health Act when it is legally possible to do so, as opposed to helping people access relevant services without detention. So it is about two, frequently opposing philosophies: the principles of autonomy from the least restriction and of security from necessary control.

We know that where (UK) police officers encounter individuals who actively want to access some kind of healthcare support for their mental health problems, they traditionally have four options. They are not always available because legal powers vary between public and private places and because 24/7 Crisis Team services usually only respond to patients already receiving mental health care.

Nevertheless, the four options are —

1. Advise the person to contact their GP (primary care), in due course
2. Advise the person to contact their MH CrisisTeam (secondary care), if one is available
3. Assist someone is accessing Accident & Emergency (urgent, unscheduled care), more or less immediately
4. Use legal provisions in the Mental Health Act 1983, if appropriate.

It does get us into all manner of problems where we think something needs to happen straight away because you have to decide whether to use the Mental Health Act in order to remove someone to a place of safety or whether to point them towards A&E or accompany them there. This is a remarkably complex decision, as the rest of this post should explain. It is made difficult by some important principles of law that creates a tension for the officer who might detain someone: a tension which you could almost always argue remains unresolved no matter which decision is taken.

NICOLA EDGINGTON

The most high-profile example of this decision – at least in my mind – was the decision taken in the case of Nicola EDGINGTON in south London in October 2011. Metropolitan Police officers had accompanied her to an A&E

department on a voluntary basis, without detaining her. It must be said, in the first instance that it was questioned whether the officers could have legally detained her at all, having first encountered her in a private place. That said, Nicola having exercised a free decision to move from that private place to A&E she then attempted to leave and the argument was suggested that Metropolitan Police officers should have detained her under s136 MHA at that point, particularly because she had a previous history of homicide and everyone accepted that she was worried she may kill or hurt someone.

She was not detained. Having then remained in A&E for further mental health assessment she was admitted to a psychiatric unit as a voluntary patient and moved to a ward. She then absented herself from that location and travelled to Bexleyheath where she attempted to kill Kerry CLARK, and then did kill Sally HODKIN. I have previously written about this case if you want more detail on it and read about the IPCC investigation that looked at this decision-making. Suffice to say, I'm now waiting to read the independent review of Nicola's treatment and care when it is published by NHS England.

So we know from this and other cases, that police decisions to leave individuals in healthcare settings who may be a risk to themselves or others is precarious business. But an 'err on the side of caution' approach directly conflicts with principles of handling people in the least restrictive way. The 'least restriction' idea is a core principle of the Mental Health Act Code of Practice, outlined very early in that document and referenced through-out. Any conversation about a decision to use mental health law – or about the particular manner in which it is applied – doesn't last very long before officers are reminded about the need for least restriction. It is an important part of the ethical application of the MHA, that restriction and restraint is only used when it is absolutely necessary to do so and the no more coercion and control is used that is absolutely necessary. Anything less could represent a human rights violation.

So at the heart of this dilemma and the method by which any tension is managed is the following question: Why would a police officer legally detain a person in order to compel that person into a process that they are willing to enter? And the answer for me lies in the definition of the word 'necessary' and in the ability of services to make sure in some case that someone not only *enters* a process of assessment, but also *finishes* it.

WHAT DOES 'NECESSARY' MEAN?

Police officers are used to considering the word 'necessary' because every arrest made under criminal law carries with it the need for a necessity test, under section 24 of the the Police and Criminal Evidence Act. When I joined

the police, we used to talk about 'arrestable offences' and if you were suspected of having committed one you could be arrested for it and that arrest would be lawful. The end. So if you knew that an allegation of assault (ABH or GBH) had been made against and you turned up to the police station to have your say about the incident or help the police with their enquiries, you may be arrested. This changed some years ago and it is now a legal requirement for the arresting officer to show why an arrest was actually 'necessary', against established legal criteria now made plain in the Act.

So we understand about 'necessity' and it's implied and inherent links to the least restriction principle.

Let me amplify these points with real examples:

Officers encounter an elderly man who is confused and disoriented. Some enquiries reveal that he is almost certainly a missing person from a neighbouring police area and he is out in winter, obviously very cold. An ambulance turns up at the officers' request and checks him over they state that they need to take him to A&E to get him checked over medically and the police area from which he is missing are telling his relatives he's been found and his wife and son are now heading to the A&E concerned.

The man is happy to go to A&E and not resisting at all, saying he'd welcome a cup of tea. The grounds for s136 were undoubtedly met: he was "believed to be suffering a mental disorder, in immediate need of care in his own interests." This is one version of the definition of s136. **Was he detained?** – NO. **Did he need to be?** – NO.

Police officers encounter a young woman in her twenties who is asking for help and saying that she "needs to be sectioned". She wants to be assessed and admitted to hospital for a period of time and has a history of suicide attempts, including a serious overdose and significant injury after self-harm. She has also been considered a high-risk missing person after having previously self-presented to A&E departments and having left in a suicidal state before being the Crisis Team arrived to assess her needs.

Although the woman is happy to go to A&E on a voluntary basis, there is the potential that this decision could change, especially if there is a protracted wait for the Crisis Team. Should she leave, there could be a significant risk to her wellbeing based upon background factors. **Could she have been detained?** – YES. **Was she detained?** – YES, because this ensures she remains detained pending the assessment outcome and ensures her various legal rights are in place.

In this latter case, if officers had not legally detained her under the MHA, she may either have been left at A&E and again become a potentially high-risk missing person should she leave; OR officers would have still remained

in hospital to ensure she didn't leave hospital, not having legally detained her. So she would have been detained *in fact*, but not *in law* – and I'll guess that no thought would have been given to her legal rights under s131 MHA or PACE.

VOLUNTARY ATTENDANCE

So you're the police officer at the incident and let's assume that all four options mentioned at the start of this post are open to you as possibilities: you can advise contact with the person's GP or Crisis Team; or you could offer to assist someone to access A&E or you could use section 136 of the Mental Health Act.

For me, the first three options are only available where risks and threats involved mean that we need to be sure that someone will *complete* the process of assessment. This may include suicide risks, someone who has taken an overdose, someone who has previously sought help and then disengaged before being seen in circumstance of some concern that need to be avoided.

Of course, something like street or telephone triage with mental health services may render an instinct to detain null and void so any decision taken must be based upon the fullest available information. But necessity needs to be judged in terms of whether the risks of a person not remaining engaged to complete an assessment are so serious as to need negating. If they are not so serious, then principles of least restriction should mean that sign-posting, referral or voluntary attendance are perfectly proportionate responses to incidents. We all accept and understand that physical injury or illness does not always require *immediate* A&E attention and so it is true of mental health issues.

19th August 2014

Personal Responsibility –

I'm going to have to be careful about the tone of this one: it just mind end up sounding a bit like a lecture or a telling-off! And I should be clear that this post is not just aimed at professionals in policing – what I am about to say is of applicability to *anyone* who has to deliver their profession within the constraints and opportunities of our mental health and capacity laws.

So whilst trying very hard not to sound too much like Mr GILBERT from the Inbetweeners, here goes —

If you are a professional reading this, you will have taken many decisions in your career which are, fundamentally, **legal decisions**. Section 136 MHA detentions; decisions about whether to grant leave under the MHA and recall a patient from it; the application of the Mental Capacity Act or issues around the application for and execution of warrants. There are countless other examples. Of course, the origins of these decisions may well be based on practice judgements, health and safety considerations or the attempts to prevent harm but as soon as you get into this territory you will come up against legal considerations. So we need to know the law.

So here's the rub: we actually have to know the law, which means we might have to study it. Here's another rub: whether or not we have a training course on offer, we might still have to know the law, which means we might have to study it. Finally, here's a real spoiler: whether or not we know the law and whether or not you have studied it, you're still accountable to it. Ignorance is no excuse, etc., etc..

STANDARDS OF KNOWLEDGE

My personal view, is that the standard of legal knowledge across the professions is actually quite shocking. I am prepared to be so blunt because I actually don't think this is the fault of individual professionals. I know that I had my views early in my career about police training, but I have subsequently come to think that legal training within various mental health professionals is far from great. The only real exception I make to this generalisation is the training given to AMHPs, because they are legally warranted and professionally examined on the Mental Health Act. It

doesn't prevent the occasional myth pervading that professional group, but their legal knowledge is usually spot on.

I've noted a few times on previous posts that I get loads of queries via social media or email about mental health law each week and and most of them are really quite basic. "What is a s37 patient?"; "Have I got a power of entry for this situation?"; "I had a job the other night, whose responsibility is to do this?"

Of course, some questions are more elementary for some professionals than others. A while ago medium secure unit in another area to mine reported a 'voluntary' patient missing and told us "The Secretary of State has issued an order for his return to this hospital." This information is actually very confusing about the legal status of this patient and what, precisely the police are allowed to do if or when they find the man. It seemed to me that there could be contradiction or confusion within the request. Since the local police area were asking officers across the force area, including mine, to attend various addresses and search for the man, I asked the duty inspector for the hospital's area to enquire of the reporting nurse, "We're just trying to clarify police powers here: is this a conditionally discharged patient and is this 'order' you're on about a warrant from the MoJ under s42(3) of the Act?"

Silence on the phone line.

Now this probably won't mean much to your average response officer as conditionally discharged patients being recalled is so comparatively rare that most officers will go a whole career without encountering the situation – it's only the fifth or sixth that I'd ever been connected to in the real world. Nurses working on medium secure units will see this far more frequently and as they are an important link to ensure that the police are properly briefed on these situations, it's important they understand their powers. Most crucially, the word 'voluntary' should never have been used in this context: the police have no powers over voluntary patients, unless we encounter them in public places and feel that section 136 should be applied. So can you imagine if this man – who it turned out had been a serious sex offender leading up to his hospitalization – were found by the police in a private address (where they would have no powers) and left there because of confusion as to his precise legal status? Imagine the horror if he offended after police contact with that opportunity to re-detain him having been missed?! It's too awful for words.

It turns out that our guess was correct: he had previously been in hospital as a restricted patient and then conditionally discharged under s42 MHA. For whatever reason to do with his care, he had been recalled to hospital and would again become a restricted patient. So at last we understood what we could and couldn't do.

This is not a knock at an individual nurse tasked with phoning the police: it is just the more potentially consequential tale from the last few months to highlight the point. There could have been the story of the woman who had been assessed under the MHA and an AMHP had applied for admission to hospital. She had not travelled to hospital on the night of the application and the following day, staff attended her home address to convey her to hospital and she refused to open the door. Could the police just force entry? …. not with a warrant we can't, no. There could have been the one about the police being asked to physically coerce the Community Treatment Order patient back to hospital before anyone had served a recall notice. The list goes on.

The police are potentially worse: perhaps you'd expect that because although mental health is core police business we know that we're not quite there yet with the provision of training. This week alone, "What's a s37 patient?", "Can we force entry to re-detain a s3 patient?", "Can't we just use s17 of PACE instead of getting a warrant?".

The list goes on – legal training all 'round.

PERSONAL RESPONSIBILITY

Here is a list of resources to help, but you might have to read and internalize them! —

- What do all the sections mean? – each important section of the Act, summarised into one or two sentences.
- Quick Guides – covering very common and some not-so-common scenarios under the MHA / MCA.
- Knowledge Check – one post which summarises into around 500 words the most crucial information.
- **But you might have to actually read it and internalize it!** – try doing it as an act of studying, rather than trying grab information at jobs when pressure is on.

I was remembering recently that the police legal syllabus doesn't include very information on mental health. The Blackstone's Manuals (2015) don't include more than passing reference to the Mental Health Act. They certainly don't include detailed knowledge of the Mental Health or Mental Capacity Acts into the legal syllabus that is the basis of the first part of both the sergeants' and inspectors' promotion exams. The examination is based upon surveys of operational supervisors as to what knowledge is needed and yet mental health doesn't feature at all, despite it being daily business! I would estimate I get several dozen queries a week about what different legal structures mean or what police powers are implied. I can't imagine how many officers with such queries don't raise them.

The hope behind the above resources was that they would allow quick reference about the sections of the Act and what those sections mean officers can do.

We have seen that the police are only going to be as good as the information they are given. Most MHA related scenarios for the police are not instigated BY the police – the obvious exception being section 136 MHA which most officers understand pretty well. Otherwise, the police are almost always acting in support of or on behalf of mental health professionals who will need to ensure police officers are properly briefed to be able to act quickly, professionally and legally.

This is important stuff and it may well mean that each of us needs to spend at least a couple of hours (or more!) **actually reading the law** itself, taking *personal responsibility* for ensuring we are well positioned to discharge our responsibilities and to work in partnership with each other.

Over to you!

29th August 2014

Inappropriate Detentions –

I'm amongst the first to admit that police officers lack the necessary training to ensure that they get s136 detention decisions consistently correct. I've written about this before, offering my view as to how the dilemma should be approached. I've also acknowledged the point made by some mental health professionals: that police officers occasionally use s136 where it is blatantly illegal – for example, in private premises – or where other powers of detention should be preferred.

What I'm also clear about – and it seems fair to mention this when I'm prepared to accept problems in some officers' usage of s136! – is that many detentions are only necessary at all because patients cannot directly access the NHS services they need or in a timescale that suits them. That's where the police often find themselves involved in taking detention decisions and I want to amplify this point yet further – some s136 detentions follow decisions taken by the NHS to seek the detention of patients or to refer incidents to the police which they ideally wouldn't. Some patients try and then fail to access their CrisisTeam or their community mental health team and end up coming to police attention when they have "one foot off the bridge" (to use a phrase from the Mind Report on Crisis Mental Health Care.) Other patients are actively deflected to the 999 system by our mental health system. Indeed there is some emerging suggestion that existing community and crisis teams are now more included to deflect demand to the police where they know the police have access to street triage service.

INAPPROPRIATE DETENTIONS

Two mental health trusts in the last month have used social media to broadcast their street triage schemes and have specifically stated that they are going to be working with their police services "to reduce inappropriate detentions". I will admit to smarting a bit at the very idea of this! Whilst accepting that forces use section 136 in very different ways and that this includes usage which may be questionable, there are many forces using s136 quite lawfully and appropriately.

There are two types of detention that seem to get labelled inappropriate –

1. Those detentions which are straight-forwardly illegal and those which should have been made under other laws.
2. We also see an emerging narrative that suggests because street triage has reduced use of s136 by a certain percentage figure, that number represents the total number of interventions that were inappropriate.

I can accept point one: I will argue vigorously about point two!

We should remember that the threshold to be satisfied for detention is actually remarkably low in the United Kingdom – far lower than in certain other countries where equivalent powers require the police to apprehend violence or harm. Mental Health Act provisions in the United Kingdom merely require the officer to be satisfied that someone immediately needs care in their own interests, a much lower threshold. As such, a greater number of circumstances can be legally justified as requiring or allowing detention.

We should also remember that far too many people who talk about section 136 MHA think that the only important measure of its effective use is the number of people who are subsequently admitted to hospital as inpatients. I've dispute this for many years: how can we argue that section 136 was inappropriate if someone in immediately need of care was kept safe from harm until assessed only for the assessment to conclude that they weren't known to the mental health trust but needed referral to the CMHT or various forms of social support? Or a patient who is already known and s136 reveals that their care plan wasn't working for them and this can be rectified?

RE-WRITING HISTORY

This alludes towards a narrative that alters how some people, including me, think we've ended up with a mental health care system consumed with criminalising vulnerable people and ensuring the justice system plays a key role in gatekeeping healthcare in a way that wouldn't be tolerated in any other arena of illness.

I've tried over the last decade to understand how I ended up – *as a police officer* – frequently gatekeeping this entry to our mental health system? Why did someone *want* the wellbeing of patients so acutely unwell that no junior doctor would go near them without bleeping the on-call registrar or consultant to be left in the hands of response officers and custody sergeants?!

I can't avoid concluding something along these lines –

- We (quite rightly) started mass de-institutionalisation of mental health care in the 1960s.
- This followed on from the discovery in the 1950s of the first generation of anti-psychotic medications.
- As the decades rolled through the 70s, 80s and 90s, we reduced the inpatient population of our mental health system by over 80%.
- We subsequently failed to invest adequately in our community mental health care system – CMHTs, CrisisTeams, etc..
- As a consequence of non-investment, the criminal justice system is drawn in to fill the vacuum that exists —

- So we see the **prisons** providing 'inpatient' mental health services for thousands of vulnerable people who arguably need hospital care;
- And we see the **police** providing 'community' crisis responses to thousands of people who arguably need accessible community care.
- We also see **probation** drawing together social provision for offenders after sentencing of all kinds.

Of course, this crude summary that misses various important medical, social and political issues but it at least suggests how we have ended up with the police playing such a prominent role in our emergency mental health care system and why that demand has been growing in most major jurisdictions over the last two decades.

The police never prepared for this, of course: promises of sufficient investment in community care were repeatedly made to suggest there was no need to worry about reduction in the inpatient estate. In fact, you'll notice that these are the messages that have been put out over the last few years as the NHS has decommissioned approximately 10% of its inpatient estate since 2010. And meanwhile, police contact with vulnerable people has been rising, use of section 136 has been rising and the number of people criminalised after being arrested under other provisions whilst unwell, has been rising.

SO WHAT DOES INAPPROPRIATE MEAN?

So back to the original point: I think the trusts concerned believe 'inappropriate' to mean the police using section 136 where a mental health nurse may not have recommended or requested it. Of course this **doesn't actually mean** that police officers' actions were inappropriate!! … back to the two bullet points above, what does inappropriate' mean unless it is illegal detention, or detention that should have occured under other law?

But an officer acting lawfully and properly where they may not have needed to do so, if only the patient could be referred to mental health services

more or less immediately is not 'inappropriate'. It's like debating a mental health nurse defending themselves by the use of force; the fact that when a police officers turns up it won't be necessary because the officer will protect the person, use force and arrest the offender, doesn't mean that the nurse is acting inappropriately by defending themselves *lawfully*. But they would be acting inappropriately by defending themselves *unlawfully* – through excessive force, for example.

Of course it's really easy to construct a narrative about how the poor police keep stuffing things up in mental health: we can point to the deaths in custody, the various IPCC inquiries and other complaints and legal cases. Even the MS v UK case (2012) was presented by the media as being the police treating people appallingly when in fact, it was a legal action against the Mental Health trust for not expediting the admission of acutely ill psychiatric patient. We have seen deaths in custody where the NHS have effectively wiped their hands of some patients who were at that time in their care – including where various statutory guidelines have been breached – and then had to watch as the police officers who were left with it gripped the rail in a criminal court.

So is whilst I'm pleased that someone is attempting to articulate what street triage is actually for – I've previously complained that no-one has articulated a particular vision or aim – I'm concerned that the narrative re-writes a significant part of the problem: mental health services are insufficiently accessible and flexible to those in need, especially those already known to secondary care services. As a consequence of this, many vulnerable people and mental health related demands drift not only to the police, but also to the ambulance service, and we then see that outcomes are not consistently what mental health services would hope them to be.

Is anyone actually shocked at this?! – that if you place a police officer in the position of a mental health professional and give them almost no background information about the person they're dealing with, that they will be risk averse about the situation by comparison? It seems perfectly predictable to me. But if we had an NHS system that was accessible to those who want it, largely on the patient's terms, then we often wouldn't have to put police officers in that position in the first place.

This is what street triage is teaching us as the results start to emerge: that if you simply get a mental health nurse to interact with the person in a timely way, that largely does the trick. So why don't we just make mental health nurses and their services accessible – able to call on police support when needed and *vice versa*?

SEPTEMBER 2014

8th September 2014

In At The Deep End –

I couldn't be more thrilled to have been given the chance to undertake a secondment to the College of Policing to coordinate their work on mental health. I'm still a West Midlands Police officer, but they've loaned me out to help with work that the College needs to do nationally. This is a total change for me, moving from a very frontline, operational police roll overseeing a 999 response team and back to an intense spell of being a Monday to Friday, office boy doing things around policy and procedure, training and guidelines.

I've worked on mental health issues twice before, so this being my third posting to this developing and important area of policing and my being hot off the back of such an intense operational posting, I'm keen to help make a difference to how my old team and others like them, can do the best possible for our public. The post at the College now exists at all because of the increased focus that this issue has achieved, in which we see individual forces investing more time and effort as well as the Home Secretary giving this prominence and attention. We are where we are on this stuff, vulnerable people are not being given the best and that means there is LOADS to do!

I started last Monday and in amidst all the boring stuff about finding out where you're going and how some stuff works in a new organisation, I was straight into the deep end on day two, in London – some months ago I chose to put forward a written submission to the Home Affairs Select Committee inquiry into policing and mental health. A few weeks ago they asked if I would go to London and give oral evidence to the Committee. What an absolutely terrifying honour that was!

WILL I STILL BE BLOGGING?

Many people have asked whether I'll still be blogging and tweeting?! Yes – without a doubt. It was something that was discussed in the first meeting I had with my new boss and the College recognises the impact that social media can have and I've been encouraged to continue. I will be thinking about how to approach it slightly differently – and for the record no-one has asked me to approach anything ANY differently. For the last three years I've been blogging in my own time, outside of work and in order to try and

chip in and drive and agenda that, frankly, I wasn't formally involved in. I'm now formally involved in it again as I was before I started using social media, so I may be doing more 'newsletter' type updates.

I've got to be honest about this job coming about at exactly the right time – because I've been running out of things to write about!! I've been posting less for the last three months and blog hits have fallen off a bit. I'm still on course to reach 1,000,000 hits by end of next year, but it's fair to say that the approach probably doesn't need to change if this is no longer me chipping with ideas or advice that I have to accept people can take or leave as they see fit.

In many ways, this merely reflects reality, doesn't it?! – there is only so much **talking** we can actually do! Eventually, we're going to have to decide what, if anything, we're actually going to do and then commit to it 100% and crack on with it. A few retired officers who heard my HASC contribution this week contacted me afterwards to say they'd been working on s136 or other issues when they were serving over thirty years ago. We can't let this happen again.

We CANNOT go on, as we are. And yet as I type this, there are at least three mental health providers in the process of shutting s136 Place of Safety services or have already done so. We need to grab this situation by the scruff of the neck and look at ourselves because there is no reason why the United Kingdom needs to be in the position it's in – we're a quite capable with what many people would argue are the best health and policing systems in the world of sorting this out. Right here, right now.

I wrote a few thoughts in a previous BLOG about what I thought the College needed to do for the service. This is now the broadest of outlines about how I'll be spending my time over the next few months to understand how we can turn that into reality and how the College of Policing can help drive the police service as a whole to a better place.

I've asked already on Twitter for anyone, no matter what you're background angle, to give any thoughts and ideas about what this will be in detail. If you want to, you should feel free to leave a comment on this BLOG post or email me, using the link on the toolbar, above.

11th September 2014

Social Media in Law Enforcement –

It was revealed yesterday that I have been awarded the 2014 ConnectedCOPS Top Cop award at the Social Media In Law Enforcement Conference, or #SMILEcon as it's tagged.

This goes once step further that last year when I was short-listed for it.

#SMILEcon 10 has just finished – the first time that the event has been staged outside north America and it was hosted by West Midlands Police in Birmingham who published a press release.

Given this award on the 10th September, I used it to try to highlight World Suicide Prevention Day – I said rather more than I normally do about the extent to which the police and emergency services are affected by stress, depression and anxiety disorders not to mention PTSD. Having deliberately gone out on a limb in front of various senior officers, I found them really receptive to the essential message about the need to improve our responses as staff sickness levels arising from psychological conditions rises. I hope this partly arose, as I pointed out, because very similar things could be said and are said about many employers. It's about how we shift our whole society's attitude towards mental health conditions and those of us who live with them.

It's worth looking at the website as many of the talks given were fascinating – I will forever remember the award winning communications team from the Royal Canadian Mounted Police in New Brunswick who expertly presented on their social media response to the triple murder of their officers on June 4th this year. I wasn't the only person wiping my eyes at the end. I also commend you to the talk given by Chief Constable Simon COLE from Leicestershire Police which shows why executive leadership on social media is vital.

The citation of my award reads –

"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.”

12th September 2014

Deprivation of Liberty Safeguards –

I once gave a talk at a conference where another speaker was talking in a general, but somewhat excited tone about the Mental Capacity Act 2005 – he said it was "the worst example of legislative drafting in over 30 years!" It is very easy to see why you may think it because the Act itself received Royal Assent in 2005 but had to be substantially supplemented in 2007 when Deprivation of Liberty Safeguards (DoLS) were introduced to it by the Mental Health Act 2007. A report by the House of Lords in 2014 stated that this legislation was not fit for purpose and the Government should look at it again – their response to this report was to outline that they do not believe there is a flaw in the legislation as framed (p29).

So in the meanwhile, we have to get on with it and this post is about one particular, very specific legal issue: whether or not the police have any 'power' when a patient who is subject to an order made under DoLS can be forcibly returned. However, just in case you've not heard of DoLS, let me explain a couple of basic things and I've kept this really superficial – I'm aware of the greater complexities but they tend to be beyond the needs of police officers and paramedics.

GENERAL BACKGROUND

The Mental Capacity Act as a whole is concerned with providing a framework by which to decide what is in someone's best interests where they lack the capacity to decide for themselves. For emergency services, there is something of a tool elsewhere on this BLOG to help you form a view about that where an urgent situation obliges you to do so – the "ID a CURE" test as I called it. A best interests assessor (BIA) is a trained professional who will take longer term decisions, in slow time about things like whether a DoLS order is required to place an elderly patient in a residential care home where they have become unable to look after themselves in their own home, for example.

Where a BIA reaches a view that a DoLS order is required – they would need to have a Doctor's confirmation that someone is suffering from a mental disorder (broadly defined) – they can instigate it. Sometimes this is referred to as a Standard Authorisation and it can last for up to twelve months in the first instance and should be regularly reviewed.

CHESHIRE WEST

Earlier this year, the Supreme Court had to reach a verdict in the case of Cheshire West – this case concerned a group of young people from both Cheshire and Sussex who were living in supervised accommodation because of their learning disabilities and were not at complete liberty to exercise autonomy. They were not permitted, for example, to go to the shop as they pleased or to visit who they wanted without consent and supervision of staff. The various hearings in lower courts led to much debate about what a 'deprivation of liberty' actually was and the Supreme Court had to determine this.

In a very memorable phrase, Lady HALE declared that "a gilded cage is still a cage" ruling that however professional and excellent the kind of accommodation and care that these young people received may be; and however much effort was expended making their lives as unrestricted and enjoyable as possible, if they could not – ultimately – come and go as they wished then they had suffered a deprivation of liberty. As such, BIAs are going to have to get busier or health areas will need far more of them in the opinion of many.

I wrote a blog in the week following the Cheshire West ruling in which I anticipated a rise of DoLS related issues for the police: whether that was around requests to convey some patients to hospitals and care homes; or whether it was connected to what the police may do if someone subject to a standard authorisation was reported missing or refused to return to the place specified in the order. We know that occasionally DoLS related requests came up so if we are now going to see more DoLS orders, we will see more police related requests in relation to it. Surely?!

DETENTION AND CONVEYANCE

So do you have a 'power' to convey or return a DoLS patient to a care home for example, if they refuse to return from visiting a relative they had permission to see or if you find them after they were missing? Best of luck trying to find a specific answer to that on the internet! This post comes around because of my good friend from West Mercia Police, Inspector Ben HEMBRY, ringing me up on Monday asking the question and it occured to me that I had not yet written a post on this. And yet since Cheshire West, I've had this question several times – I only ever received it once before this key ruling!

Yes – there are good grounds, should it be necessary, to argue that minimal force may be used to return someone to a hospital or care home who is

subject to a DoLS order. Although it was always my view that officers, paramedics and others could rely upon the protection of sections 5 and 6 of the Mental Capacity Act in their efforts to return someone, I came across the case of DCC v KH (2009) whilst researching this piece. In it, the applicant (presumably a local authority) sought an advance declaration from the court that reasonable force could be used, consistent with the principles of the Mental Capacity Act 2005, in returning someone to their determined place of residence. Those representing the man concerned argued successfully that there was no need for such an order because such possibilities were covered by the Act as it stood. The district judge published his transcript of this telephone hearing and whilst this is not a stated case as such, it is about the only legal view I can find and it doesn't appear to have been contested in the years since.

As with everything related to the MCA, you have to ensure that you are acting with regard to someone who lacks capacity and that you are acting in their best interests, in the least restrictive way. Obviously, a DoLS order demonstrates that a Doctor and a BIA have taken care of the first part for you, so it's about police officers, paramedics or others determining whether something is in the best interests of a patient and going about the application of the use of force only where absolutely necessary, using minimal force in the least restrictive way.

You will have to judge that, case by case and context by context, but should you form the view that you need to, the ability to use force to safeguard people is ultimately capable of defence according to sections 5 and 6 of the Act.

13th September 2014

Designing Training –

So here's a knotty one – on the subject of police training. We know that the police need (more) mental health awareness training because Lord ADEBOWALE told us so in a report with receommendations that were accepted after publication.

So it gives rise to a list of questions –

- How long should the course be?
- Who attends it?
- What should the course contain?
- How will it be delivered?
- Who would deliver it?

In reality there are multiple audiences amongst the police – if an inspector with no previous background in mental health policing and partnerships were to be promoted to Chief Inspector and be told to lead on the issue for their area, what would they need to know to be effective? Whatever the answer to that question, it would probably be different if we tried to address the needs of a frontline operational sergeant running a response team. It would be different again if you were an officer with some interest and experience who was newly posted to a street triage team or a custody sergeant working where a liaison and diversion scheme was just being set up.

So can we agree: the police service needs a suite of options – perhaps modular and adaptable – capable of being delivered in a range of ways and that at least some of this needs to involve classroom inputs and partner organisations?

But what problem are we trying to solve – what is it that police officers don't know that we need them to know, which we would hope effective training would address? What is it that we want them actually *do* differently?

PLAN A and PLAN B

One of the most difficult things of all will be to determine the specific legal training in circumstances where we currently know that the requirements

of law and the codes of practice are not necessarily adhered to in all areas. It's all very well running an input on AWOL patients and pointing out to officers that para 22.13 states that where a patient's location is known it is for NHS services to re-detain and return them to hospital. What are the implications of training that to police officers, if some of them work in areas where the NHS argue they don't have resources or capacity to recover missing patients? You may think that it will empower police control room staff to ask the correct questions to allow them to say, "No – that's a matter for you to undertake" where necessary. But many officers know that there can be other reactions from staff on wards who are physically not in a position to leave a ward or call upon colleagues in other mental health teams to undertake those jobs on their behalf.

So we have to think this through!

It's all very well lining up the lessons learned from IPCC investigations and Coroner's inquiries before drawing conclusions about what the police need to do differently but some change may involve the need to adapt partnership approaches. How do you provide training to protect officers and vulnerable people that takes account of all of this, if certain aspects of partnership working is yet to change or is struggling to do so? The question is not abstract: training around the proper response to a mental health emergency involving acutely disturbed behaviour – possible excited delirium: amidst restraint by several officers I can of some areas of the UK where little resistance would be met some NHS areas and it would be hotly contested in others. How do you train for that, bearing in mind that it is possible to highlight several force areas that cover multiple MH trust and acute areas where the NHS approach is not consistent? I must stress: I'm not trying to particularly knock the NHS by saying this! You could say – and I have said! – similar things of the police on various issues in this interface. These are the difficulties of partnerships and of trying to get national consistency on important issues amidst highly devolved local services.

Is training and an improved, raised awareness of legal and clinical risks something which should be trained for it's own sake in the hope of improved awareness driving change; or is it irresponsible to suggest a course of action that may set in train a conflict between operational officers and colleagues in the NHS? The reality is it would do both, because partnership arrangements, structures and the role played in different areas by ambulance and A&E services varies – or at least the capacity and involvement of them does.

PARTNERSHIP TRAINING

So what about multi-agency training? Getting police officers into rooms with mental health nurses, AMHPs and psychiatrists – not to mention getting into rooms with paramedics with whom the police work so closely at a lot of mental health affected incidents. What is best delivered to police officers alone and what should be delivered in a partnership setting? All four of the above bullet point questions above apply thereafter and you would have to be careful to make sure all of this didn't involve significant duplication.

Of course there is also a practical reality to be observed: even if you answer the above questions and conclude that just SOME officers are going to need as comprehensive a set of training opportunities as we can possibly offer – force mental health leads, street triage officers, etc. – it still doesn't address whether or not there is an appetite to allow the time for it to happen. Indeed one thing that has been discussed for years is whether Britain would benefit from the adoption of a 'Crisis Intervention Training' model that we have seen in the United States, Canada and Australia? So many reported benefits to this approach to policing and mental health but nowhere in Britain has trialled it. Do we need to design what that would look like, in outline, to help convince one senior officer that it would be worth seeing whether it improves things in a British setting.

So the major question is – do we train for the world we are actually policing or does training have a role in setting standards that could or should be delivered?

This is what we now have to wrestle with to determine what good training for the police will look like. If you have a view – please leave a comment below as this post really is a part of my attempt to gathering different views and ideas to build a balanced perspective.

13th September 2014

Decisions, Decisions! –

In these last few weeks, I've been getting to talk more about police approaches to mental health incidents with a wide variety of people. Far more than once I've found myself being asked about street triage and how we can reduce the usage of section 136 MHA. It seems in the minds of many, that this is a worthy objective in its own right, but it also seems important for various other reasons – making it easier to ensure health based place of safety when the power is invoked. It is my strong view that we do need to look more closely at how section 136 of the Mental Health Act is used – there is too much unexplained inconsistency that seems likely to arise from unintentionally varied approaches to its use.

This post is longer than the average – I've decided to run with it anyway because it's *such an important issue*, in my view.

To be fair, we've known for some while that police forces use section 136 very differently – the IPCC report (2008) showed this to us all and I've seen it again in the last two weeks. How else do we explain two police forces using this power roughly the same number of times per year when one of those forces is three times the size of the other?

Her Majesty's Inspectorate of Constabulary released their report "Core Business" last week in which they featured a couple of pages on mental health issues. This reporting was amidst a section that focussed upon reducing inappropriate demands on police officers to free up their time. The report highlighted street triage in Nottinghamshire Police, mentioning that between January and October of a given year that force used s136 a total of 909 times. So at 91 uses per month we could very roughly estimate usage per annum at around 1,100 times. This is roughly the same as West Midlands Police (before they introduced street triage) and so I looked up how big the resident populations and officer establishments were.

West Midlands = 2.8m population with c7,200 officers

Nottinghamshire = 1m population with c2,500 officers.

And yet, similar usage of section 136 of the Mental Health Act. So are people in Nottinghamshire almost three times as unwell as those in the West Midlands? – of course not. Is the West Midlands a bastion of affluence, wealth and employment in a way that Nottinghamshire is one of poverty,

deprivation and destitution? – of course not. There will be differences – perhaps in the funding for mental health services, or the way in which those services have evolved; and those police services will have evolved practices of how they discharge their responsibilities – but that surely can't account for such a differential use of this one legal power?!

In the conversations I've had this week, it seems that we do need to do more work on how police officers approach the decision to detain, where they encounter people and think about the potential of the Mental Health Act to provide that intervention. We need to break this down according to two specific problems, as I see it –

1. What to do when someone is intoxicated and threatening suicide or self-harm. (Probably more important to think about this the more drunk that person is.)

2. What to do when someone is also committing a criminal offence whilst intoxicated.

PANORAMA

Do you remember the BBC Panorama programme from September 2013? It is unfortunate that it's no long available on iPlayer but it involved the BBC filming in Hampshire Police custody for a whole week in order to focus on cases where 'mentally ill' people were brought into custody. They were ostensibly attempting to highlight how bad it was that people could not access a health-based place of safety (PoS) and to be fair, there were some fairly unusual, highly disturbed behaviours shown amongst those detained by the officers that week. But the programme showed a succession of people who had been arrested for various substantive offences like assault, criminal damage or public order offences.

So firstly, the premise of the programme was massively undermined by the examples they chose to make the point. People arrested for criminal offences do not *ever* go to a health based PoS – they go to custody, which is *exactly* where Hampshire Police took them. Various behaviours that caused officers on that programme to effectively plead that it was 'obvious' the detainees were suffering from mental health problems, were behaviours that were wholly absent once drugs and / or alcohol had worn off. Indeed, various detainees were shown the next day leaning on the cell door, drinking coffee and making remarks of regret about the previous evening in a fairly sober way, somewhat surprised at what they'd done.

This was true even for some of those arrested for assault who were known patients of the local mental health trust. It seemed that behavioural disturbances occurred for many after ingestion of substances – a point that

has been made for many years by mental health professionals I've known. Attempts to identify causative, contributory or coincidental factors during crisis incidents is bedevilled where substance use or abuse is involved.

IMPLICATIONS FOR SECTION 136

Imagine you are a police officer on patrol: you are called to a bridge where a young man is described as having climbed onto the adverse side of the barrier and appears to be threatening to jump onto the road or railway line below. The first officer there tries to engage him in conversation and others started blocking roads or requesting traffic or trains to be stopped. Someone starts trying to find out what we can learn about the individual concerned. The officer talking to the man infers intentions towards self-harm or suicide and this triggers considerations around potential use of the Mental Health Act – *if* they can talk him back over the barrier.

Eventually, the man is persuaded back over the barrier and the officers now have a decision to make. Do they detain the man under any legal authority and if so, which one? For those who are not police officers, here are the options —

1. Do nothing in law – provide help, signposting or any number of other things that may help, but don't invoke the law to detain him.

2. Detain the man under the Mental Health Act, because he was threatening to jump so he must be or may well be mentally disordered, right?

3. Detain the man for an 'on or over' offence? – it is an offence (s22A of the Road Traffic Act 1988) to put yourself on or over a road, causing a danger to road users; it is an offence (s34 of the Offences Against the Person Act 1861) to endanger railway users.

4. Detain the man for a 'public order' offence – this could include drunk and incapable, drunk and disorderly or drunk in a public place; equally it could include disorderly, threatening or violent behaviour under the Public Order Act 1986 depending on which of those were appropriate, if any.

How do you make good decisions in ambiguous, uncertain circumstances?!

DECISIONS, DECISIONS

Can we agree that Option 1 is out-of-order? – we're not going to do nothing, because we can perfectly well anticipate that if we don't detain him, we'll end up back here in half an hour doing the same thing or that if he were

merely sent on his way home – even in the charge of a friend or relative – he may still come to some other form of harm. Enough examples of both exist to mean I'm certainly not going to choose nothing – if you've brought a major road or railway line to a halt, you're going to be detained to make sure it can't just (immediately) happen again.

So we now have to choose from Options 2-4: between detaining him under the MHA or detaining him for something else. I have the sounds of mental health professionals I've known ringing in my ears here: the fact that he is on the wrong side of a bridge barrier and appears to be threatening to jump is NOT enough, on its own, to decide whether or not someone is likely to have a mental disorder. Remember, plenty of people who are not mentally ill and never have been, take capacitous decisions to end their lives. We need to see wider context and this includes consideration of drug or alcohol use as well as any other background information that may be accessible. Not easy on the top of a bridge at 11pm, but what is available should be considered.

So imagine that this young man tells you his name and it's obvious he's slurring his speech quite considerably. You manage to contact the CrisisTeam and ask whether he's known to services – the answer you get could and should really influence things here. What if he's **not known** at all and has never been seen or assessed? – or; what if he's **an established patient** who recently missed an appointment with his CPN?

How does this alter the decision?

Well I would argue, that if you establish that he's well-known to services and he recently missed a care appointment, section 136 is now well in play because of the overall context. I would think this whether the man is intoxicated or not – he's known to have mental health problems and is on a bridge threatening to jump. All of that fits the definition of section 136 without difficulty. The only practical problem, will be something that's not relevant to what I'm getting at in this post – where do we keep this person safe until such times as the alcohol has worn off and the assessment can occur? – that's another problem for another post.

If he's not known to services and there is no other objective information to hand suggesting a mental health problem, I would argue that the considerable intoxication is a barrier to s136 being appropriate. I would be detaining that man for the substantive criminal offence and subject to any immediate medical needs, be taking him to custody. Once the alcohol is worn off, he can still be seen by mental health services if the police healthcare staff feel he needs an MHA assessment. Panorama suggests – and my experience and other feedback tells me – that this will be the case only very rarely.

DIFFERENT SITUATIONS

Of course, situations vary – you could have the one where a man is carrying a knife or possessing small amounts of drugs when encountered after reports of someone 'acting bizarrely'. Should he be arrested for the possession offence, or detained under the Mental Health Act? Well in these examples – assuming he's not waving the knife around and threatening people with it – we have what you might call a victimless offence. If officers suspect a mental disorder or have good information to that effect, nothing prevents his mental health being prioritised and section 136 being used. Should that assessment reveal to an officer's surprise that the person is not mentally disordered, then when section 136 is brought to an end, criminal justice considerations can still arise around the original offences.

So what am I saying here that I suspect is not happening in areas with high rates of section 136 usage, and which have low rates of correct identification of vulnerable people with unmet mental health needs? I'm saying that you do this, whenever multiple detention options arise –

a) **Arrest the person for the criminal offence**, *unless* –
b) The offence is victimless or trivial;
c) The victim has not called the police to report a crime but to secure help for someone at risk;
d) In all the circumstances there are good reasons to suppose mental health is the most important issue to address first.
e) A greater leaning towards the MHA rather than an offence wherever children are involved.

And if officers keep in mind that behaviour is often best by drug or alcohol use where that is known to have occured it is probably best to stay clear of assumptions about mental illness – unless they have objective, corroborating information suggesting a history. Apply this approach to detentions and you will find you're not ignoring woundings, robberies and rapes by using the MHA; you're not criminalising vulnerable people for minor offences when health and wellbeing should be prioritised. It also means you've stacked your deck in such a way that means if this approach has given rise to the few cases where it isn't appropriate, you can still reverse your decision when more becomes known.

The old Code of Practice to the Mental Health Act (1999) said section 136 was not a substitute for the use of substantive police powers. This was wise advice, something I regret was removed from the latest Code (2008) and which I've suggested should be reinstated in the new one (2015). But meanwhile, the above approach is something that every police officer in England and Wales could apply now – and in some areas, I'm convinced based on my experience and my research, it would significantly lower the

use of section 136 and ease pressure on our mental health system. It would make it easier for the NHS to provide those services we want to see, like health based place of safety and street triage services.

So why don't we just do it? – by briefing and leading our staff to this effect? **Every police officer could choose this approach today.**

21st September 2014

Home Affairs Select Committee –

My evidence to the Home Affairs Select Committee from 2014, which was commended by the chair of the committee, Rt Hon Keith VAZ MP —

- Oral evidence – given on 02nd September 2014
- Written submission – from June 2014.

OCTOBER 2014

8th October 2014

A Longitudinal View –

Contemplate the idea that a vulnerable person with mental health problems is arrested for a not-especially-serious offence. In custody the Force Medical Examiner suggests they are seriously unwell and may need admission to hospital under the Mental Health Act. An AMHP and a psychiatrist join the FME in assessing the person formally and it is decided that he or she requires admission to hospital under s2 MHA for assessment of their supposed mental disorder.

What now happens to the offence?

Well – if it was not-especially-serious and the person has never really been in trouble before, is there any public interest in prosecuting the offence? Probably not – maybe there would be utility in it if the offence had been murder but where the investigation had been into shoplifting or a minor assault, government policy suggests – in Home Office Circular 66/1990 – that diversion from justice is in order.

What if it were not the first arrest?

If someone is being repeatedly arrested, things may change. If the last arrest was also for minor matters and it was several years ago it may not but surely, if diversion has occured a handful of times or more, over a few of months or even years and there is an emerging pattern of admission-recovery-discharge-disengagement-crisis-arrest for ever-more-serious-or-more-frequent offences, then another approach may be justified? Certainly, more careful consideration is justified!

What if we've now seen a fifth person assaulted and / or a history of absconding from whichever mental health unit they were admitted to after diversion? Does it matter when determining whether someone should be or could be charged that they are sectionable under the MHA? – not necessarily. What if, within the arrests for offences, there are one or more detentions under section 136 MHA – diversion away from arrest – that also indicate a revolving door and an indication of rising levels of risk?

What if offences are escalating in seriousness?

We agreed above that if a one-off offence had involved a murder, the fact that someone is 'sectionable' wouldn't prevent a prosecution. So somewhere between shoplifting and murder there appears to be a line – before this line we argue there is little public interest and seek to divert someone into health and social care services; afterwards we consider prosecution.

Incidentally, can we keep trying to find another word for 'diversion'?! – diversion is NOT what this interface between mental health and criminal justice consistently does! I know the current government pilots are called 'liaison and diversion' but no-one seems to be able to answer this:

When are we liaising, when are we diverting; who is making this decision and how?!

PHILIP SIMELANE

Last month, we saw the publication of a report into the treatment and care of Philip SIMELANE in the lead up to the killing of Christina EDKINS in Birmingham in March 2013. You may remember the case because it was a very high-profile tragedy that touched us all and the heartache arising from it has been compounded by the report which indicated that Christina's death was preventable. The report makes 51 recommendations to various agencies, including the police and CPS and I was very interested in it making case specific agency recommendations and broader, 'national' recommendations. In particular, I was fascinated by the suggestion that custody sergeants need to take a 'longitudinal view' of offending behaviour when suspects with mental health problems are in custody – fascinated because I've argued this for years, on this BLOG and elsewhere.

In other words, we should *not* look at each arrest and the potential appropriateness of diversion on an isolated basis – we should take a broader view of the risk / threat issues based upon a full understanding of offending, detentions and other health information of various kinds.

Disclaimer: Despite being a West Midlands Police officer I do not know anything about this case beyond that which can be read in the media. I was not involved in any way in the investigation or any of the previous arrests of Mr SIMELANE. I know nothing more than you.

What the report seems to be saying, is that where offenders with mental health problems come in to custody repeatedly, amidst a background of their families asking for their loved ones to be helped and supported because of mental health problems, the police and mental health services should look more closely at whether or not prosecution becomes necessary, given that this particular vulnerable person is arrested for offences more

than once or twice and the latter stages they seem to indicate a concerning level or risk posed to people other than the patient. The police should consider all the previous arrests, detentions under the MHA as well as any other information that is available. This may include information about whether patients engage with mental health services or whether they abscond from admission under the MHA. It's relevant, obviously!

What's the point of doing again, something which has been tried already and failed? Little or none, say a lot of people. That said, if the offences are not escalating especially severely and if the it is not recurring especially frequently, then this dilemma can become difficult and very subjective.

INADVERTANTLY BUILDING RISK

If this report says anything to me, it says that we need to rethink our whole approach to 'diversion' (whatever that means). We need to remember that most people who offend whilst they are mentally ill do not offend *because* they are mentally ill. As such, one question that policy makers are yet to answer in anything like a convincing way is why we have special pre-charge arrangements for offenders with mental health problems when we lack equivalent options for any other particular groups, except children. Why are mentally disordered offenders distinct from other vulnerable adult groups, including those with addictions and substance misuse issues? Why do we build a criminal justice system with mechanisms that allow for the compulsion of mentally disordered offenders and then try as hard as we can not to use it, even in circumstances where we know that less restrictive options have been tried and failed or are wholly inappropriate?

This approach builds invisible risk into our criminal justice and mental health interface. It means that risk assessment of offenders in the future is less likely to take full account of risks known about today, because we've seen through cases like this how little previous contact with mental health and criminal justice will influence how offenders in custody are handled.

One other thing appeared within the report which concerend me, despite it's intuitive nature: and it concerns the issue at the heart of many a homicide related treatment inquiry – information sharing. It was pointed out that whilst Philip SIMELANE was in custody he was assessed by doctors and nurses of various kinds and that this inforamtion was not routinely shared with his NHS clinical carers. As such, when NHS professionals were making risk related assessments about his mental health, they were unable to take advantage of this information and the report recommends the kind of routine information exchange that seems intuititive

SENSITIVE PERSONAL DATA

Of course, people are entitled to have their personal data protected and medical information is confidential just as criminal convinctions and police intelligence is confidential. Information that comes into the hands of the police (or their contracted medical providers) can only be routinely shared with other people – the NHS – with the consent of the person concerned or where the criteria in the Data Protection Act 1998 are satisifed for disclosure without consent.

But the opposite is also true! … Information and crime and offending which is known to the NHS can only be shared with the police, with consent, unless the criteria for disclosure without consent are met. So if a patient admits he has been stealing food from supermarkets whilst sleeping rough living in crisis, this remains confidential between patient and doctor unless the patient wants that informtaion disclosed – and who would?!

But if we're going to get the police and the NHS into the routine sharing of what the law calls sensitive personal data, then we need to make sure that we are doing it lawfully. What if someone in custody for offence wants NOTHING of their arrest or health information made known to anyone else? – what if they were asked for consent to disclose and expressly stated they did not consent? Where is the lawful basis for disclosure? In many cases there would be one. In some, there would not.

As with everything important in life: no generalisations and all cases on their individual merits.

11th October 2014

Something's Not Quite Right –

You may remember that in July the IPCC launched an inquiry into the death of a man in Sussex following an incident in Hayward's Heath. The family of the man who died following restraint have suggested he was tasered and subject to the use of pepper spray as officers appeared to disregard information that he suffered from epilepsy and a seizure was mistaken for violent behaviour. Initial reports suggest he may also have suffered a heart attack either during restraint or once in the police vehicle. Another tragedy for all involved, regardless of what the IPCC findings may be and I can only imagine what his family have been through.

Of course epilepsy is not traditionally viewed in medicine as a mental illness, despite the fact that for the purposes of nineteenth-century laws on insanity, it could be viewed as such. So could diabetes, for that matter. However, this incident links to concerns I have written about before for various reasons: we know that epilepsy is one of those medical conditions flagged up, along with diabetes, Addison's disease and others, as examples of non-mental health conditions where presentation could be interpreted by many people as indicators of a mental health problem. We also know that some people who suffer seizures because of epilepsy occasionally exhibit quite marked, sometimes violent behaviours and it's crucial officers know enough to stand the maximum chance of recognising this where it happens.

I've written many times on this blog about different opinions, incidents and anecdotes which show the difficulty in deconstructing behaviour at incidents into those inherently artificial categories of disease, distress or dissent. And of course, nothing prevents those three things overlapping just to make the decision a harder one – about how those issues should be prioritised. The story circulated on Twitter and amidst the expressions of regret at the human tragedy, commentators started to second-guess what the IPCC will discover during their inquiry – I would advise against such attempts given that no-one yet knows the full facts and already there are disputes about what occured.

Let the IPCC do their job, first!

So what remains of this blog is nothing whatsoever to do with the specific case, about which I know nothing beyond that reported in the media. I want to address two broader issues –

- The issue of particular awareness or training for particular medical conditions.
- The issue of deconstructing behaviour into clear decisions about whether to this 'this', 'that' or 'the other'.

AWARENESS TRAINING

We hear requests for more police awareness training on mental health and following this incident and others like it there have been calls for more epilepsy awareness training. A couple of comments also emerged in the discussion about autism training. Here is a list of the various conditions I've heard mentioned during my career amidst suggestions that police officers should have raised awareness of that particular issues, above others. Not all of them are mental health conditions but the others are conditions that officers may often mistake for indications of mental distress —

- Schizophrenia
- Bipolar
- Alzheimer's
- Dementia
- Depression
- Post-natal depression
- Autism
- Apserger's
- Learning Disabilities
- Personality Disorder
- Anxiety Disorder
- Acquired Brain Injury
- Epilepsy
- Diabetes
- Stroke
- …… plus awareness of how drugs and alcohol can confuse and conflate all of the above.

Quite a syllabus isn't it? When one asks the charities who represent those in our society who are affected by the above problems how much training would be required, you tend to get answers of between two and four hours. There are fourteen conditions listed above – even at 2hrs per input that amounts to a week of training and at the end of such a course we would still need inputs about mental health and mental capacity law as well as the operational implications for the police of all of it.

You can't do that in just one day! … so we'd already be looking at a course lasting a week and a half, if not two.

I have a more controversial question, however – to what extent do the above conditions make a difference to the way something should be policed? If there is an answer to that then I see the relevance of training it – I've argued before that I see the point of specific autism awareness training for police officers because we know that where officers deal with incidents involving someone with autism there could be considerations that wouldn't necessarily apply to other situations, if they can be accommodated. I'm not sure if that could be said of all of the above conditions, however. Would it matter to the policing of an emergency mental health incident whether someone who appeared to be in distress was psychotic because of schizophrenia or because of bipolar or because of Addison's disease? Probably not.

If police officers are going about things properly, they would be calling upon paramedics to support their decision-making about what needed to happen next where they have concerns about someone's medical welfare. But even this is a difficult balance to strike because police officers are not going to call an ambulance for everyone who is violent or resistant just to rule out encephalopathy or anything else. But there is a point where no police officer with a first-aid certificate and any amount of enhanced mental health training is going to be the right person to be making certain clinical calls.

So where is that line?

DECONSTRUCTING BEHAVIOUR

The reality is that not every police officer in the United Kingdom is going to get a two-week mental health training course – and I would ask the question whether every one of them actually needed such a course. I would argue a few need whatever we eventually decide is the most comprehensive training on offer and that most need a diluted version of that.

For many policing incidents, of course, an approach which starts with understanding particular conditions looks at things the wrong way 'round – officers are only occasionally asked to attend an incident where a family member is giving full information about medical or psychiatric history. More frequently, we meet people and have to figure it all out for ourselves from scratch. We often don't know the person's name when we first meet them and paramedics are rarely better off. We simply don't attend vast numbers of jobs where we know in advance which medical box someone fits into and even where we do things become more complicated when you introduce issues like drugs, alcohol and obviously, restraint.

And perhaps less obviously, some police incidents are going to be policed in exactly the same way *irrespective* of a mental health issue because it sometimes makes no difference to a police response whether someone is

mentally unwell or not, at least to very initial handling of an incident. All cases on their merits – everyone is an individual in those particular circumstances, whatever they may be.

I would argue that the police can be expected to make the obvious calls; but the more subtle things become the less reason there is to think the police are the right people to be deconstructing behaviour into clinical or non-clinical paradigms. Clinical support is important and it isn't always there, frankly. That's why I argue for greater involvement with our colleagues in the ambulance service and I suspect more integrated ways of working across those 999 agencies could bring enormous benefits, not just in the arena of mental health, but also domestic violence, night-time economy policing and so on. It's fair enough for police officers to see someone with a gaping, bleeding head injury and allow them to make the judgement about whether someone needs to go to A&E or not. I say this because we would all hope an officer in that situation would agree that they should! But it is far less reasonable when a knock to the head didn't lead to any visible injury or any other sign of distress. Does that mean everyone with a knock to the head goes to A&E? – no. It means we need a combination of paramedics, healthcare support in custody and A&E as suite of options with good training on how far things should be escalated.

UNREALISTIC EXPECTATIONS

The same principle holds true with diabetes or epilepsy: if a person has collapsed to the floor and appears to have slipped into a coma, we would expect officers to spot that and react, irrespective of whether they knew it was caused by diabetes or whether they were quite unsure. But where someone is disoriented but conscious, slightly incoherent and confused, would we immediately say "suspect diabetes" when a similar presentation could arise from other conditions? Probably not, unless given information from someone at the scene. Some years ago, just after West Midlands Police started routinely calling ambulances to all detentions made under s136 of the Mental Health Act, there was an incident that showed how precarious this all gets –

A gentleman outside a pub brought to police attention because of concerns by a member of the public about him being in the "confused, disoriented" category. He didn't appear to be drunk and enquiries confirmed he hadn't been in the pub and officers formed the view he may be suffering a mental health problem. They detained him under s136 and called an ambulance – he promptly collapsed in the back of it and was rushed to A&E has his blood sugar levels had fallen through the floor. He was entirely undiagnosed – he had absolutely no knowledge at all that he had diabetes and after not eating properly that day he found himself in some medical difficulty.

Of course, it must be said that the police have got a bit of form in some high-profile incidents for not making use of information and people available to them who could better help them to understand certain situations. This was true in the so-called 'ZH' autism case in London. In certain other cases, family and professionals have claimed to have given the police information that should have been seen as relevant and it was ignored or disregarded. If true, this is quite damming and officers must bear in mind how useful information and advice is from people who know those were are interacting with.

However, on the main issue here of officers' recognition of medical issues cutting across mental health and other conditions I have to wonder whether the best we might be able to hope for, is not something which approaches diagnosis or specialist awareness of particular conditions, but an ability to have a general sense that 'something's not quite right here' with a set of standard approaches to keep people safe and engaging with clinical professionals of whatever kind, as soon as possible?

16th October 2014

Erasing History –

Do you know what I mean by a 'vanilla' tweet? – the phrase refers to something fairly inoffensive on Twitter, quite bland information that doesn't tell us a huge amount but whilst purports to inform. Something like, "Great meeting with partners about mental health – loads of work going on to keep you safe" or similar. Well, I'm bumping into a fair few of them on the subject of the Crisis Care Concordat and I have a couple of concerns arising from it –

- Vanilla tweets – of themselves – don't tell us much and they never, ever have. I can see, however, that they may be infrequently necessary.
- Vanilla tweets on the subject of the CCC imply little difficulty in resolving the thirty to fifty year evolution of problems in policing and mental health.

It's almost as if history has been somewhat erased and it makes me wonder why we ever had any problems in this arena because just one or two meetings and we seem to be sorting it all out without much difficulty! This also strikes me as highly unlikely. Take it from me, it took five years of my life (that I'll never get back) just to sort out section 136 Mental Health Act Place of Safety provision in one area. That's before the subject of Liaison and Diversion (whatever that means); patients who are absent without leave; and the multitude of other problems that all areas face to one degree or another.

Principle amongst the 'other things' should the creation of a system that avoids the need for as much crisis care as possible, because help is available before people have 'one foot off the bridge', to quote the Mind report on crisis care.

CRISIS CARE CONCORDAT

You can look at the Crisis Care Concordat website for yourself if you want to read more about it or see the local progress mapped out for us all by the mental health charity, Mind. They will be chivvying people along for progress updates towards the end of the year.

One problem with the Concordat always was that it simply puts into one handy document with a checklist and a schedule of work, all the issues that we know have been problematic for decades, imperatives for which already exist. This, as Winnie the Pooh said, is "a good thing" – if you want it summarised and neatly presented and for those professionals in policing and health who are relatively new to this, it's a great tool to help you start benchmarking where you are and working out how to plug the gaps. However, if you're familiar with the field, it's all very last century in some respects. Some commentators asked upon publication, this stuff is already written down in range of documents – why do it again?

So the Concordat asks us to address crisis care and in some areas this will mean that everyone works out there is overuse of section 136 by the police and, even allowing for the overuse, under-provision of health based places of safety by the NHS. The Concordat would say you get these things into the Action Plan that is submitted with your Crisis Care Declaration in November 2014 and look to improve this position over time. So you'd probably train your officers better on the use of the power, consider a phone or street triage approach so you reduce usage and look at expanding provision. Sounds easy doesn't it?! Here's the problem —

We've known that these things needed doing for at least twenty years and there are already various statutory imperatives to do so – what does the Concordat give us that laws and statutory regulations didn't?! If we can ignore statutory guidance on the Mental Health Act, what is it about the Concordat and its implications that we won't ignore?

Well, the idea is that this will be driven a lead in a way that wasn't previously there – this is "a good thing". And there is no doubt that areas are now talking whereas previously, they weren't – this is "a good thing". Arising from discussions, some areas have filed their local Crisis Care Declaration, implying that they now have a jointly agreed action plan to allow progress in 2015 and beyond – "a good thing". However, there are many more areas that don't seem to be fairing quite as well.

IT'S GOOD TO TALK

I'm assuming that in some areas, these joint CCC meetings have led to some of the discussions that I had when you have culturally diverse organisations coming together to discuss issues. You get doctors and NHS managers who know comparatively little about the law, getting together with police officers who know little better to discuss issues that are bedevilled by the received wisdom and inherited thinking of generations of professionals who've gone before them. And they are having to do it with fairly dreadful data sets about 'stuff', in many cases.

In some areas, no-one fully knows how many section 136 detentions take place, where they go or what the outcomes are. There are myths and personal opinion abounding about what percentage of those detentions is 'appropriate – despite the fact that no-one seems to be offering a definition of what is appropriate. No-one looks at how many section 136 detentions are 'repeat' detainees or how many were already known to the MH, perhaps indicating a breakdown in the care plan. No-one knows the percentage of people arrested for offences who are known to the MH trust and no-one seems to be trying to define what 'diversion' means in terms of when the police push ahead with a prosecution decision for an offence when they know the offender is mentally unwell, as opposed to when they don't.

Legal training in all the professions is parlous: I learned again this week having a child in an 'adult' place of safety is a safeguarding risk. What do we think is not a safeguarding risk about having a child in a police cell, not too far away from a masturbating drunk who is singing sex songs or threatening sexual violence to the custody officer? I can only imagine that in just some CCC discussions about certain issues, the myths and folklore are raging hard, with professionals of all kinds arguing they can't do things they actually could do, that they shouldn't be doing things that they'd prefer the other agency to do.

LET'S TALK ABOUT VULNERABLE PEOPLE

And nothing in this blog post so far is about vulnerable people is it? … their rights to effective police responses, accessible crisis care and dignity and respect for their human rights whilst in contact with the state? Those people who experience the indignity of being detained in the cells under s136 because they had the temerity to have a few drinks (or more) – to stop the voices in their head, or at least make them quieter. None of this includes references to the difficulties that some patients have in Accident & Emergency despite very obviously being there appropriately to access some kind of care that is otherwise unavailable and inaccessible. We're not even talking about the ongoing extent to which our mental health care system is being increasingly criminalised by reliance upon the police and the justice system just to make *extra sure* that some face the extra stigma of having cops staring at them whilst the NHS do their thing with all that we know the feels like for some.

The Crisis Care Concordat will be examined next month for progress and as things stand just four areas out of 43 police forces and 57 mental health trusts have submitted a local declaration with an action plan. I've already heard that some areas feel they will be unable to submit anything by the November deadline. I've also heard that some relevant senior people have only not read the CCC, they hadn't heard about it, as of a month or so ago. Quite remarkable, really. So we need to continue to raise awareness of its

imperatives and remember, that most of them arise from existing laws and NHS guidelines anyway.

It's what we should have been already doing – for some **thirty years**, actually!

If one or two CCC meetings is all it has taken to get complete agreement about what we need to do, then I'm thrilled. I'm also quite unconvinced.

16th October 2014

Ten Minute Rule Motion –

A few weeks ago – and all of a sudden – a Member of Parliament laid down a ten minute rule motion in the House of Commons, aiming to amend section 136 of the Mental Health Act 1983. After accompanying Metropolitan police officers on a patrol one evening, Sir Paul BERESFORD MP witnessed the handling of a mental health crisis in private premises. A young woman was found stood on the window sill of the 14th floor of tower block in Wandsworth and an officer managed to talk her down from it. Whilst still in the premises and beyond the reach of section 136 of the Mental Health Act, the young woman refused all offers to voluntarily access assessment, presumably by going to A&E.

Concerns for the young woman's welfare were so serious that the officers called upon local mental health services and to be fair, were joined at the address by a mental health professional. Whether this was a mental health nurse, an Approved Mental Health Professional or any other kind, is not clear, but we do know that they believed the young woman needed to be detained for a full mental health assessment as she again refused offers of help. Although the precise legal mechanisms by which Sir Paul witnessed the woman being removed from the premises remain vague, he reported that he was stunned to learn a similar incident in a public place would have led to immediate police action to safeguard the woman, but that in private premises it was beyond the legal authority of the police.

There is a now a page on the Parliament website to track the progress of the Mental Health Act (Amendment) Bill 2014, if you wish to obtain email updates about progress.

LEGAL FRAMEWORK IN PRIVATE PREMISES

1. You can arrest people for any offences they are committing or attempting – she wasn't.
2. You can arrest to prevent or apprehend a breach of the peace – there wasn't one.
3. You can defend your intervention under the Mental Capacity Act, if it is in relation to a deprivation of liberty for life-threatening situation – once she was down from the ledge, it was no longer that serious.

If anyone else is familiar with another legal method of allowing unilateral police intervention, I'd love to learn it!

So this rehashes a very well-worn debate – we've been here so very many times before. We've seen the Metropolitan Police sued successfully for handling a very similar incident and attempting to defend actions with reference to the Mental Capacity Act – the case of Essay v SLAM and the Metropolitan Police Commissioner. We've seen South Wales Police sued for using breach of the peace in the premises and then changing over to the Mental Health Act 1983 once outside – the challenge of Seal v Chief Constable of South Wales failed on a legal technicality about section 139 MHA but Lady Justice HALE remarked in passing that what the officers did was probably unlawful.

We know from other, real examples that where criminal offences are committed amidst a mental health crisis, police officers will resort to those powers of arrest if they have no other choice, somewhat criminalising people in the process. The case of Webley v St George's and the Metropolitan Police Commissioner all began after a very obvious crisis incident in private – because the very unwell and probably very frightened Mr WEBLEY threatened officers with violence before attempting to jump from a first floor window, he was arrested for the threats to keep him safe. I wonder whether one day a barrister will challenge arrests for offences which are in all reality, proxy powers of detention under the Mental Health Act. I also wonder what they would have done if a Mental Health Act power were available to them?

We should ask ourselves why this issue keeps coming up. – The Government is conducting a full review of the legislation in sections 135 and 136 of the Act. Why are they doing this? – because we keep seeing examples of officers who feel somehow forced into a decision to act, whether or not they realise they are acting unlawfully and not to act is to leave someone at obvious risk. Why would you risk the consequences of this when so many stated cases have said it is unlawful? – Well the view is sometimes put that it's preferable to risking the consequences of not acting. Either way, it's about selecting the least bad option from a range of utterly rubbish, frustrating options that you could be justifying to inquiries and / or courts for years.

The most ridiculous thing about such an outrageous point, is that it absolutely is NOT restricted to police decision-making! It is a human instinct to want to safeguard people at risk and public sector employees are often in the jobs they are because they want to keep people safe, help them and protect them from harm.

MENTAL HEALTH PROFESSIONALS

So with the police looking as if they can't stop themselves acting illegally, what should they do to get it right?! Well, in the Essay judgment, it was remarked that the Mental Health Act 1983 affords a full suite of options to intervene, including urgently. The judge reminded us all that the police can call upon mental health services in order to ask for an Approved Mental Health Professional (AMHP) and a section 12 Doctor to attend the location and conduct an urgent assessment under s4 of the MHA.

I will admit, upon reading the judgment, I laughed at it – out loud. The idea that an AMHP would respond to a police request without first wanting a mental health nurse to screen the need for it, was fairly hilarious. Even if they would respond, by the time they've found a section 12 doctor and possibly having travelled via a Magistrates Court for any warrant they may require under s135(1) MHA, I'm not anticipating any support for at least four hours. There are simply insufficient AMHPs to ensure a 999-style response to calls for urgent assessments. Many would argue that this is not what AMHPs are for. Certainly most local authorities or mental health trusts don't staff their AMHP rotes to deliver this kind of service and since section 114 of the Mental Health Act 1983 was amended to remove the need for local authorities to ensure sufficient AMHPs to meet expected demand, there is no statutory basis for police forces or anyone else to argue that AMHPs should be available in this way.

In a seventeen year career, fourteen of which has been operational frontline policing (and three on mental health!) I have been in the position witnessed by Sir Paul BERESFORD on dozens of occasions. I had hoped that since the Essay judgment that things would change – given the legal imperative that this case nearly represents, remembering that it is not an Appeal Court ruling and bearing in mind how many protests AMHPs and Place of Safety nurses have made over the years about these kinds of actions. I couldn't have been more surprised – instead, I found that CPNs and AMHPs are actually inclined themselves to suggest the very thing that we are told the police should be trying to avoid.

"Can't you just get him outside and 136 him?!" Incidentally, if this is not phrased correctly, it could be construed as inciting the criminal false imprisonment of the person concerned! That aside, I've also seen written advice about this kind of predicament that advises misuse of the Mental Capacity Act. It turns out, that when you place mental health professionals in this position, you sometimes end up with similar instincts – to keep people safe, first and foremost.

So Sir Paul's incident is not just about the police and we shouldn't forget that it appeared to end with two police officers and one mental health

professional as well as two paramedics (and an MP!) removing a person from their dwelling whilst they were objecting. Not one of these professionals or all of them taken together has authority to do this and so the action taken appears on the face of it to be unlawful! The lawful route to MHA assessment is for an AMHP and an s12 Doctor to do an s4 Mental Health Assessment at the house, or get an s135 (1) warrant to remove the young lady to a place of safety. The only lawful thing the Metropolitan Police could have done in these kinds of jobs is to inform mental health services and walk away.

I wonder what families, Coroners and the IPCC would think if that was the action the officers had taken and then there was an untoward outcome. Do we imagine that the sound of police officers arguing technicalities as to why they could do little more would lead to everyone nodding and saying, "Fair enough"? No, neither do me.

SO WHAT DO I REALLY THINK?

I think this ten minute rule bill will fail. At the second reading on 07th November, it will be pointed out that the Government is undertaking a full, formal review of sections 135 and 136 of the Act and that this review will fully report in 2015. The Home Office is convening a particular discussion in early November about this *very* situation to determine what recommendations should be made to ministers.

I think that changing the law by extending police powers is a very poor, third-best option of how to solve what I must insist is a *real* problem. **Option One**: you have to wonder whether or not mental health professionals could be made sufficiently accessible and flexible to be able to respond? In my experience some mental health professionals agree that an increased focus on 'emergency psychiatry' is required given the model of care we operate and maybe this is something that Crisis Care Concordats could address? **Option Two**: could legislation or statutory guidance towards mental health services be amended to ensure a response in support of the police or instead of them? Well, even before s114 was amended, removing a statutory need for sufficient AMHP provision, there were never sufficient AMHPs in all areas to know that one of them could drop everything else and come running. Even in some areas where they could, they may have problems with s12 doctors and / or s135 (1) warrants. It's only after using history to evidence why Options One and Two won't or don't happen, that you reach the point where the police could do things differently – **Option Three**. If they ever will, it will require a change of law that no-one really welcomes as the ideal solution.

Of course, there are many objections to changing the law and I do understand them – it would erode our civil liberties, some argue it may impede upon our fundamental human rights —

Be let's be clear about one thing: the United Kingdom in the twenty-first century currently cannot ensure the basic safety of vulnerable people because it's mental health services are either under-resourced and / or inefficiently deployed – or because its police service is under-empowered, depending on your point of view. To avoid doubt: if that young woman did not want to leave her address and wasn't allowed to exercise her own decision to remain, then her removal was **illegal** – because no mental health professional can unilaterally make the decision to authorise it any more than a police officer can.

So it turns out that our civil liberties and human rights are at risk anyway! I truly hope someone can come up with a realistic and workable way to convince us all that options One or Two can translate into the real world. It's only because no-one has convinced me so far that I've resorted to Option Three in my head but I do remain willing to be convinced. Someone just has to say something convincing!

21st October 2014

Evidence Based Policing –

The creation of a professional college for policing – part of the professionalization agenda – is an opportunity to work towards becoming evidence based. This is something that has been made clear to me over the last two months and something I've been arguing for years, incidentally! We can look around and see that the College and individual police forces are trying to engage academics to bring research skills into policing and actively build that evidence base. West Midlands Police and the Metropolitan Police are just two forces hosting research fairs and inviting academics into their organisation with the aim of understanding what works in policing – and why?

Evidence is key to this – being the police, we should be concerned about the standard and quality of our evidence, shouldn't we?! We are in criminal trials – why haven't we been overly concerned with it terms of evaluating interventions? We see examples all around us where evidence is not being brought to bear on the claims we make – again and again, I see this in policing and mental health. For example, that the Centre for Mental Health, in writing various documents about liaison and diversion services, has said, "the evidence for liaison and diversion is just not there." It doesn't mean there is evidence of it not 'working' – whatever that means – it just means we haven't (yet) gathered the data to show it works. Let me show you another example of where we're not relying upon evidence.

I have repeatedly heard in the last two months that 'street triage is saving officer time' and other claims implying the same. You can see for yourself in the recent HMIC report 'Core Business' (2014, p116) – there is clear wording that the introduction of street triage has seen average assessment times for 136 fall 'from eight hours to five'. We see the same report imply that street triage has reduced the time spent dealing with the consequences of section 136 detentions and an example is given of a force where over 13,000 hours of time was spent in 2013 waiting for assessments. (This amount of time has more than doubled in two years, incidentally – so we can all agree that the force concerned will want to do *something* about the ever-increasing tacit consumption of their resources by the mental health system.)

So does it *actually* save time? – And is that *actually* the point of it?!

THE EVIDENCE FRAMEWORK

Let me firstly suggest that the evidence you would want to gather around you concerning street triage will be highly dependent upon what you see as the point of it all. If you're wondering about the time it saves you will need to know certain data; if there are other objectives, you'll need other data. To test the proposition that it saves time, you would look to gather *proper* evidence about time spent on s136 *and* time spent undertaking new 'street triage' approaches.

- Usage of section 136 prior to street triage
- Usage of section 136 after the introduction of triage
- Data about the average time spent by officers waiting for assessments
- Data about the average time spent by officer assisting with detention and conveyance for those patients who are subsequently admitted to hospital after assessment
- Data about time spent talking people home who were not admitted to hospital after the use of section 136.
- Data about the time taken to deal with those incidents that previously would have involved use of section 136 MHA but will now be handled differently because of street triage – these jobs don't go away, they are just handled differently and that takes time, too!
- A clear understanding prior to the introduction of 'triage' of your areas s136 usage – how much of it is appropriate / inappropriate (you may have to define this yourself!);
  – how much of it represents 'failure demand' that could and should have been prevented from reaching the police in the first place;
  – how much of it represents 'value demand' which was perfectly proper, necessary use of the power which can now be handled differently because of the ability to engage the NHS far earlier.
- If you're really doing it properly, you may need to have a control area – where 136 usage and health funding or infrastructure is similar; where demographic and epidemiological data is similar; and where police training and resourcing are similar.

Then – *and only then!* – can you start to work out what impact street triage has had. The factors mentioned so far are only those you would need to start evaluating the impact on the police – and I've cut short the list of things you'd probably examine! I could go on and on if we start to think about the impact on health and social care. I repeat the point: you have to be asking yourself evaluation or research questions which address the issue "What are you trying to achieve by this scheme." What is your objective or objectives?

WORDS AND DEEDS

This is really important to any evaluation: we need to be clear about what we're actually trying to achieve because otherwise, how do you know whether you've succeeded? I heard recently that street triage is about 'reducing the use of s136 – the end'. That's fine – so if that's what you're trying to achieve, why are street triage schemes busy trying to do other things? Are they just over-resourced for their main purpose and kindly helping out with other extraneous 'stuff' or were they actually always there for a broader purpose? This question is really important and in no way flippant – because it affects the research and evaluation questions you ask yourself in relation to which you then draw on or seek out particular quantitative and / or qualitative data.

One other area told me "We're trying to reduce the use of police cells." Great – who could object to that? But please tell me why street triage is being done in areas that weren't really using the cells anyway? It really *must* be about other, broader issues, otherwise areas like Birmingham wouldn't be doing it at all – there was cell **no** usage to reduce! Reduction in the use of the power AND a reduction in reliance upon police cells? – Still doesn't explain why triage services then do things that achieve neither purpose and it doesn't allow you to pose a proper research hypothesis that can be tested by proper inquiry.

If the activity of street triage schemes is undertaken somewhere other than in public streets, then it's clear we *must* be trying to achieve something else – as well or instead. So what is it we are trying to do? That needs to be part of your evidence base as you assess these things. I admit that I personally have long since stopped judging schemes by what they say they are trying to do – I look instead at what they are actually spending their time doing.

Points about mental health street triage from various areas:, they are not responding in their multi-agency vehicle to most of the incidents they are contacted about; they are 'dealing' with incidents (often from afar) that are two-thirds of the time being hosted in people's private homes; triage is seeking to avoid s136 usage but that was only ever a possibility in one-third of the incidents they attend and it seems to be occurring in areas regardless of whether the cells are being relied upon as a place of safety or not and irrespective of how that police force is perceived to be using the legislation in the first place.

So it's about some else or something far broader, otherwise they wouldn't be wasting their time on extraneous 'stuff'. I'll let you decide for yourself what you think it's about!

SAVING TIME

What I do know is this: a police officer works for 2,080 hours a year (without working any overtime). So we can look at the various schemes and work out how many hours and pounds are being expended in providing it. (Let's just stick with the police service, for now.) We can then look at the reductions in the use of the power and the use of the cells and work out the time and / or money saved. Let's say, that a force with 1,000 detentions per year reduced s136 use by 40%, therefore avoiding 400 instances of two officers sitting in a place of safety pending assessment by an AMHP and a Doctor.

If the average wait was four hours per detainee after the half hour that the Royal College of Psychiatry standards suggest the police should spend handing over, we can then do the —

400 (avoided detentions) x 2 (police officers per detention) x 4 (hours spent waiting per detainee) = 3,200hrs saved. If your street triage scheme requires four full time equivalent police constables to deliver this, then you are expending 8,320 hours to achieve this. If you're new improved arrangements also mean that you reduce the average wait from 4hrs to 3hrs, you can recalibrate that answer to suggest that 2,400hrs were saved, but that you also saved time for those detentions that still occurred.

600 remaining detentions) x2 (police officers per detention) x 1 (hour saved by reduced waiting times) = 1,200hrs saved. So you can celebrate a total of 3,600hrs saved overall before moving on to 'do the math's' for the health and social care investment, versus saving and pose that back against your new operating model.

You could also work out the custody time saved if police cells were still being used. Where a street triage scheme brought about end of custody being used as a place of safety after previously having seen 250 detentions per year in the cells, averaging 10hrs each, you can calculate the implications and therefore the cost. Half an hour of a sergeant's time saved per detainee booking them in, 5 minutes of a custody sergeant's time for every subsequent hour in custody; one consultation by a police doctor; 5 minutes for every hour in custody for a detainee to be attended to by the custody assistants and 10hrs of someone undertaking level three or level four observations in custody. Forces model this time and cost different – for our purposes, I'm simply making the point that you could calculate it.

REDUCING 136 AND CELL USAGE

So if we're trying to reduce s136 usage: Great, we've reduced it by 40% – job done. But we can't claim in our hypothetical model that it has actually *saved* time. It is actually **costing** you time: because in order to save 3,600hrs overall, you are posting four FTE constables to the position and expending 8,320 hours of effort. This is a net loss totaling 4,720hrs – in other words it is more than two full time officers for the area where the scheme works. Well done.

Police time is FAR from being the only important thing in these issues, however – but the point I'm making is that we are claiming we need to be evidence based and claiming we save officer time when we actually seem to be spending it! But what price human dignity, less restrictive assessment options, faster responses to incidents of mental health crisis care by the health service? ……. ALL of these things are not easily measured in terms of hours and pounds so perhaps the emphasis should be on these positive outcomes and greater human dignity which is worth paying for (up to a point, given that budgets are finite).

I was talking to professionals today at a Crisis Care Concordat meeting asked them 'How many people in your area ask for urgent help whilst in crisis?' (Accepting that 'crisis' isn't defined.) No-one knew – it's fair to say no-one knows in any area! But if we don't know how many attempts are made to seek crisis support, how can we tell how many of these incidents were managed correctly, at the first time of asking? How can we evaluate whether crisis demand for the police today, is failure demand from attempts to access support via the Crisis Team earlier today or yesterday. How many people who've attempted to access Accident & Emergency today, had attempted to access their GP or Community Mental Health Team before self-presenting?

No-one knows. So we probably need to take crisis care back even further and ask even more fundamental questions about what we're trying to achieve before we can put street triage in its proper context and determine that it's an answer to something – but only after it is properly evaluated and we have evidence, not anecdote!

28th October 2014

Learning from History –

Here are two ways of saying exactly the same thing —

- "Most people who are violent need a policeman, not a doctor!"
- "Some people who are violent need a doctor, not a policeman!"

I raise this because the first quote comes from a medical handbook I once picked up in a book shop – probably one of those Oxford University Press handbooks with very thin paper pages that you see junior doctors carrying around the place and stuffed into the lower pockets of white clinical jackets. It was part of a section on responding to violent or disturbed patients in A&E and I've left uncorrected the author's gendered stereotyping of my profession!

IN TWO MINDS

I've now told the story A LOT of the poor guy who was extremely resistant (and probably quite frightened) having been detained under the Mental Health Act by some police officers who were then told to remove him from A&E because his violent attempts to self-harm. Ongoing restraint by the police had been the only way to stop him hitting his head (which was already cut) and they were all too aware of the dangers of prolonged restraint. In terms of the effect on other people in A&E, there was certainly audible disruption but little else because the officers were ensuring that his behaviour did not physically compromise the safety of others. Nevertheless, A&E staff asked the officers to leave without any clinical examination occurring as to what could have been causing or underlying his presentation.

Three days later, the same police response team took a drug dealer into the same A&E after he'd been hit about the head with a metal bar during a dispute about money that ended badly for him. He took a serious knock to the head and had to be manhandled (under the Mental Capacity Act) to A&E because paramedics were very fearful of what may have occurred internally. His violent resistance was significantly greater than the first man's and although still largely contained by the police, it was impacting beyond the audible and he had managed to kick an A&E nurse whilst thrashing out. No request for him to leave – each could have been suffering

from a life threatening condition and / or could have suffered from the impact of restraint. The NHS have guidelines on these issues – showing that it is something that needs more than a visual inspection of how resistant someone is.

That's why I juxtapose my own, second bullet point and ask this: where there is doubt about whether a person who is violent needs a "doctor or a policeman [sic]", is it the job of the officer to determine which category someone is in, or that of the doctor? In easy in the straight-forward cases: it will be the officer – we often make judgements that someone is just angry and there are few medical risks from restraint beyond handcuffed marks to the wrists. But where restraint feels qualitatively different – mainly where the need for it is ongoing – it starts to suggest that other things could be in play and that's where the NHS needs to kick in with paramedics and from time to time, an A&E doctor.

AN EMERGING NARRATIVE

This post is not going to be much longer, because I've said all this before but in the last twelve months we see an emerging narrative that is pushing more and more for police stations to use to contain violent detainees with considerable ambiguity about how that decision has been reached. We saw in 2013 a joint inspection report from Her Majesty's Inspectorate of Constabulary, the Care Quality Commission and the Health Inspectorate for Wales, *A Criminal Use of Police Cells* which stated (p 18) "A police station should only be used where it is absolutely necessary to provide containment for someone **whose violent behaviour** would pose an unmanageably high risk to others." (My bold emphasis.) Last week we saw the CQC Report *a Safer Place to be* which states (p29) "Police stations should only be used in exceptional cases of seriously disturbed and aggressive behaviour."

Of course, we can argue about what "violent behaviour" actually means and what "seriously disturbed and aggressive behaviour" is – the fact is that none of these phrases is used in the Mental Health Act itself, or the Code of Practice – and on what basis are we going to identify these (fairly obvious) presentations but distinguish them in accordance with the two bullet points at the top of this piece? My point is, that neither HMIC nor the CQC (or anyone else!) tries to do so – not at all. As such, we don't have a public discourse about these difficult issues and the reason why they are difficult, is because we know that such presentations have been the stuff of death in custody inquiries for decades. There are currently several UK police officers being criminally investigated by the Independent Police Complaints Commission for alleged manslaughter and willful neglect arising from incidents where it turns out that they basically did what our UK inspectorates think they should be doing.

At last week's Summit in London, the Home Secretary spoke on these issues and the need to improve. Not just the need for the police to improve – Lord ADEBOWALE is out front of us all pointing out that the police cannot do this alone. We also need the NHS to improve, which is why we are now seeing various events to develop actions plans for the Crisis Care Concordat; and we also need our inspectorates to improve. We cannot, surely, continue to push out much generalized statements like this without qualifying what we mean, by introducing extra-legal considerations to our legal framework and in effect suggesting that we keep doing what we've always been doing. Various indicators suggest that mental health demands for the police are rising – suicide is rising, use of s136 MHA is rising (by 35% in the Metropolitan Police area in just the last year). As such, the very small percentage of incidents that are as unpredictable and tragic as those we've seen in history are more likely to feature in our demand.

And we're running out of excuses – if we haven't already – for why we keep bring simplistic (policing) solutions to complex (medical) problems.

NOVEMBER 2014

15th November 2014

Pavlov's Dog –

In the last few months, I've found myself in various rooms with professionals of all kinds, including police officers, finding myself saying the same thing over and over again that I was saying in 2004 when I first started working on this. Last week, I actually found that I was quite deeply boring myself witless when I realized that my mouth was on 'transmit' for some standard argument to reject a common misconception, whilst my brain was not fully engaged. I found cerebral space to remember that I have to get my car Most'd in the next month or so and somewhere in my head I could hear my voice as if it were coming from elsewhere and my brain found space to say, "Oh, for God's sake – do we gave to discuss this AGAIN?!"

Of course we do have to discuss it again – because we've still got so much progress to make and given how far we've come in the ten years I've been working on this, I'm already wondering whether this will get sorted before I retire in 2029.

For example, let's think about the Crisis Care Concordat. The process means that local areas should meet to decide whether the signatory organisations agree in principle to work together. They don't actually have to do anything – just agree to do so. Yet it's still taken nine months or more! Why!!

PAVLOV'S DOG

If you were to tell me that A&E is "not a place of safety" then there's a standard response to that. Tell me that extremely resistant or aggressive detainees have to go to police custody if they are detained under 136 of the Mental Health Act and I have a few standard responses – some take longer than others! Tell me that you can only obtain an s135 (1) warrant if we already know that access cannot be secured? – Again, a standard response will emerge.

Ten years of banging on and ON and ON; again and Again and AGAIN.

It's amazing how pervasive certain myths are – and I'm casting my aspersions widely here, including within my own profession. I still keep

hearing A&E colleagues talking about whether they are a 'designated place of safety', the implication being that unless somewhere is, the police cannot remove a person to that location under s136 of the Act. As soon as someone can tell me the legal reference for that concept, I'll be right in the conversation! In reality it's not even a 'thing' – the word 'designated' is in the Code of Practice to the Mental Health Act only twice and neither time, in relation to places of safety or section 136.

I keep finding that police officers, A&E staff as well as mental health nurses and, I'm afraid, even AMHPs keep tripping over themselves in conflation and / or confusion —

A police officer recently told me that if you find yourself in a private premises with someone who is in immediate need of care of control you can detain them to prevent a breach of the peace, as a proxy for the Mental Health Act, irrespective of whether you would want to place that person in court. Err, no … you can't! The case of Hicks v Commissioner [2014] showed us this – you must have an intention in your mind when arresting to prevent a breach of the peace, to place that person before a Magistrate as soon as one becomes available.

So I'm worried that as areas are piling in to the issues they are going to tackle as part of their work on the Crisis Care Concordat, there will be more challenges than we could do with having to handle – yet handle them we must. We know that the Concordat did not arrive with a pile of money attached and that better partnership working must be achieved within existing financial envelopes, but we also find that we don't fully understand the interface of our organisations, legally speaking. I'm still waiting for a convincing, detailed answer to the question, "When are liaising, when are we diverting; who is making this decision and how?"

FAILING TO LEARN LESSONS

Street Triage initiatives are exposing mental health nurses to some operational of the operational dilemmas that every frontline police officer knows all too well – and their reactions are proving to be the same as the ones the police have already been told off for! We know from the case of Essay v SLAM and the Metropolitan Police Commissioner [2010] that you can't use the Mental Capacity Act 2005 as a proxy for the Mental Health Act either. And yet that's exactly what a street triage nurse was arguing to police colleagues earlier this month.

I've known Crisis Teams to ask, "Can't you just get him outside and 136 him?!" Not without breaking laws, I can't – so no. But a query I had from Professional Standards Departments indicates that some officers still think they can arrest someone to prevent a breach of the peace and then, once

outside the premises, de-arrest and re-arrest under the Mental Health Act. It's more than a decade since South Wales Police did that and were sued for it. Although something of a technicality meant that challenge wasn't successful, the judge still made it abundantly clear they acted unlawfully.

If the Crisis Care Concordat means that we are going to get agencies together and do things properly for the first time since the evolution into a highly deinstitutionalised model of mental health care, it doesn't just mean agreeing to work in partnership and help each other, but it means understanding the legal framework within which that has to sit. We've seen examples of services predicated upon disregard or ignorance of legal frameworks and oddly enough, they tend to be the backdrop to various kinds of disaster and difficulty.

Writing this particular post was a fairly boring half hour of my life that I'll never get back, ameliorated only by also watching a very funny comedian whilst alluding again to those things I've said many times in BLOGS over the last three years. This post also marks the three year anniversary of my BLOG and I've now spent way over ten years working on this business, so you'll have to bear with me as everyone is finally getting excited about policing and mental health because most of the problems we have could be sorted in a year or so – if there had been sufficient will. Ten years in and I sometimes wonder whether there is – and that's why I wonder what things will look like when I retire in fifteen years' time.

I hope the Crisis Care Concordat means we've reached some kind of critical mass but whether we have or not, we're not going to get far unless everyone at this interface has appropriate legal education – from commissioners to senior managers on all sides, right down to frontline staff. Different amounts and kinds of education, varied by role. Maybe that's a specific thing that all areas should have in their action plan?! Applied legal education in mental health and related criminal law, as well as health and safety and human rights law. I'm sure I heard that somewhere once!

19th November 2014

Concordat Colors –

The Crisis Care Concordat has its National Summit in London next week – a gathering of all the signatory agencies in order to mark progress ahead of the first big deadline. For those who follow me on Twitter, you'll notice that I keep uploading a developing map of England, shaded in various colors, like this (as of November 19th 2014) —

This is what the colors mean –

- **Red** – no progress yet recorded. Doesn't mean nothing's happening or that discussions aren't occurring. Just that they haven't yet delivered the first outcome.
- **Yellow** – **the first outcome**: this means that individual areas have agreed in principle to work together to deliver what the Concordat aims to do and that they are going into 2015 with the intention of delivering an area-specific action plan to work out what in particular needs doing locally.
- **Green** – **the second outcome**: this means that areas have completed and jointly agreed their action plan with that commitment to deliver upon it.

The keen-eyed amongst you will obviously recognise that **nothing** needs to *actually happen in the real world* for an area to 'go green'. Your local services could, in theory, be completely and entirely unchanged and unaffected, despite going 'green'. For this reason, I want to put an argument for in introduction of another color … or two! Do we also need

something that says "We've delivered our Action Plan"? … Perhaps one color for 'delivered in part' and another for 'delivered in full'?!

This suggestion hits at the heart of certain frustrations that many have – and I'm not just referring to police officers here. When are we going to stop talking about this and DO something? Action plans are great – it doesn't actually mean a damned thing has changed or been done, quite frankly! Actually, whilst some areas are meeting to discuss their commitment and / or their action plans, some of them are also busy closing place of safety services and reducing hospital beds which will increase the pressure at the bottleneck of crisis care. There are AMHPs, mental health nurses and doctors working in frontline mental health services who are just as weary anyone else having worked their whole 35 or 40 year careers with the same frustrations about the crisis care interface. Difficulties in arranging the detention, conveyance and safety of vulnerable people have been ongoing for decades.

So whilst the Concordat is bringing people together and we are seeing chat, declaration and plans it's vital that local leadership turns this into an operational reality on the ground because patients and victims live there, not in meeting rooms where concordats are discussed and plans are conceived. And a final plea from me in this short post: something I've concluded all over again now that I'm back in the thick of this – Concordats need to have a detail for proper, applied legal education for all of the health, police and social care professionals who will be involved – and NOT just frontline staff. No point managers conceiving how services will be built and run, unless those services are predicated on the legal frameworks that govern us all. I still read and hear legal nonsense, most days as my last post highlighted.

More —

- Download the Concordat document itself.
- About the Crisis Care Concordat
- Load the latest version of the CCC map to check your area's progress.

20th November 2014

Witness Warnings –

The Crisis Care Concordat is ensuring that a lot of discussions occur about the interface between the police and our mental health system, amongst other things. We are quite predictably hearing a lot of the standard lines about "joint working", "partnerships", and cutting across silos and so on and so on. It's the *lingua franca* of these things that we have to work together, which I am unable to hear without recalling the Birmingham accent from that appalling Prudential advert "We want to be together!"

I've thought hard these last few months about what kind of policing and mental health interface I think we should be trying to build – not least because I'm involved again in trying to build it! What are we actually trying to achieve here? We could use the police in any number of different ways and I'm sure that views vary about the extent of the role the police should play in administering our mental health care system.

This post is about my vision for this, in the context of hearing cries by various people who argue for a blurring of boundaries – and I will warn you now that it's slightly longer than my average post, so pause and pop the kettle on before you continue!

THE ROLE OF THE POLICE

I keep coming back to this —

- I want the police to be as **uninvolved** as possible in our mental health care system;
- I want the police to be as **involved as possible** in the response to mentally disordered offenders.

I put these two things forward against the backdrop that we already know from my favorite criminological quip that "policing is what happens when something's happening that ought not to be happening about which somebody ought to do something now" and that "there is nothing that could not become the legitimate business of the police." Of course it does not following that everything *is* the legitimate business of the police, who are something of a crude safety net and checking system – the police service

(and the broader criminal justice system) is a secondary, not a principal lever of social justice.

There are ideas in both of my aspirations that need explanation —

MENTAL HEALTH CARE

Parity of esteem has to start with this, for me: we don't routinely involve the police in the care and treatment of people with hip replacements or cancer. Only in fairly weird and exceptional circumstances do the police pitch in with things connected to oncology or orthopedics and that's usually around preservation of life issues, which falls under their remit anyway. So why would we *want* the police involved in our mental health care system any more than is absolutely necessary? Notwithstanding my passionate interest in this issue, I am not and never will be a mental health professional: I am a police officer and I, like many of my colleagues, joined the service for certain reasons. I have my views about the health system, I have my views about the mental health system – and believe it or not, many of them go unexpressed on this BLOG because they're not relevant to the professional points I'm trying to make here. That being the case, it's fair enough for the police to remind everyone that we are here, constituted for a certain set of purposes:

- Prevent crime
- Bring offenders to justice
- Protect life and property
- Maintain the Queen's Peace.

But as Sir Robert PEEL made clear almost two hundred years ago: it is not *just* the responsibility of the police to do these things. The police are merely individuals paid to do on a full-time basis that which is every citizen's responsibility – the police are the public and the public are the police. This is why consent is so fundamental to British policing and over-involvement in the mental health care system means that for some of the most vulnerable, already marginalized members of our society, their involvement with the police service is not about consent, but about coercion: officers being called in by the mental health system in circumstances which are all too often connected with coercing them into systems which may or may not actually be effective. We know for example, that Community Treatment Orders don't work. We also know that when those kinds of legal orders are imposed on those of us with mental health disorders and are then 'recalled' under the Mental Health Act, this coercive revolving door is making little different to anyone and it could even be making things worse. Why should the police be involved in this, when there is absolutely no legal obligation to do so, in the majority of circumstances? Mental health services can plan and prepare for the

implications of their statutory activities if they want to – indeed the Health & Safety at Work Act 1974 rather expects them to!

But more importantly, what does the routine involvement of the police do for patient experience? You want or are perceived to need a form of healthcare and a professional who pops along has a police officer metaphorically in their medical kit. For what purpose? What is it that the police do? Well, they usually talk to people, enforce laws and apply lawful force to compel – but they are not the only ones who can do this. So what is the message here?! >> "You're having this, whether you want it or not – and I have come armed with the coercive apparatus of the state just in case the answer is 'not'. Can you see the Taser, the handcuffs and the leg restraints? – now let's talk about whether you think re-starting medication would be something you would like to consider." Remember, there are well over a million people in contact with secondary care mental health services in any given year, but only a small percentage of those are brought under the auspices of the Mental Health Act. We know that most of the contacts that mental health services have with patients do not and never will involve the application of the Act, so why involve the police in those that won't?

For all the times I've heard the argument about the presence of the police 'promoting cooperation', I've got examples where the presence of the police stigmatized and unnecessarily escalated the distress in a situation. For all the patients who have told me that the police are often a welcome, reassuring safeguard there are others who feel involvement of the police further stigmatizes and criminalizes them – so police involvement in non-criminal aspects of our mental health system is something to be done very, very sparingly indeed and without presumption about what involvement of the police will achieve. Patients are individuals with complex situations – one size doesn't fit all. This is (yet!) another reason why I have concerns about street triage: we already know that most interactions occur in places where legal 'enforcement' wasn't going to happen anyway – so what the officer is achieving by being there is a subjective thing that hangs on any given point of view or background presumption. But it does re-introduce the NHS mental health crisis system to some of its patients, which may be an end in itself.

CRIMINAL INVESTIGATION

Regardless of the reason for an offence being alleged, the police clearly have a role to play when incidents occur which involve offending behaviours or vulnerable victims. I want the police to be better at this. By better I mean, I want victims believed and supported where they are vulnerable – let's just STOP assuming that someone with a mental health problem is inherently unreliable as a witness in court. The CPS did this a few years ago in the case of B v DPP [2009] and were successfully challenged under

human rights legislation by a victim with schizophrenia who was probably far more reliable than some bankers, police officers or politicians! Many things *may* render someone unreliable as a witness, but whether it *does* so will vary from witness to witness. Anyway, does it really matter than a very unwell, victim who was attacked gave a statement to the police that seems unreliably inconsistent if the attack was also witness by two other people and captured on CCTV? Let's look to cooperate allegations with other evidence and deal with actual problems when they arise – not assume there will be problems before we've tried to secure justice for people.

I've written elsewhere on this blog: I want a more sophisticated approach to decision-making about mentally disordered offenders. Liaison and diversion sounds great to me, but only if we start talking about things and addressing issues that I've heard little about as new schemes have started to be piloted. I keep hearing about health interventions and health outcomes for mentally disordered suspects in police custody and at court: I keep hearing little about re-offending rates and crime prevention. The Centre for Mental Health admits that there is little evidence that liaison and diversion works, so let's gather proper evidence as we go and see what we learn in the future. The evidence may emerge: but concluding that we've made offenders healthier is only one side of the coin. We also need to know what happens to offending and re-offending rates.

And we need to make sure that whatever approach we take in Liaison and Diversion, we don't just build risks into a system that we thought was mitigating them. We know from the report into the treatment and care of Philip SIMELANE (who killed Christina EDKINS on a Birmingham bus in March 2013) that failing to take a longitudinal view of repeated arrests for a pattern of allegations that is increasing – in frequency, in seriousness or both – can lead to risks not being managed. But where individual offenders are arrested and on that day reach the threshold for the criteria of compulsory detention under the Mental Health Act to be applied to them, how do police and prosecutors take sound decisions about whether or not this should bring a permanent or temporary halt to an investigation? I've written about that elsewhere, but I submit that no-one is putting forward a comprehensive view of when acutely unwell offenders should be prosecuted notwithstanding how unwell they may be. And yet we know, occasionally – from time to time – it will be necessary and proper. But we also know that NHS contributions to investigations through information sharing and professional opinion are not where they need to be, either – so we all need to get better at this, for the sake of ensuring humane, non-criminalising outcomes where possible and public protection where necessary.

WE WANNA BE TOGETHER

So back to what this means for partnership working – we know that the police exists for a certain set of purposes; that this includes a broader public safety remit rather than a narrow focus on crime and that we will see officers involved in supporting the administration of the Mental Health Act and our mental health system, from time to time. But we know that there have to be limits to this – we don't want cops routinely standing on psychiatric wards and restraining people who are having medication forced upon them by medical and nursing staff. When the issue of 'safe and well' checks was being discussed on Twitter recently, there were some responses that indicated the police should just endlessly absorb requests for these things, partly because they always previously have. Apart from the unsustainability of this, it has to be remarked that some of these welfare checks are perfectly legitimately directed to the police and others are just **not** their responsibility. Agencies have a variety of means of checking up on the welfare and wellbeing of people who are not at immediate risk, who are not missing and who may benefit from checking. The resources that police forces are now pouring into checks for which there is no (broadly defined) policing purpose and which could be done equally well by others needs addressing.

"But we haven't got enough resources – we're too stretched as it is!" came the reply. If this means that things others are too busy to do because of high demand, under-resourcing or whatever other reason become police responsibilities, then we'll also have start work on fixing potholes in roads, cleaning streets after the nighttime economy binge we see each weekend and doing various other things, too. We know that the police don't fix road surface problems, but where they come across potholes that suggest dangerousness, they block roads, cone things off and call the Highways Agency. That they do this at all, doesn't mean they fix potholes – they just mitigate risks around those that may render people unsafe. But all of this begs a far more important question about 'partnership working' and 'working together across agency boundaries and silos' –

IS THIS A ONE WAY STREET?

For example, if the police are rammed busy on a Thursday night with a serious incident and high demand of 999 calls, could they ask the Crisis Team to visit addresses for late notice court warnings? Obviously, each evening, the Courts Service sometimes have to re-jig Magistrates and Crown Court trials for various reasons. This often leads to a request being made to the police that homes be visited to tell witnesses they are required at short-notice. Maybe community mental health teams could do these

things for us, if we're too busy to attend? After all, that's within the skill base of almost any sentient, responsible adult isn't it? – 'safe and well checks' on those of us with mental health problems, is actually not within the skill base and competence of a police officer!

Because remember: this is all about breaking down organisational boundaries isn't it? Let's stop working in silos, not erect exclusive criteria about whose job is what – just get yourself down to Mrs. MIGGINS and let her know she's needed up the Crown Court tomorrow morning without worrying about how you'll manage your patient caseload and your mental health assessments. The point I'm making here is not subtle one! – If the police were to say about 'police work' the sorts of things that some health professionals are saying about 'health work', it wouldn't move an inch in a partnership debate. It would be (rightly) dismissed as ridiculous!

Your police force has finite resources, folks! – we can only one thing at a time for each of the officers we have and for all the reasons made above about mental health care, deflecting demand to the police and telling them not to worry about the resource this is costing or the fact that prevents them doing something else, is actually about the opposite of partnership working which should be built on mutual respect for the differences between organisations, as well as the overlaps between them.

Some jobs are ours; some jobs are yours and some could or should involve us all – the fact that on some issues there are overlaps does NOT mean that in *all* issues there are overlaps and that we all can or should be doing everything.

21st November 2014

#CrisisTeamFail

I noticed a hashtag on Twitter last night that made me feel quite anxious but also intrigued – **#CrisisTeamFail**. Whether or not you've signed up to Twitter, you can still go on it and see the content. In short, various patients were tweeting their experiences of contacting mental health crisis teams and noting the replies that they received – it was revelatory in many respects, although I'm familiar with some of the responses people received because of what I've heard and seen as an operational police officer.

Before we get into this, I want to go out of my way to make one thing **abundantly clear** and please imagine me in a raised voice so there can be little or no doubt that I *really* mean this! —

- **We all know mental health teams are under-funded** – this is acknowledged right up to the level of HM Government ministers. We know that NHS England chooses to apply a differential funding arrangement to mental and physical healthcare, ensuring a recent 1.5% and 1.8% rise in funding allocations last year causing Department of Health Minister Norman LAMB MP to make his views very clear and he has continued to do so.
- **We know that when demand exceeds supply of staff** – this means they have to make decisions about what to prioritise. Like other public services with finite resources, this means that from time to time you will not deal with things that you would ideally like to deal with. Or, you will not deal with them as quickly or as well as you would like. The police do this too – as a duty inspector, I personally took certain decisions to that effect.

So, honestly – we *do* get it! The system is underfunded and ineffective and this is not the fault of frontline Crisis Team staff. We know this because we've seen the Crisis Care Concordat looking across the board from commissioning and commissioners to the detail of frontline provision across providers, to see what can be done better and a lot of that will be about joining up over-functionalised silos in which various kinds of healthcare provision sit. So really – we understand that 'the system' accounts for a lot.

Until it's sorted out, we understand that decisions may be taken about what staff will or will not do and that this means some demand may end deflected to the 999 services, whether deliberately or not. As long as we're not asked to do things that are illegal or asked to assume responsibility for decisions

we cannot possible make, there's a certain degree to which I don't mind, however much I'd prefer it properly sorted by correctly constituted mental health teams.

But this hashtag went way beyond all of that for me.

RAPE INVESTIGATION

In 1983, a fly-on-the-wall documentary was made in the Thames Valley Police area. It included an incident where a woman attended Reading police station to report a rape and the documentary makers were allowed to film the interview of that victim by a Detective Inspector and a Detective Sergeant. So these were supervisory CID officers. We then watched the most awful berating and disregard of that victim and it quite rightly generated public uproar, leading to disciplinary proceedings against both and to a total overhaul nationally of initial responses to rape. I'm afraid to say that the unfolding of this hashtag made me think of that.

Even now in relation to the investigation of rape as well as other offences, there are indications or perceptions in just some cases that victims question whether or not the police *believed* them. Of course, the operating presumption should be that people who walk into police stations tell the truth, unless and until something indicates otherwise. Prosecutions for wasting police time or perverting the course of justice for false reports of any kind of crime are comparatively very rare indeed, perhaps the most recently notorious of which was the prosecution being faced by Eleanor De FREITAS which led this young woman with bipolar disorder to take her own life. Validation for victims is achieved by the police taking reports serious and treating them as true allegations for the purposes of conducting a thorough investigation. In Ms De FREITAS's, case her father stated that he understood that inconsistencies in her allegation rendered a prosecution very difficult and why the police did not seek to bring charges against her alleged attacker. That man then brought a private prosecution against her for allegedly making a false allegation against him and the CPS decided to continue the case, despite objections from her solicitor and family. Very, very difficult issues. Guidance to the Metropolitan Police would have made it clear however: upon first receipt of her allegation of rape, she is to be believed, validated and the investigators go wherever the evidence takes them.

This is what concerned me about the stated responses, which we all must acknowledge were made known entirely without context on a social media platform. I'm sure mental health professionals involved in those conversations would have their views about whether comments attributed to them were accurate, or whether context alters anything. But regardless of all that, it seemed clear to me that those patients tweeting their

experience didn't feel validated. They often felt patronised or dismissed. One example included a female service user who was asked whether she had considered going for a walk – whilst on her own, late at night and whilst feeling vulnerable. Oddly enough, she didn't wish to consider this.

DISTRACTION TECHNIQUES

The suggestions about patients having a cup of tea, a hot bath or a long walk were frequently mentioned, by many. A doctor – who it must be said, was one of only a couple of professionals brave enough to become involved – pointed out that such things can be valid distraction techniques for people in crisis. It must be fair to observe, few people found this acceptable: many were beyond that stage themselves before ringing the CrisisTeam in the first place. Others had specific objections to the advice – like the woman who did not wish to go out late at night on her own for a walk. Or the person in crisis who didn't want to have a bath and see a body they loathed as part of their principal mental health condition.

A few mental health professionals have then since made the point: there are far two few professionals in a crisis team to necessarily provide an effective response, that they are trying their best and that in some situations, all they can do is encourage forms of self-care or distraction that may get someone through the night or to the next day. But that moves us on to various tweets that made reference to the police. It was someone tweeting about being 'threatened' with the police that first drew my attention towards the **#CrisisTeamFail** hashtag. Now I've been the police officer sent to a home on many an occasion and I've taken advice calls from PCs and sergeants hundreds of times about such incidents. There is often a very stark difference between the 999 call made by the CrisisTeam and the response to officers from the patient. Of course, this could be for any number of reasons: might I be bold enough to suggest that occasionally, the risk to a patient is occasionally exaggerated to ensure the police do respond and become responsible? Might I also suggest that sometimes, patients are so surprised, intimidated or unwell that when cops with stab vests and tasers suddenly appear at the door, they quite naturally attempt to downplay their crisis for fear that they will be detained in custody to keep them safe?

Regardless of the explanation, I know this – the police can confirm whether someone is **A**live, **B**reathing or **C**onscious and whether they are obviously **I**ll, **I**njured or **I**ntoxicated. They can even inform the CrisisTeam of these observations – **ABC/III**. Whether this means that a person is 'safe and well' is a *totally different* assessment and not one for the police to make, ever. It does not 'tick off' a discharged duty of care that the Crisis Team called the police, except in the sense of mitigating an immediate threat to

life. If the officers pitch up and find someone in similar circumstances to which the principles of the Seal, Sessay or Hicks cases apply, then the officers have no legal powers to act whatsoever unless there is also a criminal offence being committed or attempted. So the Crisis Team will still have to decide: "what are we now going to advise, if anything?" They are effectively back to where they were *before* they called the police because mental health care in this country is the responsibility of mental health trusts and general practitioners, not the police.

This hashtag – for me at least – showed how important it is to have good communication skills, to have a response that doesn't sound like people are being dismissed or even disbelieved and to validate people's experiences even if you are on the way to providing a response that may not be what they had hoped would happen. Some people reporting crimes as victims aren't victims at all – no matter what their belief to the contrary; and some are actually telling lies. Only a professional investigation will properly determine into which category someone falls and you'll never get that in an initial phone call. I can't see how mental health care is any less complicated!

Maybe some patients aren't in full-blown crisis when they think they are – some victims aren't victims when they think they are – it sometimes takes more than a conversation on the phone, not only to make this clear but also to explain it and then further support someone. This will be no different in those seeking crisis care responses – your perception is your reality and if we're talking about a group of patients experiencing suicidal ideation or delusional ideas, however short that falls from whatever the definition of 'crisis' is, it is effectively denying the significance of that experience by providing a response that doesn't work for the person, and is therefore no response at all.

But I repeat my original point: if this is about the capacity of CrisisTeams, then commissioners and managers need to look at that. But this is also about how frontline staff communicate, which – *of course* – is an issue in the police too, especially when pressure is on professionals to deal with volumes. Managing sensitive, high-complexity demand sometimes takes time that appears not to be there. If this is about how vulnerable patients come to better understand how to support themselves in crisis, then who could object to that. But if it is also about how we communicate with people. The police are busy and being 'rationalised' too, but I was glad to read remarks in this hashtag that patients found that the police listened, cared and tried to help whenever they were involved.

So if all else fails we seem to ring the police – and I wonder if CrisisTeams do that more now many police forces have access to street triage?! Various pieces of anecdotal evidence made known to me suggests that we are – but that's another post altogether!

24th November 2014

HASC Inquiry –

On **26th March 2014**, the **Home Affairs Select Committee** announced a new Inquiry into **Policing and Mental Health**, under its chairman, the Rat Hon Keith VAZ, MP. This page simply collates all the various links to written and oral evidence and I will update it with the final written report once published. It could be completed by the end of 2014, but watch this space!

They invited written submissions from individuals and organisations and published this on the 14th May ahead of taking oral evidence in various sessions over the remainder of the year. I submitted written and oral evidence to the Inquiry.

You can click the date of the session listed below to see the oral evidence on video. Links to the written transcripts are also given because the video streaming technology used by HASC does not play on all devices, in particular I can't get it to work on iPhones or iPads!

There have been five sessions so far —

- **1st July** – **Matilda MacATTRAM**, Director of Black Mental Health UK; **Dominic WILLIAMSON**, Chief Executive of Revolving Doors, **Deborah COLES**, Director of Inquest; **Tony HERBERT** and **Barbara MONTGOMERY**, parents of James HERBERT. (Written transcript of this session.)
- **2nd September** – **Inspector Michael BROWN**, College of Policing. (Written transcript.)
- **21st October** – **Lord ADEBOWALE**, Chair of the Independent Commission on Policing and Mental Health; **Dr MJ TACCHI**, Lead on Crisis Care, Royal College of Psychiatrists and **David DAVIES**, College of Paramedics. (Written transcript.)
- **28th October** – Custody sergeants from Devon and Cornwall Police and Essex Police; Chief Constable **Simon COLE**, Leicestershire Police and Ch Supt **Mark SMITH**, British Transport Police. (Written transcript.)
- **11th November** – Rt Hon **Normal LAMB** MP, Ministers of State for Care and Support; and Rt Hon **Mike PENNING** MP, Minister of State for Policing. (Written transcript.)

26th November 2014

Call Me An Ambulance! –

"CALL ME AN AMBULANCE!?"

"OK – you're an ambulance!", went the well worn joke. One my favourites, to be honest!

This weekend's Daily and Sunday Telegraphs carried two articles entitled —

- *"Police forced to take patients to hospital as ambulances fail to show" and*
- *"Police: stop using us as ambulance drivers".*

If you haven't read them, pause here and give them a blast, as they're both relevant to what I'm about to say.

This post is only indirectly about mental health or cognitive issues: it follows the announcement of a review to be led by the Chief Constable of Leicestershire, Simon COLE, about police officers being used as 'ambulance drivers'. A few of my views on this issue don't seem to go down well with my colleagues and even in the last twenty-hours I've been told these things are "easy to say as an inspector!" … presumably because inspectors don't go anywhere near the streets and never support their officers by taking on some of the tougher decisions. That queue of officers at my desk coming in every few minutes for advice must have been a figment …… all the Airwave radio calls must have been something I imagined.

As I understand it from the articles, we are going to see an inquiry into instances of where the ambulance service are asking the police service to attend a location instead of them because they are short staffed and of delays where officers call for ambulances to attend to ill or injured people that the police encounter when responding to crimes and other incidents.

BACKGROUND

It's important to understand why the ambulance service seems to be struggling. From the conversations I've had there are various complex, contributory reasons in the wider health service, including far longer

handover times at Accident & Emergency. A&E themselves are experiencing rising demand, which is again attributable of other service alteration in GP, minor injury and walk-in centre services – one consequence of this is that paramedics are no longer able to handover patients and leave again within the nationally agreed 30-minute target. Some paramedics have spoken of twelve hours shifts where they left their base late (because the crew using the vehicle they were due to have were delayed at A&E!) only to go to one job and remove a patient to A&E where they remained until the end of their shift waiting to hand over. Nine or ten hour handover delays! Add onto all of that, 24hr drinking, ageing population and and an increasing burden from chronic illnesses and you see how things are piling up against them. NHS England are currently doing a massive review into Urgent and Unscheduled Care, led by their Medical Director, Professor Sir Bruce KEOGH. It's a complex set of stuff to balance!

So whilst everyone's waiting in a queue outside A&E, 999 calls continue to come in and where they've fully expended all the first responders, bikes and big yellow trucks, the situation can emerge where thoughts turn to 'other options' which can include the police. Some officers may not be aware of the world of stuff going on in ambulance control rooms to mitigate against the need to do this. But where it is thought necessary, surely better to have one emergency service there with its first-aid trained staff, than no-one at all? Better that people who are ill or injured and who may need Accident and Emergency services are taken there by police officers than not taken there at all?! … or family are corralled by the police into assisting where possible.

Firstly, this has always gone on, even in the so-called 'good times' of public sector expansion. And secondly, this issue seems to open two avenues of conversation. As these articles did the rounds on social media, various cops were getting into it, often on the basis of first hand experience of attending a job where someone was injured and calling an ambulance to find a serious delay or an hour or more. On the basis of that wait having no end in sigh – even with officers dealing with things like arterial bleeds – they've taken the decision to transport someone to hospital. Other examples included the police being requested by the ambulance to force entry to a house on behalf of paramedics only to find that no crew were there, but in light of the information given to the police, they felt duty bound to force entry and try to help. Final examples included instances of where the ambulance service knew they had no-one to send and felt obliged to send the police to 'do something'.

"Policing is what happens when something's happening that ought not to be happening about which somebody ought to do something now!" —— Egon BITTNER.

PARA-POLICING

Might I suggest there are two things going on here – the jobs where the ambulance service ask for police support and can't attend along with the officers and the jobs where the police call an ambulance and then feel obliged to act after a delay. I want to focus on the second one, notwithstanding that I'm actually more interested in the first!

The thing I've often wondered which seems to cause disquiet amongst my colleagues in the police, is whether the police are calling ambulances too frequently? This kind of heresy seems to go down especially badly with some frontline officers. Unless the person concerned is vulnerable or lacks capacity, medical decisions are for people to take for themselves, so the only relevant issue is whether a person the officers have encountered has capacity to take their own decisions. There are numerous ways to access what the NHS call 'unscheduled care' and these include 111, minor injury units, walk-in centres, GPs (who do offer some urgent appointments) as well as A&E. (I particularly like the leaflet from NHS Direct Wales, which is the picture at the top of this page.) A 999 ambulance is not the only means of transport to A&E – many areas have buses, trams, taxis and pavements by which to make one's way to these other locations! Some people even have friends or family who might be able to help. Indeed, where the police have encountered someone who is a victim of crime, nothing prevents officers assisting people to A&E if that were the place they chose to go.

When these articles started circulating on social media, some of my paramedics friends understandably bristled at the articles and pushed back against this. "Stop calling us just to 'check someone over' at minor RTCs and fights, then!" I'm sorry to say, I do know what they mean! Remember what a 999 ambulance is: it is for medical emergencies and some trusts estimate that only 10% of the 999 calls they received are for genuine emergencies. There are any number of other methods by which someone who wants to get 'checked over' can do so – and by which the police can encourage them to do so, if they feel the need to reinforce that point. Accepting that there will always be some situations in which there are ambiguous symptoms compounded by issues like shock or alcohol, etc.. So it's important you understand what I am saying and what I'm **not** saying here! — if you feel calling an ambulance is justifiable and you feel you bear a duty of care to an individual, then it's a decision you're obviously free to make. Just remember what 999 ambulances are actually for, in the way that we hope to remind others what the police are actually for!

I've covered assessment of capacity (including for non-mental health incidents) elsewhere – here I just want to remind everyone that you must presume people to have capacity to take their own decisions, this includes parents and guardians having the capacity to take decisions on behalf of

their children. If you decide that someone lacks capacity, then it's a whole different ball game because the police can often walk into a situation where they then win a duty of care. Imagine forcing entry to someone's home where a crew had not yet arrived and finding an apparently unconscious person? Clearly, a lack of capacity; clearly a duty of care – officers must act in that persons best interest, whether that is starting first-aid / CPR or whether that is taking a decision that the best thing to do is get that person in a police vehicle and get them to A&E. Very difficult stuff, either way – and very far from ideal!

SPECIAL RELATIONSHIP

I've always thought the police and ambulance services have something of a special relationship – so much of their work overlaps and at many incidents they appear to be opposite sides of the same coin. Many emergencies involve both clinical and security risks to some people and often, the incident is beyond the competence of any individual police officer OR paramedic. It is sometimes necessary to operate hand in glove. This is something to be valued and cherished at all costs, in my view. However, each service seems to have a niggling complaint about the other! Some may suggest that this is typical in many close relationships – why would it be different between two organisations with closely related but distinct roles?

The police deal with security risks, in the main – but we have first aid certificates to tolerate a certain amount of clinical risk, pending the arrival of the ambulance service and (should!) have the requisite amount of common sense to be a police officer, so they should be aware that a 999 ambulance to A&E is not the only way a person who is ill or injured can receive (what the NHS call) unscheduled care. There are walk-in centres, minor injury units, GPs (who offer emergency appointments) as well as A&E departments who don't only grant access to people ferried there by the ambulance service. Equally, the ambulance service do go about their clinical business in circumstances of some security risks. They don't always demand a police escort to issues where people are drunk or shouting, or even aggressive, but there is a problem of perception between the two sets of frontline staff.

At the risk of caricature, the police often wonder why the ambulance service information about previously encountered risks means that they need an escort to an address where there were last known to be problems many years ago. It nearly tempting to lapse into pejorative banter by saying "problems in 1973!" Clearly things aren't that bad. But it is true to say, that data that influences calls from green to blue sometimes are out of date and lead to inappropriate demands for back up. Equally, police officers are often thought by paramedics to call upon the emergency section of the NHS too

quickly in some cases. Minor injury accidents where people 'just need checking over'. Is it the role of a mobile intensive care unit to give people a once over? The advertisements on the side of ambulances often remind us that it is for life-threatening situations. Why not advice such motorists to seek attention from appropriate medical professionals in due course?

ADULTS WITH CAPACITY

We should remember that all adults should be presumed to have capacity for their own decisions. Any suggestion to the contrary needs to be based upon some kind of assessment, as I've written about in posts on the Mental Capacity Act. So this is where the very general point about police officers calling ambulances for ill or injured people at incidents links back to broader points about mental capacity. If you attend a car crash and find the driver of a vehicle has hit a brick wall, wrecked his vehicle and is unconscious at the wheel, then it shouldn't take very long to work out that he lacks capacity and that officers can start taking decisions in his best interests. If that drive had merely dented the front of his vehicle at low speed and suffered a seat belt injury and a bit of whiplash it may well be a different matter. If the police are first on the scene and they find the driver walking, talking and starting to sort out his details for the owner of the garden wall, why would we want to try and take control of his medical decisions? He seems a sentient intelligence sort of human being, not drunk or otherwise vulnerable, it is up to him to sort out his medical care, so advice him to do so and sort the collision issues. It is certainly not for the police to be calling him a 999 ambulance, unless he requests it with some sort of reason for needing it. Maybe the man could even call it himself, if he is a fully functioning adult who feels entitled to call one in circumstances where officers are unconvinced. What is clear, is that whatever legal duty of care the police have towards this accident victim will vary depending upon whether it's the unconscious driver situation or the walking whiplash man.

Things change when we start talking about vulnerabilities – the duty of care shifts in its nature. If the police come across injured children, unaccompanied by responsible adults, then it is clearly different – the officers are temporarily in some form of *loco parentis* until parents become involved. The police also come across people where mental capacity, is not obviously present at the material time: drunk people can lack capacity, as well as those of us living with mental health problems and various other conditions. Where one of these vulnerabilities or temporary impairments is in play, then clearly officers win a duty of care which in some circumstances is only going to be discharged by calling for support from one of our colleagues in green. We also need to remember that the nature of some clinical risks may seem serious or ambiguous to the cop with a first-aid certificate, but clear-cut and less concerning to a paramedic. This is no different to paramedics feeling that a risk history at an address demands

police support and when the police turn up in their paramilitary kit with handcuffs, stab vest and taser, nothing untoward seems to be going on.

The police service and the ambulance service each do security risks AND clinical risks – we can manage a bit of each other's business, but that's all. Many incidents involve both. It is important that in decisions police officers make around calling upon 999 ambulances that they understand the NHS principles of '**Choose Well**' – this is the NHS initiative to encourage people to access the right kind of service for their respective health condition. It is equally important that paramedics and ambulance managers understand how the police are sometimes inappropriately drawn into health situations that should be resolved by better dialogue between NHS providers. I'd also love to see the risk based information updated to we don't get called to a house just because someone shouted at a paramedic in 1973. Ooops! – I see what I did there.

27th November 2014

Concordatum –

I experienced something last night that felt very surreal indeed – I was sat in my second rush-hour related nightmare of the day and bored. I hadn't heard proper news for some while so flicked off the music and put the radio on. To be honest, the intention was to escape into other people's reality but I immediately found myself listening to news about the NHS England commissioned report into learning disabilities care. For those who are not aware, in 2012 the 'Winterbourne View Review: Concordat Programme of Action' was published in which a whole host of organisations, including ACPO on behalf of the police service, committed to a range of things around Learning Disabilities and the report yesterday basically said that those organisations had collectively failed to deliver any real change.

After the broadcast piece, there was an interview with Norman LAMB MP, Minister of State for Care and Support. He informed the listeners how disappointed he was that despite signatory agencies to the Concordat committing to change, none had happened. Of course, if you listened to the news yesterday you will also notice that the Prime Minister made pronouncements about how important it was for more care to delivered in homes and in people's own communities, after highlighting instances of people being afforded care hundreds of miles away from their families.

I don't want to gloss over the issue of learning disabilities or the disgusting crimes that occurred in places like Winterbourne View – these are important matters and when one hears the campaigns like 'LB' and others, we can see the clear importance of these issues – but my here is not about learning disabilities or institutional care: it is about Concordats. The irony of this report is that it was published on the day immediately prior to the National Crisis Care Concordat Summit in London – I'm writing this on the train on the way to the event where I get to speak for ten minutes about what the College of Policing are contributing to this work and running a workshop and training. But listening to Norman LAMB talking yesterday, I couldn't help but think it was a somewhat surreal foreshadowing of what we might hear if we're not careful in 2016 after two years of talk and action plans.

The word concordat comes from the Latin, *concordat* or 'something agreed upon'. Therein lies one of the problems: it probably remains true that whatever the signatories to the 2012 concordat agreed upon, they still agree upon it. Agreeing on something that needs to happen doesn't mean that anything changes in the real world. It is against this background that

Norman LAMB stated that there will be a green paper on institutionalised care for people with learning disabilities in 2015 and that it may be necessary to legislate. This is the point where my irony-meter hit critical levels: because suggestions that on some issues we should legislate to give effect to change have previously been rejected on issues under active examination in the Crisis Care Concordat. For example, we could legislate to remove the words 'police station' from s135 (6) of the Mental Health Act 1983, thereby making it illegal to use such places as a place of safety. Indeed, this proposal was put forward to Parliament in 2013 in a back-bench motion involving Paul BURSTOW MP, Mr LAMB's predecessor as Minister of State. Despite suggesting a lead in time of 2017 for that legislative amendment taking effect, the proposal was rejected, in part because other methods of achieving this were preferred. Yet we have thirty years of history to show how hard this has been and there are various reasons to suspect that a lot of this stuff is too difficult for many to properly contemplate.

In recent years, whilst overall use of police custody as a place of safety has fallen, in some areas it has risen as place of safety services have been closed for one reason or another. In Cornwall, although a service has not been permanently cut, the mental health trust has transferred all PoS detentions to police custody after a mental health unit was temporarily closed for fire safety reasons. So paragraph 10.22 of the Mental Health Act Code of Practice and the implications of the Civil Contingencies Act 2005 don't seem to apply there. (For clarity, the CCA does not apply to mental health trusts, but NHS England has told them to act as if it does. So where is the contingency that avoids the need for deliberate violation of the Code of Practice for these vulnerable people?

There is no reason at all why the Mental Health Crisis Care Concordat cannot succeed as a vehicle for driving proper change, but we always knew the risks around this and why it therefore needs to be properly led: you can 'go green' on the Concordat without actually doing anything and whilst developing a local action plan which is basically a wish list if our broader crisis system won the lottery. That's why I've argued for another color to be introduced to the map of England on the Mind CCC website: we need blue for 'deliver our action plan' and a deadline by which to 'go blue'. So ahead of a National Summit at which we find ourselves ten months into a process that finds some areas unable to yet agree on the very hypothetical task of delivering on the principles of the Concordat which would mean they can 'go yellow', we should refocus and double our efforts because some people are worrying that this time next year, we will have areas struggling to 'go green' and by then we'll be nearly two years into a process that has lasted as long as the 2012 Learning Disabilities Concordat. Just to focus everybody's attention on the importance: history suggests that by the time of next year's summit, two people will have died in police custody / contact following the use of section 136 MHA and a further half-dozen people in

police custody after arrests for alleged offences. That we progress some of the most complex issues is, literally, a matter of life and death for some people to whom we ALL owe a duty of care.

29th November 2014

International Laws –

The most surprising thing about today's CAMHS related incident in police custody is that we were surprised in the first place. We know that right across children's and adult mental health care, there have been other, very similar incidents to this one before. MS v UK is a human rights case heard in 2012, which occurred in Birmingham in 2004 and saw a man detained in police custody for over three days, well beyond the statutory maximum period allowed. The bottom line in that case was debate amongst different NHS services about bed provision. I've recently heard of a young man detained for over five days, whose parents were very grateful for the undoubtedly illegal safety and care the police were able to give him, whilst the surrounding health and social care system worked out what was the best thing to do and I've previously flagged up cases in my own experience that looked similar in nature and were unnecessarily protracted because of bureaucracies that probably wouldn't survive contact with a legal challenge.

What I know about this case, I know from the media stuff we've seen – so here's as good a summary as I can infer from what I've read —

On Thursday 27th November, Devon and Cornwall Police were called to Tobey hospital where – for reasons we don't yet know – they have arrested a 16-year-old girl who they contended was breaching the Queen's Peace. She was then detained in custody at a police station in Devon pending an assessment under the Mental Health Act. The police described her as having been 'sectioned on Friday' and problems were encountered finding a bed. Following considerable media attention subsequent to use of social media by a senior officer, a bed was identified and the young woman transferred under the Act to a hospital place on Saturday evening after two days in custody.

EUROPEAN CONVENTION ON HUMAN RIGHTS

There are three separate provisions of the European Convention on Human Rights that are potentially relevant to this type of situation and we've seen many of them raised in British cases.

- **Article 2** – the right to life
- **Article 3** – the prohibition of torture

- **Article 5** – the right to liberty and security

We could touch on other aspects of the Convention, but these serve to make the point I'm trying to make, which I have made previously on this BLOG.

Let's start with the arrest decision: I had wondered as the story broke what the legal basis was of the original arrest. Maybe officers had detained the girl under section 136 of the Mental Health Act? – two days of detention is certainly not edifying but that provision allows up to 72hrs to make arrangements for treatment and care, so at least it would have an initially lawful basis. Perhaps the original incident was police called to an allegation of a crime and only after arrest for that offence were suspicions raised or information given about the suspect's background of mental ill-health?

A Common Law Breach of the Peace occurs where a person causes others to apprehend imminent unlawful violence. Using breach of the peace was challenged in a UK human rights case in 2014 which was nothing to do with mental health but which has relevance to situations where we might be tempted to think of it as a 'proxy' power in a mental health emergency. In Hicks v The Commissioner of Police for the Metropolis [2014], protestors alleged within the British Courts that the Metropolitan Police had violated Article 5 of the European Convention by arresting them for Breaching the Peace when there was never an intention on the part of the officers to bring them before a 'competent legal authority' – a Magistrate, in the English judicial context. The case ended up with an Appeal Court ruling which made it clear that in order to lawfully detain someone for a Breach of the Peace, the arresting officer should have it in mind at the point of arrest, to place the person before a Magistrate as the competent legal authority. The Metropolitan Police was able to show this and won the case but arguably, it now means that where the police respond to a seriously unwell child in a hospital, it would be interesting to know the rationale for why the incident needed to find that child in a Youth Court at the first available opportunity and why an alternative mental health related diversion was not the preferred option. The details of this decision interest me greatly, I will admit.

A quick point on the language of someone being 'sectioned' – this is informal language that can mean various things under the MHA but most usually it means that an Approved Mental Health Professional (AMHP, pronounced 'amp') has made a written application to a particular hospital for a patient's admission under either section 2, 3 or 4 of the Act. Unless and until the AMHP has made such an application, the patient is not 'sectioned'. They remain detained in police custody under whatever legal provision brought that person there in the first place. Of course, someone detained in connection with a Breach of the Peace should be released as soon as the breach is over, or placed before a Magistrate as soon as one becomes available. Did the breach really continue for two days? – three

sets of Magistrates would have sat in the local courts between Thursday evening and Saturday evening.

This then comes to the protracted detention in custody: Aerts v Belgium [1998] is not more often considered in cases where those of us who are seriously mentally unwell are detained in criminal justice settings. In this case, a man was held in a Belgian prison for seven months purely for reasons connected to his mental health. This judgement set down a precedent about the nature of the custodial environment being appropriate to the reason for detention. Clearly prisons are not built to detain those of us who are unwell when the only reason for detention is connected to poor health. This doesn't mean that unwell people cannot be in prison if they have also been sentenced there by the courts after a criminal trial.

And of course, let us not forget the MS v UK [2012] case, referred to above – this case arose in 2004 and involved a man spending over three days in custody in circumstances where he was seen quite quickly by NHS professionals who recommended that he be 'sectioned'. The subsequent delay in arranging a bed for his admission amounted to a violation of his Article 3 rights and it was held to be inhumane and degrading. If this young woman was seen on Friday morning and spent a further day and a half in the cells pending identification of a bed – largely as a result of a Twitter campaign, it would seem – then how is that different?! What would be fascinating to know based on the known facts of the incident, is the legal basis for the original arrest and how that extended to two days, during which time Magistrates were available to hear the case.

Reality appears to be, that yet again, the police were absorbing legal and safety risks because the AMHP was not afforded the opportunity to make an application for admission.

SURVIVING CONTACT WITH THE LAW

Let's widen this out, not least because the situation sounded very difficult indeed. A young person, seriously mentally unwell, needed access to the kind of inpatient service that is often in short supply and which doesn't always have sufficient out of hours provision to cope with unexpected crisis demand. Of course, most of those things are arguments about resources. We saw in paperwork submissions for the MS v UK case, European caselaw cited about violations of the Convention which arise from resource decisions countries have taken based on economic factors. I cannot for the love of me find the full reference (any human rights lawyers in the house?!) but the shortened version from the (Ukrainian?) is that the economic or 'resources' argument doesn't work. You cannot lawfully derogate from someone's human rights and then say, "Sorry, we didn't have the staff" … or beds.

I've blogged elsewhere about the 'No Beds' nightmare – I honestly think English law is quite horrendous and out of date on this. The Mental Health Act itself says that AMHPs 'shall make the application' when satisfied that one ought to be made and has taken account of any expressed views or other relevant circumstances. Nothing in this specifically about beds being available and / or hospital managers being willing. Quite separately, the Act also specifies that each area must identify those hospitals to which their AMHPs can make applications in circumstances of special urgency and which hospitals are designated for the admission of people under the age of 18yrs. The Code of Practice to the Act makes it clear (in chapter four) that AMHPs should not make applications under the Act until they have identified a hospital with an available bed. This is often cited by AMHPs as meaning that you cannot make a written application for someone's admission unless a hospital with an available space is identified and agrees to accept the patient. They will often point out that Professor Richard JONES argues in his Mental Health Act Manual (seventeenth edition) that the advice given by the former Mental Health Act Commission is of 'doubtful legality' when it recommends that AMHPs should go to the 'section 140 list' and choose a hospital identified for the relevant purpose and make the application anyway.

Whatever the rights and wrongs of this very technical and exceptionally boring argument, I do know one thing about all of this conflict between the Act, the Code and guidance from the CQC's predecessor organisation that may or may not still be in force and which is all hotly contested — **no matter what** an AMHP, police officer or assessing psychiatrist decides to do, it must be done in a way that reflects the positive duty on all of those professionals to ensure a vulnerable person's Convention Rights. You simply CANNOT get tied up in conflation and confusion about what domestic legislation and statutory guidance might or might not mean, find that the inaction gave rise to a violation of the Convention and then just keep saying "We tried our best" or "we don't have the resources". I accept a lot of this is about commissioning and managerial decision-making, which is why I'm rather than hoping that senior health and CAMHS professionals in Devon will be discussing this case by 10am on Monday morning.

And of course, whatever our domestic and then European law may say about this situation, we're into yet another ball-game altogether when you start to consider the wider international obligations the United Kingdom are part of. The United Nations operate two global frameworks that are relevant to this: the UN Convention on the Rights of the Child; and the UN Convention on the Rights of Persons with Disabilities, which includes mental health conditions. It is interesting to note that the United Kingdom is the first country to face an (ongoing) investigation into its record on the UN CRPD.

I personally think that ACC Paul NETHERTON, whose tweets on this matter set off a train of interest, outrage and activity, did exactly the right thing – he was the on-call ACC for a police force who had a fairly obvious human rights violation on his watch and a positive duty to do something about it. His decision to make it more widely known, without compromising the identify of the vulnerable young woman concerned, undoubtedly contributed to a kind of pressure that broke through the bureaucratic barriers that too often emerge from the combined effect of our commissioning structures and our ambiguous legal frameworks. In other words, he did his job!

30th November 2014

Prioritizing Human Rights –

I've been unable to stop thinking about yesterday's incident involving a mentally unwell sixteen year old girl in police custody for two days! TWO DAYS!? If the police did that to any criminal they would be investigated by the IPCC.

I admit, I'm probably more appalled by it tonight than I was last night. This is partly because there has been a fair amount of social media debriefing and debate going on about it, much of it expressing admiration for ACC Paul NETHERTON's willingness to speak out and push the envelope. We learned today that the girl's mother had taken chocolates to the police station to thank the officers for their efforts to do as much as possible. It turns out they had even made the effort to fetch her a McDonald's meal rather than keep subjecting her to microwavable police food! I'm proud that it has been a repeated theme in my work this week, to hear of patients and families who thought the officers they dealt with treated those with dignity and compassion, notwithstanding that their encounter may well have been in circumstances we'd rather not contemplate. I was glad to see that seemed to be the perception here, too.

THE LEAST BAD OPTION

So why this second post? – To highlight an issue about 'thinking' and about conflicts in law. I seem to have witnessed a recurring dialogue that focussed on all the relatively unimportant reasons that nothing more could be done rather than on the glaringly obvious reason why walls should have been broken down long before a senior police had to get involved.

For example, I know that on other occasions where a CAMHS bed has been unavailable, a child has sometimes been admitted to an adult mental health ward, with specialist nursing support to ensure safeguarding. I also know of occasions where a Mental Health Trust has shut down its s136 Place of Safety and temporarily used that space to admit a CAMHS patient who remained there for six weeks until a bed was arranged, despite the fact that the trust concerned would not otherwise allow the s136 suite to be used for 72hrs to assess a child – but they were happy enough to have the child there for six weeks!? We know that on occasions, a CAMHS patient has been 'sectioned' to an children's ward in an acute hospital or to a

specialist children's hospital which has a 'CAMHS' wing, possibly with additional nursing support.

Nobody thinks that any of these things are inherently great ideas that we should be looking to very casually – they may be things you may start to consider that might be just a bit better, if still far from ideal. I'm wondering how many mental health professionals will have read the previous paragraph and be thinking, "Hang on! You can't just do that because …"?! I want to argue that this is the beginning of inappropriate focus on the legalities involved. Let's look at the one massive reason for moving heaven and earth to sort this, not the nine less important reasons to just let things run their course —

- **"You can't admit a child into an adult mental health ward, because it is a safeguarding risk"** – the NHS have to report such things as a Serious Untoward Incident and conduct a thorough review. Fair enough – we can all understand why this happens. Doesn't mean it's always a worse idea that the problem you're fixing by doing it. It happens from time to time and if illegal, protracted detention in police custody is not a point where we start to think about it, when do we think about doing it?!

- **"You can't close a place of safety down and admit someone there – it's not a commissioned bed that is available for admissions!"** – That is a remark about NHS bureaucracy, isn't it. We know that there are many circumstances where wards are run over 100% capacity. If this is such an outrage, why does it *ever* happen? – Presumably in situations where it is less of an outrage that than the outrage that would otherwise prevail?!

- **"You can't detain a mentally unwell child on a ward of other acutely sick children, it just isn't fair."** – So the child with mental health problems loses out, because physically ill children have to take priority? What was that you said about parity of esteem?! This presumes that physically ill children can't be noisy, disruptive or emotionally affected by the experience they're going through which is one hell of an assumption to make.

Well, guess what? – You can't illegally detain a child in a cell block either, beyond the timescales prescribed by law. And so the decision becomes about which set of regrettable circumstances to which you'd prefer to be party – something that is about trying to do the best we can, however unideal it is, where we try to get close to the legal frameworks that govern us all; or something where we put issues other than patients at the forefront of our thinking? Mental health professionals can become unwitting accomplices to intransigence when they won't consider how to bash through the commissioning, budgetary and over-functionalized bureaucracy that is

our NHS system – remember that in MS v UK, the degradation occurred in police custody but it was the NHS who were found liable, not the police.

I understand the reasons why something is not ideal, but what I've been hearing all weekend is why we're going to rigidly adhere to organisational preferences and guidelines despite the very great likelihood that a child's fundamental human rights were compromised. So let's look at this in a bit more detail and think about it legally.

CONFLICTS OF LAWS

There are many situations in which laws can conflict and contradict and we see this in European Convention case law. We carry on with domestic laws until arguments are occasionally put forward that even more fundamental rights are being jeopardized. One example was the introduction of the Mental Capacity Act in 2005. The year before, the so-called 'Bourn wood' case was a challenge brought by a man who had been detained for a long time in institutional care. It was argued that he was unable to look after himself and his own affairs because of his condition but because he had a learning disability and was not "abnormally aggressive or seriously irresponsible" (s1 MHA 1983) the Mental Health Act 1983 could not be applied. Clinicians therefore ordered his detention under the Common Law *Doctrine of Necessity*. The man argued in HL v UK [2004] that this detention being indefinite and without an obvious basis to review or appeal, it violated his Article 5 rights to liberty and security. He won and as a result, the UK Government introduced the Mental Capacity Act 2005 and subsequently the Deprivation of Liberty Safeguards, to cater for such situations. It still means that individuals with similar conditions and needs can be detained or deprived of their liberty in some circumstances but it provides a framework around that situation, including a right to challenge it.

We could give other examples: in MS v UK [2012] a man was detained in police custody as a place of safety, after being detained under s136 of the Mental Health Act. Nothing specifically prevents this from happening as our domestic law caters for this very situation and allows it to happen on an exceptional basis. However, because of MS's particular presentation in the hours and days following his detention by the police, he argued that by being left in that place of safety for over two and a half days subsequent to being assessed as requiring an urgent admission, he had suffered inhumane and degrading treatment. He won this argument and it was nothing like sufficient for the Mental Health Trust involved to argue that he hadn't really come to harm and that his detention had followed a legal process. The point was that the *way* in which that process unfolded was the problem that degraded him. Had that processes unfolded following the detention of

another patient, presenting differently, there may well have been no violation of Article 3.

So some situations force a choice upon those professionals involved: what would you rather breach – your organization's bureaucracy, health service guidelines, statutory guidelines like a Code of Practice; an Act of Parliament like the Mental Health Act 1983 or the Police and Criminal Evidence Act 1984; or the European Convention on Human Rights? I've written about this kind of thing before: sometimes it's about choosing the least bad option from a range of potentially bad ideas. But in the absence of some good ideas, you might have to make the best of things?!

That's what work at the interface of policing and mental health is all about!

COMMON SENSE TEST

So let's ask some really basic questions: is it better or is it worse for a 16yr old child, acutely unwell, to be legally detained in a mental health unit that is having to draft in some extra staff to help keep her safe because they are running at 104% capacity rather than be in police custody, surrounded by cops and the other prisoners that are brought in? I won't graphically describe what some prisoners are like in custody – we can all just agree that it's a hell-hole of noise, filth and violence.

If you're going to have to breach something we'd all prefer not to breach, are you going to worry more about violating internal NHS process or violating a child's fundamental human rights? If I'm honest, I don't even find that a hard question: I'm going to breach the process that has failed to ensure her fundamental rights and dignity and my explanation will be "I have a positive duty to ensure this happens as she was being held illegally before I made my decision." As a police officer, I have faced this very dilemma: I've been posted to work in areas where the locally agreed joint protocol for how the Mental Health Act will work, breached the Mental Health Act Code of Practice or simply didn't exist. I have also worked in areas where the Code itself may well have been complied with, but to do so would have put people in danger that could lead to me being prosecuted for negligence and neglect. So sometimes, I was in effect directed to do things that other legal structures direct me to avoid.

And so I have a choice to make, whether I want it or not – and so does every mental health professional involved in emergency mental health care.

DECEMBER 2014

6th December 2014

Consequentialism –

This post just seeks to ram home again what's already known – there's nothing new to see here, but we're now one week on from the custody debacle in Devon which saw a young woman detained for two days whilst mental health services struggled to find a bed into which to admit her. We know she was eventually admitted to an adult psychiatric bed, which is less than ideal, and we don't know whether she remains there one week on. What I do know is I've had several queries this week from custody officers and various forces' mental health leads about this situation: Someone was brought into custody for reasons originally unconnected to the Mental Health Act, they have been assessed as being in need of admission to hospital under the Act, but no bed is forthcoming. The precise dilemma is: how do you manage the situation in custody if the delay in accessing the bed is protracted and beyond the timescales which normally apply to the police holding on to people?

There are a few scenarios –

- **Someone was detained under s135/6 of the Mental Health Act** – but the 72hr authority to hold them in a Place of Safety is now running out.
- **Someone was arrested after an allegation of an offence** – the legal decision around that allegation is it will not lead to a charge being brought now and the person will be released by virtue of s34(2) PACE. They should be diverted under the Act into hospital.
- **Someone was arrested to prevent a Breach of the Peace** – for those who are unfamiliar with what happens here, officers will keep determining whilst the person remains in custody whether a Breach of the Peace is still anticipated and they will either, release the person once it is no longer apprehended, OR they will place that person in front of a Magistrate once they are available. So what happens if the breach is no longer feared OR if the Magistrate becomes available?

- **Contemplate yourself as the custody sergeant** – knowing that the AMHP has not yet made an application and the Doctor who led the assessment is struggling to find a bed. Even the duty inspector may have had a word on your behalf but it's made no difference and it's now decision-time.

You have a legal and ethical nightmare on your hands, don't you?! Do you release the person from custody, out in to the street – after all, this is what the law is telling you to do in the first two situations. In the third, the only other option is to place the person before a Magistrate. I'm sure they would thank you whole-heartedly for asking them to deal with someone who is suspected to be very unwell but where there is no bed to access. In any event, if we've now decided that someone is unwell, are we still looking at their presentation as a Breach of the Queen's Peace or have we, more realistically, decided that the appropriate path to take is into the health and not the criminal justice system?

ETHICAL DILEMMA

How you look at this may depend to a degree on your ethics – are you more of a consequentialist or deontological philosopher?! Is the morally 'right' thing to do, judged by the desirability of the outcome achieved or by whether or not we followed a standard of rules that we've all agreed are the rules we will abide by. In these situations, I usually find most police officers will argue that 'doing the right thing' (as if that phrase means anything at all!) is achieved by keeping the person safe in the immediate sense, pushing hard for access to a bed, despite the fact that you are voluntarily walking in to an Article 5 European Convention of Human Rights nightmare. A person shall not be deprived of their liberty except through a process defined by law. Well, domestic law doesn't authorise this – so are you also into false imprisonment territory?!

What about the opposite approach – maybe the custody officer thinks: "the law doesn't allow me to do this without inflicting a potential human rights violation on the person … it's not my fault that the AMHP and / or the Doctor and / or the NHS as a whole may be in breach of various parts of the Mental Health Act (s13/140) which collectively give rise to the AMHP being fairly impotent here. Whilst we know it is never the AMHPs fault that they cannot access a bed, does this mean I should inflict a false imprisonment on another human being. If I'm going to contemplate this illegal action, what other illegal actions am I going to contemplate?!" – is this another form of what some policing academics have caused 'noble cause corruption'? Let's be honest: if we were allowed to scoop up half and a dozen prolific offenders and detain them arbitrarily in custody for three days, we'd be pretty confident of preventing various crimes, potentially some very serious ones. Doesn't make it right, though, does it?!

So why it might be OK to detain a vulnerable person illegally when there's no bed, but not prolific criminals when it will prevent crime?! Don't both situations involve predictions of risks to individuals and others that we're mitigating by our actions? If we're interested in the consequences of our decisions isn't it the quality of the outcome that matters? Deontologists

would argue that it's not – it's about creating an objective framework that grounds our moral reasoning in something far more rigid, which prevents expedience from issue to issue. So how are you going to decide what to do?!

ARTICLES TWO, THREE AND FIVE

We know from European case-law that the state owes a duty of care to people are known to be at high risk of suicide and a failure to discharge it can be a violation of Article 2 ECHR – SAVAGE and RABONE showed us this. We also know that the ongoing detention of people in police custody in very difficult and disturbing circumstances can amount to a violation of Article 3 ECHR – MS v UK [2012] showed us this. We know that ongoing detention in locations which are not intended for the purpose to which someone's detention is aimed, is a violation of Article 5 ECHR – Alerts v Belgium [1998] showed us this. Finally, we know that being detained without a process prescribed by law, with safeguards, is a violation of Article 5 ECHR – HL v UK [2004] showed us this.

The above paragraph leaves the original dilemma wide open, so it is one that police forces and custody officers must face up to. If you find yourself in the position of the Devon and Cornwall custody officers, *what are you going to actually do?!*

In the past, a police force has started legal action against the NHS to force the issue. I've personally written a formal letter threatening to do so, in a similar situation during a murder investigation. Last weekend, an ACC took to twitter in order to bring pressure to bear and, so you know – all three of these things 'worked', in the sense that it brought a bed into view, where an application could be made. When the IPCC investigated Greater Manchester Police for their 2004 incident, they stated that the force had little option to keep the man safe pending a bed being found and that whilst all actions after the decision under s34(2) PACE had been taken were unlawful, they were, if you like, the least unlawful thing that GMP could have done. The IPCC are consequentialists, it would seem!

But all of this post is a complete red-herring, isn't it?! The situation wouldn't emerge in the first place if we had enough beds to deal with predictable demand and contingency plans, as implied by the Civil Contingencies Act 2005. (Yes, I know the CCA doesn't apply to NHS mental health trusts – but NHS England have told them to act as if it does. And it does apply to CCGs and Local Health Boards in Wales.)

Why are AMHPs being placed in the position of not being able to make applications to hospitals, even in urgent circumstances? It comes back to the commissioning of beds by CCGs (or by NHS England for children or for

secure hospitals) and the current inability to match supply to demand. I've long worried about the lack of contingency plans within the mental health system – because it seems, all too often, that the implications of this are either illegal detention by the police for someone who went to custody or, as highlighted by award winning journalist Andy McNichol from Community Care, suicides of (at least seven) patients where risk decisions were taken that it was acceptable for them to remain at home pending a bed becoming available.

6th December 2014

Evaluating Ethics –

When I read the narratives that unfolded during incidents-gone-wrong, I often find myself thinking "been there – done that – lucky enough that it didn't go wrong for me." But not always – I've also had an incident go badly wrong and I've been left wondering how the hell it was me that became responsible for having to weigh up a fairly blunt set of options to a complex situation that could have been prevented from occurring in the first place. I'll properly tell that story only many years from now.

FRANCIS DUFFY

Meanwhile, I read about incidents like that of mental health nurse Francis DUFFY – the Independent Police Complaints Commission have undertaken an investigation into "allegations that officers failed to attend an address to detain him under the Mental Health Act" in February of this year. Two days later Mr DUFFY was found dead in his own flat after further concerns were raised. Of course, the punchline of this incident can be quickly reached: officers had no power whatsoever to detain him under the Mental Health Act because in was in his own house – and yet there was still a misconduct investigation into a control room sergeant's decision-making, albeit she was cleared of any wrong-doing.

Paramedics had attended Mr DUFFY's home address on the 4th February and were there for several hours attending to various concerns whilst he was heavily intoxicated. The attending paramedic formed a view that he needed to be detained for his own safety yet made no attempt to contact the mental health trust crisis team. She stated at the inquest into Mr DUFFY's death that in nineteen years she had become accustomed to them saying they would not attend someone who was so heavily affected by alcohol. When I read of that remark, I admit to thinking, "Fair enough!"

I fully appreciate why such doubts would emerge, but I also know why it's regrettable we don't push as far as we can. I've seen for myself disengagement by mental health professionals and organisations from those of us who are intoxicated whilst vulnerable because of mental distress and it's not unreasonable to assume that the reaction you've had the first hundred times you tried to get such support will be the reaction you get when you call again. But we all know that it can create the perception of

indifference if efforts aren't made to do the right thing. The paramedic called for the police and according to the report in local press made "a request to have him detained for his own safety."

A disclaimer here – the article I'm responding to does not explicitly state whether Mr DUFFY was known to mental health services and / or in receipt of care from them. Reading between the lines of the Coroner's recommendations, I am assuming he was otherwise his would not be a case that would need clarification about the crisis team's role.

POLICE POWERS IN PRIVATE PREMISES

So here we go again – police officers have no powers in someone's private home unless there is a criminal offence, a Breach of the Queen's Peace or circumstances where the Mental Capacity Act could be applied to a literally life-threatening situation. Accepting completely that I cannot find anything else on this incident beyond the local media coverage which I've linked, above – that news piece reads in such a way as to mean it was always obvious there would be difficulty in an approach that saw the police as the solution to a problem. Whilst he was very intoxicated, that's not illegal in your own home.

Mr DUFFY had rung the ambulance service threatening to kill himself. It was latest in a long series of 999 calls that had seen him prosecuted for an offence under the Telecommunications Act and he was awaiting an appearance at the local Magistrates' Court. The paramedic found him intoxicated that day and a post-mortem blood test showed that he was over five times the legal limit for driving. Nothing in the article jumped out at me to suggest there was anything there the police could do that a paramedic couldn't.

This case shows a particular problem that was further compounded by a decision not to contact the mental health crisis team. We know from the *Essay v SLAM and the Commissioner* case in 2010 that in situations where detention under the Act is considered necessary in a private premises, the Mental Health Act offers 'a full suite of options' – the judge in *Essay* made it clear that 'there is no lacuna' in the legislative framework.

So there – it must be true!?

MENTAL HEALTH, MENTAL CAPACITY AND ALCOHOL

What about the alcohol consumption? Well, if I had a pound for every time I've heard the line "you can't assess someone under the Mental Health Act

who is under the influence of alcohol", I'd be stressing considerably less than I am about the bill to get my car through its MOT just prior to Christmas.

Chapter Four of the Code of Practice to the Mental Health Act is often cited in these discussions, but even the Code doesn't preclude assessment in urgent circumstances. If someone were intoxicated whilst detained under section 136 MHA, then by all means let alcohol wear off if someone is safely and legally detained somewhere. But in this situation, Mr DUFFY was in his own home.

The question has been asked about whether such an amount of alcohol could affect his capacity to take his own decisions – and in principle, it could. Whether that could have been relevant would depend upon some particular specifics that aren't covered in the article. However, we do know that even if the paramedic had been able to declare that Mr DUFFY lacked capacity to refuse medical treatment, it would have still required additional concerns to allow the police to act on her behalf by removing him 'for his own safety'. You will remember that section 4B of the MCA requires that in order to deprive someone of their liberty it must be considered the least restrictive way of acting in someone's best interests and "necessary to provide a life-sustaining intervention" or to do "a vital act to prevent a serious deterioration in their condition." Whether or not these criteria were met, I cannot say and I make no judgement either way.

I can imagine it both ways 'round and I genuine wonder about the sense in which the paramedic thought Mr DUFFY's safety was compromised – the word 'safety' as opposed to 'health' inclines me to think that there were no immediate thoughts about life-threatening risks to his physical health, if we even accept a dichotomy between the 'mental' and the 'physical'. Either way, we do know that if urgent assessment or detention under the Mental Health Act were required, then it would require an AMHP and Doctor to attend the premises. That would be accessed through the crisis team that the paramedic didn't contact – whilst I can understand why she didn't, it probably should have been something that was tried.

What we can safely say, taking the description of the incident at face value, is that the police were never going to be the solution in this incident because they don't have relevant legal powers. This does show, however, the ongoing assumption that the police can coerce people and keep them safe in all the circumstances where we might want them to be able to do so.

Well, **we can't!** – And that is actually just *exactly how your Parliament wants it.* It has always been my view that the law we have is adequate only for services that are not configured as ours are – we either need to change our services or we need to change our laws. The latter is not going to

happen anytime soon and that only leaves one option – which will need to be paid for!

10th December 2014

Confusion, Conflation and Contradiction –

For an issue that is increasingly on the radar, the debate we're enjoying about policing, mental health and criminal justice is all too often void of certain important details. I suppose it's easy for me to say this – I get to do this stuff all day, every day and phrases have long since been thrown in my direction like 'lives and breathes' or even 'totally obsessed.' Fair enough, I suppose!

We see confusion in many areas, especially on anything connected to the 'Place of Safety' concept. I've said this before, but let's take time to remind everyone:

CONFUSION

A "place of safety" is a legal construct for those of us who are detained by the police under the Mental Health Act. It is **nothing whatsoever** to do with anything if someone is arrested for a criminal offence or detained under any other law – and it is **nothing whatsoever** to do any with anyone who is not detained at all. So whilst hospitals, police stations and so on may well be "a place of safety" there is no point having a conversation to that effect unless you're referring to or dealing with someone is who is detained by the police under ss135/6 of the Mental Health Act.

We saw last year how confusing this can be: Panorama set out to show how dreadful it was that vulnerable people in Southampton were being detained in police custody by Hampshire Police when a place of safety should be available, only to demonstrate this point by showing a lot of individuals who had been arrested after allegations of offences. Even some of the officers in the programme bemoaned the fact that they had to take people to custody instead of being able to access health services yet the law says that the people featured absolutely *should* be in the cells. That's what the Police and Criminal Evidence Act demands in this situation. The programme was saying, "Look at the police, acting just as the law says they should whilst being confused about it."

We saw this again last week after a piece in the local media about a man in Norfolk who had been arrested for a Public Order Act offence. Questions had been raised about his mental health in police custody and after

assessment he was in need of admission to hospital under the MHA – a lack of bed provision meant there was a wait before a hospital application could be made and the bed involved was 175 miles away, in Brighton. The piece starts with the normal narrative and then bridges a link to place of safety statistics by referencing the recent incident where a 16yr old girl was held in custody for two days in Devon. Of course, place of safety statistics are irrelevant here, except as general indicator of a related, yet totally distinct problem.

CONFLATION

Then we have the issue of when someone is 'sectioned' – the Norfolk article just cited made this error, when it talked about someone being 'sectioned' when there was no bed. I've argued before that police officers misunderstanding when someone becomes 'sectioned' has caused more problems and illegal detentions that we realise and it appeared to happen in the Devon incident, also. To talk of someone being 'sectioned' is to use informal, non-legal language. In practice, it usually means that someone has been made subject to an application by an Approved Mental Health Professional for admission to hospital under the Mental Health Act. It will usually relate to section 2 or section 3 of the MHA, but it can relate to s4 as well. The informality of this term 'sectioned' is seen by the fact that occasionally, it is used by others to mean other things: I've heard of police use of section 136 be referred to in this way and mental health professionals often object because that is something only 'they' can do. The reality is, it is informal language that could mean any number of things.

But there is something really important about this term when used in its common context: the point at which someone becomes 'sectioned' is that point at which they may be detained against their will be others. It is initially the AMHP making the application who gives effect to the condition of 'legal custody' that follows the application to a hospital. They may then detain and convey that patient under s6 of the Act to hospital and may authorise others to detain and convey on their behalf. **But until that AMHP makes that application to hospital no detention framework exists under the MHA**. So where someone is arrested for a criminal offence or to prevent a Breach of the Peace, they remain subject to the legal imperatives that follow from arrests until such time as an AMHP makes a full, complete written application to a hospital. Where the AMHP has medical recommendations from a Doctor on which to base an application, but they have not yet made it because they don't know which hospital has an available bed, the person concerned is **not** (yet) 'sectioned' under the MHA. If the person were already in police custody, they remain subject to the Police and Criminal Evidence Act 1984 or to the Common Law implications of detaining people who were occasioning a breach of the peace.

As we saw in Devon: arrested on Thursday evening, application made on Saturday afternoon or evening. The time in custody must firstly be justified without reference to the Mental Health Act. There is a potential that any police force who has done such a thing, may be able to rely upon s139 of the Mental Health Act to protect them from liability, but such circumstances have yet to be tested against this argument so we're not fully sure! Ordinarily, someone arrested to prevent a Breach of the Peace would be placed before the first available Magistrate and three sets of Magistrates are normally available between Thursday night and Saturday morning. As we saw in Norfolk: a man was arrested for a Public Order Act one day and detained for over 24hrs until eventually an application was made. Again, s139 may protect a Chief Constable from liability arising from this, but that doesn't render the actions legal.

CONTRADICTION

We've seen in recent years a range of stated cases which demonstrate that police officers really, Really, REALLY do not have powers in private premises to manage mental health related incidents. We saw that the practice of arresting to prevent a Breach of the Peace and then detaining someone under s136 when outside the premises was unlawful in the Seal case; we saw in the Essay case that relying upon the Mental Capacity Act in non-life threatening circumstances is not possible; and finally, the Hicks case has demanded that any arrest to prevent a Breach of the Peace must be made with an intention to place the person before a Magistrate. It is therefore possible to listen to people describing scenarios and, with reference to these cases, rule out coercive action unless the person is also alleged to have committed some kind of criminal offence, as in the Webley case.

So one night earlier this year, the police received a phone call from the ambulance service. A paramedic was in someone's private home that person was believed to have long-standing mental health problems and they were intoxicated. No-one was committing an offence, nothing seemed to indicate life-threatening risks and the police were asked to detain the man 'for his own safety'. Under what law? I'm not really sure any framework of detention could be invoked by the police. On this occasion, the control room sergeant formed this very same view and said so. Whatever needed to happen, it wasn't something the police could do on their own terms, so no officers were dispatched. Two days later, after the man was found dead in his flat, an IPCC inquiry was launched into the decision-making of the sergeant in the control room. I can't say whether or not the paramedics' decision making was investigated on the same footing, but the Coroner's Inquest found problems in how the NHS communicates roles and responsibilities. The sergeant was cleared of any misconduct, but what a way to have to spend 2014 – under investigation following the death of a vulnerable person because you (rightly!) asserted

that you had no powers to act and did so knowing that another professional was in just as good a position as any police officer to ensure safeguarding.

This is the contradiction we see, that won't be corrected anytime soon: the law states the police do not have all the powers in all of the circumstances to coercively safeguard people at risk. Some of those powers belong to others. When the police have historically tried to get around the rules, they have been taken to the civil courts and lost. When the police have tried to adhere to the legal frameworks laid down by Parliament, people look at them aghast for leaving people at risk and their decision-making is scrutinized with all the potential for gross misconduct hearings to follow. We also we see contradiction in the way we look at our police service to manage the most challenging of vulnerable people, those who are resistant, aggressive or violent – whether in public or even within mental health units.

CERTAINTY

Police officers and forces need to understand how to navigate these waters: how do you police incidents responsibly where you need others to do things they're not willing or able to do? When the next 16yr old is in custody, do you release the person or keep them detained; when you feel you have to use s136 on someone to keep them safe and they respond with protracted resistance to detention – quite possibly because they are just absolutely terrified – do you take them to custody because the NHS haven't commissioned services to manage their clinical needs or because it's too difficult to manage them through existing services?

How do you write-up your notes, your incident log or your custody record in such a way as to ensure that if you do end up doing something for which you're struggling to find clear legal grounds, you maximize the chance that those who look back in hindsight will find virtue and morality running through the decision-making and a clear absence of other options?

So this interface is about finding the least bad option amidst confusion, conflation and contradiction.

18th December 2014

Serendipitous Timing –

Please bear with the typos on this post, which I will correct later this evening – done on a very fast train, in a hurry and I have a raging headache from trying to proof read at 135mph. I wanted to get it 'out there' so here it is, warts and all – they will be surgically removed in a few hours!

You may be aware that the Government has spent the last year or more reviewing various aspects of the Mental Health Act 1983 (MHA), mainly focusing upon sections 135 and 136 of the Act. These are the legal powers that relate to emergency police intervention in public places and to warrants to enter private premises and remove patients in need of assessment to a place of safety. The review is published today and you can read it in full, for yourself.

1. The full report

2. The executive summary

3. The easy read report.

This post intends to summarize the highlights for you, whilst reminding that this document, in itself, means little and nothing happens immediately. It amounts recommendations for amendments to primary legislation, it would require an Act of Parliament for these things to take effect and we already know this will not be attempted until after the 2015 General Election. We may see a Green Paper putting forward suggestions in the spring, but Royal Assent to any changes will not occur for at least a year and in theory, may not happen at all, depending on the political outcome in May. Some of the findings within the review will feed into the parallel review of the Mental Health Act Code of Practice which will probably be revised in April 2015.

But first I want to divert our attention to something which may appear quite unrelated.

THOMAS ORCHARD UPDATE

The CPS and the IPCC have announced that a police custody sergeant and two civilian detention officers will be charged with manslaughter and misconduct in public office following the death of Thomas ORCHARD in Exeter in October 2012. Mr ORCHARD lived with schizophrenia and was arrested for an alleged offence under the Public Order Act 1986 before being restrained and removed to a police station. Although not detained under the MHA itself, it has been argued that he should have been given that this arrest followed a marked deterioration in his mental condition and it has already been public remarked by Mr ORCHARD's family that the mental health trust were 'on the verge' of sectioning him.

Following arrest there was a protracted restraint related intervention and he was taken to police custody. The facts of what followed will now be subject to a criminal trial so are not for comment here, but it can safely be queried why the prolonged restraint of a mentally ill man led to removal to police custody given everything we've known for decades about the dangers of restraint and how prolonged restraint of psychiatric patients should be treated as a medical emergency (according to experts who gave evidence into the death of Rocky BENNETT).

So as you read today's document and contemplate the highlights, bear in mind that the National Institution for Health and Clinical Excellence, whose job it is to draw up guidelines for the NHS, are currently consulting upon updated standards for the "the short-term management of violent and physically threatening behaviour in mental health, health and community settings". These will potentially replace the 2005 standards already in operation. I admit to still wondering how all of these things square up together, especially given the implications of existing multi-agency standards published by the Royal College of Psychiatrists on Section 136 MHA? Police officers prosecuted (again) in the criminal courts in connection with the removal to police custody of resistant, frightened and vulnerable people allegedly failing to take account.

Perhaps I'll learn details in the trial to come that helps me to understand?

REVIEW HIGHLIGHTS

They are four things to focus upon, although the document does contain much more, especially about issues which have been referred to the update of the MHA Code of Practice.

- An end to the use of police cells as a place of safety for anyone under 18yrs of age.

- Reduce the timescale for detention in a place of safety from 72hrs to 24hrs, with the possibility of extending this only in defined, exceptional circumstances.
- No legislative change to police powers in private premises – and little concrete suggestion of what will be done instead despite admission of a real problem.
- A definition of sorts, for what 'exceptional circumstances' mean when cells may be contemplated for use in the case of detained adults – see below.

There are many suggestions which have been highlighted in the legal review that have been made known to those at the Department of Health who are updating the Code of Practice to the Mental Health Act – this document is also under review with a view to a new Code by April 2015.

WHAT A DILEMMA

For me, I don't wonder whether some of the things in here will be achievable – it's fine banning children in police custody, who could disagree with that as an aspiration? Reducing time limits from 24hrs to 72hrs – again, who could argue that is a worthy aspiration? Why should someone people with mental health problems be able to be detained anywhere, but still including police custody, for longer than the police can detain a rapist? – it sends entirely the wrong message. But we know that some delays in managing people under s136 arise from an inability to identify a bed into which a patient can be admitted. This is like the 16yr old girl example in Devon last month, as the MS v UK [2012] case. Assessment occurred relatively quickly, but there was no bed. Shortening the period within which one must be found when bed capacity is still so problematic that areas sometimes struggle in 72hrs, is only going to increase the number of times that custody sergeants or place of safety staff reach the legal time limit and then have to ask themselves, "Do I now shove this vulnerable person out into the street or do I illegally detain them?" There would need to be alterations to how beds are commissioned – specifically, on how many beds are commissioned – to re-build sufficient flexibility into a system and allow Place of Safety assessments to be expedited in this new timescale.

Something that is not mentioned in the review is the point at which someone becomes 'sectioned' – it was outside the original scope of the review which focussed on ss135/6. The Devon case referred to earlier shows this beautifully — the young woman was arrested on Thursday evening and assessed under the MHA on Friday morning. It wasn't until Saturday afternoon that a bed was identified and she became 'sectioned' – more formally known as 'liable to be detained'. Somewhere between being assessed and the application to that bed being found, her detention became legally quite vague given that she was arrested to prevent a breach of the

peace and three sets of Magistrates had come and gone who could have heard the matters into her alleged Breach. Imagine she had been detained under s136 MHA in a public place – under potentially new laws, she would not have been able to be held in police custody that evening, but the local area has no CAMHS PoS provision and in any event her assessment would need to have concluded by Friday night. We know that it didn't and we know why. Nothing in those problems is addressed by reducing the timescale so we will need to hope that CCGs accept the implications of any new amendments to the MHA as a motivation to commission PoS provision in their area for every kind of child detained.

PRIVATE PREMISES

This dilemma will remain very real and we saw it writ large in a Staffordshire Inquest earlier this month. A paramedic in attendance at an address who was dealing with an intoxicated man with mental health problems called for police intervention to help keep him safe. The police sergeant took the view that the police had no powers to do what they were being asked to do and refused to attend. Although she was cleared of any misconduct arising from that decision, there was an IPCC investigation after that man's death for the decision not to attend. I accept fully that this review document makes recommendations about this issue – I believe it was taken seriously as a problem area, not least because police officers are not the only people arguing that we lack the legal tools to keep people safe. That said, we know that parts of the Mental Health Act are ignored in a variety of circumstances; the Code of Practice has been ignored on an almost industrial scale for years so I can't help but form the view that recommendations may be unlikely to have an impact.

What we know about these issues is that police officers cannot lawfully keep people safe in all the circumstances that unfold in the real world. We also know that thirty years of the MHA has shown local authorities do not staff their AMHP rotas in such a way as to mean that urgent MHA assessments can be set up in an hour or two. We also know that AMHPs in some areas won't accept referrals or requests from police officers directly – despite their being a legal duty on AMHPs to consider requests for assessments! Given that history and the restrictions on services that we're seeing, it still seems reasonable to suggest that we either need to change the way that other services can support the police or we need to see a change to legal powers.

I was always explicitly clear: I agreed that extending police powers would be the regrettable last step and if people could up with other ways to ensure that vulnerable people are consistently safeguarded, I'd be interested to learn what it is and would support it if it were realistic. For me this review leaves this question hanging.

BEHAVIOUR THAT IS SO EXTREME

Within this review, consideration was given to what 'exceptional circumstances' means – this is the phrase used to try and determine when it may, on some occasions, be acceptable to use a police cell as a place of safety. The review introduces a phrase to help define this: "Behaviour that is so extreme that it would prevent someone being safely managed in a health setting." You mean a bit like in the case of Thomas ORCHARD? Or like Sean RIGG? Or Michael POWELL? Or James HERBERT? Or Colin HOLT? Or Leon BRIGGS? … do I need to go on?!

You'll see the not very subtle point I'm trying to make here: most of the major, high-profile deaths in police custody or following contact that have involved vulnerable people with mental health problems have involved those individuals being resistant when detained, quite possibly because they're frightened by what the police are suddenly trying to do to them. In all of those cases, people were taken to custody and in some of those cases the very decision to do so, was the basis of criminally prosecuting the officers. Even in other cases where we should be thankful someone did not die, protracted detention in custody waiting for psychiatric beds was argued to amount to a violation of Article 3 of the European Convention. We know that two police forces are being corporately investigated for potential Health & Safety Act offences arising from these things.

We also know this: the Police and Criminal Evidence Act 1984 demands that custody sergeants give regard to whether or not anyone brought before them under arrest, whether for alleged criminal offences or under any other law including the Mental Health Act, has any apparent medical needs. Where they do, it is incumbent upon the custody officer to call an Approved Healthcare Professional to custody or to call an ambulance and transfer that person to hospital. I worry that any legislative amendment or Code of Practice clarification of what 'exceptional circumstances' means in practice, would have the effect of creating an impression in the minds of many health professionals, that it absolutely is the role of the police to detain some of the most challenging, yet acutely vulnerable adults in custody – away from healthcare support – despite what we should have learned from the cases mentioned above.

CONCLUSION

So I can't help but think that we would need to see the details of how these recommendations would be brought in, if they're brought in at all. There are some superficially attractive proposals in this document that few would argue with. The review also leaves some outstanding issues that means it remain difficult for police officers to call upon the requisite support from mental health trusts and / or local authorities when handling mental health emergencies in private premises. We know that street triage is assisting in the management of some of these calls, but we also know it's making little difference to others. Yet this review must be taken as a re-affirmation by our elected Government that the public, partners and politicians really, Really, REALLY don't want police officers taking unilateral action in private premises. Whether or not AMHPs, Crisis Teams or anyone else will react differently to future requests for support, I don't know. Current feedback from many AMHPs that they lack the resources even where they don't lack the will. Either way, early in the New Year, I will be writing guidelines for officers on how to police these incidents that will have to involved ensuring that the police have given every opportunity to health and mental health services to provide responses to people that officers believe are at risk and to be accountable for their response to that request, according to law.

And what do we think every custody sergeant in the country will be thinking today, having learned yesterday that their colleague from the tragic case of Thomas ORCHARD's is to be prosecuted for manslaughter and wilful neglect?! *(Sergeants – it's para 9.5 and Annex H to Code C of PACE that you need to quote in the custody record – as well as your positive duty under the ECHR and the Health & Safety Act 1974 to protect the health of anyone detained and brought to your custody area.)*

21st December 2014

A Disparity of Esteem –

Imagine two medical problems had occurred involving two separate people – an elderly lady suffering a serious asthma attack or chest pains and a young child who falls and hits his head and scrapes his hands after falling whilst playing. In terms of clinical assessment, any paramedics called to the scene may suggest A&E for the elderly asthma / chest pains patient and a local minor injuries unit for the minor wounds and scrapes injury because they probably require cleaning and dressing after a check over. Now help me think through a patient whose medical needs to have two dimensions: imagine our elderly patient fell whilst struggling to breathe and hit her head in the same way as the child. A member of the public sees her fall, notices the breathing problems and injury before calling for an ambulance.

DISPARITY OF ESTEEM

Where these two problems are combined in one patient, you would expect a one-stop shop, wouldn't you? You would gravitate to A&E because of that more serious asthma / chest pains condition and expect them to clean and dress any minor wounds and scrapes whilst they're at it. Surely you wouldn't expect A&E staff to stick a crude bandage around the wound once the breathing / chest pains matter is sorted and send that person off to the minor injury unit to get their head fixed. Right?!

No – you go to the one place that can manage the more serious matters and assuming all things can be dealt with as an outpatient, Accident & Emergency would deal with the lot. Of course, if any medical assessment indicated that person needed further treatment and care as an inpatient, it may be decided that a journey to the appropriate hospital would be needed. But basic assessment of need would all occur in one place and where possible, immediate treatment would occur in one place.

So why does mental health differ in this regard? Why would a physically injured person who is also in crisis or distress be forwarded on to a second location purely because their additional issue is a mental, not physical, condition? Well, actually, not all such patients *are* forwarded on – it's usually only those in the custody of the police who suffer this indignity. Apart from referring patients to their own GP or community

mental health team, A&E have no further place to discharge someone with outstanding, yet-to-be-assessed mental health problems. So they turn to existing Crisis Teams and / or to the hospital's psychiatric liaison service if there is one but those patients in the custody of the police can be forwarded to a second location: either to a health-based place of safety if detained under s136 of the Mental Health Act, or to police custody if there's nowhere else. Another example of clinical decisions becoming predicated upon non-clinical criteria and whether or not someone is in contact with the criminal justice system.

Imagine if it were suggested that the manner, the timing and the location of medical treatment you could receive for a medical condition or injury all hung upon whether the police had arrested or prosecuted you for something?

THE CRIMINALISATION CONTINGENCY

Imagine any kind of illness on a scale of 1-10 in terms of its seriousness and the need for urgent treatment. Level 1 is self-care, level 2 is pharmacy advice, level 3 is "Ring 111" etc., up to level 10 which is you need urgent A&E treatment. Imagine that following a medical emergency someone's need for urgent, unscheduled care is floating up at around 8 or 9 and paramedics are called and imagine one part of several medical matters in play is a mental health condition. It could be someone who has taken an overdose and / or jumped from a height whilst in crisis and seriously hurt themselves. There is a pathway that results from the paramedics' assessment of your presentation that gets you straight into A&E and you jump most of the queue because of the seriousness of your condition. Your two or three distinct but related medical matters are assessed and stabilised in A&E before they determine in conjunction with specialists where you go next and the mental health dimension to your unmet needs benefits from the involvement with the liaison psychiatry team. Imagine that after triage in A&E the overdose turns out not to be serious and there will be no lasting consequences in terms of internal damage or injury from the fall. All of that is fairly quickly assessed and treated and you await the arrival of the psychiatric liaison team

Now repeat that story and replace the word 'paramedic' with 'police officer' after we imagine a situation where there was no available ambulance to assist in initial assessment of need – this is an increasing reality, according to some. Overdose plus injury will still result in A&E, but we can start to anticipate the pathways will differ once we learn that the overdose is non-lethal and the injuries are treated. We can start to anticipate suggestion that the person be moved from A&E – especially if they were detained under s136.

But why?! – what is clinically different about this person or the situation? The only difference here is the nature of the uniform that brought the person to A&E.

I've often joked that to solve some of the problems we see in urgent, unscheduled care for mental health related demands, we would go a long way to solving the problem by having green overalls and clipboards in all police cars. If the officers just swapped into a paramedic's uniform prior to arrival in A&E it would result in a greater healthcare focus on that patient *as a patient* – it would remove the criminalisation contingency and reduce all decisions to clinical ones. But this is a ridiculous idea and whilst it always gets a laugh during presentations I give, it says a lot about the experience of trying to ensure a health focus on health issues when – as a police officer – you have assisted someone in need or when you have detained them under the Mental Health Act. Somehow, your involvement is a game-changer for clinical care.

GLASS HOUSES AND STONE THROWING

Of course, some NHS reaction to police removal of vulnerable people to A&E under s136 occurs because of police overuse of section 136 and because of the all-too-keen instinct of police officers not to have to sit around for hours in A&E departments or places of safety. We're already only part way through a journey to see more use of NHS based places of safety that our NHS is busy rising to that challenge. Figures published recently week show that we have now reduced the use of police cells to just over 6,000 times a year. Those who have followed the street triage debate over the last couple of years will have noticed a lot of NHS areas are seizing upon the initiative as a method by which to reduce the number of section 136 detentions they have to assess, by ensuring methods by which the police can bring people into faster contact with a mental health professional, without the need to legally detain them.

It needs to be recognised – the impact upon our NHS in having to handle assessment after assessment where the grounds for detention were not really thought through. I have written elsewhere about this, but it is essentially the speculation that behaviours thought by the police to be suicidal or non-normal (whatever that means) when people are intoxicated are attributable to a mental disorder. This is a really difficult call. Police officers have often asked whether someone stating they want to hurt or hill themselves whilst drunk should be taken as a sign of a mental health problem? This is question which a future blog will address. My summary answer is: if intoxication has reached the level of someone being 'drunk', then we should be very wary of making this leap. Unless the officers also have objective, independent or third-party evidence of someone's mental health issues, we should deal in the first instance with the drunkenness,

public order or other offences in front of us. If there are still concerns after someone sobers up, then mental health assessment can still be effected in police custody – and all of this whilst remembering the potential that whilst intoxicated, risks remain elevated that the alcohol is masking a medical condition. A&E teach doctors not to attribute anyone's presentation to alcohol until everything else is ruled out.

Commissioners and senior officers who should be sitting down together just about now to discuss how they are going to draft the local crisis care declarations; a requirement of the Crisis Care Concordat – **they have to be done by December 31st, folks!**

They should all be thinking about why the blockages arise and what they can do about them –

- Proper training in the police application of section 136.
- Effective diversion arrangements to avoid the need for section 136.
- Proper arrangements in section 136 PoS facilities.

Unless you start putting all of these together, you'll keep having a system that is not built to absorb the nature and variety of demand to which section 136 of the Act gives rise. And it's when the system can't absorb the demand that you start to see particular parts of the system pressuring the others – this is what links us back to the original point about two-stop, mental health shops which are never, if ever, patient focussed.

31st December 2014

Ebola –

We've now seen a couple of case of Ebola in the United Kingdom, each of them healthcare professionals from the UK who volunteered to travel to west Africa to assist with the looming disaster there. I couldn't be prouder of those nurses for their work and nothing that follows is about the healthcare that they will now be receiving. Indeed, my admiration for the first British Ebola victim, William POOLEY is immense following his decision to return to Sierra Leone to continue his volunteer work. Quite simply, inspirational stuff – and so this post is not to argue that anything we're doing on Ebola is unnecessary or over the top. It is absolutely what you would expect to see happen and very obviously necessary.

Prior to Mr POOLEY returning from Africa having contracted the condition, I remember watching the evening news and seeing a BBC report about what would happen if and when the UK did find someone with confirmed Ebola within our shores. You may remember, airports including Heathrow as an international hub, implemented various screening measures for passengers travelling from affected countries and we were able to see the special isolation areas at the Royal Free Hospital in Hampstead, London where patients would be taken. News this morning confirms that Pauline CAFFERKEY, a nurse from Lanarkshire, has been taken there after returning from a month of working in the 'red zone' in Freetown, Sierra Leone – the most dangerous area to work. You can read more about their stories, Ebola and the various responses to this international problem by choosing the links in either of their names, above.

RELEVANCE?

I was struck by an entirely new thought – were you? Why do we know – in detail, with infrastructure in place – the potential response we might need to have to a patient who may never emerge for a condition that we haven't seen for decades? Meanwhile, we don't know what will happen this afternoon with the next s136 detainee who is intoxicated whilst mentally unwell. The likelihood of an Ebola patient emerging is raised far above the ambient threat level we've known over the last few decades because of the scale of this Ebola particular outbreak compared to others. The management of any potential Ebola patient was always going to occur within the Royal Free Hospital's infectious diseases unit and the RFH is

home to the UK's only High Level Isolation Unit. Hence all UK patients are transferred there, even from Glasgow. They are not specifically focussed upon Ebola but would care for any patients alongside others admitted for other conditions that would also require them to be isolated.

But I could help but keep contrast this to preparedness for certain 'everyday' mental health emergencies, including where risks to others exist, including to professionals providing care or support. You could make the same comparison to rare forms of cancer: oncology services still provide the infrastructure and there are specialist facilities and NHS staff for particularly rare forms of cancer. The comparisons could go on in paediatric services or orthopaedics.

Over this Christmas and New Year period, the National Institute for Health and Clinical Excellence (NICE) are consulting upon new guidelines on the management of violence and aggression, updating previous guidelines from 2005. I'm busy reading the full 80 page document during the Christmas / New Year lull where I have few meetings to attend but doing so also made me mentally link back to my above thought: that NHS services acknowledge the reality that on some occasions, psychiatric patients present in various states of distress that include resistant behaviours but we aren't necessarily. So why aren't we prepared for this in the sense of having clear pathways to care, in sufficiently safe environments? We know that the multi-agency agreement, published in the form of Standards on s136 by the Royal College of Psychiatrists, requires areas to commission services which can receive patients "*even when the patient is disturbed*" (p8). We have seen report after report following deaths in police custody that calls for greater access to urgent healthcare pathways for patients detained by the police under s136 where alcohol and / or aggression are relevant to the initial handling of someone at risk.

NUMBERS

Every day in England, section 136 of the Mental Health Act 1983 is used 65 times on average. We know that some of these patients will be known to mental health services, with established histories. We know from the IPCC that 2 people a year die whilst detained under s136 MHA and that resistance to detention, especially whilst intoxicated, are particular risk factors – especially when we remember that people living with severe and enduring mental illnesses are likely to have far poorer physical health than the norm for population as a whole. Alcohol and aggression can mask the ability to tell whether there could be other, co-morbid medical issues in play and incline us to want to push people off to the cells.

We saw only this week that the President of the College of Emergency Medicine calling for those who are drunk and disorderly to be removed to

custody and it was interesting to see the extent to which other doctors waded in to that debate on social media, pushing back against his idea. They were counselling against precipitate clinical decision-making which could leave doctors open to allegations that they had missed underlying problems – some of them were sharing the things they'd missed in their clinical careers by such hasty judgement. This remains true, if not more likely, where a patient is 'drunk' and 'disorderly' because they have self-medicated to stop auditory hallucinations or delusions and / or injured themselves. If you apply the historically difficult exclusion criteria to that 65 a day, it could be as many as 30 or more who would be excluded from the NHS on the grounds that their presentation involved intoxication or aggression, all dependent on how they select and apply their particular criteria. So what is the plan, given that we know many of those 30 are at greater risk if detained in police cells, away from clinical supervision?

I repeat a standard caveat that I've mentioned many times: the police in some areas over-use s136 MHA and some officers are too quick to opt for this power when others should be chosen. It has been my view for some years that use of s136 could be lowered if we just took the time and trouble to provide proper, detailed training on its application, on less restrictive pathways, and this should including specific guidance on what 'mental disorder' means; and on how 'immediate need' and 'care or control' should be interpreted. If we did this – as we do for stop / search, domestic violence and child protection, then officers would be likely to make better informed decisions.

Nevertheless, it comes back to this: we know the healthcare infrastructures by which we will manage a condition that had not been seen in the UK for decades until August this year and which is yet to kill anyone in this country – indeed the cabinet committee COBRA met yesterday under the chairmanship of the Health Secretary and then, the Prime Minister. Such is the prominence of this issue. Meanwhile in other (unreported) news, we don't know where this evening's s136 detainees will be taken so that they are safe, if they present in distress to police officers or paramedics whilst aggressive, intoxicated or both. Why not? Such patients have no less right to care than either of the inspirational nurses mentioned above and first presentations of those of us who experience mental health emergencies can also involve, occasionally, wider risks to the public and to the professionals in the police and NHS systems who are responsible for providing safety and care. We will probably see way more than two of these incidents before tonight's celebrations in Trafalgar Square.

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